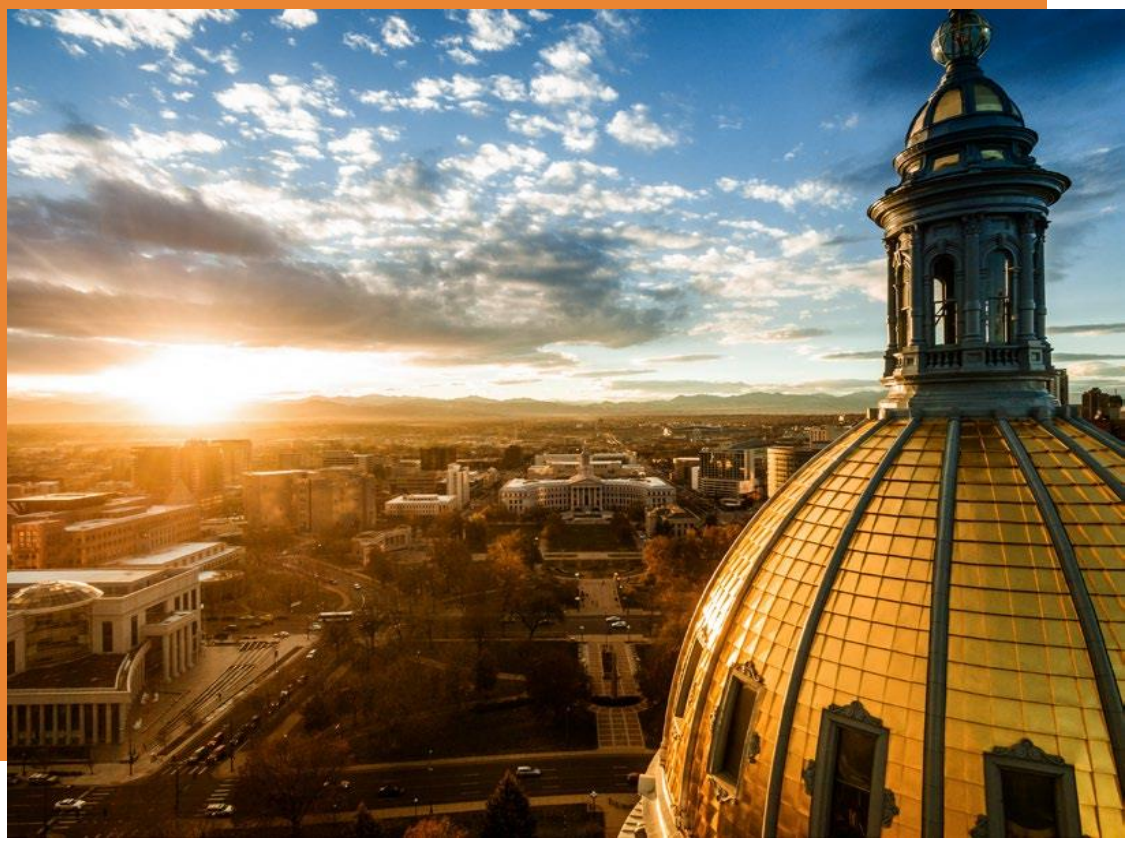


Stakeholder Policy Feedback Executive Summary July 2019

Submitted to the Colorado General Assembly

Opioid and Other Substance Use Disorders

Study Committee

COLORADO CONSORTIUM
for Prescription Drug Abuse Prevention

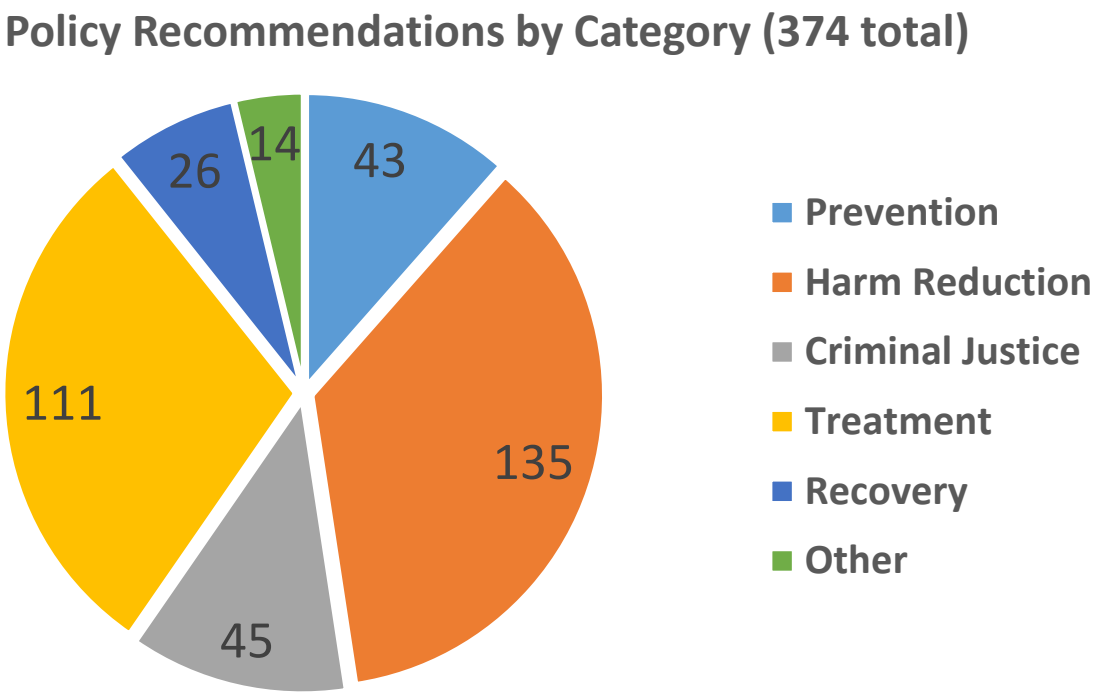
Summary of Findings

Stakeholder Engagement

Stakeholders from healthcare, local government, public health, criminal justice, professional associations, and private citizens had the opportunity to submit feedback via paper or electronic form over a period of two weeks. Results are compiled and summarized below.

Submission Responses

232 individuals or agencies submitted 241 stakeholder input forms. Since each submission could include more than one policy recommendation, in total **374** policy recommendations were received by June 25. Refer to the forms for more details.



Subcategories

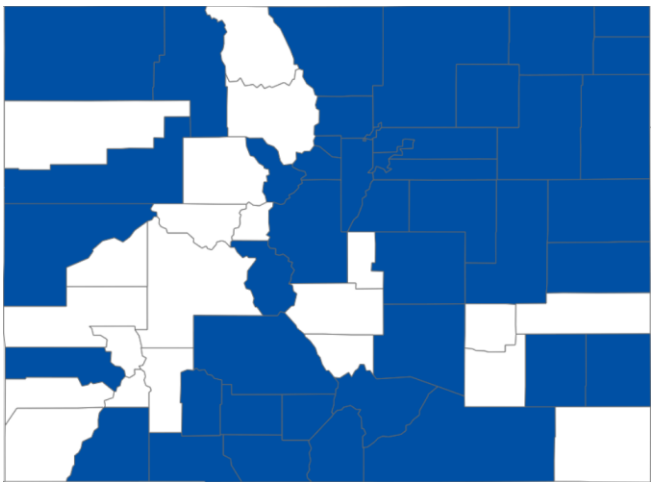
The results are organized by these subcategories:

- New Policies
- Amendments to Existing Policies
- Funding Requests
- Payment Reform
- Federal Issues
- Non-Policy Requests

Summary of Findings

241 submissions received from 232 individuals or agencies

Please see the binder folder or electronic file for all submissions



*Submissions came from individuals or agencies in **47 counties** throughout Colorado*

Most Mentioned Topics :

- Identify Gaps in Payment Reform & Insurance Coverage
- Explore Novel Harm Reduction Approaches
- Continue to Expand Treatment Access and Workforce
- Enhance Ancillary Recovery Services (Housing, Vocational, Peer Support etc.)
- Expand Beyond Opioids to Include Stimulants, Benzos, Alcohol and Other Drugs

Many respondents highlighted the importance of expanding existing services to create a more comprehensive continuum of care

Comments on Committee Process:

"Thank you for the work you're doing. The progress made by the legislature in Colorado is surpassing the work I've seen in other states. Your willingness to consider prevention and recovery as important pieces of the continuum is vital. Thank you for all you do."

