Please stand by for realtime captions
>> Please stand by for realtime captions
>>
>> Let's start.
>> Everyone is muted.
>> Going back, started beginning. Christy Blakely?
>> Here.
>> Cecile Fraley?
>> If you are on the phone, it*sixth two on mute., To on mute.

>>> This is Doctor Freeland., Fraley she is here.
>> How was your flight?
>> Pat Givens? Are you on the phone?
>> Simon Hambidge?
>> Present.
>> Bregitta use ?
>> Here.
>> Jessica Kuhns?
>> Here.
>> Amanda Moorer?
>> Charlotte Lippolis?
>> Here.
>> Donna Roberts?
>> Here.
>> David Pump?
>> Here.
>> I will do the general announcements. The next meeting is scheduled for Friday, September 3 team, the 2019 beginning at 9 AM at 303 East 17th Avenue in the conference room Denver Colorado 80 203. Is the policy of this board and the department to remind everyone in attendance at this facility is private property. These do not lock the doors or stand around the edges and these silent cell phone while in the meeting. If you are listening and lose connection click again on the link to rejoin the meeting. The Q&A is enabled and please submit your comments at the open forum time and the agenda. Identify yourself and your comments they are of public record. Testimony can be given over the phone. Please refer to the website for instructions. Testimony will be given time after the individuals in the room. Please identify yourself when speaking. There is a sign-up port testimony and for each one, if you need help finding that asked staff for help. A 5 minute limit for all testimony.

>>>
>> Good morning, Tom.
>> Good morning. glad to be her.
>> I would entertain a motion for the approval of the July 12 minutes. At this time.
>> Approval of the July minutes.
>>. All in favor?
>> Aye.

>> Opposed ? Abstain?
>> Pat, are you on the phone yet?
>> Yes.
>> Welcome.
>> Thank you, Pat. We now have you as present at the meeting. So, that passes. Let's go to the rules. We have two emergency adoption rules today. We will do document 5 1st period I am calling January Montano.
>> Good morning. I January Montano the durable medical equipment reimbursement specialist for the department. On here, I'm here to present the emergency rule with a possible rate increase for durable medical equipment. These are rules for these items. There are a wide variety of items that may not necessarily have a price or may have a variance in price. Because of that we have these rules to allow for that. There was a question from the board about what the rate increase or the reimbursement impact is to be DME providers. Is an annual increase for most of the providers that they provide. To simplify this, if you have a code or D capitol in E has a rate of $100 this increase would increase that to $101. This is an annual increase the other benefits generally don't have rule changes and this is why we are doing this. This is because we have such specialized things we need to allow for all these scenarios. That was my quick presentation. Any questions?
>> Doctor Gibbons, Givens, any questions?
>> No.
>> Any public comment?
>> On the phone or live in person -- anyone sign-up? If you did,,. I'm not seeing anybody. Nobody is waiving their homes.
>> No one that. And I would entertain a motion.
>> I move the emergency adoption of this document a revision to the medical assistance rule considering durable medical equipment section 8.590 .0 section K with the specific statutory authority contained in the records.
>> Second?
>> We have a motion that a second. All in favor?
>> Aye.
>> Doctor Givens?
>> It passes. Since this is an emergency we will see you next month.

>>> On to document sixth. Come on up. This is Chandra.
>> I was just reading something. I apologize.
>> Good morning. I'm here for the emergency rules for the Colorado healthcare, health and dental program for low income seniors. To give you a background, the program is strictly for seniors 60 and over. At or below 200 and $.50, 250% of the poverty level and they do not have any other type of dental such as private dental insurance. The reason for this emergency rule is, how is Bill 19 1326 asked mandating that the advisory committee can change the procedure rates and that no procedures in the program can be less than any the four schedule from the Colorado race. There was a goal of 36 procedures below the Colorado rates that need to be changed in Appendix A. There is some verbiage that also needs to be changed. We wanted to get this completed so that the department was following the house bill 19 1326. What I would like to do is start on page 1. 916. We changed it from 2014 to 2019. The same page 2 line 21. Page 2 line 34 this is that the program payment must

