State of Vermont
Agency of Human Services

2022–2023 External Quality Review Technical Report

for

Department of Vermont Health Access

March 2023

HSAG HEALTH SERVICES ADVISORY GROUP

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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 2022 Vermont EQR technical report for the 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 2022–2023, 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: Feb 15, 2023.

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: Feb 15, 2023.

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: Feb 15, 2023.

During the 2022–2023 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 §438.56, §438.114, and §438.206–§438.210, and the related AHS/**DVHA** intergovernmental agreement (IGA) (i.e., contract) requirements
- Prepared this annual EQR 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**, the single, statewide Medicaid PIHP/managed care entity (MCE) in the State of Vermont.

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: Feb 15, 2023.

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 2022–2023. Section 2 also includes recommendations and opportunities for **DVHA** to improve quality, timeliness, and access to care. Finally, HSAG presents trends over time as appropriate to the data available.

Section 3—EQR Assessment of DVHA's Strengths and Weaknesses and Summary of Quality, Timeliness, and Access: This section describes **DVHA**'s strengths and weaknesses, as identified through the EQR activities performed during 2022–2023. Section 3 also includes a summary of conclusions related to the quality, timeliness, and accessibility of care provided to beneficiaries.

Section 4—Assessment of Vermont's Quality Strategy: This section presents HSAG's review of the Vermont AHS Comprehensive Quality Strategy and describes how the State can target goals and objectives to better support improvement in the ***quality***, ***timeliness***, and ***accessibility of care***. The information also offers conclusions and recommendations pertaining to continuous improvement in the ***quality, timeliness,*** and ***accessibility of care*** provided to beneficiaries.

Section 5—Description of EQR Activities: For each activity HSAG performed, Section 5 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 6—Follow-Up on Prior Year Recommendations: This section presents **DVHA**'s self-reported information concerning the improvement actions the organization took in response to the recommendations HSAG made in the previous year's EQR report. The section also includes the extent to which **DVHA** was successful in improving its performance results.

Opportunities for Improvement

Table 1-1 contains a list of the opportunities for improvement for **DVHA** that includes all EQR tasks described in this contract year 2022–2023 EQR technical report. The table includes contract compliance standards that did not achieve a score of 100 percent and Healthcare Effectiveness Data and Information Set (HEDIS®)[1-5] measures that did not achieve a rate above the Medicaid 50th percentile. Vermont used the 50th percentile national benchmarks for HEDIS measures used to monitor performance in the areas of ***quality***, ***timeliness***, and ***accessibility of care***. 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	I. Availability of Services	94.7%	100%
	II. Assurances of Adequate Capacity and Services	55.6%	100%
	IV. Coordination and Continuity of Care	73.1%	100%
	V. Coverage and Authorization of Services	94.9%	100%
	VI. Emergency and Poststabilization Services	79.4%	100%
	VII. Enrollment and Disenrollment Requirements	71.4%	100%
HEDIS	*Breast Cancer Screening*	Below the Medicaid 25th Percentile	At or Above the Medicaid 50th Percentile
	Chlamydia Screening in Women—16–20 Years, 21–24, and Total	Below the Medicaid 25th Percentile	At or Above the Medicaid 50th Percentile
	Initiation and Engagement of Alcohol or Other Drug (AOD) Abuse or Dependence Treatment (Initiation)—13–17 Years—Total, 18+ Years—Total, and Total—Total*	Below the Medicaid 25th Percentile	At or Above the Medicaid 50th Percentile
	Ambulatory Care (Emergency Department [ED] Visits)—10–19 Years, 65–74 Years, 75–84 Years, and 85+ Years*	Below the Medicaid 25th Percentile	At or Above the Medicaid 50th Percentile
	Asthma Medication Ratio—5–11 Years, 12–18 Years, 19–50 Years, and Total	Below the Medicaid 10th Percentile	At or Above the Medicaid 50th Percentile
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—3–11 Years, 12–17 Years, and Total	Below the Medicaid 25th Percentile	At or Above the Medicaid 50th Percentile

[1-5] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

EQR Activity	Measure Standard	MCO Results	Standard
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—12–17 Years	Below the Medicaid 25th Percentile	At or Above the Medicaid 50th Percentile
	Weight Assessment and Counseling for Nutrition and Physical Activities for Children/Adolescents—Counseling for Physical Activity—12–17 Years	Below the Medicaid 25th Percentile	At or Above the Medicaid 50th Percentile

* Indicates that the indicator scored below the 10th 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 also must 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 an EQR annual technical report that includes 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 (May 15, 2022–May 14, 2023), HSAG conducted three mandatory EQR activities and compared the information to **DVHA**'s performance data from the prior year. This 2022–2023 EQR technical report contains the results of HSAG's review.

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: Feb 15, 2023.

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: Feb 15, 2023.

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 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 2022–2023 EQR Activities

HSAG's EQR activities in contract year 2022–2023 consisted of conducting the following:

- ***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 2021 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 regulations described at 42 CFR §438.206–§438.210 (access standards), §438.54–§438.56 (enrollment and disenrollment requirements), and §438.114 (emergency and poststabilization services) 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 2022–2023 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 2022–2023.

Validation of the Performance Improvement Project (PIP)

HSAG validated **DVHA**'s new PIP, *Managing Hypertension.* HSAG used the U.S. Department of Health and Human Services (DHHS) CMS' *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019.[2-3] as the methodology to validate the PIP. HSAG's validation assessed Steps 7 and 8 (data analysis and interpretation of results and improvement strategies).

The PIP topic addresses the management and control of hypertension and is based on the HEDIS 2022 *Controlling High Blood Pressure (CBP)* measure and technical specifications. The topic was selected after collection and analysis of data and an environmental scan for measure alignment and priority. The

[2-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1: Validation of Performance Improvement Projects (PIPs): A Mandatory EQR-Related activity,* October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Feb 15, 2023.

target population is Vermont Medicaid members 18 to 85 years of age who have a diagnosis of hypertension and whose blood pressure is adequately controlled (<140/90 mm Hg).

DVHA's *Managing Hypertension* 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—2022 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 steps. 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	1. Review the selected PIP Topic	100% (1/1)	0% (0/1)	0% (0/1)
	2. Review the PIP Aim Statement	100% (1/1)	0% (0/1)	0% (0/1)
	3. Review the Identified PIP Population	100% (1/1)	0% (0/1)	0% (0/1)
	4. Review the Sampling Method	100% (5/5)	0% (0/5)	0% (0/5)
	5. Review the Selected Performance Indicator(s)	100% (2/2)	0% (0/2)	0% (0/2)
	6. Review the Data Collection Procedures	100% (3/3)	0% (0/3)	0% (0/3)
Design Total		**100% (13/13)**	**0% (0/13)**	**0% (0/13)**

Stage	Step	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Implementation*	7. Review Data analysis and Interpretation of Results	100% (3/3)	0% (0/3)	0% (0/3)
	8. Assess the Improvement	100% (5/5)	0% (0/5)	0% (0/5)
Implementation Total		**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
Outcomes	9. Assess for Significant and Sustained Improvement	Not Assessed		
Outcomes Total		**Not Assessed**		
Percentage Score of Applicable Evaluation Elements *Met*		**100% (21/21)**		

* Conclusions related to the PIP will be formulated after completing the Outcomes phase of the PIP, Step 9, upon reporting of data or testing and implementation of interventions.

The validation results indicate an overall score of 100 percent across all applicable evaluation elements. **DVHA** initiated the PIP this year and developed the methodology (Design stage). The PIP will progress to reporting baseline results and quality improvement activities and interventions initiated (Implementation phase) during state fiscal year (SFY) 2023–2024. Outcomes will be reported in the next annual EQR technical report.

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' *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, October 2019.[2-4] The validation findings confirmed that all rates were reportable. Table 2-3 displays the HEDIS measurement year (MY) 2020 and HEDIS MY 2021 performance measure results; the denominator for each measure (i.e., number [N]); and the change for each measure rate from HEDIS MY 2020 to HEDIS MY 2021. Please note that for measures reported using the administrative methodology, the denominator is the eligible population. Additionally, HSAG compared the measure results for HEDIS MY 2021 to the National Committee for Quality Assurance's (NCQA's) HEDIS Audit Means and

[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: Feb 15, 2023.

Percentiles National Medicaid Health Maintenance Organization (HMO) Percentiles (referred to as "percentiles" in this report) for HEDIS MY 2020.

Table 2-3—DVHA HEDIS MY 2020 and MY 2021 Results

Measure	HEDIS MY 2020		HEDIS MY 2021		Change from HEDIS MY 2020 to HEDIS MY 2021	HEDIS Percentile Rank
	N	Rate	N	Rate		
Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	39,397	76.25%	49,753	75.15%	-1.10%	25th–50th
Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	21,350	82.48%	25,404	82.46%	-0.02%	25th–50th
Adults' Access to Preventive/Ambulatory Health Services—65+ Years	298	83.22%	453	79.69%	-3.53%	25th–50th
Adults' Access to Preventive/Ambulatory Health Services—Total	61,045	78.46%	75,610	77.63%	-0.83%	25th–50th
Child and Adolescent Well-Care Visits—3–11 Years	28,846	62.61%	30,015	65.33%	+2.27%	75th–90th
Child and Adolescent Well-Care Visits—12–17 Years	18,849	54.56%	20,101	58.56%	+4.00%	75th–90th
Child and Adolescent Well-Care Visits—18–21 Years	8,704	28.64%	10,530	29.91%	+1.27%	50th–75th
Child and Adolescent Well-Care Visits—Total	56,399	54.68%	60,646	56.93%	+2.25%	75th–90th
Breast Cancer Screening	5,796	48.57%	6,464	46.16%	-2.41%	10th–25th
Chlamydia Screening in Women—16–20 Years	3,821	41.48%	4,271	41.89%	+0.41%	10th–25th
Chlamydia Screening in Women—21–24 Years	2,289	54.78%	2,704	51.96%	-2.82%	10th–25th
Chlamydia Screening in Women—Total	6,110	46.46%	6,975	45.79%	-0.67%	10th–25th
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—6–17 Years	239	56.90%	215	56.74%	-0.16%	50th–75th
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—18–64 Years	873	41.81%	896	43.53%	+1.72%	50th–75th
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—65+ Years	0	NA	1	NA	NC	NC
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total	1,112	45.05%	1,112	46.04%	+0.99%	50th–75th
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—6–17 Years	239	75.31%	215	77.67%	+2.36%	50th–75th
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—18–64 Years	873	61.86%	896	62.95%	+1.09%	50th–75th

