VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

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

Board Members Present:

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

DVHA Staff Present:

✓	Christine Ryan, RN DVHA Clinical Services Team	✓	Michael Rapaport, MD DVHA Chief Medical Officer	✓	Josh Plavin, MD Associate Medical Director Comprehensive Pain Program, UVMMC
X	Addie Strumolo Acting DVHA Commissioner	✓	Ella Shaffer DVHA CST Admin Staff	✓	Erin Flynn Health Care Project Director, DVHA Payment Reform
X	Sandi Hoffman Deputy Commissioner				

Guests/Members of the Public: Margaret Haskins, Gainwell Representative; Amy Cunningham, Novo Nordisk representative; Corey Obrien, Novo Nordisk pharmacist

Topic	Presenter	Discussion	Action
Meeting Convened		The meeting was convened at 6:34 PM.	
1. Introductions and acknowledgements	Christine Dr. Rapaport	Introductions were given around the room. The minutes from January 17th were reviewed and approved. Dr. Rapaport gave an overview and update on the Change Health Care (CHC) cyberattack. DVHA was made aware of the attack on Feb 21st. Pharmacy claims processing and prior authorization capabilities were shut down as a result. DVHA leadership has conducted daily meetings to coordinate continuity of operations and mitigate impact. DVHA quickly proposed a plan to identify average weekly claims from pharmacists around the state and offered advanced payment based on this data from the past 6 months. CHC has since deployed a new claims processing environment. A cybersecurity contractor has verified the new environment is clean and, as of March 17th, CHC began processing claims again. Additionally, the cyberattack also affected the ability of some non-pharmacy providers to submit claims to DVHA, due to medical claims clearing houses and numerous claims processing modules owned and operated by CHC. Many non-pharmacy providers did not and still may not realize that they were affected, as they have no indication on their end that the submitted claims have not reached DVHA or other payers. Once DVHA became aware of the issue, they began outreach to all enrolled providers alerting them of the potential problem and developed a similar advanced payment. DVHA asked the Board to share this info with other providers as necessary as the exact affected population is unknown..	**Motion: Approve the January 17th minutes as presented** **Second: Green, Kloster, McIntosh, Riss** **Abstain: Horan** **Approved**

2. Comprehensive Pain Pilot	Dr. Josh Plavin	Dr. Josh Plavin, Associate Medical Director of the University of Vermont Medical Center (UVMMC) Comprehensive Pain Program, delivered a presentation about the Comprehensive Pain Program. DVHA is engaged in a pilot program during 2024 with UVMMC. The scope of the program revolves around the medical costs associated with chronic pain. Dr. Plavin cited a chronic paid prevalence rate of 20.5%, resulting in an estimated cost of $61.2 billion to the US economy annually. He explained that the bulk of the burden of care falls to primary care providers. The average age of the patient population was near 50 years and 2/3 of the population was female. Dr. Plavin framed the goals of the program for the Board, stating an intent to shift the paradigm of chronic pain from symptomatic to life experience. They focus on patient agency and self-efficacy, with a secondary goal to support their colleagues in primary care and specialty services. UVMMC partnered with Vermont BlueCross BlueShield (BCBS) for this program. The study was conducted as a closed cohort, 16-week trial with 12 patients per group. Patient groups attended weekly group sessions. An alternative program was offered as fee-for-service, but with reduced options due to coding differences. Dr. Plavin stressed that the program is not a support group but should be seen as a curriculum intended to be moved through. Data from the UVMMC program was presented to the Board. This data was pulled from 27 cohorts or about 300 patients enrolled in the program prior to this year. The methodology included pre-and-post surveys in several categories, including the PROMIS-29 questionnaire. Participants reported having less pain and interference with pain after program completion, with all measures except one showing significant improvement. Dr. Plavin reported a 12% reduction in total medical costs when	

		examining claims. DVHA initiated participation in a Medicaid pilot of the program with UVMMC starting in 2024. The funding is coming from the American Recovery and Reinvestment Act (ARRA) and must conclude by 12/31/24. The program will include no more than 100 patients, with eligibility based on priority populations. DVHA's primary goal with the pilot is to assess the impact on health outcomes and quality of life for members. Based on pilot outcomes, DVHA may pursue avenues to continue the program/add as a covered service. Erin Flynn, Health Care Project Director of the DVHA Payment Reform Unit, explained that this is a new frontier for DVHA, being the first program funded in this way. She acknowledged there are policy challenges ahead for DVHA as many of aspects of this program are not under the umbrella of what Medicaid has historically paid for. A key component in obtaining approval will be understanding what CMS requires. One board member asked if the therapists involved in the program were trained in spinal manipulation. Dr. Plavin explained that the occupational and physical therapists they employ are focused on a therapeutic approach that assists the patient with the apprehension of pain. The board member recommended including a physician trained in such manipulations in the future. A brief discussion ensued regarding the diagnosis of chronic pain. Dr. Plavin clarified that the term used in the report comes from a 2019 NHC report that identified prevalence. He stated that this is a self-reported condition and not a diagnosis. Another member asked for elaboration on the coordinated process of treatments as opposed to singular services. Dr. Plavin stated that social connection plays a big role in the program. The transdisciplinary component ensures that there is a community of providers at the same location who collaborate on the care that is being provided.	