not be less than the current rates within the Medicaid. On page 5, line 17, that is updating to have it listed in Appendix 8. Then, on page 31 I will announce which procedure codes have been changed. I don't want to get into the amounts. If you would like for me to, I certainly can. I think it would take more time. Page 31, you have a copy and you can read the numbers. 4355 for mouth debridement, page 33 E 5 110 complete denture maxillary.
>> Page 34 D 5120 complete denture mandibular. Page 35 5130 immediate denture maxillary. Page 36 5140 immediate denture mandibular. Page 39 D 5213 maxillary partial denture.
>> Page 40 D 5214 mandibular partial denture. Page 41 immediate maxillary partial denture. Page 42 D 5222 mandibular partial denture. Page 43 D523 immediate maxillary partial denture. Page 44 D5224 immediate mandibular partial denture. We are getting there.
>> Page 45 D 5511 repair broken denture base. 512 to prepare broken complete denture base. 5520 replacing missing or broken teeth. 5621 repair partial mandibular.
>> 5622 repair partial framework maxillary. 5630 repair or replace broken materials for a tooth. 5640 replace broken teeth per tooth. Page 46 D5660 ad to existing partial denture. Page 48 D5740 relying maxillary partial denture. 5741. Relying mandibular partial denture. Page 50. D 4710 extractions. D7210 surgical removal of an corrupted tooth. Page 51 D7220 removal of an active tooth.
>> 7230 removal of an impacted tooth, partially bone. D7240 removal of impacted tooth completely bone. D7241 removal of impacted tooth completely bone with unusual surgical complications. Page 52. D7250 surgical removal of residual tooth roots. Page 53 D7320 [Indiscernible - low volume] this will be lateral plasty not in construction with lateral. The same with extractions. D7472 removal of tourists mandibular.
>> Page 54. D9110. Palliative emergency. D9219 evaluation for moderate sedation deep sedation or general anesthesia. D9223 deep sedation. D9243 intervene yes moderate. Those are all the changes we have to get the rules up to the current healthcare Colorado race.
>> This Doctor has communicated that she is in favor of this and all the questions are answered.
>> She had a follow-up question this morning. A piece that would be good to understand that how the allocation is being used completely either by an individual or for maximum benefits where the fund is maxed out. If there is an increase in reimbursement for the individual procedures this is good for retention and recruitment of the providers yet no increase in the overall allocation. To we suspect that this could impact access positively or negatively in any way?
>> This is not going to impact anything. As far as a maximum amount there is no one. It's not like that. It depends on how many seniors are in the region. As far as how many time a senior is having this that is something I can give you. Currently we have, now up to 30 grantees. I can get some figures from last fiscal year on how many individual seniors were seen and how many individual procedures were done per Senior. I do not have that with me, however.
>> That's not exactly what she is asking. She was trying to make sure with the increase in the rates that it would still -- all the allocations. I think that's the question.

>> You got the email, too, so let me know if I am misinterpreting it.
>> We were at 3 million and we just got an increase to 4 million. With the increase we will still have more funds than last year.
>> So you had a budget increase to allocate for this increased rate?
>> It wasn't for this, but we just happened to get it.
>> Either way, I will take that as a yes. Thank you very much.
>> Any other questions from the Board?
>> No questions. Thank you
>> Any public testimony?
>> No one signed up. Anyone in the room want to testify? Okay, I would entertain a motion.
>> I will move for the emergency adoption of document MSB 19 -- 07 -- 10 -- a the revision to the medical assistant special financing rule concerning Loretto dental healthcare program for low income seniors section 8.960 incorporating the statement and specific statutory authority contained in the record.
>> 2nd period
>> All in favor?
>> Aye.
>> Post, abstaining ?
>> Doctor Givens?
>> Aye.
>> It passes. Thank you.
>> Going on to the final adoption consent agenda. That is with Erin Johnson.
>> Should we do the emergency rules first?
>> We were just discussing that.
>> That first segment, I don't think we need to do that.
>> We don't need that.
>> Okay. Did we read that?
>> Do we need to do that?
>> Did we review the language?
>> Somebody read this.
>> I would like to move that emergency rules adopted that the immediate adoption is imperatively necessary to comply with federal regulations or for the public health safety and welfare and that the compliance with CRS would be contrary to the public interest.
>> 2nd period
>> Okay, now we've done it.
>> Thank you. Now we will move to the final adoption of document 1. I would entertain a motion.
>> I would like to move the final approval of MSB 19 -- 06 -- 06 -- A regarding the rule incorporating the statement of basis and purpose and specific statutory authority contained in the records.
>> 2nd period
>> Motion is seconded. All in favor?
>> Aye.
>> Doctor Givens?
>> Aye.
>> That passes.

