VERMONT

State of Vermont
Agency of Human Services

2020–2021 External Quality Review Technical Report

for

Department of Vermont Health Access

January 2021

HSAG HEALTH SERVICES ADVISORY GROUP

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

1. Introduction and Summary of Findings 1-1
Background 1-1
Purpose 1-2
Organization of the Report 1-2
Methodology for Preparing the External Quality Review (EQR) Technical Report 1-3
Data Sources 1-4
Categorizing Results 1-4
Identifying the Department of Vermont Health Access' (DVHA's) Strengths and Opportunities for Improvement 1-4

2. Detailed Findings 2-1
Background 2-1
The Vermont Agency of Human Services (AHS) 2-1
The Department of Vermont Health Access 2-2
Scope of HSAG's 2020–2021 EQR Activities 2-3
Summary of Findings 2-3
Validation of the Performance Improvement Project (PIP) 2-3
Validation of Performance Measures 2-5
Review of Compliance With Standards 2-12
Overall Conclusions and Performance Trending 2-13
Performance Trends 2-13
Quality, Timeliness, and Access to Care Domains 2-23
EQR Assessment of DVHA's Strengths and Weaknesses and Summary of Quality, Timeliness, and Access 2-25
Performance Improvement Project 2-25
Performance Measures 2-26
Compliance With Standards 2-27
Recommendations and Opportunities for Improvement 2-28
Performance Improvement Project 2-28
Performance Measures 2-29
Compliance With Standards 2-29

3. Assessment of Vermont's Quality Strategy 3-1
Background 3-1
Methodology 3-2
Findings 3-2
Recommendations 3-5

4. Description of External Quality Review Activities 4-1
Validation of Performance Improvement Project 4-1
Objectives and Background Information 4-1
Description of Data Obtained 4-1

Technical Methods of Data Collection/Analysis 4-2
Determining Conclusions 4-3
Validation of Performance Measures 4-4
Objectives and Background Information 4-4
Description of Data Obtained 4-4
Technical Methods of Data Collection/Analysis 4-5
Determining Conclusions 4-6
Monitoring of Compliance With Standards 4-6
Objectives and Background Information 4-6
Description of Data Obtained 4-8
Technical Methods of Data Collection/Analysis 4-8
Determining Conclusions 4-12

5. Follow-Up on Prior EQR Recommendations 5-1
Introduction 5-1
Validation of the Performance Improvement Project 5-1
Validation of Performance Measures 5-2
Monitoring Compliance With Standards 5-2

1. Introduction and Summary of Findings

Background

The federal Balanced Budget Act of 1997 (BBA), Public Law 105-33, requires state Medicaid agencies to "provide for an annual external independent review conducted by a qualified independent entity of the quality outcomes and timeliness of, and access to, the items and services for which the organization is responsible under the contract."[1-1] Health Services Advisory Group, Inc. (HSAG), is under contract with the Vermont Agency of Human Services (AHS) to perform the external quality review (EQR) activities for the State.

The 2020 Vermont EQR Technical Report for the Vermont AHS (AHS) complies with 42 Code of Federal Regulations (CFR) §438.364,[1-2] which requires the external quality review organization (EQRO) to produce an annual detailed technical report that summarizes findings on access to and quality of care including a description of the manner in which the data from all activities conducted in accordance with 42 CFR §438.358 were aggregated and analyzed, and conclusions were drawn as to the quality and timeliness of, and access to the care furnished by the managed care organization (MCO), prepaid inpatient health plan (PIHP), prepaid ambulatory health plan (PAHP), or primary care case management (PCCM) entity. This report meets the requirements of 42 CFR §438.364 and does not disclose the identity or other protected health information (PHI) of any beneficiary. The AHS quality strategy establishes standards related to access to care, structure and operations, quality measurement and improvement, performance objectives, provisions for external quality review, and mechanisms to monitor compliance with the standards and objectives set forth in the quality strategy.

To meet requirements established by the federal regulations and described in the AHS quality strategy, AHS contracted with HSAG to conduct the EQR activities beginning in the EQR contract year 2007–2008. This report covers the EQR activities conducted during 2020–2021, the EQR contract year. HSAG conducted the mandatory EQR activities consistent with the Centers for Medicare & Medicaid Services (CMS) protocols established under 42 CFR §438.352.[1-3]

[1-1] U. S. Government Publishing Office. (1997). *Public Law 105-33* (p. 249). Available at: http://www.gpo.gov/fdsys/pkg/PLAW-105publ33/pdf/PLAW-105publ33.pdf. Accessed on: Nov 23, 2020.

[1-2] U. S. Government Publishing Office. (2018). *Electronic Code of Federal Regulations.* Available at: https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=0fe554e3f4a6236efe0d8c0aa9319e57&mc=true&n=pt42.4.438&r=PART&ty=HTML#se42.4.438_1340. Accessed on: Nov 23, 2020.

[1-3] U. S. Government Publishing Office. (2018). *Electronic Code of Federal Regulations.* Available at: https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=0fe554e3f4a6236efe0d8c0aa9319e57&mc=true&n=pt42.4.438&r=PART&ty=HTML#se42.4.438_1352. Accessed on: Nov 23, 2020.

During the 2020–2021 contract year, and consistent with the applicable CMS protocols, HSAG performed the following EQR activities and provided to AHS and the **Department of Vermont Health Access** (**DVHA**) draft and final reports for each activity:

- Validated **DVHA**'s performance improvement project (PIP)
- Validated a set of **DVHA**'s performance measures
- Reviewed **DVHA**'s compliance with the federal Medicaid managed care standards described at 42 CFR §438.10, §438.100, §438.214–230, §438.414, and the related AHS/**DVHA** intergovernmental agreement (IGA) (i.e., contract) requirements
- Prepared this annual external quality review technical report

Purpose

Under its federal Medicaid demonstration waiver, the State of Vermont uses a managed care model to deliver services and is subject to the Medicaid Managed Care standards/regulations found at 42 CFR §438. This report meets the federal requirement (42 CFR §438.364)[1-4] for preparation of an annual technical report that describes how data from activities conducted in accordance with 42 CFR §438.358 were aggregated and analyzed and how conclusions were drawn as to the quality and timeliness of, and the access to, care furnished by **DVHA**, Vermont's statewide Medicaid managed care model organization.

The report also includes HSAG's assessment of **DVHA**'s strengths and, as applicable, improvement recommendations in response to less than fully compliant performance and suggestions for **DVHA** to consider in further enhancing its processes, documentation, and/or performance results in providing quality, timely, and accessible care and services to its beneficiaries. Finally, the report describes **DVHA**'s self-reported improvement actions taken, still in progress, or planned in response to HSAG's prior year recommendations for each of the three activities HSAG conducted (review of compliance with standards, validation of **DVHA**'s PIP, and validation of **DVHA**'s performance measures).

Organization of the Report

DVHA, in the documentation provided to HSAG for the review, and HSAG in this report used the terms "enrollee," "member," and "beneficiary" interchangeably to designate the individuals enrolled in **DVHA** and receiving the applicable Medicaid managed care services.

[1-4] U. S. Government Publishing Office. (2018). *Electronic Code of Federal Regulations*. Available at: https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=0fe554e3f4a6236efe0d8c0aa9319e57&mc=true&n=pt42.4.438&r=PART&ty=HTML%23se42.4.438_1352#se42.4.438_1364. Accessed on: Nov 23, 2020.

Section 1—Introduction and Summary of Findings: Section 1 outlines the purpose and organization of the report. This section also describes the methodology HSAG used to develop the EQR annual technical report, to categorize the results, and to draw conclusions regarding **DVHA**'s performance results related to each EQR activity.

Section 2—Detailed Findings: This section provides contextual information about the federal Medicaid managed care requirements, AHS, and **DVHA**. This section also presents a summary of findings and conclusions about **DVHA**'s strengths and weaknesses, as derived from the EQR activities performed during 2020–2021. Section 2 also includes recommendations and opportunities for improvement in quality, timeliness, and access to care, as provided to **DVHA**. Finally, trends over time are presented as appropriate to the data available.

Section 3—Description of External Quality Review Activities: For each activity HSAG performed, Section 3 provides information related to the objectives of the activity, a description of the data obtained, technical methods of data collection and analysis, and a description of how overall conclusions were drawn related to **DVHA**'s performance.

Section 4—Follow-Up on Prior Year Recommendations: This section presents **DVHA**'s self-report of the improvement actions the organization took in response to HSAG's recommendations made as a result of conducting the previous year's EQR activities and the findings for each. The section also includes the extent to which **DVHA** was successful in improving its performance results.

Methodology for Preparing the External Quality Review (EQR) Technical Report

To fulfill the requirements of 42 CFR §438.358,[1-5] HSAG compiled the overall findings for each EQR activity it conducted and assessed **DVHA**'s strengths, areas requiring improvement, and opportunities to further strengthen its processes, documentation, and/or performance outcomes with respect to the quality and timeliness of, and access to, health care services.

HSAG used the following criteria for its evaluation and the data presented in this report:

1. Reliability: Reliable data consistently identify the event targeted for measure, and the results are reproducible.
2. Validity: Valid data make sense logically and capture the intended aspects of care.
3. Comparability: The data have comparable data sources and data collection methods, as well as precise specifications.

[1-5] U. S. Government Publishing Office. (2018). *Electronic Code of Federal Regulations*. Available at: https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=0fe554e3f4a6236efe0d8c0aa9319e57&mc=true&n=pt42.4.438&r=PART&ty=HTML%23se42.4.438_1352#se42.4.438_1358. Accessed on: Nov 23, 2020.

4. Meaningfulness: The data used are meaningful to the AHS, **DVHA**, beneficiaries, providers, IGA partners/vendors, and other interested stakeholders.
5. Controllability: The data used measure an aspect of care that is within AHS' and **DVHA**'s control.

Data Sources

HSAG used the following data sources to complete its assessment and to prepare this annual EQR technical report:

- Results of HSAG's validation of **DVHA**'s PIP.
- Results of HSAG's validation of **DVHA**'s performance measures and **DVHA**'s performance measure rates and trending of prior years' results.
- Results of HSAG's monitoring of **DVHA**'s compliance with the selected standards in the Medicaid managed care regulations and the associated AHS/**DVHA** IGA/contract requirements; a comparison of **DVHA**'s 2020–2021 performance to the results of HSAG's review of the same set of requirements in prior years; and trends in **DVHA**'s performance results across the prior EQR contract years.
- Results from **DVHA**'s follow-up on prior EQR recommendations as validated by HSAG or self-reported by **DVHA**.

Categorizing Results

Once the data sources were identified, HSAG determined whether the results of the components reviewed related to the quality and/or timeliness of and/or access to health care services based on the definitions included in the executive summary of this report.

Identifying the Department of Vermont Health Access' (DVHA's) Strengths and Opportunities for Improvement

For each of the three EQR activities, HSAG conducted a thorough review and analysis of the data. Because the activities varied in terms of the types of data collected and used, HSAG designed the methodology for identifying strengths and weaknesses to accommodate the data available for and specific to each activity.

Validation of the PIP

HSAG considers a PIP that has achieved an overall *Met* validation status and improved study indicator outcomes an area of strength. For *Partially Met* or *Not Met* evaluation components, HSAG considers these areas of weakness and makes recommendations for improvement. In addition, for any component of the PIP activities (including *Met* elements) evaluated by HSAG during its validation, HSAG may

provide a General Comment to the organization, to assist with improved processes or documentation for the next PIP submission.

Validation of Performance Measures

HSAG validated rates for a set of performance measures selected by AHS for 2020 reporting. AHS identified the measurement period for all measures as calendar year (CY) 2019. AHS required that the measures be calculated according to the National Committee for Quality Assurance's (NCQA's) *Healthcare Effectiveness Data and Information Set (HEDIS®)*[1-6] *20, Volume 2, Technical Specifications for Health Plans*. Although most measures were reported using administrative data, **DVHA** was required to report three measures using both administrative and medical record data, known as the hybrid methodology, to ensure that the rates more accurately reflected the services provided to beneficiaries.

Monitoring Compliance With Standards

HSAG determined which information, documentation, and data reflected specific aspects of care and services **DVHA** provided related to each of the standards HSAG reviewed. HSAG then analyzed and drew conclusions about the results of the compliance review with respect to the domains of quality, timeliness, and access. Seven standards in this year's compliance review included Access and Enrollment and Disenrollment requirements, and those seven standards contained elements related to all three domains.

For its review of **DVHA**'s compliance with CMS' and AHS' requirements, HSAG considers a total score of 90 percent or greater for a given standard to be a relative strength. A total score below 90 percent for a given standard is considered an area of relative weakness. Any standard area with *Partially Met* or *Not Met* scores for one or more evaluation elements requires **DVHA** to take corrective action(s) to improve performance and to come into full compliance with the requirement. In addition, while not rising to a level to be considered "noncompliance," HSAG also may make additional suggestions and recommendations for improving performance in the areas included in the compliance review.

[1-6] HEDIS® is a registered trademark of the NCQA.

Opportunities for Improvement

Table 1-1 contains a list of the opportunities for improvement for **DVHA** that includes all EQR tasks described in this 2020–2021 EQR Technical Report. The table also includes contract compliance standards that did not achieve a score of 100 percent and HEDIS measures that did not achieve a rate above the Medicaid 25th percentile. Additional information about the tasks displayed in Table 1-1 is included in the Detailed Findings section of this report.

Table 1-1—Opportunities for Improvement for DVHA

EQR Activity	Measure Standard	MCO Results	Standard
Contract Compliance Review	III. Beneficiary Information	95.5%	100%
	VI. Grievance System—Beneficiary Grievances	90.6%	100%
	VII. Grievance System—Beneficiary Appeals and State Fair Hearings	89.1%	100%
HEDIS	*Well-Child Visits in the First 15 Months of Life—0 Visits*	Below the Medicaid 25th percentile	Above the Medicaid 25th Percentile
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—3–11 Years	Below the Medicaid 25th percentile	Above the Medicaid 25th Percentile
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—12–17 Years	Below the Medicaid 25th percentile	Above the Medicaid 25th Percentile
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total	Below the Medicaid 25th percentile	Above the Medicaid 25th Percentile
	Breast Cancer Screening	Below the Medicaid 25th percentile	Above the Medicaid 25th Percentile
	Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment (Initiation)—13–17 Years—Total	Below the Medicaid 25th percentile	Above the Medicaid 25th Percentile

2. Detailed Findings

Background

The BBA, Public Law 105-33,[2-1] and as described in 42 CFR §438.364, requires state Medicaid agencies to contract with an EQRO to prepare an annual report that describes the manner in which data from activities conducted in accordance with 42 CFR §438.358 were aggregated and analyzed.[2-2] The report must also describe how conclusions were drawn as to the quality and timeliness of, and access to, care furnished by the Medicaid MCOs, PIHPs, PAHPs, and PCCM entities. AHS chose to meet this requirement by contracting with HSAG, an EQRO, beginning in contract year 2007–2008 to conduct the three CMS required activities and to prepare the EQR annual technical report bringing together the results from the activities it conducted. This report meets the requirements of 42 CFR §438.364 and does not disclose the identity or other PHI of any beneficiary.

The Vermont Agency of Human Services (AHS)

AHS is the State agency responsible for administrating the Medicaid managed care program in Vermont. In fall 2005, the Vermont Legislature approved implementation of the Global Commitment to Health Waiver, a demonstration initiative operated under an 1115 waiver. The waiver allowed the State to designate the Office of Vermont Health Access (OVHA), now **DVHA**, as the first statewide public managed care model organization. Subsequently, through a restructuring of the AHS, the organization became an AHS department. While a department of the State, **DVHA**'s role, responsibility, and funding are equivalent to that of other state Medicaid agencies' contracted MCOs. **DVHA** has written IGAs with other AHS departments to which it delegates certain administrative functions and the provision of direct services; contracts with community-based service providers; and contracts with entities to which it delegates certain administrative functions (e.g., beneficiary services and pharmacy benefit management services).

