

**The Department of Vermont
Health Access
MANAGED CARE ENTITY (MCE)
QUALITY MANAGEMENT PLAN**



**STATE OF VERMONT
Department of Vermont Health Access
Department of Mental Health
Department of Disabilities, Aging and Independent Living
Department of Health
Department for Children and Families**

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1. INTRODUCTION

On September 30, 2005, the Vermont Legislature, through its Joint Fiscal Committee, granted conditional approval for the State to begin implementation of the Global Commitment to Health Demonstration Program. The Global Commitment to Health is a Demonstration Initiative operated under the Section 1115(a) waiver and now encompasses all of Vermont's Medicaid programs with the exception of the Long Term Care Waiver, the State Children's Health Insurance Program and the Disproportionate Hospital Payments. The Legislature gave full approval for participation in the waiver on December 13, 2005.

The Global Commitment Waiver provides the State with the ability to be more flexible in the way it uses its Medicaid resources. Examples of this flexibility include new payment mechanisms (e.g. case rates, capitation, combined funding streams, incentive reimbursements) rather than individual fee-for-service payments, flexibility to pay for healthcare related services not traditionally reimbursable through Medicaid (e.g. pediatric psychiatry consultation) and investments in programmatic innovations (e.g., the Vermont Blueprint for Health). It is based on a managed care model which also encourages inter-departmental collaboration and consistency across programs.

Overview

The Federally approved waiver and corresponding changes in Vermont State statute changed the administrative structures of State government to designate the Office of Vermont Health Access (OVHA), now known as the Department of Vermont Health Access (DVHA), as the country's only Medicaid Office operating under a managed care model. The Agency of Human Services (AHS) pays the DVHA a lump sum premium payment for the provision of all Medicaid services in the State (apart from the exceptions mentioned above). The DVHA has Intergovernmental Agreements (IGAs) with various AHS Departments to provide programs and services to the Medicaid population. It is believed that the use of a managed care system will allow Vermont to purchase the best value health care for Medicaid beneficiaries, improve access to services for underserved and vulnerable beneficiary populations, and protect them from substandard care.

Structure

The Department of Vermont Health Access (DVHA) operates under a managed care model financing the provision of medical services to Medicaid-eligible Vermonters through receipt of capitated payments from the Agency of Human Services (AHS), the Single State Agency. However, DVHA is a branch of AHS, as opposed to an independent entity. DVHA's Commissioner reports directly to the AHS Secretary. Annually, and as specified by AHS, the DVHA submits to AHS data specified by AHS that enables the State to measure the DVHA's performance.

The DVHA is a large department encompassing many divisions and initiatives. In addition to managing the services provided to the general Medicaid population, the DVHA encompasses other initiatives focused on the health of Vermonters. These include the Vermont Chronic Care Initiative (VCCI), Pediatric Palliative Care, the Hub and Spoke Initiative, Vermont's health insurance Exchange (Vermont Health Connect), the Blueprint for Health and the Vermont Health Care Innovation project (VHCIP).

Although these programs are large in scope on their own, the DVHA strives to integrate all of our quality management activities across the Department.

To that end, the DVHA, in collaboration with its IGA partners, maintains a comprehensive Quality Management Plan and an ongoing quality assurance/performance improvement (QAPI) program for the services it furnishes to Global Commitment to Health Waiver beneficiaries. This DVHA Quality Management Plan incorporates activities delegated to all IGA partners. This DVHA Quality Management Plan also includes, but is not limited to describing the following activities: conducting performance improvement projects, calculating and reporting performance measures, detecting both underutilization and overutilization of services, and assessing the quality and appropriateness of care furnished to beneficiaries with special health care needs.

While there are important roles for everyone involved with the DVHA in the quality assurance and performance improvement program, much of the formal quality management work is done through various committees and teams.

Quality Committee -

The Quality Committee is made up of a cross-section of DVHA representatives and our IGA partner quality representatives. This Committee meets monthly and is responsible for: a) development of an annual Quality Action Plan, b) identifying performance measures required of IGA partners and reviewing measures regularly for improvement opportunities, c) guiding the implementation of planned improvement activities and encouraging staff to become more integrated into QI processes, d) review of DVHA and IGA Partner reporting focused on quality activities such as grievances and appeals, customer satisfaction, confidentiality and appropriateness of care.

Managed Care Medical Committee (MCMC) -

The DVHA Managed Care Medical Committee is responsible for developing, reviewing, monitoring and continuously improving our clinical operations and policies. This work includes: a.) development and management of clinical practice guidelines, b.) monitoring the performance of various contracts and procedures from a clinical perspective, c.) approving the clinical criteria used to authorize services paid for with Medicaid dollars and d.) ongoing review of standard performance measures (e.g. HEDIS) and identification of potential performance improvement projects.

The DVHA Managed Care Medical Committee is made up of inter-departmental representatives with expertise in clinical operations and clinical policy development, as well an AHS Central Office representative and subject matter experts from other AHS Departments when needed.

Compliance Committee –

This committee is charged with ensuring compliance with all state and federal requirements. This is accomplished by monitoring DVHA's and IGA Partners' compliance progress through data analysis and program/policy reviews. The work of this Committee includes: a)

coordinating reviews of Operating Procedures, b) tracking of EQRO corrective action plan follow-up, including recommendations, c) review of IGA partners' Compliance/Program Integrity Plans, as well as their compliance reporting and corrective actions, d) coordinating the managed care corrective action process for all AHS compliance issues related to managed care.

The DVHA Compliance Committee is made up of inter-departmental representatives with policy, program integrity and compliance expertise.

MCE Oversight Committee –

The Quality Committee, Managed Care Medical Committee and Compliance Committee all report up to the MCE Oversight Committee. Each committee's annual action plans and deliverables, as well as challenges and success are reported here. The MCE Oversight Committee is chaired by the DVHA's Chief Medical Officer and includes Director level staff.

AHS Performance Accountability Committee (PAC) –

Members of the DVHA Quality Committee report to the AHS Performance Accountability Committee (PAC) as an avenue for the State to remain informed of and measure DVHA's performance. The overall charge of this committee is to contribute to improving the delivery of services, consumer outcomes, and the overall health and well-being of those served by AHS. By building a consensus on how to measure and improve performance, the PAC strives to align agency-wide efforts as well as establish an agency based approach to accountability.

DVHA Data Management and Integrity Unit –

Data collection for the HEDIS measures, CMS Adult and Children Core Measures, utilization, and enrollee-to-provider ratios are performed by the DVHA Data Management and Integrity Unit.

DVHA Policy Unit –

A database of all beneficiary grievances and appeals is maintained by the DVHA Policy Unit. The DVHA Policy Unit is represented on the Quality Committee.

DVHA Quality Improvement Director -

The Quality Improvement Director oversees the DVHA Quality Unit and the implementation and progress of the annual Quality Action Plan. The Director also reports out to PAC (see above) and is a member of the MCE Oversight Committee and the DVHA Management and Strategic Planning Teams.

Quality Improvement Administrator –

The Quality Committee is co-chaired by the Quality Improvement Administrator. This position also coordinates the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, which provides an assessment of health plan performance from a consumer perspective regarding the plan's services and care delivery system. This position also leads formal CMS performance improvement projects (PIPs) and acts as a performance measures liaison between the Quality Unit and other DVHA divisions/initiatives (i.e. Hub & Spoke, the Exchange, Blueprint for Health, VHCIP).

Medical Director –

The DVHA Medical Director is a clinical expert for the organization and as such is responsible for providing medical leadership to the DVHA Quality Committee and the clinical expertise needed to guide the overall effort. The Medical Director co-chairs the Quality Committee, along with the Quality Improvement Administrator.