>> The final adoption agenda for document two. We are asking for Kathleen Homan to come up. She will talk about CES.
>> Good morning members of the board I'm Kathleen Homan and I am a huge CBS, HCBS specialist. Last time we resented these changes there have been a a few small changes. One change since the last reading is the definition of movement therapy based on stakeholder feedback. They added therapy after dance and music to indicate that movement Derek he, therapy can be provided through dance or music therapy. This was proved, approved and we also received two requested are things from the Attorney General's office and we have made that up to date.
>> We also responded to the written comments and worked to respond to all of the written suggestions. Then, we received a final comment, a last-minute, yesterday about definition of client representative. As this is the final adoption we are not specifically updating that change now but this was in response to the representative definition added to our section as an update to the case management section which was a part of the rules adopted by MSB 1904 -- 16 -- A. We will bring that comment and suggestion to the case management team and we will work with the stakeholders in the future. At this time we continue to work with stakeholders and our counterparts in this case management division.
>> Any questions? Seeing none and hearing none -- Doctor Givens, any questions?
>> No questions.
>> Thank you for clarifying this. That makes it easier.
>> Thank you very much for listening to and working with everyone. Any public testimony? No one is signed up. Okay, I will entertain a motion. No approval of this document for the long-term services reports, supports concerning the CES waiver section 8.503 providing a statement of basis and purpose with specific statutory authority.
>> All in favor?
>> Aye.
>> Opposed? Abstain ?
>> Doctor Givens?
>> Aye.
>> It passes. Thank you very much. That is a lot of work. We need to thank her. Let's go on to document 3 the revision to the medical assistance and we will ask for Adam Tucker to come up. Good morning.
>> Did you figure out that we would be with you before 9:30?
>> No. That is impressive. It's very impressive.
>> It takes nothing to create this.
>> It is your facilitation.
>> Is it?
>> Thank you very much.
>> Off we go. Tell us about this role.
>> I'm here to talk about MSB 18-12-27-A. This will is a revision to the rules around Senate Bill 18 145 two do it two basic thing, to allow for us to collect data around supported employment as well as implementing some structure and update the provider qualifications for job coaches and job developers. And the last meeting there were some questions and we went back and looked at that. I reached out to the stakeholder but have not received a response. The questions brought to us, we did not feel we could make changes based on those. I would like to give an

explanation of why. Really, the first question, the first statement made was that the stakeholder is excited about the rules and this is a really good opportunity to reiterate that. As a department we are excited about these rules. We believe in supported employment and we believe in employment first and we believe that it supports people with independence out of poverty and it is a social determinants of health. Just so you know, Governor polis made August employment first month and this is bigger than what we do and medicate and we are excited to be a part of the overall statewide team and lamenting employment first because it is important for individuals with disabilities of all stripes to really be able to access these services so they can be successful. That is one thing I want to say. The other is clarification around the national certification and training to add the names of the training and certifications to the rule. We went through an incredible amount of stakeholder feedback. It was very much suggestive that we did not do that and that we create more competencies. There is some difficulty adding the trainings to the world. Anytime he wanted to change that we would have to go back through the process. This is one of those things. However, we are working hard to make sure that in the certification training that we haven't proved that they are on the website and also on the preapproval form. In the form of a drop-down box. Every time we come and approve a new training or certification they will be added to the website and to the drop-down preapproval form. So, if it is there and easily accessible that makes it better than looking at the rules, to be frank. We felt more comfortable leaving the room away it was to allow for that. Then, the last thing was around the idea that, especially for direct care professionals working with people with the most significant disabilities, of the two years to become certified, that may not be long enough. The issue we ran into is that it is part of the statute. The two years pieces part of that statute. So, we have to keep it there as of now and we will absolutely monitor that. If we start to see that there is access issues if two years is not long enough we will address it at that point. At the same time we have five years to come into compliance. As we work through this will start to realize some of the issues around this and the implementation and we will address that as it comes up. Last, we wanted to mention that all of our stakeholder process, any meeting that we had was in combination with the vocational rehabilitation and both sets of meetings, anyone could attend either in person or on the phone or on the webinar or a combination. We worked hard to make that these meetings were accessible because we needed to hear feedback was from people directly affected by this. I wanted to reiterate that we did that as well.
>> Any questions for Mister Tucker?
>> This is a comment regarding the first consideration, putting specific programs into rule. I appreciate this.
>> You make something accessible that is workable and this solves the problem and I really appreciate that.
>> Thank you. Any other questions for Mister Tucker? Doctor Givens?
>> No questions.
>> With that --
>> Nobody signed up.
>> I thought about it and then I forgot.
>> Going on. Yes, this takes a vote. I need to entertain a motion. Did anyone want to speak? No one is raising their arms or looking excited to visit with us. Let's

