Colorado Department of Health Care Policy and Financing
Expansion Opportunities Interview Summary
Alex Weichselbaum
June 15, 2016

Interviewees: Alex Weichselbaum
Other participants: Samantha Saxe, DHCPF, and Beth Waldman and Margaret Trinity with Bailit Health

1. What is the geographic scope of and enrollment in the rehabilitation services program – how has that scope changed over time?
    - Alex is program administrator for the rehabilitation services program. Included in his responsibilities are oversight of physical and occupational therapy benefits, speech therapy, substance use disorder, imaging and radiology benefits. He keeps an eye on utilization, writes and amends policy related to these benefits, and provides program integrity oversight. "I answer a lot of providers' policy questions." He does occasionally have contact with recipients. He influences budget and rate conversations as well.

2. How many SCI clients use PT/OT services?
    - Getting that number would be easy – volume, utilization – she would like to see utilization in 2012-2013 timeframe. Are there any rehabilitative services that you manage that are not in state plan? Outpatient PT and OT services are in section 11, this is where you will see the bedrock policies of the PT OT services, including limit to 48 units per year of PT/OT (after which they move to home health benefit); children do not have a unit limit on these services. Speech therapy has only a 5 unit per day max, although typically speech therapy is only one unit per day. In home health world, adults do not have access to long term therapy, only children have access to long term therapy.
3. Do you ever receive requests from advocates for alternate therapies such as acupuncture, massage?
    - Prior to July 1, 2016, even though our policy was that adults do not have access to long term therapy, that policy was not enforced. Effective July 1 that policy will be enforced. He fully expects there to be a movement within next year to enhance the benefit. Alex noted that 20,000 recipients access the state's physical therapy benefit per quarter, on average. How many of the SCI clients have access to these services – needs to be broken out for OP and home health? Because they are all adults, there won't be utilization in home health.

4. Our understanding is that the rehabilitation services program is authorized by the state plan amendment (as opposed to waiver), is that correct?
    - Yes.

5. Given our area of investigation into alternative or non-traditional therapies for the long-term physically disabled – for the SCI program – could you please tell us whether any of non-traditional therapies or services have been implemented within (or contemplated for) the rehabilitation services program? Probe for acupuncture, chiropractic care and massage therapy, possibly nutritional services specifically.
    - Alex explained that the State Plan governs what modalities or treatments are allowed – by virtue of whether that modality is 'open' or 'closed for billing. The state plan does not cover acupuncture or chiropractic care as a covered benefit. The billing code for massage therapy is open, so it can be billed but only by physicians, or physical or occupational therapists. Alex explained that the covered massage benefit is to prepare muscle group for therapeutic activity that follows; so 30 minutes of massage 97140 and then therapeutic activity 97110 – and these two are billed separately.
    - Alex noted that aquatherapy is a covered benefit under the state plan.

6. If yes, what copays or limitations are placed on these services? How are practitioners reimbursed for these services? Is there a gatekeeper mechanism for these services?
    - Prior to this July, the gatekeeping mechanism would be a prior authorization thru EQ Health, after July 1, 2016, will not require this for adults but it will be limited to 48 units per year. Treated as any other PT/OT therapy services. Qt1 FY16 adults receiving therapeutic massage = July 1- September 30 2015 = 9220 adults received some quantity of procedure code 97140 or 97124 – difference between those two codes is kind of subtle. 97124 = therapeutic massage including 141 adults (this is the relevant figure) reimbursed units was 13.5 units most that anyone got was 80, lowest was 1 unit; 97140 = manual therapy techniques. Samantha and Alex will cross check if any of these are in SCI program.

7. If down the road we were able to get CMS approval to add these three benefits to SP, what is entailed in adding a benefit to the state plan? Would state just need to add the relevant benefit code? What about nutritional counseling services?
    - Alex responded that there would not be a need to amend the state plan if it was a licensed physical or occupational therapist performing these services, or a physician. But if it were a massage therapist or acupuncturist, that would require an amendment to the state plan.