Scope

This Quality Management Plan sets forth specifications for activities that the DVHA will implement to ensure the delivery of quality health care. The following sections establish the scope of work encompassed by the current quality assessment and performance improvement program:

- Quality Planning
- Performance Measures
- Compliance
- Monitoring & Oversight
- Performance Improvement

Purpose

The specific purposes of the Quality Management Plan are to:

1. Provide direction and guidance for all staff in the pursuit of the QAPI goals.
2. Provide a plan for systematic, objective, ongoing monitoring and evaluation of data regarding beneficiary care and identification of areas for needed improvement.
3. Provide guidance for determination of activities for the special health care needs populations.
4. Assure an information system is in place that will support the efforts of the QAPI Program.
5. Maintain standards for quality of care, access to care, and quality of service.
6. Verify that services provided to Medicaid beneficiaries are guided by professionally recognized standards of practice.
7. Provide Medicaid beneficiaries a means by which they may seek resolutions of perceived failure by providers or personnel to provide appropriate health services, access to care, or quality of care.
8. Establish, maintain, and enforce a policy for protection of confidential member and provider information.

Goals

The overarching goal of the Quality Management Plan is to improve future performance through the execution of effective improvement activities. These activities are driven by identified performance measures, tracking them and reliably reporting on them to decision-making and care-giving staff. More specifically, the goals of the Quality Management Plan are to:

1. Support improvement in the health of Vermont's population
2. Enhance efficiency of care
3. Increase effectiveness of care
4. Promote equity of care
5. Enrich patient-centeredness
6. Ensure safety
7. Assure that beneficiaries have access to high-quality health care (health care includes mental health, physical health and substance abuse treatment)
8. Improve customer and provider satisfaction

Principles:

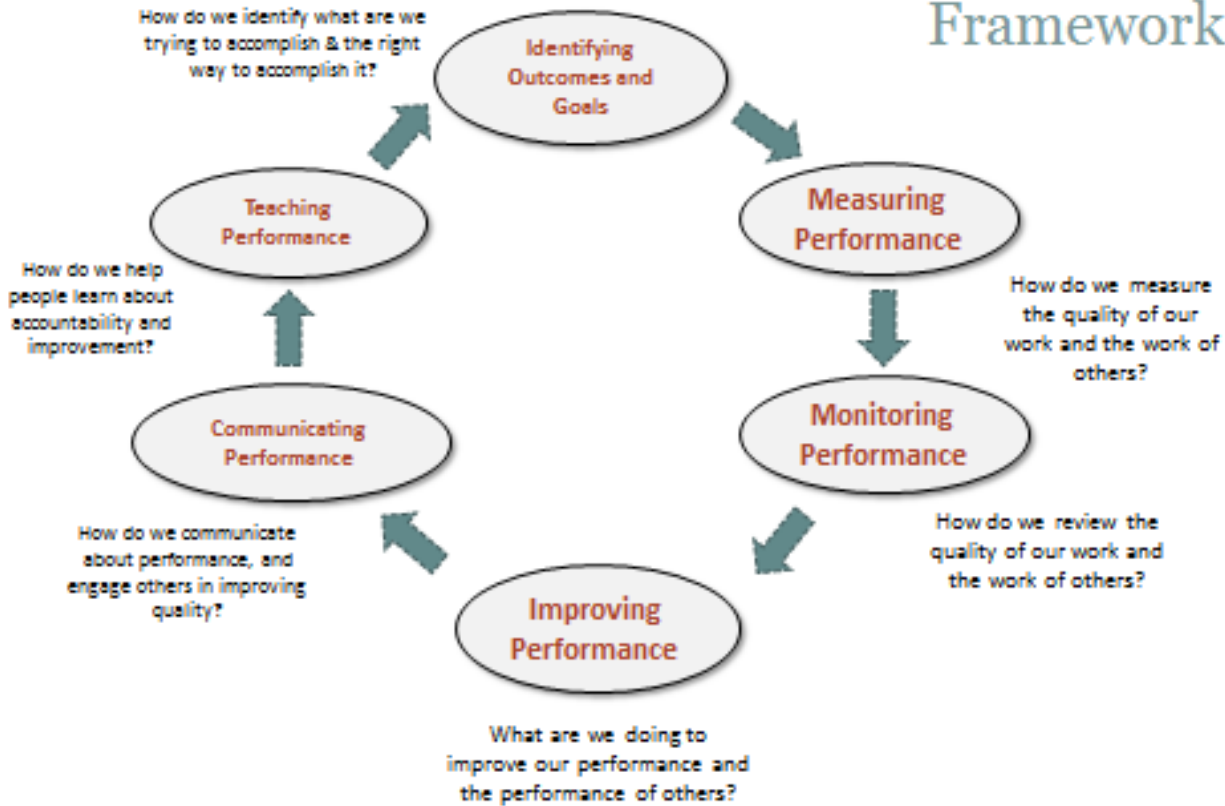
The DVHA Quality Management Plan is based on the following quality principles:

1. Quality begins with a focus on the customer (our beneficiaries and their caregivers);
2. Actions should be based on facts, data, and analysis;
3. Poor processes and systems are the cause of most problems, not people;
4. Everyone needs to be involved and committed in the effort;
5. Quality Improvement is a continuous effort.

This plan also demonstrates how the DVHA and our IGA Partners work within the Agency of Human Service's Performance Framework which outlines the key components of our continuous improvement strategy to improve outcomes for the people we serve. Each component in the Performance Framework encompasses a range of strategies, practices, processes, and activities happening within each Department and across the Agency, as well as addressed here in this Plan. The AHS Performance Framework enables us to better understand and strengthen our mechanism for remaining accountable for improving conditions of well-being for the Vermonters we serve.

The Framework is based on the understanding that in order to pursue our mission and accomplish our goals, we must actively and continually measure our performance, monitor our progress, and improve our strategies based on what we've learned. In order to embed continuous improvement as a practice into the Agency culture, we must also communicate about our progress, and help teach others about accountability and how we can work together to improve conditions of well-being in Vermont.

AHS Performance Framework



2. QUALITY PLANNING:

2.1 Identifying Opportunities for Improvement

Quality planning begins by identifying opportunities for improvement. These opportunities can be discovered in a variety of ways:

• Outcome data	• Contract oversight
• Participant complaints or input	• Identification of best practices / literature
• Critical incidents	• Strategic planning efforts
• Chart audits	• Visioning efforts
• Satisfaction data	• Professional standards
• Staff observations and ideas	• Regulatory requirements

2.2 Project Selection

While everyone involved with the DVHA has an important role in helping to identify opportunities for improvement (see AIM description later in this document), formal priorities for performance improvement are determined annually by the Managed Care Medical Committee (MCMC) in consultation with the IGA partners, the AHS and the DVHA Managed Care Compliance Director. Priority will be based on severity, frequency, prevalence, relevance to outcomes and feasibility of implementation. In addition, 42 CFR 438.240 reserves CMS the right to specify performance improvement project topics for the DVHA. Likewise, Section 2.2 of the AHS/DVHA intra-governmental agreement reserves AHS the same right.

2.3 Communication

An important part of the QAPI Program is sharing ideas, efforts, and results about quality efforts with all members of the DVHA (including IGA partners, beneficiaries and their caregivers), AHS and CMS. The DVHA communicates to its stakeholders through a variety of mechanisms. The following table outlines these mechanisms:

Mechanism	Stakeholder	Timeframe for Dissemination
DVHA Web Site/Scorecard	Beneficiaries, Providers, Public, Regulators	Ongoing updates and Quality Reporting
Beneficiary Newsletter	Beneficiaries	Annually
Banner Pages (printed and electronic)	Providers	Weekly
Medicaid Advisory Newsletter (printed and electronic)	Providers	Every 2 months
Medicaid & Exchange Advisory Board (meetings and minutes electronic)	Beneficiaries, Providers, Public	Monthly
Clinical Practice Standards	Providers	Periodic
Pharmacy Newsletter (printed and electronic)	Providers	Periodic – as needed
CMS Quarterly Report	CMS, AHS	Quarterly

3. PERFORMANCE MEASURES

Performance Measures

Performance measures are indicators or metrics that are used to gauge program performance. They provide information needed to measure the extent to which the DVHA is achieving its intended results/outcomes.

