VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

Clinical Utilization Review Board (CURB)
Meeting Minutes for July 17th, 2024

Board Members Present:

✓	Joshua Green, ND	✓	Kate McIntosh, MD		
✓	Colleen Horan, MD	✓	Valerie Riss, MD		
X	Nels Kloster, MD	✓	Matthew Siket, MD		

DVHA Staff Present:

✓	Christine Ryan, RN DVHA Clinical Services Team	✓	Michael Rapaport, MD DVHA Chief Medical Officer	✓	Stephanie Barrett DVHA Chief Fin. Officer
✓	Sandi Hoffman Deputy Commissioner	✓	Ella Shaffer DVHA CST Admin Svcs Staff	✓	Alex McCracken DVHA Dir. Comm. and Leg. Affairs
				✓	Carrie Germaine Health Program Admin

Guests/Members of the Public: Margaret Haskins, Gainwell Representative; Timothy McSherry, Johnson & Johnson representative

Topic	Presenter	Discussion	Action
Meeting Convened		Meeting was convened at 6:34 p.m.	
1. Introductions and acknowledgements	Sandi Hoffman	Introductions were given around the room. The minutes from the May 15th meeting were reviewed and approved. DVHA announced that they have 4 new Board member applicants that have been endorsed by DVHA and applications have gone on for final approval. Dr. Green and Dr. Connolly are departing to participate in new professional engagements. DVHA staff provided an update on the open Commissioner position as final hiring is in progress.	**Motion: Approve the May 15th minutes as presented** **Approve: All** **Abstain: Riss** **Approved**
2. New Announcements and Follow-ups	Christine Ryan	DVHA provided a presentation on recent and proposed changes to physical therapy, occupational therapy, and speech therapy service (PT/OT/ST) coverage requirements and requested recommendation from the CURB. Effective 1/1/23, DVHA increased the allowed amount of PT/OT/ST visits before a PA is required, from 8 per discipline to 30 combined visits per calendar year. DVHA presented a proposal to the Board to remove the 30-visit limit for combined therapies for the medically complex population. A review conducted by the DVHA Code PA (prior authorization) workgroup found no evidence of increased utilization resulting from the 1/1/23 changes. Utilization data shows an annual spike at the beginning of each year. The group also found that this change has been budget neutral for the pediatric population.	

		DVHA posed three questions to the Board: 1. Do you think initial access to services reduces long term expenses? 2. Should there be exclusions? 3. Should DVHA consider a higher visit threshold prior to PA requirement? DVHA outlined their plans for monitoring these changes should they move forward. DVHA would also develop clinical coverage guidelines to help support expectations of appropriate utilization. Dr. Rapaport explained that DVHA has always struggled with trying to reduce the burden on providers while still ensuring that services rendered are appropriate for the patient. Historically this has been accomplished through PA but there has been a trend towards alternative management strategies. One option is the creation of coverage guidelines with retrospective clinical reviews to evaluate compliance with the guidelines. This prevents the delay of services, while still providing a tool for appropriate utilization management. Additionally, for the pediatric population most PAs would be granted due to EPDST (early, periodic diagnostic screening and testing) guidelines, making the PA a redundant process. One Board member advised that the population needing complex care is likely to need these types of services consistently and routinely. DVHA identified a potential concern that services may be provided that aren't evidence based and may put the individual at harm due to delay of evidence supported services. The Board suggested that there is clinical data on this topic but that it is limited. Anecdotally, one member shared that there is no support in general for removing these services from medically complex pediatrics but that new and experimental procedures pose an area of concern which should be monitored. DVHA was advised to be careful as safeguarding against these procedures is a significant reason why many insurers find it difficult to remove prior authorizations.	

		The Board recommended that system and monitoring changes be investigated to support appropriate billing and utilization monitoring. The Board provided alternative approaches to increase access to services but ensure appropriateness. A per-member per-week cap was suggested, with caveats for school services where much of the pediatric population receives these services. If a per-member per-week cap were to be utilized, the Board further suggested making it a combined cap for all disciplines to force conversation and coordination of care. This has been explored by DVHA and poses significant system issues, therefore is not viable. DVHA shared some concerns with the idea of a retro review process and who would be the responsible party for conducting them. It was noted that retro reviews can be time consuming and more expensive to conduct. The Board cautioned that any changes made to PA won't reflect in utilization data for at least 2 years as providers acclimate. DVHA reviewed that there has been engagement with VT Medicaid enrolled therapists on this topic. The Board expressed concern about the budget, as funding is being cut while PA requirements are also being loosened. The discussion turned toward defining medically complex cases. DVHA identified there are system challenges to doing this simply by diagnoses. Data does not identify trends that support the population of interest are limited to specific providers or geographic regions. The Board proposed defining complex cases on heavy utilizers (e.g., 100+ visits per year) as these instances are likely to continue at that rate.	

