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

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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 (DVHA) 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.[2,3]

In 2020, the Clinical Utilization Review Board examined the following topics:

- Telehealth, including interprofessional consultations (i.e., E-Consults), Telemedicine, and Telephonic health care service delivery; and
- DVHA's response to the coronavirus disease 2019 (COVID-19) public health emergency, including changes to clinical prior authorization requirements and the Non-Emergency Medical Transportation Program.

The COVID-19 public health emergency required meetings of the Clinical Utilization Review Board to transition to virtual convenings while still ensuring the meetings remained opened to the public in accordance with Vermont's open meeting law. The COVID-19 public health emergency required the Clinical Utilization Review Board to make recommendations to the Department of Vermont Health Access on matters relating to service coverage. The Clinical Utilization Review Board completed these reviews through the lens of medical necessity and in consideration of utilization. During 2020, the Board provided numerous recommendations while indicating strong support for the Department of Vermont Access' efforts.

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[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

[3] https://legislature.vermont.gov/assets/Legislative-Reports/CURB-Annual-Report-15-January-2020_DVHA_FINAL.pdf

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.[4] 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

[4] 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.[5] This report provides an overview of the Clinical Utilization Review Board's activities since the report submitted in 2020,[6] inclusive of 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.

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

[6] https://legislature.vermont.gov/assets/Legislative-Reports/CURB-Annual-Report-15-January-2020_DVHA_FINAL.pdf

SUMMARY OF ACTIVITIES AND RECOMMENDATIONS

2020 Meeting Schedule

The Clinical Utilization Review Board is required to meet at least quarterly; during the 2020 year, the Board met in January, May, July, September and November.[7,8] 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 medical programs.[9] The Board is expected to complete this duty by examining current medical claims data in order to identify high-cost and high-use services.[10]

Telehealth, Telemedicine, and Telephonic Health Care Service Delivery

When the Governor of Vermont declared a State of Emergency on March 13, 2020,[11] Vermont Medicaid-participating providers and their association representatives immediately asked the Department of Vermont Health Access to support Vermont Medicaid members in receiving medically necessary and clinically appropriate health care services even if federal guidance had yet to be released regarding approved methods for delivery during the Emergency. The Department of Vermont Health Access and the Clinical Utilization Review Board responded to that request to ensure continued access to, and provision of, medically necessary health care services delivered in clinically appropriate ways during the early months of the COVID-19 public health emergency.

Firstly, the Clinical Utilization Review Board provided vital recommendations regarding Vermont Medicaid's consideration of coverage and reimbursement for interprofessional consultations. Interprofessional consultations fall under the umbrella of telehealth and are assessment and management services in which a patient's treating (i.e., attending or primary) physician/other qualified health care professional or dentist requests the professional opinion and/or treatment advice of a consultative physician/dentist (i.e., a consultant with specific specialty expertise); due to documentation requirements, interprofessional consultations are typically completed through an asynchronous telecommunications system (i.e., store and forward). Thus, Vermont Medicaid was considering the coverage expansion for interprofessional consultations performed through

[7] https://legislature.vermont.gov/statutes/section/33/019/02031
[8] The March meeting was canceled due to the COVID-19 public health emergency; https://dvha.vermont.gov/advisory-boards/clinical-utilization-review-board/curb-agendas
[9] https://legislature.vermont.gov/statutes/section/33/019/02031
[10] https://legislature.vermont.gov/statutes/section/33/019/02031
[11] Declaration of State of Emergency in Response to COVID-19.

store and forward technology in order to:

- increase access to specialists;
- have more patients treated, when appropriate, in the primary care setting; and
- provide additional support for primary care providers, including education, through the consultative physician/dentist's written treatment recommendation that is submitted back to the treating/requesting physician/other qualified health professional or dentist.

Following review/recommendation for coverage and reimbursement by the Clinical Utilization Review Board and strong support indicated by the Chairs of the House Committee on Health Care and the Senate Committee on Health and Welfare, Vermont Medicaid began providing coverage and reimbursement for interprofessional consultations when performed through store and forward technology (also referred to as provider to provider store and forward) for both the treating and consultative provider on July 1, 2020.[12]

Board Discussion on Interprofessional Consultations Performed through Store and Forward Technology Included:

- What support do we, as Vermont Medicaid-participating providers, need or want from interprofessional consultations?