The DVHA collects, analyzes and reports on the following sets of measures to assess our success in progressing towards what the Institute of Medicine calls six (6) Aims for Improvement. These aims can be summarized as care that is:

- **Safe:** avoiding injuries to patients from the care that is intended to help them.
- **Effective:** providing services based on scientific knowledge.
- **Patient-centered:** providing care that is responsive to individual patient preferences, needs and values and assuring that patient values guide all clinical decisions.
- **Timely:** reducing waits and sometimes harmful delays for both those who receive care and those who give care.
- **Efficient:** avoiding waste, including waste of equipment, supplies, ideas, and energy.
- **Equitable:** providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location or socio-economic status.

3.1 HEDIS

The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. Altogether, HEDIS consists of 83 measures across 14 domains of care.

Reporting and Analysis:

Annually, the DVHA measures and reports to AHS its performance using these standard HEDIS tool sets. Performance Measures have been required in the following focus areas:

- Prevention and Screening
- Access/Availability of Care
- Behavioral Health
- Diabetes
- Respiratory Conditions
- Cardiovascular Conditions

MCE Quality Management Plan

The DVHA runs the full set of HEDIS measures annually. Fifteen of these measures are currently required by the AHS and are validated through an external quality review organization. Below is the schedule the DVHA is following to calculate and report on the AHS chosen HEDIS measures that relate to the above focus areas:

FOCUS AREA/ PERFORMANCE MEASURE	June 1, 2008	June 1, 2009	June 1, 2010	June 1, 2011, 2012, 2013	June 1, 2014	August 1, 2015
<i>Prevention and Screening</i>						
Childhood Immunization Status	✓					
Adolescent Immunization Status	✓					
Lead Screening in Children		✓				
Breast Cancer Screening					✓	✓
Chlamydia Screening in Women					✓	✓
<i>Utilization</i>						
Well Child Visits in the First 15 Months of Life	✓	✓	✓	✓	✓	✓
Well Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life	✓	✓	✓	✓	✓	✓
Adolescent Well-Care Visits	✓	✓	✓	✓	✓	✓
Inpatient Utilization: General Hospital/Acute Care		✓				
Ambulatory Care		✓				
Outpatient Drug Utilization		✓				
<i>Access/Availability of Care</i>						
Annual Dental Visits	✓	✓	✓	✓	✓	✓
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment					✓	✓
Prenatal and Postpartum Care		✓	✓			✓ (hybrid)
Adults' Access to Preventive/Ambulatory Health Services		✓	✓	✓	✓	✓
Children's and Adolescents' Access to Primary Care Practitioners		✓	✓	✓	✓	✓
<i>Behavioral Health</i>						
Antidepressant Medication Management		✓	✓	✓	✓	✓
Follow-Up After Hospitalization for Mental Illness					✓	✓
<i>Diabetes</i>						
Comprehensive Diabetes Care		✓	✓	✓	✓ (hybrid)	✓ (hybrid)
<i>Respiratory Conditions</i>						
Use of Appropriate Medications for People with Asthma		✓	✓	✓		✓
<i>Cardiovascular Conditions</i>						
Controlling High Blood Pressure						✓ (hybrid)
TOTAL	6	14	10	9	12	15

These measures will be calculated and reported to AHS by DVHA’s Data Unit on or before the noted timeframes. DVHA contracts with a NCQA-certified software vendor to produce the measures. The data report is analyzed by the DVHA Managed Care Medical Committee to determine if goals are met and if future improvement activities are needed.

3.2 CMS Adult Core Measure Set

The Centers for Medicare & Medicaid Services (CMS) published an Initial Core Set of Measures via Federal Register Notice on January 4, 2012 signifying an important step toward better understanding, at both the State and national level, the quality of health care delivered to Medicaid covered adults.

The Adult Core Measure set consists of:

Measure Name	Measure Steward	Measure Reported by DVHA to CMS for CY 2013
Flu Shots for Adults Ages 50-64 (Collected as part of HEDIS CAHPS Supplemental Survey)	NCQA	X
Adult BMI Assessment	NCQA	X
Breast Cancer Screening	NCQA	X
Cervical Cancer Screening	NCQA	X
Medical Assistance With Smoking and Tobacco Use Cessation (Collected as part of HEDIS CAHPS Supplemental Survey)	NCQA	X
Screening for Clinical Depression and Follow-Up Plan	CMS	
Plan All-Cause Readmission	NCQA	X
PQI 01: Diabetes, Short-term Complications Admission Rate	AHRQ	X
PQI 05: Chronic Obstructive Pulmonary Disease (COPD) Admission Rate	AHRQ	X
PQI 08: Congestive Heart Failure Admission Rate	AHRQ	X
PQI 15: Adult Asthma Admission Rate	AHRQ	X
Chlamydia Screening in Women age 21-24	NCQA	X
Follow-Up After Hospitalization for Mental Illness	NCQA	X
PC-01: Elective Delivery	The Joint Commission	
PC-03 Antenatal Steroids	The Joint Commission	
Controlling High Blood Pressure	NCQA	X
Comprehensive Diabetes Care: LDL-C Screening	NCQA	X
Annual HIV/AIDS medical visit	NCQA	
Comprehensive Diabetes Care: Hemoglobin A1c Testing	NCQA	X

Antidepressant Medication Management	NCQA	X
Adherence to Antipsychotics for Individuals with Schizophrenia	CMS-QMHAG	X
Annual Monitoring for Patients on Persistent Medications	NCQA	X
CAHPS Health Plan Survey v 5.0 - Adult Questionnaire	AHRQ & NCQA	X
Care Transition – Transition Record Transmitted to Health care Professional	AMA-PCPI	
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	NCQA	X
Prenatal and Postpartum Care: Postpartum Care Rate	NCQA	X

Reporting and Analysis:

DVHA reported to CMS on 21 of these 26 measures in January 2015; 17 HEDIS measures and 4 Prevention Quality Indicator (PQI) measures. Four (4) of the selected 17 HEDIS measures are hybrid measures, meaning they are calculated through both claims based and chart review data. After analysis of our measure results, the DVHA has also undertaken Performance Improvement Projects (PIPs) on 3 of the selected measures (see Section 6, Performance Improvement, for more information on these projects).

3.3 CMS Children’s Core Measure Set

The Children's Health Care Quality Measures for Medicaid and CHIP originated from the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009. Ultimately, the goals of this core measure set are to provide a national estimate of the quality of health care for children; facilitate comparative analyses across various dimensions of pediatric health care quality; and help identify racial, ethnic, and socioeconomic disparities.

The Children's Core Measures Set consists of:

Measure Name	Measure Steward	Measure Reported by DVHA to CMS for CY 2013
Human Papillomavirus (HPV) Vaccine for Female Adolescents	NCQA	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents	NCQA	
Child and Adolescent Access to Primary Care Practitioners	NCQA	X
Childhood Immunization Status	NCQA	
Immunization Status for Adolescents	NCQA	
Frequency of Ongoing Prenatal Care	NCQA	
Timeliness of Prenatal Care	NCQA	X
Live Births Weighing Less than 2,500 grams	CDC	X
Cesarean Rate for Nulliparous Singleton Vertex	CMQCC	
Behavioral Health Risk Assessment (for Pregnant Women)	AMA-PCPI	
Developmental Screening in the First Three Years of Life	OHSU	
Well Child Visits in the First 15 Months of Life (noted here is the 6 or more visit rate, which is the recommended standard of care)	NCQA	X
Well Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	NCQA	X
Adolescent Well Care Visit	NCQA	X
Chlamydia Screening in Women (age 16-20)	NCQA	X
Percentage of Eligibles that Received Preventive Dental Services	CMS	X
Percentage of Eligibles that Received Dental Treatment Services	CMS	X
Medication Management for People with Asthma	NCQA	X
Follow-Up after Hospitalization for Mental Illness (HEDIS measure rates here are not reported by age)	NCQA	X
Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication	NCQA	X
Pediatric Central-line Associated Bloodstream Infections - Neonatal Intensive Care Unit and Pediatric Intensive Care Unit	CDC	

Ambulatory Care - Emergency Department (ED) Visits (rate of ED visits per 1,000 enrollee months broken down by age groups)	NCQA	X
Consumer Assessment of Health Care Providers and Systems (CAHPS) 5.0H (Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items)	NCQA - CAHPS	X

Reporting and Analysis:

Currently, fourteen (14) of the Children’s Core Measures are reported on by the DVHA to CMS annually. The DVHA is also doing a performance improvement project (PIP) on one of the selected measures.

