VERMONT

The Department of Vermont Health Access

MEDICAID PROGRAM 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

Produced by
MCE Quality Committee
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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 to Health Demonstration has been extended and amended multiple times since 2005, most recently in January 2015 to include authority for the former Choices for Care Demonstration. The Choices for Care program provides long-term services and supports for persons with disabilities and older Vermonters. The Demonstration authorizes HCBS waiver-like and institutional services such as: nursing facility; enhanced residential care; personal care; homemaker services; companion care; case management; adult day services; and adult family care.

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, or what we now more accurately refer to as a non-risk pre-paid inpatient health plan (PIHP). The Agency of Human Services (AHS) pays DVHA a lump sum premium payment for the provision of all Medicaid services in the State (apart from the exceptions mentioned above). 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 as a PIHP, 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, DVHA submits to AHS data specified by AHS that enables the State to measure DVHA's performance.

DVHA is a large department encompassing many divisions and initiatives. In addition to managing the services provided to the general Medicaid population, DVHA encompasses other initiatives focused on the health of Vermonters. Although these programs are large in scope on their own, DVHA strives to integrate all of our quality management activities across the Department. These other initiatives include the Vermont Chronic Care Initiative (VCCI), Pediatric Palliative Care, the Hub and Spoke Initiative, Vermont's health insurance Exchange (Vermont Health Connect), as well as payment reform models including the Blueprint for Health, the Vermont Medicaid Next Generation (VMNG) Accountable Care Organization (ACO), the Dental Incentive Program, Integrated Family Services (IFS) and Children's Integrated Services (CIS). Each of these payment models has its own performance measures and evaluation plan, which contain quite a bit of cross-over with the elements found within this document, but which will not be detailed here in this QM Plan. Additional information about these payment models can be referenced here: Making Quality Health Care Available to All Vermonters | Health Care Reform, Integrated Family Services, Children's Integrated Services.

To that end, 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 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 every other month and is responsible for: a) development of an annual Quality Action Plan, b) reviewing performance 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 as subject matter experts from other AHS Departments when needed.

Compliance Committee –

This committee is charged with ensuring compliance with all state and federal managed care 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 Committee Coordination –

The Chairs of the Quality Committee, Managed Care Medical Committee and Compliance Committee meet quarterly to assure coordination of work and to review progress on annual action plans and deliverables, as well as challenges and success.

AHS Performance Accountability Committee (PAC) –

This group focuses on the following three broad areas of responsibility: cross Agency needs and priorities, Medicaid program performance activities, and AHS performance accountability culture. There are two functional areas for the direct application of tools, best practices, and recommendations made by PAC related to measuring, monitoring, and improving: the Medicaid Program, via the Comprehensive Quality Strategy, and the Agency of Human Services, via the AHS Strategic Plan.

DVHA Data Management and Integrity Unit –

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

DVHA Quality Improvement Director -

The Quality Improvement Director oversees the DHVA Quality Unit and the implementation and progress of the annual Quality Action Plan. The Director is Chair of the Managed Care Medical Committee, a member of the Coordination Committee and of the DVHA Management and Strategic Planning Teams.

Quality Improvement Administrator –

The Quality Committee is co-chaired by the Quality Improvement Administrator. This position 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), the use of Results Based Accountability scorecards within the Department and acts as a performance measures liaison between the Quality Unit and other DVHA divisions/initiatives (i.e. Hub & Spoke, the Exchange and Payment Reform models).

Quality Assurance Manager –

The DVHA Quality Unit gained a full-time staff position starting in 2017, the Quality Assurance Manager. This position provides data analysis to the Unit/Department, coordinates the annual medical record review process to produce hybrid HEDIS measures, participates in and leads performance improvement projects and creates Results Based Accountability scorecards.

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.

Scope

This Quality Management Plan sets forth specifications for activities that 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 Measurement
- Monitoring & Oversight
- Performance Improvement

Purpose

The specific purposes of the Quality Management Plan are to:

1. Provide general context, 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. Outline the Agency of Human Services' (AHS) Performance Framework.

