VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

Clinical Utilization Review Board (CURB)
September 16, 2020

PRESENT:

Board: Thomas Connolly, DMD; Joshua Green, ND; Nels Kloster, MD; Elizabeth Newman, MD; Michael Rapaport, MD; Valerie Riss, MD,

DVHA Staff: Jenna Cebelius, MPH; Katie Collette, RN; Scott Strenio, MD (moderator); Dawn Weening, RN; Heather Bollman, RN

Guest: Heather Bollman, RN and Dawn Weening, RN, Managers of Vermont Chronic Care Initiative, DVHA; Javad Mashkuri, MD

Absent: Christine Ryan, RN, John Matthew, MD

HANDOUTS

- Agenda
- Minutes – July 15, 2020
- Skype Instructions
- Vermont Chronic Care Initiative PPT
- Out of State Utilization Data PPT
- National Telehealth Assessment PPT

CONVENE: Dr. Scott Strenio convened the meeting at 6:47 pm.

1.0 **Introductions and Acknowledgments:** Attendance was called, and board members welcomed by Dr. Strenio. DVHA staff introduced themselves. Dr. Strenio introduced Heather Bollman, RN and Dawn Weening, RN, managers of DVHA's Vermont Chronic Care Initiative, as the guest speakers.

2.0 **Review and Approval of Minutes:** Minutes from the July 15, 2020 CURB meeting were reviewed and approved.

3.0 **Old Business**

Update: State of Emergency – Dr. Strenio

The Governor has extended the state of emergency through October 15th. An update was provided around continued coverage for telemedicine codes through the state of emergency. Prior authorization end dates will continue to be extended through the state of emergency as well.

Discussion:

One board member notes that this year has certainly provided data around telemedicine utilization however it may be beneficial to continue to collect telemedicine utilization

data for periods of time where we are not in a state of emergency and to look at impacts on morbidity and mortality data points.

Update: Legislature – Dr. Strenio

Dr. Strenio reports that there may be release of a request for information (RFI) on value-based payment expansion for telemedicine e.g. a bundled payment or a per member per month payment structure for example with eConsults. Dr. Strenio asked the board about experience with eConsults and telemedicine.

Discussion:

One board member commented that one example of where there may be a role for this technology might be in management of transport/transfer consults. One challenge this board member notes is the ability for providers to be able to document, for example in the inpatient setting, within the EMR of the facility outreaching for the consult. These types of consults may help to avoid unnecessary transfers or additional ED visits by appropriately triaging care. These phone consults may pose challenges for billing related to EMR access.

OR/Dental Initiative – Dr. Strenio

Dr. Strenio discusses work being done to investigate resources and payment structure for dental care for Medicaid members with complex health care needs that may require OR time. DVHA is working to gather historical data around special rate payments for this care to develop a use case for this type of dental work. The intent of this work is to standardize or streamline the process and payment for these services going forward as well as to identify a group of providers willing to provide these services.

Discussion:

One board member asked if this was being investigated for both the adult and pediatric population. Dr. Strenio confirmed this was indeed for both populations. One board member discussed the imperative need for this care among the pediatric population and how this type of service could be beneficial for both patient outcomes and health care service utilization. She cited cases in which pediatric patients required sedation for a procedure and it would be beneficial to align the dental work to occur at the same time, saving the child two separate visits requiring sedation and health care resources to accommodate two separate visit occurrences.

One board member discussed the challenges of identifying medical providers at the facilities where the OR time for dental services could be procured that would be willing to provide oversight of medical care required for medically complex patients, e.g. patients with cardiac conditions. Therefore, the additional challenge would be securing medical management on top OR time and dental providers to provide the dental care.

4.0 **New Business**

VCCI Presentation – Heather Bollman and Dawn Weening

Heather Bollman, RN and Dawn Weening, RN are comanagers from DVHA's Vermont Chronic Care Initiative. Heather and Dawn provided an overview of the operations and activities of VCCI including mission and program structure. The Vermont Chronic Care Initiative mission includes improving access to medical homes, work to increase adherence to clinical best practice and reduce inappropriate utilization of hospital acute care services. The VCCI staffing includes a statewide team of RNs and LADC/MSWs. The VCCI staff provide short-term, intensive, and holistic management and coordination.

Historically VCCI work was targeted toward the population of Medicaid members in the top 5% of healthcare utilization as identified by claims data. Eligibility criteria included Medicaid health plan only members and the members could not have other CMS funded case management. Case management was provided in person for members voluntary to receipt of services with complex medical and social needs.

