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**CURB  
Meeting Minutes  
November 16, 2011**

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**PRESENT**

**Board:** Michel Benoit, MD, Patricia Berry, MPH, Delores Burroughs-Biron, MD, David Butsch, MD, Adam Kunin, MD, John Mathew, MD, William Minsinger, MD, Paul Penar, MD, Norman Ward, MD,

**DVHA Staff:** Michael Farber, MD (Medical Director, DVHA; moderator), Bill Clark (DVHA), Daljit Clark (DVHA), Eileen Girling (DVHA), Jennifer Herwood (DVHA), Kristin Allard (DVHA)

**Absent:** Richard Wasserman, MD

**HANDOUTS**

- Agenda
- Draft minutes from 9/21/11
- 340B
- Medicaid Transportation Update

**CONVENE: Dr. Farber convened the meeting at 6:30 pm.**

**1.0 Introductions**

**2.0 Announcements – Dr. Michael Farber**

- Nancy Hogue created a summary of 340B (handout) which was provided to the CURB members. She will be at the next CURB meeting for Q&A.
- The Out of State outpatient elective services proposal is still in progress, focusing on office visits (E&M codes) as well as other outpatient services.
- The Physical, Occupational, and Speech Therapy Services proposal for children was put into effect on 11/7/11. It is still being discussed with the rules committee.
- Last week Dr. Farber was in Washington DC at the National Association of Medicaid Directors and the Medicaid Medical Directors meetings. He will put together a list of what other states are doing for cost savings. The list will be sent out for discussion at the next CURB meeting.
- Next meeting will be January 18, 2012.

**3.0 Review of Minutes-Dr. Michael Farber**

The September 21, 2011 minutes were reviewed and accepted by the CURB members.

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**4.0 Transportation – Bill Clark**

Bill Clark presented the following:

- Total annual expenditures:
  - \$1.2 million for administrative
  - \$8.4 million in direct costs
- Annual expenditure trends
- Four areas for potential cost savings:
  - “High utilizers”: analyzed and found there are few opportunities for cost avoidance/little evidence of fraud/waste.
  - Trips to “Nowhere”: analyzed and found it is complicated by beneficiaries with multiple insurances. Little evidence of fraud/waste.
  - Ride coordination: Further review will be done looking at least costly means, combining trips (multiple riders), using fixed route buses/vans and negotiate better rates with taxi/van providers.
  - Control administrative costs: Current costs based on “ancient” rates with no documentation as to how the rates were established. One possible solution is implementing a new contract model. Per member/per month fee is being investigated (PMPM). The PMPM fee would be calculated utilizing data on how many members are being served and the cost of the service.

Discussion:

- Other insurances do not cover transportation, so Medicaid pays for the transportation but not the medical appointment for patients with other primary health insurance. This is common for our beneficiaries that have both Medicare and Medicaid, called crossover and private insurance.
- Dr. Butsch, Dr. Minsinger, Dr. Penar and Dr. Ward: Are we still discussing the role of the provider? Example provided by Dr. Minsinger: Cases are seen where a mother utilizes Medicaid transportation to get to the appointment and she meets her daughter there, who has a car and drove. Suggestion for proof that the beneficiaries need rides.
  - Further discussions are occurring around the role of providers.
  - Medicaid Eligibility does verify cars in the household and family members with cars. Currently brokers are only responsible to verify if patient has a medical appointment for 5% of all rides. Verification is done in 2 ways: Through the Medicaid Eligibility system ACCESS and DVHA’s access to the DMV database.
- Dr. Burroughs-Biron: Can family members get paid to do the transport?
  - There are 2 programs that allow this. Hardship miles where the family would be paid \$0.19 a mile and by a volunteer driver program where

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driver is paid the GSA rate. Personal choice drivers are something that Medicaid tries to avoid due to fraud issues.

- Patricia Berry: Methadone transportation cost and role of ADAP.
  - DVHA is working with ADAP on this issue as we know there is a lot of transporting beneficiaries to clinics which can be far from their home because there are no open slots in the closest methadone clinic.
- Dr. Benoit: What have other states saved by implementing PMPM fees?
  - Data is being extrapolated now. Other states have saved up to 10%.
- General discussion: At this time there are no incentives for the beneficiaries. Currently the only controls that are in place are that a ride would be denied because a ride is already available, such as from a FQHC.
- With any changes made to the program, we are trying to maintain the local infrastructure and not bring in out of state business.
- Dr. Benoit: Two phase process. Make administrative costs a level playing field and secondly, provide incentives to meet quality goals.
  - This is what is being considered with the PMPM fee and if implemented, possibly by July 1, 2012.
- Per suggestion from Dr. Benoit, Bill will look into reimbursement per mile based on rural vs. urban transport.