3.4 Health Home Measures Set:

Section 2703 of ACA added a new Section 1945 to the Social Security Act (SSA), which gives States the option to pay providers to coordinate care through a “health home” for individuals with chronic conditions. Health homes are designed to facilitate access to and coordination of the full array of primary and acute physical health services, behavioral health care and long-term community-based services and supports. The DVHA Hub & Spoke initiative is made up of health home services (care coordination, care management, transitions of care, health promotion, referral to community services, and patient and family support) applied to the Medicaid population with opiate addictions.

The **Health Home Measures** are comprised of 8 CMS required measures (which overlap with the Adult Core Measures Set) and an additional 9 measures selected by Vermont as relevant to the medication assisted treatment population. These are HEDIS or HEDIS-like measures, many of which require clinical information and cannot solely be derived from claims.

The recommended Health Home Quality Measures Set includes:

<u>CORE MEASURES</u>	<u>DATA SOURCE</u>
Adult BMI Assessment	EMR/Claims
ACSC Admission	Claims/Claims
Care Transition – record transmitted to health care professional	EMR/Claims
Follow-up after hospitalization for mental illness	Claims/Claims
All cause readmission	Claims/Claims
Clinical depression screening and follow-up plan	EMR/EMR
Initiation & engagement of alcohol and other drug dependence treatment	Claims/Claims
Controlling high blood pressure	EMR/Claims

<u>STATE MEASURES SELECTED</u>	<u>DATA SOURCE</u>
ACSC/Preventable ED visits	Claims/Claims
All cause ED visits	Claims/Claims (CMS Evaluation)
Self management for any chronic condition	EMR/EMR
Age & gender appropriate health screening: <ul style="list-style-type: none"> - Breast cancer - Cervical cancer - Colorectal cancer 	Claims/Claims
Alcohol misuse screening <ul style="list-style-type: none"> - Annual screening with AUDIT-C & documentation 	EMR/Claims
Tobacco cessation screening & receipt of advice to quit smoking	EMR/EMR
Receipt of care transition record at time of discharge	EMR/Claims

Reporting and Analysis:

The DVHA is not yet required to report out on these core and state-specific measures. However, the DVHA is pro-actively working intra-departmentally and with our Hub and Spoke provider partners to ready ourselves for data collection and reporting. Ultimately, the results of these measures will be used to evaluate care across our Hub and Spoke program.

3.5 Medicaid Accountable Care Organization (ACO) Shared Savings Program (SSP) Quality Measures Set:

The Vermont Medicaid SSP is a performance-based contract which governs the calculation and distribution of financial incentives, via shared savings, to Accountable Care Organizations (ACOs) that proactively invest in new care management programs and redesign care processes to improve the quality, efficiency and effectiveness of care delivered to Medicaid beneficiaries. (*Green Mountain Care Board, Compilation of Pilot Standards, draft as of August 20, 2013*) The Vermont Medicaid ACO Shared Savings Program pilot is administered by the DVHA.

In order to retain savings, an ACO must meet a minimum threshold for performance on a defined set of common measures. A full description of Vermont Medicaid’s ACO’s Performance Measure Set can be found here:

<http://dvha.vermont.gov/administration/performance-measures-and-shared-savings.pdf>

Reporting and Analysis:

The payers and ACOs will be partnering with a Statewide Data Analytics Contractor, the Lewin Group. After receiving on July 15, 2016:

- the final claims files for the claims-based quality measures required for the time period covering January 1, 2015 through December 31, 2015 from the payers
- the numerators and denominators for the clinical data-based reporting measures for the time period covering January 1, 2015 through December 31, 2015 from the ACOs; and

- the patient experience measures for the time period covering January 1, 2015 through December 31, 2015 from the state's survey contractor

the Green Mountain Care Board (GMCB) analytics contractor will conduct a final assessment of each ACO's Year 2 performance on both the payment and reporting measures. The analytics contractor will also assess the implications of ACO quality performance on distribution of any earned savings. The GMCB analytics contractor will compile the final quality measures report data for the Medicaid population (and for the commercially insured population covered by Vermont's commercial Shared Savings Program) for each ACO and submit the report to the GMCB no later than 45 days following the receipt of the final claims files.

The GMCB will then provide this report to DVHA (and participating commercial payers), as well as the ACOs.

3.6 Experience of Care Measures

The DVHA is also required to calculate and report out on its beneficiaries' experience of care. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey provides an assessment of health plan performance from a consumer perspective regarding the plan's services and care delivery system. The DVHA will report the following CAHPS measures:

- Getting Needed Care (The level of difficulty reported by beneficiaries as a big problem, a small problem, or not a problem with getting access to physicians, specialists, and necessary care; and delays while waiting for approval for care).
- Getting Care Quickly (Satisfaction with the frequency of always, usually, sometimes, or never getting help/advice when calling physician's office, getting appointments for routine and illness/injury care, and time spent waiting past appointment time to see a provider).
- Customer Service (The level of difficulty reported by beneficiaries as a big problem, a small problem, or not a problem in understanding the plan's written materials and getting help when calling customer service).
- Overall Rating of Health Plan (This measure uses a 10 point scale to assess beneficiary perceptions of their health plan).

The DVHA contracts with a third party vendor to conduct both the Children and Adult surveys annually. Our NCQA-certified vendor has the ability to add additional question sets to our base survey should the DVHA request and plan for such (e.g. chronic conditions question set). The surveys use random samples of all *Global Commitment to Health* beneficiaries.

Additionally, each of the IGA Partners will share with DVHA the formats and results of any satisfaction surveys conducted by the department that include *Global Commitment to Health* beneficiaries. A performance improvement project is initiated to address a deficiency while a corrective action plan is initiated for providers that fail to meet standards of care.

Reporting and Analysis

The CAHPS survey results, as well as an initial analysis of the results, are compiled by the vendor and reported to the DVHA. The DVHA will report CAHPS survey results to AHS annually. In addition, the MCE Quality Committee further analyzes the results to determine whether any quality improvement projects should be initiated.

3.7 DVHA Strategic Plan Measures:

As the DVHA strives to ensure access and provision of high quality health care to Medicaid beneficiaries, the Department's Strategic Plan provides a framework for these efforts. There are currently six (6) overarching goals within the Strategic Plan: 1. Reduce health care costs and cost growth, 2. Assure that all Vermonters have access to and coverage for high-quality health care (health care includes mental health, physical health and substance abuse treatment), 3. Reduce the complexities of health care interactions and transactions, 4. Support improvement in the health of Vermont's population, 5. Improve customer and provider satisfaction, and 6. Establish and infrastructure that assures professional workforce competency and staff satisfaction.

Each Goal is linked to a State-wide priority and a set of performance measures, used to gauge progress towards achieving that Goal.

Reporting and Analysis

Historically, the DVHA's Management Team has been charged with reporting out on the Strategic Plan measures. Management Team members are assigned ownership of measures, groups of which are reported out on regularly. A reporting template based on the Results Based Accountability (RBA) framework is used to supplement the analysis of the data. The results of the Management Team group analysis help target areas for improvement, as well as the focus for future strategic planning efforts.

The DVHA's Management Team, along with all other AHS Departments, are embarking on a new Strategic Planning cycle starting in the spring/summer of 2015.

4. ACCOUNTABILITY MONITORING & OVERSIGHT

In addition to gauging our progress on key performance measures, the DVHA's quality management approach includes quality assurance (QA). These are the monitoring and oversight functions needed to "assure" compliance with various state and federal regulations related to operating as an MCE. As you will read in the following section on Quality Improvement, the DVHA uses all of the following QA activities to inform improvement initiatives.