During the current EQR contract year (February 2020–February 2021), HSAG conducted three mandatory EQR activities and compared the information to **DVHA**'s performance data from the prior year. The results of HSAG's review are contained in this 2020–2021 EQR technical report.

As stated, in part, in its Strategic Plan, AHS strives to improve the health and well-being of Vermonters. AHS' vision includes the assurance of high-quality health care for all Vermonters. In referring to "health," AHS includes physical health, mental health, and health in the area of substance abuse.

[2-1] U. S. Government Publishing Office. (1997). *Public Law 105-33* (p. 249). Available at: http://www.gpo.gov/fdsys/pkg/PLAW-105publ33/pdf/PLAW-105publ33.pdf. Accessed on: Nov 23, 2020.

[2-2] U. S. Government Publishing Office. (2017). *External Quality Review Results.* Available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=1a64dceea153294481f0d7b923980163&mc=true&node=se42.4.438_1364&rgn=div8. Accessed on: Nov 23, 2020.

The State of Vermont's leadership, from the governor down, and AHS continue to be recognized nationally as well as by HSAG:

- As proactive leaders and innovators in designing and implementing health care reforms, implementing creative and effective health care delivery and financing models, and for their effective quality improvement and cost saving initiatives.
- For their collaboration relationships with other states to maximize and share tangible and intellectual resources, experiences, and best practices in designing and implementing creative, effective, and cost-efficient changes. The State's and its multistate health care partners are frequently featured and highlighted in national literature, health care reports, and media for their:
  - Visionary models and initiatives.
  - Collaborative, innovative, and inclusive approach to building stronger, more effective and cost-efficient models for delivering care.

The Department of Vermont Health Access

DVHA is the State department responsible for the management of Medicaid, the Vermont Children's Health Insurance Program (CHIP), and other publicly funded health insurance programs in Vermont. It is also responsible for (1) state oversight and coordination of Vermont's expansive Health Care Reform initiatives which are designed to increase access, improve quality, and contain the cost of health care for all Vermonters; (2) Vermont's health information technology strategic planning, coordination, and oversight; and (3) the Blueprint for Health.

DVHA's stated mission as the statewide Medicaid managed care model organization is to protect and promote the best health for all Vermonters through:

- Effective and integrated public health programs;
- Communities with the capacity to respond to public health needs;
- Internal systems that provide consistent and responsive support;
- A competent and valued workforce that is supported in promoting and protecting the public's health;
- A public health system that is understood and valued by Vermonters; and
- Health equity for all Vermonters.

Scope of HSAG's 2020–2021 EQR Activities

HSAG's external quality review in contract year 2020–2021 consisted of conducting the following activities:

- ***Validation of DVHA's performance improvement project (PIP).*** HSAG reviewed **DVHA**'s PIP to ensure that the organization designed, conducted, and reported on the project in a methodologically sound manner, allowing measurement of any real improvements in care and services, and giving confidence in the reported improvements.
- ***Validation of DVHA's performance measures.*** HSAG validated the accuracy of the AHS-required performance measures that were reported by **DVHA**. The validation also determined the extent to which the Medicaid-specific performance measures calculated by **DVHA** followed the HEDIS 2020 specifications.
- ***Review of DVHA's compliance with standards.*** HSAG conducted a review to determine the organization's compliance with performance standards (sets of requirements) described in the federal Medicaid managed care Structure and Operations standards (42 CFR §438.10, §438.100, §438.214–230, §438.414) and with the associated requirements contained in the AHS IGA (i.e., contract) with **DVHA**.
- ***Preparation of the external quality review annual technical report.*** HSAG compiled and analyzed all data from its 2020–2021 EQR activities and drew conclusions related to the quality and timeliness of, and access to, care and services **DVHA** furnished to its Medicaid beneficiaries. This report describes the results of that process.

Summary of Findings

The following sections summarize HSAG's findings for each of the three activities conducted during 2020–2021.

Validation of the Performance Improvement Project (PIP)

HSAG validated **DVHA**'s PIP, *Initiation of Alcohol and Other Drug Abuse or Dependence Treatment.* HSAG used CMS' PIP validation protocol[2-3] as the methodology to validate the PIP. HSAG's validation assessed Steps I through X.

The PIP topic addresses the initiation of alcohol and other drug abuse or dependence treatment for adolescent and adult beneficiaries with a new alcohol or other drug abuse or dependence diagnosis. This PIP topic represents a key area of focus for improvement by **DVHA**. Members receiving the appropriate care and services for alcohol or other drug abuse or dependence in the recommended time frames is essential to the recovery process.

[2-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-3.pdf. Accessed on: Nov 23, 2020.

DVHA's *Initiation of Alcohol and Other Drug Abuse or Dependence Treatment* PIP received a score of 100 percent for all applicable evaluation elements scored as *Met*, a score of 100 percent for critical evaluation elements scored as *Met*, and an overall validation status of *Met*, as displayed in Table 2-1.

Table 2-1—2020–2021 PIP Validation Summary Overall Score

Percentage Score of Evaluation Elements *Met**	**100%**
Percentage Score of Critical Elements *Met***	**100%**
Validation Status	***Met***

* The percentage score is calculated by dividing the total *Met* by the sum of the total *Met*, *Partially Met*, and *Not Met*.

** The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

Table 2-2 displays **DVHA**'s performance across all PIP activities. The third column represents the total number of evaluation elements *Met* compared to the total number of applicable evaluation elements for each activity reviewed, including critical elements.

Table 2-2—Performance Across All Activities

Stage	Step	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	I. Select the Study Topic(s)	100% (2/2)	0% (0/2)	0% (0/2)
	II. Define the Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III. Define the Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV. Select the Study Indicator(s)	100% (1/1)	0% (0/1)	0% (0/1)
	V. Use Sound Sampling Techniques	*Not Applicable*		
	VI. Reliably Collect Data	100% (3/3)	0% (0/3)	0% (0/3)
	Design Total	**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
Implementation	VII. Analyze and Interpret Study Results	100% (3/3)	0% (0/3)	0% (0/3)
	VIII. Implement Intervention and Improvement Strategies	100% (6/6)	0% (0/6)	0% (0/6)
	Implementation Total	**100% (9/9)**	**0% (0/9)**	**0% (0/9)**

Stage	Step	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Outcomes	IX. Assess for Real Improvement	100% (3/3)	0% (0/3)	0% (0/3)
	X. Assess for Sustained Improvement	100% (1/1)	0% (0/1)	0% (0/1)
	Outcomes Total	**100% (4/4)**	**0% (0/4)**	**0% (0/4)**
Percentage Score of Applicable Evaluation Elements *Met*		**100% (21/21)**		

The validation results indicate an overall score of 100 percent across all applicable evaluation elements. **DVHA** continued the PIP this year and reported second remeasurement results for the study indicator. The improvement from the baseline was statistically significant, indicating real improvement in outcomes. With the second remeasurement, **DVHA** achieved sustained improvement in the study indicator outcomes.

Validation of Performance Measures

HSAG validated a set of performance measures selected by AHS that were calculated and reported by **DVHA**. The methodology HSAG used to validate the performance measures was based on CMS' validation of performance measures protocol.[2-4] The validation findings confirmed that all rates were reportable. Table 2-3 displays the HEDIS 2019 and 2020 performance measure results, the denominator for each measure (i.e., Number [N]), and the change for each measure rate from HEDIS 2019 to HEDIS 2020. Please note that for measures reported using the administrative methodology, the denominator is the eligible population. Additionally, the measure results for HEDIS 2020 were compared to the NCQA's HEDIS Audit Means and Percentiles National Medicaid Health Maintenance Organization (HMO) Percentiles for HEDIS 2019 (the most current rates available). NCQA's HEDIS Audit Means and Percentiles National Medicaid HMO Percentiles will be referred to as "percentiles" throughout this report.

[2-4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Nov 10, 2020.

Table 2-3—DVHA HEDIS 2019 and 2020 Results

Measure	HEDIS 2019		HEDIS 2020		Change from HEDIS 2019 to HEDIS 2020	HEDIS Percentile Ranking
	N	Rate	N	Rate		
*Well-Child Visits in the First 15 Months of Life—0 Visits**	2,770	1.23%	2,570	0.70%	-0.53%	10th–25th
Well-Child Visits in the First 15 Months of Life—1 Visit†	2,770	0.76%	2,570	0.74%	-0.02%	10th–25th
Well-Child Visits in the First 15 Months of Life—2 Visits†	2,770	1.84%	2,570	1.83%	-0.01%	10th–25th
Well-Child Visits in the First 15 Months of Life—3 Visits†	2,770	2.42%	2,570	2.65%	+0.23%	<5th
Well-Child Visits in the First 15 Months of Life—4 Visits†	2,770	6.57%	2,570	5.41%	-1.16%	5th–10th
Well-Child Visits in the First 15 Months of Life—5 Visits†	2,770	14.19%	2,570	12.10%	-2.09%	10th–25th
Well-Child Visits in the First 15 Months of Life—6 or More Visits	2,770	73.00%	2,570	76.58%	+3.58%	90th–95th
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	12,605	75.34%	11,929	77.37%	+2.03%	50th–75th
Adolescent Well-Care Visits	25,516	52.51%	24,573	54.05%	+1.54%	25th–50th
Developmental Screening in the First Three Years of Life—1 Year	—	—	2,649	49.83%	NC	NC
Developmental Screening in the First Three Years of Life—2 Years	—	—	2,762	62.13%	NC	NC
Developmental Screening in the First Three Years of Life—3 Years	—	—	2,884	59.78%	NC	NC
Developmental Screening in the First Three Years of Life—Total	—	—	8,295	57.38%	NC	NC
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—3–11 Years	—	—	244	60.25%	NC	10th–25th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—12–17 Years	—	—	167	60.48%	NC	10th–25th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total	—	—	411	60.34%	NC	10th–25th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—3–11 Years	—	—	244	64.75%	NC	25th–50th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—12–17 Years	—	—	167	59.28%	NC	25th–50th

Measure	HEDIS 2019		HEDIS 2020		Change from HEDIS 2019 to HEDIS 2020	HEDIS Percentile Ranking
	N	Rate	N	Rate		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	—	411	62.53%	NC	25th–50th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—3–11 Years	—	—	244	56.97%	NC	25th–50th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—12–17 Years	—	—	167	60.48%	NC	25th–50th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	—	411	58.39%	NC	25th–50th
Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	37,112	79.40%	32,793	81.22%	+1.82%	50th–75th
Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	20,960	85.61%	19,101	86.80%	+1.19%	50th–75th
Adults' Access to Preventive/Ambulatory Health Services—65+ Years	381	79.27%	170	92.35%	+13.08 %	75th–90th
Adults' Access to Preventive/Ambulatory Health Services—Total	58,453	81.63%	52,064	83.30%	+1.67%	50th–75th
Ambulatory Care (Outpatient Visits)—<1 Year[†,1]	33,648	960.33	33,738	990.17	+29.84	NC
Ambulatory Care (Outpatient Visits)—1–9 Years[†,1]	111,897	305.38	109,270	311.15	+5.77	NC
Ambulatory Care (Outpatient Visits)—10–19 Years[†,1]	91,496	246.87	89,407	246.33	-0.54	NC
Ambulatory Care (Outpatient Visits)—20–44 Years[†,1]	145,013	266.76	155,975	287.07	+20.31	NC
Ambulatory Care (Outpatient Visits)—45–64 Years[†,1]	121,604	419.45	171,725	485.91	+66.46	NC
Ambulatory Care (Outpatient Visits)—65–74 Years[†,1]	1,005	288.96	41,060	687.00	+398.04	NC
Ambulatory Care (Outpatient Visits)—75–84 Years[†,1]	261	446.92	21,085	690.00	+243.08	NC
Ambulatory Care (Outpatient Visits)—85+ Years[†,1]	89	NA	10,604	517.87	NC	NC
Ambulatory Care (Outpatient Visits)—Total[†,1]	505,013	313.68	632,864	360.45	+46.77	NC
*Ambulatory Care (Emergency Department [ED] Visits)—<1 Year**[,1]	2,326	66.39	2,407	70.64	+4.25	NC
*Ambulatory Care (ED Visits)—1–9 Years**[1]	13,069	35.67	12,702	36.17	+0.50	NC
*Ambulatory Care (ED Visits)—10–19 Years**[1]	13,176	35.55	13,028	35.89	+0.34	NC
*Ambulatory Care (ED Visits)—20–44 Years**[1]	31,829	58.55	33,982	62.54	+3.99	NC
*Ambulatory Care (ED Visits)—45–64 Years**[1]	12,828	44.25	20,255	57.31	+13.06	NC
*Ambulatory Care (ED Visits)—65–74 Years**[1]	56	16.10	3,796	63.51	+47.41	NC
*Ambulatory Care (ED Visits)—75–84 Years**[1]	10	17.12	1,989	65.09	+47.97	NC
*Ambulatory Care (ED Visits)—85+ Years**[1]	8	NA	1,021	49.86	NC	NC
*Ambulatory Care (ED Visits)—Total**[1]	73,302	45.53	89,180	50.79	+5.26	NC

Measure	HEDIS 2019		HEDIS 2020		Change from HEDIS 2019 to HEDIS 2020	HEDIS Percentile Ranking
	N	Rate	N	Rate		
Breast Cancer Screening	5,885	52.90%	5,461	52.33%	-0.57%	10th–25th
Chlamydia Screening in Women—16–20 Years	3,899	50.83%	3,590	48.75%	-2.08%	25th–50th
Chlamydia Screening in Women—21–24 Years	2,347	59.65%	2,014	60.53%	+0.88%	25th–50th
Chlamydia Screening in Women—Total	6,246	54.15%	5,604	52.98%	-1.17%	25th–50th
Prenatal and Postpartum Care—Timeliness of Prenatal Care[2]	—	—	411	69.59%	NC	NC
Prenatal and Postpartum Care—Postpartum Care[2]	—	—	411	65.45%	NC	NC
Follow-Up After ED Visit for AOD Abuse or Dependence—7-Day Follow-Up—13–17 Years	—	—	34	14.71%	NC	90th–95th
Follow-Up After ED Visit for AOD Abuse or Dependence—7-Day Follow-Up—18+ Years	—	—	1,149	24.54%	NC	90th–95th
Follow-Up After ED Visit for AOD Abuse or Dependence—7-Day Follow-Up—Total	—	—	1,183	24.26%	NC	90th–95th
Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up—13–17 Years	—	—	34	23.53%	NC	90th–95th
Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up—18+ Years	—	—	1,149	36.55%	NC	90th–95th
Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up—Total	—	—	1,183	36.18%	NC	≥95th
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—6–17 Years	326	45.40%	291	46.74%	+1.34%	50th–75th
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—18–64 Years	1,207	32.56%	1,137	36.68%	+4.12%	50th–75th
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—65+ Years	0	NA	0	NA	NC	NC
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total	1,533	35.29%	1,428	38.73%	+3.44%	50th–75th
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—6–17 Years	326	68.10%	291	72.16%	+4.06%	50th–75th
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—18–64 Years	1,207	46.81%	1,137	57.52%	+10.71 %	50th–75th
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—65+ Years	0	NA	0	NA	NC	NC
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total	1,533	51.34%	1,428	60.50%	+9.16%	50th–75th
Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—6–17 Years	—	—	429	89.04%	NC	≥95th
Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—18–64 Years	—	—	705	67.23%	NC	90th–95th

Measure	HEDIS 2019		HEDIS 2020		Change from HEDIS 2019 to HEDIS 2020	HEDIS Percentile Ranking
	N	Rate	N	Rate		
Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—65+ Years	—	—	0	NA	NC	NC
Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total	—	—	1,134	75.49%	NC	≥95th
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—6–17 Years	—	—	429	91.84%	NC	≥95th
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—18–64 Years	—	—	705	75.60%	NC	90th–95th
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—65+ Years	—	—	0	NA	NC	NC
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total	—	—	1,134	81.75%	NC	≥95th
Initiation and Engagement of AOD Abuse or Dependence Treatment (Initiation)—13–17 Years—Total	214	35.98%	198	30.30%	-5.68%	10th–25th
Initiation and Engagement of AOD Abuse or Dependence Treatment (Initiation)—18+ Years—Total	4,038	39.80%	3,638	43.93%	+4.13%	50th–75th
Initiation and Engagement of AOD Abuse or Dependence Treatment (Initiation)—Total—Total	4,252	39.60%	3,836	43.22%	+3.62%	50th–75th
Initiation and Engagement of AOD Abuse or Dependence Treatment (Engagement)—13–17 Years—Total	214	15.89%	198	15.66%	-0.23%	50th–75th
Initiation and Engagement of AOD Abuse or Dependence Treatment (Engagement)—18+ Years—Total	4,038	18.70%	3,638	22.51%	+3.81%	90th–95th
Initiation and Engagement of AOD Abuse or Dependence Treatment (Engagement)—Total—Total	4,252	18.56%	3,836	22.16%	+3.60%	90th–95th
Controlling High Blood Pressure	411	49.64%	411	52.55%	+2.91%	25th–50th

* For this indicator, a lower rate indicates better performance.

