



Benefits Collaborative Public Meeting

Monday, March 3, 2014
 3:15 p.m. – 5:00 p.m.
 Department of Health Care Policy
 225 E 16th Ave, Denver
 First Floor Conference Room

Notes

Time	Topic/Agenda Item	Responsible
3:15 – 3:20 p.m.	Welcome and Introductions <ul style="list-style-type: none"> • Ground Rules & Phone Etiquette • Staff Contact Info 	Kimberley Smith
3:20 – 3:25 p.m.	Brief Benefits Collaborative Overview <ul style="list-style-type: none"> • Purpose of the Benefits Collaborative • Review the role of participants and the Department • Parking Lot List 	Kimberley Smith
3:25 – 3:30 p.m.	Frame for Today’s Discussion Today’s Focus : <ul style="list-style-type: none"> • Discuss wheelchair repair policy • Discuss revisions to policy based on feedback received throughout the Collaborative 	Kimberley Smith Eskedar Makonnen
3:30 – 3:50 p.m.	Discussion of wheelchair repair policy	Kimberley Smith Eskedar Makonnen
3:50 – 4:00 p.m.	Review Feedback Received throughout Collaborative	Kimberley Smith Eskedar Makonnen
4:00 – 4:15 p.m.	Review Revisions Made To-Date and Why	Eskedar Makonnen
4:15 – 4:45	Group Discussion of the Above	Kimberley Smith
4:45 – 5:00 p.m.	Roadmap Moving Forward <ul style="list-style-type: none"> • Updates from the Department • Identify potential dates for seating and accessories meeting 	Kimberley Smith

Note: Time allotments subject to change based on discussion.

Facilitators:

- Kimberley Smith, Benefits Collaborative Manager, Department of Health Care Policy & Financing (HCPF)

- Eskedar Makonnen, Policy Specialist, HCPF
- Dr. Judy Zerzan, Chief Medical Officer, HCPF

Welcome

Kimberley Smith, Benefits Collaborative Coordinator with the Department of Health Care Policy & Financing (Department) invited participants to introduce themselves and reviewed the ground rules for this and future Benefits Collaborative meetings, they include:

- Tough on issues, not people
- One person speaking at a time
- Be concise/ share the air
- Listen for understanding, not disagreement
- Speak up here, not outside
- In the room: Phones on silent/vibrate
- On the phone: Please mute your line
- Please introduce yourself when asking a question or making a comment

Kimberley provided her contact information Kimberley.smith@state.co.us 303-866-3977, to which participants can address their future questions and suggestions. She also reminded participants that the call is recorded and that the recording and this transcription are both posted to the Benefits Collaborative web site.

Benefits Collaborative Overview

Kimberley then briefly reviewed the concept of a Benefits Collaborative. She explained that the purpose of the Benefits Collaborative is to create a benefit coverage standard, which is the term the Department uses to refer to a benefit policy. She explained that The Benefits Collaborative is a process, not just a meeting or series of collaborative meetings; it begins with the drafting of a policy and becomes standard practice once the Medicaid Director signs it, after much public input.

She asked the group to keep the guiding principles of the Benefits Collaborative in mind: the amount, scope of duration of the benefit should be defined based on 1) what improved the health of clients, 2) whether or not the policy is cost effective and 3) based on evidence-based research and best practices.

Kimberley also reviewed the roles of participants and the Department in this process.

The Department retains ultimate decision making authority over the policy but asks participants to:

- Share diverse perspectives to expand understanding ahead of decision making
- Share new information/research

- Ask questions and provide informed insight in response to analysis offered and suggestions made

In turn, The Department will:

- Work with participants to ensure that concerns are consistently understood and considered
- Wherever possible, work to ensure concerns are reflected in alternatives developed; and
- Provide feedback on how public input influenced decisions made and explanation when input cannot be incorporated/adopted

Frame for Today's Discussion

The purpose of today's meeting is to revisit what has been suggested thus far (including power mobility devices and manual wheelchair bases policy) and the policy themes that have been emerging over the course of the collaborative in general, to make sure that the Department fully understands the input of participants ahead of moving forward with research and discussion around operationalizing changes to policy.