4.1 Coordination and Continuity of Care

The DVHA implements procedures to deliver primary care to and coordinate health care services for all beneficiaries. Each beneficiary has an ongoing source of primary care appropriate to his/her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the beneficiary.

In addition, the State has identified four (4) special health care needs populations within the larger Medicaid population:

- Children enrolled in the community mental health centers who are identified with severe emotional disturbance (SED)
- Adults enrolled in the Community Rehabilitation and Treatment Program
- Adults enrolled in Developmental Disability Services (DDS)
- Individuals enrolled in the Traumatic Brain Injury program (TBI)

The DVHA recognizes the importance of identifying beneficiaries with special health care needs and providing appropriate coordinated care. In order to identify any ongoing special conditions of beneficiaries identified as having special health care needs, the DVHA has delegated to its IGA Partners (Departments) the responsibility to maintain mechanisms to identify beneficiaries with special health needs and to assess each beneficiary identified as having special health care needs. The Department shall ensure that in the process of coordinating care, each beneficiary's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E.

The DVHA also delegates to its IGA partners the responsibility to identify any ongoing special conditions of the beneficiaries that require a course of treatment or regular care monitoring. As a result, the Departments develop care plans/service plans for the individuals identified. The plans must identify specialist services that may be accessed directly by the beneficiary as appropriate for that beneficiary's condition and identified needs. The Departments shall maintain procedures for monitoring to ensure that the treatment is provided per the terms of the plan. The Departments shall make available to the DVHA, if requested, information on individuals identified as having special health needs.

The DVHA has delegated to:

- The Department of Mental Health (DMH) the responsibility for identifying, assessing and developing treatment plans for children enrolled in the community mental health system identified with severe emotional disturbance (SED) and adults enrolled in the Community Rehabilitation and Treatment Program (CRT).

- The Department of Disability, Aging and Independent Living (DAIL) the responsibility for identifying, assessing and developing service plans for adults enrolled in Developmental Services (DS).
- The Department of Disability, Aging and Independent Living the responsibility for identifying, assessing and developing service plans for adults enrolled in the Traumatic Brain Injury Program (TBI).

Reporting and Analysis:

For coordination of care details regarding Eligibility and Assessment, Plan of Care, Monitoring and Reporting, refer to the DVHA Inter-governmental Agreements (IGA) with the DMH and DAIL. Analysis of this reporting is primarily the responsibility of the DVHA Compliance Director and Compliance Committee. When appropriate, compliance concerns and/or opportunities for improvement generated from these venues will be taken to the Quality Committee for discussion and possible Quality Improvement (QI) projects.

4.2 Availability of Services

All services covered under the State Plan need to be available and accessible to Medicaid beneficiaries. The DVHA must maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the agreement. The DVHA must meet and require its providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services. The DVHA must also establish mechanisms to ensure compliance by providers, monitor providers regularly to determine compliance, and take corrective action if there is a failure to comply.

DVHA Activities

i. Provider Network

In order to maintain the best possible access to health care for the beneficiaries the DVHA ensures that a network of appropriate providers is maintained. The DVHA ensures that coverage is available to beneficiaries on a twenty-four hour per day, seven day per week basis by establishing policy, and documenting this in the provider manual. Coverage and payment of emergency services is established in Medicaid Policy and is available for all beneficiaries. Post-stabilization care services provided on an inpatient hospital basis are paid for by the DVHA for all beneficiaries and established in Medicaid Policy.

The DVHA ensures that travel time to services does not exceed the limits outlined in the AHS/DVHA IGA by establishing Medicaid Policy. Vermont Medicaid Policy outlines the requirements for appointment waiting times, travel times, access to women's specialty care, and access to emergency services. The Medicaid Provider Manual also outlines the requirements for 24-hour/seven days per week coverage, appointment waiting times standards, and emergency care. Appointment availability meets the usual and customary standards for the community and complies with the following:

- Urgent care: Within twenty-four hours
- Non-urgent, non-emergency conditions: Within 14 days

- Preventive Care: Within 90 days.

Global Commitment to Health Waiver beneficiaries have the choice of health professionals within the network of Medicaid providers to the extent possible and appropriate. Beneficiaries also have direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventative health care services. AHS policy requires that the DVHA ensures availability of interpreter services by offering reimbursement. The DVHA participates in AHS's efforts to promote the delivery of services in a culturally competent manner.

The DVHA utilizes several resources to evaluate the provider network and adherence to the above identified standards. The Managed Care Medical Committee and the DVHA Quality Committee on a regular basis review the grievances and appeals, member complaints, health care ombudsman reports, CAHPS survey, and a provider survey to identify areas for improvement.

ii. Mapping and Network Analysis

The DVHA maintains systematic analysis of the health care provider network to monitor and evaluate capacity. Mapping allows for visual representation of the provider network and helps to identify any access issues. Specifically, geographic mapping of all health care providers enables the DVHA to evaluate and monitor access, target licensed but not enrolled providers, and evaluate providers in comparison to beneficiaries to ensure access.

A series of maps for certain provider types depict data that include, but are not limited to, the percentage of licensed providers enrolled, the percentage of enrolled providers accepting new patients, the percentage of beneficiaries receiving services from the provider type, etc.

The analysis and monitoring is a continuous process, and year-to-year comparisons will be available as maps are updated to reflect subsequent state fiscal year data.

In addition to the mapping of providers, the DVHA performs monthly random surveys and a random check of providers against the state and federal exclusion lists. The DVHA's fiscal representative, HP, performs a 100% verification upon enrollment of all providers to ensure they are eligible to contract with the state Medicaid program. Additional checks are performed by HP on a monthly basis to verify that each provider is still licensed and has not been convicted of a crime. DVHA staff perform site visits for certain providers based on the fraud risk level for that provider type.

Reporting and Analysis:

- Provider Mapping
- Result of Provider Survey (access standards)
- MCE Quality Committee and Managed Care Medical Committee Minutes addressing availability of services

Analysis of this reporting is primarily the responsibility of the DVHA Compliance Director and Compliance Committee. When appropriate, compliance concerns and/or opportunities for improvement

generated from these venues will be taken to the Quality Committee for discussion and possible Quality Improvement (QI) projects.

4.3 Confidentiality

The DVHA must use and disclose individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E, to the extent that these requirements are applicable. The DVHA uses the following definitions to guide this work.

Confidentiality – the assurance that information about identifiable persons will not be disclosed without consent except as allowed by law.

Privacy – the right of individuals to hold information about themselves in secret, free from the knowledge of others.

Security – the mechanisms by which confidentiality policies are implemented in computer systems, including provisions for the following: access control, integrity, and availability.

The *Standards for Privacy of Individually Identifiable Health Information* (“Privacy Rule”) established a set of national standards for the protection of certain health information. The U.S. Department of Health and Human Services (“HHS”) issued the Privacy Rule to implement the requirement of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). The Privacy Rule standards address the use and disclosure of individuals’ health information—called “protected health information” by organizations subject to the Privacy Rule — called “covered entities,” as well as standards for individuals' privacy rights to understand and control how their health information is used. Privacy laws regulate the types of data that can be collected and how the information can be used.

DVHA Activities:

The DVHA shares responsibility with AHS in implementing and assessing confidentiality, privacy, and security practices. As an umbrella organization, AHS promulgates standards and materials for use (e.g. Access to Information; Notice of Privacy Practices; Business Associate Agreement) that are required of the DVHA and the AHS Departments that complete delegated functions for the DVHA. AHS has implemented an online HIPAA Privacy & Security Training for all staff, in all departments.

Within this framework, the DVHA delegates to its IGA partners the responsibility to guard the confidentiality and privacy of individually identifiable health information contained in beneficiary records in a manner consistent with 45 CFR parts 160 and 164 to the extent that these requirements are applicable. Specific requirements include the following: policies and procedures for protecting beneficiary information; procedures for authorizing access to beneficiary information; policies related to accessing and distributing privileged health information: physical security procedures; and information system security procedures. Form letters have been developed for both acceptance and denial of a request to access health information and for an individual to request disclosure of their own health information. The DVHA and each Department have an identified liaison to AHS for HIPAA compliance on privacy and security.