† Rates for this indicator are presented for information only.

[1] For the Ambulatory Care indicators, N represents the number of visits instead of the denominator, and the rates displayed are the number of visits per 1,000 member months.

[2] Due to changes in the technical specifications for this measure in HEDIS 2020, NCQA does not recommend trending between 2020 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks are not performed for this indicator.

— indicates that NCQA recommended a break in trending or the measure is a first-year measure for HEDIS 2020; therefore, prior year rates are not displayed.

NA indicates that a rate could not be reported due to a small denominator.

NC indicates that a comparison to benchmarks or to the prior year's rates is not appropriate either due to a change in specifications or because HEDIS 2020 is the first year this measure is being reported.

Excluding information-only measures, **DVHA** demonstrated strength with 15 measure rates meeting or exceeding the 90th percentile and only six measure rates falling below the 25th percentile. Of the 46 reportable rates with comparable benchmarks, five rates exceeded the 95th percentile:

- *Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up—Total*
- *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—6–17 Years*
- *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total*
- *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—6–17 Years*
- *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total*

Ten rates met or exceeded the 90th percentile but were below the 95th percentile:

- *Well-Child Visits in the First 15 Months of Life—6 or More Visits*
- *Follow-Up After ED Visit for AOD Abuse or Dependence—7-Day Follow-Up—13–17 Years*
- *Follow-Up After ED Visit for AOD Abuse or Dependence—7-Day Follow-Up—18+ Years*
- *Follow-Up After ED Visit for AOD Abuse or Dependence—7-Day Follow-Up—Total*
- *Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up—13–17 Years*
- *Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up—18+ Years*
- *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—18–64 Years*
- *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—18–64 Years*
- *Initiation and Engagement of AOD Abuse or Dependence Treatment (Engagement)—18+ Years—Total*
- *Initiation and Engagement of AOD Abuse or Dependence Treatment (Engagement)—Total—Total*

DVHA demonstrated opportunities for improvement, with the following six rates falling below the 25th percentile:

- *Well-Child Visits in the First 15 Months of Life—0 Visits**
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—3–11 Years*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—12–17 Years*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total*
- *Breast Cancer Screening*
- *Initiation and Engagement of AOD Abuse or Dependence Treatment (Initiation)—13–17 Years—Total*

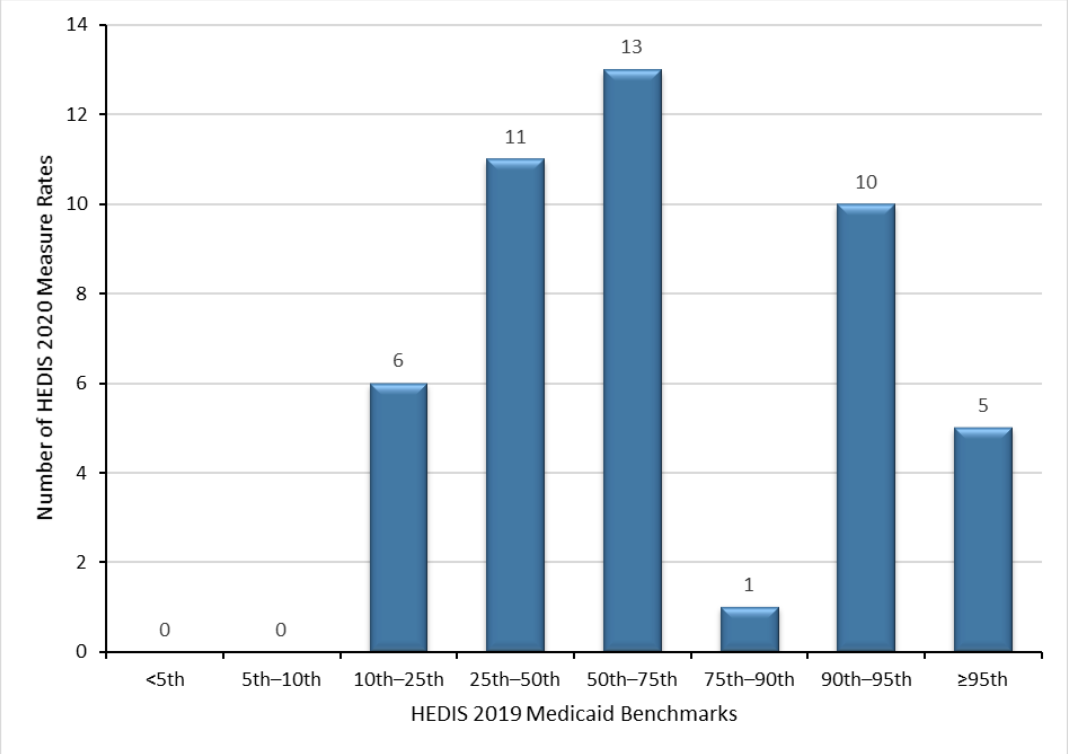
An additional 11 rates fell below the 50th percentile but were at or above the 25th percentile:

- *Adolescent Well-Care Visits*

- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—3–11 Years*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—12–17 Years*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—3–11 Years*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—12–17 Years*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total*
- *Chlamydia Screening in Women—16–20 Years*
- *Chlamydia Screening in Women—21–24 Years*
- *Chlamydia Screening in Women—Total*
- *Controlling High Blood Pressure*

Figure 2-1 shows the distribution of how the reported indicators compared to the 2019 HEDIS national Medicaid benchmarks.

Figure 2-1—Number of HEDIS 2020 Measure Rates Meeting the HEDIS 2019 Medicaid Benchmarks



DVHA performed at or above the 75th percentile for 16 of 46 (34.8 percent) measure rates appropriate for comparison to benchmarks, demonstrating strengths in well-child visits, adult access to routine and emergency health services, appropriate ED utilization, and engagement of AOD abuse or dependence treatment. Conversely, 17 of 46 rates (37.0 percent) fell below the 50th percentile, indicating efforts should be focused on ensuring young children and adolescents are receiving necessary well-child/well-care visits; young children and adolescents receive counseling for BMI percentage, nutrition, and physical activity; and young women are appropriately screened for chlamydia and breast cancer. Initiation of AOD abuse or dependence treatment and controlling blood pressure are additional areas of focus for **DVHA**.

Review of Compliance With Standards

AHS requested that HSAG continue to review one of the three sets of federal Medicaid managed care standards during each EQR contract year. For EQR contract year 2020–2021, AHS requested that HSAG conduct a review of the Structure and Operations standards.

HSAG conducted the review consistent with CMS' *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019.[2-5] HSAG reviewed **DVHA**'s written operating policies and procedures, program plans, meeting minutes, numerous written reports, and other data and documentation related to **DVHA**'s performance during the review period. Reviewers also conducted staff interviews related to each of the eight standards to allow **DVHA** staff members to elaborate on the written information HSAG reviewed, to assess the consistency of staff responses given during the interviews against the written documentation, and to clarify any questions reviewers had following the document review.

The primary objective of HSAG's review was to identify and provide meaningful information to AHS and **DVHA** about **DVHA**'s performance strengths and any areas requiring corrective actions. The information included HSAG's report of its findings related to the extent to which **DVHA**'s performance complied with the applicable federal Medicaid managed care regulations and AHS' associated IGA contract requirements for providing accessible, timely, and quality services to beneficiaries.

Table 2-4 presents a summary of **DVHA**'s performance results for the eight standard areas reviewed. The information includes:

- The total number of elements (i.e., requirements) and the number of applicable elements for each of the standards.
- The number of elements for each of the standards that received a score of *Met*, *Partially Met*, *Not Met*, or a designation of NA (not applicable), as well as the totals across the seven standards.
- The total compliance score for each of the standards.
- The overall compliance score across all standards.

[2-5] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Nov 10, 2020.

Table 2-4—Standards and Compliance Score

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Total Compliance Score
I	Provider Selection	11	11	11	0	0	0	**100%**
II	Credentialing and Recredentialing	4	4	4	0	0	0	**100%**
III	Beneficiary Information	11	11	10	1	0	0	**95.5%**
IV	Beneficiary Rights	4	4	4	0	0	0	**100%**
V	Confidentiality	5	5	5	0	0	0	**100%**
VI	Grievance System—Beneficiary Grievances	16	16	13	3	0	0	**90.6%**
VII	Grievance System—Beneficiary Appeals and State Fair Hearings	32	32	26	5	1	0	**89.1%**
VIII	Subcontractual Relationships and Delegation	5	5	5	0	0	0	**100%**
	Totals	**88**	**88**	**78**	**9**	**1**	**0**	**93.8%**

Total # of Elements: The total number of elements in each standard.
Total # of Applicable Elements: The total number of elements within each standard minus any elements that received a score of *NA*.
Total Compliance Score: The overall percentages were calculated by adding the number of elements that received a score of *Met* to the weighted number (multiplied by 0.50) that received a score of *Partially Met*, then dividing this total by the total number of applicable elements.

As displayed in Table 2-4, HSAG reviewed **DVHA**'s performance related to 88 elements across the eight standards. Of the 88 elements, **DVHA** obtained a score of *Met* for 78 elements (88.6 percent) and a *Partially Met* score for 9 elements (10.2 percent). **DVHA** obtained a *Not Met* score for one element (1.1 percent). As a result, **DVHA** obtained a total percentage-of-compliance score across the 88 elements of 93.8 percent.

Overall Conclusions and Performance Trending

Performance Trends

Performance Improvement Project Trends

DVHA continued its PIP topic, *Initiation of Alcohol and Other Drug Abuse or Dependence Treatment*, in contract year 2020–2021. **DVHA** has performed well in meeting the requirements in the Design and Implementation stages of the PIP, achieving all the validation criteria in Steps 1 through VIII. HSAG determined that **DVHA** designed a methodologically sound study. The technical design of the PIP was valid to measure reliable study indicator outcomes. **DVHA** indicated that the fishbone diagram, corresponding prioritization of barriers, and provider survey analysis that it had completed continued to guide the improvement work during Remeasurement 2. The highest priority barrier reported by **DVHA** was timely access to treatment.

The main intervention for the PIP was a focus on promoting telemedicine/telehealth visits for substance use disorder treatment. **DVHA** pursued the promotion of telehealth with substance use disorder treatment providers and monitored an interim telemedicine indicator quarterly report to gauge progress. **DVHA** expanded the scope of its work by partnering with the Vermont Program for Quality in Health Care. During Remeasurement 2, **DVHA** worked with partnering organizations to plan a "Telehealth 101" training for providers. **DVHA** reported other intervention activities during Remeasurement 2 that included the following:

- Publication of additional provider banners.
- Publication of a provider advisory newsletter article in May 2019.
- Continued presentations to stakeholder groups about the need for the PIP.
- Continued the build of a section on the **DVHA** website.

For outcomes in Step IX and Step X, **DVHA**'s PIP achieved statistically significant and sustained improvement in the study indicator results. **DVHA** reported the baseline result for the PIP as 44.2 percent. For the first remeasurement, **DVHA** reported the result as 46.7 percent, a 2.5 percentage point increase from the baseline. The improvement from the baseline to the first remeasurement was statistically significant. Using a Chi-square test to compare the baseline to the first remeasurement, the p value = 0.0086. For the second remeasurement, **DVHA** reported a result of 49.3 percent. The improvement was a 2.6 percentage point increase from the first remeasurement and a 5.1 percentage point increase from the baseline. The improvement from the baseline to the second remeasurement was statistically significant. Using a Chi-square test to compare the baseline to the second remeasurement, the p value was < 0.0001.

Table 2-5—*Initiation of Alcohol and Other Drug Abuse or Dependence Treatment* PIP for Department of Vermont Health Access

PIP—*Initiation of Alcohol and Other Drug Abuse or Dependence Treatment*				
Study Indicator	**Baseline (1/1/17–11/14/17)**	**Remeasurement 1 (1/1/18–11/14/18)**	**Remeasurement 2 (1/1/19–11/13/19)**	***Sustained Improvement**
The percentage of Vermont Medicaid members 13 years of age and older with a new episode of alcohol or other drug (AOD) abuse or dependence who have initial treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication assisted treatment (MAT) within 14 days of the diagnosis.	44.2%	46.7%↑*	49.3%↑*	Yes

* Remeasurement 2 was in alignment with HEDIS 2020: "Intake Period to end on November 13 of the measurement year."
↑* Designates statistically significant improvement over the baseline measurement period (p value < 0.05).

Performance Measure Trends

DVHA used a vendor with HEDIS Certified Measures[SM, 2-6] to calculate and report the HEDIS 2020 performance measure rates. Table 2-6 below displays the rates for measures **DVHA** reported for HEDIS 2017, 2018, 2019, and 2020; the denominator (i.e., N); and the change for each measure rate from HEDIS 2017 to HEDIS 2020.

Table 2-6—HEDIS 2017, 2018, 2019, and 2020 Results

Measure	HEDIS 2017		HEDIS 2018		HEDIS 2019		HEDIS 2020		Change from HEDIS 2017 to HEDIS 2020
	N	Rate	N	Rate	N	Rate	N	Rate	
*Well-Child Visits in the First 15 Months of Life—0 Visits**	3,045	1.67%	2,841	1.06%	2,770	1.23%	2,570	0.70%	-0.97%
Well-Child Visits in the First 15 Months of Life—1 Visit†	3,045	0.99%	2,841	0.74%	2,770	0.76%	2,570	0.74%	-0.25%
Well-Child Visits in the First 15 Months of Life—2 Visits†	3,045	1.48%	2,841	1.48%	2,770	1.84%	2,570	1.83%	+0.35%
Well-Child Visits in the First 15 Months of Life—3 Visits†	3,045	3.05%	2,841	2.85%	2,770	2.42%	2,570	2.65%	-0.40%
Well-Child Visits in the First 15 Months of Life—4 Visits†	3,045	6.11%	2,841	6.51%	2,770	6.57%	2,570	5.41%	-0.70%
Well-Child Visits in the First 15 Months of Life—5 Visits†	3,045	15.07%	2,841	14.85%	2,770	14.19%	2,570	12.10%	-2.97%
Well-Child Visits in the First 15 Months of Life—6 or More Visits	3,045	71.63%	2,841	72.51%	2,770	73.00%	2,570	76.58%	+4.95%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	12,879	73.97%	12,729	75.24%	12,605	75.34%	11,929	77.37%	+3.40%
Adolescent Well-Care Visits	26,791	50.89%	25,806	50.54%	25,516	52.51%	24,573	54.05%	+3.16%
Developmental Screening in the First Three Years of Life—1 Year	—	—	—	—	—	—	2,649	49.83%	NC
Developmental Screening in the First Three Years of Life—2 Years	—	—	—	—	—	—	2,762	62.13%	NC
Developmental Screening in the First Three Years of Life—3 Years	—	—	—	—	—	—	2,884	59.78%	NC
Developmental Screening in the First Three Years of Life—Total	—	—	—	—	—	—	8,295	57.38%	NC

[2-6] HEDIS Certified Measures[SM] is a service mark of the NCQA.