Measure	HEDIS MY 2020		HEDIS MY 2021		Change from HEDIS MY 2020 to HEDIS MY 2021	HEDIS Percentile Rank
	N	Rate	N	Rate		
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—65+ Years	0	NA	1	NA	NC	NC
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total	1,112	64.75%	1,112	65.83%	+1.08%	50th–75th
Initiation and Engagement of AOD Abuse or Dependence Treatment (Initiation)—13–17 Years—Total	156	27.56%	126	33.33%	+5.77%	5th–10th
Initiation and Engagement of AOD Abuse or Dependence Treatment (Initiation)—18+ Years—Total	3,365	45.85%	3,765	40.58%	-5.27%	10th–25th
Initiation and Engagement of AOD Abuse or Dependence Treatment (Initiation)—Total—Total	3,521	45.04%	3,891	40.35%	-4.69%	10th–25th
Initiation and Engagement of AOD Abuse or Dependence Treatment (Engagement)—13–17 Years—Total	156	10.26%	126	11.90%	+1.64%	25th–50th
Initiation and Engagement of AOD Abuse or Dependence Treatment (Engagement)—18+ Years—Total	3,365	23.18%	3,765	18.91%	-4.27%	75th–90th
Initiation and Engagement of AOD Abuse or Dependence Treatment (Engagement)—Total—Total	3,521	22.61%	3,891	18.68%	-3.93%	75th–90th
Ambulatory Care (Outpatient Visits)—<1 Year[†,1]	27,574	840.31	27,694	884.40	+44.09	90th–95th
Ambulatory Care (Outpatient Visits)—1–9 Years[†,1]	80,620	229.64	92,158	255.40	+25.76	75th–90th
Ambulatory Care (Outpatient Visits)—10–19 Years[†,1]	72,810	194.72	88,942	221.79	+27.07	50th–75th
Ambulatory Care (Outpatient Visits)—20–44 Years[†,1]	144,174	248.35	174,742	256.08	+7.73	25th–50th
Ambulatory Care (Outpatient Visits)—45–64 Years[†,1]	154,602	420.28	178,498	434.30	+14.02	10th–25th
Ambulatory Care (Outpatient Visits)—65–74 Years[†,1]	36,923	565.75	45,127	562.44	-3.31	50th–75th
Ambulatory Care (Outpatient Visits)—75–84 Years[†,1]	18,346	577.12	19,984	609.45	+32.33	50th–75th

Measure	HEDIS MY 2020		HEDIS MY 2021		Change from HEDIS MY 2020 to HEDIS MY 2021	HEDIS Percentile Rank
	N	Rate	N	Rate		
Ambulatory Care (Outpatient Visits)—85+ Years[†,1]	9,181	454.37	9,882	508.57	+54.20	50th–75th
Ambulatory Care (Outpatient Visits)—Total[†,1]	544,230	298.46	637,027	315.52	+17.06	50th–75th
Ambulatory Care (Emergency Department [ED] Visits)—<1 Year[1]	1,400	42.66	1,584	50.58	+7.92	50th–75th
Ambulatory Care (ED Visits)—1–9 Years[1]	7,581	21.59	9,066	25.12	+3.53	50th–75th
Ambulatory Care (ED Visits)—10–19 Years[1]	9,353	25.01	11,681	29.13	+4.12	10th–25th
Ambulatory Care (ED Visits)—20–44 Years[1]	27,672	47.67	33,552	49.17	+1.50	75th–90th
Ambulatory Care (ED Visits)—45–64 Years[1]	16,535	44.95	18,991	46.21	+1.26	75th–90th
Ambulatory Care (ED Visits)—65–74 Years[1]	3,523	53.98	4,121	51.36	-2.62	10th–25th
Ambulatory Care (ED Visits)—75–84 Years[1]	1,548	48.70	1,768	53.92	+5.22	5th–10th
Ambulatory Care (ED Visits)—85+ Years[1]	810	40.09	865	44.52	+4.43	10th–25th
Ambulatory Care (ED Visits)—Total[1]	68,422	37.52	81,628	40.43	+2.91	50th–75th
Well-Child Visits in the First 30 Months of Life—6 Visits in First 15 Months	2,607	70.35%	2,636	70.03%	-0.32%	90th–95th
Well-Child Visits in the First 30 Months of Life—2 Visits in 15 Through 30 Months	2,572	83.32%	2,901	79.46%	-3.86%	75th–90th
Asthma Medication Ratio—5–11 Years	511	74.95%	439	67.43%	-7.52%	5th–10th
Asthma Medication Ratio—12–18 Years	445	65.17%	430	60.47%	-4.70%	5th–10th
Asthma Medication Ratio—19–50 Years	1,199	49.96%	1,379	45.76%	-4.20%	5th–10th
Asthma Medication Ratio—51–64 Years	340	60.88%	436	61.24%	+0.36%	75th–90th
Asthma Medication Ratio—Total	2,495	59.28%	2,684	54.17%	-5.11%	5th–10th
Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—6–17 Years	284	88.73%	356	85.96%	-2.77%	≥95th
Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—18–64 Years	653	63.09%	688	65.41%	+2.32%	≥95th
Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—65+ Years	0	NA	1	NA	NC	NC
Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total	937	70.86%	1,045	72.44%	+1.58%	≥95th
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—6–17 Years	284	91.90%	356	89.89%	-2.01%	≥95th
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—18–64 Years	653	71.67%	688	72.67%	+1.00%	90th–95th

Measure	HEDIS MY 2020		HEDIS MY 2021		Change from HEDIS MY 2020 to HEDIS MY 2021	HEDIS Percentile Rank
	N	Rate	N	Rate		
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—65+ Years	0	NA	1	NA	NC	NC
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total	937	77.80%	1,045	78.56%	+0.76%	90th–95th
Follow-Up After ED Visit for Alcohol or Other Drug (AOD) Abuse or Dependence—7-Day Follow-Up—13–17 Years	28	NA	34	11.76%	NC	75th–90th
Follow-Up After ED Visit for AOD Abuse or Dependence—7-Day Follow-Up—18+ Years	1,054	22.30%	1,200	24.83%	+2.53%	90th–95th
Follow-Up After ED Visit for AOD Abuse or Dependence—7-Day Follow-Up—Total	1,082	21.90%	1,234	24.47%	+2.57%	90th–95th
Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up—13–17 Years	28	NA	34	14.71%	NC	75th–90th
Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up—18+ Years	1,054	33.11%	1,200	34.67%	+1.56%	90th–95th
Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up—Total	1,082	32.53%	1,234	34.12%	+1.59%	90th–95th
Developmental Screening in the First Three Years of Life—1 Year	2,578	43.52%	2,547	45.82%	+2.30%	NC
Developmental Screening in the First Three Years of Life—2 Years	2,651	57.56%	2,872	53.90%	-3.66%	NC
Developmental Screening in the First Three Years of Life—3 Years	2,840	57.61%	2,884	56.14%	-1.47%	NC
Developmental Screening in the First Three Years of Life—Total	8,069	53.09%	8,303	52.20%	-0.89%	NC
Prenatal and Postpartum Care—Timeliness of Prenatal Care	411	84.67%	411	81.75%	-2.92%	25th–50th
Prenatal and Postpartum Care—Postpartum Care	411	77.37%	411	82.97%	+5.60%	75th–90th
Controlling High Blood Pressure	411	42.58%	411	52.07%	+9.49%	25th–50th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—3–11 Years	—	—	254	69.69%	NC	10th–25th

Measure	HEDIS MY 2020		HEDIS MY 2021		Change from HEDIS MY 2020 to HEDIS MY 2021	HEDIS Percentile Rank
	N	Rate	N	Rate		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—12–17 Years	—	—	157	64.33%	NC	10th–25th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total	—	—	411	67.64%	NC	10th–25th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—3–11 Years	—	—	254	70.87%	NC	25th–50th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—12–17 Years	—	—	157	56.05%	NC	10th–25th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	—	411	65.21%	NC	25th–50th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—3–11 Years	—	—	254	58.66%	NC	25th–50th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—12–17 Years	—	—	157	56.05%	NC	10th–25th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	—	411	57.66%	NC	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.

— indicates that the measure is a first-year measure for HEDIS MY 2021; 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 MY 2021 is the first year this measure is being reported.

Excluding information-only measures, **DVHA** demonstrated strength, with 11 measure rates meeting or exceeding the 90th percentile. Of the 73 reportable rates with comparable benchmarks, four rates met or exceeded the 95th percentile:

- *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—6–17 Years*
- *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—6–17 Years*
- *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—18–64 Years*
- *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total*

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

- *Well-Child Visits in the First 30 Months of Life—6 Visits in First 15 Months*
- *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—18–64 Years*
- *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total*
- *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—18+ Years*
- *Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up—Total*

Excluding information-only measures, **DVHA** demonstrated opportunities for improvement with the following 20 rates falling below the 25th percentile:

- *Breast Cancer Screening*
- *Chlamydia Screening in Women—16–20 Years*
- *Chlamydia Screening in Women—21–24 Years*
- *Chlamydia Screening in Women—Total*
- *Initiation and Engagement of AOD Abuse or Dependence Treatment (Initiation)—13–17 Years—Total*
- *Initiation and Engagement of AOD Abuse or Dependence Treatment (Initiation)—18+ Years—Total*
- *Initiation and Engagement of AOD Abuse or Dependence Treatment (Initiation)—Total—Total*
- *Ambulatory Care (ED Visits)—10–19 Years*
- *Ambulatory Care (ED Visits)—65–74 Years*
- *Ambulatory Care (ED Visits)—75–84 Years*
- *Ambulatory Care (ED Visits)—85+ Years*
- *Asthma Medication Ratio—5–11 Years*
- *Asthma Medication Ratio—12–18 Years*
- *Asthma Medication Ratio—19–50 Years*
- *Asthma Medication Ratio—Total*

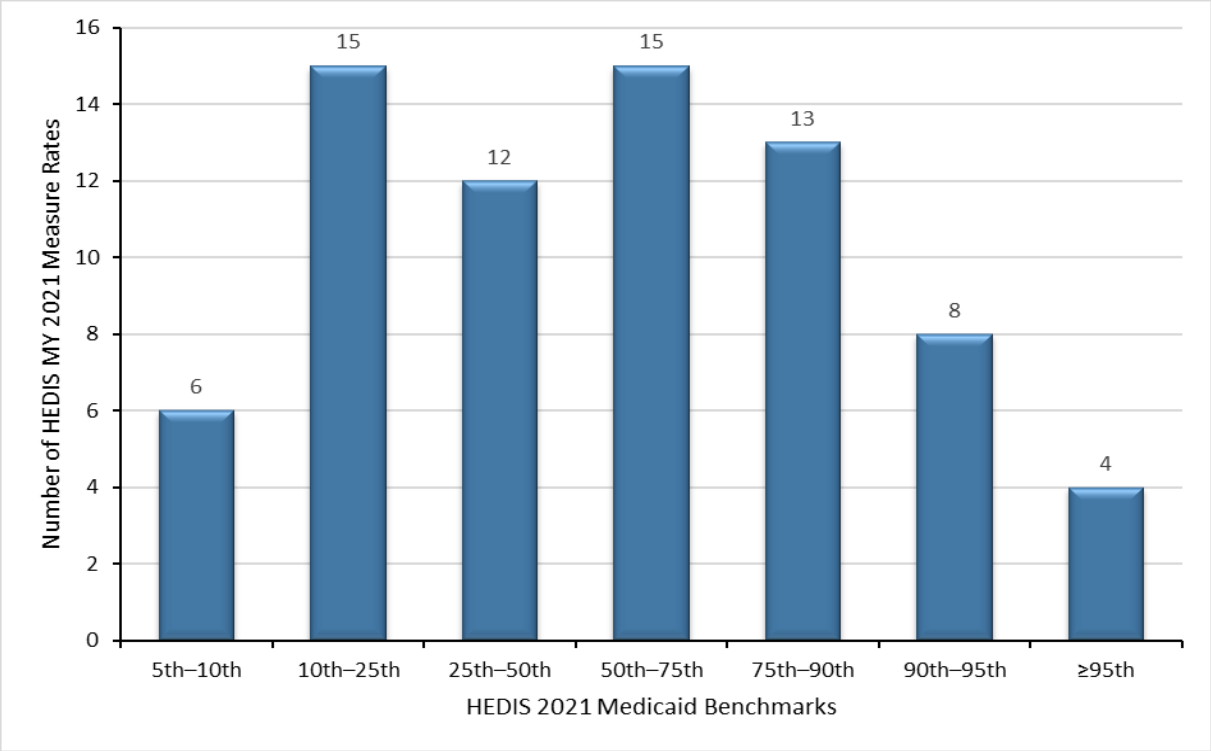
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents — BMI Percentile Documentation—3–11 Years*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents — BMI Percentile Documentation—12–17 Years*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents — BMI Percentile Documentation—Total*
- *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 Physical Activity—12–17 Years*

Excluding information-only measures, an additional 11 rates fell below the 50th percentile but were at or above the 25th percentile:

- *Adults' Access to Preventive/Ambulatory Health Services—20–44 Years*
- *Adults' Access to Preventive/Ambulatory Health Services—45–64 Years*
- *Adults' Access to Preventive/Ambulatory Health Services—65+ Years*
- *Adults' Access to Preventive/Ambulatory Health Services—Total*
- *Initiation and Engagement of AOD Abuse or Dependence Treatment (Engagement)—13–17 Years—Total*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- *Controlling High Blood Pressure*
- *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—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—Total*

Figure 2-1 shows the distribution of how the reported indicators compared to the HEDIS MY 2021 national Medicaid benchmarks.