VCCI's work has expanded to included work with members based on needs-based eligibility and is no longer limited to the top 5% of healthcare utilizers per claims data. VCCI staff now work with members stratified based on risk as well as members identified as lacking primary care or dental care. VCCI staff are now also able to work with dually insured (Medicare and Medicaid) members. VCCI staff meet with clients in whatever setting the member is able including shelters, homes, and homeless camps. Since the state of emergency related to COVID-19, VCCI staff have been connecting with members mainly telephonically, but action is being taken to obtain PPE and cleaning supplies necessary to allow return to in person visits safely.

VCCI staff engage in complex care coordination working with members on issues such as uncontrolled health conditions, nonadherence to treatment plans, unstable housing, and financial insecurity. Members that VCCI work with may have Department of Corrections or Department for Children and Family involvement. The VCCI staff use the complex care or teams-based care model for care management. Priority goals in this approach include access to health services, stabilization, and introduction or redirection back to a medical home.

New work for VCCI has also included outreach to the new to Medicaid population. Goals of outreach to this population include connecting this population to primary care, dental care, and other state offered assistance services. A risk stratification strategy is employed, which aligns with that of the ACO. Based upon the risk into which the member is stratified, VCCI staff may provide brief intervention and work to refer and link the member with appropriate referrals to the community agencies and partners and orient the member to the system of care both health and health related. If risk stratified as high or very high, VCCI enrollment and services are offered.

Discussion:

One board member asks, how are the new to Medicaid members getting to VCCI to complete the screening via phone? Dawn indicates that the DVHA Data Unit provides a monthly report with new to Medicaid phone and address information if available. For those members with phone numbers, VCCI staff outreach telephonically. For those without phones, a letter is mailed out with the screening noting that VCCI staff would like to discuss their Medicaid available benefit and services that they may qualify for. A board member asks, how are existing members identified for engagement? Dawn notes that aside from claims data, much of work with existing Medicaid members comes from referrals from primary care providers, sister departments such as DCF, Economic Services, and members themselves. The board member asks, how would a provider find out if a patient was engaged with VCCI and also, would VCCI staff be willing to collaborate with staff in setting such as a MAT treatment office where patients visit regularly? Would this be an opportunity to engage patients that qualify for VCCI case management who may have challenges around following up with other health services they may be in need of? Heather discusses that VCCI staff would be more than happy to collaborate with staff in such settings with the appropriate releases signed and in place. DVHA staff present at the meeting will follow up to provide VCCI contact information to the interested parties.

Heather notes that the new to Medicaid outreach has proven integral to supporting healthcare reform with the ACO expanded attribution model as the expanded attribution model includes new to Medicaid members where prior member ACO attribution was based on the member seeing a provider that was an ACO attributed provider. VCCI is also working with Dr. Strenio and the DOC on developing a referral system for the population exiting the DOC facility with follow up needed related to Hepatitis C. Potential collaboration with DOC and VCCI services continue to evolve and there is consideration for VCCI involvement with members exiting the DOC facilities that may have complex medical and health needs and social determinant of health challenges. OneCare Vermont has recently granted VCCI access to their care navigation platform, Care Navigator, which will allow VCCI staff a communication tool to send notifications to other lead care coordinators and members of the care team regarding progress with VCCI.

One of the board members asked about potential plans for work to improve transitions for the incarcerated population exiting facilities for health care services such as MAT. Dawn discussed that VCCI has been included in discussions with Dr. Strenio, DOC leadership, and the new health care provider for the Vermont state prison system. Dawn reported that early discussion has included processes for referral to VCCI for health care transition assistance.

One board member reports in his personal experience working with patients exiting the prison system, there are challenges in maintaining consistency and continuity in care related to the transience of the population. He also noted that medical records that are

received in care transition are minimal and there is room for improvement to ensure that important relevant medical history is communicated in transition. Another board member reports experiences of arrival of patients exiting the corrections system to residential substance abuse treatment facilities without medications that they were taking while in the correctional facility and attempts to obtain information about medical care of the patient during incarceration were unsuccessful.

Dr. Strenio reviewed discussions in process with a group from Yale University around work to allow Hub providers to oversee prescription of hepatitis C medications for patients with the virus. This is being investigated related to the frequency required for MAT dosing. One board member acknowledges that he had been in attendance on a Hub director call where some of the physicians leading the Yale work presented the idea of Hub providers overseeing hep C medication management for patients needing this treatment and the Hub medical directors on the call were universally in favor and supportive of this work. One board member notes that there may need to be discussion around reimbursement rates around this additional oversight by Hub providers related to the increased medical decision-making levels required to provide this care.

