
Health Insurance Coverage for Non-Opioid Approaches to Treating and Managing Pain

**Report to House Committees on Health Care and on
Human Services and Senate Committees on Health and
Welfare and on Finance
Pursuant to Act 7
(2018 Special Session)**

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Executive Summary

The use of illegal opioids and the abuse of prescription opioids has reached epidemic proportions nationally and locally.¹ Vermont is taking many approaches to confront the opioid epidemic. One approach is the promotion of non-opioid treatment and management of chronic pain. Vermont Medicaid and other payers are launching pilot programs to support clinical innovation in comprehensive integrated pain management. Vermont's established Hub and Spoke system for medication assisted treatment represents recent success with this type of multi-payer model and can serve as a foundation for similar intervention in the area of chronic pain management.

Through Act 7 (2018 Special Session), the Legislature directed stakeholders to consider this clinical approach and to address important questions about insurance coverage of alternative approaches to pain management. This report represents the recommendations of the working group convened under Act 7.

The working group recommends that the State address this aspect of the opioid crisis initially through fundamental changes to the delivery system instead of ad hoc changes to commercial insurance coverage, focusing on collaboration and integration instead of encouraging use of discrete modalities. Specifically, the working group recommends the continued pursuit of pilot programs in integrated pain management. This way, the State can learn through the pilots what is feasible and scalable to larger portions of the market and population. In the near term, the goal is to implement pilots in a way that does not require insurance plan design changes or new provider payment structures on a broad scale. In the longer term, the pilots will provide valuable data to inform insurance coverage of a new treatment and payment models that address chronic pain.

Notwithstanding this recommendation, the working group considered each of the questions posed in Act 7 in turn. As requested by legislators, this report addresses specific plan design issues in the qualified health plan (QHP) subsection of Vermont's insurance market. The working group does not recommend any changes to the cost-sharing mandates in QHPs for 2020 but does suggest their reconsideration in the future as more information becomes available through the pilots. It is important that insurance plan design changes today do not inhibit clinical innovation that may help Vermont address the opioid crisis tomorrow.

Background

Act 7 (2018 Special Session)² directs the Department of Vermont Health Access (DVHA) to convene a working group to develop recommendations related to insurance coverage for non-opioid approaches, including non-pharmacological approaches, to treating and managing pain. The legislation requires the working group to provide its recommendations to the House Committees on Health Care and on Human Services and the Senate Committees on Health and Welfare and on Finance, on or before January 15, 2019.

¹Vermont Opioid Coordination Council, Final Report, January 2018.

http://www.healthvermont.gov/sites/default/files/documents/pdf/OCC%202018%20Report%202018-1-9.Final_.pdf

²<https://legislature.vermont.gov/assets/Documents/2018.1/Docs/Acts/ACT007/ACT007%20As%20Enacted.pdf>

DVHA convened the Act 7 working group in October 2018. The core working group consists of Michael Costa, Erin Just, Dana Houlihan, Addie Strumolo, Beth Tanzman (DVHA); Anna Van Fleet (DFR); Kelly Lange (BCBSVT); Susan Gretkowski (MVP); Mike Fisher (HCA); and Dr. Jon Porter (Medical Director of Comprehensive Pain Program, UVM Medical Center; pain management clinician designated by VMS). The working group also relied on support from policy, actuarial, and clinical staff from the participating departments and issuers, and other subject matter experts in chronic pain management.

Consistent with Act 7 Section 5(b), DVHA first provided the working group with an overview of the clinical approach to non-opioid treatments for pain that the Department has been developing with stakeholders. This approach is discussed in detail in the next section.

The working group then conducted several working sessions to evaluate:

- (1) whether health insurance plans should cover certain non-opioid approaches, including nonpharmacological approaches, to treating and managing pain;
- (2) an appropriate level of cost-sharing that should apply to chiropractic care, physical therapy, and any other non-opioid or nonpharmacological modalities for treating and managing pain that the working group recommends for insurance coverage; and
- (3) the proper proportional relationship between the amount of the copayment and the amount of the total charge or reimbursement for services for chiropractic care, physical therapy, and other non-opioid or nonpharmacological modalities for treating and managing pain.

