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: Cory Gustafson,
Commissioner

Prepared by: J. Scott Strenio, M.D.
Medical Director

Report Date: January 15th, 2020

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

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EXECUTIVE SUMMARY

Act 146 of 2010, An act relating to implementation of challenges for change, required the Department of Vermont Health Access 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 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.[1] Act 146 of 2010 further requires the Department of Vermont Health Access to evaluate the Board's success in "improving clinical and utilization results" and report annually, by January 15th to the House Committee on Health Care and the Senate Committee on Health and Welfare, on the results of the evaluation. The Department must also provide a summary of the board's activities and recommendations since the last report.[2]

This report provides an overview of the Clinical Utilization Review Board's activities since the report submitted in 2018, includes Board-issued recommendations, and summarizes the Department of Vermont Health Access conclusions regarding the success of the Board in improving clinical and utilization outcomes for the Vermont Medicaid program. In 2019, the Board continued to monitor paid amounts per fiscal year for prior authorizations for out-of-state elective outpatient office visits, observing an overall decrease in out-of-state spending but a recent increase in spending when the last year's data was reviewed. The Clinical Utilization Review Board voted unanimously in 2019 to approve amended criteria for the Gold Card process (which exempts health care professionals from prior authorization requirements for high-tech radiology procedures); implementation of this recommendation resulted in 4 new providers qualifying for exemption of prior authorization requirements for high-tech radiology procedures. Finally, in 2019, the Board adhered to its legislatively-mandated duties by reviewing spending for laboratory services and associated best practices in the medical literature, assessing telehealth and E-consults with a focus on dentistry to address appropriate but underutilized services, and recommending coverage for advanced care planning.

[1] http://www.leg.state.vt.us/DOCS/2010/ACTS/ACT146.PDF; https://legislature.vermont.gov/statutes/section/33/019/02031
[2] http://www.leg.state.vt.us/DOCS/2010/ACTS/ACT146.PDF; https://legislature.vermont.gov/statutes/section/33/019/02032

BACKGROUND

Act 146 of 2010, An act relating to implementation of challenges for change, required the Department of Vermont Health Access 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 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.[3] Importantly, the Act addresses avoidance of duplication of efforts by mandating that the Program Integrity unit inform the Clinical Utilization Review Board of relevant practices the Unit has identified through its reviews. This required coordination provides assurance that multiple entities are not unnecessarily expending time and effort evaluating the same practices.

Pursuant to 33 V.S.A. § 2031, the Clinical Utilization Review Board has the following duties and responsibilities:

> (1) Identify and recommend to the Commissioner of Vermont Health Access opportunities to improve quality, efficiencies, and adherence to relevant evidence-based clinical practice guidelines in the Department's medical programs by:
>
> (A) examining high-cost and high-use services identified through the programs' current medical claims data;
>
> (B) reviewing existing utilization controls to identify areas in which improved utilization review might be indicated, including use of elective, nonemergency, out-of-state outpatient and hospital services;
>
> (C) reviewing medical literature on current best practices and areas in which services lack sufficient evidence to support their effectiveness;
>
> (D) conferring with commissioners, directors, and councils within the Agency of Human Services and the Department of Financial Regulation, as appropriate, to identify specific opportunities for exploration and to solicit recommendations;
>
> (E) identifying appropriate but underutilized services and recommending new services for addition to Medicaid coverage;
>
> (F) determining whether it would be clinically and fiscally appropriate for the

[3] http://www.leg.state.vt.us/DOCS/2010/ACTS/ACT146.PDF; https://legislature.vermont.gov/statutes/section/33/019/02031

Department of Vermont Health Access to contract with facilities that specialize in certain treatments and have been recognized by the medical community as having good clinical outcomes and low morbidity and mortality rates, such as transplant centers and pediatric oncology centers; and

(G) considering the possible administrative burdens or benefits of potential recommendations on providers, including examining the feasibility of exempting from prior authorization requirements those health care professionals whose prior authorization requests are routinely granted.

(2) Recommend to the Commissioner of Vermont Health Access the most appropriate mechanisms to implement the recommended evidence-based clinical practice guidelines. Such mechanisms may include prior authorization, prepayment, post-service claim review, and frequency limits. Recommendations shall be consistent with the Department's existing utilization processes, including those related to transparency, timeliness, and reporting. Prior to submitting final recommendations to the Commissioner of Vermont Health Access, the Board shall ensure time for public comment is available during the Board's meeting and identify other methods for soliciting public input.

Act 146 of 2010 further required the Department of Vermont Health Access to evaluate the Board's success in "improving clinical and utilization results" and report annually, by January 15th and to the House Committee on Health Care and the Senate Committee on Health and Welfare, on the results of the evaluation. The Department must also provide a summary of the board's activities and recommendations since the last report.[4] This report provides an overview of the Clinical Utilization Review Board's activities since the report submitted in 2018, includes Board-issued recommendations, and summarizes the Department of Vermont Health Access conclusions regarding the success of the Board in improving clinical and utilization results for the Vermont Medicaid program.

