Report to
The Vermont Legislature

Clinical Prior Authorization Requirements in the Vermont Medicaid Program: Findings and Recommendations

In Accordance with Act 140 (H.960) of 2020

Submitted to: The House Committee on Health Care
The Senate Committee on Health and Welfare
The Senate Committee on Finance
The Green Mountain Care Board

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VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

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EXECUTIVE SUMMARY

Act 140 of 2020, An act relating to miscellaneous health care provisions, required the Department of Vermont Health Access to review requirements for clinical prior authorizations in the Vermont Medicaid program and report the findings and recommendations resulting from that review to the House Committee on Health Care, Senate Committees on Health and Welfare and Finance, and Green Mountain Care Board on/before September 30, 2021.

This report provides an overview of the Department's activities related to the review of clinical prior authorizations in the Vermont Medicaid program, includes findings and recommendations on the outcomes of the prior authorization waiver under the Vermont Medicaid Next Generation Accountable Care Organization (ACO) program and in consideration of payer alignment, the denial rates of prior authorization requests, the potential for harm in the absence of a prior authorization requirement, the consequences of waiving clinical prior authorization requirements and exempting providers from requirements, and the feedback needed to capture provider and member perspectives. Finally, the report also includes consideration of State and federal approvals that would be necessary to make changes to existing requirements for clinical prior authorizations. A summary of the key takeaways from this report on the Department's review of clinical prior authorizations in the Vermont Medicaid program are as follows:

- As a managed care-like entity, the Department is responsible for efficiently managing public resources while providing access to health care services in the State, and one tool it uses to do so is prior authorization.
- There is an active waiver of prior authorization through the Vermont Medicaid Next Generation ACO program, and the Department has explored modifying prior authorization requirements at the payer level to more closely align with that waiver where appropriate.
- The Department formed a work group of various subject matter experts in February of 2021 to examine categories of health care services and issue recommendations on modifications of prior authorization requirements for those services.
- Based on that work group's findings, the Department is recommending changes to prior authorization requirements in the following areas: high tech imaging, durable medical equipment/supplies/prosthetics/orthotics, dental services, physical, occupational, and speech therapies, out-of-network services, chiropractic services, high-dollar services, and imminent harm codes.
- The Department will need to continue to gather stakeholder feedback on these

recommendations, seek State and federal approval where necessary for any modifications to its prior authorization rules, determine how to operationalize any modifications in its claims processing system, and conduct outreach, education, and communication to providers and members prior to implementing changes.

- The work group that issued these recommendations will continue to meet on a quarterly basis to monitor utilization, examine additional categories of service, and recommend further adjustments to prior authorization requirements where necessary.

BACKGROUND

In accordance with Section 12 of Act 140 (2020), the Department of Vermont Health Access was required to review clinical prior authorizations in the Vermont Medicaid program and report the findings and recommendations resulting from that review to the House Committee on Health Care, Senate Committees on Health and Welfare and Finance, and Green Mountain Care Board on/before September 30, 2021.

This report provides a summary of findings and recommendations from the Department of Vermont Health Access regarding prior authorization requirements for the Medicaid program and proceeds in sections. The first section provides an introduction to prior authorization and its history as a tool in payer programs for utilization management. The second section outlines and describes the prior authorization waiver within the Vermont Medicaid Next Generation Accountable Care Organization (ACO) program and associated findings. The third section describes the work group activity and processes that were conducted to analyze current prior authorization requirements and determine whether changes should be made. The fourth section discusses the recommendations resulting from the findings of the review. The final section outlines the processes and approvals needed to implement the recommended changes to the Department's clinical prior authorization requirements.

PRIOR AUTHORIZATION IN VERMONT MEDICAID

Prior Authorization for Utilization Management

The Department of Vermont Health Access operates as the State of Vermont's sole Medicaid managed care-like entity, and as such it is responsible for administering the State's Medicaid program as a non-risk pre-paid inpatient health plan (PIHP). The Vermont General Assembly has authorized the Department of Vermont Health Access to serve as a publicly

operated managed care organization in order to manage public resources effectively while preserving and enhancing access to health care services in the State (33 V.S.A. § 1901(d)(1)).[1] Prior authorization (also called preauthorization, prior approval, or precertification) is one tool used by Medicaid and other payers to manage costs while maintaining access to limited resources. Prior authorization is generally defined as a decision process by a payer that a health care service, treatment plan, prescription drug, or durable medical equipment ordered by a provider is deemed medically necessary and thus qualifies for payment. [2] Before rendering a service that requires prior authorization, providers must submit clinical documentation to the payer, who then conducts a clinical review to determine whether the proposed service is both clinically appropriate and the least costly option available through that payer. An assessment of State Fiscal Year 2018 estimated that prior authorization and clinical review processes saved the Department of Vermont Health Access approximately $4.8 million.

Prior Authorization to Improve Outcomes

Though prior authorization is a prominent lever used by payers to effectively manage costs, it is also used by payers like the Department of Vermont Health Access as a mechanism to ensure the safety of its members and to prevent imminent harm from occurring, as well as to uphold clearly established standards of care. For example, prior authorization and clinical review are required for complex durable medical equipment (DME) to ensure that equipment such as wheelchair and hospital beds are fitted properly to the member to avoid injury or other negative outcomes. Prior authorization is also used to ensure adherence to criteria for procedures that are appropriate for very specifically defined clinical conditions, such as low-dose computer tomography (CT) scans for certain types of lung cancer. Other secondary outcomes from the prior authorization process include the discovery of fraud, waste, or abuse, findings of quality of care issues, and addressing access issues (such as arranging transportation for out of state care).

VERMONT MEDICAID NEXT GENERATION PRIOR AUTHORIZATION WAIVER

Vermont Medicaid Next Generation ACO Program Prior Authorization Waiver and Evolution

Beginning in 2017, the Department of Vermont Health Access implemented a waiver of prior authorization through its Vermont Medicaid Next Generation Accountable Care

[1] 33 V.S.A. § 1901

[2] Preauthorization: https://www.healthcare.gov/glossary/preauthorization/ (accessed August 24, 2021).

Organization (ACO) program, negotiated with Vermont's Accountable Care Organization, OneCare Vermont. As an incentive for participation in this voluntary risk-based ACO model, providers would no longer need to seek prior authorization from the Department for services that fall under the ACO's Total Cost of Care (TCOC), as long as the member in question was attributed to the ACO and both the referring and rendering providers participated in the ACO.[3] Because the Department would pay a fixed prospective per-member-per-month payment to the ACO for each attributed Medicaid member to cover the cost of medical care by its provider network and because the ACO would assume risk for the services included in its Total Cost of Care, the parties negotiated a waiver of prior authorization for those services, members, and providers. In addition to incentivizing participation, the intent of the waiver was to decrease administrative burden while empowering providers to follow best practices and determine appropriate care for their patients. The Department implemented systems changes to its Medicaid Management Information System (MMIS) claims processing system to operationalize this change, and OneCare Vermont provided communication and education to its provider network regarding the waiver and its criteria.

