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Agency of Human Services

Memorandum

To: Representative Bill Lippert, Chair, House Committee on Health Care

From: Steven M. Costantino, Commissioner, Department of Vermont Health Access

Cc: Hal Cohen, Secretary, Agency of Human Services

Date: February 5, 2016

Re: Department of Vermont Health Access SFY 2017 Budget: Technical Adjustments to Align with Best Practices

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During DVHA SFY 2017 budget testimony, you requested additional information with regard to technical adjustments to align with best practices. The total dollar amount associated with these changes is ($7,820,882). Following represents the adjustments:

Reduce Opioid Detox ~ ($1,489,882) gross: Beginning July 1, 2015, admissions to an inpatient hospital for opioid detoxification must meet medical necessity criteria in order to be reimbursable through Vermont Medicaid. The Department of Vermont Heath Access (DVHA) utilizes the McKesson InterQual ® Level of Care Criteria. These nationally recognized, evidence-based criteria will be used to determine the medical necessity of any inpatient admission submitted to the DVHA for reimbursement.

Prior Authorize Outpatient Psychotherapy > 24 Visits per Calendar Year ~ ($2,200,000) gross: The Clinical Utilization Review Board (CURB) reviewed utilization of the outpatient psychotherapy services for adults and children. The number of outpatient psychotherapy services per person has been increasing. After reviewing the utilization data, on July 15, 2015 the CURB voted unanimously in favor of requiring outpatient psychotherapy providers. Recommendation from CURB: Require Prior Authorization for outpatient psychotherapy visits one standard deviation beyond median. This equates to after 24 visits per calendar year, a prior authorization is needed for additional visits.

Adopt Medicare's Reimbursement Practice for Oxygen ~ ($70,000) gross: Medicare limits the reimbursement for Oxygen to a 36 month rental cap. After the 36 months, the supplier is responsible for performing any repairs or maintenance and servicing of the equipment. Medicare will pay for maintenance and service no more often than every 6 months beginning 6 months after the 36 month rental cap.

Revise Psychiatric Inpatient Reimbursement Methodology to Only Apply When a Patient is Cared for on a Psychiatric Unit ~ ($1,500,000) gross: Currently any inpatient claim grouped into a psych DRG is paid using the inpatient psychiatric reimbursement methodology, including inpatient stays on medical floors. This change proposes to adjust the current inpatient psych reimbursement methodology to only apply to inpatient stays on psychiatric floors and have any inpatient stay on a medical floor be paid as other inpatient stays on medical floors, according to the DRG, without the psychiatric per diem. This would ensure that only stays receiving the full complement of psychiatric services expected to be provided on a psychiatric unit are paid with the psychiatric reimbursement methodology.

Cardiology High-Tech Imaging Prior Authorization ~ ($711,000) gross: Currently cardiology services are not prior authorized. Adopting this proposal will allow the current vendor performing prior authorizations for other hi-tech imaging services, will also perform prior authorizations and monitor inappropriate utilization for cardiac imaging.

Add-ons for Newborn DRGs ~ ($1,000,000) gross: Currently, DRG weights take into account the mean length of stay (LoS) in their development, and add-on claims do not. This proposal would adjust the add-on claim allowances to take these LoS' into consideration by limiting the number of claims, or the number of days of a stay allowed.

Add-on Code Reimbursement ~ ($175,000) gross: Medicare requires that an add-on code be reimbursed only in conjunction with a primary service (also known as a parent code). This adjustment brings Medicaid payment methodologies in line with Medicare rule.

Endoscopy Reimbursement Policy ~ ($200,000) gross: Medicare has special payment rules for multiple endoscopies performed on the same day. When two endoscopies in the same family are performed, the endoscopy with the highest fee schedule amount is allowed at 100%. The additional related endoscopies are priced by subtracting the base endoscopy price. This adjustment brings Medicaid payment methodologies in line with Medicare rule.

Generic Drug Rebate Expansion ~ ($475,000) gross: Currently, we are allowed to set a State Maximum Allowable Cost (SMAC) on all generic drugs. This has always been a pricing service contracted service through the PBM. Our new vendor GHS, who has a more robust SMAC program, is recommending new SMAC's on a number of generics which could save the state $475,000 SFY 2017. We have already implemented some new SMAC's totaling $1.5 million in savings for SFY'16, which we submitted for SFY'16 BAA.