Figure 2-1—Number of HEDIS MY 2021 Measure Rates Meeting the HEDIS MY 2020 Medicaid Benchmarks



DVHA performed at or above the 75th percentile for 25 of 73 (34.2 percent) measure rates appropriate for comparison to benchmarks, demonstrating strengths in sufficient child and adolescent care, appropriate ambulatory care (ED utilization), engagement of AOD abuse or dependence treatment, asthma medication ratios, prenatal and postpartum care, and 7- and 30-day follow-up care after ED visits for alcohol or drug abuse. Conversely, 33 of 73 rates (45.2 percent) fell below the 50th percentile, indicating efforts should be focused on ensuring adults have access to preventive and ambulatory care services, breast cancer and chlamydia screenings, initiation of AOD abuse or dependence treatment, outpatient ambulatory care, ration of asthma medication, ED ambulatory care, and prenatal care. **DVHA** also should focus on educating members on the importance of weight assessment including BMI percentile, and counseling for nutrition and physical activity for children and adolescents.

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 2022–2023, AHS requested that HSAG conduct a review of the federal Medicaid managed care standards described at 42 CFR §438.206–§438.210 (access), §438.54–§438.56 (enrollment and disenrollment), and §438.114 (emergency and poststabilization services), and the related AHS/**DVHA** IGA (i.e., contract) requirements.

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 seven standards to allow **DVHA** staff members to elaborate on the written information that 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 seven 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.

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	Availability of Services	19	19	16	2	1	0	**89.5%**
II	Assurances of Adequate Capacity and Services	18	18	8	4	6	0	**55.6%**
III	Cultural Competence	10	10	10	0	0	0	**100%**
IV	Coordination and Continuity of Care	13	13	7	5	1	0	**73.1%**
V	Coverage and Authorization of Services	27	27	24	3	0	0	**94.4%**

[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/qualiyt-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Feb 15, 2023.

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Total Compliance Score
VI	Emergency and Poststabilization Services	17	17	10	7	0	0	**79.4%**
VII	Enrollment and Disenrollment Requirements	7	7	3	4	0	0	**71.4%**
	Totals	**111**	**111**	**78**	**25**	**8**	**0**	**81.5%**

***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 111 elements across the seven standards. Of the 111 elements, **DVHA** obtained a score of *Met* for 78 elements (70.3 percent), a *Partially Met* score for 25 elements (22.5 percent), and a *Not Met* score for eight elements (7.2 percent). As a result, **DVHA** obtained a total percentage-of-compliance score across the 111 elements of 81.5 percent.

Overall Conclusions and Performance Trending

Performance Trends

Performance Improvement Project Trends

DVHA continued its PIP topic, *Managing Hypertension*, in contract year 2022–2023. **DVHA** performed well in meeting the requirements in the Implementation stage of the PIP, achieving all validation criteria in Steps 7 and 8. HSAG determined that **DVHA** designed a methodologically sound improvement project, accurately reported and interpreted baseline results, and conducted appropriate quality improvement activities and interventions. The PIP had not progressed to reporting outcomes (remeasurement data); therefore, no conclusions could be drawn related to the PIP. First remeasurement data and continued quality improvement processes and strategies will be reported in the SFY 2023–2024 EQR technical report.

Table 2-5 outlines the performance indicator for the PIP.

Table 2-5—*Managing Hypertension* PIP Performance Indicator

PIP Title	Performance Indicator
Managing Hypertension	The percentage of Vermont Medicaid members 18 to 85 years of age with a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg).

Table 2-6—*Managing Hypertension* PIP for Department of Vermont Health Access

PIP—Managing Hypertension			
Performance Indicator	**Baseline (1/1/2021—12/31/2021)**	**Remeasurement 1 (1/1/2022–12/31/2022)**	**Remeasurement 2 (1/1/2023–12/31/2023)**
The percentage of Vermont Medicaid members 18 to 85 years of age with a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg).	52.07%	TBD	TBD

The baseline rate for the eligible members was 52.07 percent. **DVHA** used a hybrid data collection process with administrative data from claims/encounters and medical record review using paper medical record abstractions, outpatient medical records, inpatient nonacute records, telephone visits, e-visits or virtual check-ins, or remote monitoring events.

Table 2-7 displays the barriers and interventions as documented by **DVHA**.

Table 2-7—Interventions Implemented/Planned for the *Managing Hypertension* PIP

Barriers	Interventions
Members do not have blood pressure monitors to use at home.	Improved members' access to automatic blood pressure cuffs by expanding Medicaid coverage for blood pressure cuffs for additional hypertension diagnoses and ensuring pharmacy coverage for blood pressure cuffs.
Lack of referral options for community programming.	Developed a community connection that provides referral support to the system of care (connecting with the Coordinator of Health Coaches for hypertension self-management and self-monitoring program for individuals diagnosed with hypertension). Vermont Development of Health funding used to provide blood pressure cuffs free of charge to program participants. The **DVHA** team helped promote these workshops through provider communications.
No simple resource tool for providers.	Developed a one-page tool that both **DVHA** and OneCare will use for communication and education of providers. The one-page tool includes background and tips associated with improving performance and member engagement on the HEDIS *CBP* measure.

Performance Measure Trends

DVHA used a vendor with HEDIS Certified Measures[SM, 2-6] to calculate and report the HEDIS MY 2021 performance measure rates. Table 2-8 below displays the rates for measures **DVHA** reported for HEDIS MY 2018, MY 2019, MY 2020, and MY 2021; the denominator (i.e., N); and the change for each measure rate from HEDIS MY 2018 to HEDIS MY 2021.

Table 2-8—HEDIS MY 2018, MY 2019, MY 2020, and MY 2021 Results

Measure	HEDIS MY 2018		HEDIS MY 2019		HEDIS MY 2020		HEDIS MY 2021		Change From HEDIS MY 2018 to HEDIS MY 2021
	N	Rate	N	Rate	N	Rate	N	Rate	
Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	37,112	79.40%	32,793	81.22%	39,397	76.25%	49,753	75.15%	-4.25%
Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	20,960	85.61%	19,101	86.80%	21,350	82.48%	25,404	82.46%	-3.15%
Adults' Access to Preventive/Ambulatory Health Services—65+ Years	381	79.27%	170	92.35%	298	83.22%	453	79.69%	+0.42%
Adults' Access to Preventive/Ambulatory Health Services—Total	58,453	81.63%	52,064	83.30%	61,045	78.46%	75,610	77.63%	-4.00%
Child and Adolescent Well-Care Visits—3–11 Years	—	—	—	—	28,846	62.61%	30,015	65.33%	NC
Child and Adolescent Well-Care Visits—12–17 Years	—	—	—	—	18,849	54.56%	20,101	58.56%	NC
Child and Adolescent Well-Care Visits—18–21 Years	—	—	—	—	8,704	28.64%	10,530	29.91%	NC
Child and Adolescent Well-Care Visits—Total	—	—	—	—	56,399	54.68%	60,646	56.93%	NC
Breast Cancer Screening	5,885	52.90%	5,461	52.33%	5,796	48.57%	6,464	46.16%	-6.74%
Chlamydia Screening in Women—16–20 Years	3,899	50.83%	3,590	48.75%	3,821	41.48%	4,271	41.89%	-8.94%
Chlamydia Screening in Women—21–24 Years	2,347	59.65%	2,014	60.53%	2,289	54.78%	2,704	51.96%	-7.69%

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

Measure	HEDIS MY 2018		HEDIS MY 2019		HEDIS MY 2020		HEDIS MY 2021		Change From HEDIS MY 2018 to HEDIS MY 2021
	N	Rate	N	Rate	N	Rate	N	Rate	
Chlamydia Screening in Women—Total	6,246	54.15%	5,604	52.98%	6,110	46.46%	6,975	45.79%	-8.36%
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—6–17 Years	326	45.40%	291	46.74%	239	56.90%	215	56.74%	+11.34%
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—18–64 Years	1,207	32.56%	1,137	36.68%	873	41.81%	896	43.53%	+10.97%
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—65+ Years	0	NA	0	NA	0	NA	1	NA	NC
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total	1,533	35.29%	1,428	38.73%	1,112	45.05%	1,112	46.04%	+10.75%
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—6–17 Years	326	68.10%	291	72.16%	239	75.31%	215	77.67%	+9.57%
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—18–64 Years	1,207	46.81%	1,137	57.52%	873	61.86%	896	62.95%	+16.14%
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—65+ Years	0	NA	0	NA	0	NA	1	NA	NC
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total	1,533	51.34%	1,428	60.50%	1,112	64.75%	1,112	65.83%	+14.49%
Initiation and Engagement of AOD Abuse or Dependence Treatment (Initiation)—13–17 Years—Total	214	35.98%	198	30.30%	156	27.56%	126	33.33%	-2.65%

Measure	HEDIS MY 2018		HEDIS MY 2019		HEDIS MY 2020		HEDIS MY 2021		Change From HEDIS MY 2018 to HEDIS MY 2021
	N	Rate	N	Rate	N	Rate	N	Rate	
Initiation and Engagement of AOD Abuse or Dependence Treatment (Initiation)—18+ Years—Total	4,038	39.80%	3,638	43.93%	3,365	45.85%	3,765	40.58%	+0.78%
Initiation and Engagement of AOD Abuse or Dependence Treatment (Initiation)—Total—Total	4,252	39.60%	3,836	43.22%	3,521	45.04%	3,891	40.35%	+0.75%
Initiation and Engagement of AOD Abuse or Dependence Treatment (Engagement)—13–17 Years—Total	214	15.89%	198	15.66%	156	10.26%	126	11.90%	-3.99%
Initiation and Engagement of AOD Abuse or Dependence Treatment (Engagement)—18+ Years—Total	4,038	18.70%	3,638	22.51%	3,365	23.18%	3,765	18.91%	+0.21%
Initiation and Engagement of AOD Abuse or Dependence Treatment (Engagement)—Total—Total	4,252	18.56%	3,836	22.16%	3,521	22.61%	3,891	18.68%	+0.12%
Ambulatory Care (Outpatient Visits)—<1 Year[†,1]	33,648	960.33	33,738	990.17	27,574	840.31	27,694	884.40	-75.93
Ambulatory Care (Outpatient Visits)—1–9 Years[†,1]	111,897	305.38	109,270	311.15	80,620	229.64	92,158	255.40	-49.98
Ambulatory Care (Outpatient Visits)—10–19 Years[†,1]	91,496	246.87	89,407	246.33	72,810	194.72	88,942	221.79	-25.08
Ambulatory Care (Outpatient Visits)—20–44 Years[†,1]	145,013	266.76	155,975	287.07	144,174	248.35	174,742	256.08	-10.68
Ambulatory Care (Outpatient Visits)—45–64 Years[†,1]	121,604	419.45	171,725	485.91	154,602	420.28	178,498	434.30	+14.85