Measure	HEDIS 2017		HEDIS 2018		HEDIS 2019		HEDIS 2020		Change from HEDIS 2017 to HEDIS 2020
	N	Rate	N	Rate	N	Rate	N	Rate	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—3–11 Years	—	—	—	—	—	—	244	60.25%	NC
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—12–17 Years	—	—	—	—	—	—	167	60.48%	NC
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total	—	—	—	—	—	—	411	60.34%	NC
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—3–11 Years	—	—	—	—	—	—	244	64.75%	NC
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—12–17 Years	—	—	—	—	—	—	167	59.28%	NC
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	—	—	—	—	—	411	62.53%	NC
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—3–11 Years	—	—	—	—	—	—	244	56.97%	NC

Measure	HEDIS 2017		HEDIS 2018		HEDIS 2019		HEDIS 2020		Change from HEDIS 2017 to HEDIS 2020
	N	Rate	N	Rate	N	Rate	N	Rate	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—12–17 Years	—	—	—	—	—	—	167	60.48%	NC
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	—	—	—	—	—	411	58.39%	NC
Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	40,955	78.24%	37,645	79.39%	37,112	79.40%	32,793	81.22%	+2.98%
Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	23,981	83.49%	21,594	85.22%	20,960	85.61%	19,101	86.80%	+3.31%
Adults' Access to Preventive/Ambulatory Health Services—65+ Years	394	72.59%	427	82.44%	381	79.27%	170	92.35%	+19.76%
Adults' Access to Preventive/Ambulatory Health Services—Total	65,330	80.13%	59,666	81.52%	58,453	81.63%	52,064	83.30%	+3.17%
Ambulatory Care (Outpatient Visits)—<1 Year[†,1]	36,328	941.04	33,567	905.75	33,648	960.33	33,738	990.17	+49.13
Ambulatory Care (Outpatient Visits)—1–9 Years[†,1]	117,053	299.28	112,957	298.10	111,897	305.38	109,270	311.15	+11.87
Ambulatory Care (Outpatient Visits)—10–19 Years[†,1]	94,823	246.51	90,621	242.35	91,496	246.87	89,407	246.33	-0.18
Ambulatory Care (Outpatient Visits)—20–44 Years[†,1]	176,166	268.48	148,279	261.51	145,013	266.76	155,975	287.07	+18.59
Ambulatory Care (Outpatient Visits)—45–64 Years[†,1]	142,090	408.41	124,066	407.84	121,604	419.45	171,725	485.91	+77.50
Ambulatory Care (Outpatient Visits)—65–74 Years[†,1]	1,131	313.38	1,223	321.08	1,005	288.96	41,060	687.00	+373.62

Measure	HEDIS 2017		HEDIS 2018		HEDIS 2019		HEDIS 2020		Change from HEDIS 2017 to HEDIS 2020
	N	Rate	N	Rate	N	Rate	N	Rate	
Ambulatory Care (Outpatient Visits)—75–84 Years[†,1]	405	530.80	438	598.36	261	446.92	21,085	690.00	+159.20
Ambulatory Care (Outpatient Visits)—85+ Years[†,1]	124	370.15	231	596.90	89	NA	10,604	517.87	+147.72
Ambulatory Care (Outpatient Visits)—Total[†,1]	568,120	311.61	511,382	306.94	505,013	313.68	632,864	360.45	+48.84
*Ambulatory Care (ED Visits)—<1 Year**[,1]	2,540	65.80	2,320	62.60	2,326	66.39	2,407	70.64	+4.84
*Ambulatory Care (ED Visits)—1–9 Years**[,1]	13,428	34.33	13,438	35.46	13,069	35.67	12,702	36.17	+1.84
*Ambulatory Care (ED Visits)—10–19 Years**[1]	13,975	36.33	13,539	36.21	13,176	35.55	13,028	35.89	-0.44
*Ambulatory Care (ED Visits)—20–44 Years**[1]	37,849	57.68	32,773	57.80	31,829	58.55	33,982	62.54	+4.86
*Ambulatory Care (ED Visits)—45–64 Years**[1]	13,628	39.17	12,962	42.61	12,828	44.25	20,255	57.31	+18.14
*Ambulatory Care (ED Visits)—65–74 Years**[1]	73	20.23	77	20.22	56	16.10	3,796	63.51	+43.28
*Ambulatory Care (ED Visits)—75–84 Years**[1]	25	32.77	26	35.52	10	17.12	1,989	65.09	+32.32
*Ambulatory Care (ED Visits)—85+ Years**[1]	10	29.85	12	31.01	8	NA	1,021	49.86	+20.01
*Ambulatory Care (ED Visits)—Total**[,1]	81,528	44.72	75,147	45.10	73,302	45.53	89,180	50.79	+6.07
Breast Cancer Screening	—	—	6,189	54.26%	5,885	52.90%	5,461	52.33%	NC
Chlamydia Screening in Women—16–20 Years	4,162	47.53%	4,003	49.74%	3,899	50.83%	3,590	48.75%	+1.22%
Chlamydia Screening in Women—21–24 Years	2,852	55.58%	2,575	58.06%	2,347	59.65%	2,014	60.53%	+4.95%
Chlamydia Screening in Women—Total	7,014	50.80%	6,578	52.99%	6,246	54.15%	5,604	52.98%	+2.18%
Prenatal and Postpartum Care—Timeliness of Prenatal Care[2]	—	—	—	—	—	—	411	69.59%	NC
Prenatal and Postpartum Care—Postpartum Care[2]	—	—	—	—	—	—	411	65.45%	NC
Follow-Up After ED Visit for AOD Abuse or Dependence—7-Day Follow-Up—13–17 Years	—	—	—	—	—	—	34	14.71%	NC

Measure	HEDIS 2017		HEDIS 2018		HEDIS 2019		HEDIS 2020		Change from HEDIS 2017 to HEDIS 2020
	N	Rate	N	Rate	N	Rate	N	Rate	
Follow-Up After ED Visit for AOD Abuse or Dependence—7-Day Follow-Up—18+ Years	—	—	—	—	—	—	1,149	24.54%	NC
Follow-Up After ED Visit for AOD Abuse or Dependence—7-Day Follow-Up—Total	—	—	—	—	—	—	1,183	24.26%	NC
Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up—13–17 Years	—	—	—	—	—	—	34	23.53%	NC
Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up—18+ Years	—	—	—	—	—	—	1,149	36.55%	NC
Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up—Total	—	—	—	—	—	—	1,183	36.18%	NC
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—6–17 Years	—	—	—	—	326	45.40%	291	46.74%	NC
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—18–64 Years	—	—	—	—	1,207	32.56%	1,137	36.68%	NC
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—65+ Years	—	—	—	—	0	NA	0	NA	NC
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total	—	—	1,324	33.91%	1,533	35.29%	1,428	38.73%	NC
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—6–17 Years	—	—	—	—	326	68.10%	291	72.16%	NC
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—18–64 Years	—	—	—	—	1,207	46.81%	1,137	57.52%	NC

Measure	HEDIS 2017		HEDIS 2018		HEDIS 2019		HEDIS 2020		Change from HEDIS 2017 to HEDIS 2020
	N	Rate	N	Rate	N	Rate	N	Rate	
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—65+ Years	—	—	—	—	0	NA	0	NA	NC
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total	—	—	1,324	52.72%	1,533	51.34%	1,428	60.50%	NC
Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—6–17 Years	—	—	—	—	—	—	429	89.04%	NC
Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—18–64 Years	—	—	—	—	—	—	705	67.23%	NC
Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—65+ Years	—	—	—	—	—	—	0	NA	NC
Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total	—	—	—	—	—	—	1,134	75.49%	NC
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—6–17 Years	—	—	—	—	—	—	429	91.84%	NC
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—18–64 Years	—	—	—	—	—	—	705	75.60%	NC
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—65+ Years	—	—	—	—	—	—	0	NA	NC
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total	—	—	—	—	—	—	1,134	81.75%	NC
Initiation and Engagement of AOD Abuse or Dependence Treatment (Initiation)—13–17 Years—Total	—	—	235	35.74%	214	35.98%	198	30.30%	NC
Initiation and Engagement of AOD Abuse or Dependence Treatment (Initiation)—18+ Years—Total	—	—	4,378	38.21%	4,038	39.80%	3,638	43.93%	NC

Measure	HEDIS 2017		HEDIS 2018		HEDIS 2019		HEDIS 2020		Change from HEDIS 2017 to HEDIS 2020
	N	Rate	N	Rate	N	Rate	N	Rate	
Initiation and Engagement of AOD Abuse or Dependence Treatment (Initiation)—Total	—	—	4,613	38.09%	4,252	39.60%	3,836	43.22%	NC
Initiation and Engagement of AOD Abuse or Dependence Treatment (Engagement)—13–17 Years—Total	—	—	235	18.30%	214	15.89%	198	15.66%	NC
Initiation and Engagement of AOD Abuse or Dependence Treatment (Engagement)—18+ Years—Total	—	—	4,378	19.67%	4,038	18.70%	3,638	22.51%	NC
Initiation and Engagement of AOD Abuse or Dependence Treatment (Engagement)—Total	—	—	4,613	19.60%	4,252	18.56%	3,836	22.16%	NC
Controlling High Blood Pressure	—	—	—	—	411	49.64%	411	52.55%	NC

* For this indicator, a lower rate indicates better performance.

† Rates for this indicator are presented for information only.

[1] For the Ambulatory Care indicators, N represents the number of visits instead of the denominator, and the rates displayed are the number of visits per 1,000 member months.

[2] Due to changes in the technical specifications for this measure in HEDIS 2020, NCQA does not recommend trending between 2020 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks are not performed for this indicator.

— indicates that NCQA recommended a break in trending or the measure is a first-year measure for HEDIS 2020; therefore, prior year rates are not displayed.

NA indicates that a rate could not be reported due to a small denominator.

NC indicates that a comparison to benchmarks or to the prior year's rates is not appropriate either due to a change in specifications or because HEDIS 2020 is the first year this measure is being reported.

Overall, 12 of the 20 (60 percent) measure rates that could be trended showed an improvement in performance since HEDIS 2017 (excluding information-only measures). Further, the *Adults' Access to Preventive/Ambulatory Health Services—65+ Years* rate improved by nearly 20 percentage points from HEDIS 2017 to HEDIS 2020. Of the eight measure rates that showed a decline in performance, *Ambulatory Care (ED Visits)—65–74 Years* declined by over 40 percentage points, *Ambulatory Care (ED Visits)—75–84 Years* declined by over 30 percentage points, *Ambulatory Care (ED Visits)—85+ Years* declined by over 20 percentage points, and *Ambulatory Care (ED Visits)—45–64 Years* declined by over 15 percentage points.

Compliance With Standards Trends

The 2020–2021 review was the first year of HSAG's three-year cycle of compliance reviews. Due to the travel restrictions and stay-at-home orders in many states in response to the coronavirus disease 2019 (COVID-19), AHS, HSAG, and **DVHA** agreed to perform this year's compliance review virtually. HSAG performed a desk review of **DVHA**'s documents, and the virtual review included reviewing additional documents and conducting interviews with key **DVHA** staff members. HSAG evaluated the degree to which **DVHA** complied with federal Medicaid managed care regulations and the associated AHS IGA in eight performance categories (i.e., standards). The eight standards (i.e., Provider Selection, Credentialing and Recredentialing, Beneficiary Information, Beneficiary Rights, Confidentiality, Grievance System—Beneficiary Grievances, Grievance System—Beneficiary Appeals and State Fair Hearings, and Subcontractual Relationships and Delegation) included requirements associated with the federal Medicaid managed care Structure and Operations standards found at 42 CFR §438.10, §438.100, §438.214—230, and §438.414.

HSAG reviews a different set of standards to evaluate **DVHA**'s compliance with federal CMS Medicaid managed care regulations and the associated AHS/**DVHA** IGA requirements during each year within a three-year cycle of reviews. The number of standards reviewed each year varies, as does the focus of the review. The three-year cycle consists of the following standards: Year 1, Structure and Operations standards (42 CFR §438.10, §438.100, §438.214–§438.230, and §438.414); Year 2, Measurement and Improvement standards (42 CFR §438.236, §438.242, and §438.330); and Year 3, Access and Enrollment/Disenrollment standards (42 CFR §438.206–§438.210 and §438.54–§438.56).

For this year (2020—the 13th year of review), HSAG evaluated the Structure and Operations standards, the same standards it reviewed in 2008, 2011, 2014, and 2017.

Table 2-7 documents **DVHA**'s performance across 13 years of compliance reviews conducted by HSAG.

Table 2-7—Comparison/Trending of Scores Achieved During Compliance Reviews

Year of the Review	Structure and Operations Standards			Measurement and Improvement Standards			Access and Enrollment/Disenrollment Standards		
	Elements	Score	Corrective Action %*	Elements	Score	Corrective Action %*	Elements	Score	Corrective Action %*
2008	90	84%	30%						
2009				29	98%	3%			
2010							76	97%	7%
2011	89	90%	20%						
2012				30	100%	0%			
2013							71	99%	3%
2014	93	92%	15%						
2015				31	97%	3%			

Year of the Review	Structure and Operations Standards			Measurement and Improvement Standards			Access and Enrollment/Disenrollment Standards		
	Elements	Score	Corrective Action %*	Elements	Score	Corrective Action %*	Elements	Score	Corrective Action %*
2016							80	97%	6%
2017	84	90%	19%						
2018				33	100%	0%			
2019							68	86%	22%
2020	88	94%	11%						

* The percentage of requirements for which HSAG scored **DVHA**'s performance as either partially meeting or not meeting the requirement.

For the Structure and Operations standards, the overall scores **DVHA** received across the five years these standards were reviewed ranged from 84 percent to 94 percent, with the overall corrective action percentages ranging from 11 percent to 30 percent. During the prior review, **DVHA** scored 90 percent across the eight standards.

Quality, Timeliness, and Access to Care Domains

The federal Medicaid managed care regulations require that "each contract with a Medicaid managed care organization must provide for an annual external independent review conducted by a qualified independent entity of the quality outcomes and timeliness of, and access to, the care and services for which the organization is responsible."[2-7] CMS has chosen the domains of quality, access, and timeliness as keys to evaluating the performance of MCOs, PIHPs, PAHPs, and PCCMs. Definitions HSAG used to evaluate and draw conclusions about **DVHA**'s performance in each of these domains are as follows.

Quality

CMS defines "quality" in the final rule at 42 CFR §438.320 as follows:

> Quality, as it pertains to external quality review, means the degree to which an MCO, PIHP, PAHP, or PCCM entity (described in §438.310(c)(2)) increases the likelihood of desired health outcomes of its enrollees through its (1) structural and operational characteristics, (2) the provision of services that are consistent with current professional, evidence-based knowledge, and (3) interventions for performance improvement.[2-8]

[2-6] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Legislative Summary: Balanced Budget Act of 1997 Medicare and Medicaid Provisions.* Available at: https://innovation.cms.gov/files/migrated-medicare-demonstration-x/cc_section4016_bba_1997.pdf. Accessed on: Nov 23, 2020.

[2-7] Department of Health and Human Services Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations.* Title 42, Vol 81, May 6, 2016.