The Department will begin a "deep dive" into policy research and discussion after this meeting and will schedule the final Benefits Collaborative meeting far enough out that there is ample time to do research, communicate the Department's tentative plans via the Listening Log and then reconvene as a group to gather final and focused feedback on the policy as a whole and also the Wheelchair Seating and Accessories policy as-yet undiscussed.

The Department has also set aside some time at the front of this meeting to discuss the topic of Wheelchair repairs, which both Dr. Zerzan and Jose Torres with CCDC identified as a topic of interest in multiple meeting previous.

Discussion

Eskedar gave a brief overview of the issue of Wheelchair repairs. She stated that concerns have been raised that parts are not readily available for repairs and that repairs are not always completed in a timely fashion.

Kimberley noted that Jose Torres with CCDC sent the Department a document titled "DME Showcase" (posted online for reference), which contained three asks of the Department:

- 1)** That provider(s) have certain -reasonable- amount of parts per equipment purchased for each of their clients
- 2)** That provider(s) have available crew of techs who can address emergency situations any day of the year
- 3)** Medicaid must allow the provider(s) to reimburse their employees for standby time and extra hours

Kimberley asked Jose to further explain #3 above.

Jose began with #1 and #2 and clarified that the request is for providers to keep enough basic parts – and some advanced parts – in stock in order to do timely repairs. Wheelchairs, although expensive, are not a luxury; they are a necessity to function and stay happy and healthy.

Jose then spoke to #3. He stated that he knows staffing is expensive and CCDC does not believe that the cost burden should rest solely with the DME provider company. CCDC asks that Medicaid reimburse for weekend and off-hour service.

Eskedar asked Jose to elaborate on what he means by “standby time” in #3 above. It is her understanding that Medicaid reimburses for services that are rendered.

The recording of this meeting temporarily failed and the response is not clear. However, Jose mentioned that there are possibly creative ways to address the need for 24/7/365 service, and reimburse for it, that are within the parameters of federal guidelines and more cost effective, such as tele-medicine (video chat).

Kimberley noted that the Department will workshop these suggestions internally. She then invited discussion of the wider group. She stressed that the Department is very interested in making sure that clients receive timely and reasonable repairs. The Department has heard several anecdotal stories that this doesn’t always happen and seeks to understand the nature of the roadblocks.

COMMENT – George O’Brian with CCDC identified two areas that he feels need to be covered and do not presently appear in the policy draft:

- 1) Colorado is a large state and the service areas are limited.
- 2) Some areas are inaccessible (for example, only reachable by snowmobile). Would that be considered DME? Kimberley identified this as belonging to a larger discussion of rural accessibility issues.

COMMENT – Phil Goy, an operations specialist, with NuMotion’s Strategic Resource Group spoke to suggestions #1 and #3 that Jose Torres made above.

In response to # 1 - The Basic Part List for a type of mobile inventory – NuMotion is always working to have those in their vans and in-stock in their shops. There are certain items, however, that must be prior-authorized. In many cases NuMotion will order an item without prior-authorization but must wait to deliver that item until the item has been approved.

Phil mentioned that NuMotion would love to see some sort of “fast picks” program by HCPCS codes (healthcare common procedure coding system), for parts that are approved 99% of the time.

RESPONSE – Michele Longo with NuMotion chimed in that, in Colorado, there are already a number of codes that don't require an authorization that NuMotion can deliver right away and that in many circumstances NuMotion does take the risk as a company to provide a needed part without prior-authorization for post-payment review.

She suggested that something to look at would be to figure out how that is working or if it can be enhanced.

Kimberley clarified that she heard two possible suggestions within this conversation:

- 1) Looking at increasing opportunities for post-payment review, so that providers can provide in-stock items without having to wait.
- 2) The other issue is making sure, wherever possible, that parts are in stock. She invited further comment on this second point.

COMMENT – Phil Goy continued by stating that NuMotion's ordering time is a 24 hour turnaround and they usually receive parts in 2-3 days.