Measure	HEDIS MY 2018		HEDIS MY 2019		HEDIS MY 2020		HEDIS MY 2021		Change From HEDIS MY 2018 to HEDIS MY 2021
	N	Rate	N	Rate	N	Rate	N	Rate	
Ambulatory Care (Outpatient Visits)—65–74 Years[†,1]	1,005	288.96	41,060	687.00	36,923	565.75	45,127	562.44	+273.48
Ambulatory Care (Outpatient Visits)—75–84 Years[†,1]	261	446.92	21,085	690.00	18,346	577.12	19,984	609.45	+162.53
Ambulatory Care (Outpatient Visits)—85+ Years[†,1]	89	NA	10,604	517.87	9,181	454.37	9,882	508.57	NC
Ambulatory Care (Outpatient Visits)—Total[†,1]	505,013	313.68	632,864	360.45	544,230	298.46	637,027	315.52	+1.84
Ambulatory Care (Emergency Department [ED] Visits)—<1 Year[1]	2,326	66.39	2,407	70.64	1,400	42.66	1,584	50.58	-15.81
Ambulatory Care (ED Visits)—1–9 Years[1]	13,069	35.67	12,702	36.17	7,581	21.59	9,066	25.12	-10.55
Ambulatory Care (ED Visits)—10–19 Years[1]	13,176	35.55	13,028	35.89	9,353	25.01	11,681	29.13	-6.42
Ambulatory Care (ED Visits)—20–44 Years[1]	31,829	58.55	33,982	62.54	27,672	47.67	33,552	49.17	-9.38
Ambulatory Care (ED Visits)—45–64 Years[1]	12,828	44.25	20,255	57.31	16,535	44.95	18,991	46.21	+1.96
Ambulatory Care (ED Visits)—65–74 Years[1]	56	16.10	3,796	63.51	3,523	53.98	4,121	51.36	+35.26
Ambulatory Care (ED Visits)—75–84 Years[1]	10	17.12	1,989	65.09	1,548	48.70	1,768	53.92	+36.80
Ambulatory Care (ED Visits)—85+ Years[1]	8	NA	1,021	49.86	810	40.09	865	44.52	NC
Ambulatory Care (ED Visits)—Total[1]	73,302	45.53	89,180	50.79	68,422	37.52	81,628	40.43	-5.10
Well-Child Visits in the First 30 Months of Life—6 Visits in First 15 Months	—	—	—	—	2,607	70.35%	2,636	70.03%	NC
Well-Child Visits in the First 30 Months of Life—2 Visits in 15 Through 30 Months	—	—	—	—	2,572	83.32%	2,901	79.46%	NC

Measure	HEDIS MY 2018		HEDIS MY 2019		HEDIS MY 2020		HEDIS MY 2021		Change From HEDIS MY 2018 to HEDIS MY 2021
	N	Rate	N	Rate	N	Rate	N	Rate	
Asthma Medication Ratio—5–11 Years	—	—	—	—	511	74.95%	439	67.43%	NC
Asthma Medication Ratio—12–18 Years	—	—	—	—	445	65.17%	430	60.47%	NC
Asthma Medication Ratio—19–50 Years	—	—	—	—	1,199	49.96%	1,379	45.76%	NC
Asthma Medication Ratio—51–64 Years	—	—	—	—	340	60.88%	436	61.24%	NC
Asthma Medication Ratio—Total	—	—	—	—	2,495	59.28%	2,684	54.17%	NC
Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—6–17 Years	—	—	429	89.04%	284	88.73%	356	85.96%	NC
Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—18–64 Years	—	—	705	67.23%	653	63.09%	688	65.41%	NC
Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—65+ Years	—	—	0	NA	0	NA	1	NA	NC
Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total	—	—	1,134	75.49%	937	70.86%	1,045	72.44%	NC
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—6–17 Years	—	—	429	91.84%	284	91.90%	356	89.89%	NC
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—18–64 Years	—	—	705	75.60%	653	71.67%	688	72.67%	NC
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—65+ Years	—	—	0	NA	0	NA	1	NA	NC
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total	—	—	1,134	81.75%	937	77.80%	1,045	78.56%	NC
Follow-Up After ED Visit for Alcohol or Other Drug (AOD) Abuse or Dependence—7-Day Follow-Up—13–17 Years	—	—	34	14.71%	28	NA	34	11.76%	NC

Measure	HEDIS MY 2018		HEDIS MY 2019		HEDIS MY 2020		HEDIS MY 2021		Change From HEDIS MY 2018 to HEDIS MY 2021
	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%	1,054	22.30%	1,200	24.83%	NC
Follow-Up After ED Visit for AOD Abuse or Dependence—7-Day Follow-Up—Total	—	—	1,183	24.26%	1,082	21.90%	1,234	24.47%	NC
Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up—13–17 Years	—	—	34	23.53%	28	NA	34	14.71%	NC
Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up—18+ Years	—	—	1,149	36.55%	1,054	33.11%	1,200	34.67%	NC
Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up—Total	—	—	1,183	36.18%	1,082	32.53%	1,234	34.12%	NC
Developmental Screening in the First Three Years of Life—1 Year	—	—	2,649	49.83%	2,578	43.52%	2,547	45.82%	NC
Developmental Screening in the First Three Years of Life—2 Years	—	—	2,762	62.13%	2,651	57.56%	2,872	53.90%	NC
Developmental Screening in the First Three Years of Life—3 Years	—	—	2,884	59.78%	2,840	57.61%	2,884	56.14%	NC
Developmental Screening in the First Three Years of Life—Total	—	—	8,295	57.38%	8,069	53.09%	8,303	52.20%	NC
Prenatal and Postpartum Care—Timeliness of Prenatal Care	—	—	411	69.59%	411	84.67%	411	81.75%	NC
Prenatal and Postpartum Care—Postpartum Care	—	—	411	65.45%	411	77.37%	411	82.97%	NC
Controlling High Blood Pressure	—	—	—	—	411	42.58%	411	52.07%	NC

Measure	HEDIS MY 2018		HEDIS MY 2019		HEDIS MY 2020		HEDIS MY 2021		Change From HEDIS MY 2018 to HEDIS MY 2021
	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	—	—	—	—	—	—	254	69.69%	NC
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—12–17 Years	—	—	—	—	—	—	157	64.33%	NC
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total	—	—	—	—	—	—	411	67.64%	NC
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—3–11 Years	—	—	—	—	—	—	254	70.87%	NC
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—12–17 Years	—	—	—	—	—	—	157	56.05%	NC
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	—	—	—	—	—	411	65.21%	NC

Measure	HEDIS MY 2018		HEDIS MY 2019		HEDIS MY 2020		HEDIS MY 2021		Change From HEDIS MY 2018 to HEDIS MY 2021
	N	Rate	N	Rate	N	Rate	N	Rate	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—3–11 Years	—	—	—	—	—	—	254	58.66%	NC
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—12–17 Years	—	—	—	—	—	—	157	56.05%	NC
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	—	—	—	—	—	411	57.66%	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.

— indicates that the measure is a first-year measure for HEDIS MY 2021; 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 MY 2021 is the first year this measure is being reported.

Overall, 14 of the 28 (50 percent) measure rates that could be trended showed an improvement in performance since HEDIS MY 2018 (excluding information-only measures). The *Ambulatory Care (ED Visits)—65–74 and 75–84 Years* rates improved by over 35 percentage points, and the *Follow-Up After Hospitalization for Mental Illness—7–Day Follow-Up—6–17 Years, 18–64 Years,* and *Total,* as well as *Follow-Up After Hospitalization for Mental Illness—30–Day Follow-Up—18–64 Years* and *Total* rates all improved by more than 10 percentage points from HEDIS MY 2018 to HEDIS MY 2021. Of the 14 measure rates that showed a decline in performance, the *Ambulatory Care (ED Visits)— <1 Year* rate declined by more than 15 percentage points, and the *Ambulatory Care (ED Visits)— 1–9 Years* rate declined by more than 10 percentage points.

Compliance With Standards Trends

The 2022–2023 review was the third 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 seven performance categories (i.e., standards). The seven standards (i.e., Availability of Services, Assurances of Adequate Capacity and Services, Cultural Competence, Coordination and Continuity of Care, Coverage and Authorization of Services, Emergency and Poststabilization Services, and Enrollment and Disenrollment Requirements) included requirements associated with the federal Medicaid managed care standards found at 42 CFR §438.54–§438.56, §438.114, and §438.206–§438.210.

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—Beneficiary Information (42 CFR §438.10); Enrollee Rights (42 CFR §438.100); Provider Selection, Confidentiality, Grievance and Appeal Systems, and Subcontractual Relationships and Delegation requirements (42 CFR §438.214–§438.230)
- Year 2—Practice Guidelines, Health Information Systems, and Quality Assessment and Performance Improvement (QAPI) Program standards (42 CFR §438.236, §438.242, and §438.330)
- Year 3—Access (42 CFR §438.206, §438.207, §438.208, and §438.210); Emergency and Poststabilization Services (42 CFR §438.114); and Managed Care Enrollment and Disenrollment Requirements and Limitations (§438.54–§438.56)

For this year (2022–2023—the 15th year of review), HSAG evaluated the Availability of Services, Assurances of Adequate Capacity and Services, Cultural Competence, Coordination and Continuity of Care, Coverage and Authorization of Services, Emergency and Poststabilization Services, and Enrollment and Disenrollment standards, the same standards it reviewed in 2010, 2013, 2016, and 2019.

Table 2-9 documents **DVHA**'s performance across 15 years of compliance reviews conducted by HSAG.

Table 2-9—Comparison/Trending of Scores Achieved During Compliance Reviews

Year of the Review	Year 1 Standards			Year 2 Standards			Year 3 Standards		
	Elements	Score	Corrective Action %*	Elements	Score	Corrective Action %*	Elements	Score	Corrective Action %*
2008	90	84%	30%						
2009				29	98%	3%			

Year of the Review	Year 1 Standards			Year 2 Standards			Year 3 Standards		
	Elements	Score	Corrective Action %*	Elements	Score	Corrective Action %*	Elements	Score	Corrective Action %*
2010							76	97%	7%
2011	89	90%	20%						
2012				30	100%	0%			
2013							71	99%	3%
2014	93	92%	15%						
2015				31	97%	3%			
2016							80	97%	6%
2017	84	90%	19%						
2018				33	100%	0%			
2019							68	86%	22%
2020	88	94%	11%						
2021				24	96%	4%			
2022							111	82%	28%

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

For the Access, Enrollment and Disenrollment, and Emergency and Poststabilization Services (Year 3) standards, the overall scores **DVHA** received across the five years ranged from 82 percent to 99 percent, with the overall corrective action percentages ranging from 3 percent to 28 percent. During the prior review, **DVHA** scored 86 percent across the seven standards.

Recommendations and Opportunities for Improvement

Performance Improvement Project

DVHA demonstrated proficiency in reporting and interpreting baseline data as well as initiating quality improvement activities and interventions. The following are HSAG's recommendations to **DVHA** based on validation of **DVHA**'s PIP:

- **DVHA** should consider shorter testing/evaluation periods for its current interventions. The testing/evaluation of interventions should allow the MCE to quickly gather data and make data-driven decisions on the status of an intervention. If the intervention is not having the desired impact, new strategies and interventions should be initiated.
- **DVHA** should apply lessons learned and knowledge gained during the PIP to make changes and revisions to quality improvement (QI) processes and activities.

- **DVHA** should continue to use Plan-Do-Study-Act cycles as part of the improvement strategies. Interventions can be tested on a small scale, evaluated, and then expanded to full implementation, if deemed successful.
- **DVHA** should ensure it addresses HSAG's validation feedback in the next annual submission.