This report addresses each of these items in turn. In response to a letter DVHA received from Senator Sirotkin and Representative Lippert on August 6, 2018, this report also addresses “continued concern about the potential impacts and possible unintended consequences of the co-payment limits established in Sections 2 and 3 of [Act 7].” We appreciate the legislators’ awareness of the time sensitivity around QHP design changes for 2020.

Clinical approach to non-opioid pain management

In its first meeting, DVHA provided the working group with an overview of the clinical approach it has been developing with stakeholders since February 2018. In brief, DVHA is working with health providers and other payers to pilot new services that provide coordinated specialists, complementary and alternative treatment modalities (CAMs), and ongoing enhanced primary care for Vermonters experiencing chronic pain conditions.

As a method to address the opioid epidemic in Vermont and help the estimated 26,000 Vermonters with chronic pain,³ DVHA and, specifically, the Blueprint for Health, convened clinical leaders and other payers to help design pilot prototypes for more integrated and

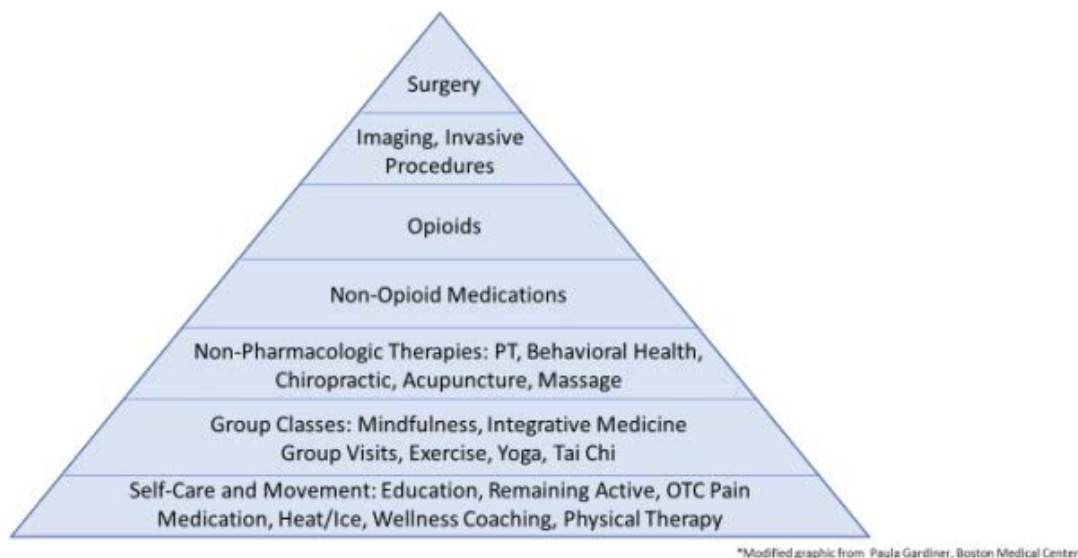
³ VHCURES Data Set, Onpoint Health Data Analysis, February 2018.

comprehensive approaches to the management of pain. On July 26, 2018, DVHA issued a Request for Information (RFI) to help inform the development of a Request for Proposals (RFP) for pilot tests of new service arrangements.⁴ These arrangements include integration of complementary and alternative modalities, alternative payment approaches, enhanced primary care services, specialty clinics and transdisciplinary consulting teams.

As detailed in the RFI and RFP, current service provision, benefits, and reimbursement patterns favor medical, pharmacological, and surgical treatments for pain; however, there is growing evidence demonstrating the importance and effectiveness of mental health treatments, exercise and physical reconditioning, nutrition, and complementary alternative modalities as first line interventions for pain management.⁵ The pilot framework is based on the hypothesis that non-pharmacological and non-surgical treatments for chronic pain can serve as the foundation for effective treatment.

Figure 1 sets forth a hierarchy of interventions where the base of the pyramid represents the least expensive and least invasive therapeutic options, all of which have efficacy in addressing chronic pain. As one ascends through the top half of the pyramid, the interventions increase in cost and sometimes carry risk of adverse outcomes to the patient – potentially without a corresponding increase in efficacy.