As with many other components of the VMNG program, incremental improvements were made to the prior authorization waiver based on feedback and learnings from internal stakeholders as well as from OneCare, its provider network, and the Vermont Medicaid provider network as a whole. Beginning in 2018, modifications were made to no longer require provider participation in the VMNG program to qualify for the waiver, such that the waiver would follow the Vermont Medicaid member through the health care system, which would more meaningfully reduce administrative burden and confusion among providers, particularly for referrals. Beginning in 2019, additional modifications were made to the Medicaid Management Information System claims processing system to allow the waiver of service limits (limits on the number of visits a member can have in a defined period of time), the authorization of which follows an approval process similar to that of prior

[3] Services included in the ACO's Total Cost of Care (TCOC) that qualify for the Prior Authorization waiver roughly correspond to Medicare Parts A and B-like services, and include inpatient hospital services, outpatient hospital services, physician services (primary care and specialty), nurse practitioner services, ambulatory surgical center services, federally qualified health center and rural health clinic services, home health services, hospice services, physical, occupational and speech therapy services, chiropractor services, audiology services, podiatrist services, optometrist and optician services, independent laboratory services, mental health and substance abuse services funded by the Department of Vermont Health Access (and not funded by other State of Vermont departments), ambulance transport both emergent/non-emergent, durable medical equipment, prosthetics and orthotics (except eyewear), medical supplies, dialysis facility services, preventive services, some physician administered drugs, and dental services billed on institutional claims.

authorization. Throughout the life of the prior authorization waiver, certain procedure codes in the ACO's Total Cost of Care have remained on the Department's imminent harm code list and will always require prior authorization to ensure the safety of its members.

Further underscoring the need for continuous evaluation and improvement to the prior authorization waiver is the fact that a greater and greater proportion of the eligible Medicaid membership has become attributed to the Vermont Medicaid Next Generation ACO program over time (see Table 1). Through its development of a more inclusive attribution methodology, the Program's attributed membership grew from approximately 21% of attribution-eligible members in 2017 to approximately 88% of eligible members in 2020, decreasing slightly to approximately 81% in 2021. The Department will continue to implement prior authorization waiver improvements to the waiver that are aligned with overall Medicaid policy and are operationally feasible.

Table 1: VMNG Program Growth (2017- 2021)

	2017 Performance Year	2018 Performance Year	2019 Performance Year	2020 Performance Year	2021 Performance Year
Health Service Areas	4	10	13	14	14
Provider Entities	Hospitals, FQHCs, Independent Practices, Home Health Providers, SNFs, DAs, SSAs				
Unique Medicaid Providers	~2,000	~3,400	~4,300	~5,000	~4,800
Attributed Medicaid Members	~29,000	~42,000	~79,000	~114,000	~111,000
% of Eligible Members Attributed	~21%	~31%	~56%	~88%	~81%

Lessons Learned and Findings

In addition to decreased administrative burden and enhanced provider empowerment, the Vermont Medicaid Next Generation waiver of prior authorization has been used as a pilot to test whether relaxed prior authorization requirements have an impact on Medicaid utilization and cost and to evaluate what changes are operationally feasible for the Department. Though there were generally no negative impacts on utilization of services through the prior authorization waiver, there have been several challenges and opportunities for improvement in the prior authorization waiver's implementation. These include:

Shifted administrative burden. Though the waiver of prior authorization seeks to decrease the burden of seeking prior authorization for ACO-attributed members for providers in the ACO's network, it shifted that burden both onto the payer and onto providers outside of the

ACO network. It has been operationally difficult for the Department to implement processes to determine which prior authorization requests received are necessary, which qualify for the prior authorization waiver, and to then communicate back to certain providers that prior authorization is not necessary in some instances. It is also burdensome on providers, especially those outside of OneCare's network (and outside of Vermont) to determine whether to submit prior authorization requests to the Department for services for Vermont Medicaid members. The Department has produced policy clarifications, provider communications and education materials, and updated the member eligibility verification system in its provider portal to include ACO attribution status for members, but provider confusion remains an issue. Additionally, providers have expressed frustration that some Medicaid members in their panels qualify for the waiver, and some do not, resulting in two sets of business processes and requirements for practices.

Gaps in care coordination and transitions of care. One of the benefits of the prior authorization process is that it serves as a communication and care coordination tool between providers and payers around transitions of care (admissions, discharges, and referrals), both for in-network and out-of-network care. Because out-of-network elective inpatient stays and elective outpatient office visits no longer require prior authorization for certain members, members could be admitted to out-of-network facilities and potentially be lost to follow-up when they transition back to in-network care. Referring providers also have difficulty determining if an out-of-network facility or provider is enrolled in Vermont Medicaid and therefore eligible to be paid by the Department of Vermont Health Access, as they are no longer required to seek approval from the Department for out-of-network stays. The Department is working to address these gaps in care coordination, transitions in care, and communication, particularly around out-of-network care, by developing workflows and joint communications through regular clinical leadership meetings with OneCare. The Department will explore development of a supportive clinical liaison role to leverage its clinical expertise and work with OneCare to ensure complex medical services are well coordinated, and to address medical necessity, access, fiscal, and policy considerations.

Confusion around the waiver in the context of the Department's coverage guidelines and rules. Though prior authorization is primarily a utilization management tool, it serves other functions and is a useful system check at the payer level to ensure provider adherence to other important requirements. Concerns have been raised that the waiver of prior authorization could be erroneously interpreted as waiving other requirements, including coverage policies, medical necessity requirements, billing requirements, and correct coding requirements of the Department of Vermont Health Access. The Department has issued policy clarifications and other provider communication to more precisely articulate the

scope of the prior authorization waiver within the Department's coverage guidelines and rules, which has decreased the volume of provider questions around the prior authorization waiver itself.

The waiver of prior authorization in the Vermont Medicaid Next Generation ACO program has shown promise in reducing administrative burden in some instances while having little negative impact on cost and utilization for the Department as a payer. Because the Vermont Medicaid Next Generation program has demonstrated significant growth and a greater and greater proportion of its members qualifying for the waiver of prior authorization year over year, a single set of rules around prior authorization for Medicaid is crucial to decrease confusion and reduce administrative burden both on providers and the Department.

PRIOR AUTHORIZATION ANALYSIS AND WORK GROUP

The Evolution of the Department's Prior Authorization Approach

Beginning in 2019, the Department's Clinical Services Team began exploring mechanisms of clinical review other than prior authorization given that a large proportion of the eligible Medicaid population began to be attributed to the Vermont Medicaid Next Generation ACO program and therefore qualified for a waiver of prior authorization for a number of services. These mechanisms included concurrent review, which is used while a service is being provided to determine if the member continues to meet criteria of care for their level of acuity, and retrospective clinical audits, which are conducted after a service has been provided to determine appropriate care. The Department's Clinical Services Team also began exploring modifications to its prior authorization requirements which included removing requirements for prior authorizations that had marginal value, retaining requirements for prior authorizations that had established value, remodeling requirements for prior authorizations that had potential value, and restructuring its utilization management processes.

