VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

Clinical Utilization Review Board (CURB)
May 20, 2020

PRESENT:

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

DVHA Staff: Jenna Cebelius, MPH; Katie Collette, RN; Alicia Cooper, Ph.D.; Christine Ryan, RN; Scott Strenio, MD (moderator)

Guest: Alicia Cooper, Health Care Project Director, Payment Reform, DVHA

Absent: Anne Goering, MD; Nels Kloster, MD

HANDOUTS

- Agenda
- Minutes – November 2019 & January 2020
- Skype Instructions

CONVENE: Dr. Scott Strenio convened the meeting at 6:40 pm.

1.0 **Introductions and Acknowledgments:** Board members present were introduced. Dr. Strenio introduced and welcomed Alicia Cooper, Health Care Project Director, Payment Reform, DVHA as the guest speaker.
.

2.0 **Review and Approval of Minutes:** Minutes from the November 2019 and January 2020 CURB meetings were reviewed and approved.

3.0 **Old Business:** No current updates for May 2020.

4.0 **New Business**

ACO Update – Alicia Cooper

Vermont Medicaid is a participant in the Vermont All Payer Accountable Care Organization model. Alicia described the goals and objectives that Vermont Medicaid developed around participation in the Vermont All Payer model keeping in mind the overarching goal of the triple aim which includes improved patient experience, improved population health, and reduced per capita cost growth. Vermont entered into an agreement with the Centers for Medicare and Medicaid Services focused on ACO based payment reform in exchange for additional payment flexibility and more Vermont-local control in return for meeting quality, financial, and Vermonter engagement targets as well as opportunities to increase alignment across payers. Provisions of the ACO program from CMS include alignment with the

Medicare Next Generation program while also allowing Medicaid-specific refinements and space for innovation to encourage all-payer alignment.

Alicia provided an overview of the ACO structure and the benefits of participation. The differences of the All Payer Model care delivery system were discussed including encouraging provider leadership in driving cost containment and quality, movement away from fee for service payment, and measuring the outcomes to identify if programmatic payer alignment matters in health care reform. DVHA began administration of the Vermont Next Generation ACO program (VMNG) in 2017. Attribution has increased with each successive year in both member and provider number with an attribution methodology adjustment in 2020. Strategies in place to encourage effectiveness and benefit of this program for DVHA include a shared risk agreement with the ACO. Strategies in place to encourage effectiveness and benefit of this program for providers include prospective payments, which ensures predictability in revenue. The VMNG is reinforced and informed by DVHA's priorities including efforts to encourage value-based payments, information technology project advancements, and outcomes as measured by performance. Continued VMNG efforts will include incremental programmatic performance improvements, identifying ongoing opportunities for payer alignment, and innovative approaches to health payment and reform.

Discussion:
Board members asked about the all-payer model scale targets. Alicia identified that the program had not reached scale targets and that drove the attribution methodology changes for 2020 with note of increased voluntary provider participation in the VT Medicaid program offering relative to other payers and attribution models differing significantly among payers. Board members asked about impact to the ACO program if scale targets were not met, e.g. federal funding. Alicia noted that scale targets would be included in future agreement discussion with CMS. Board members asked if there were efforts to outreach to providers to increase provider participation numbers. Alicia cited that DVHA has not pursued this type of effort to date as providers' participation in the Vermont Medicaid offering has seen more interest and that was felt to be in part due to the more limited provider risk in participating in the VT Medicaid ACO program offering due to the total dollars for the Medicaid population being lesser on a per person basis as compared to other payers. Additionally, the Medicaid portion of the contract has been potentially more attractive in structure to providers as for example, to hospitals, the fixed payments are truly fixed with no reconciliation after the fact.

The board members asked about addressing concerns among smaller community hospitals that may not feel comfortable taking on risk such as larger facilities might. Alicia noted that OneCare has entered into specific agreements with smaller hospitals to limit financial risk and this is shifted to the larger hospitals. Individual hospital risk agreements are negotiated and managed by OneCare. DVHA does not set expectations related to risk distribution across the ACO network.