Figure 1: Pain Management Pyramid: Comprehensive, Guideline-Based, & Multidisciplinary



Source: Graphic modified from Paula Gardiner, MD, MPH, Boston Medical Center’s presentation “The How and Why of Integrative Medical Group Visits,” April 2018

⁴ https://blueprintforhealth.vermont.gov/sites/bfh/files/Chronic_pain_RFI_20180726.pdf

⁵ CAMs includes: chiropractic, acupuncture, yoga, massage, Tai Chi, Feldenkrais, mindfulness & meditation. Psychological treatments include cognitive behavioral therapy (CBT) and trauma-specific treatment.

Individuals struggling with chronic pain often have complex clinical needs involving overlapping physical health, mental health, and substance use conditions. However, psychological, health, physical rehabilitation, and CAM services are rarely offered in a coordinated or integrated fashion. This lack of coordination can impact the success of each element of care and make it more difficult for patients to get the care they need.

On August 27, 2018, DVHA released the RFP seeking pilot prototypes for alternative systematic approaches to management of chronic pain in the Medicaid program.⁶ While DVHA is still evaluating proposal submissions at the time of publication of this report, the framework of the pilot is most likely to include foundational episodes of care with a medical home/primary care provider with the incorporation of integrated alternative therapies based on the patient's individualized needs. This model is analogous to the Hub and Spoke system of care in Vermont's Medication Assisted Treatment model.

Medication assisted treatment for opioid use disorder is the use of FDA-approved medications, in combination with counseling and behavioral therapies, to provide a "whole patient" approach to the treatment of opioid use disorder. The Hub and Spoke system of care in Vermont provides medication assisted treatment for opioid use disorder in two settings – regional, specialty Opioid Treatment Programs (Hubs), which provide higher intensity treatment and office-based opioid treatment in community-based medical practice settings (Spokes). Peer-reviewed literature has established medication assisted treatment as an evidence-based, effective approach to the treatment of opioid use disorder, based upon notable, published outcomes such as decreased opioid use, decreased opioid-related overdose deaths, decreased criminal activity, decreased infectious disease transmission and increased social functioning and retention in treatment. Many of these outcomes were supported by the recent evaluation of Vermont's Hub and Spoke system. Based upon the significant impact demonstrated by the Hub and Spoke system,⁷ Vermont is working towards gaining all payer participation in the Opioid Use Disorder Health Home model, without requiring legislative mandate. In summary, the Hub and Spoke system represents recent success with this approach—a multi-payer collaboration that can be used as a model for pain management interventions.

In the commercial market, BCBSVT has embarked on a pilot program on chronic pain similar to DVHA's. BCBSVT is working with network providers to develop two new clinics in 2019 within a value-based episode of care contract framework. The foundation of these clinics will be the mental health and physical medicine disciplines and will be separate and complementary to existing interventional pain clinics. This framework will allow BCBSVT to focus on and measure outcomes of care and their resultant costs within a global payment structure and allow providers the flexibility to include therapies not currently covered, such as acupuncture or yoga, within the integrative clinic framework. The two initial proposed sites are the University of Vermont Medical Center (UVMCC) and the Brattleboro Retreat.

⁶https://blueprintforhealth.vermont.gov/sites/bfh/files/documents/Chronic%20Pain%20Pilot%20RFP%20final_8_27_2018.pdf. The RFP was issued prior to funding the program. This was done to ensure DVHA would have a program ready that could be implemented immediately upon availability of funding.

⁷<https://blueprintforhealth.vermont.gov/sites/bfh/files/VT%20Results%20First%20Inventory%20and%20Benefit-Cost%20Analysis%20for%20the%20Hub%20and%20Spoke%20Model%202017.pdf>

In the near term, the goal is to implement pilots on alternative approaches to pain management in a way that does not require insurance plan design changes or new provider payment structures on a broad scale. For example, BCBSVT will operate its UVMMC pilot through a fee-for-service model. In this way, the pilots are testing the clinical approach, agnostic of insurance coverage issues.

It is important to evaluate the results of the pilot before making any structural changes to the insurance market. However, in the longer term, it is envisioned that coverage of such a treatment approach to managing chronic pain could take place through a comprehensive pain management benefit likely to include multiple components allowing customization according to an individual patient's needs.

