VERMONT
DEPARTMENT OF VERMONT HEALTH ACCESS

Standard Operating Procedure

Title: Team Care (Patient Review and Restriction Program)

Issuance Date: April 13, 2023

(Must be reviewed annually)

Applicable Regulations, Guidelines, and AHS Policy:

Federal statute or rule:

42 CFR 431.54(e)

Vermont statute or rule:

7107.1 Beneficiary Abuse (12/1/80, 80-62)

Purpose:

Federal Medicaid Law (42 CFR 431.54 (e)) guides Vermont's Policies regarding members who over-utilize or misuse Medicaid services. It states "[i]f a Medicaid agency finds that a recipient has utilized Medicaid services at a frequency or amount that is not medically necessary, as determined in accordance with utilization guidelines established by the State, the agency may restrict that recipient for a reasonable period to obtain Medicaid services from designated providers only. The agency may impose these restrictions only if the following conditions are met:

1. The agency gives the recipient notice and opportunity for a hearing in accordance with proceduresestablished by the agency before imposing the restrictions.
2. The agency ensures that the recipient has reasonable access, considering geographiclocation and reasonable travel time, to Medicaid services of adequate quality."

The Team Care Program is designed to:

1. Ensure appropriate utilization, eliminate misuse and abuse of covered health care services and benefits.
2. Improve coordination and quality of care by minimizing duplicate and inappropriate drug utilization.
3. Establish a method of monitoring non-emergency health care services for members who have utilized these services at a frequency or in an amount that is

not medically necessary, as determinedby current medical practice.
4. Monitor use of regulated medication for members who have utilized medications at a frequencyor amount that has not been proven to be efficacious.
5. Identify excessive prescribing patterns.

Procedure:

The Team Care Program structure requires members to have a limited team of designated prescribing providers including one primary care provider, with covering and specialty care providers as needed. Additionally, the member has one designated pharmacy to dispense all medications. Referrals can come from:

- Providers,
- pharmacists,
- family members,
- care coordinators,
- law enforcement agencies,
- other state agencies, and
- individuals in the community.

Referrals may be anonymous. There is a Team Care referral form that is utilized to begin the review process to determine eligibility for enrollment in the Team Care program. Final determinations of enrollment are not communicated to the referral source to protect member confidentiality.

Team Care Criteria:

The following criteria is considered in making decisions for new or continued enrollment in the Team Care program:

- High emergency department usage or ED visits at multiple hospitals,
- Duplication of services when received from more than two providers,
- Use of multiple pharmacies,
- Multiple prescribers of controlled substances,
- Evidence of poorly coordinated health care services (e.g., lack of primary care provider).

Clinical judgement is utilized for enrollment decisions. Claims data are reviewed by a CIU Review Care Manager and then by the CIU manager. All reviewers are licensed clinical mental health professionals. Claims are reviewed including pharmacy, emergency department, and other relevant claims data. Additionally, clinicians may seek consultation with a potential member's current treatment providers before deciding enrollment.

General Information:

1. Overutilization patterns are identified through claims data, Business Objects reports, and/or referrals. Data mining for potential new Team Care members is done annually or as needed for referrals.
2. Team Care program clinicians review claims data to determine enrollment.
3. If enrolled, the new member is notified via certified mail. The member has an option to appeal enrollment. Members have **15 business days of receipt of enrollment notification** to appeal the decision.
4. Team Care enrollment includes the identification of a primary pharmacy and a primary care physician. Physicians, nurse practitioners or physicians' assistants providing coverage within the same practice are assigned along with the PCP.
5. Enrollment in the Team Care program is a minimum of 12 months.
6. Continued Team Care enrollment is reviewed annually. After 12 months have elapsed, members may request to be disenrolled from the program, prompting an updated clinical review. For members to disenroll they must meet the following criteria:
   - Overutilization or misuse has ceased.
   - Claims data demonstrates sustained compliance for a minimum of 12 consecutive months.
   - Member meets exclusionary enrollment criteria such active cancer treatment.
7. VCCI referrals are made when appropriate.

Documentation Requirements:

1. A thorough assessment of all documentation pertaining to enrollment in Team Care is reviewed by a licensed clinician. The analysis is documented and maintained in the member's file.
2. A Team Care Enrollment Evaluation Worksheet is utilized. Included are the relevant claims data reports, the reviewer's recommendations, and final determination.
3. Members meeting criteria for enrollment receive an Enrollment Notice via certified mail explaining theprogram. The members are expected to contact Team Care Program with their choices for designated providers and pharmacy. If the member does not respond within 15 business days, a follow up notification with assigned providers will be sent via certified mail.
4. Assignment notices may also be sent as needed to the designated pharmacy, physician and any specialist thatmay be assigned to the member designated team.

Entering Team Care Information:

Review Care Managers have access to Vermont's Pharmacy Benefit Management (PBM) portal for addingand restricting services.

Changing Team Care Providers:

Members wishing to change designated PCP or pharmacy, or add a specialist, must write to the Team Careprogram, or call the Team Care program. The Team Care phone number is included in all correspondence, on the DVHA website and in the Team Care brochure. Approved changes are documented in the member's file and updated in the PBM portal.

Emergency Department Physicians:

ED physicians are added only in rare circumstances and based on a medically emergent need. All decisions are documented in the member's file.

Specialty Care Providers:
Members may have ongoing specialty care providers added to their Team Care provider list such as OBGYN, cardiology and others. Time limited providers such as surgeons and dentists will be added to the team for a brief period as appropriate to the services received.

Health care coverage ends:

If there is a lapse in Medicaid coverage for greater than six months, the member's Team Care enrollment will end. If the member Medicaid coverage is later reinstated, they will need to meet criteria for reenrollment in Team Care.

Pharmacy:

Additional pharmacies may be added in time limited situations such as:

- The member is out of town and emergency need arises,
- The pharmacy is out of specific medication.

Discontinuing Team Care:

Once a member has been disenrolled from the Team Care program records will be preserved in the Team Care Program folder within the DVHA shared drive.

Vermont Prescription Monitoring System (VPMS):

The VPMS is a web-based application used by pharmacists and prescribers. The database shows the sale of all controlled substances in Vermont. The purpose of the database is to help physicians provide betterpatient care and to reduce the danger of addiction, overdose, or diversion. Data includes prescribing physician, type of drug,

dosage, date, and the pharmacy where the prescription was filled. The Team Care program clinicians do not have access to VPMS but can request this information from the DVHA Chief Medical Officer on a case-by-case basis when conducting a review.

Revision History:

Date	Summary of Revisions
06/26/2018	First Draft.
09/24/2018	Final Draft.
12/13/2021	Revision.
02/14/2022	Revision/Reformat .
3/10/2022	OMU review, formatting changes for ADA.

Table 1 Revision History