State of Vermont

VERMONT

Agency of Human Services
(AHS)

2014–2015 External Quality Review Technical Report

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1. Executive Summary

Background

The Balanced Budget Act of 1997 (BBA), Public Law 105-33, and as described in the Code of Federal Regulations (CFR) [42 CFR §438.364], requires state Medicaid agencies to contract with an external quality review organization (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. The report must also describe how conclusions were drawn as to the quality and timeliness of, and access to, care furnished by the Medicaid managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs). The Vermont Agency of Human Services (AHS) chose to meet this requirement by contracting with Health Services Advisory Group, Inc. (HSAG), an EQRO, beginning in contract year (CY) 2007–2008 to conduct the three Centers for Medicare & Medicaid Services (CMS) required activities and to prepare the EQR annual technical report bringing together the results from the activities it conducted. This report meets the requirements of 42 CFR §438.364 and does not disclose the identity of any member.

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 the **Department of Vermont Health Access** (**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 intergovernmental agreements (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 AHS' contract year 2013–2014, **DVHA**, as the State's single statewide Medicaid managed care organization, provided health care services to the State's Medicaid beneficiaries and collected performance data. During the EQRO contract year (February 2014–February 2015), HSAG conducted the three mandatory external quality review (EQR) activities and an evaluation and analysis of **DVHA**'s performance data from the prior year. The results of HSAG's review are contained in this 2014–2015 Technical Report.

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

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

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

The Department of Vermont Health Access (DVHA)

DVHA is the State department responsible for the management of Medicaid, the Vermont Children's Health Insurance Program (CHIP), and other publically funded health insurance programs in Vermont. **DVHA** is the largest insurer in Vermont in terms of dollars spent and the second largest in terms of covered lives. It is also responsible (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:

- Provide leadership for Vermont stakeholders to improve access, quality, and cost effectiveness in health care reform.
- Assist Medicaid beneficiaries in accessing clinically appropriate health services.
- Administer Vermont's public health insurance system efficiently and effectively.
- Collaborate with other health care system entities in bringing evidence-based practices to Vermont Medicaid beneficiaries.

Scope of HSAG's 2014–2015 EQR Activities

HSAG's external quality review in contract year 2014–2015 consisted of conducting the following activities:

- ***Validation of* DVHA's *performance improvement project (PIP)***. HSAG reviewed **DVHA**'s PIP to ensure that the organization designed, conducted, and reported on the project in a methodologically sound manner, allowing measurement of any real improvements in care and services, and giving confidence in the reported improvements.

- ***Validation of* DVHA's *performance measures***. HSAG validated the accuracy of the AHS-required performance measures that **DVHA** reported. The validation also determined the extent to which Medicaid-specific performance measures calculated by **DVHA** followed specifications established by AHS.
- ***Review of* DVHA's *compliance with standards***. HSAG conducted a review to determine the organization's compliance with performance standards (sets of requirements) described in the federal Medicaid managed care Structure and Operations Standards at 42 CFR §438.214–230 and with the associated requirements contained in the AHS Intergovernmental Agreement (i.e., contract) with **DVHA**.
- ***Preparation of the external quality review annual technical report***. HSAG compiled and analyzed all data from its 2014–2015 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 it conducted.

Validation of the Performance Improvement Project (PIP)

HSAG conducted a validation of **DVHA**'s new PIP, *Follow-up After Hospitalization for Mental Illness*. The methodology HSAG used to validate the PIP was based on CMS' PIP validation protocol.[1-1] The validation covered Activities I through VIII.

The purpose of the study was to improve follow-up after an inpatient stay for selected mental health disorders. Follow-up after discharge is important for continuity of care between treatment settings and in ensuring that members receive needed care and services. Members receiving appropriate follow-up care can reduce the risk of repeat hospitalization. **DVHA**'s goal is to increase the percentage of members six years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 and 30 days of discharge. **DVHA** used data from calendar year 2013 to establish its baseline measurement.

DVHA's *Follow-up After Hospitalization for Mental Illness* 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 1-1.

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR), Version 2.0*, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

Table 1-1—2014–2015 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*.
****Met* indicates high confidence/confidence that the PIP was valid. *Partially Met* indicates low confidence that the PIP was valid. *Not Met* indicates reported PIP results that were not credible.