SUMMARY OF ACTIVITIES AND RECOMMENDATIONS

The Clinical Utilization Review Board is required to meet at least quarterly; during the 2019 year, the Board met in March, May, September and November.[5,6] 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

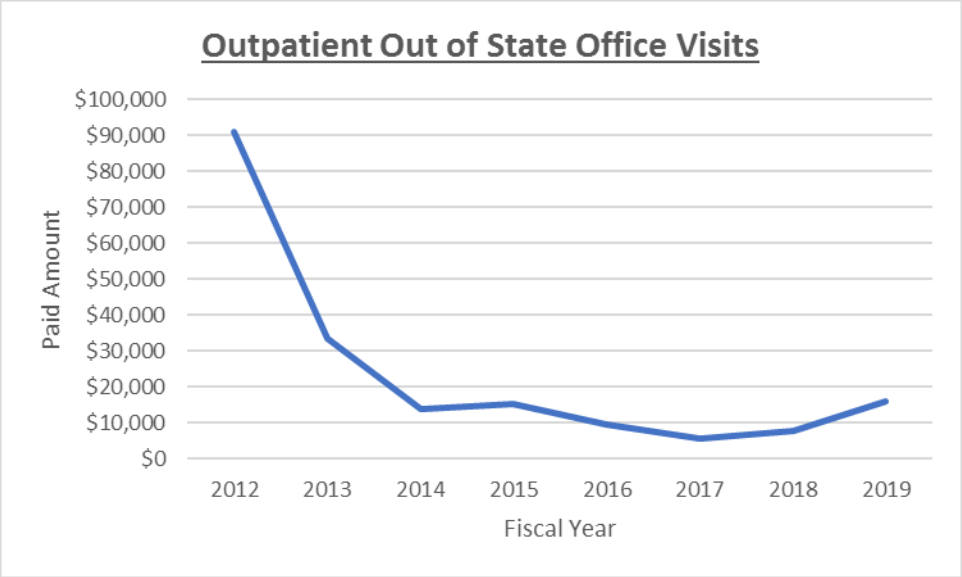
[4] http://www.leg.state.vt.us/DOCS/2010/ACTS/ACT146.PDF; https://legislature.vermont.gov/statutes/section/33/019/02032
[5] https://legislature.vermont.gov/statutes/section/33/019/02031
[6] https://dvha.vermont.gov/advisory-boards/clinical-utilization-review-board-meeting-agendas

the Department's medical programs [33 V.S.A. § 2031(1)].[5] The Board is expected to complete this duty by examining current medical claims data in order to identify high-cost and high-use services [33 V.S.A. § 2031(1)(A)].[5]

Prior Authorization Requirement for Out-of-State Elective Outpatient Office Visits

In addition to the responsibilities discussed above, the Board is also required to identify areas in which improved utilization review might be indicated, including use of elective, nonemergency, out-of-state outpatient and hospital services [33 V.S.A. § 2031(1)(B)].[5] The work of the Clinical Utilization Review Board to identify and recommend that the Vermont Medicaid program require prior authorization for out-of-state elective outpatient office visits is an example of the Board's activities and recommendations that meet the legislative requirements stated above. Since the Board's recommendation in 2012, the Board has continued to monitor paid amounts per fiscal year, observing an overall decrease in out-of-state spending, as depicted in the graph below.

Graph 1. Outpatient Out-of-State Office Visits, Paid Amount by Fiscal Year (2012-2019)



The Board's review of the most recent year of data prompted discussion regarding potential factors that are contributing to increased spending. The Clinical Utilization Review Board indicated that, "limited access to specialists, and specialized clinics within Vermont, whether it's possible to find an interim specialist when the only in-network specialty provider goes on leave, and protracted wait times for specialist visits [may be] factors in this spending." Board members would like to analyze additional data to determine if specific geographic regions, demographics (e.g. age), specialty types, or other factors are generating higher volumes of out-of-state service requests. Additional analysis would allow for the Board to develop a

recommendation or recommendations for a strategy or strategies, including facilitated outreach with providers and practices, to ensure that out-of-state spending remains medically necessary and appropriate.