The DVHA requires that all contracted external entities maintain policies and procedures that comply with Federal and State laws and regulations related to confidentiality, privacy, and security, including HIPAA. As part of the contract process, these entities are required to complete a Business Associate Agreement which details the State’s (and therefore the DVHA’s) expectations for maintaining the

integrity of privileged health information. For example, privacy and security standards are outlined in the State of Vermont Contract for Personal Services with the MCE pharmacy benefit management vendor, MedMedtrics Health Partners, Inc.

The DVHA establishes an Operating Principle for security of information technology, and AHS' IT department works with each Department in the same manner that it works with the DVHA to insure the integrity of the IS systems. Security instructions have been developed for electronic devices.

The State's Buildings and General Services division ensures the physical security of all State-owned office buildings. A safety and security assessment has been performed for the DVHA office buildings.

Reporting and Analysis:

- Safety and Security Assessments
- Incident Reports
- Security Breach Reports

Analysis of this reporting is primarily the responsibility of the AHS HIPAA Privacy Officer with support from the DVHA Compliance Director and Compliance Committee. When appropriate, compliance concerns and/or opportunities for improvement generated from these venues will be taken to the Quality Committee for discussion and possible Quality Improvement (QI) projects. Additionally, the Quality Committee collaborates with the AHS HIPAA Privacy Officer for an annual review of privacy breaches and any subsequent recommendations.

4.4 Grievance System

A Grievance System allows beneficiaries to disagree with a DVHA decision on an issue, raise a concern about administrative claims issues, or express dissatisfaction with the quality of care received from a specific provider. The DVHA must have a system in place for beneficiaries that includes a grievance process, an appeals process, and access to the State's fair hearing system.

DVHA Activities:

The DVHA maintains a grievance and appeals process that responds to all grievances, grievance reviews, appeals, expedited appeals, and State fair hearing requests initiated by beneficiaries. The DVHA maintains a database that compiles all grievance and appeals filed against the DVHA, the IGA Partners, the DVHA actions, or actions of the IGA Partners.

While the DVHA maintains electronic records of all grievances and appeals filed against the IGA Partners, the IGA Partners are responsible for complying with the AHS grievance and appeal process, and responding appropriately. The DVHA has a designated liaison who works with the grievance and appeal coordinators of the IGA Partners to ensure that they remain up-to-date on the latest policies.

To ensure beneficiary rights, the DVHA has developed and adheres to uniform grievance and appeals rules. Medicaid Rules and Operating Principles have been developed pertaining to grievances and appeals. Beneficiary's grievance and appeal rights are referenced in the Medicaid Member Handbook

and the Provider Manual. Quarterly, the Grievance and Appeal Coordinators submit a trend report to the DVHA Quality Committee. The Quality Committee reviews the quarterly reports to identify trends and areas for improvement.

The DVHA delegates to the IGA partners the responsibility to follow the Agency of Human Services Beneficiary Grievance and Appeal Procedures rules. The IGA Partners report all grievances and appeals to the DVHA for tracking.

Reporting and Analysis:

- Grievance and Appeal Annual Report
- Grievance and Appeal Quarterly Trend Reports

Analysis of the annual report is primarily the responsibility of the MCE Quality Committee. When appropriate, compliance concerns and/or opportunities for improvement generated from these venues will be taken to the Compliance Director for discussion and possible Quality Improvement (QI) projects.

4.5 Provider Selection

The DVHA must demonstrate that its providers are appropriately licensed and certified and they may not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act.

DVHA Activities:

i. Licensing and Certification

HP, the DVHA's Fiscal Agent, is responsible for the identification and enrollment of eligible Medicaid providers in the State. HP is responsible for obtaining all necessary licenses and certifications (and tracks deadlines for re-licensing/credentialing). As the fiscal agent, HP populates the State's MMIS system with the provider information and appends the appropriate controls and edits to ensure that the provider only claims services which s/he has the appropriate training and license/certification to provide. Additional checks are performed by HP on a monthly basis to verify that each provider is still licensed and has not been convicted of a crime. DVHA staff perform site visits for certain providers based on the fraud risk level for that provider type.

In order for the DVHA to ensure providers are licensed and/or certified, a system has been developed with HP to track new applications as well as re-certifications for providers whose certifications are about to expire. The State reviews a random sample of the applications each month and approves all providers.

The DVHA performs regularly scheduled independent random reviews of the providers' licensure and/or certification to ensure that providers enrolled by HP in the DVHA's provider network are licensed and/or certified where required, and that excluded providers are not enrolled. The DVHA performs a check of the Federal System for Award management website to determine providers are not excluded from participating in programs funded with federal money. Weekly meetings are held with HP

to discuss issues that HP identifies during the credentialing process. All providers are assigned a provider type and provider specialty when enrolling in the Medicaid program.

ii. Excluded Providers

The DVHA must demonstrate that it does not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the BBA.

In order to ensure quality of care provided to beneficiaries, the DVHA has adopted the AHS enrollment requirements for the Medicaid program for providers participating in the *Global Commitment to Health Waiver*. The DVHA maintains procedures for implementation of the provider selection requirements (e.g. nondiscrimination, an open network policy for providers that meeting licensing requirements); however, actual implementation of the provider selection requirement is fulfilled completely by HP.

HP maintains control of all provider selection and enrollment activities but final decisions are made by the DVHA. Since the DVHA operates as an open network for eligible providers (e.g. those that meet licensing requirements are not excluded through disbarment), HP ensures that providers have completed all forms appropriately, have records created in the MMIS, and ensure that the proper edits and controls are included in the MMIS for billing purposes.

Upon approval from the DVHA, HP enters provider information into the MMIS and programs necessary automated edit and audit checks to ensure that all *Global Commitment to Health Waiver* providers are licensed and/or certified where required, and are acting within the scope of that license and/or certification. The DVHA has developed Operating Principles to analyze provider enrollment applicants, to ensure nondiscrimination of providers, and to ensure providers excluded from acting as Medicaid providers by the Federal Government are not contracted with. Unless authorized by State or Federal statute or regulation, the DVHA is prohibited from discriminating against any provider who is acting within the scope of his or her license or certification under applicable State of Vermont law, solely on the basis of that license or certification for participation, reimbursement or indemnification.

Reporting and Analysis:

- Provider Selection Report

Analysis of this reporting is primarily the responsibility of the DVHA Compliance Director and Compliance Committee. When appropriate, compliance concerns and/or opportunities for improvement generated from these venues will be taken to the Quality Committee for discussion and possible Quality Improvement (QI) projects.

4.6 Utilization Management

Utilization Management is a systematic evaluation of the medical necessity and appropriateness of care provided to beneficiaries. These activities are designed to influence providers' resource utilization and clinical practice decisions in a manner consistent with established criteria or guidelines to maximize appropriate care and minimize/eliminate inappropriate care. At a minimum, the DVHA must have in effect a mechanism to detect both under/over utilization of services and to assess the quality and appropriateness of care furnished to beneficiaries with special health care needs.

DVHA Activities:

i. Over and Under Utilization

The DVHA's Utilization Management (UM) Program is outlined in a document which describes the UM activities provided by the DVHA, its IGA partners, and contractors for *Global Commitment to Health* beneficiaries. UM functions are intended to ensure care furnished to beneficiaries is medically necessary and appropriate. The document outlines the UM Program structure and accountability, scope, processes and information used for decision making. The UM Plan outlines the DVHA's goals, objectives, interventions and measures for evaluating and improving utilization. The UM Program and UM Plan are evaluated, updated and approved annually by the DVHA Managed Care Medical Committee (MCMC).

ii. Delegated Activities - Appropriateness of Services

The DVHA delegates to its IGA partners who provide care to the four (4) identified special health care needs populations the responsibility to develop mechanisms to assess the quality and appropriateness of care furnished to beneficiaries with special health care needs. The Department of Mental Health (DMH) monitors the quality and appropriateness of care to beneficiaries in the CRT Program and for children identified with severe emotional disturbance (SED) through the Minimum Standards Review for non-accredited agencies, the Agency Review and the Agency Designation review processes, each of which is conducted once every four years. The Department of Disability, Aging and Independent Living (DAIL) monitors the quality and appropriateness of care to beneficiaries in the DS Program and the TBI Program through the Quality Service Reviews.