Table 1-2 displays **DVHA**'s performance across all PIP activities. The second 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. The third column represents the total number of critical elements *Met* for each activity reviewed compared to the total number of applicable critical evaluation elements.

Table 1-2—Performance Across All Activities			
	Review Activities	**Total Number of Evaluation Elements *Met*/Total Number of Applicable Evaluation Elements**	**Total Number of Critical Elements *Met*/Total Number of Applicable Critical Evaluation Elements**
I.	Select the Study Topic	2/2	1/1
II.	Define the Study Question(s)	1/1	1/1
III.	Define the Study Population	1/1	1/1
IV.	Select the Study Indicator(s)	1/1	1/1
V.	Use Sound Sampling Techniques	0/0	0/0
VI.	Reliably Collect Data	3/3	1/1
VII.	Analyze Data and Interpret Study Results	3/3	1/1
VIII.	Implement Intervention and Improvement Strategies	5/5	3/3
IX.	Assess for Real Improvement	Not Assessed	Not Assessed
X.	Assess for Sustained Improvement	Not Assessed	Not Assessed

The validation results indicated an overall score of 100 percent across all applicable evaluation elements and a finding of high confidence in the reported results. The solid structure of the PIP will allow the State and other stakeholders to have confidence in subsequent remeasurements and any real and sustained improvement that is reported as this PIP progresses.

Validation of Performance Measures

HSAG validated a set of 13 AHS-required performance measures as calculated by **DVHA**. The 13 measures included 47 clinical indicators (or rates). HSAG conducted the validation activities consistent with CMS' *EQR Protocol 2*: *Validation of Performance Measures Reported by the MCO:*

A Mandatory Protocol for External Quality Review (EQR), Version 2.0, September 2012.[1-2] The performance measurement period was calendar year 2013. AHS selected the 13 measures from the 2014 Healthcare Effectiveness Data and Information Set (HEDIS®[1-3]). HSAG determined that all 13 measures were fully compliant with HEDIS specifications and were valid and accurate for reporting.

DVHA Reporting Capabilities

All measures received a validation finding of *Fully Compliant*. **DVHA** continues to implement HSAG's recommendations from the previous years to reinforce support and commitment to the performance measure reporting process. This was evident by the staff members' dedication to quality improvement and operational changes that have been made to improve performance measure reporting, specifically using hybrid methodology to test rate increases. **DVHA** also contracted with a software vendor that passed the NCQA measure certification to calculate and report the HEDIS 2014 performance measures. The data systems **DVHA** used to process and collect claims and encounters, provider data, and membership data were assessed and determined to meet all applicable audit standards. **DVHA** is implementing hybrid reporting methodology for rate testing purposes only at this point. **DVHA** has been urged to report using the hybrid methodology, but for this year, all measures were reported using the administrative method.

Performance Measure Results

Table 1-3 below displays the performance measure results, including a comparison to the prior year's rates and the HEDIS 2013 national Medicaid percentiles.

Table 1-3—DVHA HEDIS 2014 Results

	Performance Measure	HEDIS 2013 Rate	HEDIS 2014 Rate	Percentage Point Change	HEDIS 2013 Percentile Ranking
1.	*Well-Child Visits in the First 15 Months of Life—0 Visits*¥	2.06%	1.59%	-0.47	25th–50th
2.	*Well-Child Visits in the First 15 Months of Life—1 Visit*	1.29%	0.91%	-0.38	10th–25th
3.	*Well-Child Visits in the First 15 Months of Life—2 Visits*	1.83%	1.36%	-0.47	10th–25th
4.	*Well-Child Visits in the First 15 Months of Life—3 Visits*	2.22%	2.60%	+0.38	10th–25th
5.	*Well-Child Visits in the First 15 Months of Life—4 Visits*	5.40%	5.39%	-0.01	10th–25th
6.	*Well-Child Visits in the First 15 Months of Life—5 Visits*	11.97%	12.20%	+0.23	10th–25th
7.	*Well-Child Visits in the First 15 Months of Life—6 or More Visits*	75.23%	75.96%	+0.73	75th–90th

