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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: Al Gobeille, Secretary, Agency of Human Services

FROM: Cory Gustafson, Commissioner, Department of Vermont Health Access

DATE: January 8, 2018

RE: Clinical Utilization Review Board Report 2017

Pursuant to the requirements of 33 V.S.A. § 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.

Report to
The Vermont Legislature

Annual Report on
The Department of Vermont Health Access
Clinical Utilization Review Board (CURB) 2017

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

Submitted to:	**House Committee on Health Care; Senate Committee on Health and Welfare**
Submitted by:	**Cory Gustafson** **Commissioner, Department of Vermont Health Access**
Prepared by:	**Dr. Scott Strenio** **Chief Medical Officer, Department of Vermont Health Access**
Report Date:	**January 8, 2018**

VERMONT
AGENCY OF HUMAN SERVICES
Department of Vermont Health Access

The Department of Vermont Health Access

Clinical Utilization Review Board (CURB)
Annual Report 2017

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, Shelburne
David Butsch, MD, General Surgeon, Barre
Ann Goering, MD, Family Medicine, Winooski
Nels Kloster, MD, Psychiatrist, Marlboro
Jessica MacLeod, NP, Nurse Practitioner, Berlin
John Mathew, MD, General Internal Medicine, Plainfield
Paul Penar, MD, UVM, Neurosurgeon, Shelburne
Michael Rapaport, MD, Psychiatrist, Burlington
Norman Ward, MD, UVM, Family Medicine, Burlington
Vacant – under recruitment

2017 Topics

CURB held four meetings in 2017 and the following topics were discussed:

- Annual Strategy: Thematic Approach
- Past Initiatives Updates
    - Transportation
    - Pediatric Physical Therapy, Occupational Therapy, and Speech Therapy (PT/OT/ST)
    - Psychotherapy
    - Out-of-State Referrals
    - Gold Card for Radiology
- Potential New Initiatives
    - Pain Management Center of Excellence
    - Adult PT/OT/ST
- Individualized Education Plans (IEP)
- Vivitrol Pilot update
- Global Commitment Core Measures

Conflict of Interest:

The conflict of interest policy and procedure were reviewed and discussed with the CURB. There have been no conflicts to date and the CURB members have agreed to complete the questionnaire annually.

Annual Strategy: Thematic Approach:

Looking forward, DVHA and the CURB will be focusing on a set of topics annually that addresses a single theme (e.g. Shared decision-making in elective procedures). This will allow the CURB to focus more comprehensively on a single issue from multiple perspectives rather than attempting to cover several disparate topics at each meeting. The purpose of the thematic approach to CURB initiatives is to identify items across the agency, providers, payers, and the state, over the course of the year. The initiatives should be measurable, scalable, and sustainable. The CURB can focus on specific levers common to all

payers to achieve the Triple Aim (better outcomes, less cost, and improved patient satisfaction) in whatever theme it chooses. The CURB intends to focus on themes that would result in the highest return on investment. Specific initiatives to consider include levers that keep patients in-network, change reimbursement policies for hospitals and acute care, and combine services into a bundle to improve service outcomes.

Potential New Initiatives – Pain Management Center of Excellence:
The CURB will look to explore the creation of a 3-tiered bundled payment system or episodes of care for pain management in Medicaid. The first bundle would be for the evaluation and assessment of the member, an estimated time frame of 0-2 weeks. This will be followed by a 2-12 week time frame for active care management. The last tier will comprise of a 3-6 month window for maintenance therapy. The model will be like the Blueprint for Health's Hub and Spoke model that is used to treat Vermonters with opioid addiction, where the hubs are the Opioid Treatment Programs and the spokes are the Office Based Treatment Programs. Physical medicine and rehabilitation physicians, pharmacists, psychologists, physical therapists (PT), and case managers are the hub in this model. The spokes would comprise of physical therapists, occupational therapists (OT), certified counselors, chiropractors, acupuncturists, the primary care provider, and nutritionists. Recruiting this team of providers in the program is essential for the success of a pain management center.