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

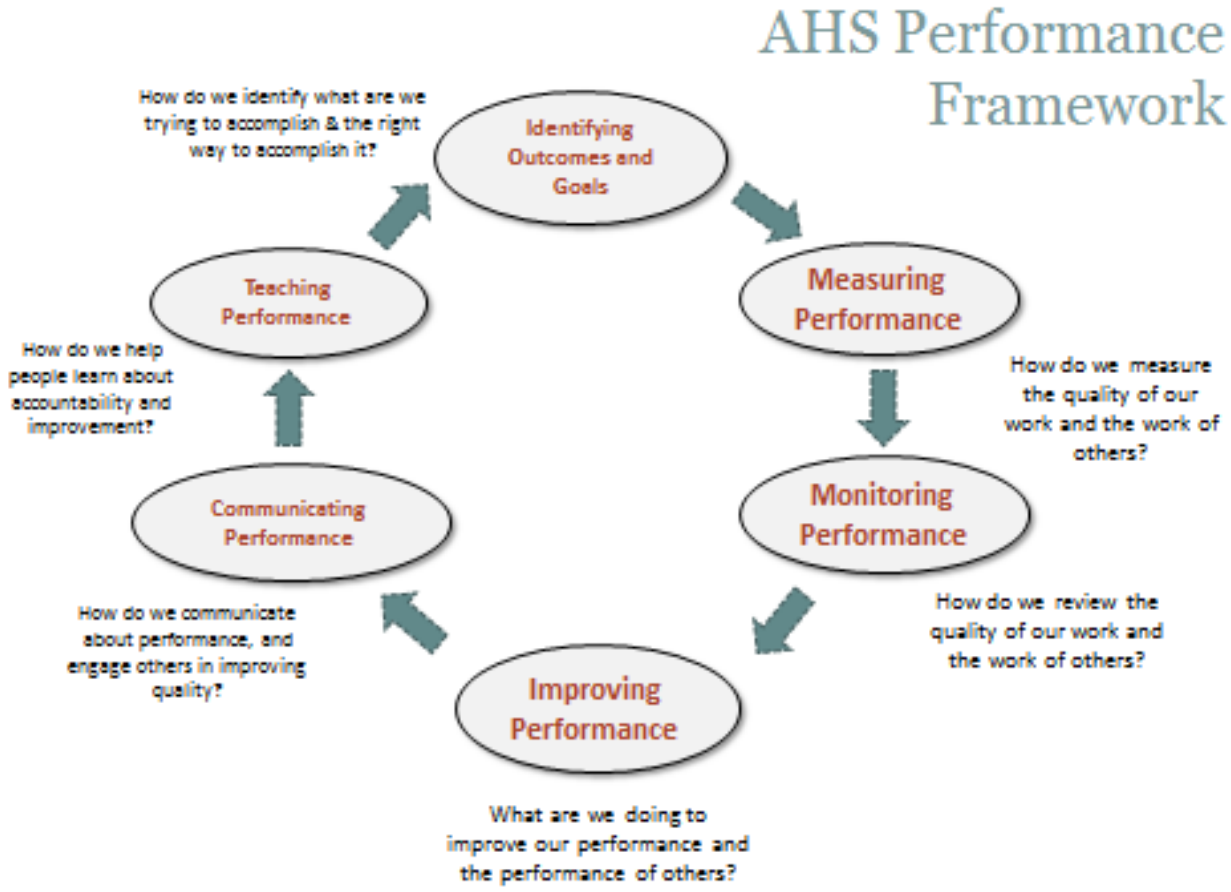
Principles:

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 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 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
How do we identify what are we trying to accomplish & the right way to accomplish it?
Identifying Outcomes and Goals
Measuring Performance
How do we measure the quality of our work and the work of others?
Monitoring Performance
How do we review the quality of our work and the work of others?
Improving Performance
What are we doing to improve our performance and the performance of others?
Communicating Performance
How do we communicate about performance, and engage others in improving quality?
Teaching Performance
How do we help people learn about accountability and improvement?

