State of Vermont
Agency of Human Services
280 State Drive, Center Building
Waterbury, VT 05671-1000

Global Commitment Register

October 17, 2017

Below please find 5 GCR policies that have been posted to the DVHA website since September 18, 2017 (in chronological order):

- 17-061: RBRVS Fee Schedule Update and Policy Changes (final)
- 17-062: Women's Health Initiative Expansion to Primary Care Providers (proposed)
- 17-063: Inpatient Postpartum LARC Add-on Increase (proposed)
- 17-072: Telemedicine (proposed)
- 17-067: Digital Breast Tomosynthesis – 3D Mammography (proposed)

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Global Commitment Register

September 20, 2017

GCR 17-061
FINAL

RBRVS Fee Schedule Update and Policy Changes

Policy Summary:

The Department of Vermont Health Access (DVHA) amended its Medicaid State Plan reimbursement methodologies for its Resource-Based Relative Value Scale (RBRVS) payments, including changes related to separate rates for eligible primary care providers.

This policy summary includes the following key provisions which are effective August 1, 2017:

1. DVHA increased the rate paid to eligible primary care providers and services to equal the Medicare calendar year (CY) 2017 payment rates. This conversion factor was formerly called an Enhanced Primary Care Payment, or EPCP. Specifically, the DVHA primary care conversion factor (CF) increased from $32.58 to $35.89, equal to 100% of Medicare's current CY 2017 CF. The total net increase in spending on eligible primary care providers is estimated to be approximately $1.6 million.

2. DVHA did not change the standard CF (i.e., the non-primary care eligible CF) for services and providers at this time such that it will remain at $28.71, or 80% of Medicare.

3. In keeping with its process of using the best available data and alignment with Medicare, DVHA adopted the CY 2017 Medicare relative value units (RVUs) which form the basis of RBRVS payments and reflects most recent data published by the Centers for Medicare and Medicaid Services (CMS). The impact of updates to the new RVUs to providers was a slight overall increase of 0.1%, weighted towards evaluation and management services.

4. DVHA updated the geographic practice cost indices (GPCIs) as well to reflect current CY2017 Medicare values and retain a floor of 1.0 for the physician work component. The practice expense GPCI is now 1.015 compared to 1.004 and the liability decreased from 0.682 to 0.595.

5. Program updates include the following:
   1) Updates to discounting policies for non-physician services. DVHA will discount all RBRVS services rendered by nurse practitioner and physician assistants consistent with Medicare policy and regardless of whether eligible for the primary care rate.

Medicare's policy is that 100% RBRVS payment is based on care provided by a physician and thus, it discounts non-physician clinician services.

2) Updates to reflect site of care differentials in primary care rate. DVHA will pay the appropriate primary care rate based on the site of care on the claim in the same manner it would a non-primary care rate-eligible service.
3) Updates to the list of services eligible for the primary care rate. DVHA will revise list of eligible primary care services to exclude those with little to no volume or identified as not directly in support of targeted primary care services as well as updates the process for providers to become eligible through attestation. Refer to Table 1 for a summary of changes and list of included services.

This amendment to the Medicaid State Plan is being done through Global Commitment to Health waiver authority, where DVHA may establish rates with providers on an individual or class basis without regard to the rates currently set forth in the approved State Plan.

Effective Date:
August 1, 2017

Authority/Legal Basis:
Global Commitment to Health Waiver: Waiver authority #5 [Section 1902(a)(13), 1902(a)(30)]; Special Term and Condition #28.

Population Affected:
All Medicaid

Fiscal Impact:
The estimated net annual fiscal impact of this proposed policy net of program changes is $926,752. The targeted estimated annual fiscal impact to services and providers eligible for the primary care conversion factor is $1,569,892. Refer to Table 2 for a comparison of the estimated payments under the August 1, 2017 changes compared to an estimated SFY2017 baseline.

Public Comment Period:
The public comment period was 7/19/17 – 8/19/17. Comment/response can be viewed here.

Additional Information:

Click here for the updated State Plan on the DVHA website.

