Please stand by for realtime captions. >> [Captioner Standing By]

Good morning, I'm going to call this meeting to order and just in case you do not know medical services board for Colorado . Blakely present. >> [Roll call] >> Okay, good morning. I think you have some folks to introduce us to that we are thrilled to meet.

I do in fact, I have three folks to introduce. I will start with the new Medicaid director Dr. Tracy Johnson.

[Applause]

Dr. Johnson brings more than 20 years of experience in health policy and program development, research and evaluation. In health policy and management from the John Hopkins, Johns Hopkins Bloomberg School of Public Health as a biography and ethics so starting next month we will have her on a permanent basis. Thrilled to have her. We also joined by Rachel our new legal division director, she joins us from the Attorney General's office. We have worked with Rachel for a long time and we are thrilled she decided to come over and join us here at the department so she will be our in-house advisor. So please feel free to welcome Rachel and also join us is ours new liaison , Nina was at the department when I worked at the office of information technology and we were able to bring her back to be the new legislative liaison bringing a wealth of knowledge and experience and we are looking forward to having her help us with our legislative agenda this year.

Welcome. Anybody have any questions for them? Any personal welcomes? Okay. Thank you very much for all of your service we appreciate you. Okay so we will go on to the general announcements, the date and location of the next medical services board meeting is scheduled to be Friday, October 11. Beginning at 9:00 A.M. 3:03 E. 17th Avenue Denver 80202. It is the policy of this board and the department to remind everyone in attendance this is a private property do not block the doors or stand around the edges of the room, please turn off cell phones in the meeting. I want to welcome you to the Friday the 13th meeting. I love when they are Friday the 13th, and a full moon we are excited about that. I am looking, [Inaudible] you are right a palindrome of dates this is fun.

This should be a great meeting.

Almost like a Halloween meeting. Okay so I am looking for a motion for approval of the minutes from August 9 or any corrections.

A motion and a second all in favor? Aye. Opposed? Dr. Fraley.

Hello.

Dr. Lippolis have you join us?

Yes I have.

Okay motion passes thank you. Let's move into the emergency rules adoption. And do you want me to read this?

When we have the presentation and we are ready to move .

Okay got it, good. So do we call Michelle? We do. Good morning.

Good morning.

Thank you for joining us. >> Thank you for having me.

Good morning my name is Michelle Greg and and the supervisor for the complex program development and evaluation unit in the office of living at the department. I am here to present an emergency rule for the home and community-based services children's habilitation residential program, this was adopted as an emergency rule in June 2019, scheduled for final consent agenda for August 2019 but inadvertently was not included on the agenda. The rule is presented again today to ensure there is no break in coverage of the rule between the expiration of the first emergency rule and final adoption. Incorporating changes by House Bill 18 1328 to improve services for children with intellectual and developmental disabilities and complex key changes one transfer of the administration of the waiver from the Colorado Department of human services to the Department of Health care policy financing which occurred July 1, 2018. Removal of eligibility requirements that the child or youth is in foster care historical families have been faced to get much needed out of home services when they are working with dependency and neglect issues. Transfer of case management from human services to case management agencies specifically the community center we specialize in services for those with intellectual disabilities as well as changing the case management services in the state plan. And for the addition of services to support children remaining in the family home to transition back to the family home. This rule is quite a long document as I am sure you have seen and significant changes have been made throughout, this is due in part because of the implementation of the changes authorized by the House Bill and that the waiver had not been updated in five years I will provide a high-level overview of the main areas of the rule we revised. First I would like to reiterate a thank you to all the stakeholders who have participated in this process there has been a variety of stakeholder engagement over the last year including benefits collaboratives multiple meetings with community boards regular meetings with County departments and services, rule revision meetings. Support need level assessment stakeholder meetings individual communication and statewide visits, stakeholders of parents and families advocates and case managers, unity centered board staff, local hospitals, health professionals, regional and accountable entities, representatives from the Department of human services, the County Department of human services and the Colorado . We look forward to this collaboration. Moving onto the main rule revision there as follows one references to the Colorado Department of human services at the administrative agency administering agencies were removed, the welcome requirement and Social Security income financial requirement were removed. Three, define additional eligibility criteria for children with extraordinary needs to put the child at risk of or in

need of out of home placement. Also to incorporate much of the stakeholder input and suggestions into finding extraordinary needs with complex medical support needs. Remove references to the County Department of human services providing case management and align case management functions with the rules on case management and quality performance. Align the waiver service definitions in the rule of the waiver itself and add the services of support , these services were designed to our benefit and we were able to incorporate much of the stakeholder input in the development of the student services. This at a requirements for rights modifications to be in compliance with the federal home and community-based rule for example requiring [Inaudible] lastly incorporated by reference the rule contained in the Colorado Department of human services quality standards for 24 hour childcare facility regarding the use of restraints, rights modification and the rights of children and youth, the reason is the habilitation service and out of home respite will be provided in homes or facilities that meet the requirements for child welfare settings even if there is not child welfare involvement. Since the adoption of the emergency rule in June we have made additional technical changes to the rule based on additional stakeholder feedback, comment from the Secretary of State and the Attorney General's office. Changes are highlighted in yellow in the document and those changes were made to include changes for consistent and clear language, correcting regulatory citation and for example the inclusion of a nurse practitioner or physician's assistant to be able to provide the diagnosis for the eligibility criteria. Those changes were made. With that I think I covered the main areas of the revision so let's stop and see if there are any questions. Do I have any questions? Anybody on the phone have a question?

No thank you.

Okay none. Hearing none. Thank you very much. Okay. [Inaudible]

There is not. Just wanted to make sure.

We are doing public testimony now. Anybody? Anybody have a desire? I do not see anybody. Okay we can move on.

First paragraph at the top. And then we will document that.

Move that all emergency rules adopted include the finding others that the immediate adoption is necessary to comply with state or federal law of regulation or for the preservation of public health safety or welfare and the compliance of CRS would be contrary to the public, I move the emergency adoption MSB 19-05-29-A revisions to the medical assistant rules concerning children habilitation residential programs incorporating the statement
of risk for specific statutory majority. >> We have a motion and a second all in favor? Aye. Opposed? On the phone?

Aye. >> Okay I heard aye ?

Aye.

Thank you very much. Okay. Document 10. [Inaudible] both coming up or just one? >> Welcome, good morning. You look dapper today.

Thank you. Good morning my name is I am the compliance officer at the department here to present [Inaudible] >> Can you talk up a little bit louder?

Here to present the adult dental annual limit increase rule. The 2019 long bill passed assembly decreasing color rate Colorado meant dental to $1500 effective July 1, 2019,
this board adopted the dental annual limit increase as an emergency rule to align with the long bill making the rule effective July 1, 2019 and again adopting as a permanent rule today.

Anybody have any questions?

Everybody has read everything and there are no questions. Anybody on the phone have a question?

No thank you.

Okay thank you.

We do have testimony.

Can we call this [Inaudible] thank you very much come up and identify yourself and who you are with. We do have come I think I read we have a five minute limit on testimony.

This will be very short. And from the Colorado dental assistant Heidi [Inaudible] so we support this adoption of the bill. We are granting dental programs and what we know is that it often the expense is either not ready for dentures or [Inaudible] so we are excited to see this increase because it would mean a lot of seniors or older adults will be able to get treatment in a timely fashion because they adopted the benefit.

Wonderful, thank you. We love to hear the positives. Thank you so much. Okay with that I will entertain a motion for the emergency .

[Inaudible] the top has been read.

I wanted to really nail it down.

Yes. Yes. Emergency adoption of document MSB 19-05-29-A revision to the medical eligibility rule concerning adult dental annual limit increase section 8.20 1.6 incorporating participants and specific statutory authorities into the record.

Second.

All in favor? Aye. On the phone?

Aye this is Dr. Fraley.

Aye Dr. Lippolis.

Thank you very much. It is appropriate you read the motion and you are a dentist. Thank you for your work we are thrilled for this bill, okay so passes. Off we go. We will keep him here. We will ask you to get up okay got it. Ready.

Another quick one. Good morning board members my name is Russell Sigler I am here to present [Inaudible] prenatal dental rule, Colorado revised statute 25.5-8-107 prenatal dental rule, Colorado revised statute 25.5-8-107182 and

plan plus coverage to pregnant women of any age effective October 1, 2019, under current rule only child health plan enrollees 18 and under are eligible for dental services. Under this rule and revision we are aligning the rule with state statute by expanding dental coverage to the plus program to enroll women of any age. To align with the statute , orthodontic services however for pregnant women 19 and above are not included in this dental expansion for child health plan plus. Neither the tele-plan plus program covers services for adults. That is all I have got, thank you for your time do you have any questions?

Anyone have any questions?

Thank you very much for presenting. I want to make sure I am getting my math correct on this particular issue. 878 would be eligible which is great. To set it up it is $310 per person to set it up with $190 worth of benefits? That seems out of whack. Is there a mistake with those dollars?

I would have to talk to the dentist service specialist.

Can we ask you to come up? Thank you.

[Inaudible]

You are correct that was the amount assigned due to system changes that were necessary on our end for these encounters of prenatal women. We do understand we have a draft of the legislature and the cost of implementing this and what the changes look like. We agreed there were some concerns from the legislature but that was the amount.

Great question. Any other questions? You may always ask.

By way of response we do not set that, that is done by legislative council. As they go to the bills. They put on their , I wish we had control but that is outside of our purview.

Okay thank you. It just seems ridiculous that it would cost that much to set up this great and wonderful lovely benefit, something seems off if it costs that much to receive encounters at 878 people.

When it comes to the application we tend to be conservative with the estimates and they may be overly conservative when there will be more

funds available regarding services. With processing and programming . >> The only eligible ones are pregnant [Inaudible]

[Laughter]

My son is eight now. It was a while ago. Do we have any other testimony?

I did not see questions did you have a question? Any questions on the phone? Okay no public testimony. We will entertain a motion.

IMovie emergency adoption of document 11 revisions of the plan for dental section 210 W incorporating statement of basis and purpose of specific statutory authority.

Second.

A motion and a second all in favor?

Aye

So passes.

Aye.

Aye .

So passes. Getting ahead of myself. Okay off we go, thank you so much for all your work and thank you for the answer. Okay we are going to the final adoption consent agenda and just read the motion. Let's just read the motion.