Prior Authorization Recommendation Work Group Analysis and Criteria

The Clinical Service Team's activities around prior authorization analysis became increasingly prominent beginning in 2019, as the Vermont Medicaid Next Generation program grew and the majority of eligible Medicaid members became attributed to the Program and qualified for its prior authorization waiver. The increased attribution corresponds to a marked decrease in the number of prior authorization requests received by the Department's Clinical Services Team beginning in 2019, though caution must be exercised when drawing conclusions regarding 2020 claims data, given the ongoing impact

of the federal COVID-19 public health emergency on Medicaid utilization and the public health emergency-related waiver of prior authorization for certain services (see Table 2 below).

Table 2: Volume of Department of Vermont Health Access Prior Authorization Requests (2016 - 2020)

	Year				
	2016	2017	2018	2019	2020
	Count	Count	Count	Count	Count
January	1,627	1,690	1,732	1,376	998
February	1,679	1,727	1,642	1,294	845
March	1,894	1,935	1,915	1,420	699
April	1,704	1,615	1,850	1,466	356
May	1,524	1,849	1,665	1,463	295
June	1,711	1,821	1,703	1,350	424
July	1,493	1,437	1,805	1,365	469
August	1,759	1,775	1,874	1,285	301
September	1,554	1,694	1,699	1,223	320
October	1,834	1,875	1,900	1,396	341
November	1,652	1,731	1,650	1,065	306
December	1,597	1,521	1,396	1,043	336
Total	**20,028**	**20,670**	**20,831**	**15,746**	**5,690**

A multi-disciplinary work group was formed within the Department to examine utilization data and make recommendations regarding the modification of prior authorization requirements for certain categories of clinical services. The work group consisted of staff representing the Department's Clinical Services Team, Quality and Clinical Integrity unit, Payment Reform unit, Data unit, the Chief Medical Officer, and the Department's Commissioner's Office. The group met over 6 months beginning in February of 2021 and conducted analyses to issue findings and recommendations around prior authorization requirement modifications for the following categories of service and code groups:

- High tech imaging;
- Durable medical equipment/supplies/prosthetics/orthotics;
- Dental services;
- Physical, occupational, and speech therapies;
- Out-of-network (OON) services;
- Chiropractic services;

- High dollar services; and
- Imminent harm codes.

The work group focused on the above categories of service and code groups based on a set of criteria it developed at its first meeting. These criteria included:

- General alignment with services in the ACO's Total Cost of Care: The work group focused on the categories of service that fall under the Vermont Medicaid Next Generation program in an effort to bridge the gap between the ACO-attributed and non-ACO-attributed populations and define one clear set of prior authorization rules for those services;
- Availability of reliable data, such as utilization, cost, and denial rate information: The work group took a data-driven approach to issuing recommendations by reviewing and analyzing its claims and internal tracking data as well as leveraging information from WorkBenchOne (OneCare's analytics platform), when available, in order to make the most informed decisions around recommendations;
- Potential opportunities for cross-payer collaboration in aligning coverage policies that would reduce confusion and administrative burden on the provider community;
- Acknowledging best clinical practices where they exist based on evidence-based literature; and
- Availability of prior authorization information from other states' Medicaid programs: When available, the work group examined Medicaid policies and requirements from comparable, rural states around certain categories of service to gauge whether it could leverage prior authorization best practices from these states.

Certain services were not deemed to have met these criteria as closely, and included, for example, outpatient visits, genetic testing, certain surgeries, drugs, and sleep studies, as well as categories of service for which the Department does not require prior authorization or service limits. Some of these services will be examined in subsequent rounds of analysis for future prior authorization requirement modification recommendations.

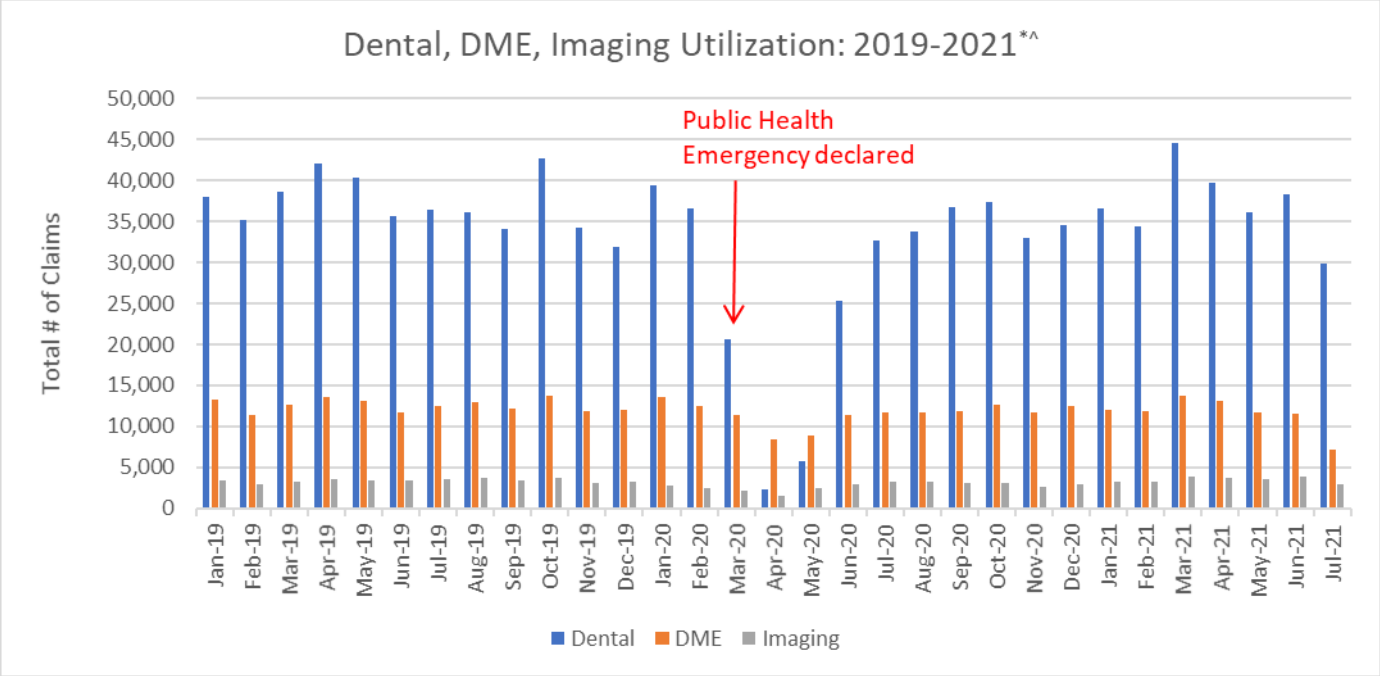
RECOMMENDATIONS FOR PRIOR AUTHORIZATION MODIFICATIONS

Introduction

The following is a summary of the recommendations and rationale for modifying prior authorization requirements for the above-referenced categories of service and code groups. These recommendations represent the starting point for further exploration of prior

authorization requirement modifications and the implementation of these recommendations would be contingent on multiple levels of vetting and approval. The process for implementing these recommendations and ongoing monitoring is outlined later in this report.