Timeliness

NCQA defines "timeliness" relative to utilization decisions as follows: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[2-9] NCQA further discusses the intent of this standard to minimize any disruption in the provision of health care. HSAG extends this definition of timeliness to include other managed care provisions that impact services to beneficiaries and that require a timely response by the managed care organization—e.g., processing expedited appeals and providing timely follow-up care.

Access

CMS defines "access" in the final rule at 42 CFR §438.320 as follows:

> Access, as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under §438.68 (Network adequacy standards) and §438.206 (Availability of services).[2-10]

To draw conclusions about the quality and timeliness of, and access to, care **DVHA** provided, HSAG determined which components of each EQR activity could be used to assess these domains (as indicated in Table 2-8). The measures marked N/A relate to utilization of services.

Table 2-8—EQR Activity Components Assessing Quality, Timeliness, and Access

PIP	Quality	Timeliness	Access
Initiation of Alcohol and Other Drug Abuse or Dependence Treatment	✓	✓	✓
Performance Measures	**Quality**	**Timeliness**	**Access**
Adolescent Well-Care Visits	✓		✓
Adults' Access to Preventive/Ambulatory Health Services			✓
Ambulatory Care	N/A	N/A	N/A
Breast Cancer Screening	✓		
Chlamydia Screening in Women	✓		
Controlling High Blood Pressure	✓		
Developmental Screening in the First Three Years of Life	✓	✓	✓
Follow-Up After ED Visit for AOD Abuse or Dependence	✓	✓	✓

[2-8] National Committee for Quality Assurance. (2016). *Standards and Guidelines for Health Plans*.

[2-9] Federal Register. *Code of Federal Regulations, Title 42, Volume 4*, May 6, 2016. Available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=fa076676cc95c899c010f8abe243e97e&mc=true&node=se42.4.438_1320&rgn=div8. Accessed on: Nov 23, 2020.

Performance Measures	Quality	Timeliness	Access
Follow-Up After Hospitalization for Mental Illness	✓	✓	✓
Follow-Up After ED Visit for Mental Illness	✓	✓	✓
Initiation and Engagement of AOD Abuse or Dependence Treatment	✓	✓	✓
Prenatal and Postpartum Care	✓	✓	✓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	✓		
Well-Child Visits in the First 15 Months of Life	✓		✓
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	✓		✓
Compliance Review Standards	**Quality**	**Timeliness**	**Access**
Standard I—Provider Selection	✓	✓	✓
Standard II—Credentialing and Recredentialing	✓	✓	✓
Standard III—Beneficiary Information	✓	✓	✓
Standard IV—Beneficiary Rights	✓	✓	✓
Standard V—Confidentiality	✓		
Standard VI—Grievance System—Beneficiary Grievances	✓	✓	✓
Standard VII—Grievance System—Beneficiary Appeals and State Fair Hearings	✓	✓	✓
Standard VIII—Subcontractual Relationships and Delegation	✓	✓	✓

EQR Assessment of DVHA's Strengths and Weaknesses and Summary of Quality, Timeliness, and Access

Performance Improvement Project

DVHA's *Initiation of Alcohol and Other Drug Abuse or Dependence Treatment* PIP submission documentation, representing quality, timeliness, and access to care, provided evidence that the PIP was a scientifically sound project supported by use of key research principles. **DVHA**'s PIP demonstrated strengths by achieving 100 percent of CMS' protocol requirements in the validation. **DVHA** demonstrated proficiency in designing a PIP that has the potential to impact member health, functional status, or satisfaction. **DVHA**'s study indicator was based on HEDIS technical specifications and focused on measuring Vermont Medicaid members 13 years of age and older with a new episode of AOD abuse or dependence who had initial treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication-assisted treatment (MAT) within 14 days of the diagnosis. **DVHA** specified a systematic administrative data collection method for collecting baseline and remeasurement data.

DVHA performed well in the Implementation stage. **DVHA** completed an annual causal/barrier analysis with a clearly documented team, process, and quality improvement tools and implemented an intervention that was logically linked to a priority barrier. In the Outcomes stage, the results demonstrated statistically significant improvement for the first remeasurement, indicating real improvement. With the second remeasurement, **DVHA** achieved sustained improvement.

Performance Measures

DVHA continued to use an external software vendor with HEDIS Certified Measures to produce the HEDIS measures under review. Using a HEDIS Certified Measures vendor ensured that **DVHA**'s rates were calculated in accordance with the HEDIS specifications and that the measures met standards set forth by NCQA.

DVHA staff utilized trending mechanisms to monitor claims submissions which ensured data completeness prior to rate production. **DVHA** also refreshed administrative data frequently to ensure the most recent claim information was available for measure calculation.

DVHA continued to partner with DXC Technologies (DXC, formerly Hewlett Packard Enterprise) to manage its core systems. **DVHA**'s oversight of DXC ensured that DXC met the requirements for data capture and HEDIS reporting. DXC actively participated in quality meetings and had an on-site presence at **DVHA**'s site.

This year, HSAG reviewed the progress of the provider management system implemented in 2018 and found additional improvements. These improvements resulted in total automation of provider onboarding and credentialing.

DVHA staff continued to review performance measures to identify areas for improvement and to identify mechanisms for improving outcomes for its beneficiaries. Several performance measures representing quality of care, access to care, and timeliness of care demonstrated strengths by meeting or exceeding the 90th percentile, including *Well-Child Visits in the First 15 Months of Life—6 or More Visits, ED utilization*, and *Initiation and Engagement of AOD Abuse or Dependence Treatment (Engagement).*

DVHA should continue to monitor and trend claims submissions throughout the year.

DVHA should continue to pursue all available data sources to supplement its data captured via claims. **DVHA** may benefit from the use of data from Vermont's Clinical Repository operated by Vermont Information Technology Leaders (VITL). The VITL repository, which retains patient information in a standardized format, could be used as an additional data source for future measure production. This will enhance measure rates by identifying additional values for numerator compliance.

The Maximus contract required Maximus to perform member services activities to include updating the computer system with eligibility information, operating a call center to assist enrollees who have questions about covered services, verifying third-party liability information, assisting with the selection

of providers, answering questions about prior authorizations and billing, and handling any other issues to assist enrollees in understanding their coverage with Green Mountain Care.

Compliance With Standards

Each of the compliance review standards included elements representing the domains of quality and timeliness of, and/or access to care. *Met* elements in seven of the eight standards reviewed this year addressed all three domains. HSAG noted the following strengths.

DVHA established procedures for selection and retention of providers by creating the State of Vermont Provider Management Module (PMM) and implementing an automated application process for providers to submit initial and reverification applications to **DVHA**. At the time of initial enrollment, providers received the Vermont Medicaid General Provider Manual (Provider Manual) that included information concerning grievances, appeals, and advance directives. The Department of Vermont Health Access General Provider Agreement required providers to comply with all applicable statutes, regulations, reimbursement manuals, policies, and properly promulgated rules of **DVHA** and included additional information concerning advance directives.

DVHA achieved provider profiling by reviewing the evaluation and management (E/M) codes submitted by Medicaid providers. DXC provider representatives met with targeted providers who used a higher percentage of level 4 and 5 codes then their peer group when requesting reimbursement for office visits to determine the population served by the office and how the office staff members selected the procedure codes for visits. **DVHA** also submitted charts and graphs to demonstrate the monitoring of providers to determine which providers were targeted for review by DXC.

During the review of enrollment and reverification files, **DVHA** demonstrated the PMM. HSAG assessed the timeliness and accuracy of DXC's verifications, and the information indicated that the average number of calendar days between the signature on the application and the approval by **DVHA** was 11.6 days for enrollment applications and 16.3 days for reverification applications. The accuracy of processing the files was excellent with the enrollment files obtaining a 100 percent score for the 10 items reviewed in each file, and the reverification files obtaining a 99.4 percent score for the 11 items reviewed in each file. **DVHA** is to be commended for developing and implementing the PMM to assist in ensuring timely and accurate processing of provider applications.

DVHA furnished a link to an online provider look-up tool to assist beneficiaries in selecting a network provider, including a primary care provider (PCP), specialist, or hospital. The searchable provider listing was accessible to beneficiaries and providers through a link on the Green Mountain Care website. **DVHA** also made a Preferred Drug List available to prescribers on the **DVHA** website. The drug list included both the brand name and generic medications covered by **DVHA** as well as information regarding prior-authorization requirements for any medications where prior authorization was required.

DVHA published an *Enrollee Bill of Rights* Operating Principle and a *Free Exercise of Rights* Operating Principle that provided guidance to **DVHA** and IGA partner staff members regarding the process to ensure that beneficiary rights were upheld. A list of the Member Bill of Rights was also included in the

DVHA Provider Manual and was posted on the Green Mountain Care website. **DVHA**'s *Enrollee Bill of Rights* Operating Principle described the process for identifying, tracking, and resolving beneficiary complaints regarding alleged rights violations. **DVHA** had policies and procedures pertaining to the protection of beneficiaries' information. The policies addressed the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements, authorizations for release of information, de-identification processes, minimum necessary disclosures, privacy considerations, identification verification, access to information, phone security, and working in remote locations. **DVHA** required all staff members to complete biannual HIPAA training and achieve a passing score on a post-training examination.

The **DVHA** Global Commitment to Health Medicaid Program Grievance & Appeals Technical Assistance Manual (Grievance and Appeals Manual) contained detailed requirements for processing grievances. The Grievance and Appeals Manual was used by **DVHA** and the following agencies: (1) Department of Disabilities, Aging and Independent Living (DAIL): Attendant Services Program, Children's Personal Care Program, High Tech Program, Outpatient/Emergency Services, and Traumatic Brain Injury Program; (2) Department of Health: Division of Alcohol and Drug Abuse Programs; (3) Developmental Disability Services; (4) DAIL: Division of Disability and Aging Services; (5) Department of Mental Health (DMH); and (6) Department of Health: Children with Special Health Care Needs.

DVHA's grievance and appeals database (used by both **DVHA** and its IGA partners) had the capability to allow users to query various reports, including the number of appeals by service and the timeliness of resolution. The database included information regarding the source of the appeal, the member's Medicaid enrollment status, service category, date the appeal was filed, name of the person deciding the appeal, and whether or not that person was involved in any previous review or decision related to the appeal.

DVHA was bound by a Procurement and Contracting Procedures bulletin published by the State of Vermont Agency of Administration as a guide for soliciting, awarding, processing, executing, and overseeing contracts with its IGA partners, vendors, and providers. The bulletin provided information regarding the competitive bidding process, standards for drafting contracts, contract routing and approvals, and contract execution. **DVHA** had a process in place for ongoing monitoring of subcontractor key performance indicators.

Recommendations and Opportunities for Improvement

Performance Improvement Project

DVHA has demonstrated proficiency in designing and implementing a PIP. Additionally, the study indicator results demonstrated statistically significant improvement indicating real improvement in the outcomes. **DVHA** sustained the improvement.

The following are HSAG's recommendations to **DVHA** based on validation of **DVHA**'s PIP:

- **DVHA** should retire the *Initiation of Alcohol and Other Drug Abuse or Dependence Treatment* PIP from submission for validation at the direction of AHS. **DVHA** submitted the PIP for four annual validations. HSAG validated the PIP through Step X and **DVHA** achieved sustained improvement.
- **DVHA** should continue its quality improvement efforts for the topic to further sustain improvement in the study indicator results.
- **DVHA** should continue to evaluate the intervention for effectiveness. If the results indicate that there is a decline after the PIP has ended, **DVHA** should add additional interventions as needed, evaluate the changes for effectiveness, and continue to monitor the study indicator data.
- **DVHA** should begin a new PIP if appropriate, at the direction of AHS, that would be submitted for an annual validation in 2021–2022.

Performance Measures

HSAG offers the following recommendations related to improving **DVHA**'s data collection and reporting processes:

- **DVHA** should pursue all available data sources to supplement its claims capture. **DVHA** should continue to explore the use of Vermont's clinical repository operated by VITL. VITL could potentially be an untapped resource for capturing supplemental data for measures.
- HSAG's recommendation remains from prior years as it did not appear that **DVHA** captured any data using Vermont's clinical repository.
- In addition, **DVHA** should continue its processes to monitor and trend claims submissions.

Compliance With Standards

HSAG offers the following recommendations related to improving **DVHA**'s compliance with standards:

During the virtual review, one provider recredentialing file did not contain evidence of malpractice insurance on the date of revalidation. **DVHA** must ensure that every file processed for revalidation includes a malpractice insurance certificate that is valid on the date of reverification.

The Member Handbook did not include language regarding how beneficiaries are to report suspected fraud and abuse. **DVHA** must include language in its Member Handbook regarding how beneficiaries are to report suspected fraud and abuse as required by the IGA §2.3.2 and §2.3.3 and the CFR.

DVHA must ensure that, with the beneficiary's written consent, a provider may serve as the beneficiary's representative for the purpose of filing a grievance and assisting the beneficiary with the proceedings of the grievance.

DVHA must ensure that, if the grievance decision constitutes an action adverse to the beneficiary, the grievance review process does not delay or inhibit a beneficiary's ability to request a State fair hearing, as required by the IGA §2.11.6.5 (A).

DVHA must inform its providers about the beneficiary's right to request continuation of benefits during an appeal or State fair hearing filing; if **DVHA**'s action is upheld in a hearing, the beneficiary may be liable for the cost of any continued benefits; and any state-determined provider appeal rights to challenge the failure of the organization to cover a service, as required by the IGA §2.4.4.

As required by the IGA §2.10 and the CFR, **DVHA** must ensure that Medicaid coverage appeals are processed in accordance with applicable Appeals Rules and Fair Hearing Rules, as promulgated separately by the Human Services Board pursuant to 3 V.S.A. 3091; have uniform AHS-approved appeals rules and policies in accordance with applicable Appeals Rules and the hearing rules, as promulgated separately by the Human Services Board fair hearing rules (humanservices.vt.gov/boards-committees/HSB/Fair-Hearing-Rule); and ensure that its IGA partners, including Designated Agencies (DAs) and Specialized Service Agencies (SSAs) acting within the delegated authority of **DVHA**/the DMH adhere to the policies and procedures.

DVHA must ensure that, when an expedited appeal is requested, **DVHA** contacts the beneficiary by telephone to inform the individual that all evidence and allegations of fact or law must be presented as soon as possible within the 72-hour resolution period, as required by the IGA §2.11.4.1 and the CFR.

DVHA staff members must ensure that, when an appeal has been resolved, **DVHA** or its IGA partners provide to the beneficiary the results and date of the appeal resolution, as required by the IGA §2.11.3 (I) and the CFR.

DVHA must ensure that a beneficiary, his or her representative, or the representative of a deceased beneficiary's estate shall be parties to a State fair hearing, as required by the IGA §2.11.1, §2.11.5, and the CFR.

DVHA must continue the beneficiary's services if the beneficiary or provider files the appeal timely (i.e., within 10 days of **DVHA** mailing the notice of action), as required by the IGA §2.11.4.3 (B) and the CFR.

DVHA must furnish information about its beneficiary appeal and State fair hearing requirements and processes to all providers at the time when they enter into a contract with **DVHA**, as required by the IGA §2.11 and the CFR.