[1-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

[1-3] HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

Table 1-3—DVHA HEDIS 2014 Results					
	Performance Measure	HEDIS 2013 Rate	HEDIS 2014 Rate	Percentage Point Change	HEDIS 2013 Percentile Ranking
8.	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*	69.32%	71.49%	+2.17	25th–50th
9.	*Adolescent Well-Care Visits*	46.27%	46.97%	+0.70	25th–50th
10.	*Annual Dental Visits—Ages 2–3*	46.96%	46.47%	-0.49	75th–90th
11.	*Annual Dental Visits—Ages 4–6*	72.78%	71.61%	-1.17	75th–90th
12.	*Annual Dental Visits—Ages 7–10*	78.02%	77.85%	-0.17	75th–90th
13.	*Annual Dental Visits—Ages 11–14*	72.76%	72.19%	-0.57	75th–90th
14.	*Annual Dental Visits—Ages 15–18*	65.56%	65.64%	+0.08	>95th
15.	*Annual Dental Visits—Ages 19–21*	44.72%	43.02%	-1.70	75th–90th
16.	*Annual Dental Visits—Combined Rate*	68.23%	67.72%	-0.51	75th–90th
17.	*Children's and Adolescents' Access to Primary Care Practitioners—12–24 Months*	98.31%	98.55%	+0.24	90th–95th
18.	*Children's and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years*	91.70%	92.13%	+0.43	75th–90th
19.	*Children's and Adolescents' Access to Primary Care Practitioners—7–11 Years*	94.48%	94.46%	-0.02	75th–90th
20.	*Children's and Adolescents' Access to Primary Care Practitioners—12–19 Years*	93.73%	93.90%	+0.17	90th–95th
21.	*Chlamydia Screening in Women—16–20 Years*	--	47.35%	--	25th–50th
22.	*Chlamydia Screening in Women—21–24 Years*	--	54.85%	--	10th–25th
23.	*Chlamydia Screening in Women—Total*	--	50.55%	--	10th–25th
24.	*Adults' Access to Preventive/Ambulatory Health Services—20–44 Years*	84.09%	84.21%	+0.12	50th–75th
25.	*Adults' Access to Preventive/Ambulatory Health Services—45–64 Years*	88.93%	89.37%	+0.44	50th–75th
26.	*Adults' Access to Preventive/Ambulatory Health Services—65+ Years*	93.04%	94.31%	+1.27	90th–95th
27.	*Adults' Access to Preventive/Ambulatory Health Services—Total*	86.94%	87.32%	+0.38	75th–90th
28.	*Comprehensive Diabetes Care—HbA1c Testing*	64.19%	65.07%	+0.88	<5th
29.	*Comprehensive Diabetes Care—Eye Exams*	46.68%	47.03%	+0.35	25th–50th

Table 1-3—DVHA HEDIS 2014 Results					
Performance Measure		HEDIS 2013 Rate	HEDIS 2014 Rate	Percentage Point Change	HEDIS 2013 Percentile Ranking
30.	*Comprehensive Diabetes Care—LDL-C Screening*	45.03%	46.24%	+1.21	<5th
31.	*Comprehensive Diabetes Care—Medical Attention for Nephropathy*	60.27%	61.36%	+1.09	<5th
32.	*Follow-Up After Hospitalization for Mental Illness—7-day Follow-up*	--	41.61%	--	25th–50th
33.	*Follow-Up After Hospitalization for Mental Illness—30-day Follow-up*	--	61.77%	--	25th–50th
34.	*Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation)—13-17 Years*	--	42.63%	--	50th–75th
35.	*Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation)—18 Years and Older*	--	33.88%	--	10th–25th
36.	*Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation)—Total*	--	34.33%	--	10th–25th
37.	*Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Engagement)—13–17 Years*	--	18.91%	--	50th–75th
38.	*Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Engagement)—18 Years and Older*	--	13.26%	--	50th–75th
39.	*Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Engagement)—Total*	--	13.56%	--	50th–75th
40.	*Use of Appropriate Medications for People With Asthma—5–11 Years*	88.24%	90.04%	+1.80	10th–25th
41.	*Use of Appropriate Medications for People With Asthma—12–18 Years*	88.42%	86.43%	-1.99	50th–75th
42.	*Use of Appropriate Medications for People With Asthma—19–50 Years*	79.93%	75.92%	-4.01	50th–75th
43.	*Use of Appropriate Medications for People With Asthma—51–64 Years*	84.65%	80.62%	-4.03	75th–90th
44.	*Use of Appropriate Medications for People With Asthma—Total*	84.71%	82.41%	-2.30	25th–50th
45.	*Antidepressant Medication Management—Effective Acute Phase Treatment*	68.81%	63.30%	-5.51	90th–95th
46.	*Antidepressant Medication Management—Effective Continuation Phase Treatment*	51.98%	44.12%	-7.86	75th–90th
47.	*Breast Cancer Screening*	--	38.10%	--	5th–10th