"KEEP COORDINATING, especially at the state level; having strategic planning and communication across state agencies on a regular basis will make response to new funding opportunities smoother!

"The Interim Committee should take this year to focus on substances outside of opioids (methamphetamines, benzodiazepines, and alcohol for example]."

Stakeholder Responses: Prevention

New Policies

- Require screening for Adverse Childhood Events (ACE) Assessments in healthcare settings or schools
- Require prescribers to have a case manager to monitor patient opioid use through the duration of care
- Require prescribers to mandate treatment or mental health therapy as part of agreement to prescribe narcotics
- Create more mandatory educational campaigns for patients prescribed opioids
- Require that physicians receive written informed consent from patients prior to writing an initial benzodiazepine prescription

Amendments to Existing Policies

- Integrate Prescription Drug Monitoring Program (PDMP) into all electronic medical records (EMRs)
- Review policy options to limit the prescribing of benzodiazepines, particularly with opioids
- Add language for funding for "evidence-based programs" to "evidence-based approaches" in the prevention grant program
- Require that prescribers of controlled substances undergo training on the PDMP

Payment Reform

- Increase access to and funding for non-medication pain treatment options like physical therapy, massage, acupuncture, and pain psychology therapy, which are evidence-based and best practice
- Address coverage of gym memberships for low-income individuals, particularly those that are immobile
- Reevaluate Medicaid and private insurance limits on physical therapy after recent injury
- Create codes and payment mechanisms to cover physician oversight of continuous peripheral nerve blocks (CPNB) home infusions
- Remove health plan prior authorization or step therapy requirements and ensure coverage for all relevant services and drugs, including naloxone dispensed upon hospital discharge
- Increase access to safer abuse-deterrent opioids and atypical opioids like tapentadol, buprenorphine buccal films and transdermal patch for chronic pain patients
- Increase funding for access to pain management for low-income individuals
- Restructure block grant funding for management of statewide prevention initiatives

Funding Requests

- Ensure any future substance use funding that is implemented in a Colorado county by a state agency include at least partial funding to local public health agencies to connect efforts
- Expand on public education campaigns (addressing nature of addiction, information on benzos)
- Expand provider education (alternatives to opioids, benzo prescribing)
- Create more funding for early childhood prevention programs with parent involvement
- Provide funding for evidence-based alcohol and drug early intervention (SBIRT, BASICS) in public schools
- Support workforce compensation for prevention workers
- Provide direct services funding for primary prevention efforts in schools and after-school programs
- Provide incentives to encourage use of trauma-informed approach at schools
- Expand home visitation programs

- Fund provider consultations via telemedicine so that every primary care provider has access to pain management consultation

Federal

- Support research of additional non-opioid medication assisted treatments
- Prevent direct to consumer marketing of pharmaceuticals
- Offer universal mental health and substance use care with trauma-informed focus

Non-Policy Requests

- Expand the use of mental health first aid programming
- Provide greater support for implementation of substance use programming in local libraries
- Provide education for medical providers on the endocannabinoid system and up-regulation of endogenous anandamide for pain modification, opioid withdrawal symptoms and addiction
- Provide physician education and clarification from Department of Regulatory Affairs (DORA) of acceptability to prescribe long-term opioids for conditions that cause pain, including above the recommended morphine milligram equivalent (MME)
- Ensure allowance of opioid prescriptions in the emergency room when needed
- Provide education on marijuana for parents and public; conduct research on regulation of CBD oils

Stakeholder Responses: Harm Reduction

New Policies

- Require naloxone co-prescribing for patients prescribed any opioid
- Authorize the establishment of a pilot supervised use site as approved by Denver City Council

Amendments to Existing Policies

- Include permissive language into statute for syringes to be sold by local pharmacies to non-prescription holders
- Give statutory authority to Department of Regulatory Affairs (DORA) for discretion as to which drugs are monitored by PDMP (i.e. such as allowing addition of naloxone)
- Lower the Family Unification Program housing requirements of a residence to six months rather than one year as requirement for being free of methamphetamine residue
- Amend Children's Code to remove positive toxicology test at birth as a definition of child abuse or neglect
- Remove Board of Health approval as a requirement for starting a syringe access program