Dr. Strenio asked Heather to review case management services for pediatric patients. Heather discussed that VCCI does provide case management for the pediatric population if eligible and the member is not receiving any other CMS funded case management.

One member asked Heather and Dawn about VCCI's ability to connect members to dental homes. Dawn reported that this has become more challenging in the midst of the pandemic. She discussed that the FQHCs are frequent providers for this home. The board member asked further about VCCI's experiences related to seeking out resources for emergency dental care. Heather reports that during the COVID pandemic, it has been increasingly challenging to identify resources for this care for Medicaid members.

Out of Network Data – Dr. Strenio

Dr. Strenio discussed the growth of out of network spending over the last 5-8 years. This has been identified as concerning for several reasons including 1) the additional costs associated with out of network care, 2) the loss of patient populations for in-network specialists that may offer the same service in turn limiting ability to maintain a specialist pool in network and maintain residency programs, 3) the challenges of transitioning patients back in network once care has been provided out of network, and lastly, with the increase in use of telemedicine, identifying situations when a telemedicine visit may be more cost effective if clinically appropriate, e.g., for a member that lives near the Massachusetts border, to go to Boston instead of traveling to an in-network provider much further away geographically.

One board member asked about where there are increased costs for out of state services. Dr. Strenio reviewed the ability for out of network facilities to obtain enhanced rates. Dr. Strenio reviewed the second opinion policy clarification that while Vermont

Medicaid does allow for second opinions, this does not infer that the member is able to go anywhere in the country to obtain the second opinion. If there is another provider within the network that can offer a second opinion, this would be the option made available to the member in lieu of any out of network evaluation.

A deidentified and safe harbor compliant dataset was presented to the CURB around OON utilization. The data showed the top 10 states in which VT Medicaid has spent the most dollars out of network as well as the greatest number of members going out of state.

Dr. Strenio asks the board members to describe their experiences around OON care. One board member reports that around 2014, the state of Vermont terminated their management of the Children with Special Health Needs Craniofacial Clinic program and at that point, there was loss of control of where these patients landed with complex craniofacial anomalies. Additionally, referral patterns for children with cleft lip and palate were contingent upon the recommendation of the PCP. The board member suggests that there may be a lack of awareness around loss of this population to in network providers.

One board member discusses that for the pediatric population, there is a deficiency of specialist services available in network, e.g. for behavioral health or psychiatric inpatient treatment. She also reports UVM has lost a pediatric neurosurgeon,

One board member discusses there must be a point at which you can establish accepted lines or limits to where members are going for specialist care, e.g. does a patient need to go to Washington state if the service is available in Boston.

One board member asks when a Vermont Medicaid member goes out of state,e.g., to Boston, is DVHA paying the same rate that Massachusetts Medicaid would pay for that service, or does the facility get carte blanche on the rate? This will be a point of investigation for DVHA. One board member acknowledges that we are fortunate to have a place like Boston close by with an abundance of specialty services.

Dr. Strenio reviewed with the board members that as there is increased attribution of Vermont Medicaid members to OneCare ACO, there is discussion and examination around what services will continue to require prior authorization and one bucket of services being looked at for continued requirement of prior authorization was OON care. OneCare and the ACO provider network have not had this on their purview for oversight through the ACO

One board member asks, wouldn’t many of the patients going out of state meet the criteria for VCCI case management and wouldn’t it make sense to have a perhaps dedicated case manager or nurse to oversee the population seeking out or being referred to OON care? Could the case be made for a pilot project where there are some dedicated case managers to oversee this populations? Another board member discussed that there might be room for increased oversight or management of back transfers. Additionally,

the board member recommends looking at the data by diagnosis codes to rule out conditions for which there are no in network specialists and then narrowing in on out of network services from there. Dr. Strenio notes that the rub is determining who will be the body overseeing this monitoring – would it be the providers, the ACO, or DVHA?

The composition of the data was reviewed for the board members and it was clarified that the data was inclusive of all OON services – labs, diagnostics, etc.

One board member asked as for discussion around reimbursement rates for VNA services as a future agenda topic as there are challenges in obtaining VNA care for pediatric patients with complex care needs.

Adjournment – CURB meeting adjourned at 8:29 PM

Next Meeting

November 18, 2020
Time: 6:30 PM – 8:30 PM
Location: Teams teleconference