
**Clinical Utilization Review Board (CURB)
Meeting Minutes
February 18, 2015**

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PRESENT:

Board: Michel Benoit, MD, Delores Burroughs-Biron, MD, David Butsch, MD, Ann Goering, MD, Paul Penar, MD, Norman Ward, MD, Richard Wasserman, MD

DVHA Staff: Daljit Clark, Aaron French, Jennifer Herwood, Susan Mason, Thomas Simpatico, MD (moderator)

Guests: Dubravka Abramovic, Jay Persico, Lisa Schilling

Absent: John Matthew, MD, William Minsinger, MD, Scott Strenio, MD

HANDOUTS

- Agenda
- Draft minutes from 1/21/2015
- Agenda Topics Listing

CONVENE: Dr. Thomas Simpatico convened the meeting at 6:35 pm.

1.0 Introductions

2.0 Old Business

Budget Deficit

Thomas Simpatico presented that the State has a \$100 Million state revenue shortfall in the budget. DVHA is asking the CURB and Drug Utilization Review Board (DURB) to find \$7 Million to cut in State Fiscal Year (SFY) 2016 budget. CURB has statutory authority. CURB can make recommendations to the DVHA Commissioner that can be approved and implemented without further legislative action. Dr. Simpatico explained that this meeting is to explore strategies that we can use to find additional savings. He will present strategies that the DVHA feel are workable for the group to get a sense of what we are talking about. These strategies may actually improve care as well as save the state money. We will keep with the triple aim; improve care, improve services and enhance the value of what we are spending.

The initial proposed areas of interest are:

- Outpatient Psychotherapy Services in general
- Limit Group Psychotherapy 90853
- Utilization Management (UM) for 30 day hospital readmissions for certain conditions
- UM for certain procedures

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Not looking for conclusions at this meeting. Looking for input regarding our strategies and the board's thought on our ideas.

1. Outpatient Psychotherapy Services –

A distribution of how psychotherapy is purchased through Vermont Medicaid was presented. The chart showed the numbers of people and the amount spent for psychotherapy by the number of visits per year. As an example, it might make sense to limit to 25 sessions per year. After 25 visits we might become more inquisitive about the services. This would be a learning experience as to the level of psychotherapy that is being provided. An estimated \$3.4 million dollars is spent on recipients receiving over 25 visits per year. A percentage of this might go into the savings. In addition, this would give us better clarity as to how psychotherapy is being used. We currently don't know what we are covering and there are no limits. We do not want to compromise care. The data excludes Community Rehabilitation and Treatment Services (CRT) and the Hub and Spoke therapies. The data is for private practitioners. We propose looking at evidence-based coverage. For example, there is good evidence for the use of cognitive behavioral therapy for post-traumatic stress syndrome (PTSD) and borderline personality disorders.

Questions/Thoughts for Discussion:

- To what extent are the disciplines being used and for what diagnosis?
- What is the standard of care?
- What is beneficial for the patient?
- What are other states and private insurers covering?

2. Group Therapy -

The billing for group therapy is done in 15 minute units. VT Medicaid pays for 1 to 2 hours or more for each group therapy session. Group psychotherapy is broadly used for PTSD, substance abuse treatment and personality disorders. There are two categories of group therapy. It is a group where there is either exploratory/acclimation or ongoing unearthing type of work. There is a federal compliance issue with this. Medicare only pays up to 1 hour of group therapy. If we limit the groups to 1.5 hours, VT Medicaid would save an estimated \$200,000/year.

Questions/Thoughts for Discussion:

- What is the standard of care?

3. UM for 30 day Hospital Readmissions for Certain Conditions –

The four conditions are Acute Myocardial Infarction (AMI), Pneumonia, Congestive Heart Failure, Asthma and Chronic Obstructive Pulmonary Disease (COPD). Medicare also looks at these 4 conditions. We would propose that we align with what Medicare is already doing. We don't have to mimic Medicare but the Centers

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for Medicaid & Medicare Services (CMS) must approve our plan. There are other states doing this as well. The facility would be penalized if the patient was readmitted in 30 days or less for the same condition as the first admission.

Questions/Thoughts for Discussion:

What penalty rate is acceptable and how is it administered?

Why did the patient return to the hospital?

Who drives the admission?

Are there conditions that are more appropriate to the Medicaid population?

Would this encourage the providers to cherry pick due to patient noncompliance?

Is it fair to the hospital if they are penalized if the patient is noncompliant?

It is important to look at the cause of the readmission rather than the diagnosis.

4. UM for Certain Procedures -

UM for High Tech Cardiology, Certain Elective Surgeries (Knee Replacement, Hip Replacement or Back), Echocardiograms & Nuclear Stress Tests and Sleep Study. Sleep study will look at home sleep study vs hospital.

Questions/Thoughts for Discussion:

Hip and Knee replacement surgery benefits are well known. There is a quality of life issue. We will review the criteria.

Some of these recommendations would require just edits or audits and others would require a prior authorization (PA). If implementation costs are high than the return, we may not implement. We are open to other ideas from board member and will look at what other states and regional private insurances are doing.

Other Suggestions/Ideas:

Transportation Expenses

Ambulance Expenses

Look for the bad apples, instead of punishing all

Emergency Room (ER) Care

Pattern recognition and outliers in the data

Look beyond procedures

Board members to bring other suggestion and ideas that we can explore

Action: DVHA will gather more data on one topic as well as look at what other private insurers and other states are doing. We will look at trends, growth over time, standards of care and present this at our next meeting in March.

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3.0 Review and Approval of Minutes

Dr. Simpatico asked the group to review the minutes from the January meeting and to email Jennifer Herwood with any modifications.

Adjournment – CURB meeting adjourned at 8:00 PM

Next Meeting

March 18, 2015

Time: 6:30 PM – 8:30 PM

Location: Department of Vermont Health Access, Williston, VT