Figure 1: Utilization of Services under Temporary Public Health Emergency-related Prior Authorization Waiver[4]



*Excludes Imminent Harm code-related claims
^Excludes ACO claims

High Tech Imaging

Current state. High tech imaging includes magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), computer tomography (CT), and computer tomography angiography (CTA). Prior authorization was required until March 2020 for high tech imaging and all prior authorization requests were processed through a contracted vendor, eviCore. Prior authorization for high tech imaging was temporarily waived in March 2020 due to the Covid-19-related Public Health Emergency (PHE). Prior authorization for high tech imaging has also been waived for ACO-attributed members since 2017.

[4] See Appendix B for chart specifications.

Recommendation. Remove Medicaid prior authorization requirements for high tech imaging.

Rationale. The temporary waiver of high tech imaging prior authorization requirements in response to the public health emergency did not result in a significant increase in claims utilization data (see Figure 1 on page 11). Additionally, prior authorization for high tech imaging has been waived for ACO-attributed members since program inception and this recommended modification would align requirements between ACO-and non-ACO-attributed members. Finally, a high tech imaging vendor such as eviCore would no longer be needed if prior authorization requirements were removed, representing administrative savings to the State.[5]

Durable Medical Equipment (DME), Supplies, Prosthetics and Orthotics

Current state. Durable Medical Equipment (DME) includes medical equipment designed for long-term use, such as wheelchairs, hospital beds, continuous positive airway pressure (CPAP) machines, mobility aids, and oxygen concentrators, while supplies tend to be disposable and include items such as blood sugar test strips, incontinence products, protective gloves, and bandages. Prosthetics include artificial limbs and accessories and orthotics include therapeutic footwear. Prior authorization and service limit (excess quantity) authorization was required until March 2020 for various types of DME, supplies, prosthetics and orthotics. Prior authorization for these categories was temporarily waived in March 2020 due to the Covid-19-related Public Health Emergency (PHE). Prior authorization for these categories has also been waived for ACO-attributed members. Codes in these categories that fall under the Imminent Harm code list require prior authorization for patient safety reasons, even for ACO-attributed members (see below for Imminent Harm code list recommendations).

Recommendation. Remove Medicaid prior authorization and service limit authorization requirements for all DME, supplies, prosthetics, and orthotics except for complex DME and supplies on the Imminent Harm code list, which should continue to require prior authorization.

Rationale: The temporary waiver of DME, supply, prosthetics, and orthotics prior authorization and service limit requirements in response to the public health emergency did not result in a significant increase in claims utilization data (see Figure 1 on page 11). Additionally, prior authorization for these categories (except for imminent harm codes) has been waived for ACO-attributed members since program inception and this recommended

[5] eviCore 33924-3 Final Execution (accessed August 24, 2021).

modification would align requirements between ACO-and non-ACO-attributed members.

Special Considerations: The work group notes the relatively high denial rate for each of these categories of service (see Appendix A: Denial Rates) and additionally recommends that the Department's Program Integrity and Data Analytics units implement processes to track utilization and claims data in 2022 to monitor for post-public health emergency increases in DME, supplies, prosthetics, and orthotics utilization and claims submissions. Additionally, DME providers have expressed questions and concerns about who ultimately has accountability for ensuring appropriateness between ordering physician and supplying vendor for some of these items and services.

Dental Services

Current state. Dental services include clinical oral evaluation, radiography, preventive treatment, topical fluoride treatment, restorative procedures, endodontics, periodontics, removable prosthodontics (dentures), fixed prosthodontics (implants), and oral and maxillofacial surgery. Dental coverage is limited to a $1,000 maximum dollar amount per year (i.e., an annual limit or cap) for adults aged 21 and older; there is not an annual limit for pregnant women or for pediatric Medicaid members. Prior authorization was required until March 2020 for cone beam CT imaging, endodontic procedures, full/partial dentures and denture fittings/repairs, crowns and pontics (bridges), and orthodontics. Prior authorization for dental services was temporarily waived in March 2020 due to the Covid-19-related Public Health Emergency. Uniquely among these overarching categories, dental services are not included in the ACO's Total Cost of Care and therefore dental prior authorization requirements apply uniformly to all Medicaid members (including those attributed to the ACO).

Recommendation. Remove Medicaid prior authorization requirements for all dental services with the exception of orthodontic services, cone beam imaging, and unspecified dental codes (which will continue to require a descriptive prior authorization).

Rationale. The temporary waiver of dental prior authorization requirements in response to the public health emergency did not result in a significant increase in claims utilization data (see Figure 1 on page 11). For services for which prior authorization requirements would be reinstated, clinical prior authorization ensures medical necessity. Specifically, orthodontics are expensive and the Department's clinical criteria offers services to those most in need and ensures that costly services aren't being performed for cosmetic reasons, cone beam imaging is expensive, has the potential for overuse, and could be used to plan for services not covered by the Department, and unspecified dental codes require a descriptive prior

authorization to determine clinical appropriateness and pricing. Additionally, the consistently low prior authorization denial rate (see Appendix A: Denial Rates) across years supports the removal of prior authorization requirements, as does the policy decision to increase the Adult Medicaid Dental Benefit annual limit from $500 to $1,000 (effective January 1, 2020).

Physical, Occupational, and Speech Therapies

Current state. Physical, occupational, and speech therapies together comprise rehabilitative therapy services which include diagnostic evaluations and therapeutic interventions that are designed to improve, develop, correct, prevent the worsening of, or rehabilitate functions that affect the activities of daily living that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital anomalies, or injuries.[6] Adult coverage (ages 21 and older) includes 30 visits per calendar year of any combination of therapies. Prior authorization is required for additional therapy visits beyond the initial 30, and only if the member meets specific clinical criteria. Pediatric coverage (ages under 21) includes 8 visits per therapy discipline per calendar year. Prior authorization for non-health-home-agency therapies is required for additional visits beyond the initial 8 per therapy discipline. Rehabilitative therapy treatment provided through a home health agency for both adults and children is limited to 4 months of services before prior authorization is needed. Prior authorization for additional therapy visits is waived for ACO-attributed members (adults and children). Through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) exception, Medicaid will provide comprehensive services and furnish all Medicaid coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions for Medicaid members under age 21.

Recommendation. Maintain 30 visit per calendar year limit for adult therapy services, increase calendar year limit for pediatric therapy services from 8 per therapy discipline to 10 per therapy discipline (30 total visits), reinstate service limits for ACO-attributed members to align with these recommendations.