Final adoption of document 1 19-07 -17-A revision to medical assistance benefits concerning pharmaceutical section 8.800.4 point V incorporating statement of specific statutory authority contained in the records.

Motion and a second all in favor?

Aye.

Opposed?

Dr. Fraley, aye.

I heard Dr. Lippolis to give a much. I will stop doing that and calling you by names so we can do one at a time. Okay. So passes. We are going now to January , I can say it. Did I get it?

Close enough.

I like to do it right. Honor your name.

In morning I am the medical equipment benefits specialist here, I believe this is the second and final adoption of this rule , across-the-board increase that applies to all benefits and all providers within

the department and just as a reminder the benefit is the only benefit that does have a rule essentially to identify those that do not have a special price in the manufacturer suggested retail price, etc. Essentially this will adjust those percentages annually. I don't know if anyone has further questions.

Any questions? I do not see or hear any. Anybody on the phone have a question?

No thank you.

Any public testimony? Is there anybody in the room that wanted to sign up for this rule and did not? Nobody jumping around let's entertain a motion. >> I'm of the revision of medical service concerning durable medical equipment section 820 590 section 825 90

[Inaudible]

The very bottom. I got it I was just slow. Move the final approval of document 19-03-5 -A revision medical assistance regarding durable medical equipment incorporating basis of purpose by the authority contained in the documents.

A motion and a second. All in favor?

Aye.

Opposed? Dr. Fraley?

Aye.

Dr. Lippolis?

Aye. So passes. Boy are you guys doing a great job, thank you so much we appreciate your. Okay we are going on. Document 3. That is Michelle Craig. She gets to come back up here. Come on down do we get to see him more than this?

I think this is the last time. So I am still Michelle Craig and I am back to present the 8.508 for final consent issuing the change between the adoption of the emergency rules and now but if you have any additional questions I am happy to answer those.

I will tell you that this is a wonderful wonderful change and a wonderful need that has been underutilized, this program so we are thrilled to see it. It meets the needs of the population. So, thank you for all the work. I know it has been a lot of work so thank you for all you have done. Okay, if there are no questions do we have any testimony? >> [Inaudible]

Yes. >> It just missed the agenda last month and if we don't do emergency today there will be a lapse.

Emergency rules last 120 days. And then what would happen is the emergency rule drops off, reverts to the previous language but because we are doing final adoption of the rules today that will become the effective language and then when the emergency drops off the language you are adopting as final continues until it is revised.

Okay thank you. Are there any questions?
No testimony so read the motion.

Final approval of document 3 19-02-05-A revision to the medical assistance concerning children
residential program section 8.508 incorporating statement of data business with specific statutory authorities.

Motion and a second? All in favor? Aye Dr. Fraley?

Aye

Dr. Lippolis

Aye.

So passes we are moving right on thank you so much. Okay going to document 4 and I am calling up [Inaudible] you get to come back up. Isn't that exciting? I do take this stuff seriously. If everybody does it gets really boring. We are getting the work done. As long as everybody is okay with the. >> Login compliance and policy analyst for the department here to present the adult dental and limit increase. Again here to present the adult mental annual limit for final adoption. I have nothing to add to my original presentation so I will leave it at that.

Any questions? Everybody looking around. Good stuff. Okay so nobody has any questions, anybody on the phone have a question? Okay. Thank you. Anybody signed up for testimony? Okay so let's go on .

Final adoption of document 4 MSB 1905 25 A eligibility rules concerning adult dental and limit section 3.8 point limit section 3.8.1.6 [Indiscernible - poor audio] contained in the record.

Second.

Okay. Everybody in favor? Opposed? Okay Dr. Fraley

Aye

Dr. Lippolis

Aye.

And so passes, thank you so much and thank you for all you have done. Moving onto the initial approval agenda and we are calling up Mr. Underwood, Chris Underwood. Is he here?

Perfect.

Did you think we would be closer to 10:00?

[Indiscernible - poor audio]

Welcome gentlemen. I will ask you to introduce yourselves . Thank you very much. >> Okay on the phone I apologize .

[Inaudible]

Okay great ready gentlemen, introduce yourselves and tell us who you are and why you are here and what you're doing tonight. For the weekend? I'm joking.

My name is Chris Underwood and I am the department Deputy Chief of Staff.

I am the provider of fiscal operations director to the public.

We are here to present our role to the revision medical assistance a rule concerning the Colorado national provider number for the NPI. This rule is being presented to the board today to implement House Bill 18 1282 to the board today to implement House Bill 1812 82 the department is implementing this statue and requirement through this regulation. House Bill 1812 82 requires newly enrolling and currently enrolled organization providers to obtain and use unique NPI for each service location and provider type enrolled in the Colorado Medicaid program. Starting next calendar year the department will require new providers to enroll with distinct NPI so that department members and policymakers have more transparency to those provided. This law does not impact individual practitioners. Individuals who provide healthcare such as doctors or nurses or those with what we call in a group or within billing individuals they only ever get one NPI, it follows them for their entire life no matter where they go . We are talking about a term the feds use in regulations called organizational healthcare providers. Those are institutions, businesses, companies that maybe have different locations or different sites where they provide are where they offer services. Over the years

providers have expended to create a number of separate physical locations for delivering healthcare. When individuals seek healthcare at inappropriate locations delivery of that level of care in this setting may increase cost to the overall healthcare system. Under this law providers will no longer share the same identifier across sites as their affiliated locations and because the cost associated with care to delivery at different locations is not always transparent it may be impossible for the department understand the basis for cost and for policies for makers who evaluate these texts. Therefore the General assembly passed a law to provide this transparency so we can have better information on claims of where services are being provided. So under federal regulations most providers may obtain NPI at no cost and in reality they are required to obtain NPI and are required to build using the NPI. There are some rare providers who do not have an NPI that provide services to Medicaid clients such as transportation. A

good example is those laws take them into account how they can use Medicaid ID number rather than the national NPI to identify claims and enroll with the provider. So everyone is on the same page in national provider identification or NPI is a unique identifier that is used for covered healthcare providers. Under federal regulations healthcare providers and all health plans and healthcare clearinghouses must use NPI in the administrative and financial transactions under the above. The NPI is a 10 digit number assigned by CMS as outlined in federal regulations providers must share NPI with other providers of health plans clearinghouses and other entities that need it for billing purposes. Under this regulation and under the law of this rule and law going into effect on January 1 of 2020 of new healthcare providers that are not currently enrolled in the Medicaid program. The inflammation date currently is January 1, 2021 so we are getting all the current providers one extra year to comply with this law. However there is one nuance in the law that off-campus locations must also comply with January 1 of 2020 and this aligns with Medicare implementation, Medicare is requiring all off-campus hospital locations to have a separate NPI in identifying those off-campus locations on their claims, that was postponed it was supposed to go into effect in March they postponed to July and now to October and getting all of those systems ready for that. Providers will need to enroll with the unique NPI for each provider type that they provide services under Medicaid and each site where they provide services for Medicaid. We have some examples I will go through to explain what that means. In preparing regulations we actually have spent over the last year working internally and with stakeholders to get ready to bring these regulations forward and implement the law. We have released draft proposed regulations in May 2019 for public comment even before we came to the board. We asked for the public comment to be set before the end of June and based on that, we were able to revise regulations that we are presenting here today. We did various provider meetings during this time I personally went to the hospital engagement meeting to meet with stakeholders, I presented at meetings, advisory committees, I went to the home health conference as well. We posted a webinar of one of my presentations on our website so people who cannot attend could watch the presentation on the webinar. We had various provider communications setting up our own email inbox

that is active where people can ask us questions so we can receive input and then we are developing frequently asked questions. We have one posted online and I we are doing target audiences. The groups have asked for their own FAQs and we are preparing another one for nonemergency transportation's so we are doing or is it best to get outreach and inform providers on how we can help them implement this law. I talked about how Medicare is doing this already when I first talked to hospitals there was concern about how they would implement it and then you all realized Medicare was doing the same thing and that concern has pretty much dropped off from hospital partners. We have worked with hospital partners working with billing agents on how they can implement this correctly and not, some of the billing agents were asking them to do things outside of what Medicare and what we were asking them to do so we were able to help them work through some of the details. Going through the regulations, that are before you, you will see that 14 of the pages of this regulation from pages two to page 11 are definitions of provider types. This was necessary because the

department has 57 different provider types that have never been in regulations before. We did not want these provider types to be hardcoded in statutory language when the bill came drafted so we worked with the drafter to say as defined by the department or set by regulations that allowed us to put the provider types into regulations rather than statute and they were having a tough time when they were writing the bill defining what a provider type was and we did not want 57 different things put in the statute because they would conflict with the other program and policy folks as you begin to read those they define what a physician is, that may be defined somewhere else in regulations and in the law and we did not want to sour the statute . Giving you flexibility into the regulation. The rule also contains technical definition such as what is a billing provider bill and what is a service location on page 11. These are used on a claim form when a provider builds Medicaid or Medicare and they follow the regulations on what they are and how they are populated so a lot of the regulations and what we are saying is a lot of repeat of federal regulations that are required so we wanted to be specific in our regulations and guidance to providers so we did not want providers to think we were having them change all the billing IDs and information where they get checks or the remittance advice, instead we are allowing providers to use what we call service facility location on a claim to put in this new NPI, yes they must enroll all locations with the NPI with Medicaid but there are three different locations on the claim where you could put identification of who is providing the service. The first one is the billing ID and that is almost all providers no matter how many locations. They like to have one billing ID that is where the check goes to, that is the account accounting department and that does not change. On the third field is a service facility location which is used when you provide services that are not exactly the same place as your billing ID and you populate that with this new NPI. Currently we do not edit on this field so providers can populate the field and we will not deny the claim as long as it will meet the 10 digit code so what we as providers to do, as you populate the claims with the new NPI and when we are to the point where this is working and all the providers enrolled which will not happen until 2021 because we have to wait for current providers to get the new NPI on the enrollment record then we begin to edit to make sure they are enrolled IDs in the claim system for all providers. So with that I would like to go to some of the examples that you have in front of you with this handout to show you how this works in practice. The first one were some questions we got so with this right now, they have this example, this is two locations where they provide services and one of them happens to have a dental clinic at the same location as they are providing healthcare services. Under the new regulation this will now have to have three unique NPI's, currently they could be doing all of these services under one NPI. We will asked him to get three different NPI's, one to identify the different locations where they provide services, site one and site two. And then the dental clinic which is a different provider type then the enrollment will need a separate NPI so this will now need three unique NPI's.