The board members commented on the potential impact of the COVID-19 pandemic on provider decision regarding ACO participation. Some providers have noted that the fixed

payments received as part of the VT Medicaid ACO participation agreement during this uncertain time that there is a benefit to having the cash flow predictability during a period of time with decreased utilization across settings. One member recommended having a breakdown of which providers (i.e. big vs rural hospitals, private providers, etc.) are changing to the ACO with private insurers.

<u>COVID-19 Updates</u> – Dr. Strenio/Christine Ryan

Christine discussed the work that has been done by DVHA to respond to the COVID-19 emergency. One of the responses from DVHA is the DVHA COVID-19 website which was created to provide up to date information and resources related to DVHA's response to COVID-19.
Highlights around clinical and policy aspects of the DVHA COVID-19 emergency response include:

1. Eligibility and enrollment- DVHA has allowed extension for eligibility and enrollment for Medicaid members during the state of emergency. For example, eligibility extensions are being granted for postpartum women whose eligibility to receive dental care would be expiring.

2. Extension of prior authorizations. Prior authorization set to expire during the state of emergency have received 6-month extensions. This is being done on a month by month basis for the duration of the emergency.

3. Procedure codes related to telemedicine have been reviewed at the code and claim level and code coverage additions made in efforts to address health care needs during the COVID-19 emergency. Looking at codes that are specific to Telehealth to open them up for coverage during the emergency period. Dr. Strenio noted that DVHA has been collaborating with other payers on additions and exceptions made regarding telehealth/telemedicine coverage. DVHA has been in close contact with Dr. Plavin at Blue Cross Blue Shield.

4. Expansion of coverage of services for migrant workers - DVHA has provided testimony to the Vermont Legislature to expand services to migrant farm workers and ensure they have access to Medicaid services

Other work that DVHA has been focused on is Durable Medical Equipment. There has been much engagement with DME vendors around codes that were not included on a particular list, that may pose imminent harm concerns, while also ensuring that there has not been interruption in getting supplies to members. DVHA has also been working closely with vendors when members are discharging from hospitals to help them the equipment they need right away. DVHA has been responsive to the Legislature with received inquiries.

The board voiced that during the state of emergency there has been challenges with discharge planning around home health care needs in the pediatric population. Among the pediatric population with complex medical needs, challenges have been noted regarding arranging home nursing services after hospital discharge. These challenges have included uncertainty and lack of clarity from home nursing providers about ability to go into homes and when they will be allowed to go into the homes. This issue was noted to be more prevalent for pediatric patients new to home health needs.

Dr. Strenio discussed that in reviewing telemedicine codes for coverage, particularly telephonic only codes during the state of emergency, DVHA has been looking through the lens conducting strictly telephonic visits while maintaining valuable integrity of care.

Discussion

Board members indicated interest in identifying and reviewing data that might detect if the changes to coverage - telemedicine codes as well as telephonic codes – have affected care and outcomes. It was noted anecdotally that in the SUD population, providers have found that use of telemedicine has decreased missed appointments and tardiness related to e.g. childcare and transportation needs. Some provider offices have had nursing staff call patients prior to the provider telemedicine visit to update medications, health maintenance information, medical history, etc. and then the provider calls the patient using a telemedicine platform. One issue encountered with this approach was that when the nursing staff call the patients with their own communication line vs telemedicine platform, the call may display as "blocked line." Providers are noting a start of backlog in health maintenance care, e.g. vaccinations and other care that needs to be received in person. Also, certain services, e.g. diabetic shoes, rule requires a face to face visit to view the diabetic patient's feet do not support use of telemedicine.

In the substance use disorder population, providers note there may be some patients not doing very well with telemedicine visits only, e.g. patients that may be homeless with SUD are being housed in emergency housing settings in some cases, such hotels, that may be supportive for patient at higher risk regarding exposure to substances and potential for relapse. Volumes of urine drug screening and in turn observed UDS have greatly decreased. There has been an identified need to resume observed UDS. Anecdotally, providers view the decrease of COVID-19 cases as reassuring and providers are beginning to feel lower risk in resuming in-person care. A point of dissatisfaction with telemedicine use has been noted to be lack of privacy in the patient's home setting, e.g. in situations where there may be conflict between family or cohabitants in the setting where the patient is attending the telemedicine visit. This is of particular concern for teens interacting with their physicians and mental health providers, according to Board Members.