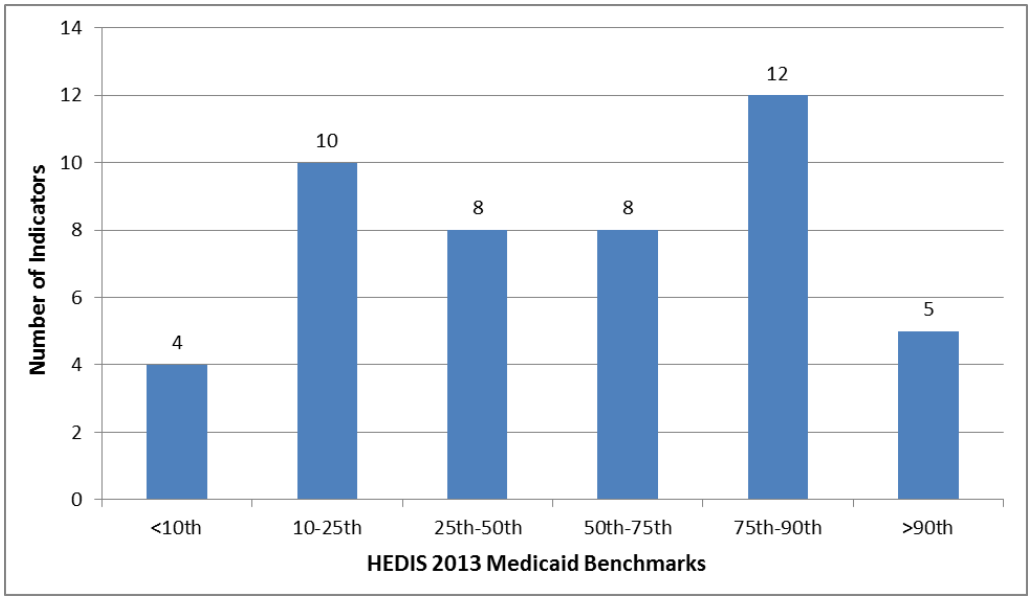
¥ A lower rate indicates better performance for these indicators. Therefore, lower rates lead to higher percentile rankings. A negative Percentage Point Change value indicates improvement.

DVHA performed well on certain clinical indicators and below the 25th percentile on other clinical measures. Of the 47clinical indicators reported, performance for five (*Annual Dental Visits—Ages 15–18, Children's and Adolescents' Access to Primary Care Practitioners—12–24 Months, Children's and Adolescents' Access to Primary Care Practitioners—12–19 Years, Adults' Access to Preventive/Ambulatory Health Services—65+ Years,* and *Antidepressant Medication Management—Effective Acute Phase Treatment)* exceeded the national Medicaid HEDIS 2013 90th percentile. In addition to those five indicators, another 12 surpassed the 75th percentile. High performance was also observed in the *Antidepressant Medication Management* measure (both indicators), *Children's and Adolescents' Access to Primary Care Practitioners* measure (all indicators), *Annual Dental Visits* measure (all indicators), *Well-Child Visits in the First 15 Months of Life—Six or More Visits* indicator, *Adults' Access to Preventive/Ambulatory Health Services–Total* indicator, and *Use of Appropriate Medications for People with Asthma—51–64 Years* indicator.