Rationale. The Department's clinical staff raised safety concerns that omitted or over-provided therapies can result in imminent harm to members. The Clinical Services Team analyzed rehabilitative therapy service utilization data from 2019 (most recent complete year) for children with chronic conditions and found that of the 10% of children who received high levels of therapy services (30 visits or more), 89% of them were attributed to

[6] The Department of Vermont Health Access clinical criteria for physical, occupational, and speech therapies: https://dvha.vermont.gov/sites/dvha/files/documents/providers/Forms/1ptotst-guidelines-010120.pdf (accessed August 24, 2021).

the ACO, while only 55% of eligible Medicaid members were attributed to the ACO in 2019. This led to concerns that a lack of oversight led to higher levels of service than anticipated, and to higher levels of services for ACO-attributed members than to non-ACO attributed members, while noting that ongoing high levels of care may indicate inefficacious habits of practice and may lead to an overdependence on therapy services. Additionally, these recommended changes would align the Department's prior authorization requirements for ACO-attributed and non-ACO-attributed members as well as align with Blue Cross and Blue Shield of Vermont's prior authorization requirements for therapies, which are limited to 30 visits per calendar year. The denial rate for rehabilitative therapies is not particularly high, but it is worth noting that the Department's clinical staff work very closely with providers to ensure that treatment plans are appropriate, often leading to eventual approval of most prior authorization requests.

Out-of-Network Services

Current state. Out-of-network services include elective inpatient admissions, elective outpatient procedures, and elective office visits at out-of-state hospitals that are not designated as out-of-state in-network hospitals or extended-network hospitals by the Department (these include certain border hospitals in New Hampshire, New York, and Massachusetts).[7] Prior authorization is required for elective inpatient admissions, elective outpatient procedures, and elective office visits for services at out-of-network facilities. Prior authorization is also required for elective inpatient admissions and elective outpatient procedures at extended-network hospitals. Urgent and emergent out-of-network stays are excluded from analysis and recommendations because they do not require prior authorization. Prior authorization is waived for elective inpatient admissions, elective outpatient procedures, and elective office visits at out-of-network hospitals for ACO-attributed members.

Recommendation. Remove Medicaid prior authorization requirements for out-of-network elective inpatient admissions for the following facilities: Albany Medical Center, Baystate Medical Center, Benchmark Behavioral Solutions, Berkshire Medical Center, Boston Children's Hospital, Dana Farber Cancer Institute, Lahey Clinic, and Tufts Medical Center. Continue to require prior authorization for out-of-network elective outpatient procedures and elective office visits and reinstate prior authorization requirements for ACO-attributed members for out-of-network elective outpatient procedures and elective office visits to align with these recommendations.

[7] See https://dvha.vermont.gov/providers/provider-network-info/green-mountain-care-network for a complete list of these hospitals.

Rationale. An analysis of the out-of-network facilities with the highest paid claims and most marked increased growth in the last 5 years revealed that the vast majority of care was medically necessary and did not raise concerns. An analysis of facility usage by members' last known residence indicated that several of the facilities (Albany Medical Center, Baystate Medical Center, Berkshire Medical Center) were the closest facilities available for some members living on Vermont's border with other states (see Appendix C). The remaining facilities provide additional or specialized services not available in Vermont to members, such as specialized pediatric care, transplant services, and certain cancer treatments. Analysis also showed that the proportion of Medicaid spend at these facilities in 2017-2019 for ACO-attributed members is consistent with the proportion of the Medicaid population that is attributed to the ACO, indicating that the waiver of prior authorization for ACO-attributed members did not lead to increased utilization (see Appendix D). The Department should explore options to refine post discharge transitions and improve or require care coordination for members returning to Vermont rather than require prior authorization. Additionally, reinstating prior authorization requirements for out-of-network elective outpatient procedures and elective office visits would ensure that in-state specialists and medical residents would retain a sufficient population base to maintain their skill set, and would decrease the significant risks of coordinating care with out-of-state facilities. Finally, these recommended modifications would align policy between ACO-and non-ACO-attributed members.

Chiropractic Services

Current state. Chiropractic care includes corrective treatment of subluxation of the spine. Federal regulations limit chiropractic services for Medicaid to treatment for the correction of a subluxation of the spine (42 CFR § 440.60). Coverage for members 12 and older includes 10 visits per calendar year. Prior authorization is required for additional visits beyond the initial 10. Prior authorization is required for all visits for children under the age of 12. Prior authorization and documentation of medical necessity from a primary care provider are required for all visits for children aged 5 and under. Prior authorization is waived for ACO-attributed members ages 12 and older who have exceeded the initial 10 visits per calendar year. All prior authorization requirements apply to ACO-attributed members under the age of 12.

Recommendation. Increase initial visit limit from 10 per calendar year to 12 per calendar year for members ages 12 and older and require prior authorization after the initial 12 visits. Reinstate this recommended requirement to all Medicaid members (including those attributed to the ACO). Continue to require prior authorization for ACO-attributed and non-ACO-attributed children under the age of 12 but allow pediatric chiropractic providers

with the identified credentials of DC, CACCP to submit prior authorization requests and clinical documentation to be processed through an automated "Gold Card" approach. Any "Gold Card" approvals will be valid for one year, after which a chart review will take place and the Gold Card either extended or withdrawn contingent upon findings. Maintain current prior authorization requirements for ACO-attributed and non-ACO-attribute children ages 5 and under.

Rationale: These recommendations are consistent with denial rate data (see Appendix A: Denial Rates) for chiropractic services, which are high and have increased for pediatric (under age 12) chiropractic services and decreased for adult (over age 12) chiropractic services. The increase in number of initial visits from 10 to 12 for members ages 12 and older is aligned with chiropractic prior authorization requirements for Blue Cross and Blue Shield of Vermont. These recommended modifications would align policy between ACO-attributed and non-ACO-attributed members. Chiropractic coverage requirements in other states include a wide variety of approaches (such as acute and maintenance visits) and attention was paid to requirements in comparable states (specifically Maine and South Dakota, which both fund additional services with general fund dollars), but it was determined that Vermont should tailor its requirements to its specific needs.

High Dollar Services

Current state. Inpatient stays with billed amounts over $300,000 are considered high dollar services. A provider must submit a service authorization (not a prior authorization) with accompanying clinical documentation to the Department after the member is discharged but prior to claims submission. Clinical documentation is then reviewed by the Department's clinical staff to determine appropriate use of services and medical necessity. This requirement applies to both ACO-attributed and non-ACO-attributed members.

Recommendation. Discontinue the high dollar process and service authorization requirement for all inpatient stays as of October 1, 2021.

Rationale. Analysis of the high dollar clinical review data demonstrated no significant savings after one year of implementing a refined clinical review process. Additionally, the Department's Program Integrity unit continues to conduct a targeted claims analysis and audit with respect to concerns of over-utilization of high dollar claims. Further, removal of service authorization requirements reduces administrative burden for both facilities and administrative/clinical staff at the Department.

Imminent Harm Codes

Current state. Beginning in 2019, a list of imminent harm codes was developed to require prior authorization for all the Department's members regardless of ACO attribution, recognizing that the Department, as a payer, is responsible for the care and safety of its membership and should retain clinical oversight in certain areas. Imminent harm codes include complex durable medical equipment such as wheelchairs, hospital beds, standers, positioning devices, and gait trainers, surgical procedures with a diagnosis of gender dysphoria, hysterectomies, and various miscellaneous codes that require a descriptive prior authorization.

Recommendation. Maintain prior authorization requirements for imminent harm codes for all Medicaid members and clarify that hysterectomies do not require prior authorization but must adhere to federal documentation requirements around consent.