In response to item #3 that Jose Torres raised, Phil explained that there are capacity issues around serving clients on weekends and in off-hours. NuMotion is doing mandatory overtime in some locations just so that people can receive the services they need. This incurs overtime expenses. NuMotion is always trying to drive efficiency and optimization. For example, NuMotion is using GPS enabled scheduling and routing but there is still added cost for being on-call afterhours and on the weekends.

COMMENT – Jose Torres with CCDC acknowledged that NuMotion has made strides to address timeliness and issues. There was a very constructive meeting at Atlantis a while ago but, with respect, he pointed out that, presently, there is a NuMotion client who has waited nine months to get a motor replaced. The chair is functional, but barely; it doesn't stop properly. He pointed out that he may have the power to call the right people and get the problem remedied but he has not because many clients are not in this position.

RESPONSE – Kimberley asked Jose if, in this instance, he knew if the hold-up was on the Department side or the provider side.

Jose stated that the provider explained it is a problem with the manufacturer.

Kimberley noted that this example seems to be about replacement of motors. She asked if there was an attempt to repair the motors.

Jose stated that the motor cannot be repaired.

Kimberley then asked the providers in the room and on the phone if this is a typical amount of time to wait for a motor replacement.

Susan Kennedy with NuMotion stated that this is not a common amount of time to wait for a repair but, unfortunately, due to the combination of manufacturer problems and the number of parts on backorder this was a situation that was unique to that manufacturer.

She noted that, the issues with this particular manufacturer have put many people in a compromised position. She also explained that NuMotion desires to work with those individuals to communicate what has been going on and get people the temporary help they need, perhaps in a different chair, while waiting on the part.

Jose pointed out that this is also something CCDC is asking of the Department – that replacement chairs be available as backups when the primary chair is broken. Not all chairs are made alike.

Kimberley asked the providers in the room if there was something on the Department/policy side that is preventing providers from getting clients who may find themselves in the situation outlined above (manufacturer issues) from getting timely information and equipment that really meets the client's needs in the interim.

COMMENT – Michele Longo with NuMotion noted that nothing comes to mind on the policy side. The issue above really occurred due to FDA policies and procedures.

Michele noted that this is a big, complicated subject: setting up policies for repair. With regard to what is timely, Michele states that we have to be honest here and noted that a huge scooter store and manufacturer went out of business and NuMotion experienced a huge influx of clients who came to NuMotion for repairs? NuMotion spent months catching up from that and is starting to get ahead of the game. She is curious if a separate task force meeting should be set up to dive into all of these issues and really peel them apart to understand what the things are on the policy side that would make a difference. NuMotion does have a lot of parts in stock but the reality is that not every part can be in stock. There are a lot of codes that don't need prior-authorization but, when needed, this can really hold up a repair.

COMMENT – George O'Brian with CCDC noted that Colorado has a Wheelchair Lemon Law and asked what it says on the matter.

RESPONSE – Michele explained that that law states you cannot have the *same* issue with a wheelchair piece of equipment multiple times, if you do, the chair must be replaced.

Rich with NuMotion clarified that there is a first-year warranty and if, for example, in that first year a joy stick control on the wheelchair fails three times, the chair itself would be considered faulty and replaced. After the warranty, the Lemon Law doesn't apply.

COMMENT – Susan Kennedy with NuMotion suggested that, perhaps, a repair threshold (for example, \$5,000) could be set for certain chairs/equipment, under which the provider would not have to seek prior-authorization to provide the repair.

COMMENT– Dr. Judy Zerzan (on phone) reiterated that the Department really wants to know if there are policy things that can be put in place around repairs because Dr. Zerzan sees this as a really important issue and that we don't necessarily have the right balance at present. Are there policy pieces that need to change? Are there reimbursement rates that need to change? She suspects it is a bit of both.

COMMENT – Jose Torres with CCDC asked for some time to provide the following suggestion in writing but briefly offered the following. Let's say that, because of CMS rules, we cannot get rid of prior-authorization completely. Perhaps we could require providers to keep in stock a certain number of parts that they know will not require prior-authorization.

RESPONSE – Rich Salm with NuMotion noted that this conversation is not new; there are a lot of elements that are involved in the process. A comprehensive review of this process may illuminate where there is opportunity to shave time off of the repair process.

