VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

Clinical Utilization Review Board (CURB)
Meeting Minutes for September 18th, 2024

Board Members Present:

✓	Jennifer Chambers, LICSW	✓	Colleen Horan, MD	X	Valerie Riss, MD
✓	Amela Dulma, RN	✓	Nels Kloster, MD	✓	Sam Russo, ND
✓	Albert Hardy III, DMD	X	Kate McIntosh, MD	✓	Matthew Siket, MD

DVHA Staff Present:

✓	DaShawn Groves, DrPH, MPH DVHA Commissioner	✓	Christine Ryan, RN DVHA Clinical Services Team	✓	Brendan Krause AHS Dir. Health Care Reform
✓	Sandi Hoffman Deputy Commissioner	✓	Ella Shaffer DVHA CST Admin Svcs Staff	✓	Lisa Hurteau Dir. DVHA Pharmacy
✓	Michael Rapaport, MD DVHA Chief Medical Officer				

Guests/Members of the Public: Margaret Haskins, Gainwell Representative; Kimberly Sampson, MD, Obesity Specialist; Jill Sudhoff-Guerin

Topic	Presenter	Discussion	Action
Meeting Convened		Meeting was convened at 6:32 pm.	
1. Introductions and acknowledgements	Sandi Hoffman	Introductions were given around the room from DVHA Staff. DaShawn Groves introduced himself as the new DVHA Commissioner. His past experience includes Special Projects Officer to the Medicaid Director at the Department of Health Care Finance for the District of Columbia, where his work focused on embedding system improvements and health equity into departmental priorities. Prior to that, he was a Lead Project Manager at the Health Care Reform and Innovation Administration where he participated in innovative models of care and payment among Medicaid providers. Brendan Krause introduced himself as the new Director of Healthcare Reform for the Agency Current members of the Board introduced themselves followed by the new Board members. Dr. Sam Russo has a specialty in naturopathy and sports medicine. Jennifer Chambers is a licensed social worker and serves as the Director of Case Management at Springfield Hospital. Dr. Albert Hardy is an oral and maxillofacial surgeon at the Fanny Allen Campus and also in Stowe. Amela Dulma is the Health Care Reform Director with the UVM Health Network. The minutes from the July meeting were reviewed and approved.	**Motion: Approve the July 20th minutes as presented** **Approve: Siket, Horan, Riss** **Abstain: Kloster** **Approved**
2. Completion of Public Health Emergency (PHE) Unwind	Dr. Rapaport	Dr. Rapaport provided an update on the DVHA PHE “unwind” renewal restart and the data dashboard. The renewal dashboard contains enrollment numbers tracked over the 12–14-month renewal period that was kickstarted in April 2023 with the end of the PHE. Dr. Rapaport explained that since March 2020, states were required to keep people on Medicaid with very few exceptions. The Consolidated Appropriations Act of 2022 saw	

		the phase down of this continuous coverage, ending it in 2023. DVHA has completed the unwind as of spring 2024. DVHA stressed that over this unwind renewal process, members were offered multiple opportunities via various outreach modalities to update for review of reenrollment with Medicaid. Outreach occurred via mail, email, and text messaging when applicable. Eligible populations were auto renewed. The most recent dashboard from August shows that 69% of members continued their enrollment over this process while 22% saw their enrollment end. Dr. Rapaport reported that the majority of disenrollments were through administrative means – cases where DVHA was unable to reach the member after multiple attempts or did not receive requested information after outreach. He also noted that VT retained a higher percentage of members from this process than other states going through the unwind. One Board member asked for details comparing the before and after population. DVHA reported that 173,529 members remained eligible after the renewal restart from a peak of 220,000 members. They estimated that 30,000 members were a part of programs that had permanent eligibility status, such as SSI groups. Another board member shared that extended hospital stays during the unwind resulted in outreach attempts going unanswered as members were effectively living in the hospitals. Discussion arose around comparison of data to other states. DVHA noted that Vermont did this work in-house while other states with higher populations may have handled the process very differently. The national average disenrolled population was 27% compared to Vermont's 22%.	

3. CMS – States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model	Brendan Krause	Brendan Krause shared a presentation with the Board outlining the States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model. He explained that the AHEAD model is a partnership between states and the Center for Medicare & Medicaid Services (CMS) to implement a combination of hospital global budgets and support for primary care. Vermont and Maryland are two states selected for possible participation in the first cohort of this model. Brendan clarified that VT is interested in being a part of this project early to aid ability to influence the nuances of the model while there is still the ability for change. As part of the model process, VT is invited to negotiate over the next year for a new version of a global payment model. Brendan reported that a goal of this new model is flexibility. Vermont wants to shift care out of hospitals when able to and support community-based organizations that enable other adjacent health needs that aren't typically covered by Medicaid. DVHA thinks that VT is an outlier in how low its Medicare spending is compared to the rest of the country. They claim that other states are happy with budget draw downs, but the costs are often prohibitive to VT. Brendan noted negotiations thus far have been frontloaded with the payment parts to ensure the right number is reached for VT. CMS allows states to use their methodology or to propose a different one. VT wants to propose a different method. Brendan was hopeful that these details will be confirmed by mid-November. He stressed the difficulty of getting all of the signatories -- CMS, the Governor's Office, the Medicaid Director, and the Green Mountain Care Board (GMCB) – aligned. Discussions on this model will continue on through next July. Brendan detailed another 3 streams of work that are being funded as part of the agreement. Continued negotiations, modeling, etc.	