3. Budget Process and FY24 Update	Stephanie Barrett	Stephanie Barrett provided a presentation on the DVHA budget process going into the new fiscal year. The budget cycle begins internally in August/September then is handed off to the Governor's office by December, where it is prepared for the next legislative session. She explained that the process is a collaborative effort between DVHA, the AHS Central Office, the Finance and Management Office, and the Joint Fiscal Office of the legislature. DVHA builds the budget based upon caseload projections and cost profiles of the different eligibility groups. Recently, the public health emergency (PHE) unwind has been a constraint, but it is leveling out with the renewal restart in 2023 and wrap up this spring. Last year at this time, the budget saw significant rate increases totaling $55.7 million. The ACO reconciliation payment for CY22 (calendar year 2022) and Brattleboro Retreat alternative payment model also had major impacts for fiscal year 2024 (FY24). Stephanie reviewed Medicaid eligibility groups and pointed out as a key takeaway from this data that comparison of the estimate and actual caseloads shows less than a 300-member difference. The Board asked how these populations compare to the state as whole. DVHA explained that trends in the eligibility populations do not reflect trends in total state population. Stephanie went on to share the final FY24 budget. DVHA is down $31 million in the total program budget, with $18 million of that resulting from the Change Health Care cyberattack. DVHA explained that the cyberattack disrupted the pharmacy rebate process which made up most of the loss. They are confident that this difference will be recouped in FY25 as rebates resume. The FY25 budget started with estimates made back in January this year, so these realized deficits have required rebuilding the budget. Stephanie noted that while	

		caseload and utilization was part of consensus process, it reflects a reduction in caseload utilization from the unwind. The FY24 budget was off, in part, due to lack of acuity in how the PHE would leave utilization. Discussion ensued about utilization following the unwind. It was noted that a large portion of those disenrolled by the unwind were lower utilizers. This population may have included people enrolled in the early pandemic who had other coverage or remained enrolled without using the program at all. This data was corroborated by the ACO, who saw similar deficits in their claims. DVHA reported that acuity of the caseload estimate is being further investigated. DVHA identified budget pressures related to the FY26 budget including: • Utilization (acuity) for caseload • Medicare savings program expansion in SFY26. This starts halfway through the year (Jan 2026) but must be planned into budget still. • Blueprint Hub & Spoke expansion pilot. There is consideration on whether it will move into the base. • Medicaid rate pressure across providers • Federal policy on insurance marketplace tax credits. Loss of credits if not maintained affects access to other policies by members. Stephanie provided some likely economic context for the above – State revenue growth is beginning to slow. The current total of eligibility groups is significantly below the SFY25 estimate. Stephanie explained that this suggests the caseload estimate for FY25 is still too high. DVHA is seeing caseloads nearly back down to 2020 levels. DVHA noted a summary of the PHE unwind will be provided at the September meeting.	

		The Board asked if high claims cases over a given period are changing as a percentage of the total. DVHA is looking into this and shares that instances like this garner attention from the Clinical Team. DVHA concluded noting this budget information and presentation must be considered when the CURB is reviewing policy, utilization, and budget impacts.	
4. Legislative Report	Alex McCracken	Alex McCracken provided an update on the recent legislative session. DVHA testified on multiple bills and topics this year, focusing on access and affordability for Vermonters. The Big Bill for FY25 included one-time appropriations for the Global Hospital Payment Pilot Program; for technical analysis of the health insurance marketplace; and for the implementation of the MSP expansion. Additionally, the bill provided additional language on topics including a report on payment methodology for nonemergency medical transportation; special education school-based Medicaid services; Dr. Dynasaur premium suspension; technical analyses on the insurance marketplace; ABLE accounts; estate recovery and probate timelines; and the MSP expansion and VPharm. DVHA expects to provide recommendations following the MSP expansion. The expansion is expected to: • Raise qualified Medicare beneficiary program eligibility • Effectively eliminate the specified low-income Medicare beneficiary program • Raise program eligibility for qualifying individuals Alex shared that in total these changes will be a significant help for older Seniors with dual enrollment. A number of bills passed by the 2024 legislature were reviewed with the Board. Of note, S.109 (Act 97) relates to Medicaid coverage of doula services; H.861 (Act 108) related to	

		reimbursement parity for telemedicine and audio-only services; and H.233 (Act 127) relates to licensure and regulation of pharmacy benefit managers. Alex highlighted S.55 (Act 133) in particular as it relates to the VT Open Meeting Law. He explained that in general this bill will not affect the CURB but does allow for residents and the press to request a physical meeting location be provided.	
5. Closing		DVHA hopes to hold the September meeting as hybrid, with an in-person option. No public comment was offered.	
Adjournment		Meeting adjourned at 8:08 p.m.	