AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

Clinical Utilization Review Board (CURB)
Meeting Minutes for November 20th, 2024

Board Members Present:

✓	Jennifer Chambers, LICSW	X	Colleen Horan, MD	✓	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:

X	DaShawn Groves, DrPH, MPH DVHA Commissioner	✓	Christine Ryan, RN DVHA Clinical Services Team		
✓	Sandi Hoffman Deputy Commissioner	✓	Ella Shaffer DVHA CST Admin Services Staff		
✓	Michael Rapaport, MD DVHA Chief Medical Officer	✓	Carrie Germaine DVHA Health Program Admin		

Guests/Members of the Public: Margaret Haskins, Gainwell Representative; Dr. Dino Santoro, Medical Director North Country Behavioral Medicine PLLC

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Topic	Presenter	Discussion	Action
Meeting Convened		Meeting was convened at 6:34pm.	
1. Introductions and acknowledgements	Sandi Hoffman	Introductions were given around the room. The Board approved the September minutes. DVHA reminded the Board to fill out the annual conflict of interest forms.	**Motion: Approve the September minutes as presented** **Approve: All** **Abstain: Riss** **Approved**
2. Transcranial Magnetic Stimulation (TMS) Update	Dr. Rapaport	DVHA delivered a presentation on transcranial magnetic stimulation (TMS). DVHA previously sought board recommendations on allowing up to 36 TMS visits without a prior authorization. This went into effect 5/1/2024. The board had cautioned about the possibility of an increase in unnecessary services. Dr. Rapaport reported that there has not been a significant increase in utilization. TMS coverage in Vermont is currently limited to physician providers. DVHA recently received a request to allow coverage of TMS when provided by non-physician providers (NPP) including physician assistants and nurse practitioners. The request for review came from Dr. Dino Santoro, who attended the meeting as a public guest. Dr. Santoro is the Medical Director of North Country Behavioral Medicine PLLC and sees patients in Plattsburgh and St. Albans. To support his request Dr. Santoro noted a change in a CMS Local Coverage Determination (L33398) that permitted trained NPPs to perform TMS. He explained that his request was that DVHA extend coverage to non-physician practitioners (NPP) without the presence of a physician and in accordance with state practice agreements. He shared that he has experienced difficulties with providing TMS coverage to different practices and facilities that are distributed across the state. This change would align DVHA with other payors and increase access to the service. DVHA asked the Board if they would endorse this change to	DVHA agreed to circulate their clinical guidelines for TMS with the Board. **Motion: Allow NPP (nurse practitioners and physician assistants) to administer TMS according to DVHA guidelines** **Approve: All** **Abstain: None** **Approved**

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		TMS coverage and, if so, what additional stipulations should be put in place. Dr. Rapaport explained that DVHA would continue to require PA for greater than 36 visits. The Board discussed TMS certification training for NPPs, determining that the training is the same as for physicians. Further concern was expressed about TMS indication. DVHA assured that there would be no change to the indications as outlined in DHVA's clinical guidelines. One Board member discussed that the TMS field is growing rapidly to include treatment for other conditions, but that for many indications TMS is still considered experimental. DVHA confirmed that guidelines indicate TMS only for Major Depressive Disorder and agreed to distribute the guidelines to the Board for their review. Discussion continued about potential side effects of TMS and if NPPs would be equipped to handle these. Dr. Santoro explained that seizures were not observed during clinical trials for TMS but started to appear after approval in certain practices. He shared that seizures that do occur typically resolve quickly and with no lasting effects. A motion was made to allow NPPs (nurse practitioners and physician assistants) to administer TMS according to DVHA guidelines. The Board approved this unanimously.	
3. Sleep Studies	Christine Ryan	DVHA reviewed changes to prior authorization requirements for facility-based sleep studies that occurred effective 8/1/24. DVHA removed the Prior Authorization (PA) requirement for facility-based sleep studies effective 8/1/24. The change impacted CPT codes 95805, 95807, 95808, 95810, and 95811. The rationale behind the change was low denial rates of requests for these services, reduced administrative burden, and PA requirement alignment for all members. This change was communicated via Vermont Medicaid banner from 7/26/24. Between calendar years 2019 and 2023, DVHA had an approval rate for these services of 94%. DVHA has publicly available	DVHA will share their clinical guidelines for Sleep Studies with the Board.