[Inaudible]

What about integrated behavioral health? Does that require additional NPI?

If the behavioral health is covered under the provider type which I believe it is, they provide services under that that they do not need a separate NPI so it is not services and this is where it gets confusing. The services provided versus the provider type you enroll. For example a hospital can provide, they have the outpatient hospital license they can provide a variety of services you may consider to need a different kind of position physician service so they don't have to enroll which is the outpatient hospital license that covers those kinds of clinical services. The FQAC will cover those behavioral health services.

Any other questions? >>
tran23

The off-campus distinction and definition in the role is specific only to hospitals. Those with or without the license, they are allowed to have off-campus locations on the license. So under the federal regulations your campus is everything in the main building for 250 yards. If you have if you have another campus at the hospital, clinic or anything else beyond 250 yards we put it on the addendum and they list out
all the physician locations and there can be other kinds of what you would consider another obstacle on some of those addendum's and they can be very long. When you show up on that addendum as off-campus each one of those have to have a separate NPI where before they could use that one hospital NPI for everything.

My question is for health centers or freestanding clinics not affiliated with the hospital do they go live 2020 or 2021?

If they are currently enrolled they will go live my 2021 if they open up a new site between now, between January 2020 and January 2021 at the new site we will ask them for a new NPI because that is considered a new enrollment.

All you have to do is call one 800, I'm joking.

It is quite easy to get a new NPI. We can go online fill it out. I have given this presentation in front of the rural health committee. We had a physician to it as I was talking. They asked me how do I put this on my enrollment form? We said we have not implemented the system changes yet to allow providers to do this, we are doing rules first. We are doing rules first and then we will do the system changes and issue the billing guidance to get ready.

I sigh hand up. >> What about for smaller locations like oftentimes they ran through health centers and things like that? Do they get separate NPI and then the provider types as well?

We called them community locations. Such as schools, you can bill using the main clinic . You go to a community health center or something you don't need your NPI.

So we would associate those that were close to the clinics you would associate that with one of the specific plans.

When we talk to the FQAC a lot of them have NPI rules. You can get an NPI for any location and you don't have to on the location. We had University physicians, I practiced at the University hospitals at the clinics and at the time they do not want to share the NPI with the billing so they got their own NPI for each one of the clinics. Now technically there was a hospital under federal regulations they should be sharing the NPI even though it is yours you can give it to somebody else. As long as it's not the billing or the service location you can share that it is no secret.

What about mobile units? Like a truck or a dental one?

Those would be registered at the clinic location. You could still use that. You don't have to put down every address. >> Can I ask a question? I am putting my hand up.

Okay perfect. Thank you for presenting this. As a private practice multi clinic group this is , I totally understand where you guys are coming from in terms of tracking data and we are on the team currently so I just wanted to clarify. Is the rule for private practice multiple clinics the same as the FQAC in terms of what was mentioned that it is still January that it is still January 2021? For the private practice clinic? As pediatricians we are not governed by Medicare because we don't take that.

[Inaudible]

Yes, if you have multiple clinics you are running and administering and they are currently enrolled with Medicaid you need to get the new NPI before January 2021 not 2020.

Go ahead.

If you have one clinic but 20 doctors work for you there is no change. We will not change anything because everybody has their own individual NPI.

I thought the claim needed to be to have the location . I thought part of this is not just about the physician NPI's but the claim needs to reflect the location of the clinic. That the service was delivered.

That is true but I was giving the example of if you are a single clinic and you are billing out of the clinic then nothing changes for you because you have the NPI for your clinic, you are populating that and then you are rendering doctors who already have their own NPI's so since you are one location with one service there is no change. If you happen to have two and using one NPI then yes.

More than one clinic, then you do need another NPI.

There is some impact I know if it's how the EH are works but that does have workflow impact increasing cost on the clinic side. You know I get it. It makes sense to me you guys want to track where the services are happening.

Yes that is true. There are some programming's that will need to occur in the provider EH are if they're using that for billing it will help locate that location and your EH are vendor should be able to do that for you. I also want to remind everyone we are asking for everyone to have a separate NPI by location. It is actually already a transaction requirement that you already populate the service location field if you provide services outside different from your billing ID you are supposed to populate that we just don't require a separate NPI for it.

So we are really in the weeds. I want to make sure that , we have a lot of examples. I don't know we need this many examples but maybe we pick a couple of we can continue with the question and answers. I'm assuming we have public testimony.

We do not but we have a comment on the webinar.

Let's get the comment on the webinar.

Is it possible to determine if the NPI will be required for each provided service provider specifically residential service under the DD waiver or data
location?

That is a great question and it goes into , sorry everybody this is Chris Underwood again. If we went to the third example in the handout on page 4 we get this question a lot from providers in the community and once again what really would be helpful for them to understand is HBS enrollment is a provider type all by itself so under this they must have 40 or 50 different specialties, there is a lot under HCS provider type we are not saying every one has to have a separate NPI. You can have one NPI for your home and community-based services and that would cover all the waivers and on the services you provide underneath that. If you happen to be a provider who has home health or provides a clinic those are two different provider types and you have to build a separately for those, they are not covered under your services. Those are two provider types so you would have to get extra NPI for your home health services you are providing and your clinic services you are providing as long as they are outside of the specialties you are providing so it does get a little nuanced because some of the services you provide under HCS they might be home health services that if you're providing under the HCS waivers and those cards then you are fine you will have one NPI for those services.

I'm going to go in the weeds. So one provider under a waiver and you are providing three different services. You have one NPI because you are one location. And like so you don't need any additional,
what if you have a therapist coming in? They would have the NPI so you don't need another. I'm sure there are a lot of providers listening trying to understand so I want to make sure that is the same thing.

We will issue some detailed billing guidance for those providers so they can understand the differences between services and provider types.

That would be helpful. There are a lot of mom-and-pop providers. Okay so, any other questions, do you have any other examples you would like? I want to speed this up a little bit. I want us to understand.

The only other documentation in your handout is to kind of show you how we do NPI and where the provider populates them during the portal. On page 5. Of the handout. I will walk you through these
if you have questions or where do I put my NPI when I bill a claim on the portal? Where's the service location bill? We wanted to give you the examples so you have the visual, now if you're using a transaction through the billing system you would never see this, these are for people who manually build the claims but if your billing electronic claims you and your electronic claims vendor will know how to populates this or they better or you need a new billing person. If they cannot answer that question then you need a new filler.

Can we get electronic copies of this?

There will be electronic copies sent out. I'm assuming it will be on the web. Awesome. That will help everybody. Any other examples?

I have covered it.

Any other questions? Dr. Fraley or Dr. Lippolis any other questions?

No thank you. >> No, I do appreciate the thorough explanation because I'm sure many people are confused and this has been helpful for me.

I am not trying to not understand but everybody is kind of getting it so do we have somebody?

Additional comment.

They say doesn't each provider need a different NPI for different service locations? Yes. So the provider has two locations where they provide services at those locations and they will need two
NPI's.

Yes so if you are a provider approved service agent and you have more than one person under your
PASA for each location of the client you would need the NPI?

No. Not the location of the client only the billing location if it's different. >> Where is it coming out of? The main unit?

That would be the NPI so for a client they do not need that . I think that was the question that was being asked. I think so. >> Individuals only ever have one NPI.

Okay all right. This is confusing stuff so I want everybody to understand.

Point of clarification that is really appreciated in the definitions and with the rules , for the interpretation here and I was in the health center world I was looking for the definition. Reference to community health centers in this and definitions. I think there is a revision of clinic or something like that. I don't know if I just missed it. There's a lot of detail.

I think what you're asking for is the provider type can be defined as enrollment and in the healthcare clinic?

Page 7 clinic I'm not sure. There's another spot where there is a reference to community health center in the body of the definition but there is no definition of what the community health center is of what is so the community clinic is one provider type and FQAC is a different provider type . It is number 16 of page 5 or 14 federally qualified health center FQAC.

There are probably some spots where it is referred to as community health centers so we are referring to them as epic UHC so we should fix the language here.

Good point.

Each one of these is a standalone definition. So FQAC would never enroll as a community clinic those are different licensors so when we went through these we have definitions verified by the program staff and the public health environment and community services to make sure we correctly defined each one of the provider types.

If I find a afterwards I can send it to you but there is specific language in their where community health centers not community clinic and I don't know what that is meant for. [Inaudible]

It could be we were trying to talk about those areas that do not need a separate NPI like when you provide services within the community which I was talking about before so we may be slightly mixing up a little bit of those words. >> We do refer to ourselves as community health centers so I want to make sure people here that.

We made sure we had partners read that definition very closely.

If you look that up we have another comment on the web. Did I see a hand? Okay. So from the webinar.

On the webinar if a PASA went through revalidation a couple years ago didn't they already have to comply with these requirements?

The question was if they recently went through this re-eligibility a couple years ago have they met the NPI requirements?

Not necessarily, depending on if they have multiple locations. They could've enrolled multiple locations with one NPI a couple years ago or all locations could have unique NPI's in which case they would be compliant but they are not required at that point.

When you talk about locations because these are locations where you have a client list so you are talking about the clinic. Or offices or the PASA if you have multiple. Did I get that right? Okay hopefully that clarifies. Did somebody find for you what we were talking about? >> We were looking at some of the definitions for dental clinic perhaps.

I think I have it on my hard copy and I left it at home.

Page 414? Page 414.

I feel like I have read somewhere lowercase community health center.

They will come back next time so we will need that to figure out. So it is good and clear. Are there any other questions at this point? Do we have testimony? Okay all right. I think we have done it. So I would entertain a motion. Hello?

Initial approval [Inaudible] revision to the medical assistance rule concerning Colorado national provider identifying number section 8.126 [Inaudible] >> I have a motion and a second. All in favor? Opposed? Dr. Fraley?

Aye.

Dr. Lippolis? >> Aye.

Okay so passes, thank you gentlemen. We look forward to seeing you next month and thank you for being so thorough and we appreciate all you have helped us understand today. Okay we are going on to document six and I will call somebody down. Mr. Jeff [Inaudible] did I get it? I have been practicing. Okay. Welcome. Please identify yourself tell us why you're here.