For details regarding these delegated activities, including monitoring and reporting specifics, refer to the Inter-governmental Agreements (IGAs).

Reporting and Analysis:

- DVHA Utilization Management Work Plan

The IGA partners will provide the results of the following departmental monitoring activities to the DVHA based on an agreed upon schedule:

- DMH – Minimum Standards Audit Reports, Accreditation Reports and Agency Reviews
- DAIL – Quality Service Reviews

Analysis of this reporting is primarily the responsibility of the DVHA Compliance Director and Compliance Committee. When appropriate, compliance concerns and/or opportunities for improvement generated from these venues will be taken to the Quality Committee for discussion and possible Quality Improvement (QI) projects.

4.7 Practice Guidelines

Practice guidelines are systematically developed statements on practice designed to assist practitioner and patient decisions about appropriate health care treatment for specific clinical conditions. Their successful implementation should improve quality of care by decreasing inappropriate variation and expediting the application of effective advances to everyday practice. Adherence to guidelines can also result in a reduction of overall treatment costs. These documents are used to direct practice across the state, educate members and providers, provide the basis for utilization management decisions, and enhance service delivery.

Activities:

The DVHA must adopt, disseminate, and apply (at a minimum) two practice guidelines that meet the following criteria:

- Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;
- Consider the need of its beneficiaries;
- Are adopted in consultation with contracting health care professionals; and
- Are reviewed and updated periodically as appropriate

The DVHA must also disseminate the guidelines to all affected providers and, upon request, to beneficiaries and potential beneficiaries. Finally, decisions for utilization management, beneficiary education, coverage of services, and other areas to which the guidelines apply must be consistent with the guidelines. The DVHA has adopted practice guidelines for Buprenorphine and Diabetes. The DVHA will develop additional practice guidelines as topics emerge that are appropriate. The Managed Care Medical Committee (MCMC) has a process for selecting and implementing practice guidelines.

Reporting and Analysis:

- Practice Guidelines

4.8 Health Information Systems

The DVHA shall maintain a management information system that collects, analyzes, integrates and reports data. The system(s) must provide information on areas including, but not limited to, utilization, grievances, and appeals. The system(s) must collect data on beneficiary and provider characteristics, as specified by AHS and on services as set forth under Section 2.12.1 of the AHS/DVHA IGA. The DVHA must collect, retain and report encounter data, defined currently as a provider claim, in accordance with the *Global Commitment to Health Waiver's* Terms and Conditions. The DVHA must ensure that data received from its providers is accurate and complete. All collected data must be available to AHS and the CMS upon request.

DVHA Activities:

The DVHA collects, analyzes, integrates and reports data that, at a minimum, provides key information related to the following areas:

- Utilization
- Grievance and appeals

Through its health information system (HIS), the DVHA collects, and requires its IGA partners to collect, information on both beneficiary and provider characteristics. The HIS must also collect information on services furnished to beneficiaries.

The DVHA also has processes to ensure that:

- HP edits and audits provider claims for accuracy, timeliness, correctness and completeness
- Claims submitted are only for *Global Commitment to Health Waiver* beneficiaries

Encounter data is currently defined by the AHS as a “claim”. All claims for payments are currently submitted to HP and undergo a series of automated edits and audits to ensure accuracy, timeliness, correctness, and completeness. Claims must represent services provided to *Global Commitment to Health Waiver* beneficiaries only. The DVHA performs validation on a random sample of all claims to ensure that services were actually provided.

As part of its responsibility as the fiscal agent services provider to the DVHA, HP is responsible for the REOMB program integrity reporting. REOMB reports contain beneficiary name, address, MID, provider of service, date service received, description of service, and Medicaid reimbursement amount of service. REOMB processing is used to identify potential provider fraudulent billing by engaging Vermont Medicaid beneficiaries in a review of provider billing activity. Specifically, quarterly mailings are issued to a random sample of beneficiaries. The mailings include a list of the services provided to the specific beneficiaries. Beneficiaries are asked to review the claims associated with their healthcare services and to notify the DVHA if they identify any services being billed that are not connected with services they have received.

Reporting and Analysis:

- HIS generated reports
- Quarterly Grievance and Appeal reports

Analysis of this reporting is primarily the responsibility of the DVHA Compliance Director and Compliance Committee. When appropriate, compliance concerns and/or opportunities for improvement generated from these venues will be taken to the Quality Committee for discussion and possible Quality Improvement (QI) projects.

4.9 Authorization of Services

The DVHA may require authorization for certain covered services including, but not limited to, inpatient hospital admissions, home and community based services, and certain pharmaceutical products. For the processing of requests for initial and continuing authorizations of services the DVHA, with its IGA partners, must have in place and follow written policies and procedures. Mechanisms to ensure consistent application of review criteria must be in effect and the requesting provider is consulted when appropriate. Any decision to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested is made by a healthcare professional who has appropriate clinical expertise in treatment of the beneficiary's condition. The DVHA, and its IGA partners, shall notify the requesting provider and give the enrollee written notice of any decision by the DVHA, or its IGA partners, to deny a service authorization request or to authorize a service in the amount, duration or scope that is less than requested.

Activities:

The DVHA has and follows written authorization policies and procedures that include criteria for processing requests for initial and continuing authorization of medically necessary covered services, mechanisms to ensure consistent application of review criteria, and requirements for the denial or reduction of a service authorization request.

Approved criteria and resources include the following:

Clinical Operations Unit (COU) and Quality Improvement & Clinical Integrity Unit (QICIU):

DVHA Clinical Operations Unit Procedure Manual
McKesson Health Solutions InterQual® Guidelines
Vermont State Medicaid Rules
Hayes and Cochrane New Technology Assessments
DVHA Prior Authorization Clinical Criteria Procedure
DVHA-Developed Clinical Coverage Guidelines
McKesson Health Solutions InterQual® Behavioral Health Criteria
Dental Supplement Manual
Dental Standing Orders
Other Nationally Recognized Evidence-Based Criteria
Standard Operating Procedures Manual for Vermont Medicaid Inpatient and Detoxification Authorizations

Pharmacy:

Pharmacy Preferred Drug List and Criteria

Ensuring Consistency in Applying Criteria:

The DVHA provides training to all new staff and conducts periodic staff testing, peer review, and chart audits to help ensure inter-rater reliability (IRR) across reviewers. The DVHA annually evaluates the

consistency with which health care professionals involved in authorizations apply criteria in making authorization decisions. Those evaluated include Clinical Operations Unit (COU) UM nurses, licensed mental health professionals, and pharmacist reviewers. The Managed Care Medical Committee (MCMC) annually reviews the audits and corrective action plans of inter-rater reliability assessments.

The Clinical Operations Unit utilizes a standardized tool and the minimum passing rate of an IRR review is 80%.

New pharmacy reviewers have all their completed PAs reviewed, with the number of required reviews decreasing as the reviewer gains experience (15 PAs per week for the first month and then 30 PAs per month for the next two months). Experienced reviewers have 30 randomly selected PAs reviewed three times a year (twice annually for those not working full-time). Discrepancies are discussed with the reviewer and corrective actions taken, as needed.

For inpatient behavioral health the LOCUS and CALOCUS inter-rater reliability test is utilized. New staff members are evaluated quarterly for the first year and all staff is evaluated annually after their first year. During evaluation, the staff person is given three sample cases to rate. If an outlier is identified, the staff person is reviewed quarterly until consistency is achieved. The minimum passing rate is 80%. If consistency is not achieved after three quarters, additional training is provided with a corrective action plan, if deemed necessary.

The same process is followed for staff making authorization decisions for inpatient detoxification services in a psychiatric unit or facility.