Performance Measures

HSAG offers the following recommendations related to improving **DVHA**'s performance rates of quality, timeliness, and access-related measures; data collection; and reporting processes:

- With 33 of 73 rates (45.2 percent) falling below the 50th percentile, **DVHA** should consider focusing efforts on ensuring that adults have ***access*** to preventive and ambulatory care services, breast cancer and chlamydia screenings, ED ambulatory care, asthma medication ratios, and prenatal care. **DVHA** also should focus on child and adolescent measures likes weight assessment and counseling for nutrition, physical activity, and BMI percentiles. Initiation of AOD abuse or dependence treatment is an additional area of focus for **DVHA**.
- **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 Vermont Information Technology Leaders (VITL). VITL could potentially be an untapped resource for capturing supplemental data for measures.
- HSAG recommends that **DVHA** begin capturing data from electronic health records (EHRs) from providers. These sources would complement administrative capture and reduce reliance on hybrid abstraction.

Compliance With Standards

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

- **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. Producing and analyzing the required geographic reports to determine compliance with the required access standards could assist in identifying areas on which to focus efforts to improve the ***accessibility of care*** provided to beneficiaries.
- **DVHA** must ensure that if the contracted network is unable to provide medically necessary services, covered under the AHS IGA, to a particular enrollee, **DVHA** adequately and in a timely manner covers these services out-of-network for the enrollee, as long as the entity is unable to provide them. Such processes could assist in identifying access issues and serve as an area on which to focus efforts to improve the ***quality***, ***timeliness***, and ***accessibility of care*** furnished to beneficiaries.
- **DVHA** must develop and implement an Access to Care Plan that meets all AHS requirements outlined in the AHS/**DVHA** IGA.

- **DVHA** must develop plan documents that include information for providers regarding timely access to care requirements based on the beneficiary's urgency of need.
- **DVHA** did not have an Access to Care Plan in place throughout the review period and the Medicaid General Provider Manual (General Provider Manual) did not inform providers about access to care requirements. **DVHA** must ensure that access standards for preventive care and nonurgent, nonemergent, and urgent conditions are disseminated to all network providers. This finding also was noted in the SFY 2019–2020 review for this standard.
- **DVHA** must generate geographic access reports to determine if the requirement for beneficiaries to access primary care physicians (PCPs), hospitals, ophthalmology/optometry, laboratory, advanced imaging, pharmacy, and dental services is met.
- **DVHA** must monitor IGA partners' performance through a formal review according to a periodic schedule established by the State, consistent with industry standards or State laws and regulations. HSAG recommended during the 2019 compliance review of this standard that **DVHA** develop a formal monitoring process to ensure that IGA partners' case management care plans and care coordination activities are conducted and documented in compliance with established rules and IGA requirements.
- **DVHA** must ensure that oversight and monitoring activities are documented to support compliance with established rules and IGA requirements.
- **DVHA** must develop processes and implement mechanisms to ensure that beneficiaries with special health care needs are assessed and have a treatment plan that is: (a) developed by appropriate health care professionals and (b) developed by the enrollee's PCP with enrollee participation and in coordination with any specialists caring for the enrollee.
- **DVHA** must ensure that care coordination treatment plans identify specialist services that may be accessed directly by the enrollee as appropriate for that enrollee's condition and identified needs.
- **DVHA** must ensure that care coordination treatment plans for enrollees with special health care needs conform to the State's quality assurance and utilization review (UR) standards.
- **DVHA** must ensure that there is a unified treatment plan for enrollees with special health care needs to prevent enrollees from receiving duplicative case management/care coordination services.
- **DVHA** and its IGA partners must ensure that in the process of coordinating care, each enrollee's privacy is protected in accordance with the privacy requirements in 45 CFR §160 and 164 Subparts A and E, as applicable.
- **DVHA** and its IGA partners must document and ensure that written processes to ensure compliance with Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy rules are approved by the Compliance Committee.
- **DVHA** and its IGA partners must provide best efforts to conduct an initial screening of each enrollee's needs, within 90 days of the effective date of enrollment for all new enrollees, including subsequent attempts if the initial attempt to contact the enrollee is unsuccessful.

- **DVHA** must ensure that the contract with each IGA partner accurately reflects the partner's responsibility for approving prior authorizations. **DVHA** also must ensure that the Vermont Department of Health (VDH) documents its prior authorization processes and that the written processes are approved by the **DVHA** Compliance Committee.
- Two of the 10 records in the UR denial sample did not meet the requirement to make standard authorization decisions and provide notice to the beneficiary and provider within 14 calendar days of the request. **DVHA** must ensure that the MCE meets the timelines established for standard authorization decisions and notifications as required in 42 CFR §438.210(d)(1). This finding also was noted in the SFY 2019–2020 review of this standard.
- **DVHA** must provide education for all staff responsible for making authorization decisions regarding the specific federal time frame requirements for making expedited authorization decisions as described in **DVHA**'s Clinical Operations Unit Procedure Manual.
- **DVHA** must create plan documents to confirm that **DVHA** and its IGA partner delegates do not limit or define what constitutes an emergency medical condition based on a list of diagnoses or symptoms.
- **DVHA** must develop plan documents to confirm that **DVHA** and its IGA partner delegates do not refuse to cover emergency services based on a failure on the part of the emergency room provider, hospital, or fiscal agent to notify the enrollee's provider, the responsible department, or **DVHA** of the beneficiary's screening and treatment within 10 calendar days of the enrollee's presentation for emergency services.
- **DVHA** must create plan documents to confirm that **DVHA** and its IGA partner delegates do not refuse to cover and pay for emergency services when the enrollee was instructed by **DVHA** or an IGA partner delegate representative to seek emergency services, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of an emergency medical condition.
- **DVHA** must create plan documents to support the requirement that **DVHA** and its IGA partner delegates do not refuse to cover and pay for emergency services when an enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the federal regulations and the AHS/**DVHA** IGA when defining an emergency medical condition.
- **DVHA**'s plan documents must include information concerning the requirement that **DVHA** and its IGA partner delegates are financially responsible/pay for poststabilization services obtained from any provider, regardless of whether the provider is within or outside **DVHA**'s provider network, that are not prior authorized by a **DVHA**/IGA partner delegate provider or representative but are administered to maintain, improve, or resolve the enrollee's stabilized condition if:
  a. **DVHA** or the IGA partner delegate does not respond to the provider's request for precertification or prior authorization within one hour.
  b. **DVHA** or the IGA partner delegate cannot be contacted.
  c. **DVHA**'s or the IGA partner delegate's representative and the attending physician cannot agree concerning the enrollee's care/treatment and a **DVHA**/IGA partner physician is not

available for consultation. In this situation, **DVHA** or the IGA partner delegate allows the treating physician to continue with care of the enrollee until a **DVHA**/IGA partner delegate plan physician is reached or the enrollee/patient is discharged.

- **DVHA**'s plan documents must include information concerning the requirement that **DVHA** and its IGA partner delegates retain financial responsibility for poststabilization services they have not approved until one of the following occurs:
  a. An in-network provider with privileges at the treating hospital assumes responsibility for the enrollee's care.
  b. An in-network provider assumes responsibility for the enrollee's care through transfer.
  c. **DVHA**'s or the IGA partners' delegate representative and the treating physician reach an agreement concerning the enrollee's care.
  d. The enrollee is discharged.
- **DVHA** must create documentation to confirm that, in the event the enrollee receives poststabilization services from a provider outside of **DVHA**'s network, **DVHA** limits charges to the member to an amount no greater than what **DVHA** would charge if he or she had obtained the services through an in-network provider.
- **DVHA** must monitor the contents and mailing of member handbooks to ensure that every newly enrolled beneficiary receives notification concerning enrollee rights, appeal and State fair hearing rights, confidentiality rights, availability of the Healthcare Ombudsman, and enrollee-initiated disenrollment.
- **DVHA** must have documentation to support the requirement to make a good faith effort to provide notice of termination of a contracted provider within 15 days after receipt or issuance of a termination notice and monitor to ensure that each enrollee who received his or her primary care from, or was seen regularly by, the terminated provider received the notice.
- **DVHA**'s documentation concerning disenrollment must include a list of prohibited disenrollment to include an adverse change in the enrollee's status, utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from the enrollee's special needs.
- **DVHA** must create plan documents to define the process to review individuals who lose eligibility in the *Global Commitment to Health Demonstration* by comparing, at least monthly, the active *Global Commitment to Health Demonstration* enrollee list with the Economic Services Division's eligibility list to confirm Medicaid status for all *Global Commitment to Health Demonstration* enrollees.

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

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."[3-1] CMS has chosen the domains of quality, access, and timeliness as keys to evaluating the performance of MCOs, PIHPs, PAHPs, and PCCMs.

The following subsections include information concerning the objective of each activity included in this report, the technical methods of data collection and analysis, the description of data obtained, and how conclusions were drawn. The categorization of how HSAG formulated conclusions according to the quality, timeliness, or accessibility of care are based on the following definitions:

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.[3-2]

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."[3-3] 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.

3-1 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: Feb 15, 2023.

3-2 Department of Health and Human Services Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Vol 81, May 6, 2016.

3-3 National Committee for Quality Assurance. (2020). *Standards and Guidelines for Health Plans*.

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).[3-4]

The CFR also requires that the EQR results include a description of how the data from all activities conducted in accordance with §438.358 were aggregated and analyzed and conclusions were drawn as to the quality, timeliness, and accessibility of care furnished by the MCO, PIHP, PAHP, or PCCM entity in §438.364(a)(1).[3-5] HSAG follows a three-step process to aggregate and analyze data collected from all EQR activities and draw conclusions about the *quality*, *timeliness*, and *accessibility of care* furnished by each MCO as well as the program overall.

First, HSAG analyzes the quantitative results obtained from each EQR activity for each MCO to identify strengths and weaknesses in each domain of quality, timeliness, and accessibility of services furnished by the MCO for the EQR activity. Second, from the information collected, HSAG identifies common themes and the salient patterns that emerge across EQR activities for each domain, and HSAG draws conclusions about the overall quality and timeliness of, and access to care and services furnished by the MCO. Lastly, HSAG identifies any patterns and commonalities that exist across the program to draw aggregated conclusions about the ***quality***, ***timeliness***, and ***accessibility of care*** for the program.

The following subsections of the report include the strengths and opportunities for improvement and provide an assessment and evaluation of the quality and timeliness of, and access to care and services for each MCO by task. That information is followed by a subsection which identifies common themes and patterns that emerged across the EQR activities for the MCO and includes conclusions about the quality and timeliness of, and access to care and services for the Vermont Medicaid beneficiaries.

Conclusions Related to the Performance Improvement Project

To draw conclusions about the ***quality***, ***timeliness***, and ***accessibility of care*** **DVHA** provided, HSAG determined which components of the *Managing Hypertension* PIP activity could be used to assess these domains. Table 3-1 illustrates the **quality**, **timeliness**, and **access** domains related to the *Managing Hypertension* PIP.

Table 3-1—PIP Activity Components Assessing Quality, Timeliness, and Access

PIP	Quality	Timeliness	Access
Managing Hypertension	✓	✓	✓

[3-4] 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: Feb 15, 2023.

[3-5] U. S. Government Publishing Office. (2017). *Electronic Code of Federal Regulations*. Available at: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-E/section-438.364. Accessed on: Feb 15, 2023.

DVHA's *Managing Hypertension* PIP submission documentation provided evidence that the PIP was a scientifically sound project supported by use of key research principles, and the MCE reported and interpreted baseline results accurately and conducted appropriate QI processes and interventions. **DVHA** demonstrated strengths by achieving 100 percent of CMS' Protocol 1 requirements in the validation criteria for Steps 7 and 8. The PIP had not progressed to reporting outcomes (Step 9); therefore, no conclusions could be drawn related to the PIP.