Good morning my name is Jeff [Inaudible] and the unit lead in the finance division here to present on rule 19 1907 19 A revision to medical service correction to the hospital incentive payment. Of this change is not as complex or lengthy as a previous rule, a minor revision to the hospital groups are excluded from hospital incentives. We noticed the previous rule stated
psychiatric hospitals long-term care hospitals and rehab hospitals were not qualifying when in reality it was just the psychiatric hospitals. This is a correction to what the actual methodology is that we currently use. So this change would just be a correction to the current ruling it would not change methodology for the hospitals in which it is in compliance with the methodology approved by the board last year. Very quick change, any questions or concerns?

This is just a point. Originally we were saying when we get to the motion .

We are on document six and that says B.

Reset there. The document says A and we are saying P.

Hold on a minute.

I want to make sure we are using the right one. On the iPad it has the A and on the motion and agenda it has B.

That is very important.

On my laptop it is B.

Open the document and it has the aromatic. I can see that should be a B. >> No worries. Okay we have to wait a minute. We can see what's going on. I will go with B.

It is there. My apologies.

We need to change that on the motion as well. On this document. Very good catch. Had you finished?

I can do a recap of what we discussed.
Kind of confusing. This is a very minor revision for which hospitals are excluded from the hospital quality incentive payment. Previously we had listed psychiatric long-term care of rehab hospitals that were excluded from this payment when in reality it was only psychiatric hospitals so this is a correction to an error from the past. We are now, the language is excluding. We are not changing methodology or any payments we are following what has been approved by the board so this is a minor revision to the rules.

If that was not caught you would have had to come back for another correction. This is why these guys get paid.

Thank you so much. So other any questions to this correction?

[Inaudible]

The language was stating only psychiatric hospitals were the ones on this rehab and psych hospitals have been included. There are no rules or there's no financial physical impact on hospitals or the stage. Nothing is changing besides this little language. Exactly.

Thank you for that clarification. Any other questions? Any testimony? Dr. Lippolis?

No thank you.

Anybody want to testify?
Nothing, okay then I would entertain a motion.

I move the initial approval of document -- revision to medical assistance for corrections of hospital quality incentive payment
otherwise known as supplemental language payment incorporating statement and purpose specific statutory contained in the records.

Second.

A second and a motion all in favor? Opposed? Dr. Fraley?

Aye.

Dr. Lippolis ?

Aye.

Okay so passes thank you so much.

Thank you. >> Okay now on to document 7. >> Before we start the next one on the last rule for reference [Inaudible]

He is not in the room.

I can tell you where it is.
It is actually in the dental section and it is a nonprofit organization defined as community health center.

There should be a definition added for community health centers on document 5.

[Inaudible] >> This is why you are a team and you are amazing so I appreciate it. Good morning folks. Tell us who you are and why you're here.

Good morning I am the medical transportation compliance specialist at the department here to present the transportation for initial approval.

I am the development stakeholder relations specialist for the programs office.
I have been asked to talk more about stakeholder [Inaudible]

We want to point out my colleague and predecessor is here she was heavily involved so she is around for historical context if you needed. Before diving into the roles I thought it would be helpful to give a brief overview of what we do around the state. So nonemergency medical transportation is [Inaudible] such as physical therapy primary care dialysis or chemotherapy etc. Services according to bistate designated entities we have three types of state designated entities in Colorado. Multicounty collaboratives and stay contracted brokers which serves the nine counties. The department transition vendors the proposed regulation is statewide to Allstate entities, the impact of the regulations it's important to understand the differences between the broker and County designated entities. There is no contract to administer NEMT the county uses department policy [Inaudible]

policies and procedures so long as they comply with the department policies and regulations this means that counties have flexibilities in running the NEMT at a local readable level. The department has a contract in place with a broker to administer NEMT to the counties of Adams Arapahoe Golden Broomfield Denver Douglas Jefferson Larimer and Weld. The broker does not provide or is contracted to provide transportation services. The broker is administrative service organizations for the dental benefit, the contract with the broker outlines the responsibilities including scheduling and all call-center activities, provider and network oversight, complaint investigation, distribution of bus pass mileage distribution mile notices and number of appeals, information and education, claims of adjudication in Medicaid management information system and provider payments. In May 2017 the department began the benefit process by drafting regulations to move benefit coverage standards and other policies into regulation and to address informal stakeholder feedback prior to formal stakeholder input, the department held the benefits collaborative January 8, 2018 to gather input on regulations along with input on the upcoming request for proposal and draft medical transportation regulations. The stakeholders provided feedback during and after the meeting which was responding to written answers. Regulations were amended and sent to participants prior to the second meeting. Based on feedback from the first meeting there was a second meeting March 5, 2018 focusing on broker request for proposal. Provider input before and after the meeting and put in the manager document a number of 128 people participated. Highlighting recent changes before final adoption stakeholders request and we remove the word unplanned from the urgent care definition at 8.014 the department agrees to this change and it will be reflected in the final rule. We are also making a minor change adding pages by reference which will be changed before final adoption. If it appears these are new regulations you are correct the existing regulations are [Inaudible] most of the changes made were for existing policy moved to regulation, original changes include adding responsibilities, streamlining definitions, early outlining provider eligibility and responsibilities. Including adding requirements and multiple providers outlining when providers [Inaudible] creating exceptions to reimbursement for the shortest distance, establishing a timeline for members to submit documentation to the state entity, finding closest provider requirements and establishing major entities for providers establishing acceptance for the state designated entity to reimburse personal vehicle mileage and shortest distance were not possible and must have a longer route to meet needs for the purpose of using out-of-state NEMT. Some remaining concerns, out of the 120th stakeholders involved in the benefits collaborative there are still concerns, based on conversations there many concerns outside the purview of these rules. First is the community the coalition community board broker contract serving the primary counties. Second defining adequate networks, the center of transportation coalition request the term adequate network be defined, this term is not used in regulation and would not be meaningful, adding the adequate network definition would place the burden on departments of human services when outlined in the contract with the NEMT broker. Contract oversight, the coalition has commented that the department has lacked oversight of the broker contracts, this has been addressed

through establishing regulations through legislation and budget request to increase staffing. [Inaudible]

contract language has also changed to the extent possible to allow the department to have better oversight. Member disappointment after the red. The coalition commented many members have looked forward to their ride but were then disappointed, the department does not like to hear this about any service, numbers can request another provider to take them on their next trip and file a complaint with the broker. This language barrier, the coalition commented that many members may not speak fluent English, many providers have drivers that speak many languages, unfortunately driver turnover would make it burdensome to have languages list of each provider. They do not recruit the broker and the counties provide services for members contacting the broker's. Provider entry into the network, the coalition commented that this is a valuable benefit to be a provider and the companies have the right to provide services in the network. Through contract language a new broker in the upcoming transportation service provider entry process is standard but the department has to ensure health and safety and the broker has to enter the network is sustainable for example the providers have enough troops to cover expenses. Keep in mind the department only has oversight of the nine front range counties so we are not able to do much statewide at this time but we welcome changes to the broker model in 2020. At this point I would like to turn it over to the stakeholder engagement process.

Good morning. My name is -- and the policy development stakeholder. For the health program office and I appreciate you allow me to take a few moments to talk about [Inaudible] as mentioned we did conduct a benefits collaborative process around these goals. As way of refresher or those of you who may not be familiar to benefits collaborative process is the formal evidence-based public process for Colorado programs and coverage policies. This includes duration of benefits of covered services but may also include other defining characteristics. In this process the department invites stakeholders to share their diverse perspective, experience and diverse expertise to inform policy development. We work to ensure every stakeholder has an equal opportunity to share their perspectives and that each perspective is considered on an equal basis so we give equal consideration across the board. As we conduct benefits collaborative's as I mentioned we report stakeholder questions and consideration. We then researched those questions and considerations and then we produce a shared document reflecting feedback along with the department response for this collaborative I think it is [Inaudible]

it is pretty extensive and pretty thorough. At the office we had ours on collaborative with a comment period in which we heard from one stakeholder and responded to that stakeholder. I believe as I recall the concerns with the concerns brought up in earlier stakeholder meetings so we reiterated our response to that person. And then in preparation for the presentation of these rules of course there was public rule review meetings, at the first meeting we did have stakeholders attend. We listened to their concerns and subsequently made an informed change on work that was objectionable and also took back other concerns and again looked at those to see if there were differences from what we had heard prior so we did a second review in August at which time none came up.

There was a pretty extensive stakeholder engagement process so I appreciate you allowing me to explain a little bit more about how that all happened.

Thank you.

Thank you very much. Do we have any questions? That was a lot of information fast. Any questions? Yes.

Just five sentence summary would be great on a little bit more on the 2020 statewide broker model.

Absolutely. We have heard a lot from the counties that it's burdensome to administer the program as a result the legislature asked for increased budget, we expand the broker model from the nine county area to the remaining 55 counties so we will request for proposal at the end of the year. Dividing the state up into regions and having folks bid on those and the rest of the state will be administered how the current contract with the broker and the vendors are administered giving us more oversight . It is centralized so rather than calling multiple counties it is one point of contact and it takes a lot of lift off the counties and it does not decrease administrative funding.