3. Assessment of Vermont's Quality Strategy

Background

HSAG conducted a review of the Vermont Medicaid Comprehensive Quality Strategy dated March 19, 2020, to verify that it met the requirements detailed in the revised federal regulations, specifically, 42 CFR §438.340. The final rule issued by CMS, Department of Health and Human Services (HHS) was published in the Federal Register on May 6, 2016. According to 42 CFR, the final rule:

> *"...modernizes the Medicaid managed care regulations to reflect changes in the usage of managed care delivery systems. The final rule aligns, where feasible, many of the rules governing Medicaid managed care with those of other major sources of coverage, including coverage through Qualified Health Plans and Medicare Advantage plans; implements statutory provisions; strengthens actuarial soundness payment provisions to promote the accountability of Medicaid managed care program rates; and promotes the quality of care and strengthens efforts to reform delivery systems that serve Medicaid and Children's Health Insurance Plan (CHIP) beneficiaries. It also ensures appropriate beneficiary protections and enhances policies related to program integrity. This final rule also implements provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) and addresses third party liability for trauma codes."*[3-1]

The Vermont Medicaid Comprehensive Quality Strategy includes five goals of the Global Commitment to Health waiver program: (1) promote delivery system reform through value-based payment models and alignment across public payers; (2) increase access to affordable and high-quality health care by assisting lower-income individuals who can qualify for private insurance through the Marketplace; (3) improve access to primary care; (4) improve the health care delivery for individuals with chronic care needs; and (5) allow beneficiaries a choice in long-term services and supports and provide an array of home and community-based services (HCBS) alternatives recognized to be more cost-effective than institutional-based supports. HSAG works with AHS to ensure that the EQR activities support and enhance the strategies established in the Vermont Medicaid Comprehensive Quality Strategy to improve the health and well-being of the State's Medicaid beneficiaries.

[3-1] National Archives and Records Administration. *The Federal Register*. May 6, 2016. Available at: https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered. Accessed on: Sept 18, 2020.

Methodology

Vermont AHS provided HSAG with the most recent version of the Vermont Medicaid Comprehensive Quality Strategy.[3-2] After receiving the document, HSAG compared each requirement in the Vermont Medicaid Comprehensive Quality Strategy to the requirements and determined if evidence of each requirement was found in the document.

Findings

HSAG's review determined that all of the applicable federal requirements were partially or fully addressed in the State's Quality Strategy. Two federal requirements were not applicable to Vermont because there were no PCCM entities in the Vermont Global Commitment to Health waiver program, and there were no recognized tribes in Vermont. Table 3-1 shows the summary results of HSAG's review of the Vermont Medicaid Comprehensive Quality Strategy.

Table 3-1—Results of the Contract Year 2020 Quality Strategy Review

Citation		Section	Topic	Addressed/Not Addressed/Partially Addressed in Quality Strategy
1.	§438.340	(a)	General Rule	Addressed
2.	§438.340	(b)(1)	Clinical Practice Guidelines	Addressed
3.	§438.340	(b)(2)	Goals and Objectives for Continuous Quality Improvement	Addressed
4.	§438.340	(b)(3)(i)	Quality Metrics and Performance Targets	Addressed
5.	§438.340	(b)(3)(ii)	Performance Improvement Projects	Addressed
6.	§438.340	(b)(4)	Annual External Independent Review	Addressed
7.	§438.340	(b)(5)	Transition of Care Policy	Addressed
8.	§438.340	(b)(6)	Identifying, Evaluating, and Reducing Health Disparities	Addressed
9.	§438.340	(b)(7)	Sanctions	Addressed
10.	§438.340	(b)(8)	Assessing Outcomes for PCCM Entities	Not Applicable
11.	§438.340	(b)(9)	Identification of Persons Needing Long-term Services and Supports and Persons with Special Needs	Addressed

[3-2] State of Vermont. Agency of Human Services. (March 19, 2020). *Vermont Medicaid Comprehensive Quality Strategy and Statewide Transition Plan.* Available at: https://dvha.vermont.gov/global-commitment-to-health/comprehensive-quality-strategy. Accessed on: Oct 20, 2020.

Citation		Section	Topic	Addressed/Not Addressed/Partially Addressed in Quality Strategy
12.	§438.340	(b)(10)	Non-duplication of External Quality Review (EQR) Activities	Addressed
13.	§438.340	(b)(11)	Definition of Significant Change	Addressed
14.	§438.340	(c)(1)(i)	Public Comment	Addressed
15.	§438.340	(c)(1)(ii)	Consulting with Tribes	Not Applicable
16.	§438.340	(c)(2)	Updating Quality Strategy	Addressed
17.	§438.340	(c)(2)(i)	Evaluation of the Effectiveness of the Quality Strategy	Addressed
18.	§438.340	(c)(2)(ii)	Quality Strategy Review Posted to Website	Addressed
19.	§438.340	(c)(2)(iii)	Recommendations to the Quality Strategy	Addressed
20.	§438.340	(c)(3)(i)	Submitting the Quality Strategy to CMS	Addressed
21.	§438.340	(c)(3)(ii)	Submitting Revised Quality Strategies to CMS	Addressed
22.	§438.340	(d)	Availability of the Final Quality Strategy on the Website	Addressed

As specified in 42 CFR §438.340(b)(2), a State's quality strategy must include goals and objectives for continuous quality improvement, which must be measurable and take into consideration the health status of all populations served. The Vermont Medicaid Comprehensive Quality Strategy listed the following Global Commitment to Health Demonstration goals: *to increase access to care, contain health care cost, improve the quality of care, and eliminate institutional bias.* The Vermont Medicaid Managed Care Program Objectives identified priority areas, established performance targets, and offered time frames for achieving the objectives.

The Vermont Medicaid Comprehensive Quality Strategy addressed the requirements of 42 CFR §438.340(b)(3)(i) related to quality metrics and performance targets. Vermont requires **DVHA** to report performance measures. **DVHA** collects, analyzes, and reports on the following sets of measures: Global Commitment to Health Core Measure Set/HEDIS, CMS Adult Core Measure Set, CMS Child Core Measure Set, and Experience of Care Measures (i.e., CAHPS survey). The Vermont Medicaid Global Commitment to Health waiver program has selected performance targets and metrics, including preventive care and annual care measures.

Table 3-2 includes the 2017 performance rates for preventive care measures and annual treatment measures in which Vermont has met its performance targets in advance of the 2021 target date.

Table 3-2—Preventive Care and Annual Treatment Measures and Performance Targets Achieved in Advance of the 2021 Target Date

Measure		Description	2021 Target	2017 Performance Score
1.	CMS Child Core Set/HEDIS (AWC)	*Adolescent Well-Care Visits*	49.20%	51.60%
2.	CMS Child Core Set/HEDIS (W15)	*Well-Child Visits in the First 15 Months of Life—6 or more visits*	70.75%	72.80%
3.	CMS Child Core Set/HEDIS (W34)	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*	76.23%	76.70%
4.	CMS Child Core Set/HEDIS (ADV)	*Annual Dental Visit—Children Age 2–20 Years—Total*	68.11%	71.10%
5.	CMS Adult Core Set/HEDIS (BCS)	*Breast Cancer Screening*	56.93%	54.30%
6.	CMS Adult Core Set/HEDIS (CHL)	*Chlamydia Screening in Women*	55.15%	53.20%
7.	CMS Adult Core Set/HEDIS (AAP)	*Adults' Access to Preventive/Ambulatory Health Services—Total*	79.57%	81.70%
8.	CMS Adult Core Set/HEDIS (MMA)	*Medication Management (50% Compliance) for People with Asthma*	74.68%	73.90%
9.	CMS Adult Core Set/HEDIS (FUH)	*Follow-Up After Hospitalization for Mental Illness–7 days*	45.27%	52.70%
		Follow-Up After Hospitalization for Mental Illness–30 days	62.53%	71.80%
10.	CMS Adult Core Set/HEDIS (IET)	*Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation)*	36.74%	46.60%
11.	CMS Adult Core Set/HEDIS (IET)	*Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Engagement)*	15.04%	23.90%

Table 3-3 includes the 2017 performance rates for preventive care measures and annual treatment measures that were within 3 percentage points of the 2021 targets. Interventions continue to maintain and improve all scores and focus on achievement of 2021 quality targets.

Table 3-3—Preventive Care and Annual Treatment Measures and Performance Targets Within Three Percentage Points of the 2021 Target Date

Measure		Description	2021 Target	2017 Performance Score
1.	CMS Adult Core Set/HEDIS (BCS)	*Breast Cancer Screening*	56.93%	54.30%
2.	CMS Adult Core Set/HEDIS (CHL)	*Chlamydia Screening in Women*	55.15%	53.20%
3.	CMS Adult Core Set/HEDIS (MMA)	*Medication Management (50% Compliance) for People with Asthma*	74.68%	73.90%

Recommendations

To strengthen the Quality Strategy, AHS could consider identifying specific objectives and interventions associated with continuous quality improvement efforts to improve performance rates. Once specific objectives and interventions have been established for performance measures, AHS has the ability to review performance indicator rates and identify opportunities for improvement. Once opportunities for improvement are identified, AHS may prioritize areas of low performance and define quantifiable improvement targets to indicators so that **DVHA** and other key stakeholders may know the level of achievement that is expected in future years.

4. Description of External Quality Review Activities

Validation of Performance Improvement Project

During the 2020–2021 EQR contract year with AHS, HSAG validated one PIP conducted by **DVHA**. This section describes the processes HSAG used to complete the validation activities. HSAG described the details related to its approach, methodologies, and findings from the PIP validation activities in its Performance Improvement Project Validation Report—*Initiation of Alcohol and Other Drug Abuse or Dependence Treatment* for **DVHA** provided to AHS and **DVHA**.

Objectives and Background Information

The AHS quality strategy required **DVHA** to conduct a PIP in accordance with 42 CFR §438.330. The purpose of a PIP is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical or nonclinical areas. This structured method of assessing and improving the Medicaid managed care model organizations' processes is expected to have a favorable effect on health outcomes and beneficiary satisfaction. AHS contracted with HSAG as the EQRO to meet the federal Medicaid managed care requirement for validating **DVHA**'s PIP. Validation of PIPs is a CMS mandatory activity.

The primary objective of HSAG's PIP validation was to determine **DVHA**'s compliance with requirements set forth in 42 CFR §438.330(d)(2)(i-iv), including:

- Measurement of performance using objective quality indicators.
- Implementation of interventions to achieve improvement in the access to and quality of care.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing or sustaining improvement.

Description of Data Obtained

HSAG reviewed the documentation **DVHA** submitted for the one PIP validated by HSAG. The PIP was submitted using HSAG's PIP Summary Form, which HSAG developed to collect all required data elements for the PIP validation process. **DVHA** completed the PIP Summary Form following instructions provided by the HSAG PIP Review Team regarding the level of documentation required to address each PIP evaluation element. **DVHA** also was instructed to submit any supporting documentation that could provide further details and background information. HSAG was available to provide technical assistance to **DVHA** before the PIP submission to answer questions. **DVHA** achieved all validation criteria with the first submission, and a resubmission was not necessary.

Technical Methods of Data Collection/Analysis

HSAG conducted the validation consistent with the CMS protocol, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. HSAG, with AHS' input and approval, developed the PIP Validation Tool to ensure uniform and consistent validation of the PIP. Using this tool, HSAG determined the overall methodological validity of the PIP, as well as the overall success in achieving improved study indicator outcomes, and evaluated the following CMS protocol activities:

- Activity I—Select the Study Topic
- Activity II—Define the Study Question(s)
- Activity III—Define the Study Population
- Activity IV—Select the Study Indicator(s)
- Activity V—Use Sound Sampling Techniques
- Activity VI—Reliably Collect Data
- Activity VII—Analyze Data and Interpret Study Results
- Activity VIII—Implement Intervention and Improvement Strategies
- Activity IX—Assess for Real Improvement
- Activity X—Assess for Sustained Improvement

HSAG's PIP validation process consisted of two independent reviews that included a review by team members with expertise in statistics, study design and methodology, and quality and performance improvement. The PIP team conducted the validation process as follows:

- HSAG reviewed the PIP submission documentation to ensure that all required documentation was received.
- The validation review was conducted, and the PIP Validation Tool was completed.
- The scores were reconciled by a secondary review. If scoring discrepancies were identified, the PIP Review Team discussed the discrepancies and reached a consensus for the final evaluation element score(s).
- Each required protocol activity consisted of evaluation elements necessary to complete the validation of that activity. The PIP Review Team scored the evaluation elements within each activity as *Met*, *Partially Met*, *Not Met*, *Not Applicable* (*N/A*), or *Not Assessed*. To ensure a valid and reliable review, HSAG designated some of the elements as critical elements. All critical elements must have received a *Met* score to produce valid and reliable results. The scoring methodology included the *N/A* designation for situations in which the evaluation element did not apply to the PIP. HSAG used the *Not Assessed* scoring designation when the PIP had not progressed to the remaining activities. HSAG used a General Comment when documentation for an evaluation element included the basic components to meet the requirements for the evaluation element (as described in the narrative of the

PIP); however, enhanced documentation would demonstrate a stronger application of the CMS protocols for completing a PIP.

- HSAG's criteria for determining the score were as follows:
  - *Met*: High confidence/confidence in reported PIP results. All critical evaluation elements were *Met,* and 80 percent to 100 percent of all evaluation elements were *Met* across all activities.
  - *Partially Met:* Low confidence in reported PIP results. All critical elements were *Met* and 60 percent to 79 percent of all evaluation elements were *Met* across all activities; or one or more critical evaluation elements were *Partially Met.*
  - *Not Met:* All critical evaluation elements were *Met* and less than 60 percent of all evaluation elements were *Met* across all activities; or one or more critical evaluation elements were *Not Met.*
  - *Not Applicable (N/A):* Elements designated *N/A* (including critical elements) were removed from all scoring.
  - *Not Assessed*: Elements (including critical elements) were removed from all scoring.
- In addition to a validation status (e.g., *Met*), HSAG gave the PIP an overall percentage score for all evaluation elements (including critical elements), which was calculated by dividing the total elements *Met* by the sum of all applicable elements that were assessed (as *Met*, *Partially Met*, and *Not Met*). A critical element percentage score was then calculated by dividing the total critical elements *Met* by the sum of the applicable critical elements that were assessed (as *Met*, *Partially Met*, and *Not Met*).
- After completing the validation review, HSAG prepared the draft and final **DVHA** Performance Improvement Project Validation Report—*Initiation of Alcohol and Other Drug Abuse or Dependence Treatment* for AHS and **DVHA**.

Determining Conclusions

HSAG analyzed **DVHA**'s PIP process and documentation to draw conclusions about the validity of the PIP and about **DVHA**'s quality improvement efforts.

The PIP validation process was designed so that a well-planned, strategically conducted, fully documented, and valid PIP could score 100 percent on HSAG's PIP Validation Tool. HSAG's validation process accommodates for each PIP's stage of development, evaluating only those steps that should be completed to support the PIP's progress each validation year.

Validation of Performance Measures

Validation of performance measures is a CMS mandatory EQR activity required by the BBA. State Medicaid agencies must ensure that performance measures reported by their MCOs are validated. The state, its agent that is not an MCO, or an EQRO, can perform this validation. HSAG, the EQRO for AHS, conducted the validation activities. For CY 2019, **DVHA** provided physical, mental, and behavioral health services to Medicaid-eligible recipients. HSAG validated a set of performance measures selected by AHS that were calculated and reported by **DVHA**. HSAG conducted the validation activities as outlined in the CMS publication, *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, October 2019, cited earlier in this report.

Objectives and Background Information

The primary objectives of HSAG's validation process were to:

- Evaluate the accuracy of the performance measure data **DVHA** collected.
- Determine the extent to which the specific performance measures calculated by **DVHA** followed the specifications established for each performance measure.

AHS selected 15 HEDIS measures for HSAG's validation. The measurement period addressed in this report was CY 2019.

Description of Data Obtained

As identified in the CMS protocol, the types of data the EQRO should use to complete the performance measure validation task include:

- The **Record of Administration, Data Management, and Processes (Roadmap)**, which was completed by **DVHA**. The Roadmap provides background information concerning **DVHA**'s policies, processes, system capabilities, and data in preparation for the WebEx validation activities.
- **Supporting documentation**, including file layouts, system flow diagrams, system log files, policies and procedures, data collection process descriptions, and file consolidations logic or extracts.
- **Current and prior years' performance measure results**, which were obtained from **DVHA**.
- **WebEx review interviews and demonstrations**, which were conducted by HSAG. Information was obtained through interaction, discussion, and formal interviews with key **DVHA** staff members, as well as observation of data processing functions and demonstrations.