- Every few years the acupuncturists ask us if they will cover their provision of acupuncture services. We have been asked recently about coverage of dry needling. Alex stated that his understanding is that CMS is averse to covering acupuncture in state plans because it is not a widely accepted medical procedure, however he has not specifically asked CMS for its views on this. He noted that he does not believe there is internal support from chief medical officer to incorporate acupuncture or chiropractic services in state plan – perhaps massage therapy might be in similar boat. He believes that the lack of support stems from a lack of solid evidence to support inclusion of these services in state plan, especially from a cost savings perspective.
- State plan does not give state authority to directly pay a nutritional counselor unless he/she has license or is enrolled as existing provider. However, if a physician practice employs a nutritional counselor, those services can be billed under supervision of physician. Further, if a physician billed for such a service, it would be billed under standard visit code, and he would not necessarily be aware of provision of nutrition counseling. Richard Delaney might be able to assist us with utilization data.

8. Would the provision of acupuncture, chiropractic care and/or massage therapy services be of benefit to Medicaid recipients served by the rehabilitation services program? If yes, which specific subpopulations?
    - Alex stated that he does not routinely scan the medical literature on this; would certainly like to see these services offered.

Colorado Department of Health Care Policy and Financing
Expansion Opportunities Interview Summary
Sarah Hoerle
June 16, 2016

Interviewees: DHCPF' Sarah Hoerle
Other participants: Margaret Trinity and Beth Waldman with Bailit Health

1. Can you provide us with an update on the waiver simplification efforts?

   Sarah leads the waiver redesign for the state's long term services and support programs; she also leads implementation of the Community First Choice option for CO. More specifically, Sarah oversees the adult waiver simplification efforts for the Persons with Brain Injury (BI), Community Mental Health Supports (CMHS), Persons who are Elderly, Blind and Disabled (EBD) and Persons with Spinal Cord Injury (SCI) waiver programs. She started with the department in 2012, left in 2014 for a year, and returned in April 2016 to oversee the waiver simplification effort.

   - **Community First Choice (CFC) Option**. Sarah explained that the Community First Choice Option allows states to provide home and community-based attendant services and supports to eligible Medicaid enrollees under the Colorado State Plan. This State plan option was established under the Affordable Care Act of 2010. This option became available to states in October 2011 and provides a 6 percentage point increase in Federal matching payments to States for service expenditures related to this option.
     - The Community First Choice Advisory Council has recommended shifting non-medical transportation, residential services, behavioral health, mental health, independent living skills training, and community transition services into the CFC option. The Department has hired a contractor to examine which services are the best candidates to transition to state plan benefits, taking into account the potential fiscal impact of such potential shifts. Sarah notes that some states made these shifts too quickly without considering the potential budget impact – this is a lesson that Colorado hopes to avoid.
     - Sarah stated that services that *must* shift from waiver program status to state plan status include: personal care, homemaker, health maintenance and personal emergency response system. *Under consideration* for shift from waiver services to state plan

services are behavioral services, mental health, non-medical transportation, and transition services.

- The Department aims to have a final report from their contractor that has recommendations of services that could be shifted from the waiver programs to the CFC option by June 30th. Sarah noted that the state would not be able to target services by age, disability or county once they are shifted from waiver to state plan benefit. However, services currently available to a limited population via waiver programs would be available to many more individuals under state plan. For example, some waiver programs have a wait list for specific services offered under the waiver – so shifting some of these services to state plan would open these services to people on wait list.
- Following transition of some services from waiver to state plan status, a limited set of services would remain in the waiver programs, for example respite care, alternative care facilities and residential services. In addition, the supported living program and transitional living program would remain services under the Brain Injury waiver program due to the expense of these services for which there is currently a wait list.
- While the Department does not currently have wait lists for enrollment in any of the waiver programs, there are wait lists for specific services offered under certain waiver programs, e.g. supported living services under the Persons with Brain Injury waiver program.