		clinical criteria for coverage of services in place, reviewed annually, and works with the DVHA Special Investigations Unit to conduct clinical audits as necessary. DVHA asked the board for further recommendations towards monitoring sleep study utilization. Dr. Rapaport noted that during a clinical audit, they found evidence of unnecessary home sleep studies being ordered by providers as it was believed they were prerequisite to facility-based studies. In making the PA change, DVHA predicts that allowing facility studies without PA may reduce unnecessary home studies. One Board member commented about the necessity of criteria to support the utilization management of payors. He went on to explain his experience with sleep studies and their very positive effect on diagnosing apnea. Sleep is foundational to health so access and ability to perform these studies is key. The Board discussed facility-based tests versus home tests. Dr. Rapaport added that an additional benefit of facility studies is the ability to complete split-night studies to allow confirmation of diagnosis of OSA and then also complete CPAP titration. One Board member requested that DVHA circle back on the topic after the meeting so he may review the literature before making a recommendation.	
4. Global Commitment & HEDIS Measures	Sandi Hoffman	Sandi presented information related to the Healthcare Effectiveness Data and Information Set (HEDIS). HEDIS is a set of standardized performance measures allowing for comparison of performance between health care organizations. Measures focus on prevention and screening, chronic care and care coordination, member access and satisfaction, evaluation of overuse or receipt of inappropriate care, and utilization. New	

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		measures are added periodically. The DVHA Medicaid Quality Committee reviews the Global Commitment Core Performance Measure set annually which incorporates some HEDIS measures as well. DVHA shared a document outlining the 2024 Global Commitment Core Measure set with links to scorecards of the various measures. DVHA's goal in reviewing these measures with the CURB was to look at measures for which DVHA's performance did not meeting benchmarks and to request CURB recommendations for potential next steps to make improvement. The Chlamydia Screening in Women measure was reviewed first. It showed that 46% of 16–24-year-old women in the VT Medicaid population are screened annually, compared to a national average of 56%. DVHA noted that they perform consistently below the 50th national percentile in this category. DVHA shared that the VT DOC had instituted a policy of chlamydia screening for inmates, but the DOC does not submit claims to DVHA and would not affect DVHA's score on this measure. It was also noted that this is a relatively small population and even if they were included as DVHA members it would likely not significantly raise DVHA's score on the measure. The Board discussed events that may have contributed to lower rates over the years aside from the COVID pandemic. DVHA observed that Vermont historically has one of the lowest rates of chlamydia in the country. DVHA discussed that lack of screening could be impacting prevalence data as well. The Board suggested the rural nature of VT may be contributing. DVHA agreed to investigate the connection between rurality and screening access. The Board noted that it is difficult to suggest solutions without understanding the cause. The Board discussed that intake lab screening for opioid use	

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		disorder includes syphilis. DVHA could work to implement chlamydia screening as part of the intake process as well. DVHA shared that The BAART Berlin clinic had previously attempted to partner with the OB/GYN clinic at CVMC, who would have providers come to the BAART Clinic 2 x a month to provide reproductive health services, but the plan fell through due to expectations of a significant financial load for supporting this new clinic outreach. Nonetheless it was reaffirmed that the chlamydia screening can be done from a urine sample and would not require a gyn exam to collect a sample. The Board asked how chlamydia screening rates compared with other STD screenings. The expectation would be parity between the different STD screenings so a discrepancy here could be enlightening. DVHA shared that they do not measure these rates, but that Vermont Department of Health (VDH) does. The Board inquired if DVHA lost screening sites during the pandemic. They requested that DVHA investigate if there has been a decrease in screening sites and what may have contributed to this. DVHA agreed to investigate where screenings are done historically and what might have changed at these sites between 2019 and 2020. A member suggested Planned Parenthood and student health outreach may be good locations to investigate change in these rates. The discussion moved to the next Global Commitment Measure - prenatal and postpartum care, which was also a lower performing measure for DVHA. The Board was interested in how this metric might compare with the chlamydia measure as they often conduct screenings during perinatal care. Recently, coverage for perinatal care was extended to 12 months after prenatal ends. The Board noted that the prenatal and postpartum care trendline on the rise indicates but doesn't seem to be impacting chlamydia screening rates.	