		Dr. Plavin shared that there is no pediatric population yet. They expect the model to be different as the entire family needs to be considered for pediatrics. Dr. Rapaport expressed another goal for this pilot – the possibility of this service being recreated in other places in VT. He also stated that while that was one of the goals of the pilot, there are numerous health care services that Medicaid covers and which can only be accessed through hospitals like UVMMC. Dr. Plavin reported that when he was with VT BCBS, he reached out to other hospitals to gauge their interest in developing similar programs. He noted that Brattleboro Memorial Hospital and Springfield Hospital both expressed interest, but reported that because Medicaid members make up a significant portion of the populations they serve, it would not be economically feasible unless Vermont Medicaid was willing to provide coverage Dr. Plavin explained that a unique component of their program is the coordination of care that is often lost when providers refer patients for multiple services across different locations and facilities.	
3. Weight Loss Medications and Lifestyle	Dr. Rapaport	Prior to this meeting, DVHA circulated the executive summary for its Weight Loss Medications and Lifestyle project. Dr. Rapaport addressed the content of the summary for the Board. The report outlines that DVHA supports coverage for weight loss medication in a clinically appropriate and fiscally responsible manner and in conjunction with the following recommendations: • Treatment of obesity in accordance with national guidelines, which indicate comprehensive lifestyle intervention (behavioral modifications) as the recommended initial step. • Coverage of select medications, when utilized according to current treatment guidelines and FDA indications, including the use of lifestyle interventions in conjunction with the medications. • Additionally, DVHA urges healthcare leaders in the State to	**DVHA agreed to recirculate the report to the Board for review within the next week.**

		explore the development of comprehensive lifestyle programs for the treatment of obesity, to help reduce the need for lifelong medication use. DVHA stated that while they support the use of weight loss medications, the current budget cannot absorb the potential impact. DVHA explained that the cost could be $40-80 million depending on uptake by the population and final cost projections will be available soon. One Board member observed that other states are covering these medications with limitations. They noted that some payers offered coverage early-on but ended up with dramatic budget impacts. As a result, many are stepping back to explore lifestyle programs and other non-pharmacologic interventions. This member addressed the Novo Nordisk representatives in attendance regarding the cost of weight loss medications, stating that the cost is not in line with the Institute for Clinical and Economic Review (ICER) report. Novo Nordisk responded, saying that drug pricing is complex and the ICER report did not take all causes of obesity into account. When a board member asked if Nordisk would take on risk with VT and entering into a value-based agreement was proposed, Nordisk responded that that would be a question to take back to their team. The Board stressed that the discontinuation rate of these drugs is extremely high and wasteful. Novo Nordisk explained that they expect to see better adherence as more competitors come to market and the supply chain increases. Novo Nordisk summarized their position as wanting to focus on obesity as a chronic illness. They would be happy to work with VT to advance this and offered to provide DVHA with their financial modeling based on their predicted utilization in the Vermont Medicaid population. Another member asked if there are any pilot programs	

		examining lifestyle changes in support of weight loss drugs. A discussion broke out, with consensus being there are many studies that show that on-going support significantly improves adherence rates. It was noted that these programs are strict and require consistent engagement. Successful candidates may not need medication in the first place if they succeed in these programs. Novo Nordisk commented regarding the cost discussion. They claimed that the DVHA report did not consider rebates nor the effect of utilization management strategies. Other states with these drugs on the formulary saw 1-2% utilization in the first year. One Board member offered their experience with out of state coverage. Massachusetts is covering these medications but has forbade them from being covered within the 340b drug pricing program such that any rebates go to the state instead of the hospital. The Board discussed DVHA's incisive language in the report and whether it should be amended to indicate that DVHA would re-evaluate coverage within a specific timeframe. DVHA clarified that their intent is not to say that weight loss drugs would never be covered, but that there are many things that would need to be considered, such as the possible need for an increased appropriation in the budget to cover the medications, as well as the need for DVHA to be allowed to manage the drugs in a fiscally responsible manner. The Board supported the document language as it stands. The Board requested that the executive summary be forwarded again for review and approval within the next week.	
4. Mental Health Service Coverage for Social Determinants of	Christine	Christine shared a brief presentation outlining DVHA's intent to use a social determinants of health (SDOH) diagnosis code, Z71.9 "Counseling, unspecified," as a primary diagnosis for VT Medicaid beneficiaries under 21 receiving mental health	

Health		services. A member of the board suggested the code might be used until an accurate diagnosis could be made. DVHA clarified that the goal of this change would be to allow coverage for services without a specific mental health diagnosis going on the patient's record. DVHA acknowledged the importance of recognizing how SDOH can have a major impact on an individual's physical and mental health, wellbeing, and quality of life. DVHA shared that they are currently working on a guidance document with the Department of Mental Health (DMH) to confirm agreement that all concerns have been considered. This will be shared with the CURB once complete. The Board asked about telemedicine policies for out-of-state providers, recommending that this policy be limited to in-state providers to avoid potential fraudulent use. Another member proposed there be no age limit and instead utilize a numerical limit of 3-5 visits.	
5. CURB Meeting Survey Review	Dr. Rapaport	DVHA circulated a survey regarding the duration and frequency of CURB meetings. Limited feedback was gathered at the time. Dr. Rapaport proposed that DVHA could collect comments from the Board beforehand regarding agenda topics. DVHA could then provide concise and efficient addresses for concerns and comments. Discussion broke out pertaining to the duties of the CURB and how meeting time is best utilized. The Board agreed that knowing the agenda topics ahead of time is important to be able to prepare. They asked that DVHA provide a summary of topics and voting proposals before each meeting, allowing time for the Board to better prepare.	**DVHA will prepare summaries of agenda items for Board distribution before future meetings.**

6. Closing		No public comments were offered.	
Adjournment		Meeting adjourned at 8:45pm.	