Payment Reform

- Prohibit insurers from discriminating against people who fill naloxone prescriptions
- Require insurance to cover nasal naloxone at a zero co-pay cost
- Require insurers to reimburse hospitals for naloxone distributed to high risk individuals/or families

Funding Requests

- Scale funding for harm reduction services
- Establish treatment-on-demand pilots for syringe access programs
- Link those whose lives have been saved by naloxone with follow-up treatment to begin and sustain recovery
- Continue to expand access to free naloxone and/or decrease the cost of naloxone
- Increase the use of fentanyl test strips
- Fund naloxone grants or bulk purchasing for hospitals to distribute naloxone to high risk individuals if hospitals encounter regulatory obstacles to billing for naloxone
- Fund a pilot program that allows harm reduction programs to carry and utilize TruNarc devices
- Fund treatment programs that are compatible with a harm reduction approach

Federal

- Allow heroin-assisted treatment
- Ban Kratom at the federal level

Non-Policy Requests

- Address stigma for people who use drugs
- Encourage all Emergency Departments and hospitals to have take-home naloxone programs
- Incorporate information on infectious diseases (such as HIV, HBV and HCV) into educational materials that discuss the opioid crisis

Stakeholder Responses: Criminal Justice

New Policies

- Require probation and parole to complete training on evidence-based options for substance use disorder treatment
- Require post-incarceration linkage to care for jails and prisons
- Require mandatory education for youth substance use offenders in the judicial system
- Require law enforcement agencies to actively engage in alternative to arrest programs
- Abolish local urban camping bans and address police engagement on trespassing
- Decriminalize opioids
- Decriminalize all drugs
- Expungement/release for all marijuana-related drug charges
- Require law enforcement to have due cause to be stationed near syringe access program

Amendments to Existing Policies

- Revise SB19-008, Section 7: Require use of methadone, buprenorphine AND naltrexone in jails receiving funding from JBBS
- Allow parole violators returning to jail to count voluntary treatment towards good-time in sentencing

Payment Reform

- Allow jail inmates on work release to use Medicaid to cover Medication Assisted Treatment (MAT)

Funding Requests

- Increase funding for community-based services to frequent utilizers of withdrawal management services
- Expand service array for involuntary commitment clients to invest in after-treatment recovery services
- Support continuation of Law Enforcement Assisted Diversion (LEAD) in pilot counties

Funding Requests

- Advocate at the federal level for jail inmates on work release to be able to use Medicaid to access MAT

Non-Policy Requests

- Provide additional support for judicial, criminal justice and law enforcement who are highly impacted
- Address the supply of opioids both from legal sources such as through a prescription as well as illicit sources (on the street/internet)
- Allow for all drug related charges to be dropped if person remains in recovery greater than two years
- Disallow incarceration for positive urine analysis unless there is some other violation of supervision conditions (i.e. parole/probation)

Stakeholder Responses: Treatment

New Policies

- Require prescribers of MAT to include psychotherapy component
- Ensure all licensed professionals can provide trauma-informed care
- Establish a report card system for substance use treatment services in Colorado

Amendments to Existing Policies

- Update the Community Needs Assessment for SB16-202 funding to be required bi-annually by a third-party organization and require community engagement in funding decisions
- Integrate co-occurring services into state incentive measure and require this for residential providers
- Amend Office of Behavioral Health Rule 21.210.1.B., language of "At least fifty percent (50%) of all treatment staff in substance use disorder programs….shall be certified, or actively working toward, a Certified Addiction Counselor, CAC II, CAC III or Licensed Addiction Counselor (LAC)"
- Amend and revise 27-81 and 27-82 (remove stigmatizing language, align civil commitment processes etc.)
- Remove all prior authorizations for medication assisted treatment (MAT)
- Reverse the state's Block Grant funds from indigent-only so that it aligns with the goals of the Federal Block Grant
- Allow individuals with a sexual offence charge to participate in substance use treatment

Funding Requests

- Create withdrawal management and inpatient SUD treatment centers
- Expand housing for individuals completing treatment; partner with licensed behavioral health treatment agencies to add recovery beds/housing to their programs
- Expand funding for behavioral health treatment specifically for youth/adolescents
- Scale access to substance use disorder treatment and support high-risk patients by making sure that they have ready access to naloxone and MAT on demand
- Increase funding rates for intensive programming such as for withdrawal management to be incorporated in crisis stabilization units
- Expand treatment services (such as opioid treatment providers and options for court-mandated clients) in rural/frontier counties, particularly in eastern Colorado and on the western slope