2. The 2013 report "Concept Paper for Waiver Simplification in Colorado" provides information on enrollment and services provided under each of the state's six waiver programs. Have there been any significant changes in any of these programs in last three years?
    - There is an effort by the state to make in-home support services (IHSS) that are currently available under the EBD waiver program also available under the CMHS waiver program and the Supported Living Services (SLS) waiver, which is under the auspices of the Division of Intellectual and Developmental Disabilities (DIDD), but the state lacks a legislative mandate to do so. This would have enabled a seamless integration of the EBD and CMHS waiver programs as it is the only service that is not currently offered under both programs. The Department is still hopeful that combining these two waiver programs might be feasible in the future so as to make easier for clients to navigate and less of burden on administrative staff to manage.
3. Can you provide an overview of how the BI, CMHS, EBD and SCI waiver programs are coordinated? I.E. what coordination exists between Colorado's various waiver programs, especially with the SCI waiver program?
    - If you are in waiver program, you can only access services in that waiver program. An individual might have targeting criteria for multiple waiver

programs, however an individual would need to choose a single waiver program based on results of functional assessment. All the adult waiver programs are managed by single entry point case managers. Clients can access one waiver program and also be on wait list for a second program.

4. As you know, the SCI program is the only waiver program that offers acupuncture, chiropractic services and massage. Are these services ever requested by individuals enrolled in the other waiver programs? By advocates?
    - The SCI waiver program is very small and concentrated in the Denver metro area. If these three services were shown to decrease hospitalizations and costs, there would be broader support for offering them. She has heard discussion of interest for these services as part of Mental Health Supports waiver – people talked about wishing these services were available. People in different counties wishing these services offered more broadly. There are definitely consumers and advocates who would like access to these services but reside outside the five county Denver metro area.
5. What about nutrition counseling?
    - Sarah has not heard same level of interest for this service as she has heard for acupuncture, chiropractic and massage services. She has heard of discussion of need for nutrition counseling for individuals enrolled in SCI waiver program, given that these individuals are not as mobile and their nutritional needs must be considered carefully for sake of their quality of life. She noted some interest in home delivery of meals, but there has not been discussion of nutritional counseling.
6. Are there any non-traditional therapies offered within these waiver programs?
    - Mental health counseling, while not a non-traditional service, is a service that is offered under the Brain Injury waiver program. This service is not offered under the Mental Health waiver – and they receive a lot of inquiries about this -- because people with mental illness are covered under state plan for mental health services from a behavioral health organization. The Children with Life Limiting Illnesses waiver offers bereavement counseling offered under this waiver – also expressive therapy. The children's waiver programs offer more non-traditional therapies than the adult waivers.

Colorado Department of Health Care Policy and Financing
Expansion Opportunities Interview Summary
Tyler Deines and colleagues
June 20, 2016 Draft

Interviewees: DHCPF' Tyler Deines, Matt Baker, Alicia Etheredge, and Noushin Berdjis.

Other participants: Samantha Saxe, DHCPF, and Margaret Trinity and Beth Waldman with Bailit Health

1. What is the geographic scope of and enrollment in Supported Living Services (SLS) waiver program and the Waiver for Persons with Developmental Disabilities (DD) waiver program (cap of 4525 individuals with wait list) – this is the program that offers the 24 hours residential access (does not offer professional services such as massage)? Have there been any changes to these programs since November 2013 (waiver simplification report)?
    - The DD waiver program offers 24 hour residential services, behavioral services, day habilitation, prevocational service, transportation, specialized medical equipment and supported employment services.
    - The SLS waiver provides more intermittent services, for example home maker services, mentorship, personal care, and home modifications.
    - The SLS waiver offers professional services, including massage, hippotherapy and movement therapy, but does not provide chiropractic or acupuncture services. Under the SLS waiver, massage therapy can be provided as a professional service; the provider qualifications required for providing this service are fairly broad. Massage service must simply meet criteria that it "promote physical well-being…to relieve muscle spasm and muscle tension;" there is no requirement that massage services be therapeutic. In addition to the SCI waiver, currently the SLS and Children's Extensive Support (CES) waivers are the only ones that offer massage services.
    - For the SLS waiver program, a person is assessed using the Supports Intensity Scales (SIS) tool, and most services provided under waiver program are subject to that person's support level limits as determined by the SIS assessment scores.
    - What are the limitations of these services? Under SLS waiver, professional services are subject only to the support level limits.
    - Do you have any utilization and expenditure data for these services?
        - Yes, Tyler will forward info to us.
    - Do you have sufficient provider capacity for massage services?