In a naturopath office, telemedicine use is noted to be 99.9% at the time of this meeting. One of the barriers with telemedicine use was noted to be long download times for platforms. Providers have been experiencing inability to see as many patients with the extended download times, thus have been working longer hours. Additionally, bandwidth has impacted download times. The ability to get good visualization of a patient, e.g. to

examine a rash, can take longer with poor internet connectivity. Patient's knowledge and experience with the technology also has posed challenges including delayed appointments and requirement of support staff to provide technical assistance to the patient prior to the visit. One board member recommends reimbursing telephonic care at a higher rate to aid providers and limit financial impact.

In small rural practices, other barriers to telemedicine discussed included inability to provide patient educational handouts and barriers that PPE may pose to care, such as requirement of masks and the barrier this poses for a patient that may be deaf and read lips. The board would like to find a way to get patients safely into the office. There have also been questions and confusion around testing office staff before returning to work and procedures and processes for how best to reopen.

Dr. Strenio asked the board members, what services are reasonable for using telemedicine vs going into the office? There are the clinical considerations as well as need to evaluate a patient's ability to navigate/participate in telemedicine (technical skill).

Board members report that in some practices, medical assistants spend 5-10 minutes on the phone speaking with patients prior to their appointment to provide support around comfort and troubleshooting with the technology. One group practice has noted benefit in use of telemedicine for patients with mental health issues. There has been note of increased engagement and comfort level from patients during telemedicine visits because the patients have the providers undivided attention because the provider is looking at them through the screen instead of at the EMR while typing. Board members expressed concern about ensuing discrimination against recipients living in rural areas, or elderly recipients, if DVHA incentivizes video calls over telephone calls by paying more for them.

DVHA has received some negative feedback from members regarding whether the care that they are receiving is satisfactory compared to what they are used to when in the office. Some have expressed insecurity related to privacy issues limiting their ability to discuss specific issues when there may be conflict in the setting.

In a pediatric care setting where a portion of the patient population resides in upstate New York, some providers have had to obtain NY State medical licenses to provide care. From the Vermont Medicaid standpoint, it would be interesting to see what happens with for example, Boston providers that provide care for Vermont pediatric population and ability to accommodate via telemedicine.

Legislative Updates – Dr. Strenio/Christine Ryan

Dr. Strenio introduced an issue being discussed in the legislature regarding the use of store and forward technology, or asynchronous telemedicine. The Legislature passed a bill during the state of emergency related to COVID-19 (Emergency Rule H-2020-02-E Coverage of care services delivered through telehealth, telephone, or store and forward means) that stated that all health insurance plans should cover store and forward for health care or dental services by May 1, 2021. Vermont Medicaid currently covers store and forward use for

dermatology and ophthalmology. Because Vermont Medicaid is not considered a health plan, DVHA is not obliged to participate in this rule unless specified in the language. In lieu of the ongoing state of emergency, DVHA continues to consider coverage for store and forward as directed in the rule and seeks feedback from the CURB. Dr. Strenio asked the board to consider use of store and forward around the following scenarios:

1. A patient sends a picture of a cut to their provider for advice related to need for suture.
2. A PCP and consultant both participate in an eConsult. There are procedure codes that the PCP could utilize to bill for taking the time to send the data via store and forward as well as consult codes the consultant could bill for reviewing the store and forward data.

Christine reviewed that the legislature has cited several questions in consideration of the pending legislation:

1. In providing coverage for reimbursement for store and forward, is using fee for service payment appropriate? When this claims data is reported how would you recommend evaluating the effectiveness of the store and forward approach?