[Captioners transitioning]

>>That new model starts next year January July? Does that Jen change, the discussion and the basis for the conversation you're having today. >>In terms of incorporating additional feedback is that what you're asking? >>Please identify yourself before you speak that where the people on the telephone know which voice they are hearing. >>This is Mr. right. We are hoping to revisit some of the things that are been brought it because it's a little more appropriate once we have oversight of overall counties for some of these concerns we can benefit these requirements that I currently can't do. >>Say so there's 1 or 2 changes. >>Good question. I think it would be just down to 1. It would be just one, the same type for that program model. It would be several of them. >>That sounds great. To that answer your question? >>So that plan to have that statewide model is already in place and is happening? >>Legislation has approved and we are going to solicit proposals towards the end of this year hoping to have contracts starting up the beginning of April so when trips start July 1, everything is in place. >>Excellent thank you. >>It sounds like I have been reading this letter for the transportation coalition and the requests for having additional wording in the rule. It sounds like you are saying it's better handled to the contract so that's just the point of the stakeholders? >>I believe at this time it's a statewide rule and a lot of the changes we can only implement in the nine counties. >> As a part of your question it's also much more enforceable to have a built-in contract language to hold them to performance standards that we might not be able to do much adding it to the rules. I will say also that as we take this out to counties the model has worked for the nine metro counties but as we take it out to the rural counties we are going to get considerable County feedback and stakeholder engagement. Because if you have seen one county, you have

seen one County. So there's a lot of geographic concerns as well. >>I keep you know in all of the benefits I think this one is up there in terms of challenges for our clients. In terms of quality and service. I have heard about it as recently as last week. So I think there is work to be done. >>I will say this also that we strongly believe, and we are one of the few states that actually offer it as a bounty it's not really required. So I'm aware of the challenges that's just an observation. >>Yes Again we believe in the benefits so we are doing the best we can. >>Let me ask a question that has to do with language that the transportation collation is asking for. What's the guarantee that it gets to the contract if it's not in their, how do we ensure that that language gets to the contract? >>I'm just asking the question from somebody I don't know who. >>I guess my answer to that would be we are open to feedback though we can't necessarily guarantee it. Because we've got one concept for those nine counties and the rest of the statements are substantially similar I think this far out I'm unable to guarantee just indicate that I'm open to the content. >>And

I'm interested in this issue interested from the mental health perspective in that the way the contracts and subcontracts have happened in my opinion was a part of how come we have such a mess and getting appropriate mental health services and now it's being managed more as the other healthcare services and not so contracted. So I had the same concerns being voiced. Wondering if there is a way to put into rule what must be in a contract at least some way to ensure that there is a process that applicable, how can we make sure that in 64 counties but don't have 64 non-urgent transportation services. Whatever it is. I just worry about things being in contract having worked on that side

is there a guidance enroll that needs to be around the contract at least to provide ensuring member services are appropriate. Just curious on that. >>Let me ask a clarifying question. I am assuming that many of our rules and programs require contracts. My question is more theoretical in terms of do we put any kind of guidance or rules about contracts. Because I don't think we should start here if that not a consistent pattern that we have across our rules. We talk about contracts often here. So I just need that as a. >> I have never seen that in any of the other rules. You have to start of the statute and what priority is given to the board. Usually we are talking general program benefits this is how it started you know what are the benefits needed. I have never seen that in any rule to see what that contract looks like I'm not sure that be 30 but without seeing after language I mean it's hard to sit here and say okay we are not seeing some actual language. That I agree. >>Thank you. Obviously I wouldn't want a prejudice contract initiation but I will tell you that the department is taking a very broad look on all of our contractual arrangements with the multitude of vendors that we deal with. We decided we were probably inadequate in the ability to inform or enforce some of our contracts I think you'll start seeing more of this built-in to incentivize contracts there's a balance as we created. A balance as we create the other side of the equations so we will be looking at this contracts. We can't really commit to anything because we haven't seen the language but I'm sure were going to have more direct of as to how we enforce contracts as to how we incentivize. >>So then with the statewide broker model are we going to see more equity about that coming soon or

has that already. >>Mr. McGuire to my knowledge there's nothing in the works that we have decided to explore. Before having a contract in place >>We've got a number of people making public comments so let's go ahead and call them up. And for housekeeping. >> Allow some space and we are going to go through document 8 and then do a closing motion in the rules and then take a break before we do work preview. I know we have got some stuff with that one so that everybody knows there is a break coming and otherwise take care of herself as you need to. There is a great coming that's the plan here. >>Mr. Stein. Will you please come up and introduce yourself you look a little surprised your signed up for public testimony. >>You sent us some documents and we welcome you. Please introduce yourself. >>I'm Paul Stein here as a preventative of a convener facilitator for the people center collation. You have referenced and have got the letter that we provided. Thanks so much for reading it and thanks for your questions. I have listened to the testimony and I don't think accountability should be outside the preview of rules. That is what I'm hearing on the comments. So I wanted to give office to the letter that you already have and answer some questions. We have been a part of the transportation services benefit collaborative for its duration. Going back to January 2018 from its convening. It put forward some of its own guiding principles and they said that policy suggestions will be bullet points and guided by recent clinical resource for faith-based practices wherever possible. Because of reasonable limits upon services for health and functioning Medicaid clients. It doesn't really address that for rule reasons. It might be outside the rules but somehow rules should adhere to principles and create a framework for accountability and in particular in the regulatory analysis there is a very reasonable template question and that asks to the attent what's practical describe the troubled quantitative impact on the proposed rule and economic or otherwise upon affected classes of persons. In response to this the department response that many of the updates included in the revision incorporate existing practices and requirements all of the updates being made to the rule amended to add clarity and predictability for writers and clients. We have seen a lot and it's a step forward the contract steps forward over the past. I'm not here to say that the department is doing whatever on your desk can we do better. So in its answer the department promises predictability but there are no metrics associated with it. No accountability. So for us predictability without accountability is like a clock without a battery. It's static and doesn't really tell you where you're at. We hold fast to our beliefs that the community board needs to have an expression in rule in order to have a framework for you and for other stakeholders and legislatures to ask what's working and what is not. The bigger problem is that nowhere does the department document existing best practices and requirements are supported by clinical research and evidence-based practices that they are cost effective or that they promote the health and functioning of Medicaid clients on its own guiding and supports. We think that per the recommendations of our letter this can be significantly strengthened. I want to call attention to some national research on this topic conducted by the national academies of medicine, science, and engineering. So no slouches when it comes to evidence-based research. There's a lot of work out there already that could inform simply the questions that we ask. So I wanted to pay attention

to our for very good framing questions that the national academies ask in the 2018 have for transportation coordination. An excellent document that I'm hoping we can utilize. So let me ask these questions. What strategies can help to document better health outcomes. What strategies contribute to better quality of services for NEMT and what services delivered within available resources. Pretty much all the aim is couple covered in this questions is a good way to frame the discussion of our rules providing adequate framework for oversight that goes beyond transactional compliance

these recommendations that we slow down the adoption of these rules to consider whether or not the language of the transportation board about an adequate network can be incorporated in the rule when we go statewide. There needs to be revisions again and other stakeholders might have additional input for what you suggested today. Thank you very much >>Does anybody have questions? There's a balance here in trying to find vendors in our rural communities. There is balance in finding contractors so that's a part of that balance that the state is playing. I just wanted to clarify that with you, you've brought a very good points but we also have to make the balance in order to get the vendors in the door. Because some transportation is better than no transportation. Especially in our community and state. Just wanted to say that so that you know. >>I know the challenge of having any vendor let alone a good vendor I think that the recommendations we are making are in the spirit of collaboration. For creating adversarial relationships is in the spirit of can we all sit in the table together to use the collective wisdom. The expertise that we all bring to make sure that the system works as well as possible in the interest of both the vendor as well as patients and transportation providers. >>Any questions for Mr. Stein? Thank you so much for your time we appreciate your time and passion for this. Let's go on to Bethany. >> I just wanted to note that NEMT is a difficult benefit to provide and there have been problems in many states. National partners have pointed out the need for more robust oversight I do think that just putting in a plug for the community board that it may be that having that rule will ensure that members can contribute and that that contribution can help the department do better oversight. It can provide the opportunity for members to come up with their own solutions for some of these issues. It's more difficult to make sure those are up and running and properly staffed and noticed. Having something in a rule would help with that. If that's something in the next iteration of the rule I think it's very worth putting some thought into making that more actionable and to help with enforcement. >>You see this community board being advisory in nature or having a rulemaking authority. Because here lies the issue. NEMT is a very difficult method we have worked very hard to try to make progress as we move forward with this. But I have a concern that if we give too much rulemaking authority to the community board and they start crafting rules to become unattainable, we have had vendors walk from these contracts in the past when were having to scramble to get these procured. As referred to there's got to be a balance between enforcement rules and how much we can actually have provided by community board versus contractual enforcement that the department oversees. >>Thank you. I need to think more about that. >>So I think it might be that there's a mechanism needed to ensure that the department responds in some way so if the advisory board raises issues

that this needs to be addressed by the broker some sort of accountability. I'm not saying necessarily that it has to be rulemaking but some level of authority by the board so that issues that arise are addressed more quickly. >>I think that's an issue of the class broker that there were many personal accounts of problems that weren't necessarily getting addressed in a timely way. This provides a forum if it's got some sort of accountability it would prevent that hopefully in future contracts. >> You will take all of this under advisory. >>Thank you so much was up next. >>Jordan Sanchez. >>Hello we are here to support the removal of unplanned from the medical changes that ask for that. These nonemergency rides are for our clients to get dialysis treatment. Not all of these are occurring as planned. Some patients need urgent transport to get to the dialysis treatment so taking that is very helpful. We drafted a letter we really wanted to thank Bill and Mallory for helping us with that. Any other questions otherwise we can entertain a motion for this. >>One of the downsides for delaying this session based on the questions that we've heard, you know. >>I think the downside is that we still have a one paragraph rule that is somewhat unclear. I also wanted to point out that these are questions that were addressed of the downside is that we don't have a rule in place for a timely manner we have been working on this for 18 months. I guess I'm not sure what more you need to come to. I want to circle back only currently have in sight of those 9 counties. >>I was going to ask if we could get some feedback on this robust dialogue about advisory councils. How do we close that loop. It feels like a very important conversation I don't want to pass this without some sense of closure. >>That we just point out that the broker has acquired in his nine counties to administer the advisory board and it all comes back to us. That's something that we are actually paying for. It exists to some extent does not in that depended mode. >>Come the time 2020 happens then all the counties would then to follow this rule. In a sense it's common that accountability? >>That's the hope behind the statewide program. I certainly say that accountability [Indiscernible] >>I am having a difficult time reframing my thought on this so give me just a second as I stumble through this. This rule would be applied to 2020 statewide that does not include the rule, the contract, the rules state does not have any community center discussion. A contract just making sure he understood it. Getting to this point where we've got a lot of stakeholder engagement and comments and then we come to where we have this impasse where we can't appease everybody on this rule. I think typically what we have done in the past is say go back and have more conversations but it seems like they were already at the table that's the difficulty that I'm having with the rule. What I'm hearing wrong is that it's currently inadequate. Only five or six sentences and currently whatever have we have to do something to be able to move forward. >>What happens if this goes down? I want to know because I think that's what people are thinking around the table so I'm just thinking out loud. >>There are not guidelines in place for members or providers we would certainly need to have these conversations that we are at an impasse we've had these for 17 to 18 months so I'm concerned we are stalling and making progress extending the rule for the sake of continuing. >>So moving forward something versus status quo is what

were doing. >>Does everybody understand that? >>I know it doesn't make you happy I know that.

