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Agency of Human Services

M E M O R A N D U M

TO: House Committee on Health Care
Senate Committee on Health and Welfare

CC: Hal Cohen, Secretary, Agency of Human Services

FROM: Mark Larson, Commissioner

DATE: January 15, 2015

RE: Clinical Utilization Review Board Report 2014

Pursuant to the requirements of 33 VSA § 2032(e); please find enclosed the results of the most recent evaluation or evaluations and summary of the Department of Vermont Health Access Clinical Utilization Review Board's activities and recommendations since the last report.

Please do not hesitate to contact me if you have questions or would like additional information.

Report to
The Vermont Legislature

Annual Report on
The Department of Vermont Health Access
Clinical Utilization Review Board (CURB) 2014

In Accordance with
33 V.S.A. § 2032(e)

Submitted to:	**House Committee on Health Care; Senate Committee on Health and Welfare**
Submitted by:	**Mark Larson** **Commissioner, DVHA**
Prepared by:	**Aaron French** **Deputy Commissioner, DVHA**
Report Date:	**January 15, 2015**

VERMONT
AGENCY OF HUMAN SERVICES
Department of Vermont Health Access

The Department of Vermont Health Access

Clinical Utilization Review Board (CURB)
Annual Report 2014

Overview

The CURB was created to examine existing medical services, emerging technologies, and relevant evidence-based clinical practice guidelines and make recommendations to the Department of Vermont Health Access (DVHA) regarding coverage, unit limitations, place of service, and appropriate medical necessity of services for the Vermont Medicaid program. The Board is comprised of ten members with diverse medical expertise appointed by the Governor upon the recommendation of the Commissioner of DVHA. The Chief Medical Officer of DVHA serves as state liaison and moderator for the CURB.

CURB Board Members

Michel Benoit, MD, UVM, Orthopedic Surgeon, Hand Surgery, Shelburne
Patricia Berry, MPH, UVM, VCHIP, Burlington
Delores Burroughs-Biron, MSN, MD, Family Medicine
David Butsch, MD, General Surgeon, Barre
Ann Goering, MD, Family Medicine, Winooski
John Mathew, MD, General Internal Medicine, Plainfield
William Minsinger, MD, Orthopedic Surgeon, Randolph
Paul Penar, MD, UVM, Neurosurgeon, Shelburne
Norman Ward, MD, UVM, Family Medicine, Burlington
Richard Wasserman, MD, UVM, Professor of Pediatrics, Burlington

2014 Topics

CURB held six meetings in 2014 and the following topics were discussed:

- Gold Card for Radiology Procedures
- Transient Ischemic Attack (TIA)Treatment Protocol and Outcome
- VT Medicaid Transportation Update
- Update on Partial Hospitalization Program
- Technology Requests
    - Genetic Testing
    - Sovaldi and Hepatitis C
    - Low Dose Chest CT Scan for Lung Cancer Screening
- The Listening Tour/Provider Code Review Form
- Psychiatry Embed in Primary Care Model
- Hub and Spoke
- Information Sharing
- Episodes of Care
- Gender Reassignment Protocol

Gold Care for Radiology Procedures:

In January, 2013 through the CURB's recommendation, DVHA implemented the Gold Card process for radiology. Annually, the radiology benefit manager runs data to identify which providers meet the criteria to qualify for a Gold Card.

The qualifications are providers who have:

- Requested 100 or more radiology procedures in 18 months
- 3% or less denial rate

There are currently 12 providers in the Gold Card program for radiology procedures.

Transient Ischemic Attack (TIA) Treatment Protocol and Outcome:
Dr. Mark Gorman, Director of the Stroke Program and Neurologist at University of Vermont Medical Center (UVMC) presented a proposal to implement Rapid Evaluation and Management of TIA/Minor Stroke program (REMOT). The proposal is that within 8 hours of a patient presenting with TIA the patient needs neuro and vascular imaging, echocardiogram, telemetry and labs. The patient is quickly risk-stratified and it is determined which method of treatment is best. Individuals with carotid stenosis can be directed toward an endarterectomy; those with atrial fibrillation can be directed toward proper medical treatment, and individuals at high risk for stroke can be admitted for treatment with antiplatelet medications and statins. This proposal is not to add testing; the proposal is to do it more quickly, within 8 hours of the TIA.