In one small rural practice, providers have found store and forward successful in regard to assistance with patient care related to dermatological conditions and felt compensation for consult via store and forward for this purpose was appropriate. In another small practice, providers have noted store and forward a successful aid for dermatological conditions in triaging care for inmates.

Dr. Strenio noted that commercial payers were prepared to pay for store and forward services across the care setting spectrum, but asked the board members to consider if there might be settings and/or conditions for which, store and forward may not be appropriate.

One member brought up the successful use of live video consult with NICU and neurology providers in tertiary care settings for assistance with newborn resuscitation and triaging transfer needs. This has already been occurring and if there was the ability to bill for these services, this may promote increased use and potential cost savings if these consults ultimately assisted to limit unnecessary transfers to higher levels of care.

The board discussed that use of store and forward may be self-selective in that providers would not request a store and forward consult for a condition/service that does not lend itself to the technology. Dr. Strenio imported that the distinction for store and forward is that this is a technology which involves asynchronous data transfer, e.g. a picture is taken and then submitted at another point in time to another provider for review and impression. He posed to the Board, is there any scenario in which you do not think that it would be appropriate? DVHA staff reviewed with the Board members that at current, telemedicine consultations cannot be recorded (Sec. 1. 8 V.S.A. § 4100k is amended to read: § 4100k. COVERAGE OF HEALTH CARE SERVICES DELIVERED THROUGH TELEMEDICINE; Act No 64 (2017), S.50).

The board members discussed again that use of store and forward would likely be self-limiting and felt it appropriate that coverage for these services be available for all health care settings. The group discussed that there may be room for medical error with store and forward as only a component of the patient's clinical picture may be sent and it is important to consider that there may be other clinical information that may be relevant, and for this reason, it was discussed that compensation for consultation via store and forward may not be appropriate to the degree of a more thorough in person or telemedicine consult visit requiring higher level of medical decision making.

2. In considering use of eConsult in evaluating a potential for a value-based care model, what questions should we as a payer and representing Vermont providers be asking an eConsult organizations? What do we need or want to support our Vermont providers as an eConsult concept? Different ways to implement eConsult were reviewed including hiring a group of specialists from an eConsult company to manage and provide eConsult, or you could have in internal/more local group of specialists at a tertiary care center act as and provide eConsultation. The question was asked, to what degree does this threaten the livelihood of a specialist who is willing to provide the service via eConsult versus in person? Christine extended the opportunity to join an upcoming call with DVHA related to eConsults to the board members.

Board members endorsed eConsult service use with provision to include commitment to some in-clinic time to encourage some face to face relationship. In other words, in considering stipulation or inclusions for eConsult in regard to a value-based care model, physical presence of the specialist in clinic at some regular hours was felt to be important. The group favored payment and compensation for eConsult services. The group discussed complications from a systems perspective that may arise due to limited resources and providers and longer wait times to see someone. Members might push to see someone online sooner rather than later.

3. The group was asked for input and thoughts on payment structure for eConsults considering fee for service versus value-based payment for a specific population such as a per member per month.

The group discussed that eConsults may offer additional support around medical necessity decisions, the data sent via store and forward would enable specialist consults to make recommendations with respect to the need for continued specialty care, or triage to other treatments or care plan suggestions. The thought was that providers may feel more in favor of decisions around care planning supported by provider consultation than payer-derived decisions as the consultant is an active clinician. In other words, there would be support for store and forward and eConsultation as this is direct payment to a provider participating in the care versus a payer simply reviewing the care.

In dentistry, use of eConsult has evolved into a form of triage, due to rural geographic location of some patients, to identify issues that may require more immediate care versus

issues that may be triaged to later or lesser complex care. The board discussed that eConsultation provides a valuable opportunity to identify and provide care that may be rendered in the interim, or in preparation for, care that will require in person services and visit to the specialist in cases where there is a wait to be seen. Additionally, as consultation still requires time out of the providers normal work, it was voiced that it would be important for appropriate compensation to the consultant.

Adjournment – CURB meeting adjourned at 8:36 PM

Next Meeting

July 15th, 2020
Time: 6:30 PM – 8:30 PM
Location: Skype or update TBD