DVHA performed below the 25th percentile on 14 indicators, including *Well-Child Visits in the First 15 Months of Life—1, 2, 3, 4,* and *5 Visits; Comprehensive Diabetes Care—HbA1c Testing, LDL-C Screening, and Medical Attention for Nephropathy; Use of Appropriate Medications for People With Asthma—5–11 Years; Chlamydia Screening in Women 21–24 Years* and *Total; Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation)—18 Years and Older,* and *Total;* and *Breast Cancer Screening.*

The graph below shows the distribution of how the reported indicators compare to the 2013 HEDIS national Medicaid benchmarks. The horizontal axis displays the following HEDIS 2013 Medicaid benchmark ranges: below 10th percentile, 10th to 25th percentile, 25th to 50th percentile, 50th to 75th percentile, 75th to 90th percentile, and greater than 90th percentile. The vertical axis shows the number of performance indicators that fall into each of the percentile groups. As shown in this graph, four indicators are in the below 10th percentile group, 10 indicators in the 10th to 25th percentile, eight in the 25th to 50th percentile, eight in the 50th to 75th percentile, 12 in the 75th to 90th percentile, and five are in the greater than 90th percentile category.

Figure 1-1—Number of Indicator Rates Meeting the HEDIS 2013 Medicaid Benchmarks



Review of Compliance With Standards

Under its EQRO contract, AHS requested that HSAG continue to review one of the three sets of federal Medicaid managed care standards during each EQRO contract year. For EQRO contract year 2014–2015, AHS requested that HSAG conduct a review of the Structure and Operations standards.

HSAG conducted the review consistent with CMS' *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[1-4] 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 previous year. Reviewers also conducted staff interviews related to each of the eight standards to allow **DVHA** staff members to elaborate on the written information HSAG reviewed, to assess the consistency of staff responses given during the interviews against the written documentation, and to clarify any questions reviewers had following the document review.

The primary objective of HSAG's review was to identify and provide meaningful information to AHS and **DVHA** about **DVHA**'s performance strengths and any areas requiring corrective action. 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 1-4 presents a summary of **DVHA**'s performance results for the eight standard areas reviewed. The information includes:

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

Table 1-4—Standards and Compliance Score

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Total Compliance Score
I	**Provider Selection**	12	**12**	**12**	**0**	**0**	**0**	**100%**
II	**Credentialing and Recredentialing**	**1**	**1**	**1**	**0**	**0**	**0**	**100%**
III	**Beneficiary Information**	**20**	**20**	**12**	**8**	**0**	**0**	**80%**
IV	**Beneficiary Rights**	**5**	**5**	**4**	**1**	**0**	**0**	**90%**

[1-4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

Table 1-4—Standards and Compliance Score								
Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Total Compliance Score
V	Confidentiality	2	2	2	0	0	0	100%
VI	Grievance System—Beneficiary Grievances	14	14	13	1	0	0	96%
VII	Grievance System—Beneficiary Appeals and State Fair Hearings	33	33	29	4	0	0	94%
VIII	Subcontractual Relationships and Delegation	6	6	6	0	0	0	100%
	Totals	93	93	79	14	0	0	92%

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 (multiplied by 0.50) number that received a score of *Partially Met*, then dividing this total by the total number of applicable elements.

As displayed in Table 1-4, HSAG reviewed **DVHA**'s performance related to 93 elements across the eight standards. Of the 93 requirements, **DVHA** obtained a score of *Met* for 79 of the requirements and a score of *Partially Met* for 14 elements. As a result, **DVHA** obtained a total percentage of compliance score of 92 percent across the applicable elements.

With scores at or above 90 percent in seven of the eight standard areas reviewed, **DVHA** demonstrated numerous performance strengths in meeting the federal structure and operations regulations and AHS contract requirements. Four of the seven standards indicated significant areas of strength, with scores of 100 percent. For the only standard area with a score below 90 percent—Beneficiary Information—**DVHA** scored *Partially Met* on eight of the 20 evaluation elements and, therefore, has targeted opportunities for improvement in those areas.

DVHA's performance represented improvement compared to its overall performance for HSAG's 2010–2011 review of the same standards. For that review, **DVHA** scored 90 percent across the eight standard areas as compared to 92 percent this year. All but one standard area either maintained the previous high performance or improved. The score for only one standard declined from the previous review—Beneficiary Information.

Overall Conclusions and Performance Trending

Performance Trends

Performance Improvement Project Trends

This was the first year **DVHA** conducted its PIP—*Follow-up After Hospitalization for Mental Illness*. **DVHA**'s performance suggests its thorough application of the PIP design. The PIP's sound study design will provide the foundation for **DVHA** to progress to subsequent stages. **DVHA** appropriately conducted the data collection activities of the Design stage. These activities ensured that **DVHA** collected the necessary data to produce accurate study indicator rates. **DVHA** provided

baseline results for the first year's submission; therefore, trending is not yet possible but will be included in subsequent reports.