- Tyler explained that the Department does not measure provider capacity. However, he has not heard issues of provider capacity for massage services.
- To date, the delivery of services under this waiver may be provided by community-centered boards (CCBs), private not-for-profit agencies in local communities that determine eligibility and provide services, directly or through purchase of services. So, for example, a CCB could organize massage services through any licensed therapist and the CCB would then reimburse the massage provider. Professional service providers may also enroll directly. However, most professional services are delivered by providers overseen by the CCBs and the CCBs reimburse providers directly. Right now, however, the Department is finalizing its plans to remove the conflict of interest for CCBs to comply with new federal rules in this area.

2. Please discuss waiver simplification efforts for these two programs. Are there specific services that you are considering shifting from these waiver programs to state plan?

    - Tyler described the efforts of the Community Living Advisory Group, beginning in 2012, and a separate waiver redesign workgroup, in 2013. The waiver redesign workgroup began meeting in late 2013 in order to develop recommendations for Department – a comprehensive set of recommendations for redesigning services offered under SLS and DD waivers – with a focus on services for people with intellectual and developmental disabilities. Tyler described a process whereby initial recommendations were vetted with stakeholders in local communities and across the state.
    - The workgroup included recommendation for a broader "purpose-based" definition - "health and wellness professional services." To date, these services have included only massage, hippotherapy and movement therapy under the SLS waiver program. The workgroup recommended a broader definition that might include, for example, services to support individuals in maintaining healthy weight or supporting general health. The department is now working on narrowing the definition of health and wellness professional services so as to define a list of services and thereby enable: 1) setting provider rates; and 2) determining provider qualifications. The Department is in process of developing a recommended definition that will preserve health and safety while also offering the flexibility that clients requested.
    - During stakeholder meetings, Tyler reported that the workgroup did hear mention of services offered under SCI waiver (massage, chiropractic, and

acupuncture) as services that clients would like to see under a new waiver program.

3. Was there discussion of chronic pain, and acupuncture and massage services as possibly meeting these needs? Or as part of definition?
    - Tyler stated that these would meet need of health and wellness definitions.
4. What is the timeframe for developing new waiver program?
    - Target date is to submit a waiver application by this time next year, so the Department is developing service and coverage standards, which covers details of an included and excluded service. Right now focusing on service and coverage standard and the actual service scope.
    - Will seek additional input from stakeholders on details of service inclusion and coverage this fall.
    - July 2017 is target date for submitting waiver with implementation in July 2018. Tyler stated that they will be working to recruit, credential, and enroll providers into the system, thereby build capacity to meet client needs. Department aims to be able to deliver services under this new waiver program in July 2018.
5. Will the current SLS and DD waiver programs continue, or will they be folded into new waiver program?
    - The Department will be operating the new and existing waivers concurrently for some time with SLS and DD waivers in order to ensure an adequate phase-in and phase-out schedule and allow individuals to transition to the new waiver. Tyler explained that the SLS and DD waivers currently are in place thru July 2019, but will likely need to be renewed for some period of time to allow for that transition. However, the new waiver program is intended to replace the SLS and DD waivers.

Colorado Department of Health Care Policy and Financing
Expansion Opportunities Interview Summary
Kelli Metz, Pharm D
July 8, 2016

Interviewees: Kelli Metz, PharmD, DHCPF

Other participants: Samantha Saxe, DHCPF, and Margaret Trinity and Beth Waldman with Bailit Health

1. Could you give us an overview of the Pharmacy Unit and the services that Medicaid provides?

   The Pharmacy Unit covers medications that can be taken at home or administered in the home by the member or a home health care nurse. Other medications that are administered in the hospital or doctor's office, for example IVs or some injections, are medical benefits.