- It was noted that interprofessional consultations offer opportunity for additional support for primary providers related to medical necessity decisions; store and forward technology can enable specialist consultations and result in recommendations with related to the need for specialty care, or other treatments or care plan recommendations for the patient to continue treatment with their primary provider.

- In considering potential coverage/reimbursement by Vermont Medicaid for interprofessional consultations, and in evaluating potential for inclusion within a value-based care model, what questions should we, as a Payer, and in representing Vermont providers, be asking?

- Who will form the network of specialists? Will it be local, Vermont-based providers, out-of-state providers, or a combination of both in order to meet primary provider

[12] https://humanservices.vermont.gov/sites/ahsnew/files/documents/MedicaidPolicy/GCRFinalPolicies/20-075-Final-GCR-Interprofessional-Consults.pdf

needs for consultations? (Caution was indicated with having a network that would be only out of state, as it could negatively impact local, Vermont-based specialists.)
    - One Board member noted that the region in which they are a provider, a couple of cardiologists will be leaving. Interprofessional consultations could be very helpful in times/situations such as this.

- The Board discussed that interprofessional consultations provide a valuable opportunity to identify and provide care in the primary setting; that care may serve as a bridge until the patient can have a follow-up visit with a specialist. However, time is required of both providers (treating and consultative) so it would be very important to ensure appropriate compensation for both providers; some states have chosen to only provide coverage/reimbursement for one set of providers and this has resulted in issues that ultimately limit utilization of the model.

- What would be the preferred manner to implement interprofessional consultations?
    - Implementation requires workflow changes in provider to support successful adoption; would the State offer a Request for Proposal, initiate a contract, etc. that would allow implementation specialists from company with specialized expertise to offer support to practices?
    - Monitoring of quality of care by the State would be necessary if an external vendor was hired to support implementation.
    - Market research may first need to be completed through speaking with a company currently offering support for implementation of interprofessional consultations in order to understand what type of support can be offered for provider organizations, how quality of care can be monitored, whether there is available data to demonstrate the benefits of the model, and how specialist networks are developed, etc.

Secondly, in consultation with the Clinical Utilization Review Board, Vermont Medicaid-participating providers were encouraged to continue to use telemedicine to care for their Medicaid members during the COVID-19 public health emergency. However, it was identified that it may not be possible for Medicaid providers to reach all of their Medicaid members requiring care during the Emergency through telemedicine (defined as 2-way, real-time audio and video/visual interactive communication). Thus, it was necessary to assess whether health care service delivery by telephone could provide access to clinically appropriate diagnosis, treatment and care for Vermont Medicaid members who would otherwise not have access to care in the context of the COVID-19 public health emergency. As a result, Vermont Medicaid issued guidance for Medicaid-participating providers

regarding new, temporary coverage of telephonic services furnished during the emergency response to COVID-19.[13]

Effective Monday, March 23rd, Vermont Medicaid implemented several changes to support Medicaid-participating providers in responding effectively to the emergency produced by COVID-19. These changes were intended to assure access to care for Vermont Medicaid members and enable Medicaid providers to receive reimbursement for services provided for their patients during the State of Emergency produced by COVID-19 **without requiring**:

- patients to travel to a health care facility; or
- the use of telemedicine (defined as two-way, real-time, audio and video/visual interactive communication) as many patients may not be comfortable with, or equipped, to use telemedicine during the Emergency and best practice guidance indicates the importance of social distancing in order to reduce the risk of COVID-19 transmission.

In order to prevent Vermonters from unnecessarily traveling to health care facilities, to further protect the most vulnerable Vermonters, and to ensure that Medicaid-participating providers are reimbursed for the medically necessary and clinically appropriate services they provided during the public health emergency, Vermont Medicaid implemented the following changes for March 23rd, 2020:[14]

1). Providing coverage and reimbursement for the use of 3 'triage codes' – G0071 for FQHCs and RHCs only and G2012 & G2010 for providers located in non-FQHC/RHC settings – to allow providers to receive payment for brief virtual communication services used to determine whether an office visit or other service is needed.