One of the areas of great inefficiency, as Rich sees it, is that, when technicians are on the road and need to drive one, two or three hours, they are not reimbursed for that time. There is a tremendous cost to the company associated with that services. This is one factor out of many that contribute to the problem.

In general, across providers, providing repairs is not a profit center. The fact that all the providers in the room continue to give their best to address repairs is testimony to their commitment. Having said that, he recognizes there are gaps to be addressed.

One of the challenges of maintaining an inventory is that, by nature, complex rehabilitative technology is so complex; each chair is so individually configured to a particular individual that there is often only one chair like it. Chairs can be configured in tens of thousands of different ways.

Also equipment, such as control models, change all the time. Keeping parts in stock for all possible configurations would not only be prohibitively expensive but also a waste of money, given that many of the parts would become obsolete before they were needed and newer parts would need to be ordered.

Kimberley asked if there is more that could be done in a systematic way to understand what parts are replaced the most and to make sure those are in stock more often.

COMMENT – Susan Kennedy of NuMotion explained that what NuMotion has done is to make sure there is a 24 hour turnaround ordering timeline to make sure the part arrives in 2-6 days.

Phil explained that this policy just went into effect last week. Full implementation is expected in the next two weeks, as training comes up to speed.

Kimberley concluded this discussion topic by stating that the Department is going to be taking a deeper dive on the topic of repairs over the next seven weeks and researching what the Department is able and willing to do to address timely and adequate repairs. She invited the group to be thinking about this topic at the same time we are and to provide data and suggestions via email to Kimberley.smith@state.co.us

Dr Zerzan added that she is willing to look at how prior-authorizations are processed to figure out where the pain-points are and how we can make this easier for clients.

COMMENT – Jose Torres with CCDC asked Rich Salm to clarify his comment above.

RESPONSE – Rich stated that the manufacturers will continue to make OEM (or original) parts for existing chairs. The point Rich was making above refers to instances where NuMotion may provide a client with a chair and, six months later, they may provide the same chair model to another client but, in the interim, the manufacturer has changed the motor and joystick on that chair such that the parts that are in stock on hand to fit the first client's chair may not fit the newer chair, even though it is the exact same make and model. The company then must order newer parts and, because the older parts are now obsolete, there is no opportunity to sell them.

Rich expressed concern that, if requirements to do this were written into policy, smaller providers may not be able to meet them.

COMMENT – Chris Hinds noted that, it is a concern that repairs are not a profit center but a bigger concern of his is that Rich stated it was a cost center; it is one thing not to make a profit, it is another to be losing money. An even bigger concern is that they prefer not to be in the repair business at all.

Also, having parts in stock is an issue but sometime the lack of timely service/any service is unrelated to parts.

Kimberley stated that it sounds like there is more to do as a Department to understand this issue and that the Department may be reaching out to individual participants in the next seven weeks with specific questions that help us to understand the issue and brainstorm solutions.

Kimberley then invited Eskedar to highlight some of the other big themes that have come up in the course of the Wheelchair Benefits Collaborative thus far, which way we are leaning on those themes and solicit further group feedback. She also reminded the group that these themes are collected from the meeting minutes and listening log items that can be found online.

Eskedar mentioned that the Department has received over 120 comments thus far and is actively researching these suggestions. She did not go over each but, rather, highlighted the topics that repeat frequently. Among them, again, is the subject of wheelchair repairs, both in terms of timeliness, part type and also the need for backup chairs. In addition, the theme of simplifying the prior-authorization process is a recurring one.

Eskedar further summarized the comments received thus far by separating them into two general groups: language revisions and policy revisions.

Examples of language revisions include, but are not limited to:

- revising the definition of individuals that require manual wheelchair bases to be more inclusive; and
- similarly revising the definition of individuals who require wheelchair seating;
- rewording the definition standard manual wheelchair K005 so that it does not appear to exclude amputees (which was not the policy intent).
- Defining “accommodated” and “non-accommodated”

Policy revisions include, but are not limited to:

- Addressing validity of equipment that is prescribed by a physician enrolled with Colorado Medicaid. There is a process that allows medical providers to prescribe equipment regardless of whether or not they are a Medicaid enrolled provider. There may be some provisions in the Affordable Care Act that may require us to modify this process; this is something we are researching.
- Requiring less prior-authorization requirements for replacement and repairs; as discussed we are working to define what this will look like. Repairs are no longer require a prescription from a physician.
- Auto accident, where the accident was someone else’s fault and litigation could take years; the Department is investigating ways for the client to get equipment and be reimbursed later.

