Clinical Utilization Review Board (CURB)
March 20, 2019

PRESENT:
Board: Michael Rapaport, MD, Christie Allen, RN, Nels Kloster, MD, Valerie Riss, MD, John Matthew, MD, Thomas Connolly, DMD, Joshua Green, ND

DVHA Staff: Katie Collette, Scott Strenio, MD (moderator), Christine Ryan, RN Suellen Bottiggi

Guests:

Absent: Jessica MacLeod, NP, Ann Goering, MD

HANDOUTS

- Agenda
- Draft minutes from 09/12/2018 Meeting and 11/14/18 Meeting
- Operating Procedure Gold Card from 2012
- CURB Recommendation Form for Updated Gold Card Criteria
- Draft Out-of-Network Outpatient Criteria

CONVENE: Dr. Scott Strenio convened the meeting at 6:30 pm.

1.0 **Introductions**

The CURB welcomes Joshua Green, ND and Dr. Thomas Connolly, DMD to the Board. Dr. Joshua Green is a naturopathic physician with a primary care practice in Burlington. Dr. Thomas Connolly is an oral and maxillofacial surgeon that practiced in South Burlington for 40 years, retiring in 2018. Dr. Connolly remains active in the Vermont Dental Society and worked with the Children for Special Health Needs Clinic for 30 years.

Options for Attendance - Christine Ryan
Christine reviewed the recent move of meeting location from Williston to Waterbury and presented ideas for future meetings to optimize CURB member engagement and attendance. Current ideas include an option for each CURB member to teleconference for one meeting per year, adjustment of meeting times, for example hold a portion of the meetings in the late afternoon and the remainder in the evening. DVHA is also investigating a future meeting location at Albany College of Pharmacy in Colchester. Recommendations are welcomed and Christine will follow-up with an email communication requesting additional suggestions.

2.0 **Review and Approval of Minutes**
The minutes from the 09/12/2018 and 11/14/18 meetings were reviewed and approved. There was one correction to the 9/12/18 minutes to include Dr. Matthew as absent.

Clarification related to the legislative update for bill H.404 (Act 138) will be discussed at the next CURB board meeting.

3.0 **Old Business**

Updates on Prior Topics and Discussion

Acupuncture RFP Update – Scott Strenio
Dr. Strenio reviewed the prior pilot initiated in 2017. Robert Davis, MS, L.Ac. led the 2017 pilot. Cost effectiveness analysis for this pilot was inconclusive and no attributable cost savings identified. Robert consulted with Brandeis University to identify what would be necessary for a well-designed cost effectiveness study related to this topic. Brandeis proposed a cohort of 600 individuals receiving acupuncture treatment over at least 6 months, a study duration of 2 years, and ~$200,000 to fund the project. Legislature heard this testimony from Robert Davis and allocated $100,000 for the project. Per legislative order, an RFP was issued. There is currently only one bid from a group from Southern California. This group proposes a retrospective study design to look at both commercial and Medicaid claims data to compile a sample large enough for analyses. At this time, this proposal is unlikely to be accepted but remains an active bid.

At the same time, there is also a Chronic Pain RFP that aims to develop alternative comprehensive pain treatment approach via a multidisciplinary approach. This would include acupuncture as well as other complementary and alternative medicine approaches.

Tobacco Cessation/Incentive – Scott Strenio
DVHA is working to identify funding for provider incentives for those who address tobacco cessation. One target population would be pregnant women who smoke.

Updates on Past Initiatives and Discussion

Out of Network – Katie Collette
A 2012 CURB initiative included addition of prior authorization for out-of-network (OON) office visits. The Clinical Operations Unit (COU) has worked to put together and review raw OON data and identified that spending on OON services has greatly increased across the board (inpatient, professional, outpatient, nursing home) from 2010 to 2018. The COU has been working to review and strengthen existing criteria for OON office visits to help provide clarity for in-network referring providers when sending members OON for outpatient office visits, to limit the use of resources that are otherwise available in-network, and to ensure that members receive the most effective and least costly treatment. The COU aims to provide support to primary care providers for locating services in-network when available and ensuring members can get to the specialists needed when the services are not available in-network. The why and perceived benefits for review and revision of the OON outpatient visit criteria include retention and recruitment of specialists within the state,

retention of Medicaid dollars within the state, reduced costs (OON facilities sometimes negotiate higher reimbursement rates and OON visits incur additional costs such as meals, lodging, and transportation), promote use of community health teams, and improvement in efficient healthcare delivery and health outcomes within our network and population.