Although the steps provide more accountability than what is in place. There's still in improvement even if it's not as improved a sometimes you wanted to be. >>Is there precedent having stakeholders come back to talk to us in 6 to 12 months to hear how things are going. Has a happened before? >>We have asked for people to come back and we have the right to do that so yes we could say let's revisit it. >> >>We are happy to do that obviously. Trying to graph the best. I don't think it falls within the purview of this board. This rulemaking board to be deeply immersed in contract negotiation. >>I think we are making progress in creating a progress this is really an up or down vote we, I don't think it's within your curfew to >>The vote today is either going to vote this down or up and not complete make the stakeholders happy. >>Is an affirmed commitment to the department at this point visiting all of our contracts. This is been historical we feel like we have been inadequate in our oversight for the accountability to focus I would just say as a general statement we are looking at all of our contracts with that in mind. >>We asked for a date in six months that we put down on the note's. >>Misuse do you have something. >>We've also got monthly that ability for open forum. So consistent with a stakeholders can make a comment. Make it on the forefront of our memories how things are going. >>Let me ask for a motion to be read. >>Revision to the medical consistent role for nonemergency medical transportation section 8.0 . >>I have a motion and a second by misuse. All in favor. All opposed. Abstained. Thank you very much even though we are having fun with this transportation thing I'm saying let's move up to document 8. So let's take a 10 minute break . >> All right I give you an extra minute I think we all needed it. But let's go on document number eight. He says you did not have to sit up there. And you're Mallory today? >>Gal we are just seeing her. I'm Ryan Dwyer non-emergency driver I'm here to present the emergency medical transportation or EMT approval governing medical transportation being in the rule up to date for members and providers. This rule is being revised for provider eligibility and responsibility requirements, change terminology of critical care transportation to specialty care transportation to add critical definitions for clarification. The department receives questions from stakeholders around mental health transportation for individuals experiencing a mental health crisis. The department plans to review the data from the pilot program and may revise policy based on the findings. We plan to work with behavioral health to identify best practices and opportunities for education moving forward. Any questions? >>Thank you. >> I Moses the director policy member engagement for the Colorado behavioral healthcare Council is a membership association for Colorado 17 call centers for service organizations as well as to specialty clinics. Or is we think of them an integral part of the behavioral safety net healthcare system. I'm here to talk about was what Mr. Dwyer brought up. Throughout the collaborative process we've been involved with different engagements just to let them know where we are coming from on this feedback. We've received great feedback and communication as well very dedicated to providing timely effective high-quality and well-informed evidence-based care to the whole population served. Especially in times of acute need or healthcare

crisis. Historically for individuals, transportation is sometimes needed to get to facility to facility or wherever they might need to get the best care for that specific crisis. In the past is been delivered in all sorts of ways. Sometimes by ambulance sometimes my police. Or through partnerships with transportation providers, or other types of models. The model that Mr. Dwyer brought up today is one of those evidence-based best practices models that we are trying to see enhanced and established across the nation. The reason those models are evidence-based is because they don't use an ambulance. Ambulatory transports for individuals in crisis often can be traumatizing or stigmatizing and unfortunately sometimes harmful as well. So these pilots provide a secure therapeutic approach to get individuals where they need to be. Even though somebody under 72 hour hold is covered, these models of non-ambulatory transportation is not covered so it's limited across the state. Currently only available in the community is where the two pilots are currently operating. Because of that nuance we pay close involvement to this process and made recommendations early on in the process to include language to the rules you have in front of you that include a new covered service for nonambulatory emergency secured transportation that's specifically equipped to transport individuals who are undergoing a behavioral health emergency without those acute medical concerns that would warrant an ambulance. We believe that this edition expands access to much-needed practice for individuals and would promote equality for those Medicaid members who need that behavioral health transportation during an emergency or crisis. We also understand the response to wait and see where the pilot and going and what the results are. There's an evaluation that is expected to be ready shortly. I'm here today to express our dedication to continue working with the department to encourage this board to continue looking at this opportunity I think it can have an incredible impact for other states that it done similar things not just an increasingly it's quite a bit of cost savings as well for the system. So I'm here today just to expressed our dedication and encouraging support to look into this opportunity wherever it may be available. >>Thank you this is Kristi, let me ask was there a fiscal matter figured out for that was there something figured out for that it was a suggestion and we didn't do quite the analysis on that? >>My understanding is that we did not go as far as to looking into what it would cost. I don't know if the department did anything. >>To my knowledge I don't think we are as far yet is looking at this. >>This is Kristi. Having done some work with creative solutions being diagnosed for behavioral I know we have had a number of who can fly commercially, because we have booted restrictions and safety measures. So I know there is a need. Just wondering if there was any money calculations put to it. >>Any questions?

Is there anybody else to cover testimony or anybody else wants to step up? I will entertain a motion . >>A revision [Indiscernible - Low Volume] all in favor. All opposed. Estate.

Thank you very much it passes. Thanks for your time. Sorry I mixed you guys up this time. We need to go to the consent agenda and >>Six and 8. I feel like seven if there's more dialogue. So let's move to add document for the consent agenda. >> I say that we meet the criteria of the state administrator procedures at incorporated by reference. I just take that as a consent kind of thing. So let's go on to rural

previews to see home modification. How is your baby? >>Good just turned a year old. >>Happy first birthday. >>Thank you good morning I'm Cassandra Keller the home community-based services supervisor here to talk to you about two sets of rules. The first is the home accessibility adaptation for CES and SLS. I am here on behalf of Diane who owes me big-time [laughter] . The home modifications and accessibility benefits provides modifications to a person's home to help them remain in the community safely and independently. There's similar benefits existing in the other adult waivers. So just a little bit of background. The division of housing or DOH is overseeing the home modification that if it's rather waivers since late 2014. This is improved quality of work they've been performing inspections and enforced repairs and timeliness. They provided trainings and construction expertise over that benefit. The legislator approved expansion of the DOH oversight to the CES community children's extensive labor supported living services workers what we are doing is incorporating that oversight of DOH into these other waivers. We will continue to use the housing and construction expertise to guide case managers, providers, people receiving services including consistency as a benefit for streamlined processes to approve the quality of work through construction standards, provider standards, inspections and complaint resolutions for warranty and repair enforcement. Lighting those processes to reduce confusion. These resolutions are nearing much of what is in the elderly home modification. Diane is engaged with stakeholders extensively having monthly meetings with them since December 2018 and sharing it with other groups she was talking to the children's disability advisory committee this past week so engaging with stakeholders to get their feet back on that. She will be here next month to talk more about it. >> Proposing to make changes to residential habilitation for services and supports for regulations. Those regulations and services are under the waiver for developmental disabilities that serves over the main service for that waiver so we are proposing to make changes to that service. Over the past few years we have met and discussed concerns about health, safety, and welfare, and residents receiving the services due to lack of oversight. So we saw need for enhanced oversight of the service. We put forth a budget request and that was approved this last session. It will transfer funds over to the division of housing and then they will be able to complete inspections of our nonmember or family-owned settings including homes and providers of settings. We are reaching out to our partners at DOH since they are such experts in housing. While we have the regulation open we are going to make a good overhaul of this rule to incorporate incident report requirements, contract requirements and those independent contractors that they have we've included requirements for the Colorado adult secret services background check and submitted by CHS including their home community-based settings, additional safety revisions, responsibility of the home environment and a lot of other things about fire and safety that we have gotten. >>Responsibility the home environment? What is that mean. >>We have engaged with stakeholders for the past few years on this and gotten great feet back from providers, advocates, and our partners at the local fire jurisdictions to get the best rules possible. Any questions? All right no question so we'll see you next month. Thank you very much. >>Let's move on to the hospital expenditure report with Rebecca

parent. Welcome . I'm with the special financing division specifically the hospital cost analysis team. I'm going to be previewing a rule that implies the implementation of house Bill 19 1001 and hospital expenditure reports. 19 1001 is a Bill that came out in 2019 for the General assembly regular session. It's passage gives the authority to collect data from hospitals. Specifically audited financial statements, Medicaid and other reported data like financials utilizations, and hospital physician group purposes. The data is being collected and compiled as a data set to be used for another requirement of the bill the hospital expenditure report. The data collection authorized by this Bill in the future reports as a part of the strategic roadmap to saving people money on health care. This report provides hospital specific financials and utilizations of information to review the hospital care industry. It's a slaters have the opportunity to review the financial health of hospitals in the district. Consumers and consumer advocates will have the opportunity to review the financial health and utilization trends of hospitals in their communities. The department has the opportunity to assess cost shifting and review hospital cost control efforts. That's pretty specific in its requirements but there are details that need to be flushed out. That's the proposed rule that will be presented at the next medical services board meeting. The proposed rule provides clear definitions for what is requested from hospitals and in order to ensure an accurate complete data set for the hospital expenditure report. This proposed rule provides exceptions, not defined in the bill, and timelines for the hospitals and the department. Ensuring the board that the department is actively engaged with the hospital community in the development of this proposed rule. The department has regular meetings with the Colorado Hospital Association who plays an active role in the development of the proposed rule. We have also asked for feedback from extended hospital communities and created a website it should be, on all things related for hospital 119 00 and hospital transparency. This first week of posting the proposed rule on the website there were 23 unique downloads indicating that the hospital community is actively engaged in the stakeholder feedback process. Thanks for your public service and dedication for your time to this and thank you for taking the time to hear the preview. I look forward to speaking with you next month and am happy to answer any questions. >> Is there an estimate of the FTE required for that reporting for this rule on each of these hospitals. >>All the steps needed , everyone is accounted for. So no additional FTE exempt. >>On the hospital side. And just thinking of the rule around the recent change in having to justify every admission which required down the road, us to have about half a dozen FTE. Just wondering if that has been calculated in this rule >>Is a good question that'll have to come back to. >>Any reporting is going to you know this an increase for this for the cost I know to do this. >>Rebecca, I can come back with an answer. >>Thank you missed parent we appreciate that answer. Any more questions? >>Thank you we've got David Smith with pooled trusts. We've got a lot of input from people who have signed up on open forum for this. We've also got one more after David and that is Aaron Thatcher. >>Before Mr. Smith get started. We don't usually get public testimony at rule previews as you're aware but for the full trust rules there have been a lot of interest so I've collected emails that individuals have sent to us and I'm going to hand them out just