After having reviewed this information in the context of Act 7, the working group identified the following critical features of this approach to addressing chronic pain:

1. A comprehensive and individualized approach to the complex problem of chronic pain is key. Do not focus on individual procedures—different modalities will work for different patients.
2. Care coordination is the essence of the model. Do not set up barriers to integration.
3. The clinical methodology must drive this project instead of payment and coverage structures.
4. We must learn through pilots what is feasible and scalable to larger portions of the market and population.

With this background, the working group took up the specific questions posed in Act 7 Section 5. The following sections of the report address each in turn.

Insurance coverage of non-opioid pain management approaches

Act 7 directs the working group to consider whether health insurance plans should cover certain non-opioid approaches, including nonpharmacological approaches, to treating and managing pain. The working group supports insurance coverage of non-opioid approaches to treating and managing pain. However, the group strongly recommends a holistic coverage model that can be established within the insurance market infrastructure, without mandating coverage of specific procedures.

The non-opioid pain management modalities are detailed in the pyramid model described above. Evidence demonstrates the importance and effectiveness of mental health treatments, exercise and physical reconditioning, nutrition, and complementary alternative modalities as first line interventions for pain management.⁸

Several of these non-opioid modalities are mandated insurance benefits in the state of Vermont based on state law and the essential health benefit (EHB) benchmark plan.⁹ These include

⁸ International Association for the Study of Pain, Integrative Pain Medicine: A Holistic Model of Care, May 2014

⁹ <https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html#Vermont>

mental and behavioral health, chiropractic services, physical therapy, and certain nutrition services. Some insurance plans also cover additional services such as massage therapy and comprehensive dietary services through riders.

The working group does not recommend mandating coverage of specific additional alternative modalities at this time. The EHB benchmark plan is comprehensive and not prohibitive of coverage of additional modalities through a combined benefit.¹⁰ The current work by private insurers and Medicaid indicate progress despite a legal mandate. We suggest that policymakers continue to monitor implementation of these programs, participation, and results to determine whether progress is being made without a mandate.

Rather, the group recommends issuers continue to work with providers to explore the provision of an integrated pain management benefit which could include an array of services as described in the clinical model. Additional research is needed to address how this would be incorporated into insurance plan designs. Most likely, it can be established through insurance policies (contracts) without the need for federal permission or other structural changes to the market. For example, services that would be provided under a benefit are traditionally outlined in the certificate of the plan; the alternative modalities could be described in the certificate to codify the coverage within a comprehensive benefit.

Cost-sharing for non-opioid pain management approaches

Act 7 directs the working group to recommend an appropriate level of cost-sharing that should apply to chiropractic care, physical therapy, and any other non-opioid or nonpharmacological modalities for treating and managing pain that the working recommends for insurance coverage. The working group determined that traditional cost-sharing for individual services does not make sense when applied to comprehensive pain management. The working group instead recommends leaving maximum flexibility in insurance plan design to allow for coverage of the integrated care embodied in the clinical model described above.

The “appropriate level” of cost-sharing is dependent on the design of the insurance plan in question. For generous plans, cost-sharing is low. For less generous plans, cost-sharing is higher. The generosity of a plan is known as its “actuarial value” (AV), and AV standards for certain types of insurance plans are set forth in federal law.¹¹ Where specific AVs are targeted, increasing or decreasing the cost-sharing for one service may require the cost-sharing to decrease or increase on another in order to keep the overall AV and premiums the same. Certain plan designs, such as high deductible health plans (HDHPs) are comprehensively dictated by federal law. HDHPs have high deductibles but no further enrollee cost-share for most services once the deductible is met. The IRS issues annual guidance to issuers of HDHP plans on three required components: a health savings account (HSA) annual contribution limit, a minimum deductible

¹⁰ It is also important to note that the state must pay the cost of any insurance mandates enacted after 2011. 45 CFR § 155.170.

¹¹ See 45 CFR § 156.140.

amount, and a maximum out of pocket (MOOP) amount.¹² While plan design is one tool to consider in the provision of specific benefits, it is important to understand the parameters for innovation in this area.