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		Next DVHA asked the Board for feedback on dental access. The data showed that only 26.5% of Vermont Medicaid adults over 21 have any dental visit annually, down from 33.4% in 2019. DVHA shared that they currently have 330 dental providers enrolled in Medicaid. One Board member explained that this doesn't imply much as many providers have limitations in place for Medicaid beneficiaries. The Medicaid population is often a low priority for dental providers due to higher rates of no-show appointments, lower reimbursement rates, and an aging population that typically requires more work. Discussion turned to the effects of the COVID pandemic on the industry. Many dental offices shut down during the pandemic and now as they reopen this has resulted in high volumes of patients seeking services and overwhelming practices. In addition, the field is seeing large amounts of retiring dentists and the consolidation of private practices by larger corporations. The Board recommended DVHA contact the Vermont Dental Society as they offer stronger outreach to the larger providers. The Board suggested that more time is needed to catch up on patient backloads because of the pandemic. DVHA increased dental reimbursement rates effective 7/1/23, but this effect won't be felt until offices start seeing Medicaid populations again. One member stressed that it's crucial that primary care providers also know of the increased dental benefits for the purposes of patient education as well as triage of dental issues. DVHA asked for feedback from the Board on ideas for improving performance on measures where they are not currently performing well and if examination of these measures by the Board is something the Board finds useful regarding CURB responsibilities.	

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5. Exception Requests	Christine Ryan	Christine provided a presentation about the coverage exception process that DVHA has in place. The exceptions process is an avenue to request coverage for noncovered services. DVHA noted that DVHA Pharmacy operates differently as VT Medicaid aligns with Medicare policy closely for excluded drugs. FDA approved drugs with manufacturer rebates for CMS must be covered unless otherwise excluded by the state plan. DVHA reviewed that members under 21 may request coverage of noncovered services via the Early Periodic Screening Diagnostic Treatment (EPSDT) program. Members over 21 may request noncovered services through the exception request process. They shared that the number of exception requests submitted is low, usually less than 10 per quarter. Dr. Rapaport stressed the importance of considering how a patient may be harmed from lack of a service when determining these exceptions. DVHA discussed that there is a process in place to track exception requests to identify trends in same service requests that may warrant consideration of the service for future adoption as a covered service. DVHA explained they also have the internal Multidisciplinary Team (MDT) which aids to review and determine service coverage requests. Providers can submit a non-covered code form for a review for general coverage for the service. The Board asked if weight loss medications, which are currently excluded from the VT Medicaid State Plan, were allowed through this process. DVHA noted that on rare occasion they did and also commented that DVHA saw an uptake in exception request for this drugs this during the last 4 months. This is a result of the cyberattack on Change Health Care which left them unable to process pharmacy PAs for 6 months. When the PA process was turned back on DVHA learned that many members had been started on weight loss medication without a PA in	

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		place. Consequently, the adults 21 and over who had been started on them were now submitting exception requests. For members under 21 DVHA looks at them through the lens of EPSDT. Significant comorbidities may see occasional approvals under EPSDT and less so for adults. The Board asked how frequently these submissions result in adding coverage for a service. DVHA explained that the non-covered code requests are submitted less frequently than specific exceptions requests. A Board member pointed out that there are likely more members who would be seeking coverage exceptions, but there are hurdles in place preventing them. DVHA shared that they are working a report for the January meetings that would outline considerations and decisions of the MDT.	
6. 2025 CURB Annual Workplan	Christine Ryan	DVHA presented the 2025 CURB Workplan for the Board. The proposed topics were as follows: • CURB Legislative Annual Report • Genetic Testing Prior Authorization Requirements • Palliative Care Proposal • Out of State Services • Utilization Data and Claims Review • Emergency Department Per Diem • Budget report • Legislative report • Comprehensive Pain Pilot • 2026 Clinical Practice Guidelines • AHEAD model update • HEDIS measures DVHA queried the CURB for suggestions on additional topics for inclusion in the 2025 CURB workplan. One member shared they appreciate when updates on past topics are brought to the agenda -- hearing the outcomes of past discussions would be a	

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		great addition. Another suggestion was raised about bringing subject guest speakers for certain topics when the Board does not have a member with the subject matter expertise to enhance discussions. DVHA agreed to review. DVHA noted that the OneCare ACO will not exist in 2026, and they will be working on fulfilling outstanding contracts. They expect to have more updates at future meetings. DVHA also noted there are likely to be updates regarding changes to federal government policies in the March and May meetings.	
7. Closing and Public Comments	Sandi Hoffman	No public comment was offered. The next meeting is to be held Jan 15th, 2025.	
Adjournment		Meeting adjourned at 8:12pm.	

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