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 DVHA has an important role in helping to identify opportunities for improvement, formal priorities for performance improvement are recommended annually by the MCE Quality Committee to the Managed Care Medical Committee (MCMC). Priority will be based on severity, frequency, prevalence, relevance to outcomes and feasibility of implementation. In addition, 42 CFR Subpart E reserves CMS the right to specify performance improvement project topics for DVHA. Likewise, Section 2.10 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 DVHA (including IGA partners, beneficiaries and their caregivers), AHS and CMS. 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 MEASUREMENT

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 DVHA is achieving its intended results/outcomes.

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 Global Commitment to Health Core Measure Set/HEDIS

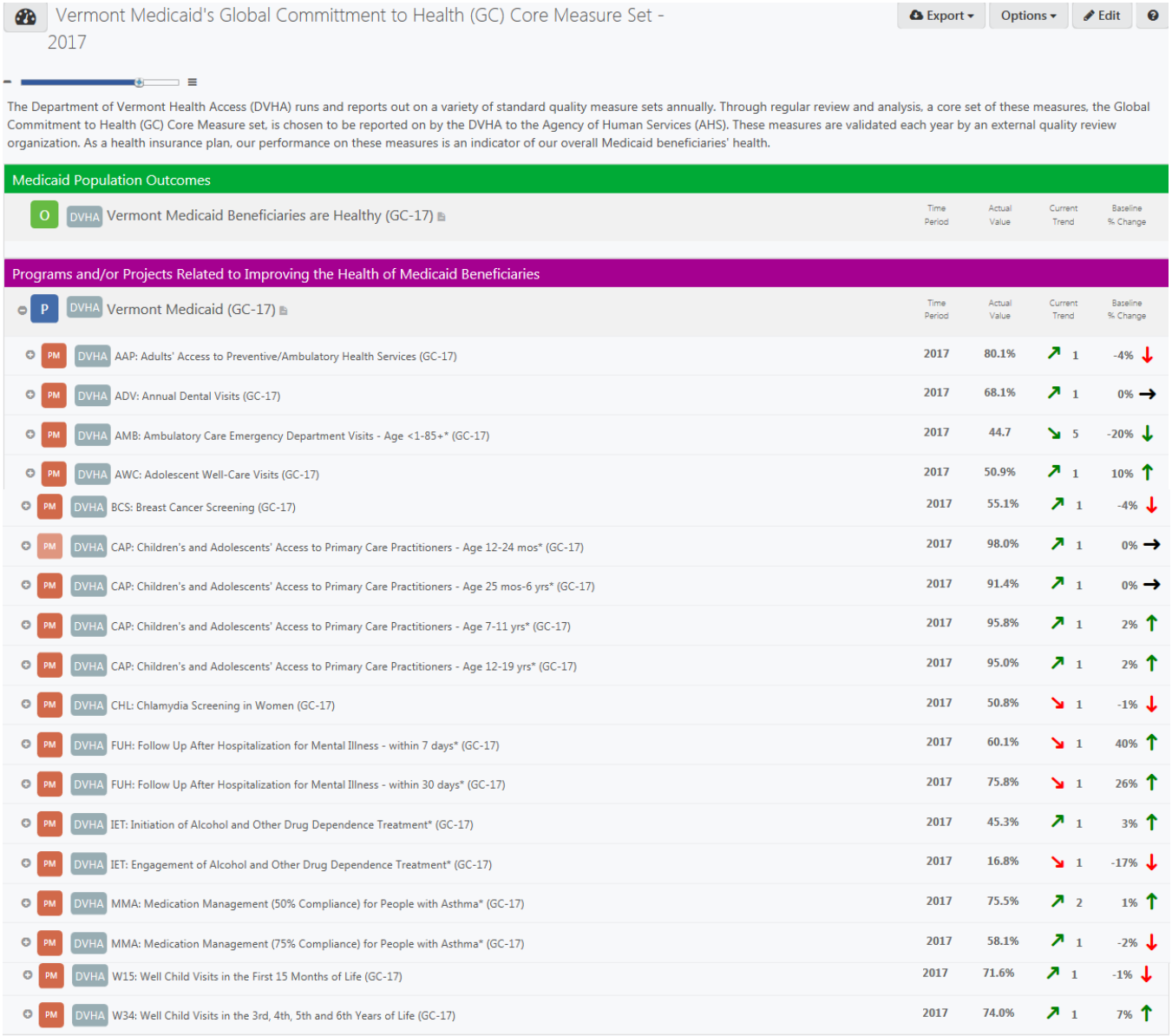
The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. Altogether, HEDIS consists of 80+ measures across 14 domains of care.