		Developing metrics and creating a dashboard to monitor changes made to the system ACT 167 recommendations to provide robust technical assistance to hospital systems and local communities towards feasibility, cost, and quality outcomes. The Board asked for reassurance about the feasibility of this project due to needing GMCB support. Krause reiterated to the Board that they are receiving funding from CMS to help manage the process, which alleviates some concern. Brendan reported positive discussion thus far in GMCB executive sessions. The discussion shifted to alternative models and whether this model will move forward. Krause explained that they would need to find alternative funding should the model not be adopted readily. There would be a transition year and a return to fee-for-service (FFS) while determining how to continue. Updates on this project will be provided to the CURB periodically.	
4. Review, Input, Recommendations: DVHA Review of Obesity and Implications for Covering Obesity Medications	Dr. Rapaport	Dr. Rapaport introduced meeting invitee Dr. Kimberley Sampson. She is an OBGYN and obesity medicine specialist from Dartmouth Health practicing in the Bennington area. Before the meeting, DVHA circulated a draft copy of its weight loss drugs report for the Board's review. Dr. Rapaport gave an overview of the report and provided a brief update on the introduction and availability of these medications. He explained that VT is currently prohibited by state plan from covering these drugs for the indication of obesity. DVHA would need to pursue an amendment to the state plan to provide coverage of weight loss drugs to treat obesity. It was further explained that when Medicare designed the Part D benefit, several drugs encompassing obesity treatment were excluded due to poor efficacy of the products on market at the time that the law was	**DVHA will send a survey to the Board regarding coverage of these medications.**

		written. The Institute for Clinical and Economic Review (ICER) conducted a 2022 cost-benefit analysis of these new weight loss drugs. They determined that the benchmark cost in order to see a return on investment (ROI) would need to be $800/month. Dr. Rapaport noted that the wholesale price of these drugs is currently around $1400/month. Sandi emphasized that DVHA doesn't currently have funds allocated for coverage of these drugs for this indication. Any funding for this coverage would require reallocation of funds from elsewhere within the budget. To that end, DVHA would need to develop a cost impact prediction and then find support for that cost in the budget. The DVHA Pharmacy Team estimated the wholesale cost, assuming uptake being 5%-10% of the eligible population, to be $30-$55 million per year. The manufacturers support an uptake rate much lower than these estimates, but DVHA is concerned about uptake rates due to experience during the Change Health Care cyberattack earlier this year. The cyberattack impacted operation of safeguards and system edits around drug utilization, allowing the use of drugs for noncovered indications. DVHA posed several questions to the Board: What has been your experience with these drugs? What patient population do you see benefiting the most? What priority should DVHA place on lifestyle modification? One Board member shared experience with prescribing semaglutide, claiming it to be very effective with few complications. This Board member asked what DVHA's plan would be once members reach their long-term target weight. Discussion from the Board ensued. Literature suggests that weight returns in most cases once adherence to the medication stops. The Board expressed concern that there will be no long-	

		term benefit to the health of members if the causes of obesity are not treated. DVHA referenced Part 2 of their report, which stresses the use of lifestyle modification in addition to the use of semaglutides. Another Board member indicated that a dual hormone approach has been effective in her experience -- a combination of semaglutide and GLP-1. She noted that Eli Lily is working on a cheaper model of injector pen to hopefully reduce cost. There was also talk of oral forms of these drugs on the horizon, but generic forms likely won't be available until 2031. DVHA expressed concern that new forms of these medications could see the cost rise higher. Dr. Rapaport cited a Yale study showing that the cost to manufacturers of these drugs is around $0.79 per month. The Board agreed that the current price points are a concern. Discussion continued around the additional cost savings from comorbidity reduction in association with reduced obesity rates. The Board spoke to the approval and/or renewal process of prescriptions for these drugs and how they relate to monitoring health metrics. BlueCross BlueShield conducted a study on adherence rates for GLP-1 used to treat diabetes. They found that 40% of the population discontinued use after 1 year. They also found that when prescribed by specialists, there was better adherence. DVHA posed the question to the Board: does it make sense to only allow specialists to prescribe these medications? Conversation turned to considering use for particular patient populations, with one Board member recommending their use towards treatment of sleep apnea. Another Board member recommended use in the metabolic syndrome population. Another suggested those with limited mobility or disabilities as a potential population.	

		DVHA inquired if these medications should be considered as an approach towards improving health outcomes associated with obesity. Commissioner Groves requested of the Board specifically if obesity treatment medications should be a priority for DVHA and, if so, then for what population. A comparison was made between the weight loss medications and the medications used to treat opioid use disorder (OUD). Historically, OUD treatment has veered away from a focus on lifestyle modification in favor of treatment with medications. Treatment for Hepatitus-C was considered as another comparison, as in the past there was an expectation of a certain level of liver damage before approval for treatment. At current, Medicaid covers treatment at the outset due to cost savings down the road due to the preventative care. The Board praised DVHA for its work on the report and for providing it for review ahead of time. One member expressed skepticism due to the high attrition rates and the sustainability of short-term losses but wanted to be convinced by the downstream effects. Dr. Rapaport offered Dr. Sampson the opportunity to speak to these concerns. Dr. Sampson stressed the complicated nature of these drugs. She echoed the comparison to mental health and substance use treatments of the past. Her focus was on how to provide better healthcare, emphasizing to the Board that the decision towards discontinuation of the medication was entirely dependent on the patient and that every patient was different. She warned that drawing a line on who is eligible for these medications is hard as the quality of life gained from weight loss cannot be depicted by just the number on a scale. DVHA will send a survey to the Board in follow up, seeking recommendations related to coverage of these medications for treatment of obesity.	

		DVHA noted that this information will be shared with the Drug Utilization Review Board (DURB) looking for additional feedback.	
5. Closing and Public Comments	Sandi Hoffman	No public comment was offered. DVHA is aiming for November to be an in-person meeting.	
Adjournment		Meeting adjourned at 8:01pm.	