Clinical Utilization Review Board (CURB)
November 13, 2019

PRESENT:
Board: Nels Kloster, MD; Thomas Connolly, DMD; Joshua Green, ND; Elizabeth Newman, MD; Michael Rapaport, MD; John Matthew, MD;

DVHA Staff: Katie Collette, RN; Scott Strenio, MD (moderator); Christine Ryan RN; Jenna Cebelius, MPH

Absent: Anne Goering, MD; Valerie Riss, MD

HANDOUTS

- Agenda
- Minutes – May and September
- Meeting schedule 2020
- CURB Legislative Section
- Executive Summary Legislative Dental Task Force

CONVENE: Dr. Scott Strenio convened the meeting at 6:35 pm.

1.0 **Introductions**

All present introduced themselves. Dr. Strenio briefly discussed options for attendance including the teleconference option that was presented during the March CURB meeting.

We discussed allowing time at the initiation of each meeting to complete required paperwork. The annually required conflict of interest forms were provided and completed by the board members along with expense reports.

2.0 **Review and Approval of Minutes**

The minutes from the May 15th, 2019 and the September 18th, 2019 meetings were reviewed and approved with no changes.

3.0 **Old Business**

Updates on Past Initiatives, Prior Topics, and Discussion

Palliative Presentation to the Medicaid and Exchange Advisory Board (MEAB)
DVHA did not historically reimburse providers for completing advance care planning with patients. Work was completed to provide coverage of advance care planning effective August 15, 2019. A goal of this work is to improve access to and utilization of hospice in a for Vermont Medicaid members by starting the conversation earlier with patients and to do that, we wanted to make the service reimbursable.

Ongoing work within the Clinical Operation Unit will include investigating development of a program for adult palliative care to bridge to the pediatric palliative care program delivered by the Vermont Department of Health that ends for those members once they age out of the program at age 21.

Discussion
Another population that needs palliative care are patients with complex chronic illness that need extra support at the end of life. There are palliative care models, for example, the VNA of Chittenden County run by the hospice nurses that allows for transition of patients receiving palliative care to hospice. Additionally, Kaiser has found it cost effective to have care teams including nurses, social workers, NPs, and physicians devoted to performing home visits in urban areas. NY state has invested seed money in palliative care that a FQHC has utilized to invest in care team models. This work was found to be so successful that they have continued to keep funding these teams though the grants have run out. It was suggested that this might be a place where OneCare may step up to invest grant money to start seed programs around palliative care that may be modeled around existing successful palliative care models.

Additional comments made included that there should be investment in programs/services that facilitate placement of patients with complex medical needs into appropriate community settings in order to avoid lengthy high dollar hospitalizations when the acute level of care is not required. It was also commented that a Medicaid ombudsman would be helpful to assist with unusual or odd situations encountered with providing care for Medicaid members. This may identify a pattern of issues for Medicaid services/members that needs to be addressed.

DVHA Medicaid dollars are bucketed to be distributed to pay for services provided by other departments. DVHA pays for more typical services such as hospital care, emergency room visits, and operations. Other departments receive DVHA dollars to pay for the different services that the respective department is responsible for. For example, DHVA money goes to DAIL to pay for Choices for Care and nursing homes. DVHA money goes to VDH to cover designated agencies and Community Rehabilitation and Treatment (CRT) programs.

Dental Task Force Update – Christine Ryan and Dr. Thomas Connolly
Christine reviewed the work happening around dental services within Medicaid including the cap increase from $510 to $1000 annually (effective 1/1/20 with two allowable preventative visits outside of the cap), the CURB recommendation, and the legislative dental task force. Christine asked Dr. Connolly to speak to the provided executive summary and the results that came from this work. Dr. Connolly was a member of the task force mandated by the Legislature to deliver a report to the DVHA Commissioner by November 1, 2019 for subsequent delivery to the legislature. The task force met several times over the summer to address the legislatively designated mandates including 1) evaluation current Medicaid reimbursement rates with the intent of identifying if there were specific services for which the rates could be improved to attract more dental providers, 2) explore other potential

expansion of services such as teledentistry and explore if inclusion into an ACO model would be possible and, 3) consider expansion of services to Medicare patients, the most rapidly growing segment of the population with no consistent dental benefit. The Task Force came up with 11 separate recommendations and an explanation and defense for each recommendation which included:

- Establishment of a process for annual review of rates and review of progress toward achieving other recommendations;
- Investigate barriers to provision of dental services for Medicaid members by dental practitioners such as low reimbursement rates and administrative burden;
- No rate increase for preventative services at this time due to the addition of preventative services being provided outside of the cap with the new legislation;
- Increase rates to within 60% of usual/reasonable and customary rates. To start, this would be based on the Delta premier rates.
- Investigate utility of store and forward technology;
- Investigate debt reduction for dentist assuming they take a larger portion of Medicaid patients in an effort to recruit and retain dental services

The estimated fiscal impact of these efforts is $973,252.