   The Pharmacy Unit has been extensively involved in the past few years making the public and providers aware of opioid use, misuse and abuse, and the risks associated with opioids. Dr. Metz developed a webpage that addresses many issues including paid evaluation, guidelines for pain treatment and opioid tapering, opioids and pregnancy, alternatives to opioids, naloxone administration, patient education, and offers information and resource links to substance abuse/misuse programs. The Unit updates the webpage on a continual basis, and is committed to investigating alternatives to opioid prescriptions for treatment of pain, including non-pharmaceutical therapies.

   Dr. Metz explained that clinical pharmacists are trained in evidence based medicine. Some non-pharmaceutical pain treatment alternatives have shown benefit, but do not have the robust evidence supporting the benefits that commercially available pharmaceuticals have. There is definitely literature available to support the benefits of non-pharmaceutical treatments, but the cost effectiveness is weak. The cost effectiveness evidence in an important factor in benefit decisions.

2. What initiatives are occurring in the Pharmacy Unit, specifically around opioid usage (and misuse) and prescription drug misuse more broadly?

   Dr. Metz noted that there is a nationwide movement to reduce opioid use. She explained that DHCPF is following an initiative established in 2013 by the Governor's Task Force in its efforts to reduce the misuse of prescription opioids. She described the work of the Colorado Consortium for Prescription Drug Abuse Prevention (Consortium), which recently launched a takemeseriously.com public awareness campaign. Dr. Metz and another member in the Pharmacy Unit are integral participants in the Consortium work groups and have been since its inception.

The Pharmacy Unit has undertaken two initiatives in this arena. As described on the Pharmacy Unit's Pain Resources webpage, to support this campaign DHCPF established limits on morphine equivalents and pill quantities

- In 2014, the Unit established a quantity limit on short-acting opioids of four tablets per day maximum, equating to 120 tablets per 30 days. The webpage notes that "through this policy we are attempting to reduce client utilization of short-acting opioids and maintain or improve client levels of stability and functionality."
- Effective February 2016, DHCPF placed a limit of no more than 300 milligrams of morphine equivalents (MME) per day (Metz noted that this is a very high limit). The intention is to slowly taper members MME utilization to a limit that is supported by the QUAD-Regulator Joint Policy for Prescribing and Dispensing Opioids. From listening to providers, and how patients are tapering, she anticipates that future efforts to further taper morphine will be successful. Eventually, DHCPF would like to establish a limit of 120 MME per day or lower, which Dr. Metz described as a "gold standard." Reaching such a limit may take a few years. DHCPF is transitioning to a new PBM vendor, which controls all the pharmacy systems, later this year; this transition has slightly increased the time of the tapering process for many members.

3. What have your analyses revealed about prescription drug misuse within the SCI waiver population (if any)? about opioid use? within the Medicaid population more generally?

   No such analyses are available regarding the SCI waiver population or a comparison to the general Medicaid population. However, a comparative evaluation of the ECHO Program before/after is close to completion.[i]

   An analysis of the 2014 limits on short acting opioids to four per day as described above, found that short acting opioid use decreased more than long acting opioid use increased, thus overall opioid utilization decreased.

   No formal analysis has been performed on the MME per day limit that was effective February, 2016, as the policy has only been in effect for a few months.

4. Are there any points of comparison vis a vis opioid usage between the SCI waiver population and the Medicaid population more broadly?

   No such data available.

[i] Colorado's Medicaid Accountable Care Collaborative established in 2015 the Chronic Pain Disease Management Program, which uses telehealth technology to help primary care providers address chronic pain and reduce opioid prescription abuse among Medicaid members. The ACC's primary care providers have access to chronic pain specialists via HIPAA-compliant video technology. This initiative is modelled after the Project ECHO programs developed by the University of New Mexico.