
Clinical Utilization Review Board (CURB)

March 16, 2016

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PRESENT:

Board: Michel Benoit, MD, David Butsch, MD, Jessica MacLeod, NP, John Matthew, MD, Paul Penar, MD, Michael Rapaport, MD, Norman Ward, MD, Richard Wasserman, MD

DVHA Staff: Kristy Allard, Daljit Clark, Brad Gabree, Megan Mitchell, Howard Pallotta, Thomas Simpatico, MD (moderator), Scott Strenio, MD

Guests: Melissa Kamal, Sanchit Maruti, MD, Chrissy Racicot

Absent: Ann Goering, MD, Nels Kloster MD

HANDOUTS

- Agenda
- Draft minutes from November 18, 2015 Meeting
- 2016 Meeting Schedule

CONVENE: Dr. Thomas Simpatico convened the meeting at 6:30 pm.

1.0 New CURB Members

Dr. Michael Rapaport is our newest CURB member. Welcome.

2.0 Introductions

3.0 Review and Approval of Minutes

The minutes from 11/18/2015 meeting were reviewed and approved as written.

4.0 Updates: Part 1

Conflict of Interest

Howard Pallotta: The conflict of interest forms were reviewed. There are no conflicts. We will ask that CURB members complete the questionnaire annually.

Meeting Schedule 2016/Attendance Policy

Meetings will continue to be held in Williston. Quorum is needed to hold the meeting. We have 6 meetings a year.

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5.0 New Business

Day 1: Presented By Dr. Sanchit Maruti

Transformation at Day One: University of Vermont Medical Center (UVMMC) is utilizing their Primary Care Provider (PCP) network to increase the capacity of providers seeing patients on buprenorphine (spokes in the Hub and Spoke model). They are attempting to utilize the model of treatment that is used for chronic conditions, such as diabetes. The Hub will continue to evaluate and assess the patient and provide the intensive outpatient treatment. When the patient is determined to be stable enough, they will be transitioned to a PCP. Knowing that PCP practices are busy, the system built allows for the PCP to easily transition the patient back to the Hub if any issues occur, such as relapse.

This process was started due to the waiting lists for people to get the care they needed.

Discussion:

- Maple Leaf Treatment Center is working on a similar program for patients after their residential treatment. Maple Leaf's program should be opening next month. Location is at the old Fanny Allen Building.
- Substance abuse is a big topic nationally.
- According to the American Psychiatric Association Buprenorphine is being underutilized.
 - Discussion to this point is the concern that it may be over utilized in the wrong way.
- Barriers: PCPs are concerned that there may be a complaint filed against them by a patient which prompts the Board of Medical Practice to look at the doctor's records for the past 5 years. A possible solution would be to create a protocol for this type of complaint, such as it would first go to a board of peers to be reviewed instead of going to the Board of Medical Practice. (Example – a person seeking narcotics and not getting what they want is a different type of complaint that could be handled by peer review.)
 - There is a discussion, brought to the legislature by the Medical Society, on the Board of Medical Practice at this legislative session that could impact this discussion.
- Substance abuse is a public health crisis and we need to mobilize our resources to help impact it. Predictive economic models have shown this model to be successful.
- This fits the Triple Aim definition.
- This program is also benefiting people who haven't seen a PCP in many years or don't have a PCP.

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- This program will also help people, who are started on buprenorphine in corrections, have a successful transition to the community upon being released into the care of a PCP.
- The cost of avoiding 1 valve replacement will make the program start paying for itself. This system will help save money and decrease the overall cost of health care, but still not a powerful argument at this time. Great model that we need to sell.
- Do we need to build some intermediary structures because we can't expect the PCP population to absorb nearly the number needed and it is overkill to keep the members at Hubs? "Hublette"?
- PCP offices are already busy. Care for this population takes a team at the PCP's office, example a staff to do the urine drug test and a staff for counselling. The team needs to be trained and the practice needs an overhaul. Build the structure and have the other services available to them as well.
- Deaths from opioid overdose will be greater than deaths from automotive accidents.
- Encourage the PCPs to share the burden of treating this population.
- PCPs are encouraged to follow the Hubs recommendations. PCPs may need to lowers dosing from time to time. There is strong support for the PCPs from the Hub.
- It would be helpful if there was a mobile unit that could travel to the rural parts of the state to help because of the lack of resources.
- In rural areas, consider creating a "Spokelette".

Action items for next meeting:

- Update of the legislative decision on the Board of Medical Practice
- Update from Dr. Sanchit Maruti
- Support from the Commissioner based on action items developed from this group to help move this issue forward.

Vivitrol

Vivitrol is a long acting medication with a reasonable impact on alcohol craving and possible to opioids. Vermont is starting to put this in its toolkit. It is also being used with the corrections population, starting in Rutland. In the next week or so the first group will be coming out of Marble Valley on Vivitrol. Next it will be expanded to St. Albans' Men's Correctional Facility and Chittenden's Women's Correctional Facility. By our next meeting this Vivitrol pilot program will be implemented. We will look at recidivism and relapse rates. This meets triple aim.

Discussion:

- Monthly injection
- If it is injected into you, there will be no opportunity for diversion.