Individualized Education Plans (IEP):
Vermont Medicaid requires a signed IEP, received by the Vermont Agency of Education (AOE), in order to receive Medicaid payment for school based services for children. The IEP must be signed by a Vermont enrolled medical practitioner. The services are provided whether or not there is a signed IEP. If the IEP is not signed, the school itself is responsible for funding the services. While the IEP must be signed by a Vermont enrolled medical practitioner, the providers that sign do not have to be the Primary Care Physician (PCP), currently live in Vermont, or have ever seen the member. Vermont schools have been contracting with physicians out of state to get all the required IEPs signed. In most cases, the contracted provider has never seen the member and is not their PCP. This issue came to light when data trends showed that AOE has one of the highest portions of Medicaid spending. DVHA is working on a new initiative consisting of outreach and education to school nurses and PCPs about the services included in the IEP and the importance of having an in-network PCP sign the form. The PCPs are most often in the dark about one of their patients even having an IEP. DVHA has partnered with the Vermont Department of Health and the Agency of Education on this initiative.

Global Commitment Core Measures:
DVHA's Quality Unit monitors performance and quality within Vermont Medicaid and leads efforts to improve quality of care for Medicaid members. Medicaid operates under a Global Commitment to Health Waiver. This waiver currently covers most of the Medicaid population in Vermont. The waiver allows Vermont to work on innovation within Medicaid. This falls under section 1115 of the Social Security Act. Through the DVHA Data Unit and a certified national vendor, the Quality Unit creates the standards of measures. These are reported out regularly to the Centers for Medicare and Medicaid Services (CMS). DVHA has a core set of measures: the Global Commitment core measure set. DVHA regularly reviews and analyzes the core measure sets for utilization trends. DVHA has a dashboard that shows the measures and the trend in quality performance. The dashboard compares the Medicaid performance to the national 50th percentile average or the All Payer Model target. Most follow Healthcare Effectiveness Data and Information Set (HEDIS) guidelines. The data is based on claims data. The Quality Unit has been using a guide sheet that outlines measures that Vermont Medicaid is above and below standards on.

The CURB can help by recommending specific topics. The topics that are of the most interest are the ones that are rated the lowest. Breast cancer screening and preventive services are of interest to the board. Preventive services measure dovetails nicely with the screening measure, where screening measures help

in early detection of undiagnosed diseases. These two combined could have a large positive impact on the Medicaid population.

PAST CURB INITIATIVES UPDATE

Pediatric PT/OT/ST Reviews:

Earlier oversight for pediatric (ages 0 until the end of the 20th year) PT/OT/ST reviews began as a CURB initiative in 2012. Prior to this initiative there was minimal oversight of PT/OT/ST services provided. The initiative has led to less recoupments by DVHA and less investigation by DVHA's Program Integrity Unit for providing incorrect, non-covered, and non-proven services for Medicaid members. The initiative has also served to increase provider engagement and education through in-service trainings coordinated by DVHA.

Gold Card for Radiology Procedures:

DVHA implemented the Gold Card process in 2013. The radiology benefit manager runs data annually to identify which providers meet the criteria to qualify for a Gold Card. Providers who qualify for a Gold Card are exempt from being required to request prior authorizations for radiology procedures.

The qualifications for Gold are:

- Providers who requested 100 or more radiology procedures in 18 months and
- Had a denial rate of 3% or less.

In November 2017, the data was run to identify new providers who may qualify. No new providers met the gold card qualifications for 2017. As of January 2017, the Gold Card privileges have been extended to a total of 13 providers.

Low Dose Chest CT Scan:

The recommendation was for VT Medicaid to cover low dose CT Scans for lung cancer screening. This initiative was approved by DVHA Commissioner and became effective in March 2015.

As of October 20, 2017, a total of 431 recipients have received this service.

Outpatient Out-of-Network Elective Office Visits PA Requirement:

The CURB member's recommendation in 2012 was to institute a prior authorization requirement for elective Out-of-Network office visits.

In the first year, there was a 63% decrease in the claims paid for out-of-network office visits, and a 59% decrease in year two. However, in year three there was a 6% increase in claims paid. Year four and five showed a 38% and 42% decrease respectively. Overall there was approximately a $85,000 decrease in claims paid over the five years. This represents a 90% decrease in the yearly amount DVHA spends on out-of-network office visits. The total Medicaid population has increased 25% over the same time frame. In-network elective office visits saw a slight increase (11%) in claims paid for the four-year period.

90853 Psychotherapy:

The recommendation was to bring the group therapy procedure code (90853) into compliance with national correct coding initiative (NCCI) guidelines, by implementing one session per day for group psychotherapy (90853). Effective July 1, 2015, Medicaid requires all providers to bill this code per session as opposed to per fifteen minutes. 1 Unit = 1 Session.

As of October 20, 2017, there was a decrease of approximately $1.5 million in claims paid between FY2015 and FY2017. However, there was an increase of approximately $3 million in yearly claims paid for individual psychotherapy for the same time frame.