In the context of chronic pain management, the working group does not believe cost-sharing levels should be specified by service. Instead, the focus should be on a coordinated care model, not on single interventions. While it is important to facilitate access to alternative treatment modalities, the working group does not recommend defining the parameters of insurance coverage of each individual modality.

Cost-sharing for chiropractic and physical therapy benefits in qualified health plans

As requested, the working group addressed the question of the “appropriate level of cost-sharing” in part by looking closely at the previously-legislated requirements for chiropractic and physical therapy (PT) benefits in QHPs.¹³ In doing so, the working group acknowledged that QHPs make up a very small percentage of Vermont’s health insurance market and that it is preferable to consider an approach that is not tied to such a specific portion of the market.¹⁴

For 2020, Act 7 Sections 2 and 3 specify that, in silver and bronze level QHPs, any required copay for chiropractic services or PT shall be between 125 and 150 percent of the amount of the primary care copay.¹⁵ This effectively creates a “third tier” of copayment for chiropractic and PT benefits in certain QHPs. Whereas QHPs had previously included copays at either a primary care or a specialty care level, this directive creates an intermediate copay level for these alternative services.

While the policy goal of decoupling these alternative services from the higher specialist copays is certainly understood, the specificity of this mandate has unintended consequences. For example, it disallows copays lower than 125-150 percent of primary care to the extent those are considered in a future plan design. It increases premiums (albeit marginally) for all enrollees whether or not they utilize the service. This would be exacerbated if additional alternative services were added to this third tier, leading to less flexibility in plan design and reimbursement structures.

For plan year 2020, the impact of these changes has been estimated by issuers and actuaries. The Federal AV impact is estimated to be less than 0.1%.¹⁶ The impact on claims cost and premium is similarly modest and is summarized in Figure 2.

¹² As an example, for the 2019 benefit year the HSA annual contribution limit is \$3,500 individual/ \$7,000 family; the minimum plan deductible amount is \$1,350 individual/ \$2,700 family, and the maximum out of pocket (MOOP) amount is \$6,750 individual/\$13,500 family.

¹³ QHP is used throughout this report for simplicity, but the term also includes reflective plans under 33 VSA § 1813.

¹⁴ By enrollment, QHPs make up about 12% of the market; compare with large employer at 34% or Medicaid at 24%. https://info.healthconnect.vermont.gov/sites/hcexchange/files/Health_Coverage_Map-2018Q2.pdf

¹⁵ 8 VSA §§ 4088a(a)(4), 4088k.

¹⁶ Wakely Consulting, November 2018. Based on 2019 federal AV calculator. Federal AV calculator does not include chiropractic services.

Figure 2: Estimated impact of Act 7 copay requirements for 2020

Anticipated claim cost increase for chiropractic services	Anticipated claim cost increase for physical therapy services	Anticipated premium impact due to chiropractic and physical therapy mandate (no change in utilization)	Anticipated premium impact due to chiropractic and physical therapy mandate (with increased utilization)
\$0.06 - \$0.09 pmpm	\$0.19 pmpm	0.04% - 0.05%	0.1%

Source: November 2018 actuarial estimates from MVP, BCBSVT

For context, a 0.1% premium increase on a silver plan with a \$620 monthly premium equates to about \$7 annually. The issuers' analyses are based on internal 2017 claims data and a copayment equal to 150% of the primary care services to the silver and bronze standard deductible plan designs.¹⁷ Note that the impacts include an estimate both with and without higher utilization of the services. Utilization is likely to increase due to the reduction in cost-sharing.

