Report to
The Vermont Legislature

Clinical Utilization Review Board Annual Report

In Accordance with 33 V.S.A. § 2032

Submitted to: The House Committee on Health Care
The Senate Committee on Health and Welfare

Submitted by: Andrea De La Bruere, Commissioner
Department of Vermont Health Access

Prepared by: Sandi Hoffman, Deputy Commissioner
Department of Vermont Health Access

Report Due Date: January 15th, 2023

VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Act 146 of 2010, "An act relating to implementation of challenges for change", requires the Department of Vermont Health Access ("Department") to create a Clinical Utilization Review Board to examine existing medical services, emerging technologies, and relevant evidence-based clinical practice guidelines. The Clinical Utilization Review Board ("Board") is required to make recommendations to the Department on matters pertaining to coverage, limitations, place of service, and appropriate medical necessity of services in the State's Medicaid program. Act 146 of 2010 further requires the Department to evaluate the Board's success in "improving clinical and utilization results" and report on the results of the evaluation annually by January 15th to the House Committee on Health Care and the Senate Committee on Health and Welfare. The Department must also provide a summary of the Board's activities and recommendations since the last report.[1] In 2022, the Clinical Utilization Review Board made the following recommendations:

1. Increase the limit of individual psychotherapy services from 24 to 260 sessions per calendar year prior to requirement of prior authorization
2. Allow Non-invasive Prenatal Testing (NIPT) screening to all pregnant members, regardless of age or baseline risk
3. Adoption of position statement for PA changes related to hysterectomy services for gender dysphoria related diagnoses that; 1. Removes PA requirement for hysterectomy requests for members 18 years of age or older with gender dysphoria related diagnoses and 2. Requires PA for hysterectomy requests for members less than 18 years of age with gender related diagnoses
4. Approval of adding seven codes to the current Imminent Harm Code list (two surgical codes, two speech generating device codes, and three wheelchair codes)

In addition, the Board examined the following topics through the lens of medical necessity and utilization:

- Telemedicine and Remote Patient Monitoring
- Changes to Clinical Prior Authorization Requirements
- Consumer Assessment of Healthcare Provider & Systems Reporting
- Alignment of ACO and DVHA Quality Measures
- Identification of Preventive Clinical Guidelines; and
- COVID-19 Flexibilities

The Clinical Utilization Review Board is required to meet at least quarterly. In response to the pandemic, the Board met virtually while maintaining required access for members of the public.

[1] http://www.leg.state.vt.us/DOCS/2010/ACTS/ACT146.PDF; https://legislature.vermont.gov/statutes/section/33/019/02032

SUMMARY OF ACTIVITIES AND RECOMMENDATIONS

During 2022, the Clinical Utilization Review Board ("Board") met as required. Duties and responsibilities of the Board include identification and recommendation of opportunities to improve quality, efficiencies, and adherence to relevant evidence-based clinical practice guidelines in the Department's clinical programs. The Board completes this function through review of claims data and information provided by the Clinical Services Team. [2]

Telemedicine and Remote Patient Monitoring

The Board was asked to review telemedicine data compiled by the Department of Vermont Health Access ("Department"). The Department has supported continued access to, and provision of, medically necessary health care services via telemedicine at parity with in-person visits. Monitoring and modification to alternate delivery methods continues to ensure clinically appropriate delivery of services.

Telemedicine Utilization

Data show that telemedicine utilization peaked in April 2020. Since then, telemedicine utilization has decreased and in-person visits have increased (Appendix II). This includes telemedicine provided via audio and visual connection as well as audio-only telemedicine. The Board reviewed data and offered the following:

- Recommended empowering providers to use clinical judgement to determine best use of audio-only telemedicine services;
- Encouraged the Department to develop exclusionary (versus inclusionary) guidelines for audio-only services; and
- Endorsed audio-only monitoring for chronic conditions

Prior Authorization (PA) Requirements

Per requirement of legislative bill H.960 (Act 140) of 2020[3], "a health plan shall review the list of medical procedures and medical tests for which it requires prior authorization at least annually and eliminate the prior authorization requests for those procedures and tests for which such a requirement is no longer justified or for which requests are routinely approved with such frequency as to demonstrate that the prior authorization requirement does not promote health care quality or reduce health care spending to a degree of sufficient to justify the administrative costs to the plan." The Department has convened a work group to gather and analyze prior authorization (PA) data to inform proposals. The information is shared with the Board. The

[2] https://legislature.vermont.gov/statutes/section/33/019/02031
[3] https://legislature.vermont.gov/Documents/2020/Docs/ACTS/ACT140/ACT140%20As%20Enacted.pdf

Board recommended the following to the Commissioner of the Department of Vermont Health Access (see board minutes for rational and detail):

- Removal of prior authorization requirement for hysterectomy for members 18 years of age or older regardless of diagnosis;
- Increase the individual outpatient psychotherapy limit from 24 sessions to 260 sessions per calendar year;
- Align and expand criteria coverage to allow non-invasive prenatal testing regardless of maternal age and baseline risk; and
- Adoption of seven additional codes (Durable Medical Equipment & Surgical) to the Imminent Harm list.