The following State Plan page was amended:

- Attachment 4.19-B page 10 was amended

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Global Commitment Register

September 22, 2017

GCR 17-062
PROPOSED

Women's Health Initiative Expansion to Primary Care Providers

Policy Summary:

The Blueprint for Health, a program of the Agency of Human Services (AHS), is expanding the Women's Health Initiative (WHI) recurring per member per month (PMPM) payments to Blueprint primary care providers (PCPs) who implement the WHI strategies. Through the WHI, these providers will provide enhanced health and psychosocial screening along with comprehensive family planning counseling that emphasizes the effectiveness of different birth control options and same-day insertion for women who choose long acting reversible contraceptives as their preferred method of birth control. Payments will support effective follow-up to provider screenings through brief, in-office intervention and referral to services for depression, substance abuse, intimate partner violence, food, and housing. For the first 12 months of participation in the program, practices will be paid a $1.25 PMPM on Medicaid beneficiaries seen in the past two years; in subsequent years of participation, practices will be paid a base payment of $1.00 PMPM plus a quality payment of up to $0.50 PMPM based on performance measures. The WHI will work to ensure participating providers have the resources they need to help women be well, avoid unintended pregnancies, and build thriving families.

Effective Date:
October 1, 2017

Authority/Legal Basis:
Global Commitment to Health 1115 Waiver. Waiver authority #5 [Section 1902(a)(13), 1902(a)(30)]; Special Term and Condition #28.

Population Affected:
Female patients 15 – 44 years old with Vermont Medicaid as primary payer or dual-enrolled in Medicare and Medicaid without having a commercial insurer as the primary payer.

Fiscal Impact:
The estimated budget impact for the first year of this expansion is $400,000. The estimated impact for subsequent years is $480,000.

Public Comment Period:
9/22/17 – 10/22/17

Send comments to:
AHS Medicaid Policy Unit
280 State Drive, Center Building
Waterbury, VT 05671-1000

Or submit a comment via e-mail.

There is no public meeting scheduled at this time. If one should be scheduled, that information can be found at the DVHA website either through the calendar or listed under upcoming events.

Additional Information:

- The Vermont Blueprint for Health is a state-led, nationally-recognized initiative transforming the way primary care and comprehensive health services are delivered and paid for. More information about the Blueprint can be found by visiting the Blueprint for Health website.

- Women's Health Initiative section in the Blueprint Manual

- WHI attestation document for Blueprint providers

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Global Commitment Register

September 22, 2017

GCR 17-063
PROPOSED

Inpatient Postpartum LARC Add-on Increase

Policy Summary:

The Agency of Human Services (AHS) is proposing to increase the inpatient postpartum long-acting reversible contraceptive (LARC) add-on to $800. Currently, the Vermont Medicaid LARC add-on rate is $200. Increasing the add-on payment to $800 will create a financial incentive for providers to offer postpartum LARC insertion in the inpatient setting and will overcome the cost related barriers of the devices.

Effective Date:
October 1, 2017

Authority/Legal Basis:
Global Commitment to Health Waiver: Waiver authority #5 [Section 1902(a)(13), 1902(a)(30)]; Special Term and Condition #28.

Population Affected:
All Medicaid

Fiscal Impact:
The estimated annualized budget impact is $34,864.

Public Comment Period:
9/22/17 – 10/22/17

Send comments to:

AHS Medicaid Policy Unit

280 State Drive, Center Building
Waterbury, VT 05671-1000

Or submit via e-mail to AHS.MedicaidPolicy@vermont.gov.

There is no public meeting scheduled at this time. If one should be scheduled, that information can be found at: http://dvha.vermont.gov/ either through the calendar or listed under upcoming events.

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Global Commitment Register

September 25, 2017

GCR 17-072
PROPOSED

Telemedicine

Policy Summary:

The Agency of Human Services (AHS) is proposing to expand telemedicine services to align with Act 64 (S.50) from the 2017 legislative session. Currently, Vermont Medicaid reimburses for telemedicine services provided facility to facility, or in the case of primary care services, facility to community/home.