Now that 2020 QHP design is underway, the working group does not recommend mandating a new copay approach with respect to chiropractic services and PT in silver and bronze plans. Though the estimated AV and premium impacts of Act 7 appear to be relatively low, the working group does not feel that the presence of a third tier will solve coverage affordability issues in the long term and strongly recommends against mandated additional services to be included in it. The working group does not believe that a unique copay stream is the right method to encourage use of alternative modalities. As more information becomes available over time on the recommended clinical model, it may make sense to reconsider the mandates included in Act 7 for the QHP market. However, the guidance issued through Act 7 clarifies legislative intent and guides future application of the chiropractic coverage mandate.¹⁸

Cost-sharing for non-opioid pain management approaches

In general, cost-sharing is a deterrent – especially for services that people need with any frequency.¹⁹ Copays are not tied to diagnostic status but only to services rendered. Rather than mandating certain cost-sharing, the working group highly recommends the continued exploration of a bundle of alternative services, or the integration of available and appropriate health-care strategies and disciplines for the patient's benefit, included under an integrated pain management benefit. The payment structure for such a benefit should be established through negotiated provider reimbursement, and the specific cost-sharing associated with such a benefit, if

¹⁷ Vermont also has standard high deductible health plans (HDHPs) at the silver and bronze levels. The HDHP plan designs have coinsurance and not copays for chiropractic and PT services and therefore will not be impacted by Act 7.

¹⁸ 8 VSA § 4088a.

¹⁹ Rice, T., Quentin, W., Anell, A., Barnes, A. J., Rosenau, P., Unruh, L. Y., & van Ginneken, E. (2018). Revisiting out-of-pocket requirements: trends in spending, financial access barriers, and policy in ten high-income countries. *BMC health services research*, 18(1), 371. doi:10.1186/s12913-018-3185-8

applicable, should be determined through plan design as more information becomes available through the pilots.

Given the State's desire to develop new treatments through the pilot projects, the working group asked the actuaries to discuss their considerations when setting the cost-sharing for new or novel interventions. The actuaries acknowledged that setting cost-sharing for a new intervention is challenging due to uncertainty:

- The take-up rate of the services is unknown.
- Overall utilization is unknown.
- Cost is unknown.
- Efficacy of the treatment is unknown.
- Impact of the treatment on the utilization of other services is unknown.

Beyond uncertainty, there is risk in setting the cost-sharing at the wrong level. Set too high, cost-sharing can discourage utilization and assessing the efficacy of the treatment can be made more difficult. Conversely, the cost-sharing should not be so low that it could lead to abuse or significant losses if utilized more than anticipated. Other factors include simplicity of the cost-sharing structure to make sure the member is clear about how the cost-sharing will work and what services are covered.

These factors militate towards delaying the design of cost-sharing; embarking on this type of plan design process for pain management is premature at this stage. Providers already face significant challenges and barriers to offering patients appropriate and successful care for chronic pain conditions. The care management and panel management services required to organize care across disciplines are not adequately reimbursed. The time needed for transdisciplinary teams to meet, formulate treatment plans, and monitor progress is also not sufficiently supported within payment systems. The potential cumulative copay cost associated with the evidence-based frequency and duration of interventions for pain improvement may be burdensome. It is important that insurance coverage create more not less flexibility to implement appropriate reimbursement structures to support needed interventions. In short, mandating additional individual cost-sharing levels could result in the unintended consequence of being a tremendous barrier to care. It would limit the ability to pursue clinical approaches and further develop a promising new paradigm.

Proportional relationship between copayment and total charge for non-opioid pain management approaches

Act 7 directs the working group to address the proper proportional relationship between the amount of the copayment and the amount of the total charge or reimbursement for services for chiropractic care, physical therapy, and other non-opioid or nonpharmacological modalities for treating and managing pain. As has been discussed, the working group does not recommend a cost-sharing approach to coverage of alternative modalities. However, the working group addressed this question by looking at chiropractic services as an example.

When determining cost-sharing for commercial insurance plans, many factors come into play. These include, but are not limited to, what portion of total costs should the member pay and are there services that should be incentivized for use over others (for example, urgent care or PCP over emergency room). In general, a copay should be less than the total charge for the service.

In 2018, the Legislature identified a concerning outcome in the coverage of chiropractic services in certain health plans. The average charges for standard chiropractic office visit services in Vermont range between approximately \$65 and \$100 as reported by MVP and BCBSVT. Under the previous silver QHP design wherein the chiropractic copay was aligned with the specialist copay, the copay was in some cases greater than the cost of the service (though customers were never charged more than the cost of the service). That deficiency has been addressed for 2019 and 2020 under Act 7.