go on. I will move for the final approval of 18-12-27-A revision to the medical assistance rule concerning employment first incorporating the statement in the basis and the purpose and the specific statutory authority contained.
>> I have a motion and two seconds. All in favor -- Aye?
>> Opposed?
>> Doctor Givens?
>> Aye.
>> It passes. Thank you, Mister Tucker. Next, the initial approval of document 4 and that would be Kristina Gould.
>> Good morning.
>> I like this.
>> You like this?
>> She likes this role.
>> Mandy is excited about this. Good morning. I am the policy specialist here to present a revision to the pharmaceutical services rule 19-07-17-A. I have presented this before and it was approved so it probably sounds familiar. There was a technical administrative error so I have to do this again. The change is the same and I will briefly run through it again. This drug is used to treat a dysfunction in the grade in the brain. It was recently approved. We have recently removed this designation from investigational experimental drugs. We will continue to cover this drug. It is very simple. Any questions?
>> Questions?
>> Okay. Any questions, Doctor Givens?
>> No questions.
>> Any public comment?
>> No public comment. Does anyone want to publicly comment? Not seeing any, I would entertain a motion.
>> I move that MSP 19-07-17-A incorporating the statement of basis and purpose in specific statutory [Indiscernible - low volume]. 2nd period
>> A motion and a 2nd period on paper?
>> Aye .
>> Doctor Givens?
>> Aye.
>> Thank you. We need to go on to the consent agenda. I move to and document format.
>> Do we need to add the emergency rules?
>> We can't.
>> Okay, we will and document format to the consent and then we can do a closing motion.
>> We need to vote on that?
>> Sorry. All in favor --
>> Aye.
>> Doctor Givens?
>> Aye.
>> It passes.
>> We have one on the consent agenda for next time. Now we will go to public comment if there is anybody.
>> We that this means these procedure incorporated by the records.

>> 2nd period
>> We have emotion. Do we have consent about finishing and closing?
>> I will not go through this whole thing.
>> We are moving fast.
>> I'm having trouble keeping track of this. We are having fun.
>> We will go to the will previews and we have Chris Underwood first. The Colorado national provider identifier. That sounds like fun. There is some copy for this one. You miss me when I'm gone.
>> You will still get to participate. Yes, but I don't get to talk as much. Good morning.
>> I'm Chris Underwood. I am currently transitioning from my current role I was the director of the health information office and transitioning into the chief of staff for the department and this is one of the last items on my agenda to slowly condition. I am transitioning to Scott, our operations director.
>> That seems to be news to Scott.
>> [Laughter]
>> I don't have emotion. I will bring you up to speed.
>> I'm good. Today I am here for technical support. I will take over once he is gone.
>> Good for you.
>> This is implementing house bill 18 1282 the Colorado NPI law. This law requires a separate NPI by provider type and location. This gets into some detailed work we've had to do for the last year. We have been working on this regulation and definitions for a year internally and with our stakeholders. It is more detailed than you would expect. Most of the rule is purely definitions providing, defining what a provider type is. And the law has an ID that providers fill up to get an ID based on the services they provide. We require an NPI anytime a provider in roles or bills for service and so does Medicare. These can be shared across provider types and locations. We are trying to stop that and have NPI s to be distinct and they are free and easy to get. Unfortunately, providers have enrolled in our system and they need one NPI for 30 or 40 locations and now they have to update those locations with a new NPI so this will take some burden of the providers. Scott and his team are setting up a portal to make it easy to do. When we get to that. We need to pass the regulation because in the law it says we got to do it by provider type and in the law we didn't want to define 80 different provider types. Sometimes they change. Sometimes we add new in. This depends on the needs of the department. Therefore, they said you would have to put it in regulations. Here we are ready to put 80 different provider types and regulations. It's a little difficult sometimes. You would think that you would know what a hospital or home health agency is. You should know what kind of requirements they should have for Medicare to enroll with Medicaid or for a license. It's not an easy exercise in reality because licensing names changed and they don't always align with our provider type names. You have to go to every program specialist in the department to make sure to know what to look for. We have been doing this exercise for a year and we posted the draft rules on a webinar so people could answer questions and we published these on our website for 2 1/2 month. So the stakeholders and providers can login and see and give us comments. We wanted comments in case we were doing something wrong. We didn't want to mess anything up with our provider types. Based on these comments we created a