Delegation:

The DVHA delegates to its IGA partners the authorization of the following covered services for the special health needs populations:

- DMH
 - Psychiatric inpatient for beneficiaries enrolled in CRT
 - Inpatient ECT for beneficiaries enrolled in CRT
 - Psychiatric partial hospitalization
 - Children’s specialized community services
 - Children’s residential services
- VDH
 - Children’s personal care services
 - High Technology Children’s Program
 - Alcohol and Drug Abuse Program (ADAP) Hub Services
- DAIL
 - High Technology Adult Program
 - Adult Personal Care services
- DCF
 - Children’s residential
 - Woodside Juvenile Rehab Center

For additional details related to authorization of the above mentioned services, monitoring by and reporting to DVHA, refer to the Inter-governmental Agreements (IGAs).

Reporting and Analysis:

- Annual results of DVHA's Inter-rater reliability reports

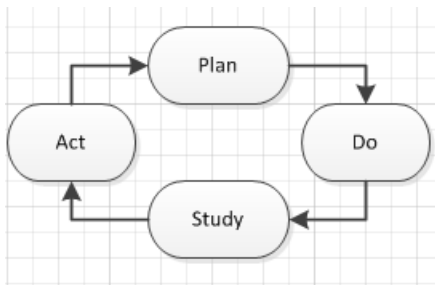
Analysis of this reporting, as well as that of IGA partners, is primarily the responsibility of the DVHA Compliance Director and Compliance Committee. When appropriate, compliance concerns and/or opportunities for improvement generated from these venues will be taken to the Quality Committee for discussion and possible Quality Improvement (QI) projects.

5. PERFORMANCE IMPROVEMENT

5.1 General Quality Model and AHS Performance Framework:

Improvements in quality require change. Having a proven, sound approach is helpful in making changes more successful and enjoyable. The MCE has adopted methodologies for addressing deficiencies through performance improvement projects. These methodologies all include the key elements found in the Plan-Do-Study-Act (PDSA) model of improvement (see diagram below).

The P-D-S-A Cycle



PLAN

- Define the problem, need for change
- Establish desired outcome or goal
- Learn about the current process
- Analyze data using appropriate tools/methods as necessary
- Determine the root cause/s of the problem
- Develop action plan for change

DO

- Implement your action plan
- Pilot test as needed (small & large tests of change)

STUDY

- Continue to collect and analyze data to study effectiveness of your actions.
- Did you achieve what you wanted?
- Did you meet your target or goals?
- Did you identify other problems?
- Did your actions work? Why?
- What would you do differently?

ACT

- If your actions were successful, proceed with expansion and/or standardization of changes
- Routinely reassess to assure maintaining gains
- If not as successful as you would have liked, begin a new PDSA cycle
- Note lessons learned

5.2 Specific Approaches:

There are a number of approaches used by the DVHA and our IGA Partners to improve quality. Those include:

- Performance Improvement Projects (PIP's) - All DVHA formal PIPs will be conducted in a manner that is consistent with the CMS Protocol. (*Conducting Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities*, final protocol, Version 1.0, May 1, 2002)
- Results Based Accountability (RBA) – RBA is a disciplined way of thinking and taking action that can be used by agencies to improve the performance of their programs. It can also be used by communities as a whole and therefore is broken out into two parts: population accountability and performance accountability. The Agency of Human Services has adopted an RBA-based software tool that every Department within the Agency is using to present their performance measure data, as well as the narrative behind that data, the partners they work with and the improvement strategies they employ.
- Agency Improvement Model (AIM) Projects – AIM is an important part of our performance framework and one of the ways we can ensure we are being successful in our efforts of intentionally building a culture of accountability for our organization. AIM is a simple approach to process improvement where staff directly involved with the work engages in a structured methodology to recommend and implement changes. These approaches are data driven, in order to identify whether a change has been an improvement or not, and is more often used for program level improvement. All departments within the Agency Of Human Services, including DVHA and its IGA partners are trained in this approach.

5.3 Performance Improvement Activities:

The DVHA and its IGA partners maintain an ongoing program of formal (PIPs) and informal performance improvement projects designed to achieve, through ongoing measurement and intervention, significant improvement sustained over time in clinical and nonclinical areas.

The DVHA incorporates the following into their formal PIP process:

- Use of objective quality indicators to measure its performance and that of its IGA partners;
- implementation of system interventions designed to achieve improvement in quality;
- evaluation of the effectiveness of the DVHA's interventions and those of its IGA partners; and
- planning and initiation of activities to increase or sustain improvement in the DVHA and its IGA partners' performance.

The DVHA (and, as applicable, its IGA partners) completes each PIP in a reasonable time period so as to generally allow information on success of the PIP in the aggregate to produce new information on quality of care every year.

Major performance improvement efforts during 2014/2015 include:

i. Formal Performance Improvement Projects (PIPs following CMS methodology):

- *Follow-up after Hospitalization for Mental Illness:*

During the 2013/2014 time period, this PIP implementation team will focus on defining the study question, identifying the target population, developing and calculating the baseline measures and implementing the interventions. In subsequent years, the PIP will evaluate the effectiveness of interventions taken with beneficiaries and their providers to increase follow-up after hospitalization for mental illness.

- Two (2) quality improvement projects were selected as part of the Adult Medicaid Quality Grant, and the decision made to follow the CMS PIP protocols. The projects were each required to relate to one of the CMS Adult Core measures. After data analysis of our performance on these measures, the two measures chosen were: *Increasing Breast Cancer Screenings* and *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment*. These issues were identified as critical health concerns by the State.

ii. Agency Improvement Model (AIM) Projects during 2014 included:

[Decreasing Excessive Dental Prior Authorization Paperwork](#)

[Improve New Hire Orientation](#)

[Improvement Project Request Communication](#)

[Improved Information On Federal Grant Spending](#)

[Improving Immunization Rates](#)

[Improving Staff Meeting Experience](#)

[Increase Child Care Vaccination Reports](#)

[Increase Efficiency of Medical Clearance Process For Out Of State Inmates](#)

[Increase Employment Referrals](#)

[Increase Performance Evaluation Completion Rates](#)

[Increase Show Rates Of Prenatal WIC Clients](#)

[Increase Use of WIC Health](#)

[Increase Vaccine Rates](#)

[Increase Waitlist Reporting Time](#)

[Increase WIC Show Rates Barre](#)

[Increases WIC Show Rates Brattleboro](#)

[Increased Satisfaction With Contracting Process](#)

[Increased Satisfaction With RFR Process](#)

[Increasing Efficiency Of Main Phone Line](#)

[Increasing Request Log Use](#)

[Keeping Tabs On The Burlington District Office](#)
[Maintain and Enhance Office Culture](#)
[Office Suite Reconfiguration](#)
[Purchase Order Process](#)
[Timely Completion of Preliminary Plan Of Care](#)
[Tracking Referrals](#)

More information about each of these projects, including completed Story Boards can be found here: [AIM Projects](#)

Annual Quality Action Plan:

The MCE has created an annual Quality Action Plan to capture these performance improvement initiatives, assign ownership and track deadlines. Other recommendations for performance improvement projects made to the Quality Committee by the Managed Care Medical Committee (MCMC) will also be included on the annual work plan. The Action Plan also includes activities related to quality assurance, planning and communication efforts.

Please see Attachment A to this document: Annual Quality Action Plan CY 2015.

5.4 Implementation of the MCE Quality Management Plan

The DVHA Quality Improvement Director and the Medical Director, along with the MCE Quality Committee has the following responsibilities:

- Ensures that all DVHA staff and IGA Partner representatives are involved in the development and implementation of the QAPI program.
- Facilitates the formation of QI teams to address specific quality improvement initiatives.
- Analyzes customer service satisfaction reports, feedback, appeals and disenrollment reports and initiates action to increase satisfaction.
- In consultation with AHS, sets priorities for performance improvement considering prevalence and severity of identified problems and give priority to improve activities that effect beneficiaries' health outcomes.
- Continuously monitors progress toward goals and applies improvement and problem solving processes as necessary to ensure satisfactory outcomes.