Effective October 1, 2017, Vermont Medicaid will broaden its telemedicine policy to include the reimbursement of existing Medicaid covered services outside a facility as long as it is clinically appropriate and within the Medicaid provider's licensed scope of practice. Providers are expected to adhere to the same program restrictions, limitations and coverage which exist for the service when not provided through telemedicine; this includes prior authorizations. Vermont Medicaid will not reimburse distant site providers if there is insufficient information to render a clinical decision. Additional information for providers can be found below.

Effective Date:
October 1, 2017

Authority/Legal Basis:

- Medicaid State Plan
- Act 64 of the 2017 Vermont Legislative Session

Population Affected:
All Medicaid

Fiscal Impact:
No fiscal impact.

Public Comment Period:
9/25/17 – 10/25/17

Send comments to:
AHS Medicaid Policy Unit

280 State Drive, Center Building
Waterbury, VT 05671-1000

Or submit via e-mail to AHS.MedicaidPolicy@vermont.gov.

There is no public meeting scheduled at this time. If one should be scheduled, that information can be found at: http://dvha.vermont.gov/ either through the calendar or listed under upcoming events.

Additional Information:

Qualified Providers shall:

(a) Meet or exceed applicable federal and state legal requirements of medical and health information privacy, including compliance with HIPAA.

(b) Provide appropriate informed consent to include:

(1) Identifying the patient, the physician and the physician's credentials; and
(2) The types of transmissions permitted using telemedicine technologies; and
(3) The Patient agrees that the physician determines whether or not the conditions being diagnosed and/or treated is appropriate for a telemedicine encounter; and
(4) Details on security measures taken with the use of telemedicine technologies; and
(5) Disclosure to the patient that information may be lost due to technical failures; and
(6) Requirement for express patient consent to forward patient-identifiable information to a third party.

(c) Take appropriate steps to establish the physician-patient relationship and conduct all appropriate evaluations and history of the patient consistent with traditional standards of care.

(d) Maintain medical records for all telemedicine patients that are consistent with established laws and regulations governing patient health care records.

(e) Establish an emergency protocol when care indicates that acute or emergency treatment is necessary for the safety of the patient.

(f) Ensure continuity of care for patients.

(g) Uphold patient safety in the absence of a traditional physical examination if prescriptions are contemplated.

In order for providers to bill for services delivered through telemedicine they must follow the billing procedures below:

- Use a 'GT' modifier (via interactive audio and video telecommunications systems) with the code for the service(s) provided to indicate the services were not delivered face to face.

- Indicate place of service (POS) code'02' (telehealth).

- Procedure Code Q3014 and POS code '02' must be used by the originating site (location of the patient) to be reimbursed the site facility fee of $16.00. If the provider and the originating site facility are both employed by the same entity, providers cannot bill for this service.

Information on expanded telemedicine services will be available in the Medicaid Provider Manual by October 1, 2017.

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Global Commitment Register

October 4, 2017

GCR 17-067
PROPOSED

Digital Breast Tomosynthesis – 3D Mammography

Policy Summary:

The Agency of Human Services (AHS) is adding digital breast tomosynthesis (also known as 3D mammography) as a Medicaid covered service. The National Comprehensive Cancer Network (NCCN) recommends 3D mammography as an adjunct to digital (2 dimensional) mammography. This service will allow for more accurate screenings for breast cancer and help to eliminate call back screening. 3D mammography will not require prior authorization.

Effective Date:
November 1, 2017

Authority/Legal Basis:
Medicaid State Plan

Population Affected:
All Medicaid

Fiscal Impact:
The estimated gross annualized budget impact is $61,070.40.

Public Comment Period:
10/4/17 – 10/31/17

Send comments to:

AHS Medicaid Policy Unit

280 State Drive, Center Building
Waterbury, VT 05671-1000

Or submit via e-mail to AHS.MedicaidPolicy@vermont.gov.

There is no public meeting scheduled at this time. If one should be scheduled, that information can be found at: http://dvha.vermont.gov/ either through the calendar or listed under upcoming events.

Additional Information:

Per National Correct Coding Guidelines, G0279 is an add-on code that can only be billed when also billing G0204 or G0206.