Reporting and Analysis:

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

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

DVHA runs the full set of HEDIS administrative measures, and strives to produce at least one hybrid measure, annually. A representative sample of these measures across various measure domains are required by the AHS and are validated through an external quality review organization. We call this our Global Commitment (GC) Core Measure Set. Below is the most recent GC Core Measure Set results Scorecard:



Vermont Medicaid's Global Committment to Health (GC) Core Measure Set - 2017

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The Department of Vermont Health Access (DVHA) runs and reports out on a variety of standard quality measure sets annually. Through regular review and analysis, a core set of these measures, the Global Commitment to Health (GC) Core Measure set, is chosen to be reported on by the DVHA to the Agency of Human Services (AHS). These measures are validated each year by an external quality review organization. As a health insurance plan, our performance on these measures is an indicator of our overall Medicaid beneficiaries' health.

Medicaid Population Outcomes

	Time Period	Actual Value	Current Trend	Baseline % Change
O DVHA Vermont Medicaid Beneficiaries are Healthy (GC-17)				

Programs and/or Projects Related to Improving the Health of Medicaid Beneficiaries

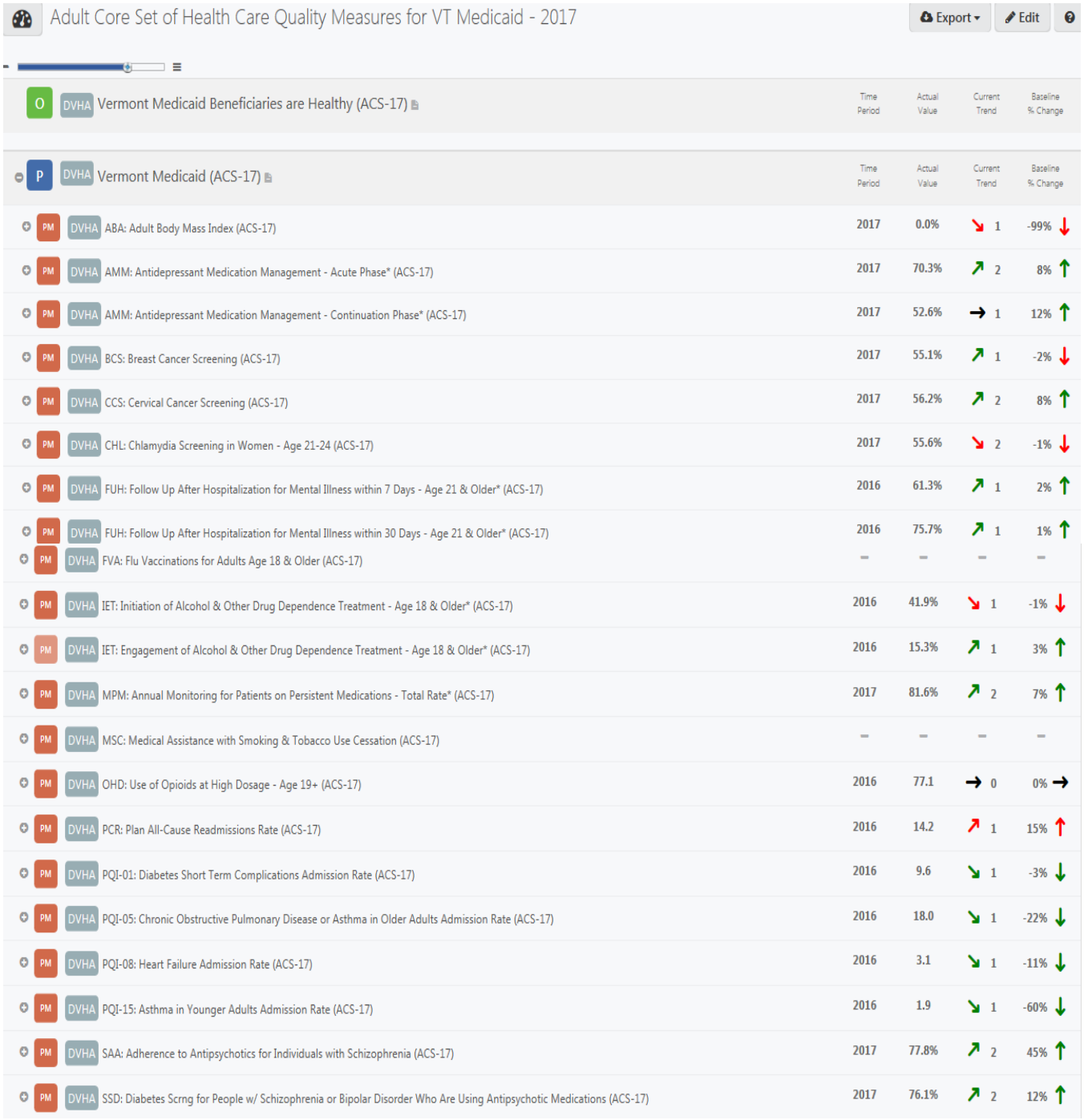
	Time Period	Actual Value	Current Trend	Baseline % Change
P DVHA Vermont Medicaid (GC-17)				
PM DVHA AAP: Adults' Access to Preventive/Ambulatory Health Services (GC-17)	2017	80.1%	↗ 1	-4% ↓
PM DVHA ADV: Annual Dental Visits (GC-17)	2017	68.1%	↗ 1	0% →
PM DVHA AMB: Ambulatory Care Emergency Department Visits - Age <1-85+* (GC-17)	2017	44.7	↘ 5	-20% ↓
PM DVHA AWC: Adolescent Well-Care Visits (GC-17)	2017	50.9%	↗ 1	10% ↑
PM DVHA BCS: Breast Cancer Screening (GC-17)	2017	55.1%	↗ 1	-4% ↓
PM DVHA CAP: Children's and Adolescents' Access to Primary Care Practitioners - Age 12-24 mos* (GC-17)	2017	98.0%	↗ 1	0% →
PM DVHA CAP: Children's and Adolescents' Access to Primary Care Practitioners - Age 25 mos-6 yrs* (GC-17)	2017	91.4%	↗ 1	0% →
PM DVHA CAP: Children's and Adolescents' Access to Primary Care Practitioners - Age 7-11 yrs* (GC-17)	2017	95.8%	↗ 1	2% ↑
PM DVHA CAP: Children's and Adolescents' Access to Primary Care Practitioners - Age 12-19 yrs* (GC-17)	2017	95.0%	↗ 1	2% ↑
PM DVHA CHL: Chlamydia Screening in Women (GC-17)	2017	50.8%	↘ 1	-1% ↓
PM DVHA FUH: Follow Up After Hospitalization for Mental Illness - within 7 days* (GC-17)	2017	60.1%	↘ 1	40% ↑
PM DVHA FUH: Follow Up After Hospitalization for Mental Illness - within 30 days* (GC-17)	2017	75.8%	↘ 1	26% ↑
PM DVHA IET: Initiation of Alcohol and Other Drug Dependence Treatment* (GC-17)	2017	45.3%	↗ 1	3% ↑
PM DVHA IET: Engagement of Alcohol and Other Drug Dependence Treatment* (GC-17)	2017	16.8%	↘ 1	-17% ↓
PM DVHA MMA: Medication Management (50% Compliance) for People with Asthma* (GC-17)	2017	75.5%	↗ 2	1% ↑
PM DVHA MMA: Medication Management (75% Compliance) for People with Asthma* (GC-17)	2017	58.1%	↗ 1	-2% ↓
PM DVHA W15: Well Child Visits in the First 15 Months of Life (GC-17)	2017	71.6%	↗ 1	-1% ↓
PM DVHA W34: Well Child Visits in the 3rd, 4th, 5th and 6th Years of Life (GC-17)	2017	74.0%	↗ 1	7% ↑

DVHA contracts with a NCQA-certified software vendor to produce the measures. The scorecard report is analyzed by the MCE Quality Committee annually to determine if goals are met and if future improvement activities are recommended. Those recommendations are passed to the Managed Care Medical Committee for further clinical analysis and decision-making.

Scorecards for each individual performance measure listed above, including historical data and narrative, can be found on the DVHA website here: Global Commitment Core Measures

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. This measure set is now updated annually by CMS. Below is Vermont Medicaid's most recent Adult Core Quality Measure Set Scorecard:

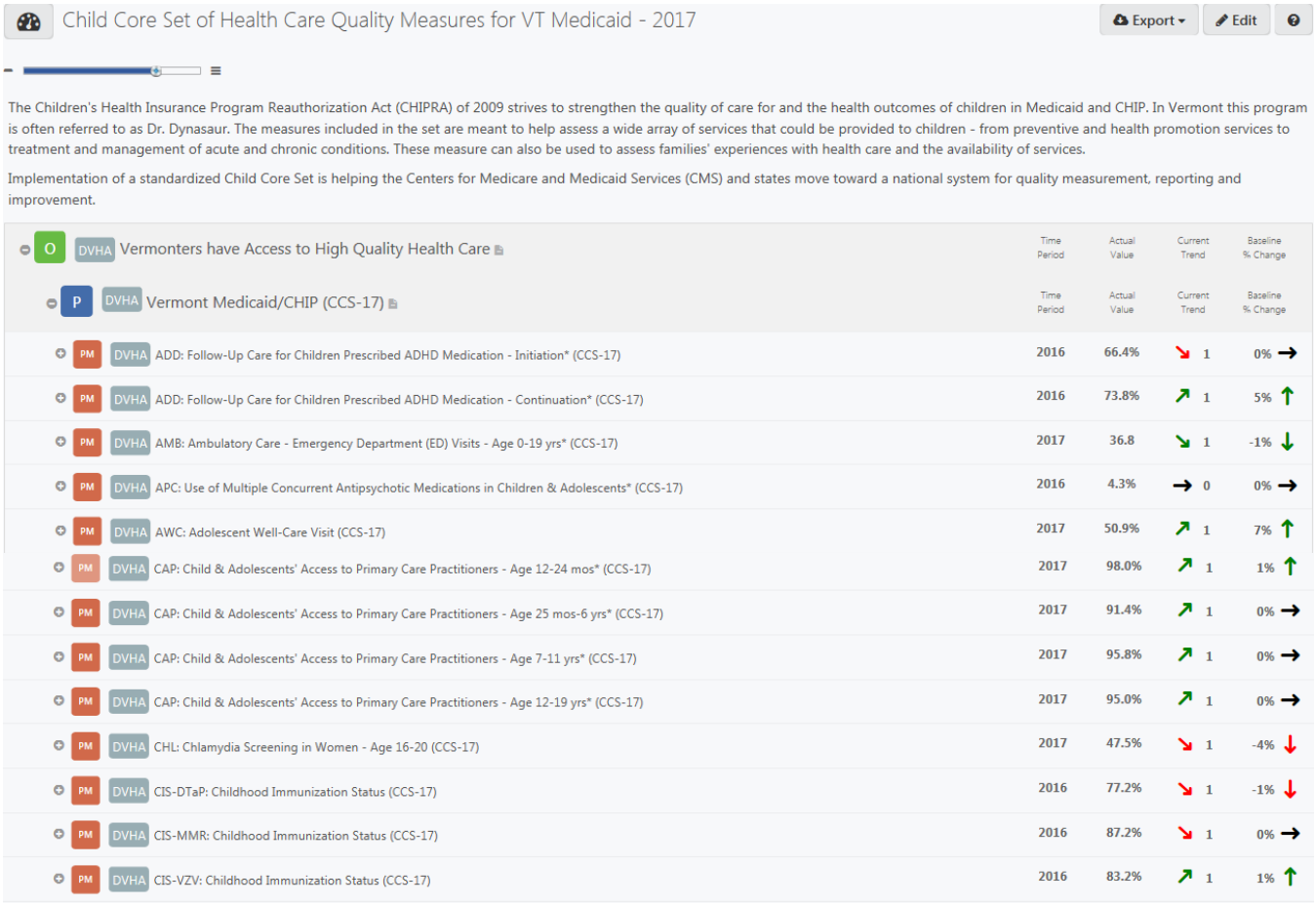


Reporting and Analysis:

DVHA reported to CMS on 23 of these 33 measures in January 2017. After analysis of our measure results, DVHA has also undertaken Performance Improvement Projects (PIPs) on 2 of the measures in this set. (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. Below is Vermont Medicaid's most recent Child Core Quality Measure Set Scorecard:



Child Core Set of Health Care Quality Measures for VT Medicaid - 2017

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The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 strives to strengthen the quality of care for and the health outcomes of children in Medicaid and CHIP. In Vermont this program is often referred to as Dr. Dynasaur. The measures included in the set are meant to help assess a wide array of services that could be provided to children - from preventive and health promotion services to treatment and management of acute and chronic conditions. These measure can also be used to assess families' experiences with health care and the availability of services.

Implementation of a standardized Child Core Set is helping the Centers for Medicare and Medicaid Services (CMS) and states move toward a national system for quality measurement, reporting and improvement.

	Time Period	Actual Value	Current Trend	Baseline % Change
O DVHA Vermonters have Access to High Quality Health Care				
P DVHA Vermont Medicaid/CHIP (CCS-17)				
PM DVHA ADD: Follow-Up Care for Children Prescribed ADHD Medication - Initiation* (CCS-17)	2016	66.4%	↘ 1	0% →
PM DVHA ADD: Follow-Up Care for Children Prescribed ADHD Medication - Continuation* (CCS-17)	2016	73.8%	↗ 1	5% ↑
PM DVHA AMB: Ambulatory Care - Emergency Department (ED) Visits - Age 0-19 yrs* (CCS-17)	2017	36.8	↘ 1	-1% ↓
PM DVHA APC: Use of Multiple Concurrent Antipsychotic Medications in Children & Adolescents* (CCS-17)	2016	4.3%	→ 0	0% →
PM DVHA AWC: Adolescent Well-Care Visit (CCS-17)	2017	50.9%	↗ 1	7% ↑
PM DVHA CAP: Child & Adolescents' Access to Primary Care Practitioners - Age 12-24 mos* (CCS-17)	2017	98.0%	↗ 1	1% ↑
PM DVHA CAP: Child & Adolescents' Access to Primary Care Practitioners - Age 25 mos-6 yrs* (CCS-17)	2017	91.4%	↗ 1	0% →
PM DVHA CAP: Child & Adolescents' Access to Primary Care Practitioners - Age 7-11 yrs* (CCS-17)	2017	95.8%	↗ 1	0% →
PM DVHA CAP: Child & Adolescents' Access to Primary Care Practitioners - Age 12-19 yrs* (CCS-17)	2017	95.0%	↗ 1	0% →
PM DVHA CHL: Chlamydia Screening in Women - Age 16-20 (CCS-17)	2017	47.5%	↘ 1	-4% ↓
PM DVHA CIS-DTaP: Childhood Immunization Status (CCS-17)	2016	77.2%	↘ 1	-1% ↓
PM DVHA CIS-MMR: Childhood Immunization Status (CCS-17)	2016	87.2%	↘ 1	0% →
PM DVHA CIS-VZV: Childhood Immunization Status (CCS-17)	2016	83.2%	↗ 1	1% ↑