Gold Card Process – Exemption from Prior Authorizations for Radiology Procedures

In accordance with 33 V.S.A. § 2031(1)(G), the Clinical Utilization Review Board must consider the possible administrative burdens or benefits of potential recommendations on providers, including examining the feasibility of exempting from prior authorization requirements those health care professionals whose prior authorization requests are routinely granted. The work of the Clinical Utilization Review Board to identify and recommend that the Vermont Medicaid program implement a process, or processes, for exempting health care professionals whose prior authorization requests are routinely granted from prior authorization requirements is exemplified by implementation of the Gold Card process. In its 2018 Annual Report, the Clinical Utilization Review Board indicated that 13 providers met the criteria for exemptions of prior authorization for high-tech radiology procedures through the Gold Card process. At the time the report was written, the current qualifications required that a provider must have at least 100 prior authorization requests for high-tech radiology procedures with a less than or equal to 3% denial rate within an 18-month period of time. Providers that met the criteria were then exempted from submitting prior authorization requests for 1 year. In its 2018 report, the Board indicated that it was evaluating a revised recommendation that would allow for an expansion to additional health care professionals, including primary care providers, thus increasing the number of eligible providers participating in the Gold Card process.

In 2019, the Board voted unanimously to approve amended criteria such that the standard to qualify for exemption from prior authorizations was 75 prior authorization requests for high-tech radiology procedures within an 18-month period of time and qualifying providers are now exempted from submitting prior authorization requests for high-tech radiology procedures for 2 years. The denial rate of less than or equal to 3% within 18-months remained unchanged. As a result of the Board's recommendation and implementation of the revised Gold Card process, 4 new providers qualified in 2019. Board discussions regarding denial rates indicated that it is frequently referral departments that complete radiology prior authorization requests. As such, the Board identified that issuing notices directly to providers for denials of prior authorization requests when the request does not meet required criteria may prove to be a valuable outreach and educational initiative. Finally, Board discussions also included the topic of preliminary low-tech radiologic screening as providers have indicated frustration with this requirement. As the Board looks to its 2020 activities, it may decide to evaluate the existing evidence-base for preliminary

low-tech radiologic screening as a requirement.

Review of Best Practices, Appropriate but Underutilized Services and Recommendations for New Services

Pursuant to 33 V.S.A. § 2031(1)(C)(E), the Clinical Utilization Review Board is responsible for reviewing medical literature on current best practices and for identifying appropriate but underutilized services and recommending new services for addition to Medicaid coverage. In 2019, the Board adhered to these duties by reviewing spending for laboratory services (a mandatory benefit) and associated best practices in the medical literature, assessing telehealth and E-consults with a focus on dentistry to address appropriate but underutilized services, and recommending coverage for advanced care planning.

Vermont Medicaid Spending on Laboratory Services

In state fiscal year 2018, Vermont Medicaid spent approximately $35 million dollars on laboratory services. The table below provides additional information on spending, providing information by setting and state fiscal year.

Table 1. Vermont Medicaid Spending on Laboratory Services, by Setting & State Fiscal Year

	2016	**2017**	**2018**
Independent Lab	$3,389,187	$8,827,425	$13,762,178
Physician Lab	$2,986,359	$3,482,751	$4,087,121
FQHC	$1,608,778	$1,651,228	$1,863,394
RHC	$124,550	$126,337	$104,675
Outpatient Hospital	$12,515,401	$14,419,075	$15,791,671
Total	**$20,624,275**	**$28,506,816**	**$35,609,039**

Further analysis identified that between state fiscal years 2016-2018, the laboratory service with the largest amount of growth in spending was urine drug testing related to opioid use disorder treatment. The total spending on urine drug testing related to opioid use disorder treatment dramatically increased, with Vermont Medicaid spending approximately $2.4 million in state fiscal year 2016, $10.1 million in 2017, and $14.8 million in 2018.

Table 2. Vermont Medicaid Program Spending on Urine Drug Testing Related to Opioid Use Disorder Treatment, State Fiscal Years 2016-2018.

State Fiscal Year	2016	2017	2018
VT Medicaid Program Spending on Urine Drug Testing, Related to Opioid Treatment	$2,368,740.30	$10,146,055.80	$14,823,920.52

Subsequent to the analysis of spend by state fiscal year, the frequency of urine drug testing per unique Medicaid member was assessed. The results indicated that the number of unique Medicaid members receiving that particular laboratory service nearly tripled from 2016-2018. Further analysis of medical claims data from 2016 indicated that approximately 6 urine drug tests were performed per unique member. In 2017, the number increased to approximately 12 tests performed per unique member. By 2018, approximately 15 tests were performed per unique Medicaid member.

Table 3. Number of Unique Medicaid Members & Count of Urine Drug Tests by State Fiscal Year

	Unique Medicaid Members	Count of Tests
2016	**4,755**	**28,781**
2017	**9,360**	**118,300**
2018	**11,503**	**177,453**

These findings initiated work that occurred throughout 2019 wherein the Department of Vermont Health Access worked collaboratively with subject matter experts, Payers, and community stakeholders to review medical literature for established best practices and identify opportunities for improvement in clinical practice and utilization related to urine drug testing when it is employed as part of opioid use disorder treatment. This work will form the basis for development of a Best Practice Guideline for Urine Drug Testing.