Note: Typically, the EQRO also reviews the source code used to calculate the performance measures. **DVHA** continued to contract with a software vendor to calculate the measures since all the performance measures under the scope of this validation were approved by NCQA under the measure certification program. HSAG did not perform additional source code review.

Technical Methods of Data Collection/Analysis

HSAG followed the same process when validating each performance measure, which included the following steps:

Pre-WebEx Review Activities:

- **DVHA** was required to submit a completed Roadmap to HSAG. HSAG performed a cursory review of the Roadmap to ensure that each section was complete and that all applicable attachments were present. The review team used the Roadmap to determine if the systems' capabilities were sufficient to report the HEDIS measures.
- **DVHA** was responsible for completing the medical record review (MRR) section within the Roadmap. In addition, HSAG requested and reviewed the following attachments: medical record hybrid tools and instructions, training materials for MRR staff members, and policies and procedures outlining the processes for monitoring the accuracy of the reviews performed by the review staff members. To ensure the accuracy of the hybrid data being abstracted by **DVHA**, HSAG requested that **DVHA** participate in the review of a convenience sample.
- **DVHA** used a software vendor with HEDIS Certified Measures for HEDIS 2020 calculation and reporting. All performance measures under the scope of this review were certified by NCQA for HEDIS 2019; therefore, **DVHA** was not required to submit source code.
- HSAG reviewed previous years' validation of performance measures reports to assess for trending patterns and rate reasonability.

WebEx Review Activities:

- HSAG conducted an opening session to review the purpose, required documentation, basic meeting logistics, and queries to be performed.
- HSAG's evaluation of systems included a review of the information systems, focusing on the processing of claims and encounter data, patient data, and provider data. Based on the desk review of the Roadmap, HSAG conducted interviews with key **DVHA** staff members familiar with the processing, monitoring, and calculation of the performance measures to confirm findings from the documentation review; expand or clarify outstanding issues; and verify that written policies and procedures were used and followed in daily practice.
- HSAG completed an overview of data integration and control procedures. HSAG also reviewed any supporting documentation for data integration and addressed data control and security procedures. HSAG evaluated the data collection and calculation processes, including accurate numerator and denominator identification and algorithmic compliance (which evaluated whether rate calculations were performed correctly, all data were combined appropriately, and numerator events were counted accurately). HSAG conducted primary source verification to validate the output files. This was accomplished by tracking the cases back through the information systems to the original data source and confirming numerator, denominator, and enrollment/eligibility criteria.

- HSAG conducted a closing conference to summarize preliminary findings based on the review of the Roadmap and WebEx review activities (including any measure-specific concerns) and discussed follow-up actions.

Post-WebEx Review Activities:

- HSAG evaluated follow-up documentation **DVHA** provided to address measure-specific issues.
- HSAG evaluated **DVHA**'s performance measure results and compared them to the prior year's performance and HEDIS 2018 national Medicaid benchmarks.

Determining Conclusions

Upon HSAG's evaluation of the performance measure results, HSAG assigned a validation finding to each performance measure.

Monitoring of Compliance With Standards

Monitoring compliance with federal Medicaid managed care regulations and the applicable state contract requirements is one of the CMS mandatory activities a State must conduct. AHS contracted with HSAG to perform the **DVHA** compliance review. HSAG followed the guidelines in CMS' *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019, cited earlier in this report. HSAG described the details related to its approach, methodologies, and findings from the compliance activities in its *2020–2021 External Quality Review of Compliance with Standards Report* provided to AHS and **DVHA**.

Objectives and Background Information

According to 42 CFR §438.358,[4-1] a review to determine an MCO's, PIHP's, PAHP's, or PCCM's compliance with state standards must be conducted within a three-year period by a state Medicaid agency, its agent, or an EQRO. These standards must be as stringent as the federal Medicaid managed care standards described in 42 CFR §438—Managed Care, which address requirements related to access, structure and operations, and measurement and improvement. To meet these requirements, AHS:

- Continued to ensure that its IGA with **DVHA** included the applicable CMS Medicaid managed care requirements and that they were at least as stringent as the CMS requirements.
- Contracted with HSAG as its EQRO to conduct reviews to assess **DVHA**'s performance in complying with the federal Medicaid managed care regulations and AHS' associated IGA with **DVHA**.

[4-1] U. S. Government Publishing Office. (2018). *Electronic Code of Federal Regulations.* Available at: https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=0fe554e3f4a6236efe0d8c0aa9319e57&mc=true&n=pt42.4.438&r=PART&ty=HTML#se42.4.438_1358. Accessed on: Nov 23, 2020.

- Maintained its focus on encouraging and supporting **DVHA** in targeting areas for continually improving its performance in providing quality, timely, and accessible care to beneficiaries.
- Requested that, as allowed by CMS, HSAG continue its three-year cycle of reviewing **DVHA** performance in complying with the federal Medicaid managed care regulations. This gives **DVHA** time to focus its improvement efforts and implement new initiatives. For the review covered by this report, AHS requested that HSAG review the CMS Structure and Operations requirements described at 42 CFR §438.10, §438.100, §438.214–230, §438.414, and the associated AHS IGA requirements. The primary objective of HSAG's review was to provide meaningful information to AHS and **DVHA** to use to:
  - Evaluate the quality and timeliness of, and access to, care and services **DVHA** and its IGA partners furnished to beneficiaries.
  - Identify, implement, and monitor interventions to continue to drive performance improvement for these aspects of care and services.

HSAG assembled a review team to:

- Collaborate with AHS to determine the scope of the review as well as the scoring methodology, data collection methods, desk review and virtual review activities and timelines, and virtual review agenda.
- Collect data and documents from AHS and **DVHA** and review them before and during the virtual review.
- Conduct the virtual review.
- Aggregate and analyze the data and information collected.
- Prepare the report of its findings and any recommendations or suggestions for improvement.

HSAG compiled and submitted to AHS, for its review and approval, a data collection tool to assess and document **DVHA**'s compliance with the Medicaid managed care regulations, State rules, and the associated AHS/**DVHA** IGA requirements. The review tool included requirements that addressed eight performance areas associated with the CMS Medicaid managed care regulations described at §438.10, §438.100, §438.214–230, and §438.414.

I. Provider Selection
II. Credentialing and Recredentialing
III. Beneficiary Information
IV. Beneficiary Rights
V. Confidentiality
VI. Grievance System—Beneficiary Grievances
VII. Grievance System—Beneficiary Appeals and State Fair Hearings
VIII. Subcontractual Relationships and Delegation

As these same standards were reviewed during four prior audits (i.e., 2008, 2011, 2014, and 2017), HSAG evaluated **DVHA**'s current performance and compared the results to those from the earlier review of these same standards.

Description of Data Obtained

Table 4-1—Description of DVHA's Data Sources

Data Obtained	Time Period to Which the Data Applied
Documentation **DVHA** submitted for HSAG's desk review and additional documentation available to HSAG during the virtual review	August 1, 2019–March 31, 2020
Information obtained through interviews with **DVHA** staff members	July 15, 2020–July 16, 2020

Technical Methods of Data Collection/Analysis

Using the AHS-approved data collection tool, HSAG performed a desk review of **DVHA**'s documents and a virtual review that included reviewing additional documents and conducting interviews with key **DVHA** staff members. Pre-virtual review activities included:

- Developing the compliance review tool HSAG used to document its findings from the review of policies, procedures, reports, and additional plan documents. The compliance tool also included sections to insert findings from the virtual interviews conducted with **DVHA** staff members.
- Preparing and forwarding to **DVHA** a customized desk review request form and instructions for submitting the requested documentation to HSAG for its desk review. The form provided information about HSAG's compliance review activities and the timelines/due dates for each.
- Developing and providing to **DVHA** the detailed agenda for the two-day virtual review.
- Responding to any questions **DVHA** had about HSAG's desk- and virtual review activities and the documentation required from **DVHA** for HSAG's desk review.
- Conducting a pre-virtual desk review of **DVHA**'s key documents and other information obtained from AHS. The desk review enabled HSAG reviewers to increase their knowledge and understanding of **DVHA**'s operations, identify areas needing clarification, and begin compiling and documenting preliminary findings and interview questions before the virtual review.

For the review activities, three HSAG reviewers conducted the two-day virtual review, which included:

- An opening conference, with introductions; **DVHA** staff members' overview of **DVHA** and its relationship with its IGA partners, providers, and subcontractors; **DVHA** updates concerning any changes and challenges occurring since HSAG's previous review; a review of the agenda and logistics for HSAG's virtual activities; HSAG's overview of the process it would follow in

conducting the virtual review; and, the tentative timelines for providing **DVHA** and AHS a draft report for AHS' and **DVHA**'s review and comment.

- Review of the documents HSAG requested that **DVHA** had available during the virtual review.
- Interviews with **DVHA**'s key administrative and program staff members. Separate interviews were scheduled and conducted for each of the standards included in the review tool.
- A closing conference during which HSAG reviewers summarized their preliminary findings. For each standard, the findings included HSAG's assessment of **DVHA**'s performance strengths; any anticipated required corrective actions and reviewers' suggestions that could further enhance **DVHA**'s processes; documentation; performance results; and the quality, access to, and timeliness of services provided to beneficiaries.

HSAG reviewers documented their findings in the compliance review tool. The tool served as a comprehensive record of the desk review and virtual review activities and the performance scores achieved by **DVHA**. HSAG made recommendations for any element that was scored as *Partially Met* or *Not Met,* and offered suggestions to **DVHA** to further strengthen and drive continued improvement in **DVHA**'s performance. The completed tool was included as one section of HSAG's compliance report. Table 4-2 lists the major data sources HSAG used in determining **DVHA**'s performance in complying with requirements and the time period to which the data applied. Table 4-2 also presents a more detailed, chronological description of the above activities that HSAG performed during its review.

Table 4-2—The Compliance Review Activities HSAG Performed

Step 1:	**Established the review schedule.**
	Before the review, HSAG coordinated with AHS and **DVHA** to develop the compliance review timeline and assigned HSAG reviewers to the review team.
Step 2:	**Prepared the data collection tool for the standards included in this year's review and submitted it to AHS for review and comment.**
	To ensure that all applicable information was collected, HSAG developed a compliance review tool consistent with CMS protocols. HSAG used the requirements in the IGA between AHS and **DVHA** to develop the standards (groups of requirements related to broad content areas) to be reviewed. HSAG also used Version 2.0 of the federal Medicaid managed care protocols effective October 2019. Additional criteria used in developing the monitoring tool included applicable State and federal requirements. Prior to finalizing the tool, HSAG submitted the draft report to AHS for its review and comments.
Step 3:	**Prepared and submitted the Desk Review Form to DVHA.**
	HSAG prepared and forwarded a desk review form to **DVHA** and requested that **DVHA** submit specific information and documents to HSAG within a specified number of days of the request. The desk review form included instructions for organizing and preparing the documents related to the review of the standards, submitting documentation for HSAG's desk review, and having additional documents available for HSAG's virtual review.

Step 4:	Forwarded a Documentation Request and Evaluation Form to DVHA.
	HSAG forwarded to **DVHA**, as an accompaniment to the desk review form, a documentation request and evaluation form containing the same standards and AHS IGA (i.e., contract) requirements as the tool HSAG used to assess **DVHA**'s compliance with each of the requirements within the standards. The desk review form included detailed instructions for completing the "Evidence/Documentation as Submitted by **DVHA**" portion of this form. This step (1) provided the opportunity for **DVHA** to identify for each requirement the specific documents or other information that provided evidence of its compliance with the requirement, and (2) streamlined the HSAG reviewers' ability to identify all applicable documentation for their review.
Step 5:	**Developed a virtual review agenda and submitted the agenda to DVHA.**
	HSAG developed the agenda to assist **DVHA** staff members in their planning to participate in HSAG's virtual review, assembling requested documentation, and addressing logistical issues. HSAG considers this step essential to performing an efficient and effective virtual review and minimizing disruption to the organization's day-to-day operations. An agenda sets the tone and expectations for the virtual review so that all participants understand the process and time frames allotted for the reviews.
Step 6:	**Provided technical assistance.**
	As requested by **DVHA**, and in collaboration with AHS, HSAG staff members responded to any **DVHA** questions concerning the requirements HSAG used to evaluate its performance.
Step 7:	**Received DVHA's documents for HSAG's desk review and evaluated the information before conducting the virtual review.**
	HSAG compiled and organized the information and documentation, and reviewers used the documentation **DVHA** submitted for HSAG's desk review to gain insight into areas such as **DVHA**'s structure and relationship with its IGA partners; information provided to beneficiaries and providers; composition and accessibility of the provider network; covered services, including emergency and poststabilization services available to beneficiaries; processes for responding to requests for service and the associated documentation related to coverage and authorization of services; coordination and continuity of care; cultural competence; disenrollment requirements; and **DVHA**'s operations, resources, information systems, quality programs, and delegated functions. Reviewers then: • Documented in the review tool their preliminary findings after reviewing the materials **DVHA** submitted as evidence of its compliance with the requirements. • Identified any information not found in the desk review documentation in order to request it prior to the virtual review. • Identified areas and questions requiring further clarification or follow-up during the virtual interviews.

Step 8:	Conducted the virtual portion of the review.
	During the virtual review, staff members from **DVHA** answered questions and to assist the HSAG review team in locating specific documents or other sources of information. HSAG's activities completed during the virtual review included the following: • Convening an opening conference that included introductions, HSAG's overview of the virtual review process and schedule, **DVHA**'s overview of its structure and processes, and a discussion about any changes needed to the agenda and general logistical issues. • Conducting interviews with **DVHA**'s staff. HSAG used the interviews to obtain a complete picture of **DVHA**'s compliance with the federal Medicaid managed care regulations and associated AHS IGA requirements, explore any issues not fully addressed in the documents that HSAG reviewed, and increase HSAG reviewers' overall understanding of **DVHA**'s performance. • Reviewing additional documentation. HSAG reviewed additional documentation during the virtual review and used the review tool to identify relevant information sources and document its review findings. Items reviewed included, but were not limited to, written policies and procedures, minutes of key committee or other group meetings, and data and reports across a broad range of areas. During the virtual review, **DVHA** staff members also discussed the organization's information system data collection process and reporting capabilities related to the standards HSAG reviewed. • Summarizing findings at the completion of the virtual portion of the review. As a final step, HSAG conducted a closing conference to provide **DVHA**'s staff members and AHS participants with a high-level summary of HSAG's preliminary findings. For each of the standards, the findings included HSAG's assessment of **DVHA**'s strengths; if applicable, any areas requiring corrective actions; and HSAG's suggestions for further strengthening **DVHA**'s processes, performance results, and/or documentation. • **DVHA** staff members were readily available throughout the virtual review to answer HSAG's review questions and to assist in locating specific documents or other sources of information.
Step 9:	**Documented reviewer findings in the Documentation Request and Evaluation Tool.**
	Beginning prior to and continuing through the virtual review, HSAG reviewers documented their preliminary findings related to **DVHA**'s performance for each requirement. Following the virtual review, the reviewers completed the tool and finalized the documentation of **DVHA**'s strengths; required corrective actions; and any suggestions for further strengthening **DVHA**'s performance related to the written documentation and to providing accessible, timely, and quality services to enrollees.
Step 10:	**Calculated the individual scores and determined the overall compliance score for performance.**
	HSAG evaluated and analyzed **DVHA**'s performance in complying with the requirements in each of the standards contained in the review tool. HSAG used *Met*, *Partially Met*, and *Not Met* scores to document the degree to which **DVHA** complied with each of the requirements. A designation of *NA* was used if an individual requirement did not apply to **DVHA** during the period covered by the review. For each of the standards, HSAG calculated a percentage of compliance score and then an overall percentage of compliance score across all the standards.