DVHA's performance indicator was based on HEDIS technical specifications and focused on measuring the rate of Vermont Medicaid members 18 to 85 years of age with a diagnosis of hypertension whose blood pressure was adequately controlled (<140/90 mm Hg). **DVHA** specified that a systematic hybrid data collection method following HEDIS technical specifications will be used for collecting baseline and remeasurement data.

Conclusions Related to Performance Measures

To draw conclusions about the ***quality***, ***timeliness***, and ***accessibility of care*** **DVHA** provided, HSAG determined which components of each performance measure could be used to assess these domains. Table 3-2 illustrates the ***quality***, ***timeliness***, and ***access*** domains related to the performance measures included in this report. Items marked not applicable (NA) are measures evaluating utilization of services.

Table 3-2—Performance Measures Activity Components Assessing Quality, Timeliness, and Access

Performance Measures	Quality	Timeliness	Access
Adults' Access to Preventive/Ambulatory Health Services			✓
Child and Adolescent Well-Care Visits	✓		✓
Breast Cancer Screening	✓		
Chlamydia Screening in Women	✓		
Follow-Up After Hospitalization for Mental Illness	✓	✓	✓
Initiation and Engagement of AOD Abuse or Dependence Treatment	✓	✓	✓
Ambulatory Care	NA	NA	NA
Well Child Visits in the First 30 Months of Life	✓		✓
Asthma Medication Ratio	✓		
Follow-Up After ED Visit for Mental Illness	✓	✓	✓
Follow-Up After ED Visit for AOD Abuse or Dependence	✓	✓	✓
Developmental Screening in the First 3 Years of Life	✓	✓	✓
Prenatal and Postpartum Care	✓	✓	✓
Controlling High Blood Pressure	✓		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	✓		

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 HEDIS specifications and that the measures met standards set forth by NCQA. [***Quality***]

DVHA staff used trending mechanisms to monitor claims submissions which ensured data completeness prior to rate production. **DVHA** also refreshed administrative data frequently to ensure inclusion of the most recent claim information available for measure calculation. [***Quality***]

DVHA partnered with Gainwell Technologies (formerly DXC Technologies) to manage its core systems. **DVHA**'s oversight of Gainwell ensured that Gainwell met the requirements for data capture and HEDIS reporting. Gainwell actively participated in quality meetings and participated in **DVHA**'s virtual review. ***[Quality]***

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 the ***quality***, ***timeliness***, and ***accessibility of care*** demonstrated strengths by meeting or exceeding the 90th percentile, including *Follow-Up After ED Visit for Mental Illness—7-Day and 30-Day Follow-Up—6–17 Years, 18–64 Years, and Total,* and *Follow-Up After ED Visit for AOD Abuse or Dependence—7-Day and 30-Day Follow-Up—18+ Years and Total.*

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 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. Using the VITL repository will impact the ***quality***, ***timeliness***, and ***accessibility of care*** received by beneficiaries. **DVHA** should begin to utilize data captured from EHRs from providers. EHR sources would complement administrative capture and reduce reliance on hybrid abstraction. **[*Quality*]**

Conclusions Related to Compliance With Standards

To draw conclusions about the ***quality***, ***timeliness***, and ***accessibility of care*** **DVHA** provided, HSAG determined which components of each compliance review standard could be used to assess these domains. Table 3-3 illustrates the ***quality***, ***timeliness***, and ***access*** domains related to the compliance review standards.

HSAG evaluated the standards reviewed during 2022–2023 and determined the following conclusions concerning the domains of ***quality***, ***timeliness***, and ***access***. Table 3-3 illustrates the ***quality***, ***timeliness***, and ***access*** domains related to the compliance review standards.

Table 3-3—Compliance Review Standards Components Assessing Quality, Timeliness, and Access

Compliance Review Standards	Quality	Timeliness	Access
Standard I—Availability of Services	✓	✓	✓
Standard II—Assurances of Adequate Capacity and Services	✓	✓	✓
Standard III—Cultural Competence	✓	✓	✓
Standard IV—Coordination and Continuity of Care	✓	✓	✓
Standard V—Coverage and Authorization of Services	✓	✓	✓
Standard VI—Emergency and Poststabilization Services	✓	✓	✓
Standard VII—Enrollment and Disenrollment Requirements	✓	✓	✓

Each of the compliance review standards included elements representing the domains of ***quality***, ***timeliness***, and ***access***. *Met* elements in the standards reviewed this year addressed all three domains. HSAG offered the following conclusions and recommendations for continued performance improvement.

- **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. Producing and analyzing the required geographic reports to determine compliance with the required access standards could assist in identifying areas on which to focus efforts to improve the ***accessibility of care*** provided to beneficiaries.
- **DVHA** must ensure that if the contracted network is unable to provide medically necessary services, covered under the AHS IGA, to a particular enrollee, **DVHA** adequately and in a timely manner covers these services out-of-network for the enrollee, as long as the entity is unable to provide them. Such processes could assist in identifying access issues and serve as an area on which to focus efforts to improve the ***quality***, ***timeliness***, and ***accessibility of care*** furnished to beneficiaries.
- **DVHA** did not have an Access to Care Plan in place throughout the review period and the General Provider Manual did not inform providers about access to care requirements. **DVHA** must ensure that access standards for preventive care and nonurgent, nonemergent, and urgent conditions are disseminated to all network providers. Informing network providers about and monitoring compliance with access standards could assist **DVHA** to improve ***timeliness*** and ***accessibility of care*** to beneficiaries.
- **DVHA** must generate geographic access reports to determine if the requirement for beneficiaries to access PCPs, hospitals, ophthalmology/optometry, laboratory, advanced imaging, pharmacy, and dental services is met. Geographic access report findings could assist **DVHA** to identify network insufficiencies and implement strategies to improve the ***accessibility of care*** furnished to beneficiaries.
- **DVHA** and its IGA partners must provide best efforts to conduct an initial screening of each enrollee's needs, within 90 days of the effective date of enrollment for all new enrollees, including subsequent attempts if the initial attempt to contact the enrollee is unsuccessful.

Increased efforts to conduct screenings of enrollees' needs could improve the ***quality***, ***timeliness***, and ***accessibility of care*** furnished to beneficiaries.

DVHA Aggregated Conclusions Concerning Strengths and Weaknesses in the Quality, Timeliness, and Access Domains

Table 3-4—Aggregated Conclusions Regarding DVHA Strengths in the Quality, Timeliness, and Access Domains

Quality	Timeliness	Access	Strengths
✓	✓	✓	The compliance review revealed that **DVHA** and its IGA partners had mechanisms to assess each enrollee identified as having special health care needs in order to identify any ongoing special conditions of the enrollee that required a course of treatment or regular care monitoring. **DVHA** scored at or above the 95th percentile for the following utilization of services HEDIS measures: *Follow-Up After ED Visit for Mental Illness—7-Day—6–17 Years, 18–64 Years, and Total,* and *Follow-Up After ED Visit for Mental Illness—30-Day—6–17 Years.* These measure strengths provide **DVHA** with the opportunity to impact the ***quality***, ***timeliness***, and ***accessibility of care*** furnished to beneficiaries.
✓			**DVHA**'s PIP topic validated for 2022–2023, *Managing Hypertension*, addressed the management and control of hypertension and was based on the HEDIS 2022 *Controlling High Blood Pressure (CBP)* measure. **DVHA**'s *Managing Hypertension* PIP received a score of 100 percent for all applicable evaluation elements in the Design and Implementation stages and received and an overall validation status of *Met.* The activities associated with the PIP assisted in **DVHA**'s achieving a 9.49 percentage point positive change in the MY 2021 HEDIS rating from the rate achieved in MY 2020. The PIP strengths provided **DVHA** with the opportunity to impact the ***quality*** of care furnished to beneficiaries.

Table 3-5—Aggregated Conclusions Regarding DVHA Weaknesses in the Quality, Timeliness and Access Domains

Quality	Timeliness	Access	Weaknesses
✓	✓	✓	**DVHA** scored below the 25th percentile for the following preventive care HEDIS measures: *Breast Cancer Screening* and *Chlamydia Screening in Women—16–20 Years, 21–24 Years, and Total.* Related to this, the compliance review activity identified clinical practice guidelines (CPGs) available to **DVHA**'s providers that could positively impact rates for these measures: *Preventive Screenings/Care Recommendations: U.S. Preventive Services Task Force A and B Recommendations.* **Recommendation:** To improve the *Breast Cancer Screening* and *Chlamydia Screening in Women* measures, **DVHA** should consider developing mechanisms to outreach to both members and providers and communicate the importance of preventive care screenings. This activity could positively

Quality	Timeliness	Access	Weaknesses
			impact the ***quality***, ***timeliness***, and ***accessibility of care*** furnished to beneficiaries.
✓	✓	✓	The 2022–2023 compliance review revealed that **DVHA** did not document best efforts to conduct an initial screening of each enrollee's needs, within 90 days of the effective date of enrollment for all new enrollees, including subsequent attempts if the initial attempt to contact the enrollee was unsuccessful. **DVHA** scored below the 50th percentile for the following utilization of services HEDIS measure, which could affect the ***quality***, ***timeliness***, and ***accessibility of care*** furnished to beneficiaries: *Ambulatory Care (ED Visits)—10–19 Years, 65–74 Years, 75–84 Years, and 85+ Years.* **Recommendation: DVHA** should consider developing plan documents related to emergency care and ensure that members and network providers are informed of the emergency care requirements. This activity could positively impact the ***quality***, ***timeliness***, and ***accessibility of care*** furnished to beneficiaries.
✓	✓	✓	During the 2022–2023 compliance review, **DVHA** did not produce evidence of monitoring the appointment wait times to ensure that appointment wait times did not exceed 90 days for preventive care, including routine physical examinations for calendar year (CY) 2021. Since **DVHA** did not determine if providers met the wait-time requirements, ***accessibility of care*** may have been a major factor in the following preventive care HEDIS ratings scoring below the Medicaid 25th percentile: *Breast Cancer Screening; Chlamydia Screening in Women—16–20 Years, 21–24 Years, and Total; Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—3–11 Years, 12–17 Years, and Total;* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—12–17 Years.* **Recommendation: DVHA** must conduct monitoring of appointment wait times to ensure that appointment wait times do not exceed 90 days for preventive care, including routine physical examinations. This activity could positively impact the ***quality***, ***timeliness***, and ***accessibility of care*** furnished to beneficiaries.
✓	✓	✓	During the SFY 2022–2023 compliance review, **DVHA** did not produce evidence of monitoring to ensure a maximum 30-mile travel distance standard to PCPs and a maximum 60-mile travel standard to specialty care, including cardiology, urology, and mental health and substance use treatment specialists. Staff members confirmed that **DVHA** did not produce geographical information **s**ystems (GIS) maps in CY 2021. Since **DVHA** did not determine if providers met the GIS distance requirements for substance use treatment specialists, ***timeliness*** and ***accessibility of care*** may have been a major factor in HEDIS ratings for *Initiation and Engagement of AOD*

Quality	Timeliness	Access	Weaknesses
			Abuse or Dependence Treatment (Initiation)—13–17 Years—Total, 18+ Years—Total, and Total—Total scoring below the Medicaid 25th percentile. **Recommendation: DVHA** must conduct monitoring to produce GIS maps to ensure compliance with the maximum travel distance to PCPs and specialty care provider access standards. This activity could positively impact the ***quality***, ***timeliness***, and ***accessibility of care*** furnished to beneficiaries.