Underutilization of Dental Services by Medicaid Members

The Clinical Utilization Review Board followed and reviewed the sections of S.94 (Act 72 of 2019) for expanding Medicaid beneficiaries' access to dental care and testimony provided by the Department's Commissioner regarding utilization of dental benefits by adult Medicaid

members.[7, 8] Underutilization of dental services was illustrated by state fiscal year 2018 data that indicated that only 25% of adult Medicaid members received any dental service, with only 9% of the 25% receiving a preventive cleaning. The Department of Vermont Health Access, in consultation with the Vermont State Dental Society and Board of Dental Examiners, requested that a member of the Clinical Utilization Review Board participate in the dental access and reimbursement working group established by Act 72 of 2019 in section E.306.3.[9] The dental access and reimbursement working group submitted a legislative report in accordance with Sec. E.306.3(b)(1) of Act 72 (2019); the report contained a total of 11 recommendations for consideration.[10] The recommendations provide an opportunity for the Clinical Utilization Review Board to continue its work in 2020 to improve utilization of the dental benefit by adult Medicaid members and adhere to its legislatively mandated duties and responsibilities by:

- Completing a review of utilization and reimbursement rates for preventive dental services following the end of the last quarter in state fiscal year 2020 to assess the impact and/or effectiveness of the adult dental benefit change (effective 1/1/20, Recommendation Number 2);
- Study and report on the national use of, and estimated fiscal impact for, expansion of coverage for store and forward technology for dental services that are appropriate through this method and medically necessary (Recommendation Number 6).

The Clinical Utilization Review Board began discussions and evaluation of telehealth strategies, to include store and forward technology and E-consults, to employ for addressing underutilization of the Medicaid adult dental benefit. These discussions and assessments will continue into the 2020 year and require coordination with multiple units within the Department as telehealth is explored as a tool for improving access to care.

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[7] https://legislature.vermont.gov/bill/status/2020/S.94

[8] https://legislature.vermont.gov/Documents/2020/WorkGroups/Senate%20Health%20and%20Welfare/Bills/S.94/Written%20Testimony/S.94~Cory%20Gustafson~Dental%20Information~2-28-2019.pdf

[9] https://legislature.vermont.gov/Documents/2020/Docs/ACTS/ACT072/ACT072%20As%20Enacted.pdf

[10] https://legislature.vermont.gov/assets/Legislative-Reports/Sec.-E.306.3-Act-72-of-2019-Dental-Access-Reimbursement-1-November-2019_DVHA_FINAL.pdf

Recommendation for Coverage of Advanced Care Planning

As Vermont's population ages, the need for advanced care planning has increased substantially. Ranked one of the two lowest states in hospice utilization, health plans in Vermont were challenged to cover preliminary steps (of which advanced care planning is one). With this recommendation and subsequent approval, Vermont Medicaid now joins the other major insurers in providing coverage for advanced care planning.

EVALUATION OF CLINICAL UTILIZATION REVIEW BOARD SUCCESS

Act 146 of 2010 further required the Department of Vermont Health Access to evaluate the Board's success in "improving clinical and utilization results" and report on that evaluation within the annual report submitted by January 15. In consideration of the success of the Board in improving clinical and utilization results, the Department highlights the work of the Clinical Utilization Review Board to identify and recommend that the Vermont Medicaid program require prior authorization for out-of-state elective office visits as an example of work by the Board that demonstrates successful improvements in utilization results, and fiscal accountability, for the Vermont Medicaid program. Furthermore, implementation of the Gold Card process described in detail within the Summary of Activities section provides a notable example of success in improving clinical results and reducing administrative burden for health care professionals. Finally, the Board's work in 2019 to review utilization data and best practices within existing medical literature for urine drug testing related to opioid use disorder treatment, as well as recommendations for improving underutilization of dental services and providing coverage of advanced care planning, indicate the success of the Board's endeavors for the 2019 year.

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. Please note: There are currently 2 vacancies on the Clinical Utilization Review Board at this time due to resignations and/or term limits.

Member Name	Field of Practice & Location
Dr. Ann Goering (MD)	Family Medicine, Winooski
Dr. Joshua Green (ND)	Naturopath, Burlington
Dr. Nels Kloser (MD)	Psychiatrist, Southern Vermont
Dr. John Matthew (MD)	Internal Medicine, Plainfield
Dr. Thomas Connolly (DMD)	Dentistry, Retired
Dr. Elizabeth Newman (MD)	Family Medicine, Colchester
Dr. Michael Rapaport (MD)	Family Medicine, Central Vermont
Dr. Valerie Riss (MD)	Pediatric Hospitalist, Burlington