PM	DVHA	DEV: Developmental Screening in the 1st 3 Years of Life - Total Rate* (CCS-17)	2016	75.2%	↘ 1	-2% ↓
PM	DVHA	FUH: Follow-Up After Hospitalization for Mental Illness - 7 day - Age 6-20* (CCS-17)	2016	69.6%	↗ 1	2% ↑
PM	DVHA	FUH: Follow-Up After Hospitalization for Mental Illness - 30 day - Age 6-20* (CCS-17)	2016	87.3%	↗ 1	5% ↑
PM	DVHA	IMA: Immunization Status for Adolescents - Combo 1 Rate* (CCS-17)	2016	63.5%	↗ 1	9% ↑
PM	DVHA	IMA: Immunization Status for Adolescents - Combo 2 Rate* (CCS-17)	–	–	–	–
PM	DVHA	LBW: Live Births Weighing Less Than 2,500 Grams (CCS-17)	2016	8.1%	↗ 1	8% ↑
PM	DVHA	MMA: Medication Management for People with Asthma - 50% Compliance - Age 5-20* (CCS-17)	2016	68.8%	↘ 1	-1% ↓
PM	DVHA	MMA: Medication Management for People with Asthma - 75% Compliance - Age 5-20* (CCS-17)	2016	49.4%	↘ 1	-4% ↓
PM	DVHA	SEAL: Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk (CCS-17)	2016	34.1%	↘ 1	-3% ↓
PM	DVHA	W15: Well Child Visits in the First 15 Months of Life - 6+ Visits* (CCS-17)	2017	71.6%	↗ 1	1% ↑
PM	DVHA	W34: Well Child Visits in the 3rd, 4th, 5th, & 6th Years of Life (CCS-17)	2017	74.0%	↗ 1	2% ↑

Reporting and Analysis:

Currently, 20 of the 27 Children's Core Measures are reported on by DVHA to CMS annually. DVHA is also participating in 3 quality improvement projects related to measures in this measure set. (Please see Section 6, Performance Improvement, for more information on these projects.)

3.4 Experience of Care Measures

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. 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).

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 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. Below is Vermont Medicaid's most recent Adult & Child Experience of Care Scorecard:

Vermont Medicaid's Experience of Care Scorecard

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This scorecard represents results from the Department of Vermont Health Access' annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) Medicaid Adult and Children surveys. Vermont Medicaid uses a nationally recognized experience of care survey tool, administered by a nationally certified vendor to a sample of both our adult and child beneficiaries. Most of the performance measures (PM) listed below are composite measures.