Accountable Care Organization/Department Quality Measures

To orient new Board members to the Vermont all-payer model and keep current members apprised of our intent to use the ACO model to improve the health of our members, the Department provided an annual presentation about the health care quality measures the ACO uses to align quality of health care across payors (Medicaid, Medicare, and Commercial insurance). The Department presented that Vermont Medicaid's participation in the ACO is through an agreement between the state of Vermont and the federal Centers for Medicare and Medicaid services (CMS). The Department explained that the significance of the all-payer model is that it allows the payors of healthcare in Vermont to pay ACO providers differently than fee-for-service. Without this agreement, Medicare would not have been permitted to pay differently.

Three important population health goals in the all -payer ACO model agreement encourage public health and community service providers to work together to improve quality and the integration of care. These are:

1. Improving access to primary care
2. Reducing deaths from suicide and drug overdose
3. Reducing prevalence and morbidity of chronic disease (COPD, Diabetes, Hypertension)

EVALUATION OF CLINICAL UTILIZATION REVIEW BOARD SUCCESS

The Department is required to evaluate the Board's success in "improving clinical utilization results" and report on that evaluation within the annual report submitted by January 15th. In consideration of the Board's work to review and provide recommendations to ensure a sustained effective response during the ongoing COVID-19 public health emergency, the Board demonstrated its value for the Vermont Medicaid program amidst the ongoing challenges for providers of health care services. The Board's work in 2022 resulted in recommendations specific to prior authorization changes, telemedicine and remote telemonitoring, and the

identification of preventive clinical guidelines. All recommendations align with the Department's mission to improve the health and well being of Vermonters by providing access to quality healthcare cost-effectively.

In 2023, the Board will focus on its legislative responsibilities. This includes the Board's vision and work plan to support future endeavors to issue recommendations to advance operational, clinical improvement, and payment reform within the Vermont Medicaid program.

APPENDIX I BOARD MEMBERSHIP

In accordance with 33 V.S.A. § 2031, the Clinical Utilization Review Board shall be comprised of 10 members with diverse medical experience. This year three new Board members have joined the Board, resulting in two remaining vacancies.

Member Name	Field of Practice & Location
Dr. Thomas Connolly (DMD)	Dentistry, Retired
Dr. Joshua Green (ND)	Naturopath, Burlington, Vermont
Dr. Nels Kloster (MD)	Psychiatrist, Southern Vermont
Dr. John Matthew (MD)	Internal Medicine, Plainfield, Vermont
Dr. Michael Rapaport (MD)*	Family Medicine, Central Vermont
Dr. Valerie Riss (MD)	Pediatric Hospitalist, Burlington, Vermont
Dr. Zail Berry (MD)	Internal Medicine/Hospice & Palliative Care, Burlington, Vermont
Dr. Kate McIntosh (MD)	Pediatrics, Shoreham, Vermont
Dr. Matthew Siket (MD)	Emergency Medicine, Burlington, Vermont
Dr. Colleen Horan (MD)	Obstetrics & Gynecology, Central Vermont

*As of 9/6/2022, Dr. Rapaport ended his term on the Board and now serves as Department Liaison to the Board.

APPENDIX II: VERMONT MEDICAID TELEMEDICINE, VOICE ONLY, AND BRIEF COMMUNICATION SERVICES

Month	Telemedicine # of services	Voice Only # of services	Brief Communication† # of services
May 2021	42321	6204	297
Jun 2021	39661	5827	224
Jul 2021	31935	4609	166
Aug 2021	31501	4722	294
Sep 2021	32976	4861	416
Oct 2021	31734	4701	358
Nov 2021	32079	4820	361
Dec 2021	32356	4931	388
Jan 2022	39811	5681	518
Feb 2022	36333	4856	154
Mar 2022	39270	4937	106
Apr 2022	32228	4288	48
May 2022	32603	4404	69
Jun 2022	31845	4066	48
Jul 2022	26152	3765	39
Aug 2022	29133	4191	38
Sep 2022*	27328	3895	40
Oct 2022*	20581	2840	28

Number of services based on claim ID and date of services.
*Services count will increase as more claims are submitted for current dates of services.
Telemedicine includes paid claims with POS '02' or a 'GT' Procedure Modifier.
Voice only includes paid claims with both POS '99' and procedure modifier 'V3',
or paid claims with CPT codes: 99441-99443, 98966-98968.
†Brief communication services include paid claims for HCPCS G2010, G2012, and G0071.