take a packet and pass it along. One packet each. Obviously the rule is not but for discussion at this meeting but if you could take them into consideration for the October 11 initial. >>There are some people who are testifying at open forum so you know. Mr. Smith, thanks for being here in good morning. >>I appreciate this opportunity to talk to you. I'm David Smith I manage a group of employees for the third-party liability recovery section. What we do is, I'm actually not going to talk to about the proposed rule today. I really wanted to talk to about the topic of pooled trust in general. That being said. We did release a rule draft back in May so that's been on the street now for a few months. And we gave a face-to-face to the predominant pull trust organization in Colorado and we also sent it to the other trust organizations as well as interested parties. So the rule draft has been around. I really wanted to provide a roadmap of what this is. Because the area of Medicaid trust as I've told you in the past is really an arcane area and it's not something that's people are very familiar with. It's not easy to get one's arms around this topic. In terms of the history of these trusts. You've got to look back to one of these big congressional off of us measures to understand what these vehicles are about. Back in Oprah -- back in 93 Congress looked at ways to save taxpayer dollars. One thing that Congress was trying to rein in was the fact that people were sheltering money and assets in trust that could otherwise be used to pay for their care. And in other words Medicaid spend down to confirm Medicaid eligibility to receive services by artificially impoverishing themselves. One thing that did come out of that budget manager was forms of trust that are sanctioned by the Medicaid program. These trusts are vehicles to allow people to come onto Medicaid and be either income eligible or resource eligible and receive benefits. For example, an income trust. Individuals in nursing facilities who are over the income threshold 300% SSI level, $2000 and change. Could not afford the $8000 nursing facility bill so Congress enacted this income trust provisions so that there was a vehicle for folks who did have too much income and could still receive and if it's. Similarly disability trusts, disabled individuals who have more than $2000 in resources can still receive long-term care services and support by placing their assets in this vehicle. In other words, it is an exempt resource vehicle and still retaining Medicaid eligibility. Pooled trusts walk and talk a lot like a disability trust the beneficiaries are disabled individuals and we call them pooled trusts,

this refers to the individual accounts of specific beneficiaries and those assets are interned [Indiscernible] You will hear more today from the committee as to what a pooled trust organization does and it's nonprofit status. My message here is that these are all congressional act actions and indigenous to the Medicaid program that share similar features. There's a benefit of that for Medicaid services in return the state's the remainder beneficiary on these accounts. Medicaid then in turn collects the remaining balances. That's one common feature of these vehicles. There are some wrinkles in the law specifically in the area of pooled trust.

Congress is silent on any age restriction in the pooled trust arena. What they did not do, remember these are exempt asset vehicles

so there in lies the reason while I am here today. Has created a lot of friction because it's difficult for my staff to administer.

Because if you don't accept these assets when there transferred. That transfer incurs a potential period of ineligibility. In other words they look at the amount of assets that have been transferred into the trust and divide them by the average facility pay rate.

Because of this discrepancy or ambiguity there's been a lot of judicial action that my unit has been engaged in. The Todd case in 2006 and the vehicle case and most recently back in 2018. Unfortunately the judicial determination in this case did little to clarify or harmonize this area for long. In terms of how my employees treat these transfers who are age 65 and older. And another example for the lack of clarity in this area is what to do with remaining balances of on term determinations of these trusts. One provision states that the state should receive the amounts from the trust. Another provision sets states to the extent not held onto by the full trust organization. So there's a real question in terms of to what extent does the state show the remaining balances my unit reviews trusts when they come in approves them and on the backend we administer the termination and recruitment of any remaining balances. Because of the lack of clarity in the law it takes a lot more time to process these requests similarly as I mentioned it creates litigation in addition to administrative appeals. So applying that law that I've been given so my message to you today is lack of clarity in the law and the difficulty that I have in applying the law to this area of trust is an area right for your action. It's an area that MSP could help harmonize and reduce the use litigations between us and our beneficiaries. >>We have a lot of people who want to talk and I appreciate what you're saying we will have a rebuttal as we have those conversations. >>Let me just add one more thing if I may. >>That would be I saw comment from counsel that asserting that you did not have authority to adopt rules in this area, the statute actually mandates that you write rules in this area to describe permissible distributions, and efforts in monitoring the expenses of these trust. So that is hardcoded into the medical assistance that. So that I love to hear any questions. >> Clarity on that particular point comes next year so is no terms [Indiscernible - Low Volume] >>So there's other pieces to this rule. Taking half of the former persons , there's another a number of changes. That's a part of what they fine.? In terms of procedure at this point. Were not actually looking at those rules we don't have any details. >>We have not seen the rule yet. >>So the feedback is open forum feedback? >>Yes. >>So is this an appropriate time in which this community at this point in time. >>Some of the ask is for more time. And more dialogue with stakeholders. As the preview we have not restricted people from open forum. When I was contracted that was the only way that people could have a dialogue to get themselves heard. >>I was thinking the same thing. My understanding is that the department will update and if they for wanting to speak then they'd have the open forum time prior to after the rule, so are we saying now that stakeholders are now able to have comments during this time as well . >>One more and then we will have open forum. >> I think that's fine I have it reviewed the role know as seen it. >>There was not a lot of stakeholder engagement, by all dialogue reducing clarity between the two without seeing any rules

when they contacted me earlier this week my recommendation was to talk during open forum if there's things that need to be discussed

prior to that. We are losing some unpaid members . Thanks for all your time. So are we understanding. To we want to change anything as we move forward? >>I think your recommendation , I think we need to be careful like Jen stated. When we really don't have the context which is why, I feel like we should allow Mr. Smith to give a preview and then we listen to the open forum contents. >> Just to make sure I'm clarifying, the not necessarily to allow a dialogue after the open forum regarding this were going to reserve that dialogue. >>I think in light of the length of this meeting and that we have lost a couple of board members that this might be an actual valid way to do that. >>So Mr. Smith you're welcome to stay there or leave while Ms. Thatcher comes up I will ask her to be quite brief not that we don't value her but you're welcome to stay there when coming up again. >>Thank you I will hang out in the event that there's some further questions I can answer. >>I am Erin Thatcher with the office of community living on the participant director liaison and I'm here to give a brief preview of the rule implementing Senate Bill 19 -- 164 which was passed by the General assembly this year. It's also known as the pastor for homemaker services. Essentially that bill was passed in May and requires the department to get an 8.1% increase. In addition there's tracking and reporting requirements of this bill and a minimum wage. So essentially this is implementation of the bill it's based on the information that we received approval for for house Bill 1407, with that I opened up to any questions. >>Were going to see that next month. >> So is got these 5+ these two that didn't make consent. >>But there's six previews given because Cassie gave to for Diana and one for herself. >>Plan for a rather lengthy meeting next month as well. So now that we have done housekeeping on that. Any questions for this lovely lady who has come to give us a preview. We appreciate your time and look forward to reading your rule. >>All right. Let's go to open forum and public comment and who is first up? >>Megan. Do we have something in writing? >> Given the comments just now let's keep our comments brief and educational and work towards those other discussions in the future. I'm Megan Brandon the executive director of CFP the call a lot of funds for people with disabilities. A nonprofit organization founded in 1983 and we are the largest locally managed longest standing pooled trust here and Colorado. I've been here for 16 years, 10 years I have been the executive director and we are governed by a board of directors our organization came together with people from the Atlantis and those groups from early on our organization as David mentioned is a pooled trust. The money is pooled for management purposes we currently have about 700 individuals who received services from us and over time we have had about 1400. One thing that set us apart was the case management that we provide and this sets us apart not only here in Colorado but on a national level. Every beneficiary of our trust is assigned to a case manager who goes out and meets with them. Assesses their needs. There government benefits the eligibility's and helping and making recommendations for expenditures from the trust moving forward. That's always there point of contact. The other thing that David touched on a little bit was our charitable fund. As individuals in our trusts as they died the money does move into the charitable fund. Over the years we have been able to do quite a bit with those funds in helping people across the state of Colorado. One of the biggest things is that we are the largest organizational

representative payee that requires know whether service connection to services. We assist individuals in the very basics of receiving Social Security benefits paying their rent and medical and food so that they can continue to be members of our community. That's just one of the examples that I will give and you will hear from others and that you have seen in these emails about the work we do with those charitable funds. To support people across the state with disabilities who have very low incomes. So that's what I have for today and if you've got any questions for me now I'm happy to address those. >>This is Kristi. I want to help people understand that if a parent leaves a child money, with a disability, if they leave money that person could be kicked off of services. So that's the reason for the pooled trust that money can go into. Because not everything is covered by Medicaid. We did a major expenditure on a van and a lift that is covered. If you get $5000 your doing really well. Things like white's for adults. Things that you don't always think about. So that's some of the expenditures she's talking about and it's a part of what makes these pooled trusts or the disability trusts, necessary and needed for our loved ones who have disabilities. I'm speaking for myself with a daughter who's 37. We've got a trust that will be funded once we pass away. But in the meantime we fund things that are necessary for them because we don't have a funded trust. But these are other ways and often times they don't have family existing, living, or capable, to support. So elderly parents will then go to to the pooled trust. Did that help? >>That helped and in my effort to shorten I left out an important piece. The other piece we are often referred to as the entity that steps up when others step back either due to appearance deaths or to people who have burned all their bridges due to their mental illness or brain injury and secondly the average pooled trust over the last five years is $32,500. We are not talking about big amounts of money but to an individual who has a resource limit of $2000, that is a big amount of money so it's got to be very protective of those >>So what is the remainder go. Let's use your $33,000 to the XYZ person who has now passed away there's about $15,000 left in that pooled trust. What happens with that money. >>[Captioners transitioning]

The nonprofit organization has been before, and we have retained 100% those funds move into our charitable funds just put numbers on that in the last 10 years the average amount of the routine coming in over $160,000 and we use them in the ways that we have talked before, in our program, we supplemented case management I described, we wouldn't be able to do that solely on the things that we charged, and a lot of education and community on the guardianship all of those things. And when I give you the full written material you will see the full example of them. That was my hand letting me be as professional as I need to be this week. I apologize. I've gone over but I think we got what we needed and what we wanted to say thank you.