Discussion
It would be valuable to look at cost offsets of increasing access to dental services or evaluate the cost savings impact of spending/investing money in dental care to avoid significant long term sequelae related to poor oral health.

E-Consults – Dental Pilot Results Update – Christine Ryan
A group in Connecticut recently went out into the community in a van with a chair, camera, and Dental hygienist to schools and homeless shelters etc. The overall cost for this mobile dental unit was around $27,000. Lessons learned centered around ease of use of the camera, challenges of working with small children, and use of live consult or video for store and forward in the future.

Discussion
Store and forward or asynchronous technology may be beneficial to allow dentists to view the data when they have available time. Plainfield has a dental van that travels around to schools throughout the year. Regarding provision of these services to Medicaid members, it is imperative to have a person dedicated to ensuring the necessary paperwork and administrative tasks have been completed.

Transportation – Katie Collette
After the May meeting, the Clinical Operations Unit connected Dr. Rappaport with Suellen Bottiggi from the Provider Member Relations unit to discuss possible solutions for improving the required process for Medicaid members to receive transportation. Currently there are 6 different forms on the DVHA Transportation website all for exceptions which

qualify a member for receipt of transportation services. Provider Member Relations worked to create a condensed form. Dr. Rappaport discussed that one of the greatest improvements has been an improved chain of communication and understanding of the rules and regulations that affect the process. Additionally, the bus service has added a stop immediately outside of his office instead of nearly 6/10s of a mile away. A remaining barrier is the requirement of a provider signature for all requests which is time consuming. There are still underlying issues with certain carriers, but it is a work in progress. The Clinical Operations Unit will reach out to Suellen to identify if the new form is available on the DVHA transportation website for use for all and investigate if a communication can be sent out to the provider community to notify of the new form.

Discussion
Timing is the biggest issue and barrier around transportation for Medicaid members. There are federal rules that apply to this process. There are multiple transportation agencies, which also create issues related to consistency.

4.0 **New Business**

CURB Reclassification – Katie Collette
The Clinical Operation Unit is working on efforts to streamline the renewal/reapply process. We aim to divide CURB members and put them in to 3 groups with staggered terms. We are working with legal counsel to identify the details of the membership mandates and requirements such as evaluating staggering and arrangement of terms and improving processes. We are looking at the structure of the board that will support work and time on the board and aligning for what is needed in the future.

Discussion
The meeting location is more convenient for some members than others. There are logistical indications for holding the meetings at Albany College of Pharmacy in Colchester including the Drug Utilization Review Board (DURB) meetings are also held at this location and this allows for some efficiencies between the two boards. However, this can be a consideration going forward and was a consideration when adding teleconferencing as an option for participation.

ACO Update – Dr. Scott Strenio
DVHA continues to explore opportunities for collaboration, improvements, and efficiencies in the transitions of healthcare reform and participation with the Vermont Medicaid Next Generation ACO model. DVHA has worked to identify clinical initiatives that would benefit Vermont Medicaid members and collaborate with OneCare Vermont in attempts to realize efficiencies. One of our top priorities is identifying smaller, hidden populations of Medicaid members that may not be easily identified by population health metrics. DVHA meets regularly with the ACO and continues to be at the table of payor collaboration around clinical objectives. CURB members are encouraged to bring their ideas for clinical initiatives/objectives relevant to Medicaid members to these meetings.

Discussion:
A couple of populations that could be looked at include COPD patients and CHF patients.

Is there a way to look at Medicaid data to identify practices that are costing the least amount of money and being the most efficient? For example, look at the practices with the shortest hospitalization stays, that are providing good care, and costing less to identify what interventions/characteristics of these providers/practices are employing to produce these quality outcomes with lower costs. Is there a way to objectify/quantify this information? Would a "where you rank among your peers" be useful?

Things that we are working on with the ACO on currently include investigating urine drug testing practices and opportunities that may exist for improvement in these practices, chronic pain pilots, and dental initiatives. Also working to align metrics across payers.

The executive summary around the urine drug testing will be brought to the CURB when completed. The ACO update topic will be added as a standing agenda item for future CURB meetings.

Adjournment – CURB meeting adjourned at 8:38 PM

Next Meeting

January 15, 2020
Time: 6:30 PM – 8:30 PM
Location: Albany College of Pharmacy and Health Sciences