Rationale. The Department maintains the responsibility for the safety of its members and prior authorization is one method of clinical oversight for ensuring that the right services are provided at the right time. Requiring prior authorization for safety reasons continues to be best practice. Hysterectomy prior authorization requirements have been removed (and hysterectomy codes have been removed from the Department's imminent harm code group), but providers must adhere to federal requirements around consent for all hysterectomy procedures. These requirements are overseen by the Department's claims processor and providers submit consent forms at the point of claim submission.

IMPLEMENTATION OF RECOMMENDED MODIFICATIONS

Clinical Utilization Review Board: Feedback on Recommended Modifications to the Department's Clinical Prior Authorization Requirements

The cumulative set of recommendations were presented to the Clinical Utilization Review Board (CURB) during its July 2021 meeting and a discussion ensued on each of the specific proposal. Details surrounding the rationale for the proposed changes to each category were presented and the Board voted to adopt each recommendation without a dissenting vote. Following the Board's vote to adopt each recommendation, the recommendations were then sent to the Acting Commissioner, Adaline Strumolo, of the Department of Vermont Health Access for consideration and implementation planning.

Additional Stakeholder Feedback on Recommendations

The Department is in the process of gathering feedback from additional stakeholders and

will continue to do so where appropriate and feasible. The recommendations were presented to clinical representatives of OneCare Vermont on September 10, 2021, with no concerns raised regarding the recommendations as proposed. The recommendations were next summarized and presented to the Medicaid and Exchange Advisory Committee on September 27, 2021 with several Committee members indicating strong support for the recommendations as proposed. For prior authorization requirements that would remain, one Vermont Medicaid member advised that the Medicaid member's rationale for requesting a service should be considered alongside the rationale provided by the provider. The Department will continue to take any feedback received into account as it moves forward in the approval and implementation process. Finally, it is the policy of the Agency of Human Services and Department of Vermont Health Access to issue public notice on these types of proposed changes. Public notice will occur 30 days prior to the implementation of any changes related to these recommendations, at which time additional feedback from stakeholders and the public will be gathered and considered.

Necessary Federal and State Regulatory Approval and Timeline

Changes to the Medicaid benefit or coverage policies in some cases require federal approval and/or modification to the State's rules for the Medicaid program, e.g., the Health Care Administrative Rules (HCAR, also referred to as Medicaid Rule).[8]

State Plan Amendments will be required to remove prior authorization requirements for high tech imaging services, to increase service limits for pediatric physical, speech, and occupational therapies, and to increase service limits for chiropractic care and institute a "Gold Card" process for pediatric chiropractors that meet credentialing criteria. The Centers for Medicare and Medicaid Services (CMS) has 90 days from the submission of a State Plan Amendment to respond, during which it can approve the State Plan Amendment or issue follow-up questions about the proposed changes (which would restart the 90-day time period). State Plan Amendments can be submitted and approved retroactive to when a change was implemented (but must be submitted in the same fiscal quarter as the implemented change).

Amendments to the State's rules will be required to remove prior authorization requirements for high tech imaging services, to increase service limits for pediatric physical, speech, and occupational therapies, to increase service limits for chiropractic care and institute a "Gold Card" process for pediatric chiropractors that meet credentialing criteria,

[8] See 33 V.S.A. § 1901(a)(1), which gives the Secretary of Human Services or designee the authority to adopt rules that are required to "administer a medical assistance program under Title XIX (Medicaid) and Title XXI (SCHIP) of the Social Security Act."

and to clarify prior authorization requirements for out-of-network inpatient services, Durable Medical Equipment, and supplies. Rule amendments under the Vermont Administrative Procedures Act take an average of twelve months to adopt, factoring in necessary rule preparation and stakeholder engagement prior to formal rule filing. To the extent that changes reflect expanded access, prior authorization changes may be implemented under State Plan authority while rule amendments are in process. It should be noted that none of the recommended modifications represent a more limited Medicaid benefit but rather loosen requirements around prior authorization or reinstate already-existing prior authorization requirements to bring the Department into internal policy alignment.

Systems Changes Needed to Operationalize Policy Changes

The Department is engaging with its fiscal intermediary and claims processor, Gainwell Technologies, to review the proposed recommendations and determine what systems changes may be needed and the associated timeline to operationalize them. If recommendations are approved, the Department anticipates implementing them simultaneously or in as few batches as possible. This will minimize the number of workflow adjustments providers may need to make to their practices to accommodate changes to prior authorization requirements. If any of the recommended changes prove too operationally difficult or costly to implement, the Department may consider modifying or no longer pursuing those recommendations. The Department is targeting between January 1 and October 1 of 2022 for implementation of any changes, dependent on developer capacity for claims processor modifications.

Communication to Medicaid Providers and Members

The Department conducts outreach and notification prior to implementing policy changes to coverage or benefits that will impact providers or members. If the recommendations above are adopted, the Department will communicate these changes through a number of avenues, such as issuing banner pages (notifications) to the affected provider types or organizations, leveraging OneCare's network communication tools (such as its Network Newsletter and its education platform, VT Health Learn), publishing the changes in the Department's newsletter for Medicaid members, and outreaching to the Vermont Medical Society and Health First, as well as other statewide specialty organizations, such as the Vermont Association of Hospitals and Health Systems, the Bi-State Primary Care Association, and the Home Medical Equipment and Services Association of New England (HOMES).

Ongoing Utilization Monitoring for Affected Categories of Service

The Department uses a data-driven approach to recommending changes to prior authorization requirements and other requirements that may impact utilization. If the recommendations above are adopted, the work group recommends implementing an ongoing utilization monitoring process to detect any increases in utilization for the affected categories of service and code groups, recognizing that prior authorization continues to be a utilization management tool that the Department could deploy if needed. As the Agency of Human Services continues its negotiations around a new Global Commitment to Health 1115 Waiver, the Department will want to continue to have all tools at its disposal for ensuring the effective allocation of public funds. Through its utilization monitoring process, the work group will meet on a quarterly basis to review utilization for services where prior authorization was removed and will build further capacity to monitor data and perform clinical audits. The work group will also analyze services that were not included in its first set of recommendations, including, for example, genetic testing and sleep studies, for which recommendations for changes to prior authorization requirements could be made. The work group will also discuss any new issues that arise related to prior authorization requirements or the recommended modifications to those requirements.

The Vermont Medicaid Next Generation ACO Program Prior Authorization Waiver in the Future

One goal of compiling recommendations for these modifications was to align the Department's overall prior authorization requirements under one set of rules for ACO-attributed members and non-ACO-attributed members. The Vermont Medicaid Next Generation ACO program waiver of prior authorization has been a useful pilot to determine the impact on utilization for a subset of the Medicaid population if prior authorization requirements are removed. The prior authorization waiver will continue, though it may lessen in scope as these recommendations, and any future recommendations around additional services, are implemented.