2). Providing reimbursement at the same rate for medically necessary, clinically appropriate services (e.g., new patient and established patient office visits, psychotherapy, etc.) delivered by telephone as the rate currently established for Medicaid-covered services provided through telemedicine/face-to-face as long as the service code had been approved/published on the Reference Chart, the claim is submitted to Vermont Medicaid with a V3 modifier (to indicate "service delivered via telephone, i.e., audio-only") and a place of service code of "99 – other" and all other requirements had been met.

The members of the Clinical Utilization Review Board were instrumental in ensuring continued access to, and provision of, medically necessary health care services during the COVID-19

[13] https://dvha.vermont.gov/covid-19 and Vermont Medicaid: Telehealth, Telemedicine and Telephonic Coverage.
[14] https://dvha.vermont.gov/covid-19

public health emergency. The State's liaison to the Board, DVHA's Medical Director, also collaborated with the medical directors of other Payers in Vermont to ensure payer alignment to the extent possible in additions and exceptions for coverage of heath care services delivered through telehealth modalities.

Board Discussion on Telehealth, Telemedicine, and Telephonic Service Delivery Included:

- In a naturopathic office, telemedicine is now being used 99% of the time.

- Challenges have been identified due to the rapid expansion of telemedicine services across the country. Long download times for platforms are problematic as it decreases time available to see patients. Some providers have increased access hours to accommodate the extended download times. There are also technological challenges (bandwidth) that have affected service provision. Poor internet connectivity may limit visibility (e.g., rash examination) and extend the "visit."

- Patient's knowledge and experience with the technology has posed challenges, including delayed appointments and a need for clinic support staff to provide technical assistance to the patient prior to the visit.

- Strategies for improving services have included nursing staff calling patients prior to the actual telemedicine visit to update medications, health maintenance information, medical history, etc. Then, the provider connects with the patient using a telemedicine platform. One issue noted with this approach was the initial call may display as "blocked line" resulting in hesitation by the patient to answer the call.

- Board members report that in some practices, medical assistants spend 5-10 minutes on the telephone speaking with patients prior to their appointment to provide support and troubleshooting with the technology.

- Providers now feel more comfortable with the technology and have indicated they are more able to focus on the patient.

- Board members expressed concern about patients living in rural areas without connectivity as well as populations that may not have the technology or experience with technology to be comfortable receiving health care services through telemedicine.

- It was noted that the use of telemedicine for patients with mental health conditions had demonstrated significant benefits.
    - Providers on the Board specifically indicated a reduction in missed/late appointments for patients with substance use disorders.
    - Providers did express concern about the lack of in-person visits for patients receiving treatment for substance use disorder due to proximity to others in the environment who may still be using substances.
    - There have been significant modifications to urine drug screening practices based on risk stratification, including a reduction in observed urine drug screening. Providers identified a need to resume observed urine drug screening.

- An identified challenge with telemedicine: the lack of privacy with others in a home setting. According to Board members, this is especially concerning for adolescents receiving mental health treatment.

- It was noted that this year has provided an opportunity to collect data around telemedicine utilization and it may be beneficial to continue to collect such data beyond the public health emergency and to look at impacts on morbidity and mortality data points.

- A Board member commented that one example of appropriate use of health care service delivery via telemedicine may be to help avoid unnecessary transfers or additional emergency department visits by appropriately triaging care.

- Board members indicated interest in identifying and reviewing data that might detect if the changes to coverage (for example, the temporary expansion of coverage for coverage and reimbursement of services delivered by telephone) have affected care and/or health outcomes.

DVHA Response to the COVID-19 Public Health Emergency

The Department of Vermont Health Access' role in the response to the public health emergency was focused on facilitating initial enrollment into, or preservation of continuous, health care coverage for Vermonters, ensuring no co-payments applied for COVID-19 testing, diagnosis, treatment, or vaccination services, and assuring access to health care services for Vermont Medicaid members. As flexibilities and waivers were being implemented, the Department worked closely with the Clinical Utilization Review Board to ensure the Board had an opportunity to provide feedback and recommendations on these important actions.

For example, in order to support Vermont Medicaid-enrolled providers in providing health care services for Vermont Medicaid members, Vermont Medicaid instituted the following flexibilities:

- Removing clinical prior authorization requirements for imaging services, durable medical equipment and supplies, and dental services, excepting services with the potential to cause imminent harm; and
- Extending pre-existing prior authorizations for certain clinical services set to exhaust in April for an additional six months.