Step 11:	Prepared a report of findings and if required, corrective actions.
	After completing the documentation of findings and scoring for each of the standards, HSAG prepared a draft report that described HSAG's compliance review findings; the scores assigned for each requirement within the standards; HSAG's assessment of **DVHA**'s strengths; any areas requiring corrective action; and HSAG's suggestions for further enhancing **DVHA**'s performance results, processes, and documentation. HSAG forwarded the report to AHS and **DVHA** for their review and comment. Following AHS' approval of the draft, HSAG issued the final report to AHS and **DVHA**.

Determining Conclusions

HSAG used scores of *Met*, *Partially Met*, and *Not Met* to indicate the degree to which **DVHA**'s performance complied with the requirements. HSAG used a designation of *N/A* when a requirement was not applicable to **DVHA** during the period covered by HSAG's review. This scoring methodology is defined as follows:

Met indicates full compliance, defined as *both* of the following:

- All documentation listed under a regulatory provision, or component thereof, is present.
- Staff members are able to provide responses to reviewers that are consistent with each other and with the documentation.

Partially Met indicates partial compliance, defined as *either* of the following:

- There is compliance with all documentation requirements, but staff members are unable to consistently articulate processes during interviews.
- Staff members can describe and verify the existence of processes during the interview, but documentation is incomplete or inconsistent with practice.

Not Met indicates noncompliance, defined as *either* of the following:

- No documentation is present and staff members have little or no knowledge of processes or issues addressed by the regulatory provisions.
- For a provision with multiple components, key components of the provision could be identified and any findings of *Not Met* or *Partially Met* would result in an overall finding of noncompliance for the provision, regardless of the findings noted for the remaining components.

From the scores it assigned to **DVHA**'s performance for each of the requirements, HSAG calculated a total percentage-of-compliance score for each standard and an overall percentage-of-compliance score across the standards. HSAG calculated the total score for each standard by adding the weighted value of the scores for each requirement in the standard—i.e., *Met* (value: 1 point), *Partially Met* (value: 0.50 points), *Not Met* (value: 0.00 points), and *Not Applicable* (value: 0.00 points)—and dividing the summed weighted scores by the total number of applicable requirements for that standard.

HSAG determined the overall percentage-of-compliance score across all the standards by following the same method used to calculate the scores for each standard (i.e., by summing the weighted values of the scores and dividing the results by the total number of applicable requirements).

Standards Required by CMS to be Included in EQR Compliance Reviews

CMS established the required activities that must be monitored by EQROs during the review, conducted within the previous three-year period, to determine the MCO's compliance with the standards, and validation of network adequacy (pending the publications of the protocols for that activity). The topics required to be included in the compliance reviews are defined in 42 CFR §438 Subpart D[4-2] and 42 CFR §438.330.[4-3] Those requirements are shown in Table 4-3.

AHS elected to establish a cycle of reviewing one-third of the compliance review standards each fiscal year. Table 4-3 includes the location of the requirements in the Vermont compliance tool and the year those requirements are included in the compliance review.

Table 4-3—CMS Requirements, Location of Requirements in the Vermont Compliance Tool, and Year Requirements are Reviewed

CFR	CMS Standard	Standard in Vermont Compliance Tool	Year the Requirements are Reviewed in Vermont		
			Year 1	Year 2	Year 3
438.206	Availability of Services	Standard I—Availability of Services			X
		Standard II—Furnishing of Services			X
		Standard III–Beneficiary Information	X		
		Standard VI—Emergency and Poststabilization Services			X
438.207	Assurances of Adequate Capacity and Services	Standard II—Furnishing of Services			X
438.208	Coordination and Continuity of Care	Standard I—Availability of Services			X
		Standard IV—Coordination and Continuity of Care			X

4-2 U. S. Government Printing Office. (2019). *Title 42 Part 438 Subpart D*. Available at: https://www.govregs.com/regulations/expand/title42_chapterIV_part438_subpartD_section438.206. Accessed on: Oct 6, 2020.

4-3 U. S. Government Printing Office. (2019). *U.S. Code of Federal Regulations Title 42 Subpart E*. Available at: https://www.govregs.com/regulations/expand/title42_chapterIV_part438_subpartE_section438.330. Accessed on: Oct 6, 2020.

CFR	CMS Standard	Standard in Vermont Compliance Tool	Year the Requirements are Reviewed in Vermont		
			Year 1	Year 2	Year 3
438.210	Coverage and Authorization of Services	Standard V—Coverage and Authorization of Services			X
438.214	Provider Selection	Standard I—Provider Selection	X		
		Standard II—Credentialing and Recredentialing	X		
438.224	Confidentiality	Standard V—Confidentiality	X		
438.228	Grievance and Appeals System	Standard VI—Grievance System—Beneficiary Grievances	X		
		Standard VII—Grievance System—Beneficiary Appeals and State Fair Hearings	X		
438.230	Subcontractual Relationships and Delegation	Standard VIII—Subcontractual Relationship and Delegation	X		
438.236	Practice Guidelines	Standard I—Practice Guidelines		X	
		Standard VIII—Subcontractual Relationships and Delegation	X		
438.242	Health Information Systems	Standard III—Health Information Systems		X	
438.330	Quality Assessment and Performance Improvement Program	Standard II—Quality Assessment and Performance Improvement Program		X	

5. Follow-Up on Prior EQR Recommendations

Introduction

This section presents **DVHA**'s responses and a description of actions it took or is taking to address HSAG's recommendations made in the prior year's EQR report. The report included HSAG's recommendations to improve **DVHA**'s performance related to HSAG's findings from validation of **DVHA**'s performance improvement project and performance measures, and the review of its performance in complying with the federal Medicaid managed care regulations and associated AHS IGA requirements.

Validation of the Performance Improvement Project

During the previous EQR contract year (2019–2020), HSAG validated **DVHA**'s PIP, *Initiation of Alcohol and Other Drug Abuse or Dependence Treatment*. The validation process included **DVHA**'s submission of the PIP and HSAG's completion of the validation tool. For the nine review activities that **DVHA** completed and HSAG assessed, **DVHA** received a score of *Met* for 100 percent of the evaluation elements. There were no recommendations included in the PIP validation tool; however, HSAG provided the following recommendations in the annual PIP validation report.

Table 5-1—Performance Improvement Project—Recommendations/Suggestions and DVHA Responses

HSAG Recommendations	DVHA Response/Actions/Outcomes
DVHA should continue its quality improvement efforts to sustain improvement in the study indicator rate. **DVHA** should continue to evaluate the intervention for effectiveness and add additional interventions as needed.	**DVHA response:** **DVHA** continued its quality improvement efforts to sustain improvement in the study indicator rate. **DVHA** continued to evaluate the intervention for effectiveness. **DVHA** pursued the promotion of telehealth with substance use disorder treatment providers and monitored an interim telemedicine indicator quarterly report to gauge progress. **DVHA** expanded the scope of its work by partnering with the Vermont Program for Quality in Health Care. During Remeasurement 2, **DVHA** worked with partnering organizations to plan a "Telehealth 101" training for providers. **DVHA** reported other intervention activities during Remeasurement 2 that included the following: • Publication of additional provider banners. • Publication of a provider advisory newsletter article in May 2019. • Continued presentations to stakeholder groups about the need for the PIP. • Continued the build of a section on the **DVHA** website.

Validation of Performance Measures

HSAG validated 15 performance measures during the previous EQR contract year (2018–2019). HSAG auditors determined that all 15 were compliant with AHS' specifications and that the rates could be reported. As a result of HSAG's review of provided documentation and a WebEx audit, HSAG described the following areas for improvement.

Table 5-2—Performance Measure—Recommendations/Suggestions and DVHA Responses

HSAG Recommendations	DVHA Response/Actions/Outcomes
HSAG recommended that **DVHA** continue to train MRR staff in all hybrid measures to decrease the error rates among abstractors.	**DVHA response:** In 2020, we have trained our RNs to abstract CBP and our licensed mental health providers to abstract WCC. All staff passed the IRR with a score of over 90% and maintained a compliance score of over 90% for the entire abstraction period. We would prefer to continue to have each group focus on the measure that best suits their professional expertise.
HSAG recommended that **DVHA** increase the number of over-reads for abstractors to ensure accuracy.	**DVHA response:** In 2020, all abstractors passed the IRR with a score of over 90% and maintained a compliance score of over 90% for the entire abstraction period. In the 2020 MRRV Results Report HSAG reviewed CBP, PPC & WCC and no critical errors. At this time, **DVHA** does not believe additional over-reads are necessary.

Monitoring Compliance With Standards

During the 2019–2020 compliance audit, HSAG evaluated the degree to which **DVHA** complied with federal Medicaid managed care regulations and the associated AHS-**DVHA** IGA (i.e., contract requirements) in three performance categories (i.e., standards). The seven standards included requirements associated with federal Medicaid access standards found at 42 CFR §438.206–§438.210 and the enrollment and disenrollment requirements (§438.54–§438.56), which are part of CMS' Structure and Operations standards. The standards HSAG evaluated were those related to Availability of Services, Furnishing of Services, Cultural Competence, Coordination and Continuity of Care, Coverage and Authorization of Services, Emergency and Poststabilization Services, and Disenrollment Requirements.

HSAG reviewed **DVHA**'s performance related to 87 elements across the seven standards. Of the 87 requirements, **DVHA** obtained a score of *Met* for 68 elements, a score of *Partially Met* for 13 elements, and *Not Met* for six elements. As a result, **DVHA** obtained a total percentage of compliance across the 87 requirements of 85.6 percent, for which HSAG offered suggestions to **DVHA** to further strengthen its processes, performance, and documentation.

Table 5-3—Monitoring Compliance With Standards—Recommendations/Suggestions and DVHA Responses

HSAG Recommendations	DVHA Responses/Actions/Outcomes
DVHA must ensure that, in establishing and maintaining the provider network, consideration is given to the geographic location of providers and Global Commitment to Health Demonstration enrollees related to distance, travel time, and the means of transportation ordinarily used by Medicaid enrollees.	**DVHA response:** As of January 2020, the network access report contains information about both time and distance and includes all of the required provider types.
DVHA must ensure that urgent care access standards are disseminated to all primary care and specialty providers in the Green Mountain Care provider network.	**DVHA response:** The access standards will be included in the next update to the Provider Manual on or before January 15, 2021.
DVHA must ensure that access standards for non-urgent, non-emergent conditions are disseminated to all primary care and specialty care providers in the Green Mountain Care provider network.	**DVHA response:** The access standards will be included in the next update to the Provider Manual on or before January 15, 2021.
DVHA must ensure that access standards for preventive care are disseminated to all primary care and specialty providers in the Green Mountain Care provider network.	**DVHA response:** The access standards will be included in the next update to the Provider Manual on or before January 15, 2021.
DVHA must generate geographic access reports to determine if PCPs meet the requirement for enrollees to access their services within 30 miles.	**DVHA response:** As of January 2020, the network access report contains information about both time and distance and includes all of the required provider types.
DVHA must generate geographic access reports to determine if hospitals meet the requirement for enrollees to access their services within 30 minutes.	**DVHA response:** As of January 2020, the network access report contains information about both time and distance and includes all of the required provider types.
DVHA must generate geographic access reports to determine if general optometry providers meet the requirement for enrollees to access their services within 60 miles.	**DVHA response:** As of January 2020, the network access report contains information about both time and distance and includes all of the required provider types.
DVHA must generate geographic access reports to determine if lab and X-ray providers meet the requirement for enrollees to access their services within 60 miles.	**DVHA response:** As of January 2020, the network access report contains information about both time and distance and includes all of the required provider types. Please note that all hospitals include lab and X-ray services and are already included in the report. These services will be specifically listed in the access report after January 15, 2021.
DVHA must ensure that care plans are developed with the participation of the enrollees' PCP and enrollee, in consultation with any specialists caring for the enrollee.	**DVHA response:** The Compliance Committee will work with the AHS departments responsible for delivering Medicaid services to ensure compliance with this standard by March 1, 2021.

HSAG Recommendations	DVHA Responses/Actions/Outcomes
DVHA must ensure that the care plan identifies specialist services that may be accessed directly by the enrollee as appropriate for that enrollee's condition and identified needs.	**DVHA response:** The Compliance Committee will work with the AHS departments responsible for delivering Medicaid services to ensure compliance with this standard by March 1, 2021.
DVHA must ensure that the care plan for enrollees with special health care needs conforms to the State's quality assurance and utilization review standards.	**DVHA response:** The Compliance Committee will work with the AHS departments responsible for delivering Medicaid services to ensure compliance with this standard by March 1, 2021.
DVHA must ensure that its IGA partner delegates provide written notice of adverse action to beneficiaries of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.	**DVHA response:** This deficiency was specific to notices that were not being sent by the Department for Children and Families (DCF). DCF will begin sending these required notices on or before March 1, 2021.
DVHA must ensure that written notice of action forms used by the MCE and by its IGA partner delegates meet all content requirements described in 42 CFR §438.404(b) and in the AHS/**DVHA** IGA.	**DVHA response:** During the winter of 2019–2020, the Clinical Operations Unit worked with the Policy Unit to review all notices and procedures to ensure compliance with notice language requirements and timelines. The process and documents were revised as required to meet the standard.
DVHA must ensure that the MCE and its IGA partner delegates meet the timelines for making standard authorization decisions and notifications no later than 14 calendar days from receipt of the request for service as required in 42 CFR §438.210(d)(1).	**DVHA response:** During the winter of 2019–2020, the Clinical Operations Unit (COU) worked with the Policy Unit to review all notices and procedures to ensure compliance with notice language requirements and timelines. The process and documents were revised as required to meet the standard. During the audit period, there were staffing and process challenges that caused some prior authorizations (PAs) to miss the required decision timelines. These cases were reviewed with staff and a more efficient system of administrative support and tracking were put into place to reduce the possibility for future timeline issues. Targeted provider education was also performed to ensure faster responses from providers involved with PAs.
DVHA must ensure that expedited authorization decisions be made, and notice provided, consistent with the 72-hour time frame requirements in 42 CFR §438.210(d)(2)(i). **DVHA** must train staff members and review and revise all MCE/IGA partner delegates' documentation to conform to the 72-hour requirement.	**DVHA response:** The COU reviewed and updated their procedures to ensure that all care meeting the requirements of §438.210(d)(2)(i) will not require any prior authorization. All urgent and emergent care can be accessed directly without PA. When the COU does receive a request for an expedited review, they now meet the 72-hour requirement.

HSAG Recommendations	DVHA Responses/Actions/Outcomes
DVHA must ensure that all network providers are informed about the requirement to make services included in the IGA contract available 24 hours a day, seven days a week.	**DVHA response:** The PCP manual currently contains this required language. The access standards will be included in the next update to the provider manual on or before January 15, 2021, to cover all other provider types.
DVHA must delete or revise the following statement in the Member Handbook to ensure that enrollees are advised that Green Mountain Care is responsible to pay for emergency services rendered in network or out of network: *Please note that Green Mountain Care cannot guarantee that out-of-state or out-of-network providers will choose to accept your Green Mountain Care insurance and you may have to pay for services yourself.*	**DVHA response:** The Member Handbook language will be updated to reflect this requirement on or before January 15, 2021.
DVHA needs to ensure that enrollees in the Choices for Care Program receive education about systems to prevent, detect, report, investigate, and remediate abuse, neglect, and exploitation.	**DVHA response:** This language will be added to the Member Handbook, which covers all Choices for Care recipients, by January 15, 2021.
DVHA must ensure that a notice of termination of a contracted provider is furnished to enrollees who receive their primary care from that provider, or were seen regularly by the terminated provider, within 15 days after receipt or issuance of a termination notice.	**DVHA response:** In late 2019, the Member and Provider Services unit updated their procedures to ensure compliance with this standard.