FAQ document. The document is there as a reference. This is important because as we transition it confuses providers. What is my actual NPI and billing number? Where do I put my new NPI on a claim? It's very technical. The rules get into this technicality. 20 provider bills us they can still use the current number but on the claim form there are different locations to put different numbers and NPI s. We are asking them to put this in the service location field in this will not mess up any remittance and it is a new area they have to populate on the claim. They will have to update their enrollment to get the NPI on there. we will have a transition period. Under the law all new providers must have this affected January 2020. All current providers must have it affected by January 2021. We have a phased-in approach and we have to go through validation. Every five years they must re-sign with Medicaid and Medicare and go through the screening process. We will link this NPI to the revalidation process. Hopefully, it will be a one-step process for the provider and hopefully we will have an easy update website where people go to update these. These rules help us to get to that. There is a caveat. This is causing some confusion with hospital providers. Off-campus locations of the hospital must comply by January 2020. This has caused some concern. What is an off-campus location and how we we get this done by January 2020? While this law was passed Medicare came along and said the same thing so all the hospitals had to be compliant with having the off-campus NPI with the care by July of this year. That concern went away with a lot of the hospital providers because they had to do this before and we have worked with some of our large systems and sat down with them and we are still having meetings to help with the transition. That is the basics of the rule. If anyone has technical questions we can try to answer them or if you want to try to talk after the fact we can get into more details.
>> My question is to clarify. This is called Colorado NPI but it's really Colorado PI. It's not like the I, NPI number that is everywhere. This would not be nationally used. It's specific to Colorado. Colorado Medicaid. Help me understand that.
>> We will use the national NPI. Everybody that signs up to the national NPI. We will not be Colorado specific. It will go to the national website to get their numbers. For a doctor it's a little different.
>> I will try to understand.
>> Doctors are allowed to have one NPI no matter where you practice.
>> I like that much better.
>> Help me understand how this works. I'm very attached, because I have to be, to that one number that is needed for every pharmacy and everybody. This is the confusion around this. The additional numbers.
>> The additional numbers apply to organizational healthcare providers.
>> Yes.
>> Those are institutions or businesses, home health agencies may have five different locations around the state and they may be one company. They have one NPI that they use for all five locations. This law and requirements requires each location to have its own NPI and they must register with us.
>> Thank you. My understanding is that the NPI system currently in use for healthcare providers is being expanded to include a lot of other people and organizations needing to use these numbers that don't have it now.
>> Yes, that is my understanding. They are working on this to expand this

>> Thank you. I was having over this. Five different numbers. I did not fully understand this.
>> This is Christy Blakely. I will try to summarize this. If you have an NPI number it will not change. As a provider you have the NPI number. Unless you have multiple sites for your company or agency. Been you would have an NPI number for each location, but still a national number?
>> And provider -type. There are providers such as a home health agency providing other services. A different provider types. They will need two NPI s for these. For each site. It can get complicated. I have multiple examples I can walk through. Like, what if I am a rural health care provider with two clinics in the city and I transfer patients. We walk through those examples. Those are five different providers that you need to get. Five different NPI.

>>> This is the introduction for next time when this will be discussed. We got some time. I have a quick question. My sense is that this is already happening. We have a new clinic with a new location. We needed to go through this. I'm clarifying -- you are nodding yes.
>> Yes, it is probably have a little more informally because of what is Medicare is doing and providers are already adapting. A lot of times we told people it is a best practice. We don't have enforcement regulations to comply yet.
>> And I want to address billing and different locations. I would be curious about that. That has created some hangups for us in Durango. When you bring this back it would be interesting. There has been some confusion around the spirit of the law and the actuality.
>> I will see if I can do this.
>> Next time you will go into the weeds.
>> On the claim form there are different locations but a lot of times it is done electronically. I don't know if I can bring you a paper claim form to show you.
>> I would be happy if you acted it out, too.
>> Yes, what was expected is different for different systems. I totally understand that you are trying to do this. Trying to enter different portals is complicated.
>> Yes.
>> I have had these conversations. We are more than happy to push back. When your vendor tells you they can do this. We know that they can do it. We've had those conversations.
>> Oh, the fun we will have!
>> Hello. I'm David Pump. Generally, what percentage of riders and locations and provider types still need to do this work?
>> Question. We are going through the process of changing the system right now I'm part of the requirement is generating a report to tell us that. So when we open this up we will know how many we are looking at and who to contact. We plan to reach out and let them know if you have five locations you've got to comply and this is how to do this. We are not there yet but we will work on that.
>> Yes, we will hear the initial in September. This is a preview. Any other questions?
>> Gentlemen, Thank you for the preview. Can you hold that for public comment? I see your hand. We don't normally take public comments or questions at this point.
>> Let's do a preview of the emergent and nonemergent medical transportation with