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6.0 Updates: Part 2

Outpatient Psychotherapy Proposal, PBR, State Plan, CMS

We were unclear as to what we were paying for under the banner of psychotherapy. So we came up with a compromise to decide anything beyond 24 sessions would trigger a need for prior authorization (PA) for a provider to state the necessity of the visits over 24.

Megan Mitchell: Processes needed to occur to move this forward. A PBR (Policy/Budget/Reimbursement – a process where initiatives are review by these units to ensure all aspects of an issue are reviewed and weighed in on prior to implementation) review was completed. Discussions are occurring with HPE around the system requirements, and currently the policy is out with our sister departments that may have providers who may be impacted by the PA process. Also, to implement this change, a State Plan Amendment needs to occur. The AHS Policy is working on drafting this in order to get CMS’ approval.

Discussion:

- A heads up at 20 visits that you need a PA would be helpful. This is part of DVHA’s review to make sure the correct communications go out to providers.
- This is not about limiting care. We want to understand what care we are paying for and is it the best use of our dollars.

Follow Up: Involuntary Treatment

Behavior health and general health need to have harmony and coordination across the agency so we are not having redundant services. It takes a long period of time before due process, therefor someone is warehoused for often many days before a decision is made whether they will receive treatment. From a Medicaid point of view, this has been recognized as a problem for several reasons: it is not good practice (no one else in the country does it, and spending Medicaid money on hospitalization where no treatment is occurring. This group decided they want to do something about this and to let the commissioner know. This was brought to the Legislature. Triple Aim.

To help bring more expertise in on this topic, two national experts were invited to give grand rounds at UVMHC.

- 1) Prof Mark Heyman, University of Chicago Law School. He is the foremost mental health law expert in the country.
- 2) Hon Steve Leifman, Circuit Judge Miami-Dade County. Celebrated by the Supreme Court for his fantastic program using correction and judiciary to get people the resources they need.

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Both speakers discussed their work and commented on the status of things in Vermont. They both had strong opinions on what was happening in Vermont and that it is not a good thing.

From a financial point of view, here is the model developed.

Discussion:

- This group can make recommendations to the commissioner, which can potentially obviate the need to go to the legislature.
- This isn't the first time this issue has come up.
- Getting the right people to make the decision as to what the best clinical practice is and put that into practice. How can we go about this? There needs to be a change in the law as we need a judicial remedy. The judicial remedy is to stretch out the process. It is being used currently in defense of the people who are refusing treatment.
- The vehicle that Medicaid has is not paying for services. This is not the best way to do things.
- Dr. Simpatico to write an opinion piece for the board. This would include best clinical practice.
- Argument should be "Best Clinical Practice" vs. cost savings.
- Civil liberty – personal choice not to get treated.
- Frustration despite this issue coming up many times, we still end up in the same place. Hospital Association went to the MEAB a few years ago with this and it went nowhere.
- This change will benefit the workers at the State Hospital, because the employees wouldn't feel scared of getting beat up due to un-medicated patients.
- Better treatment will lead to more capacity and cost savings.
- Focus on clinical quality, less on the money.
- Corrections need to be kept in this discussion as well.
- Treatment can be done in an Emergency Room without consent.

Action item:

- Dr. Simpatico to draft a letter for CURB comments on this topic by the next meeting.

Year in Review (2015)

Daljit Clark reviewed all the topics discussed during the CURB meetings in 2015 and the recommendations that were implemented.

1. Group psychotherapy 90853. We made the comparison with other states. Code was brought into compliance as we were found Medicaid was overpaying. Phased approach. Code was brought into compliance in July 2015. Then in January 2016 there was a reduction in the payment. The code is now billed as a session. We also

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- now enforce Medicaid Rule regarding the number of patients and how often they can attend per week.
2. Individual psychotherapy. In the process but not yet fully implemented.
 3. Utilization management for readmission less than 30 days. Following Medicare. Analysis is being done. Complex issue. Still being explored.
 4. Utilization management – select procedures/services.
 - a. High tech cardiology. We have done the analysis and received approval from our commissioner and the proposal has been sent to the legislature. High tech cardiology will be managed by a vendor. Prior to implementation a rule change will be required.
 - b. Home sleep studies and facility based sleep studies. Criteria has been written and initiative implemented for facility based sleep studies. It is comparable to what other insurers are doing. Facility based sleep study require a prior authorization.
 5. Data driven decisions. Dash board creation. Dr. Strenio working with data team to create a real time dash board. It is complicated, but we are close to a final product, but an issue is that 5 departments could be spending money on an individual. The issues/concern is; what resources do we have to take action on the data. For example, we only have 1 staff assigned to concurrent review.
 - a. Discussion – help getting people out of the hospital that are stuck there. It can be a struggle based on community resources. There is a program that can help you make a sensible decision to get someone out of the hospital, example giving someone a little more money to care for a patient at home.

The CURB met 6 times last year. An annual report was written and sent to House Committee on Health Care and Senate Health and Welfare.

Adjournment – CURB meeting adjourned at 8:10 PM

Next Meeting

Suggested agenda items:

- Psychiatrists – bracing, and the amount of paperwork that is needed. The issue and information will be sent to Daljit for review.

May 18, 2016

Time: 6:30 PM – 8:30 PM

Location: Department of Vermont Health Access, Williston, VT