	Time Period	Actual Value	Current Trend	Baseline % Change
O DVHA Vermonters Receive High Quality Healthcare				
Adult CAHPS Survey				
P DVHA Vermont Medicaid Program - Adult CAHPS Survey				
PM DVHA Getting Needed Care - % of surveyed adult Medicaid beneficiaries who responded "usually" or "always" when asked if they could get care when needed through their health plan and from specialists	2017	84%	↗ 1	-2% ↓
PM DVHA Getting Care Quickly - % of surveyed adult Medicaid beneficiaries who responded "usually" or "always" when asked if they received care and got appointments as soon as they needed	2017	83%	↘ 1	0% →
PM DVHA How Well Doctors Communicate - % of surveyed adult Medicaid benefiaries who responded "usually" or "always" when asked how well personal doctor explains things, listens to them, shows respect for what they have to say and spends enough time with them	2017	90%	↘ 1	2% ↑
PM DVHA Customer Service - % of surveyed adult Medicaid beneficiaries who responded "usually' or "always" when asked about getting information needed and treatment by customer service staff	2017	90%	↗ 2	20% ↑
PM DVHA Shared Decision-Making - % of surveyed adult Medicaid beneficiaries who responded "a lot" or "yes" when asked about their experience with doctors discussing the pros and cons of starting or stopping a prescription medicine and being asked what they thought was best for them	2017	86%	↗ 1	72% ↑
PM DVHA Health Promotion and Education - % of surveyed adult Medicaid beneficiaries who responded "yes" when asked about their experience with their doctor discussing specific things to do to prevent illness	2017	75%	↗ 1	3% ↑
PM DVHA Coordination of Care - % of surveyed adult Medicaid beneficiaries who responded "usually" or "always" when asked about their perception of whether their doctor is up-to-date about the care he/she received from other doctors or health providers	2017	80%	→ 2	0% →
PM DVHA Overall Rating of Health Plan - % of surveyed adult Medicaid beneficiaries who rated their overall health plan a "8,9 or 10" when asked to use a scale of 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible	2017	77%	↘ 3	-10% ↓
Child CAHPS Survey - General Population				
P DVHA Vermont Medicaid Program - Child CAHPS Survey				
PM DVHA Getting Needed Care - % of surveyed child Medicaid beneficiaries who responded "usually" or "always" when asked if they could get care when needed through their health plan and from specialists	2017	91%	→ 1	3% ↑
PM DVHA Getting Care Quickly - % of surveyed child Medicaid beneficiaries who responded "usually" or "always" when asked if they received care and got appointments as soon as they needed	2017	92%	↘ 2	-2% ↓
PM DVHA How Well Doctors Communicate - % of surveyed child Medicaid benefiaries who responded "usually" or "always" when asked how well personal doctor explains things, listens to them, shows respect for what they have to say and spends enough time with them	2017	97%	↗ 2	1% ↑
PM DVHA Customer Service - % of surveyed child Medicaid beneficiaries who responded "usually' or "always" when asked about getting information needed and treatment by customer service staff	2017	84%	↘ 1	-2% ↓
PM DVHA Shared Decision-Making - % of surveyed child Medicaid beneficiaries who responded "a lot" or "yes" when asked about their experience with doctors discussing the pros and cons of starting or stopping a prescription medicine and being asked what they thought was best for them	2017	88%	↗ 1	0% →
PM DVHA Health Promotion and Education - % of surveyed child Medicaid beneficiaries who responded "yes" when asked about their experience with their doctor discussing specific things to do to prevent illness	2017	69%	↗ 1	-3% ↓
PM DVHA Coordination of Care - % of surveyed child Medicaid beneficiaries who responded "usually" or "always" when asked about their perception of whether their doctor is up-to-date about the care he/she received from other doctors or health providers	2017	90%	↗ 2	1% ↑
PM DVHA Overall Rating of Health Plan - % of surveyed child Medicaid beneficiaries who rated their overall health plan a "8,9 or 10" when asked to use a scale of 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible	2017	86%	↗ 2	1% ↑

Reporting and Analysis

The CAHPS survey results, as well an initial analysis of the results, are compiled by the vendor and reported to DVHA. 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 Performance Accountability Plan Measures:

As DVHA strives to ensure access and provision of high quality health care to Medicaid beneficiaries, the Department's Performance Accountability Plan provides a framework for these efforts. Follow this link to see DVHA's current Performance Accountability Plan, which includes key performance indicators for each DVHA unit: https://app.resultsscorecard.com/Scorecard/Embed/8819

Reporting and Analysis

The DVHA Performance Accountability Plan is monitored regularly through Unit Director reports to the DVHA Management Team. Deputy Commissioners work closely with their Units to set performance measure targets when appropriate and identify strategies for improvement when those targets aren't met.

4. ACCOUNTABILITY, MONITORING & OVERSIGHT

In addition to gauging our progress on key performance measures, 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, DVHA uses all of the following QA activities to inform improvement initiatives.

4.1 Coordination and Continuity of Care

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 Five (5) special health care needs populations within the larger Medicaid population:

- Children enrolled in the community mental health centers who are identified with severe emotional or mental health conditions (through our Children's Integrated Services program 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)
- Individuals eligible to receive services from the Choices for Care program

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, 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.

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 DVHA, if requested, information on individuals identified as having special health needs.

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 and mental health conditions 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).
- The Department of Disability, Aging and Independent Living is also responsible for managing the Choices for Care program.

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. 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. 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. 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 DVHA ensures that a network of appropriate providers is maintained. 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 DVHA for all beneficiaries and established in Medicaid Policy.

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 DVHA ensures availability of interpreter services by offering reimbursement. DVHA participates in AHS's efforts to promote the delivery of services in a culturally competent manner.

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

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 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 number of licensed providers enrolled, the number of enrolled providers accepting new patients, the number 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, DVHA's fiscal representative, DXC, 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 DXC 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

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. 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:

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 DVHA and the AHS Departments that complete delegated functions for DVHA. AHS has implemented an online HIPAA Privacy & Security Training for all staff, in all departments.

Within this framework, 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. DVHA and each Department have an identified liaison to AHS for HIPAA compliance on privacy and security.

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 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.

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 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 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. 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:

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. DVHA maintains a database that compiles all grievance and appeals filed against DVHA, the IGA Partners, DVHA actions, or actions of the IGA Partners.

While 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. 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, 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.

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

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

DXC, DVHA's Fiscal Agent, is responsible for the identification and enrollment of eligible Medicaid providers in the State. DXC is responsible for obtaining all necessary licenses and certifications (and tracks deadlines for re-licensing/credentialing). As the fiscal agent, DXC 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 DXC 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 DVHA to ensure providers are licensed and/or certified, a system has been developed with DXC 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.

DVHA performs regularly scheduled independent random reviews of the providers' licensure and/or certification to ensure that providers enrolled by DXC in DVHA's provider network are licensed and/or certified where required, and that excluded providers are not enrolled. 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 DXC to discuss issues that DXC identifies during the credentialing process. All providers are assigned a provider type and provider specialty when enrolling in the Medicaid program.

ii. Excluded Providers

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, DVHA has adopted the AHS enrollment requirements for the Medicaid program for providers participating in the *Global Commitment to Health Waiver*. 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 DXC.