Ryan.
>> I'm Ryan Dwyer and I oversee the transportation benefits. I'm here to preview the rule for emergent and nonemergent medical transportation. This affects all who use transportation. Major changes you will see next month will be especially for any MT, significantly bigger than what is there. more in depth. There will be more requirements. Were criteria. It will flesh out more than we have now. So, what we have heard and discussed in the last 18 months from stakeholders, we don't think this would be appropriate to include in the rule. A lot of what we've heard the last 18 months such as from the transportation community board and people out there and that kind of things are things that need to be done in the contract. So, we incorporated will be put into the rule for this process. Other than that we are happy to talk moving forward about what we can change in the contract for the stakeholders to see. With that said we made one change in the feedback from July 22. We remove the ability for services to be denied because of potential he disrupted behavior. What is disruptive to one person isn't necessarily to another. We struck that altogether we thought that would be the easiest way to do it. The other thing being discussed that we've been working with is transportation for people in mental health crisis. That is outside the scope of the rule but we hear this a lot. We are researching what other states are doing. To see what we have in terms of provider bandwidth and that is something that will require a new benefit. This is something that we are hearing. I hope the rule I bring will be pretty straightforward. We have heard a lot and at this point we think we have captured most of what we can.
>> Any questions? Donna? This Roberts?
>> I have a question.
>> Speak up.
>> In these area, areas of Colorado many people were escorted with the use of the deputy sheriff. This is entirely inappropriate. Many of them are trained but not all of them are. To be handcuffed and put in the back of a car and transported to a facility in an urban area was a catastrophe most of the time. That is my concern.
>> Yes, this is the integral health peace. I have heard this as well. Issue is, we need to identify the providers capable of performing these things. I hope to address your concerns and I will keep this in mind.

>>> Also has a psychiatrist working in the ER this is a huge problem. The police officers are the people that end up doing it if there is no more transportation available. They will because they have to. So, I'm excited for this rule to come forward because medical asportation is a shockingly difficult function for our patients to access. In rural areas. No matter what. I am interested to see how this comes forward. I wouldn't be surprised if we had a couple of issues.
>> Tom Massey?
>> No.
>> Any other questions? He is on his way out of here. Thank you so much. We look forward to seeing that next month. Thank you for the comments related to behavioral health and rural issues. We appreciate the knowledge at this table bringing the passion. We appreciate that.
>> We will go to open form and public comment. Is anyone signed up? Sir, you had a question. I don't know your name.

>> It has been covered.
>> You got the answer? Share what you learned. I didn't mean to shut you down.
>> I'm a nurse and I have owned a few agencies and I was interested in knowing the NPI information. I also had a transportation company.
>> I am glad that you're here. We need you next month, too.
>> Exactly. We have a nonmedical emergency transportation. I was asking if we needed to create these numbers. My concern was that we had to create NPI numbers. According to him, not necessarily. Therefore, we will be able to keep our providers separate and create one new NPI to cover the one that doesn't have this. That was my question.
>> Yes.
>> Thank you for bringing this up. There will be technical assistance because this can be complicated
>> Yes.
>> Everybody wants to do the right thing. We don't always have the answers.
>> According to them this will not affect because there is already a provider number.
>> Yes. Thank you.
>> Next, Bregitta Hughes --
>> For those that didn't attend in Colorado Springs, this was our host.
>> Thank you for hosted.
>> It was fun.
>> You say that with such enthusiasm. [Laughter]
>> Yes, I think your expertise will be needed next month. Thank you very much. Anyone else?
>> I would like to make a response. Some of this is incredibly complicated. I won't go into the weeds, but when you add another practice, it is super helpful if we do not live in that specific slice of the medical world to understand that. We got tripped up and that is uncommon. I am in close contact and it made me reflect even for bigger practices that are used to this, how obligated this can be. The smaller you are, I think smaller practices with one person wearing a lot of hats it can be challenging. Some people get right up but it's complicated.
>> Yes.
>> There are a lot of connections that you don't realize. When one thing moves other things you need to realize that. Is
>> This is Simon Hambidge. It seems like the positives outweigh the negatives.
>> Mister Massey?
>> Honestly, part of the problem is when we can't track individual claims to locations. Under a single NPI number with multiple locations we can't collect the data we need. Claims data. This will help us to be more specific.
>> I want to make a comment. I have been in the position of wanting information that we don't have. Talking to them, is not available. I would love to have a better sense of where this is happening. So you can look up a patient claim. You have no idea where it happen. That piece is a problem for Medicaid. This affects our rules. It was one of those standalone outpatient hospitals where it was an issue in terms of understanding what was happening. As cumbersome as it is I am in favor of data collection if we can get better information.
>> Mister Massey?