Figure 3: Average allowed cost compared to copay for chiropractic services in standard silver QHPs 2018-2020

Plan		Average Allowed Cost per Visit (Provider Payment) ¹	Average Copay/Coinsurance Per Visit ²	Average Plan Payment per Visit	Notes
2018	Silver Deductible	\$65 - \$100	\$65 - \$75	\$0 - \$25	Assumes member pays lesser of provider allowed amount and plan copay of \$75, copay applies prior to deductible
2019	Silver Deductible	\$66 - \$103	\$30	\$36 - \$73	Chiropractic services copayment equal to PCP, copay applies prior to deductible
2020	Silver Deductible	\$67 - \$106	\$38 - \$45	\$22 - \$68	Copayment equal to 125% - 150% of PCP, assumes PCP copay is same as 2019 at \$30, copay applies prior to deductible

Source: Wakely Consulting, November 2018

1. Allowed costs per visit for 2018 were provided by MVP and BCBSVT. These costs have been trended forward to the applicable year based on the total unit cost trend reported in MVP and BCBSVT rate filings for 2019.
2. Does not include the impact of the deductible or MOOP, assumes that member has met their deductible, but has not yet reached their MOOP.

It is not possible to recommend more specifically the appropriate proportional relationship between copay and total charge for non-opioid pain management approaches. Cost-sharing is dependent on the design of the insurance plan in question. For generous plans, such as platinum level QHPs, cost-sharing is low. For less generous plans, such as bronze level QHPs, cost-sharing is higher. Moreover, as has been discussed, the copay model simply does not work for the comprehensive pain management approach recommended in this report. The working group

recommends leaving maximum flexibility in insurance plan design to allow for coverage of the integrated care embodied in the clinical model described above.

Alternative approach next steps

The working group supports the clinical model to provide coordinated specialists, complementary and alternative treatment modalities, and ongoing enhanced primary care for Vermonters experiencing chronic pain conditions. It urges legislators to follow the progress of the pilots underway and collect more information in another year and beyond. There is simply not enough data to definitively respond to the questions of optimal insurance coverage design and reimbursement structures at this time. As stated previously, the working group's recommendation is to allow for further study through the pilot process and, in doing so, consider an entirely new treatment and reimbursement paradigm.

On August 27, 2018, DVHA released the RFP seeking pilot prototypes for alternative systematic approaches to management of chronic pain in the Medicaid program. DVHA may make award(s) and roll out the pilot to a subset of the Medicaid population during 2019.

BCBSVT is continuing to work toward an early 2019 deployment in their two pilot sites. They are meeting regularly on the process to set the codes and price. While both programs focus on members experiencing chronic pain, the designs are unique. The Brattleboro Retreat envisions a program that resembles the design and reimbursement structure of an intensive outpatient program. Services are provided a specific number of days per week and a specific number of hours per day, and they are uniform for each patient, with some flexibility built in. Prior to engagement in the Retreat's program, members will receive a medical evaluation with a physical medicine and rehabilitation physician. The goal is to determine the best course of treatment for the member, recognizing that optimal treatment may be less or more intensive than program participation. Reimbursement will be on a per day or per week basis, with all individual services bundled together under one rate. At UVMMC the program is more fluid. Care plans are customized, and reimbursement will be on a fee-for-service basis, with the goal of building bundled rates in year two.

MVP Health Care will also be collecting data through its fee-for-service model to support exploring mechanisms of comprehensive coverage for integrated chronic pain treatment programs. Given that <15% of members attributed to commercial plans in Vermont are with MVP, MVP looks forward to also learning from the results of other commercial and non-commercial payer's pilots, which will be critical to informing next steps in product development for supporting integrated chronic pain management.

Conclusion

The working group appreciates the legislators' awareness of the time sensitivity around plan design changes for 2020. The group does not recommend any changes for 2020, but notes that the already-enacted changes will put modest pressure on premiums and limit flexibility.

Instead, the group recommends continued support of the pilot programs in integrated pain management, which could bring more integration to the system by combining traditional and nontraditional modalities to address chronic pain. The alternative, encouraging utilization of single modalities, perpetuates disjunction in the health care system. DVHA and other working group members would be pleased to provide additional information as this work unfolds. The working group members look forward to continued collaboration on this subject.