The REMOT program would:

- Likely be revenue neutral
- Cause little net movement of patients
- Alleviate anxiety/doubt/uncertainty
- Likely reduce stroke rate
    - Decrease overall morbidity/mortality
    - Save system money

Recommendation:
There was a general consensus and a motion was made to recommend the approval of the REMOT initiative. The Board approved recommending and voted unanimously in favor of the proposal for providing the REMOT project in Vermont facilities.

Dr. Gorman has begun to deploy the REMOT system within the UVMC. DVHA will work with Dr. Gorman to assess outcomes for Medicaid beneficiaries over the coming year.

Transportation Update:
Bill Clark, Managed Care Compliance Director at DVHA provided an update regarding VT Medicaid's transportation program. Transportation is provided to Medicaid recipients by regional brokers for medically necessary transportation. Medicaid uses public transit, volunteer drivers, cabs and special needs vehicles. This does not include ambulance services.

There are 7 regional brokers who are paid a capitated per member per month (PMPM) payment. The PMPM is based on cost allocation and benchmarking. The broker assumes some of the risk if their performance slips.

Partial Hospitalization Program:
Cindy Thomas, Quality Improvement and Clinical Integrity Director at DVHA updated the group on the status of the Partial Hospitalization Program. Cindy reviewed the standards that have been proposed. The funding to support the enhanced payment for the first year has not been determined. She explained

that she is working with the DVHA Commissioner on this. Updates will be provided to the CURB once the funding has been finalized.

Technology Requests:
Drs. Strenio, DVHA Medical Director, and Wheeler, BCBS Medical Director, presented on the different methodologies they use to review new requests for new technology/procedures.

Genetic Testing:
Requests for genetic testing are received and reviewed for analytic validity, clinical utility, budget impact and ethical implications. DVHA determines clinical utility based on many resources including:

- Peer-reviewed literature
- Technology assessments
- Professional association opinions and guidelines
- Direct discussion with providers
- Other medical and commercial policies

Next Steps:
DVHA is pursuing an evidence-based and clinically focused tool for creating sound policy, which will enable appropriate coverage decisions.

Sovaldi and Hepatitis C:
Sovaldi is a drug covered by VT Medicaid to treat Hepatitis C. The cost is roughly $84,000 per prescription and when combined with other prescriptions used to treat Hepatitis C it can be $125,000 for the 12 week therapy. The cure rate is 90%. There are 600-700 new cases per year in Vermont[1].

Low Dose Chest CT Scan for Lung Cancer Screening:
Dr. Scott Strenio presented his recommendation to cover low dose chest CT scans for lung cancer screening.

There are15-20% fewer deaths from lung cancer in the low dose CT (LDCT) group. The net benefit is moderate or substantial. The recommendation is for an annual screening for 55-80 year olds with a 30 cigarette pack per year history who smoke or smoked within the past 15 years.

UVMC has a pilot integrated screening program. A dedicated database will be developed to:

- Track individuals eligible for screening
- Mark all interactions with patients and their primary care providers
- Update all tobacco data

Recommendation:
The CURB members agreed to recommend that we cover the low dose CT scan for lung cancer screening. This recommendation was approved by Mark Larson, DVHA Commissioner in December, 2014. The DVHA Clinical Unit is working on the implementation of this new benefit.

[1] This is the total number of new Hepatitis C cases reported to the Vermont Department of Health in 2013. Some of the 600–700 reported cases could be Medicaid beneficiaries or individuals in the Department of Corrections, also including private insurers. Medicaid received approximately 100 requests for treatment of Hepatitis C in 2014.