Discussion:
Is there anything in the data that helps indicate patterns within the increased spending? UVM has a few specialty clinics for specific conditions. UVM has coordinators to assist with coordination of visits for pediatric patients. It was suggested that within a second opinion clause, language may be included to address provision of additional services besides the initial second opinion office visit. Can the data be reviewed to identify if there are specific geographic regions generating higher volumes of OON service requests than others? Would an ombudsperson be useful for the provider community? DVHA is working on a communication blog to help provide a place for providers to identify specialists and services and where they are available within the network. Would it be beneficial to reach out to billing offices at OON offices to help make them aware of the services that will and will not be reimbursed? Is the population utilizing OON services disproportionately pediatric? Are back transfers encouraged, especially among the pediatric population? Do Medicaid members receive newsletters for example, prior to flu season, for health maintenance reminders? It is difficult to maintain accurate addresses for the Medicaid population. The VCCI staff is now working with new-to-Medicaid members to help orient this population. Would it be possible to hire in interim specialist when there is only one specialist for that condition in the network, and they go out on leave? Wait times for availability to see specialist should be considered in criteria. Review of the data should include identification of outliers of subspecialties or geographic regions that are more inclined to refer OON. Is there a difference in housing and transportation costs for Boston versus Burlington? Further discussion needs to occur with OneCare to collaborate in ensuring that services available in-network are provided in-network.

Gold Card Vote
Initial gold card parameters reviewed. Updated parameters reviewed to include change in threshold of minimum number of tests to be ordered from 100 to 75 high-tech imaging tests. Future modification of gold card parameters might include collaborating with Blue Cross to pool number of tests ordered.

The vote was unanimously approved.

4.0 **New Business**

Telehealth – Suellen Bottiggi
DVHA has been working on a process improvement project (PIP) investigating initiation and engagement of treatment of substance use disorders. This PIP has involved work with the Vermont Alcohol and Drug Abuse Program (ADAP) and the DVHA Quality Departments. This PIP project centered around the Healthcare Effectiveness Data and Information Set (HEDIS) measure for initiation and engagement of alcohol and other drug dependence treatment (IET) which measures 1) initiation of treatment within 14 days of a diagnosis related to alcohol or other drug abuse or dependence and 2) engagement in treatment to include two or more alcohol or other drug dependence treatment services or MAT within 34 days. The goal of the project was to improve initiation and engagement. This measure is also part of core quality measures, the Medicaid Global Commitment Waiver, the ACO payment measures, the Medicaid Substance Abuse 1115 Waiver, all-payer model, and Blueprint. Initial data showed that for every 10 members that received a diagnosis related to alcohol or other drug abuse or dependence 44% received a follow-up treatment visit after and of the 44% only 24% stayed in treatment during the 34-day period. The project group held a brainstorming session to identify challenges to initiation and engagement. New SUD related diagnoses were reviewed by provider type. Intervention for year one of the project included community engagement and a pilot process to provide education related to billing structure and coding. Initial approaches did not yield significant momentum. The group reevaluated the challenges and hypothesized that transportation could be the greatest challenge. Next step interventions included investigation into telehealth and a multipronged provider engagement communication related to telehealth. The workgroup found that the engaging providers in communications and education related to utilization of telehealth greatly increased telehealth use across all services.

Dr. Strenio reviewed that DVHA has talked with a FQHC in Connecticut that provides eConsults for providers referring to specialists. The desired subspecialist from the group reviews the clinical documentation from the PCP to help to determine if the patient needs the consult or not.

During the discussion Suellen and Dr. Strenio reviewed the overhaul of the DVHA website specific to providers with anticipated go live May 2019.

Discussion:
Can we look at prescribing providers by region across the state and review the data to identify opiate prescribing patterns? Can this be investigated at the provider level? Identification of providers that have higher prescribing rates and providing outreach/education targeted toward opiate prescription reduction may be helpful in impacting regional/geographic pockets with higher rates. It may be beneficial to analyze the data by specialist by diagnosis/condition and provide education to providers with higher rates of opiate prescription how their numbers compare with the same provider types for the same condition. VPMS was be beneficial for this data. DVHA PBM provides internal

reviews of this kind of data and DVHA also has Quality of Care Program to investigate these kinds of findings. Tapering of opiate use in primary care is challenging because patients who have chronically been on opiates require very significant time for effective tapering. One important challenge to provide disclosure around might be to identify some of the aberrant behaviors around patients receiving opioids and getting patients channeled into the appropriate treatment for example opiate use disorder treatment as opposed to pain treatment. In other words, it may be helpful to provide provider education related to getting patients to the correct setting for pain treatment versus opiate use disorder treatment.

5.0 **Next Steps**

DVHA will work to provide teleconference option for the May CURB meeting and reach out to CURB board for ideas and suggestions related to promoting CURB board member engagement. The telehealth presentation from the March meeting will be dispersed via email to the CURB board members along with meeting minutes. DVHA will continue work on OON data analysis.

Adjournment – CURB meeting adjourned at 8:20 PM

Next Meeting
Suggested agenda items:

- **Investigation of the Blueprint data per capita expense per practice and incentive use for extended office hours and effects of higher care costs such as emergency room visit expenditures**
- **Investigate Medicaid telehealth clinical pharmacy pilot**
- **Present COU utilization management strategy ideas to the CURB**

May 15, 2019
Time: 6:30 PM – 8:30 PM
Location: TBD

Adjournment – CURB meeting adjourned at 8:05 PM

Next Meeting
5/15/19
Suggested agenda items:

May 15, 2019
Time: 6:30 PM – 8:30 PM
Location: WSOC, Waterbury, VT