4. Assessment of Vermont's Quality Strategy

Background

As specified in 42 CFR §438.340(b)(2), a State's quality strategy must include goals and objectives for continuous QI, which must be measurable and take into consideration the health status of all populations served. The Vermont Medicaid Comprehensive Quality Strategy (CQS), dated October 11, 2021, 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 CQS 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 and Health Outcomes[4-1] measures (i.e., Consumer Assessment of Healthcare Providers and Systems [CAHPS®][4-2] survey). The Vermont Medicaid *Global Commitment to Health* waiver program has selected performance targets and metrics, including preventive care and annual care measures.

The Vermont Quality Strategy defined measures and baseline rates using NCQA's Quality Compass[4-3] national Medicaid HMO percentiles for HEDIS. Vermont established the 50th percentile annually as the benchmark for access to care and quality of care measures. Table 4-1 displays those measures and identifies the five-year goal listed in the quality strategy. The table compares the MY 2019 score with the MY 2020 and MY 2021 performance scores for those measures. The table also identifies the percentile achieved for MY 2021.

Table 4-1—Quality Strategy Goals Comparison of MY 2019, MY 2020, and MY 2021 Performance Rates

Quality Strategy Goal (1/1/2017—12/31/2021)	Performance Measure	MY 2019 Performance Score	MY 2020 Performance Score	MY 2021 Performance Score	MY 2021 Percentile Rank
AHS will maintain its performance in preventive/ambulatory care visits of Adult Medicaid managed care beneficiaries over the next five years **[*Quality* and *Access*]**	*Adults' Access to Preventive/Ambulatory Health Services—Total*	83.30%	78.46%	77.63%	25th–50th

4-1 ECHO® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
4-2 CAHPS® is a registered trademark of the AHRQ.
4-3 Quality Compass® is a registered Trademark of the National Committee for Quality Assurance (NCQA).

Quality Strategy Goal (1/1/2017—12/31/2021)	Performance Measure	MY 2019 Performance Score	MY 2020 Performance Score	MY 2021 Performance Score	MY 2021 Percentile Rank
AHS will demonstrate an improvement in enrollee breast cancer screening over the next five years **[*Quality*, *Timeliness*,** and ***Access***]	*Breast Cancer Screening*	52.33%	48.57%	46.16%	5th–10th
AHS will demonstrate an improvement in enrollee chlamydia screening in women ages 16–24 years over the next five years **[*Quality*, *Timeliness*,** and ***Access*]**	*Chlamydia Screening in Women—Total*	52.98%	46.46%	45.79%	10th–25th
AHS will demonstrate an improvement in follow-up after hospitalization for mental illness (7 day) over the next five years **[*Quality*, *Timeliness*,** and ***Access*]**	*Follow-Up After Hospitalization for Mental Illness—7-day Follow-Up—Total*	38.73%	45.05%	46.04%	50th–75th
AHS will demonstrate an improvement in follow-up after hospitalization for mental illness (30 day) over the next five years **[*Quality, Timeliness,* and *Access*]**	*Follow-Up After Hospitalization for Mental Illness—30-day Follow-Up—Total*	60.50%	64.75%	65.83%	50th–75th
AHS will demonstrate an improvement in initiation and engagement of AOD dependence treatment over the next five years **[*Quality, Timeliness,* and *Access*]**	*Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation)—Total—Total*	43.22%	45.04%	40.35%	25th–50th
AHS will demonstrate an improvement in initiation and engagement of AOD dependence treatment over the next five years **[*Quality, Timeliness,* and *Access*]**	*Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Engagement)—Total—Total*	22.16%	22.61%	18.68%	75th–90th
AHS will demonstrate an improvement in controlling enrollee high blood pressure over the next five years **[*Quality, Timeliness,* and *Access*]**	*Controlling High Blood Pressure*	—	42.58%	52.07%	25th–50th

DVHA achieved or exceeded the benchmark of the 50th percentile rate for three of the eight measures listed in Table 4-1.

Recommendations

It is possible that COVID-19 impacted performance rates due to the public health emergency and temporary closing of providers' offices. Behavioral health performance measure improvements could have been impacted by increased access to telehealth services.

To improve preventive care and access-related performance measures, and to improve performance of the compliance review requirements, AHS should consider focusing improvement efforts on the recommendations listed below.

- The Vermont Quality Strategy maintained that AHS' monitoring activities included requiring **DVHA** and the Departments to provide evidence of having adopted CPGs for the treatment of at least two acute or chronic health conditions. To strengthen the Quality Strategy, AHS should consider requiring the adoption of additional CPGs for performance areas that have demonstrated a decreased performance rate or have not achieved the target performance rate, such as controlling high blood pressure, breast cancer screening, and chlamydia screening. Including CPGs for these performance areas could improve the ***quality***, ***timeliness***, and ***accessibility of care*** provided to beneficiaries.
- AHS should consider requiring **DVHA** to identify health care disparities within the preventive care and access-related performance measure data to focus its QI and PIP efforts on disparate populations. Improvement efforts in these areas could impact the ***quality***, ***timeliness***, *and* ***accessibility of care*** provided to beneficiaries.
- Periodically, HEDIS measures may be retired, or performance measure specifications may be modified. AHS should consider reviewing the Quality Strategy priority areas and associated objectives and performance targets to ensure these objectives and performance targets align with current HEDIS performance measure specifications. Periodic review of priority areas, objectives, and performance targets could impact the ***quality***, ***timeliness***, and ***accessibility of care*** provided to beneficiaries.
- To strengthen the Quality Strategy, AHS could consider establishing specific objectives, quantifiable performance targets, and interventions associated with continuous QI efforts to improve and sustain optimal performance rates. Once specific objectives and interventions have been established for performance measures, AHS could review performance indicator rates and identify opportunities for improvement in the ***quality***, ***timeliness***, and ***accessibility of care***. After 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. AHS also could consider evaluating whether the 50th percentile benchmark is appropriate for all measures.
- AHS also could consider establishing a methodology for reducing the gap between the performance measure rates and achieving the established goals. For example, AHS could recommend reducing the gap between the actual rate and the performance measure goal by 10 percent annually. Identifying the desired improvement percentages and specifying improvement targets based on the current rates for each measure could impact the ***quality***, ***timeliness***, and ***accessibility of care*** for beneficiaries.

- **DVHA** could consider conducting telephone outreach or virtual member focus groups to determine barriers to care that exist for beneficiaries eligible to receive mammograms or chlamydia screenings with Pap smears (e.g., lack of telephone to schedule appointments, lack of transportation, lack of childcare, and homelessness). This could improve the ***timeliness*** and ***accessibility of care***.
- **DVHA** also could consider implementing measures to ensure appointment availability to PCPs and obstetricians/gynecologists for access to breast cancer and chlamydia screenings. This could improve the ***timeliness*** and ***accessibility of care***.
- AHS/**DVHA** also could consider incentive payments to beneficiaries for preventive care visits, which could improve the ***timeliness*** and ***accessibility of care***, and impact preventive care performance rates.
- **DVHA** could consider giving beneficiaries blood pressure monitors to ensure that they have a mechanism to monitor blood pressure at home. This effort could improve the ***quality***, ***timeliness***, and ***accessibility of care*** and impact the *Controlling High Blood Pressure* performance measure.
- AHS/**DVHA** also could consider developing a formal oversight and monitoring program for IGA partners to improve the consistency in coordination and continuity of care. This effort could improve the ***quality***, ***timeliness***, and ***accessibility of care*** for beneficiaries.
- AHS/**DVHA** could consider establishing specific goals and benchmarks related to initial health screenings of all newly enrolled beneficiaries within 90 days of enrollment. This effort could enhance the identification of beneficiary special health care needs and impact the ED visit performance rates and improve the ***quality*** and ***accessibility of care*** for beneficiaries.

5. Description of External Quality Review Activities

Validation of Performance Improvement Project

During the 2022–2023 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 *Managing Hypertension* PIP validation activities in its Performance Improvement Projects Validation Report for **DVHA**. HSAG provided this report 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(b)(1). The purpose of a PIP is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical and 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 system interventions to achieve improvement in the access to and quality of care.
- Evaluating the effectiveness of the interventions.
- Planning and initiation of activities for increasing and sustaining improvement.

Description of Data Obtained

HSAG reviewed the documentation that **DVHA** submitted for the one PIP validated by HSAG. The PIP was submitted using HSAG's PIP Submission Form, which HSAG developed to collect all required data elements for the PIP validation process. **DVHA** completed the PIP Submission Form following instructions provided by the HSAG PIP 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 throughout the PIP process. **DVHA** achieved all validation criteria with the first submission, and a resubmission was not necessary.

Technical Methods of Data Collection/Analysis

Data Collection Methods

Table 5-1—Performance Improvement Project Topics, HEDIS Measure, and Data Source for DVHA

PIP Topic	HEDIS Measure	Data Source
Managing Hypertension	*CBP*	*Hybrid*

HSAG conducted the validation consistent with the CMS publication, *Protocol 1: Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019, cited earlier in this report. 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, and in future submissions, will determine the overall success in achieving significant and sustained improvement. Over the course of the PIP, HSAG will validate the following CMS Protocol 1 steps:

- Step 1—Review the Selected PIP Topic
- Step 2—Review the PIP Aim Statement
- Step 3—Review the Identified PIP Population
- Step 4—Review the Sampling Method
- Step 5—Review the Selected PIP Indicator(s)
- Step 6—Review the Data Collection Procedures
- Step 7—Review Data Analysis and Interpretation of Results
- Step 8—Assess the Improvement Strategies
- Step 9—Assess for Significant and Sustained Improvement

HSAG's PIP validation process consisted of two independent validations that included a validation by team members with expertise in statistics, PIP 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.
- HSAG conducted the validation, and the PIP Validation Tool was completed.
- HSAG reconciled the scores by a secondary review. If the two reviewers produced scoring discrepancies, the PIP Team discussed the discrepancies and reached a consensus for the final evaluation element score(s).
- Each required CMS Protocol 1 step consisted of evaluation elements necessary to complete the validation of that activity. The PIP Team scored the evaluation elements within each activity as *Met*, *Partially Met*, *Not Met*, *Not Applicable* (*NA*), 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 *NA* 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 element (as described in the narrative of the PIP); however, enhanced documentation would demonstrate a stronger application of the CMS Protocol 1.

- 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 (NA):* Elements designated *NA* (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, HSAG prepared the draft and final **DVHA** Performance Improvement Projects Validation Report for AHS and **DVHA**.

Determining Conclusions

To draw conclusions about the ***quality***, ***timeliness***, and ***accessibility of care*** **DVHA** provided, HSAG determined which components of the PIP could be used to assess these domains. During contract year 2022–2023, the **DVHA** PIP completed Steps 7 and 8, reported baseline data, and conducted quality improvement processes and interventions. Therefore, no conclusions could be drawn related to the PIP. These conclusions will be formulated after remeasurement data are reported (Step 9) and results from intervention testing are provided. PIP outcomes will be reported in the SFY 2023–2024 EQR technical report.

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 MY 2021, **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 MY 2021.

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 virtual review 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**.
- **Virtual 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 HEDIS measures. Since all the performance measures under the scope of this validation were approved by NCQA in 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-Virtual 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** completed 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 MY 2021 calculation and reporting. All performance measures under the scope of this review were certified by NCQA for HEDIS MY 2021; 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.

Virtual 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 virtual review activities (including any measure-specific concerns) and discussed follow-up actions.

Post-Virtual 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 years' performance and national Medicaid benchmarks.

Determining Conclusions

To draw conclusions about the ***quality***, ***timeliness***, and ***accessibility of care*** that **DVHA** provided, HSAG determined which components of each performance measure could be used to assess these domains. 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. 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.

Objectives and Background Information

According to 42 CFR §438.358,[5-1] 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. 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**.

[5-1] 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: Feb 17, 2023.