APPENDICES

Appendix A: Denial Rate Report (as of April 29, 2021)

	CY2016				CY2017				CY2018				CY2019				CY2020			
	# Approved	# Denied	Total #	Denial Rate	# Approved	# Denied	Total #	Denial Rate	# Approved	# Denied	Total #	Denial Rate	# Approved	# Denied	Total #	Denial Rate	# Approved	# Denied	Total #	Denial Rate
ATTENDANT CARE PLANS	0	0	0	0.0%	1	0	1	0.0%	1	0	1	0.0%	0	0	0	0.0%	0	0	0	0.0%
CHIROPRACTIC CARE	16	47	63	74.6%	27	40	67	59.7%	33	39	72	54.2 %	22	20	42	47.6 %	6	11	17	64.7%
DENTAL	4,309	242	4,551	5.3%	4,888	273	5,161	5.3%	5,464	379	5,843	6.5%	5,972	253	6,225	4.1%	1,315	50	1,365	3.7%
DME	736	851	1,587	53.6%	1,072	919	1,991	46.2%	1,721	729	2,450	29.8 %	1,276	579	1,855	31.2 %	1,143	422	1,565	27.0%
GENETIC TEST	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	162	166	328	50.6 %	80	63	143	44.1%
HEARING AIDS	31	25	56	44.6%	16	22	38	57.9%	37	16	53	30.2 %	34	12	46	26.1 %	24	4	28	14.3%
HIGH DOLLAR INPATIENT	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	8	0	8	0.0%
IMAGING	24	25	49	51.0%	29	9	38	23.7%	28	4	32	12.5 %	6	4	10	40.0 %	14	1	15	6.7%
INPAT CONCURRENT RVIEW FOR COU	94	63	157	40.1%	102	170	272	62.5%	0	0	0	0.0%	0	0	0	0.0%	1	0	1	0.0%
OCCUPATIONAL THERAPY	621	109	730	14.9%	654	144	798	18.0%	598	101	699	14.4 %	167	22	189	11.6 %	40	13	53	24.5%
OFFICE VISIT - OUT OF NETWORK	403	86	489	17.6%	634	128	762	16.8%	751	136	887	15.3 %	356	98	454	21.6 %	122	28	150	18.7%
ORTHOTICS/PROSTHETICS	48	96	144	66.7%	42	74	116	63.8%	176	69	245	28.2 %	101	55	156	35.3 %	41	15	56	26.8%
OTHER	459	508	967	52.5%	506	411	917	44.8%	488	480	968	49.6 %	79	107	186	57.5 %	3	2	5	40.0%
PHARMACY	612	59	671	8.8%	621	32	653	4.9%	579	17	596	2.9%	720	4	724	0.6%	714	0	714	0.0%
PHYSICAL THERAPY	2,082	466	2,548	18.3%	1,969	441	2,410	18.3%	1,848	313	2,161	14.5 %	465	131	596	22.0 %	102	34	136	25.0%
PRE-ADMISSION	55	24	79	30.4%	52	15	67	22.4%	36	15	51	29.4 %	18	4	22	18.2 %	13	4	17	23.5%
SLEEP STUDY	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	95	23	118	19.5 %	63	13	76	17.1%
SPEECH THERAPY	383	98	481	20.4%	378	90	468	19.2%	350	66	416	15.9 %	113	13	126	10.3 %	36	10	46	21.7%
SUPPLIES	191	125	316	39.6%	108	86	194	44.3%	174	81	255	31.8%	212	89	301	29.6%	167	32	199	16.1%

	CY2016				CY2017				CY2018				CY2019				CY2020			
	# Approved	# Denied	Total #	Denial Rate	# Approved	# Denied	Total #	Denial Rate	# Approved	# Denied	Total #	Denial Rate	# Approved	# Denied	Total #	Denial Rate	# Approved	# Denied	Total #	Denial Rate
SURGERY	296	203	499	**40.7%**	368	206	574	**35.9%**	323	205	528	**38.8 %**	219	72	291	**24.7 %**	161	48	209	**23.0%**
VISION	692	85	777	**10.9%**	423	49	472	**10.4%**	548	52	600	**8.7%**	462	29	491	**5.9%**	0	0	0	**0.0%**
OTHER LIMITATION OVERRIDES	1	1	2	**50.0%**	0	0	0	**0.0%**	0	0	0	**0.0%**	0	0	0	**0.0%**	0	0	0	**0.0%**
PSYCHIATRY/ PSYCHOLOGY	0	0	0	**0.0%**	0	0	0	**0.0%**	5	0	5	**0.0%**	0	0	0	**0.0%**	1	0	1	**0.0%**
RESPIRATORY	0	0	0	**0.0%**	0	0	0	**0.0%**	0	0	0	**0.0%**	0	0	0	**0.0%**	0	0	0	**0.0%**
WAIVER PLANS	0	0	0	**0.0%**	0	0	0	**0.0%**	0	1	1	**100.0 %**	0	0	0	**0.0%**	0	0	0	**0.0%**
HI-TECH CARE	0	0	0	**0.0%**	0	0	0	**0.0%**	3	1	4	**25.0 %**	0	0	0	**0.0%**	0	0	0	**0.0%**
TRANSPORTATION	0	0	0	**0.0%**	0	0	0	**0.0%**	0	0	0	**0.0%**	0	0	0	**0.0%**	0	0	0	**0.0%**
TOTAL	**11,053**	**3,113**	**14,166**	**22.0%**	**11,890**	**3,109**	**14,999**	**20.7%**	**13,163**	**2,704**	**15,867**	**17.0 %**	**10,479**	**1,681**	**12,160**	**13.8 %**	**4,054**	**750**	**4,804**	**15.6%**

Appendix B: COVID-19 Dashboard Specifications

1. Dental claims include any claim designated type of service = Z; DME claims include any claim designated type of service A,B,H,K, and L; Imaging claims include any procedures typically authorized by eviCore as identified by Procedure Date Code 1238.

2. The claim count calculation is a summary of claim detail records not an unduplicated count of unique ICNs. Unique claims for procedures on the Imminent Harm list were removed. Claims that fell under a recipient's Medicare Coverage were removed. Any claim outside a period of Medicaid eligibility was removed. ACO claims were removed.

3. Some EKG services payments may not be included when bundled into all-inclusive office visits at an FQHC; however, the instance of an EKG would still be included in the claim count since the EKG service is recorded on its own detail line on the claim.

4. 10/14/2020 - 2019 was added as a comparison group. It remains difficult to conclude if the waiving of prior authorization requirements for select Dental, DME, and Imaging services had any observable quantifiable impact on provider administrative burden over the last several months or that this easing of requirements encouraged utilization that would not have otherwise occurred. This is because there was no pandemic in 2019, and the shut down of elective medical procedures in the state may have caused a backlog of demand for a supply limited due to the pandemic as well as staffing shortages and protective measures to help healthcare facilities prevent transmission, all of which were also not present in 2019. We also believe this is understandable due to the lack of availability of elective services during the period of time for which prior authorizations were waived. The lack of availability of the services was a result of emergency measures concurrent to the prior authorization waiver. These measures suspended all elective medical services and visits effectively removing most opportunities to observe the effect of waiving prior authorizations. While it may only be reasonable to view the above utilization data as a way to confirm that a decrease in payments and claim volume did occur over the beginning of the year there may be value in continuing to monitor the data if DVHA continues to waive prior authorizations as providers begin to operate at a capacity more consistent with historical utilization levels. Of note are a very small number of billing providers that demonstrated some claim volume equalization or uptick in May from their April utilization lows. A discussion with these providers may offer some valuable input about how the prior authorization waiver enabled providers to more easily resume operations while coping with staffing shortages and other operational challenges. Additionally, the input from these providers may help guide DVHA in planning a response in advance to future emergency scenarios that require easing of requirements for providers. Finally, we recommend continuing to monitor this data here or elsewhere if for no other reason than to track the rate at which utilization returns to volumes comparable to the months prior to the COVID-19 pandemic.