Next month -- Next up, Kelsey.

Come on down, tell us who you're with and what you're doing.

I will also be brief and respectful of the time. My name is Kelsey and I'm a law attorney in the a cole relation -- Have been asked to speak on your behalf that would reduce the charitable fund I just want to talk about , and to the charitable funds. The services provided as we just talked about case management just spoke about. These services if they go away I don't know of another organization that will survive. We are not really here to share the story, but I want to leave the board a message, Express how important these services are. I hope you take these into consideration going forward. I want to ask you. They are against this right now. Is that what you are telling us?

Yes we are strongly opposed.

Any changes.

All right sorry about that.

Okay.

Thank you so much.

If you have questions.

>> Good afternoon thank you for correct thing.

Thank you about 20 years I have worked closely with the always and special needs trust law. On trust law and I just wanted to tell you , because of my relationship with trust all over the country. I work with most. Let me tell you what Colorado fund, for these disabilities that they don't do. As they said, we didn't get into those homeless programs, but they are absolute fantastic, and also teaching nationally on best practices. And this whole process seems to be arbitrary let me explain. Today we have never asked for a review. That's it.

Thank you. >> I'm trying to put A, B, C, this would make more sense, and would have something to do with the remainder in what happened with that.

That we have a separation they would be interested in that. The documentation is actually here.

I want to ask if there is been one, if so that is what I'm asking at this point having talked to Ms. brand, and the lobbyist. And Mr. Smith. Which --

Please. >> The original purposes that Mr. Smith was going to talk about what they were, and we are trying to familiarize you with the different parts of the department and purely information. It might be in the works but it is a separate issue. We realize it was something coming, and we look at the opportunity of the potential rule. And just to educate you on what the cool trusts are.

I also heard on the committee, and the amount of the stakeholder involvement. Maybe there is a need for more conversation ? When I said come do the open forum.

We had a room .

Right now. >> I appreciate you saying that. And I appreciate there is a draft rule out for a couple months now. That rule is not coming next month .

It is coming. Yes it is. >> There is a role and a draft rule, that rule is coming next month, we did not get a preview of said role. Only an overview.

There is still a process. There will be a public engagement of the rulemaking. That hasn't occurred yet that's why you haven't seen the rule yet.

I respect that. >> Next month when we look at the miss here and the material, we will see the draft rule, there will be chances at that time and if there needed to be slowed down or given another month whatever, and have in the opportunity as a stakeholder, or a person and I heard such differences in what had transpired. If I may have an opportunity with some of our newer board members that weren't there two years ago, when the board went through our retreat, and we discussed a lot of times, a lot of times Medicaid lots of different programs going on. It would be helpful to have previews as to what rules will be coming next month. That is the genesis of this. Obviously. Many cases right the rule preview. It sparks interest. And certainly as the board we never attempted to put restrictions on open forum, or limit in any way.

This is another decision this committee had made. It's your meeting. You get to do as you wish. And the board did ask for previous. As a department we work very hard to bring roles. You will see these next month, and basically what happens, the rules haven't actually made it through the internal process. What they will do later this month. They will get there to the public rule meeting
there is an opportunity for stakeholders to have one on one conversation in the conference room in this building. And that is a standard meeting. This is just to say look you are getting labor rules .

When I hear these things, that is what we talk . >> Specifically what happens with the remainder of these dollars, and at the onset , and they are talking about this item.

In my discussion with Mr. Smith. I confirm. He was saying, I was just going to give my [Indiscernible] -- The rule is coming and he was giving [Indiscernible - low volume] is there more of? [Laughter]

Could. Good afternoon , the remainder of the board that is still here, I am an attorney again I'm just going to add a little bit of the information that you heard in general and similar to trust and

completely a different animal the things involved with that. All the different versions of that we have, we are currently in compliance under statute and federal regulations. That is been litigated and there has been question to that, individuals over 65 if they have a disability there option is the trust, under federal law and current state law there is not a penalty for the individual to join at 65 or older. The question that remains from someone over the age of 65 , does it constitute in Medicaid terms a gift or transfer without consideration we use the department current regulations to analyze and determine that they are for consideration otherwise there would be a penalty imposed as Mr. Smith talked about. There are rules and regulations and statutes in place to analyze these as they are now. The transfer to the trust does create a red -- A rebuttal. We have had litigation in this case, consistently it has come about those transfers are to be analyzed. Not a denial. I understand the amount of work that the department does put in. As Mr. Smith said it does take time to review these. Just because it takes time to review these transfers. Go it doesn't mean that we should be penalizing beneficiaries without having to do the work. It is going to take work I understand that. The one piece that I really want to stress. We will provide and enough time to do this. There were specific legal pieces. We will provide substantial written material to the service board prior to the next meeting. And the initial time. One of the other things I really wanted to stress. These trusts do not lose other characteristics. The beneficiary for those needs and to take care of the beneficiary, when these needs are transferred, the trustee doesn't lose anything they have under hundreds of years of statute law , that trustee, in this particular case, it may be another trust, and an individual disability trust. It is their duty to manage their beneficiary needs, and restrictions to make sure that they get there to be a compliance, whatever they may be on, they do not lose that duty, he can't presume that they will preach their duty just because it is the disabled beneficiary in a big trust company. That is something that is crucial, courts have relied on making a determination on how these trusts should be administered. Obviously you heard there is litigation. We will provide that, and we are trying to give you some of the basic trust information the way it works in Colorado . Go these changes I believe

you don't have them yet so I won't get to them that I want to make sure that this board knows these trusts have all of these built-in safeguards and any other trust has. We are in compliance with federal law. And we are in compliance with the memos with years ago, and the last time.

Thank you so much.

Anybody else?

Okay done with that. I mean any comments?

One week get this why now? Which is part of it.

The regulatory analysis.

Sometimes it is because that's why.

There are some changes. Yes. I just continue to as the question. Has there been enough stakeholder feedback. If we ask for more of that before we see it next month. There is still lots of time for this conversation. I heard a lot and saw a lot of this and I wanted to nip it in the bud some way.

I have a question.

At of all of these people in the open form today. We may understand the process for participating. Oh

The day is posted on the website.

Actually precise, I communicated with Ms. brand, and laying out the dates of review, October 11, and final reduction moving forward. Yes. I believe Ms. Brent has communicated that.

With that we will move forward. Thank you all for your comments and all of that we appreciate it. I have someone text me that we didn't do a motion for the agenda. I thought we did. You read it.

Thanks I thought we did. But I couldn't -- I just wanted to make sure. So with that we will go to open updates, do you have updates for us?

For the federal updates. And then we will do board elections and adjourn.

If you are with us. The members of the board, I'm not raising my hand but I'd like to keep my hand over my head. I haven't done it the whole time.

I wouldn't say no. >>[Laughter]

I will keep it very brief. We are working towards developing a budget . They were sending appropriators , over language regarding abortion policy. Funding for domestic programs. And we do see this yesterday and tomorrow morning. To move forward on this rule fund, I just want to take a moment to discuss Department of Homeland Security. In the public chart This is a final version of the rule. Proposed in October 2010. The public role is the definition of public benefit for the purpose of immigration determination. They will find these and indicated as a benefit that can be used. That being said most citizens that could be subject are not eligible for Medicaid. Significantly it narrows the impact on the members. We do know it is very complex and concerning for many in our city. We had the department suggest a name, any member that is worried, and we can take more questions about that. >> Thank you so much and thank you for being here for us.

Thank you.

I will be very brief.

I have submitted budget. And we go back and forth with this budgeting. And as we had today put in appeals anything this was denied as one of our final determination, at the end of next week. And we would be able to discuss this at the next board meeting. And we are also finalizing our agenda for the year. In working with the Attorney General's office, and making sure everything is compliant. That is the new process. You met the legal division director, the liaison, please do not hesitate to make use of those folks. To have all three of them. Utilizing these services. Very quick on some of these benefits. Dental services will be available. And the health plan plus will be a benefit for these services, and for her current children, except orthodontics. The annual maximum allowable for the calendar year, July 1 through June 3, and the eligible members. All families with a higher income may be required to pay a co-pay when they receive services. The other is substance use uptake, finalize the draft and application allowing federal transparency requirements, and completed two meetings. One on August 30 in Grand Junction in September 6. The period ends on September 27. 5 PM. 2019. We may amend the application as appropriate based on the comments we have received. And see any additional information thank you for your services. We are glad to be included in this update.

Thank you so much I appreciated.

Let's move on to the board elections.

I make a motion that Amanda more be our new chair. Anybody in agreement ? I would like to ask that
we consider. And pass the baton.
All in favor?

Aye.

Would anybody like to step up for vice chair ? That person tends to roll into the role , and how it set up, so that we can be prepared there are a lot of moving parts in this committee. And it helps to be a wing man up it before your front and center.

Just for clarification these positions are two-year. FYI.

And we need to look at who is on long enough that they are not going to come off before . Does anybody want to put themselves up? >> Yes I have not right? Given some interest, we haven't heard prior to this. I was going to say three.

Is there someone interested? >> That would be yes.

Would you be interested?

We would love for you to step up for vice chair.

I'm stepping up. >> [Laughter]

All in favor.

Aye.

That is astounding. >>[Laughter]

If I would've known , we needed a boost today.
>> -- I think we got Aye from both. Now we have Ms. Moore , and [Indiscernible] lead us into the future. >>[Laughter]

It's over. >>[Laughter] >> We have these previous.

And my predecessor actually. I was vice chair and my vice chair was not renewed and I came in to the meeting finding out I was suddenly chair. This was my point yes.

The only thing changes now you have [Indiscernible].

It has been very helpful. It has been very helpful for Amanda not only to be my wing man but pay attention to what I screwup and also to catch me on consent agenda and keep track on things like that while I am keeping track of others. >>[Laughter] >>
Yes.

[Indiscernible - low volume]

You can thank me later for coming to this meeting. >>[Laughter]

Okay. We are adjourned. I appreciate everyone sticking with us. Thank you all for stepping up to leadership.

Thank you.

Have a good day.

[Event Concluded]