Performance Measure Trends

DVHA used software from a vendor whose measure source code was certified by NCQA to calculate and report the HEDIS 2014 measures. Table 1-5 below displays the rates for measures **DVHA** reported for HEDIS 2011, 2012, 2013, and 2014, and the overall trended rate. The trends displayed are calculated from the first reported rate to the HEDIS 2014 rate. Measures with no rates displayed (--) were not reported in prior years; therefore, trending was not applicable.

Table 1-5—HEDIS 2011, 2012, 2013, and 2014 Rates and Trended Results

Performance Measure	HEDIS 2011		HEDIS 2012		HEDIS 2013		HEDIS 2014		Overall Trend
	N	Rate	N	Rate	N	Rate	N	Rate	Change
Well-Child Visits in the First 15 Months of Life—0 Visits¥	2,966	2.16%	3,131	1.72%	3,109	2.06%	3,082	1.59%	-0.57
Well-Child Visits in the First 15 Months of Life—1 Visit	2,966	1.55%	3,131	1.05%	3,109	1.29%	3,082	0.91%	-0.64
Well-Child Visits in the First 15 Months of Life—2 Visits	2,966	1.72%	3,131	1.72%	3,109	1.83%	3,082	1.36%	-0.36
Well-Child Visits in the First 15 Months of Life—3 Visits	2,966	3.03%	3,131	3.29%	3,109	2.22%	3,082	2.60%	-0.43
Well-Child Visits in the First 15 Months of Life—4 Visits	2,966	6.74%	3,131	5.94%	3,109	5.40%	3,082	5.39%	-1.35
Well-Child Visits in the First 15 Months of Life—5 Visits	2,966	12.61%	3,131	12.36v	3,109	11.97%	3,082	12.20%	-0.41
Well-Child Visits in the First 15 Months of Life—6 or More Visits	2,966	72.18%	3,131	73.91%	3,109	75.23%	3,082	75.96%	+3.78
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	12,794	69.02%	13,137	69.70%	13,186	69.32%	13,170	71.49%	+2.47
Adolescent Well-Care Visits	22,022	46.25%	22,547	46.17%	22,441	46.27%	22,630	46.97%	+0.72
Annual Dental Visits—Ages 2–3	6,522	44.59%	6,407	47.15%	6,418	46.96%	6,378	46.47%	+1.88
Annual Dental Visits—Ages 4–6	9,495	73.06%	9,857	73.36%	9,981	72.78%	9,947	71.61%	-1.45
Annual Dental Visits—Ages 7–10	12,027	78.13%	12,441	78.05%	12,659	78.02%	12,782	77.85%	-0.28
Annual Dental Visits—Ages 11–14	11,481	74.21%	11,869	73.48%	12,123	72.76%	12,139	72.19%	-2.02
Annual Dental Visits—Ages 15–18	9,705	67.06%	9,841	66.15%	9,740	65.56%	10,098	65.64%	-1.42
Annual Dental Visits—Ages 19–21	3,114	44.70%	3,119	40.53%	2,641	44.72%	2,664	43.02%	-1.68
Annual Dental Visits—Combined Rate	52,344	68.13%	53,534	68.10%	53,562	68.23%	54,008	67.72%	-0.41
Children's and Adolescents' Access to Primary Care Practitioners—12–24 Months	3,344	98.18%	3,487	98.34%	3,423	98.31%	3,453	98.55%	+0.37
Children's and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	15,764	91.56%	16,004	92.18%	16,175	91.70%	16,077	92.13%	+0.57
Children's and Adolescents' Access to Primary Care Practitioners—7–11 Years	13,301	94.05%	13,834	94.54%	14,221	94.48%	14,460	94.46%	+0.41
Children's and Adolescents' Access to Primary Care Practitioners—12–19 Years	17,427	93.52%	17,999	93.56%	18,212	93.73%	18,485	93.90%	+0.38
Chlamydia Screening in Women—16–20 Years	--	--	--	--	--	--	3,092	47.35%	--
Chlamydia Screening in Women—21–24 Years	--	--	--	--	--	--	2,299	54.85%	--