During each discussion, the Board voiced support for each of the actions taken by the Department of Vermont Health Access and requested continued updates at future meetings as the response to the COVID-19 public health emergency continues.

Vermont Medicaid Non-Emergency Medical Transportation Program: Changes in Response to the COVID-19 Public Health Emergency

The Vermont Medicaid Non-Emergency Medical Transportation program, also known as the NEMT program, implemented an initial questionnaire (developed jointly by staff of the Department of Vermont Health Access and the Department of Health) to determine if Vermont Medicaid members will need to be transferred by ambulance or other non-emergency modes of transportation in order to protect the health and safety of Vermont Medicaid members and providers of transportation services, ensure alignment with health and safety requirements during the COVID-19 public health emergency, and ensure transportation is available for Vermont Medicaid members requiring transportation for non-emergency medical/dental appointments.

The new questionnaire includes five questions and asks the Vermont Medicaid member:

1. **Have you or someone you live with traveled outside of Vermont for an extended period? If so, where?**
    - The Vermont Department of Health website includes a link to estimated active coronavirus cases per million that the Transportation program is utilizing as a resource for nonemergency medical transportation determinations. There is funding for Ambulance only transporting of COVID-19 positive members. Ambulance transport is occurring for members with presumed positive COVID-19 test results. Transport vehicles are being disinfected post-transport according to Health guidelines and all drivers are updated weekly regarding PPE requirements with appropriate PPE

provided.

2. **Have you been in contact with any person who has been infected with the novel coronavirus or COVID-19?**

3. **Over the past 14 days have you had the following symptoms?**
   - Symptoms are being updated regularly by the Department of Health. Members that answer 'yes' to any are being transported via ambulance. Some of the federal funding the Department has received for the COVID-19 response is being allocated for these types of scenarios. Therefore, at this point, none of the funds for ambulance transports for members answering 'yes' to questions related to positive COVID-19 symptoms are coming from the existing annual transportation budget.

4. **Have you discussed other possible options with your provider other than going into the office, such as phone screening, video conferencing or rescheduling?**
   - Phone screening and video conferencing are being utilized extensively for screening regarding nonemergency transportation requests. This is something that has been effective and highlights a tool that has beneficial use moving forward; for example, for trips where a telemedicine visit may be appropriate and will be a valuable tool even after the pandemic.

5. **Are you aware that your transportation to this appointment may result in you being in close proximity to a person who may end up testing positive for COVID-19 and that this transportation may have potential additional health risks due to the current situation?**
   - Some people are deciding to postpone appointments when consideration these questions. Unfortunately, there have been incidents where members did not answer the questions truthfully and it has been important for discussion as it can lead to exposure for others.

Board Discussion on NEMT Program Changes Involved:

- There has been concern around potential for driver exposure to the novel coronavirus and the impact this could potentially have on transportation capacity.

- Have vehicles been outfitted with barriers between the driver and the passengers? Procedures now include limiting passengers to one per volunteer vehicle per trip, with the passenger in the backseat. Some of the vans for transportation are only

putting 2-3 passengers per van to allow for social distancing and these vans have been outfitted with a barrier between the driver and passengers to provide some barrier to the driver. Installation of a barrier is a challenging idea for the private, volunteer cars as there is not a clear funding source to pay for this for these drivers.

- If there is a maximum of two passengers in a vehicle, are there attempts to ensure the two passengers are from the same family?
  Yes, this is the goal. Passengers who are not from the same household are transported individually or in a vehicle that allows for social distancing.

- It was noted that it is likely that the volume of trips will increase with continued requirements for limiting the number of patients per trip in accordance with the guidelines for social distancing.
  Requests to DVHA for transportation will be provided in accordance with expert-provided guidance.

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 Board's work to review and provide recommendations to ensure an effective response to the COVID-19 public health emergency, the Board demonstrated its value for the Vermont Medicaid program even during an unprecedented public health crisis that presented any number of challenges for providers of health care services. The Board's work in 2021 will focus on its legislative responsibilities inclusive of refining its vision and future endeavors to issue recommendations in support of continued operational improvement 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. Please note: There are currently 3 vacancies on the Clinical Utilization Review Board at this time due to the public health emergency, resignations and/or term limits.

Member Name	Field of Practice & Location
Dr. Joshua Green (ND)	Naturopath, Burlington
Dr. Nels Kloster (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