Payment Reform

- Develop and promote health plan network adequacy standards ensuring insured patients with substance use disorders (SUD) have adequate access to a multi-modal approach to care and treatment on demand
- Develop adequate rate setting methodology to determine appropriate Medicaid reimbursement rates
- Require insurance carriers to use American Society of Addiction Medicine (ASAM) screening criteria
- Require Medicaid and private insurance agencies to pay for psychiatry and all levels of ASAM SUD care regardless of substances
- Fold all healthcare treatment services for Medicaid into Regional Accountable Entity (RAE) system, remove existing carve-outs for behavioral health and substance use
- Require all denials of insurance claims/appeals to be overseen by a third party state agency
- Increase reimbursement rates for substance use disorder services
- Ensure equity for workforce provider substance use provider rates with state salary rates

- Require private insurance to cover greater than 2 weeks of residential treatment for substance use disorder when identified as need
- Address access to treatment during lapses in Medicaid and private insurance coverage
- Change insurance requirements for inpatient eligibility for SUD treatment that requires a person seeking rehabilitation in an inpatient setting to have a positive drug screen on the day of admission

Federal

- Examine federal versus state restrictions on the prescribing and dispensing of MAT medications and Medicaid reimbursement (e.g., Medicaid should reimburse for pharmacist-administered Vivitrol)
- Reduce regulations on opioid treatment providers (OTPs)
- Eliminate waiver requirement for prescribing buprenorphine
- Send a letter to the President, Congress, Senate and DEA to eliminate the buprenorphine X-waiver
- Allow advance practice nurses to prescribe methadone and conduct physicals
- Allow any treatment facility with appropriate medical oversight to store and return Vivitrol free of charge if unused
- Ease regulations on CFR Part 2 to allow sharing of treatment-related information with other providers
- Require Medicare coverage for suboxone or other medication assisted treatments
- Increase flexibility of federal grants such as the Substance Abuse Prevention and Treatment (SAPT) Block Grant (42 U.S.C. 300: 21, et seq.)
- Improve coordination of funding at the federal level

Non-Policy Requests

- Restructure current funding system; require competitive bid process for Management Service Organizations (MSOs) and regular reporting mechanisms to ensure transparency
- Streamline process for providers to access Medicaid
- Improve coordination of funding and implementation efforts at the state level
- Address stigma for people with substance use disorder accessing treatment
- Improve continuity of care between psychiatrists, medical doctors, and substance use counselors
- Reduce Deportment of Regulatory Affairs (DORA) delays in approvals for CAC, LPC, LCSW licenses
- Reduce delays in complaints to Department of Regulatory Affairs (DORA)
- Review credentialing requirements, process, and timelines for substance abuse treatment providers

Stakeholder Responses: Recovery

Amendments to Existing Policies

- Reevaluate zoning laws and eligibility restrictions around prior drug-related convictions and other barriers that prevent individuals from attaining housing
- Offer loan forgiveness and scholarships to those seeking certification as Peer Support Specialists and Recovery Coaches
- Require transitional residential housing programs and sober living sites to accept all forms of MAT treatment for their residents and applicants

Payment Reform

- Amend current funding structure which creates unnecessary competition among recovery support service providers (i.e. peer support services are sometimes competitors rather than collaborators)
- Fund Recovery Housing, halfway houses, and recovery support services across the state with capital expenses allowable
- Allow Medicaid-reimbursable, autonomous peer service delivery in Colorado (an administrative task out of the Department of Health Care Planning and Finance (HCPF) to implement the rules, regulations, codes & standards of care)

Funding Requests

- Offer non-restricted grant funding that can cover the administrative and indirect costs associated with running a peer support program
- Expand options for supportive housing in the rural and frontier Colorado
- Create recovery residences that utilize a harm reduction system
- Include after-treatment recovery in types of services offered to involuntary commitment clients
- Increase access to peer recovery supports for people in a parenting or caregiving role to sustain recovery

Non-Policy Requests

- Fund peer support business models