- 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 requirements described at 42 CFR §438.56–§438.56, §438.114, and §438.206–§438.210, 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 three performance areas associated with the CMS Medicaid managed care regulations described at §438.54–§438.56, §438.114, and §438.206–§438.210.

I. Availability of Services
II. Assurances of Adequate Capacity and Services
III. Cultural Competence
IV. Coordination and Continuity of Care
V. Coverage and Authorization of Services
VI. Emergency and Poststabilization Services
VII. Enrollment and Disenrollment

As these same standards were reviewed during four prior audits (i.e., 2010, 2013, 2016, and 2019), HSAG evaluated **DVHA**'s current performance and compared the results to those from the earlier reviews of these same standards.

Description of Data Obtained

Table 5-2—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	January 1—December 31, 2021
Information obtained through interviews with **DVHA** staff members	August 30–31, 2022

To assess **DVHA**'s compliance with federal regulations, State rules, and contract requirements, HSAG obtains information from a wide range of written documents produced by **DVHA**, including, but not limited to, the following for the SFY 2022 compliance review:

- Committee meeting agendas, minutes, and handouts
- Written policies, procedures, and other plan documents with creation or revision dates prior to the end of the review period (i.e., December 31, 2021)
- The Member Handbook, newsletters, and additional documents sent to members
- The Provider Manual, newsletters, and other **DVHA** communication to providers/subcontractors
- The automated member website
- The automated provider portal and directory
- Narrative and/or data reports across a broad range of performance and content areas
- MCO Questionnaire sent to the MCO with the pre-site documents

HSAG obtains additional information for the compliance review through interactive discussions and interviews with **DVHA**'s key staff members.

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 one and one-half days 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 one and one-half days 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. HSAG included the completed tool as one section of the compliance report. Table 5-3 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 5-3 also presents a more detailed, chronological description of the above activities that HSAG performed during its review.

Table 5-3—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 development of CPGs, dissemination of the guidelines to providers and beneficiaries, QAPI initiatives and activities, and **DVHA**'s operations, resources, and information systems. 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 assisted 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 documenting **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

While the focus of a compliance review is to evaluate if **DVHA** correctly implemented the federal and State requirements, the results of the review can also determine areas of strength and weakness for **DVHA** related to the ***quality***, ***timeliness***, and ***accessibility of care***. Once HSAG calculates the scores for each standard, the reviewers evaluate each element scoring *Met, Partially Met,* and *Not Met* to determine how the elements relate to the three domains as defined on page 3-1. At that point, HSAG can draw conclusions for **DVHA** concerning the ***quality***, ***timeliness***, and ***accessibility of care*** from the results of the compliance review.

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 *NA* 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). If requested, HSAG also can assist in the review of CAPs from **DVHA** to determine if their proposed corrections will meet the intent of the requirements that were scored *Partially Met* or *Not Met*.

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, §438.56, §438.100, §438.114, and §438.330 of the BBA, and the State contractual requirements.[5-2,5-3,5-4] Those requirements are shown in Table 5-4. The 2022–2023 compliance review included standards for Year 3 of the three-year cycle.

[5-2] U.S. Government Printing Office. (2019). *Title 42 Part 438 Subpart D*. Available at: https://www.govregs.com/regulations/expand/title42_chapterIV_subpartD_section438.206. Accessed on Feb 17, 2023.

[5-3] 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: Feb 17, 2023.

[5-4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care*, §15, page 72818, Nov 2020. Available at: https://www.federalregister.gov/documents/2020/11/13/2020-24758/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care. Accessed on: Feb 17, 2023.

AHS elected to establish a cycle of reviewing one-third of the compliance review standards each fiscal year. HSAG and AHS established the three-year cycle in 2007–2008, the first year that HSAG operated as the EQRO for Vermont. That same cycle has been maintained for the compliance reviews throughout the years. The cycle was established to ensure that the HSAG reviewed the required CFR elements at least every three years. Table 2-9 lists the overall scores achieved during the compliance reviews each year. Table 5-4 includes the location of the requirements in the Vermont compliance tool and the year those requirements are included in the compliance review.

Table 5-4—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 2020–2021	Year 2 2021–2022	Year 3 2022–2023
§438.10	Information Requirements	Standard III—Cultural Competence			X
§438.56	Disenrollment: Requirements and Limitations	Standard VII—Disenrollment Requirements			X
§438.100	Enrollee Rights	Standard IV—Beneficiary Rights	X		
§438.114	Emergency and Poststabilization Services	Standard VI—Emergency and Poststabilization Services			X
§438.206	Availability of Services	Standard I—Availability of Services			X
		Standard III–Beneficiary Information	X		
§438.207	Assurances of Adequate Capacity and Services	Standard II—Assurances of Adequate Capacity and Services			X
§438.208	Coordination and Continuity of Care	Standard IV—Coordination and Continuity of Care			X
§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		

CFR	CMS Standard	Standard in Vermont Compliance Tool	Year the Requirements Are Reviewed in Vermont		
			Year 1 2020–2021	Year 2 2021–2022	Year 3 2022–2023
§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	
§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	

6. 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 (2021–2022), HSAG validated **DVHA**'s PIP, *Managing Hypertension*. The validation process included **DVHA**'s submission of the PIP and HSAG's completion of the validation tool. For the first six steps validated 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 6-1—Performance Improvement Project—Recommendations/Suggestions and DVHA Responses

HSAG Recommendations	DVHA Response/Actions/Outcomes
DVHA should use quality improvement tools such as a causal/barrier analysis, key driver diagram, process mapping, and/or failure modes and effects analysis to determine and prioritize barriers, drivers, and/or weaknesses within processes. The use of these tools will help the MCE determine what interventions to test and implement.	**DVHA response: DVHA** used appropriate quality improvement tools as it progressed to conducting quality improvement activities. **DVHA** created and reviewed a project charter and completed a cause-and-effect diagram for its causal/barrier analysis. **DVHA**'s PIP team brainstormed the bones of the diagram to prioritize the identified barriers to determine what interventions to test and implement.
DVHA should develop active, innovative interventions that have the potential for impacting the performance indicator outcomes.	**DVHA response: DVHA** developed appropriate active interventions that aligned with the identified barriers and have the potential to impact the desired outcomes for the PIP.
DVHA should develop a process or plan to evaluate the effectiveness of each individual intervention.	**DVHA response:** For each individual intervention, **DVHA** had a corresponding method to evaluate the effectiveness and will report results with the next annual submission.
DVHA should use Plan-Do-Study-Act (PDSA) cycles as part of the improvement strategies. Interventions can be tested on a small scale, evaluated, and then expanded to full implementation, if deemed successful.	**DVHA response: DVHA** has methodologically sound evaluation processes in place for each intervention.

HSAG Recommendations	DVHA Response/Actions/Outcomes
DVHA should revisit the causal/barrier analysis tools used at least annually to ensure the MCE remains on track and the identified barriers and opportunities for improvement are still relevant and applicable.	**DVHA response: DVHA** will ensure that it revisits its causal/barrier analysis as it progresses through the first remeasurement period.
DVHA should use the PIP Completion Instructions as additional steps of the PIP process as completed. This will help **DVHA** ensure all documentation requirements have been addressed.	**DVHA response: DVHA** met all of the documentation requirements. **DVHA** references the PIP Completion Instructions to ensure all documentation requirements are addressed.

Validation of Performance Measures

HSAG validated 15 performance measures during the previous EQR contract year (2020–2021). 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 6-2—Performance Measure—Recommendations/Suggestions and DVHA Responses

HSAG Recommendations	DVHA Response/Actions/Outcomes
While COVID-19 restricted many of the potential areas for improvement in measurement year 2020, prior HSAG recommendations noted that **DVHA** should continue to strengthen medical record retrieval processes to achieve improved medical record retrieval rates.	**DVHA response: DVHA** increased its medical record retrieval rate by enforcing providers' contractual obligations that allow **DVHA** access to medical records for quality improvement and performance measurement activities.
HSAG also continues to recommend that **DVHA** utilize all available resources to capture supplemental data. It did not appear that **DVHA** captured any data using Vermont's clinical repository, operated by Vermont Information Technology Leaders (VITL). VITL could potentially be an untapped resource for capturing supplemental data.	**DVHA response: DVHA** is pursuing supplemental data sources to improve service gap closures.

Monitoring Compliance With Standards

During the 2021 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 three standards included requirements associated with federal Medicaid standards found at 42 CFR §438.236, §438.242, and §438.330. The standards HSAG evaluated were those related to the following:

I. Practice Guidelines
II. QAPI Program
III. Health Information Systems

HSAG reviewed this same set of standards during the 2009, 2012, 2015, 2018, and 2021 compliance reviews.

The standards included, but were not limited to, performance requirements for **DVHA**'s processes and related documentation for:

- Adopting and applying practice guidelines.
- Requirements for conducting performance improvement projects (PIPs).
- Collecting, measuring, and reporting performance for AHS-required measures regarding the quality and timeliness of, and access to care.
- Mechanisms for detecting both under- and overutilization of services.
- Mechanisms for assessing the quality and appropriateness of care furnished to beneficiaries with special health care needs.
- Performance in maintaining a management information system for collecting, analyzing, integrating, and reporting data on key performance indicators, reasons for beneficiary disenrollment, beneficiary and provider characteristics, and services furnished to beneficiaries.
- Ensuring the completeness, accuracy, and validity of provider claims data.

HSAG reviewed **DVHA**'s performance related to 24 elements across the three standards. Of the 24 requirements, **DVHA** obtained a score of *Met* for 22 elements and a score of *Partially Met* for two elements. As a result, **DVHA** obtained a total percentage of compliance across the 24 requirements of 95.8 percent, for which HSAG offered suggestions to **DVHA** to further strengthen its processes, performance, and documentation.

Table 6-3—Monitoring Compliance With Standards—Recommendations/Suggestions and DVHA Responses

HSAG Recommendations	DVHA Responses/Actions/Outcomes
DVHA must ensure that the QAPI program includes mechanisms to assess the quality and appropriateness of care furnished to enrollees using long-term services and supports (LTSS). The information should include an assessment of care between care setting and a comparison of services and supports received with those set forth in the enrollee's treatment/service plan.	**DVHA response:** In October 2021, **DVHA** initiated a comprehensive assessment of the QAPI activities across the Agency of Human Services. **DVHA**'s objective was to assess the current state of QAPI activities and develop a standardized set of reporting requirements and monitoring procedures for all Medicaid programs in Vermont, including our LTSS programs. This assessment was completed in the first half of 2022 and after collaboration with each program, Medicaid Reporting Scorecards were established that include performance measures specific to treatment/service plans. These reporting scorecards will be presented on a rotating basis to **DVHA**'s Quality Committee. **DVHA** is also participating in an AHS-lead process to develop Home- and Community-Based Services (HCBS) Assurances Performance Measures that will identify a mechanism to assess the quality and appropriateness of care furnished to enrollees using LTSS.
DVHA must ensure that the QAPI plan includes mechanisms to assess the appropriateness of care for members with special health care needs. Specifically, the treatment plan must identify specialist services that may be accessed directly by the beneficiary as appropriate for that beneficiary's condition and identified need.	**DVHA response:** In October 2021, **DVHA** initiated a comprehensive assessment of the QAPI activities across the Agency of Human Services. **DVHA**'s objective was to assess the current state of QAPI activities and develop a standardized set of reporting requirements and monitoring procedures for all Medicaid programs in Vermont, including programs that serve special healthcare needs populations. This assessment was completed in the first half of 2022 and after collaboration with each program, Medicaid Reporting Scorecards were established that include performance measures specific to treatment/service plans. These reporting scorecards will be presented on a rotating basis to **DVHA**'s Quality Committee.