5. Data source: DVHA Data Unit Medicaid Data Warehouse Extracts for Calendar Year 2021, DXC Reference and Prior Authorization Universes, Analysts JC and AK

Appendix C: Out of Network Service Claims by County of Residence

	CY 2018							CY 2019							CY 2020 (Incomplete)						
	Type of Service							Type of Service							Type of Service						
	Office Visits	IP Admits	OP Procedures	Chemo therapy	Radia tion	MH IP	MH OP	Office Visits	IP Admits	OP Procedures	Chemo therapy	Radia tion	MH IP	MH OP	Office Visits	IP Admits	OP Procedures	Chemo therapy	Radiat ion	MH IP	MH OP
County	Claim Count							Claim Count							Claim Count						
ADDISON	13	24	486	36	89	2	68	14	64	668	27	0	8	18	7	24	253	3	0	0	10
BENNINGTON	104	278	3391	156	0	41	60	77	329	4173	220	5	38	132	76	163	1578	87	0	34	62
CALEDONIA	10	99	405	14	0	0	0	17	80	566	12	8	4	7	6	35	111	12	0	0	4
CHITTENDEN	68	103	1576	42	115	41	64	94	186	2187	45	14	39	61	48	89	620	36	0	9	27
ESSEX	67	102	222	14	0	0	0	51	115	258	16	0	0	0	12	44	76	4	0	0	0
FRANKLIN	15	22	813	63	49	0	30	34	52	881	102	66	0	60	14	38	384	32	30	2	27
GRAND ISLE	2	0	24	2	0	0	0	2	0	42	1	0	0	0	0	0	0	0	0	0	0
LAMOILLE	1	19	71	2	0	2	28	14	10	161	52	0	2	8	2	2	15	7	0	0	15
ORANGE	17	179	1228	5	0	2	87	12	130	2258	10	22	0	16	0	60	829	2	0	0	0
ORLEANS	14	40	1013	38	2	6	0	13	77	710	52	88	0	23	6	27	222	3	0	8	11
OUT OF STATE	8	27	383	20	0	7	56	19	19	413	55	0	8	15	0	3	26	3	0	0	14
RUTLAND	23	194	1492	22	13	33	89	43	210	1176	131	1	39	97	19	103	531	72	0	19	17
WASHINGTON	9	60	381	8	0	22	21	14	46	582	23	24	27	23	7	15	362	11	0	4	21
WINDHAM	101	460	1834	82	63	73	105	137	160	2468	146	89	53	127	40	30	1109	29	0	16	28
WINDSOR	95	420	1278	102	0	20	3	84	397	714	80	0	17	44	32	163	230	9	1	0	14

Appendix D: Out of Network Utilization: All Department of Vermont Health Access and ACO members

Table 1: Total High-Dollar Claim Counts/Spend for All DVHA vs. ACO (Calendar Year 2017 – Calendar Year 2019)

	CY 2017					CY 2018					CY 2019				
	Members	Claims		Paid ($)		Members	Claims		Paid ($)		Members	Claims		Paid ($)	
PROVIDER NAME[11]	*Total Sum*	*Total Count*	*ACO Count*	*Total Sum*	*ACO Sum*	*Total Sum*	*Total Count*	*ACO Count*	*Total Sum*	*ACO Sum*	*Total Sum*	*Total Count*	*ACO Count*	*Total Sum*	*ACO Sum*
Albany Medical Center	100	396	5	778,969.45	*1,147.68*	106	365	*118*	1,014,464.62	*387,503.19*	107	279	*207*	1,172,405.38	*568,526.37*
Berkshire Medical Center	127	858	19	41,106.02	*1,045.56*	119	790	*124*	59,964.74	*52,870.29*	128	988	*162*	241,844.32	*116,105.72*
Brigham and Womens Hospital	27	74	9	185,158.46	*18,064.28*	34	147	*30*	477,118.02	*41,251.77*	37	130	*26*	261,796.89	*30,393.36*
Childrens Hospital Boston	171	1548	83	4,002,732.57	*281,952.81*	221	1994	*179*	5,997,973.14	*599,605.00*	227	2151	*313*	8,022,042.90	*2,645,739.73*
Dana Farber Cancer Institute	27	357	3	16,684.99	*1,561.02*	28	474	*33*	42,641.19	*9,426.70*	43	831	*65*	524,022.22	*115,988.96*
Mass. General Hospital	55	343	15	556,814.78	*38,952.98*	47	386	*75*	855,874.08	*560,749.42*	59	465	*118*	840,192.24	*497,717.50*

[11] Half of the highest-spend providers had claims for fewer than ten members in one or more year and have been removed from this table. These include Benchmark Behavioral Solutions, Cumberland Hospital, LLC, Lahey Clinic Hospital, LLC, Maine Behavioral Health DBA Spring Harbor, Spaulding Rehabilitation Hospital, and Walden Behavioral Center.

Table 2: Out-of-Network Utilization: ACO Spend as Percentage of Department of Vermont Health Access Spend (Calendar Year 2017 - Calendar Year 2019)

ACO spend as % of DVHA spend			
Provider	***CY 2017***	***CY 2018***	***CY 2019***
Albany Medical Center	0.15 %	38.20 %	48.49 %
Benchmark Behavioral Solutions, LLC	0.00 %	83.74 %	60.35 %
Berkshire Medical Center	2.54 %	88.17 %	48.01 %
Brigham and Womens Hospital	9.76 %	8.65 %	11.61 %
Childrens Hospital Boston	7.04 %	10.00 %	32.98 %
Cumberland Hospital, LLC	0.00 %	48.78 %	0.00 %
Dana Farber Cancer Institute	9.36 %	22.11 %	22.13 %
Lahey Clinic Hospital, LLC	89.37 %	0.16 %	4.43 %
Maine Behavioral Health DBA Spring Harbor	100.00 %	0.00 %	88.74 %
Mass. General Hospital	7.00 %	65.52 %	59.24 %
Spaulding Rehabilitation Hospital	0.00 %	0.00 %	4.37 %
Walden Behavioral Care LLC	30.18 %	13.45 %	49.45 %
Overall %	**10.54%**	**20.88%**	**37.38%**
ACO-attributed population as % of overall Medicaid population[12]	**14.45%**	**22.27%**	**42.22%**

[12] Overall Medicaid population includes members who are not ACO-attribution eligible, such as Medicare/Medicaid dually-eligible members, members with a limited benefits package, and members with third party liability or evidence of other insurance.