>> To address your question we think the end result justifies the means. Even though there is some burden, this will provide much better data collection. As we move toward this it will be beneficial for the practices.
>> Good. One more person for public comment.
>> Paul Stein. Come on down. We are not giving away anything today. Sorry. We won't make you spin a wheel, we will just listen to you.
>> Maybe a consolation prize is a good system.
>> Yes, that would be wonderful.
>> I'm Paul Stein. I used to be a coordinator in the Department of human services. I'm working on immigrant and refugee cross-cultural transportation issues for a long time. I'm here to offer a couple of comments, especially after the disappointment of hearing that a lot of our stakeholder comments will not be in the new state rule, they will be relegated to the contract. I was a participant in the patient-centered transportation coalition for what feels like many years and it has been many years. I had a productive relationship making recommendations. The two recommendations I would say do belong in the state rules, a higher level mechanism for oversight than just a contract or one for the transportation bored. And a definition of what constitutes an adequate transportation metric. The contract oversight with deference to the current attentions, the contract oversight of the past was extraordinarily lax. There was no on-ramp for public input for stakeholder comments to deal with all of the other primary particiipate in this system. The healthcare providers and transportation providers and the patients themselves. It was simply contract management to provide [Indiscernible - low volume]. This is an important component of health outcomes. We have been proposing a mechanism for greater input so that we could have therapeutic transport. So that the patient looks forward to the ride rather than dreading the ride back. I'm very disappointed to hear that something as basic as stakeholder input through transportation can't be included and that an adequate network cannot be defined to include basic elements such as geographic distribution, transportation modality distribution. We have been proposing some kind of public matrix for what they knew transportation writer is developing. How many providers different languages. This was seen like a basic mechanism to see if you have an adequate network for the broad diversity of users in transportation. I suspect that we would find that linguistically not proficient users are a greater percentage of this network than not. So, this is something that is basic. Tele ride is assembling a new network. I am connected to many drivers who don't know what the process is and the criteria. What the on-ramp is. This is a valuable benefit to be a transportation provider and we overlooked that. There needs to be some oversight of the contracting process. When I was with human services we gave a lot of contracts. Every subcontract required approval by our department. You can't just willy-nilly handout the valuable resource of state funds without some oversight. I'm not saying that in the current system. In the current establishment. So, I would urge that the board looks more closely at the rules. As stakeholders there is anticipation of dialogue about the rule process moving forward. And we will pay attention to stakeholder input through the transportation board and what, exactly, is an adequate network to ensure that all patients have a ride that makes them happy to go to their healthcare provider. Thank you.

>>> Thank you. Any questions for Mister Stein? I assume that you will be back next month.
>> Many of my colleagues are here today. I'm not just speaking in my role.
>> You got the short straw. I did, too. That's why I'm here.

>>>
>> Thank you for your comments and input and your passion for the work you're doing. Will pay attention to this when it comes forward.
>> Thank you so much.
>> Any other public comment? I'm not seeing any or hearing any. All right, we are going to department updates. Mister Massey, you are on the hot seat.
>> Yes.
>> Good morning. this is a rather expeditious meeting and that's good. There is a lot going on as you can see. A lot of internal changes. We are in the process of working with the governor's office to finalize our legislative agenda. This year we feel good because we are a little bit ahead of the curve. Generally we don't get the agenda approved until later in the year. Within the next few weeks we will have that finalized. We are working closely with the office of state planning on our budget request for the next year. We seem to be somewhat ahead of the curve. We have a lot of legislative friends. 101 partners down the street dying to help us with our healthcare agenda. We are working with them. With some trepidation. [Laughter]
>> That's part of the process. If you will indulge me, we have the federal rules director here. Can you give us an outline of what is going on?
>> Good morning. join us.
>> We are lucky to have Lauren here during these changes.
>> I am changing my name in a few days.
>> Congratulations.
>> We will not be hearing too much from Congress. They are focused on drug pricing and billing and I don't think we can expect true movement on this until after January at this point. They are struggling to get the budget passed. I think we will probably see a CR, continuing resolution. They have sent the budget to the president. There is a lot going on in rulemaking in general. We are commenting to the governor's office through recent conscience rules coming out of HHS which would strip away some antidiscrimination from ACA interpretation and we are watching that closely. Otherwise it has been a little bit slow going through August. We will keep it moving. Any questions?
>> Ms. Roberts?
>> I was curious to see this in the budget -- and initiative for the Medicaid programs to receive funding for direct primary care by providers. Has that trickled down? They were saying, it sounded like a robust opportunity. I just wondered if it had been initiated.
>> I have not seen any rulemaking on that. Let me look into the budget and see if it as past, with what the house put forward.
>> Thanks.
>> In that regard, if you have any questions, get them to me and I will get them to Lauren and we will research this and have an answer the next board meeting.
>> Great question.