Eskedar also pointed out the robust and ongoing group discussion around the definition of Complex Rehabilitative Technology (CRT).

Kimberley mentioned that, so far, Aspen Seating, Colorado Hospital Association, CAMES and CCDC have provided their thoughts on the definition.

Kimberley reminded the group that there is a definition of CRT in the standard presently and, at the time it was first discussed, the group was in agreement with the definition as written. Since that time, the Department became aware of the Washington state definition of CRT and contemplated using that definition instead. The Department put this out to the group for comment. In general, so far, participants seem to be suggesting a hybrid definition. All suggestions are posted [online](#) for the group to review and provide further comment. The Department will continue to unpack these suggestions and will come back to the group with a new and improved suggested definition of CRT.

COMMENT – Vickie Agler explained that CAMES would like to suggest to combine the Washington state definition with small additions from the previously agreed upon definition currently in the Benefits Collaborative, like so:

Definition: Complex Rehabilitation Technology means INDIVIDUALLY CONFIGURED wheelchair SYSTEMS, POWER WHEELCHAIR SYSTEMS, ADAPTIVE seating systems, ALTERNATIVE POSITIONING SYSTEMS, STANDING FRAMES, GAIT TRAINERS AND SPECIFICALLY DESIGNATED OPTIONS AND ACCESSORIES classified as durable medical equipment that:

(i) Are individually configured for individuals to meet their specific and unique medical, physical, and functional needs and capacities for basic activities of daily living and instrumental activities

of daily living identified, INCLUDING EMPLOYMENT, as medically necessary to PROMOTE MOBILITY IN THE HOME AND COMMUNITY AND OR prevent hospitalization or institutionalization of a complex needs CLIENT;

(ii) Are primarily used to serve a medical purpose and generally not useful to a person in the absence of an illness or injury; and

(iii) Require certain services PROVIDED BY A QUALIFIED COMPLEX REHABILITATION TECHNOLOGY PROVIDER to allow for appropriate design, configuration, and use of such item, including patient evaluation OR ASSESSMENT OF THE COMPLEX NEEDS CLIENT BY HEALTH CARE PROFESSIONAL AND CONSISTANT WITH THE CLIENT'S MEDICAL CONDITION, PHYSICAL AND FUNCTIONAL NEEDS AND CAPACITIES, BODY SIZE, PERIOD OF NEED AND INTENDED USE.

Vickie also explained that these words are not only meant to convey policy but that the language was chosen to convey the feeling that clients should have about the Department's commitment to them.

COMMENT – Jose Torres with CCDCC added that item (ii), which states, CRT is “primarily used to serve a medical purpose and generally not useful to a person in the absence of an illness or injury” should be changed because some disabilities are not illness or injury related.

He was generally supportive of the definition as provided by CAMES.

COMMENT - Susan with NuMotion suggested we also define who a complex rehabilitative provider is.

RESPONSE – Kimberley noted that this is found elsewhere in the benefit coverage standard but noted the suggestion that, if using the CRT definition above, which references “CRT provider” we would want to make sure the provider definition that exists currently marries up with this definition.

COMMENT – Colleen Wolstenholm with Aspen Seating noted that some individuals any with disabilities requiring & benefiting from CRT are not typically considered ill or injured but rather may have a congenital disorder. Would individuals with a diagnosis of spina bifida, Osteogenesis Imperfecta, or cerebral palsy, etc. still qualify for CRT using the WA State definition because it would serve a “medical purpose”?

RESPONSE – Kimberley noted that this is something the Department will have to research further.

To be clear, Kimberley explained that the CAMES suggested definition above was reviewed in the meeting because Vickie was kind enough to bring copies and is not necessarily the definition that the Department is suggesting.