DXC maintains control of all provider selection and enrollment activities but final decisions are made by DVHA. Since DVHA operates as an open network for eligible providers (e.g. those that meet licensing requirements are not excluded through disbarment), DXC 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 DVHA, DXC 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. 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, 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, 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

DVHA's Utilization Management (UM) Program is outlined in a document which describes the UM activities provided by 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 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 DVHA Managed Care Medical Committee (MCMC).

ii. Delegated Activities - Appropriateness of Services

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 Choices for Care, DS and TBI Programs 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 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:

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

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. DVHA has adopted practice guidelines for Buprenorphine and Diabetes. Revisions to the Buprenorphine, now Medication Assisted Treatment, guidelines have been completed. The Developmental Screening for Young Children Guidelines and the Diabetes Guidelines are also under revision. DVHA has also developed the Applied Behavior Analysis clinical guidelines. DVHA will continue to 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

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. 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. 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:

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), 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.

DVHA also has processes to ensure that:

- DVHA's Fiscal Agent, DXC, 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 DXC 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. DVHA performs validation on a random sample of all claims to ensure that services were actually provided.

As part of its unit responsibilities, DVHA's Program Integrity Unit 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 DVHA if they identify any services being billed that are not connected with services they have received. The Program Integrity Unit also does targeted EOBs for services and DME that are more susceptible to fraud, waste and abuse.

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

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 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. DVHA, and its IGA partners, shall notify the requesting provider and give the enrollee written notice of any decision by 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:

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
Change HealthCare InterQual® Guidelines
Vermont State Medicaid Rules
Hayes and Cochrane New Technology Assessments
DVHA Prior Authorization Clinical Criteria Procedure
DVHA-Developed Clinical Coverage Guidelines
Change HealthCare 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:

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. 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:

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
    - Choices for Care Program 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

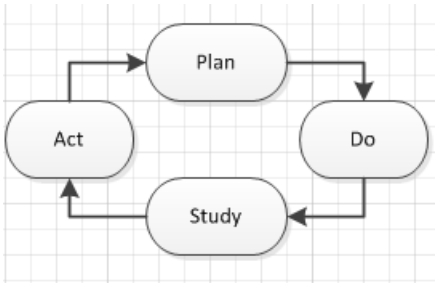
Analysis of this reporting, as well as that of IGA partners, is primarily the responsibility of the DVHA Compliance Director and Compliance Committee. When appropriate, compliance concerns and/or opportunities for improvement generated from these venues will be taken to the Quality Committee for discussion 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 DVHA and our IGA Partners to improve quality. Those include:

- Formal Performance Improvement Projects (PIP's) - All DVHA formal PIPs will be conducted in a manner that is consistent with the CMS Protocol. (*EQR Protocol 7: Implementation of Performance Improvement Projects*, Version 2.0, September 2012.) Formal PIPs have 3-year cycles and summaries are submitted annually by DVHA to AHS and our external quality review organization (EQRO) for validation.

- Informal Quality Improvement Projects – staff within the DVHA Quality Unit both lead and participate in quality improvement projects on a variety of topics. These projects are "informal" in that they do not require EQRO validation and are often shorter in duration. They do, however, follow a standard quality improvement methodology of Plan, Do, Study, Act.

- 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. Additionally, this methodology combined with LEAN concepts is the basis for a set of internal trainings that are actively building an Agency Improvement Network of staff who are trained to facilitate process improvement.

- Agency Improvement Model (AIM) Projects –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, to identify whether a change has been an improvement, and is more often used for program level improvement. Staff within DVHA and its IGA partners are trained in this approach.

5.3 Performance Improvement Activities:

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.

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 DVHA's interventions and those of its IGA partners; and
- planning and initiation of activities to increase or sustain improvement in DVHA and its IGA partners' performance.

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.

Current major performance improvement efforts include:

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

- *Substance Use Treatment Initiation* – this formal PIP started in July 2016 and the primary study measure is the HEDIS IET initiation rate. The implementation team includes members from the DVHA Quality Unit and Data Units, the Blueprint for Health, the Dept of Health's Alcohol and Drug Abuse Program (ADAP) and OneCare Vermont (Vermont's Medicaid ACO). Interventions are focusing on treatment access and billing/coding education and innovation.

ii. Informal Cross-Departmental QI efforts:

Adolescent CoIIN – this Collaborative Improvement & Innovation Network (CoIIN) is led by the Vermont Dept. of Health and the Vermont Children's Health Improvement Program (VCHIP). The project aims to increase the rate for adolescent well care visits. One intervention that the DVHA Quality Unit is involved in is sending gap-in-care reports to a small cohort of practices that they can then use to outreach adolescents that haven't been seen for a well care visit within the last year.

Follow-Up After Hospitalization for Mental Illness – this is multi-payer project lead by the Vermont Program for Quality in Health Care (VPQHC). The core implementation team has worked with key stakeholders to explore barriers to follow-up care and share best practices through community meetings. This project is scheduled to end in June 2018.

The Quality Unit is leading informal QIPs on two topic areas: *chlamydia screening and adults' access to preventive/ambulatory health services*. These topics were selected after annual review of program performance by the MCE Quality Committee, Managed Care Medical Committee and the Clinical Utilization Review Board (CURB). Both groups meet monthly and plan to further explore data, perform root cause analyses and choose targeted interventions that we can test using rapid cycle evaluation.

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 SFY 2018.

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.