>> [Indiscernible - low volume] . There are more physicians setting up prepayments and would focus on patient care and the autonomy of the patient, etc. I would assume psychiatrists are doing on as well. There is no Medicaid reimbursement for that individual. Even if they were to charge they could not collect it because they can't help it to Medicaid, obviously.
>> I will add that when people choose to do that and the Pearl, the poor doctors are not contracted, we get frantic calls from people who have not been able to get prescriptions. Is something interesting that pops up.
>> Yes, this turns all the patients into cash pay because they can't get prescriptions with their insurance.
>> Yes, this changes things for the patient.
>> That was Doctor Lippolis, the third voice that you heard.
>> Thank you. I appreciate it. I didn't mean to you on the spot.
>> Mister pump, did you have a question?
>> No.
>> Thank you very much.

>>> Another update.
>> As this is starting to get rearranged I will keep you days. We just hired a gentleman to be our chief of operations for our new office, the office of Medicaid operations. He comes to us from the private sector with extensive experience as a CFO and CEO in various healthcare delivery systems. Different insurance organizations. We will try to streamline a lot of the operations with his help and we would be glad to have him on board. Is that different from the Medicaid director?
>> Yes.
>> Who does he report to?
>> The Executive Director.
>> So it essentially creates two directors?
>> No, this is operations rather than the program, so to speak. I'm asked regularly when we will hire a new Medicaid director. We have gone through the interviews and we are doing the final negotiations. We will have a new Medicaid director in place in short order and get this information to you. We are about to finalize, with help from our stakeholders, finalizing some interviews yesterday. We are about to hire a new legal division director.
>> Yes, Paul. He has gone to New Mexico and has taken a position there. chief legal counsel. Our Medicaid tabulation is about 20% in Colorado and in New Mexico it is over 50%, a more significant population. He has found a home there. they are anxious to go. We wish him well. We will have an announcement shortly. Hopefully, by Monday, who our new legal Director, legal division director is.
>> We have a new legislative liaison starting on the 19th. Nina Schwartz. We have worked with her previously. We brought her back because she is very capable. We will have a strong legislative team this year. Joe Mullen is moving to a senior position with Lauren. We have a strong state and federal team. This will fold well for us going forward. As you heard Chris Underwood is transitioning from health information office to Deputy Chief of Staff and we are recruiting for a Chief of Staff. A lot of changes.
>> No kidding!

>> Yes.
>> It sounds like the dust is settling.
>> It would be helpful to have a roadmap.
>> Yes, we are finalizing that and we will get you a chart. You asked about that regularly.
>> It keeps it more fun to have everybody guessing. [Laughter]
>> There is a lot about opioid abatement. We are proud of what the department in a few years ago limiting the number of opioids going out. We reduced that by 50%. We are proud of this. Is actually an interim committee meeting down the street, a legislative interim committee on opioid use and abuse. We will work closely with them every aspect to see more legislation around the. Also the private sector mirroring some things that we've done. It is going to be an active year. Dealing with the public option plan and touring the state, hitting all the counties and municipalities and we've got this to work with. That is a work in progress. It is a busy year. Let me see if I am missing anything.
>> Finalizing the department performance plan. The healthcare affordability and Medicaid cost control. Improving member help. Improving customer service. Really towards operational excellence. Everything that we are doing keeps this framework in mind. I think it will be an interesting, innovative, busy time. For the next year for sure. We appreciate your work on the medical services for. We couldn't do it without you. Thank you for your service. I will take any questions.
>> This is Doctor Fraley. Could you talk about the transformation? I understand in the moment but not at a hospital, I don't understand how long this is and if and when it will end.
>> Let's do this. Instead of me going through this, why don't we try to arrange --
>> I have you hostage.
>> I'm well aware of that. [Laughter]
>> Let's try for the next meeting to bring in Nancy Dawson, the lead on that, to give you an update.
>> Yes. Be helpful to understand.
>> It's a big initiative and it would be good to hear directly from the source. I will ask her to attend the next meeting.
>> Great. Thanks.
>> Ms. Roberts?
>> Back to the question I asked last time. Individuals with type I diabetes. The newest monitor is around $1500. I would think that this would be cheaper then an ER visit. I'm curious if there will be funding for that through Medicaid for individuals over 21.
>> Let me follow up on that.
>> From birth to 21 they are covered but I soon as they are 21 they can't have CPM. I think that that would save millions of dollars in ER visits and unintended depths.
>> Okay. I will talk to them about this.
>> This was on our radar last fall.
>> And is it 10% of the people with diabetes that are type I?
>> Yes, it is changing but it's around 10%.
>> Let me see if I can find out if there are changes.
>> Thank you

>> Hopefully I will have an answer for you.
>> Anything else?
>> All right. With that, we will adjourn. We will reconvene. Will you give us 15 minutes to get to the other room?
>> I can give you more.
>> Let's go to 25 until the hours to give you time to make phone calls and then we will convene in the other room. Thank you for joining us. Best wishes on your baby. For not having it this morning. I know that you are ready.