Kimberley then summarized by stating that the above constitutes, what the Department views as, the big ticket items/themes that are in need of further research and review. While the Department will research all suggestions and questions received, these topics represent much of the Department's focus. With that said, Kimberley invited the group to identify any topics that were not discussed above that they perceive to be big issues.

COMMENT – Jose Torres mentioned the issue of adequate backup wheelchairs.

RESPONSE – Kimberley noted that Eskedar did bring this up above and it is an area of the Department's focus.

The Department also recognizes that this issue becomes more important in light of the repairs conversation above.

Kimberley thanked the group. She noted that one of the primary objectives for today's meeting was to demonstrate to the group that the Department has heard the feedback provided thus far. She noted that the group and the Department seem to be on the same page. The Department will now spend the next seven weeks drilling down into some of these themes.

Kimberley then asked for final comments.

COMMENT – Vickie with CAMES made a comment with regard to the “individually configured” section of the CRT definition that is unclear in the meeting recording. The Department will follow-up.

COMMENT – Rich Salm with NuMotion took the opportunity to communicate to Chris that he in no way meant to convey that NuMotion does not care about repairs. NuMotion is 100% committed to providing the best service in the world.

RESPONSE – Chris noted this and stated that they should be fairly compensated.

Jose Torres concurred.

COMMENT – Michele Longo with NuMotion stated that NuMotion had a rough year. During that time, they did not take care of clients in the way that it is committed to. NuMotion is now investing a huge amount of resources to make sure they have adequate staff. The new direction of the company is really inspiring and exciting to Michele. These new efforts have not yet shown up in the community yet.

She again suggested that the creation of a task force to address some of the provider-client issues identified today, to hammer out details and come back to the Department with some sophisticated recommendations around timeframes, etc. and suggest ways that policy can help to address them.

RESPONSE – Kimberley stated that the Department always appreciates help. Kimberley is intrigued by the idea and will float it with internal Department staff and discuss how and if the Department can/should be involved and on what timeframe.

COMMENT – Jose Torres thanked Michele for being helpful. He stated that his intent is not to be harsh but, being an advocate, it is his duty to say the reason CCDC cares so much about this and is being so vocal on these issues is that it is important while people are listening to get basic protections into policy and rule, so that these rights are protected when people are not listening.

He said that, to be totally candid, CCDC has one large issue and several smaller ones. Chiefly, CCDC wants to see greater provider competition.

RESPONSE – Michele understood completely. NuMotion does not care about limiting competition, they are committed to clients receiving quality services.

Michele pointed to the example of someone recently who was telling her how long he had to wait to get his car fixed. He then said, that's my car – it's not my legs. Michele repeated that she gets that access to appropriate equipment is critical and wants to work with everyone to improve access.

Michele's concern is around her clients and how NuMotion gets on track. We can work together to create strong policy that all can abide by.

COMMENT – Unattributed commentator made comment not captured clearly on meeting recording.

COMMENT – Jose Torres made a final comment that he has been told, most recently by Suzanne Brennan, that the DME Advisory Group is not the place to discuss these types of issues. The Benefits Collaborative is just focusing on wheelchairs. The solution is not another meeting, as the disability advocacy community is stretched thin. Therefore, Jose requests that the DME advisory group expand to include such discussion.

RESPONSE – Kimberley noted that the Benefits Collaborative has a specific charter/mandate and always has a beginning and an end. She offered to communicate this request within the Department but also asked Jose to send an official request to Suzanne Brennan.

Jose noted that he already had.

COMMENT – Rich Salm with NuMotion spoke to the DME Advisory Group suggestion above. He noted that, to date, the group has not created a taskforce to address a specific DME issue or set of issues out of respect for the other members of that group, who may not be able to contribute to that particular discussion based on their area of expertise.

That's why NuMotion suggests a special taskforce that can then get back to the committee.

RESPONSE – Jose noted that he agrees with the idea of a taskforce around CRT issues but he is looking for a place where he can discuss DME policy issues on a regular basis.

Kimberley ended the meeting by asking that the group continue to send feedback her way. She let the group know that, at the next meeting, the group will be able to review a near-finished policy, which will include the Wheelchair Seating and Accessories policy as yet undiscussed.