The Listening Tour:
At the CURB's suggestion, DVHA has been looking for efficient ways for providers to communicate with DVHA. DVHA is working with their fiscal agent, Hewlett Packard (HP) to provide an electronic form for providers to request review of non-covered codes via the provider portal. While HP is working on developing the software, DVHA's Chief Medical Officer went on a "listening tour" and has met with providers at local hospitals. He plans to visit all service areas to hear the suggestions and concerns of Medicaid providers.

Psychiatry Embed in Primary Care Model:
Dr. Robert Pierattini, Chair of Psychiatry at FAHC and University of Vermont (UVM) Professor of Psychiatry, presented a proposal to provide one model of co-locating psychiatric providers in Medical Homes.

The Medical Home Primary Psychiatry Pilot will:

- Increase access
- Support the Medical Homes
- Support primary care physicians
- Provide psychiatric expertise in a setting familiar and convenient to the patient
- Interface with external mental health programs

Next Steps:
DVHA will explore the potential for support and further deployment of this model.

Care Alliance for Opioid Addiction Services:
In the current Care Alliance model, individuals are identified and referred to a treatment "Hub." Individuals then flow based on assessment to "Spoke" providers once they have stabilized.

The New England Comparative Effectiveness Public Advisory Council (CePAC) analyzes two problems per year and tries to distill the issues and report on the economics of the topic. In 2014, CePAC focused on Vermont's Care Alliance model. The CURB review CePAC's findings, including:

- Methadone and Suboxone both help to retain people in treatment and decrease the illicit drug trade.
- The 2 year costs of untreated opioid dependence are estimated to total $250,000 per untreated individual. These costs are reduced by nearly half with maintenance treatment and by 30% with the least effective strategy (oral naltrexone alone).
- Any expansion of the treated population will produce cost reductions of approximately $1.80 for every dollar invested over a 2-year period.
- If 50% of the currently untreated patients had treatment available to them, cost savings for New England would be $3 billion and 700 lives would be saved, 100 of which would be adolescents.

Future work to evaluate the Care Alliance model includes looking at the level of arrests and incarcerations to be used to assess cost effectiveness.

The CURB also reviewed current challenges within the Care Alliance, including:

- Waiting lists and timely access to care at the Hubs.
- Limited providers willing to serve as Spokes. A perception amongst providers that the Vermont Board of Medical Practice (VMPB) has a high level of scrutiny and severe sanctions is one

possible deterrent to provider participation. In addition, the Spoke providers find the Vermont Prescription Monitoring System (VPMS) system difficult to use.

The CURB continues to explore possible solutions to these challenges.

Information Sharing:

Information sharing in VT is limited by Health Insurance Portability and Accountability Act (HIPAA) fears and the additional restrictions of 42 CFR Part 2 regulations about the exchange of information regarding substance abuse. The US is high on health services expenditures and low on social service expenditures compared to much of the world. There are fundamental impediments and doctors need to increase their involvement in guiding and changing these laws. VT Medicaid wants to have better strategies for good communication vs information privacy. The Vermont Medical Society (VMS) likes the idea of the push notices for evidence-based practice.

Episodes of Care:

Kara Suter, DVHA Director of Payment Reform and the State Innovation Model (SIM) has a three year grant from the Center for Medicare and Medicaid Services (CMS) to create a payment model based on analytics. Vermont is one of six testing states. Kara presented on the SIM and asked the Board for recommendations. It is based on an episode of care from trigger to post event. It is based on an episode of care grouper. There is episodic bundling happening in certain contexts such as a hospital based surgery.

Gender Reassignment Protocol:

Dr. Scott Strenio presented the current State of Vermont guidelines versus the World Professional Association of Transgender Health guidelines for gender reassignment. He discussed a case that challenged the State of Vermont guidelines. He presented potential changes to the State of Vermont guidelines.

Next Steps:

DVHA will do more research on this topic and will look at what other states are doing. DVHA will bring back to the group any formal recommendation or suggestion for any policy changes.