### **5.0 Emergency Rooms – Eileen Girling and Dr. Farber**

- ER Data discussion: Eileen Girling
  - VCCI overview: DVHA has expanded scope of population and conditions since June 2011 focusing on top 5% of Medicaid utilizers. The top 5% account for the following: 14% of ambulatory sensitive ED costs, 53% of admissions for ambulatory sensitive diagnoses, and 91% of all 30 day readmission cost.
  - High volume hospitals for ER visits (ambulatory sensitive conditions,) are North Country Medical Center (NMC), Fletcher Allen Health Center (FAHC), Central Vermont Medical Center (CVMC) and Rutland Regional Medical Center (RRMC).
  - For beneficiaries with 12 or more visits a year (N=261), 87% have at least 1 narcotic prescription within 7 days after visit.
  - Strategies:
    - Co-location – 0.5 full time employee (FTE) medical social worker in NMC and 0.5FTE RN in RRMC
    - Data exchanges being set up for direct data sharing with CVMC, FAHC and NMC to expedite direct referrals.
    - Data tracking
    - Team Care referrals (formally known as the Lock-in Program – 1 provider, 1 pharmacy)

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- Begin to assess why beneficiaries are utilizing the ED: No PCP – (access closed to Medicaid patients or beneficiaries who have been “fired” from providers), may owe provider money, due to transportation (i.e. VHAP – no ride during the day but can get to ED at night), perceived emergency, beneficiary convenience, no beneficiary disincentives (no co pay collected at ED)
- Challenges/opportunities:
  - VCCI is voluntary
  - Poor access to primary care
  - Vermont Prescription Monitoring System (VPMS) is voluntary for providers – (how is this being utilized?)
  - Transportation barriers
  - Department of Corrections: No medical home after release.
- Concomitant mental health diagnosis. Discussion:
  - Dr. Mathew: His ER (CVMC) dispenses 6 tablets of pain medication.
  - Dr. Benoit agrees with the 6 tablets and then has the beneficiary see their PCP, but there is currently no incentive for the beneficiary to see PCP.
  - Beneficiary ER pattern needs to be tracked – hospital/ED shopping.
  - ED/pharmacies need to be accountable to the DEA for dispensing narcotics, but how can DVHA get the information? (through VPMS?)
  - Dr. Minsinger: If beneficiaries are visiting multiple EDs – what other services (tests etc) are being duplicated.
  - Dr. Mathew: FQHC accepts all Medicaid beneficiaries and Dental vouchers. There is a Social Worker at the ER who makes appts and arranges transportation. Beneficiaries get referrals from EDs, but there are no incentives to go to FQHC. Incentives need to be discussed.
  - Dental pain appears to be a ticket to narcotics.
  - Dr. Burroughs-Biron: Corrections send inmates to prisons away from their homes, so placing inmates in a medical home close to their home upon release can be problematic. There is a program that works with substance abuse inmates.
  - Dr. Farber: Other states have limited the number of ED visits for their beneficiaries. DVHA considered this in the past (12 visit limit), but CMS did not approve. This may be a possibility again in the future. At this time, DVHA is trying to case manage, in real time. Not aware that other states are trying this case management model at this time.
  - Dr. Kunin: Are there proposed cost savings for the next few years?

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- APS is a full risk contract for savings
  - Clinical evaluation via evidence based metrics (is using claims based registries to show data to PCPs and intervene)
  - VCCI to eventually have “biomedical data” via link to DocSite/Blueprint registries regarding clinical metrics.
  - VCHIP evaluation for 2 ERs where collocated and compare to similar hospital at co-location.
- Ambulance Data – Dr. Farber
  - ED visits: Top reasons: Were presented and all appeared to be legitimate reasons for requesting ambulance services

## **6.0 Carpal Tunnel – Dr. Farber**

- Data presented:
  - Recipients who saw a Hand Specialist for Carpal Tunnel and had Nerve Conduction Procedure either before, after, or not ever in relation to specialist visit. Most beneficiaries that were identified had a nerve conduction evaluation prior to specialist visit.
  - Recipients who saw a Hand Specialist for Carpal Tunnel and Received a Wrist Orthotic either before, after, or not ever in relation to specialist visit. Only 33% of beneficiaries revealed a claim for wrist orthotics. This could be a coding issue. DVHA is not sure whether codes checked were complete for identifying a wrist orthotic or brace.
- Discussion: DVHA will continue to look at the data. What other conservative treatments were used prior to surgery? Volume of recipients is so small may not be worth pursuing. CURB members questioned whether the data identified all patients with carpal tunnel since only 30 beneficiaries were identified.
- Dr. Mathew: A vehicle is needed to provide relevant clinical information to providers.
  - DVHA does send out messages with the provider remittance statements. These messages (Banner pages) are also available on the web site <http://www.vtmedicaid.com/Information/whatsnew.html>
  - Dr Mathew: the Banners go to their billers and the providers don't see them.
  - Suggestions:

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- DVHA send out an email with information
- Providers work with their offices to ensure they are given the banner pages from the remittance statements.
- Coordinate with the Vermont Medical Society and put the information in their newsletter (about 2/3 of the MDs are members). This will be explored by DVHA.

**7.0 Future Topics**

- Discuss list that will be compiled by Dr. Farber, of cost saving topics discussed at the 2011 Fall Medicaid Medical Directors Meeting.
- Narcotic use by Vermont Medicaid beneficiaries: General discussion
  - What are other states doing regarding this issue?
  - Vermont Medicaid seems ahead of what many states are doing with availability of VPMS.
  - Vermont is developing a CME requirement on this medical issue.
  - Patterns seen – people on suboxone are also prescribed narcotics.

**Adjournment – CURB meeting adjourned at 8:15 PM**

**Next Meeting**

**January 18, 2011**

**Time: 6:30 PM – 8:00 PM**

**Location: Department of Vermont Health Access, Williston, VT**