Table 1-5—HEDIS 2011, 2012, 2013, and 2014 Rates and Trended Results									
Performance Measure	HEDIS 2011		HEDIS 2012		HEDIS 2013		HEDIS 2014		Overall Trend
	N	Rate	N	Rate	N	Rate	N	Rate	Change
Chlamydia Screening in Women—Total	--	--	--	--	--	--	5,391	50.55%	--
Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	28,803	83.09%	30,444	81.39%	30,936	84.09%	31,658	84.21%	+1.12
Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	18,716	84.88%	20,393	83.59%	20,947	88.93%	21,700	89.37%	+4.49
Adults' Access to Preventive/Ambulatory Health Services—65+ Years	7,531	82.09%	7,488	79.49%	7,615	93.04%	7,718	94.31%	+12.22
Adults' Access to Preventive/Ambulatory Health Services—Total	55,050	83.56%	58,325	81.92%	59,498	86.94%	61,076	87.32%	+3.76
Comprehensive Diabetes Care—HbA1c Testing	5,764	62.02%	6,073	63.84%	6,152	64.19%	6,364	65.07%	+3.05
Comprehensive Diabetes Care—Eye Exams	5,764	45.18%	6,073	46.69%	6,152	46.68%	6,364	47.03%	+1.85
Comprehensive Diabetes Care—LDL-C Screening	5,764	47.24%	6,073	46.70%	6,152	45.03%	6,364	46.24%	-1.00
Comprehensive Diabetes Care—Medical Attention for Nephropathy	5,764	59.21%	6,073	59.72%	6,152	60.27%	6,364	61.36%	+2.15
Follow-Up After Hospitalization for Mental Illness—7-day Follow-up	--	--	--	--	--	--	1,567	41.61%	--
Follow-Up After Hospitalization for Mental Illness—30-day Follow-up	--	--	--	--	--	--	1,567	61.77%	--
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation)—13-17 Years	--	--	--	--	--	--	312	42.63%	--
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation)—18 Years and Older	--	--	--	--	--	--	5,715	33.88%	--
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation)—Total	--	--	--	--	--	--	6,027	34.33%	--
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Engagement)—13–17 Years	--	--	--	--	--	--	312	18.91%	--
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Engagement)—18 Years and Older	--	--	--	--	--	--	5,715	13.26%	--
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Engagement)—Total	--	--	--	--	--	--	6,027	13.56%	--
Use of Appropriate Medications for People With Asthma—5–11 Years	744	93.68%	632	92.72%	621	88.24%	552	90.04%	-3.64
Use of Appropriate Medications for People With Asthma—12–18Years	*	*	523	87.57%	518	88.42%	501	86.43%	-1.14
Use of Appropriate Medications for People With Asthma—19–50 Years	*	*	823	79.10%	857	79.93%	897	75.92%	-3.18
Use of Appropriate Medications for People With Asthma—51–64 Years	*	*	185	81.62%	202	84.65%	227	80.62%	-1.00

Table 1-5—HEDIS 2011, 2012, 2013, and 2014 Rates and Trended Results									
Performance Measure	HEDIS 2011		HEDIS 2012		HEDIS 2013		HEDIS 2014		Overall Trend
	N	Rate	N	Rate	N	Rate	N	Rate	Change
Use of Appropriate Medications for People With Asthma—Total	*	*	2,163	85.34%	2,198	84.71%	2,177	82.41%	-2.93
Antidepressant Medication Management—Effective Acute Phase Treatment	1,923	66.98%	2,147	68.42%	2,578	68.81%	4,161	63.30%	-3.68
Antidepressant Medication Management—Effective Continuation Phase Treatment	1,923	51.38%	2,147	54.54%	2,578	51.98%	4,161	44.12%	-7.26
Breast Cancer Screening	--	--	--	--	--	--	7,543	38.10%	--

¥ A lower rate (decline) indicates better performance for this indicator.
* The reported age bands changed for this measure for HEDIS 2012; therefore, HEDIS 2011 results are not presented.

Overall, 16 of the 35 indicators with rates that could be trended showed an increase in performance since the first reported rate. All *Adults' Access to Preventive/Ambulatory Health Services* indicators demonstrated overall increases, ranging from 1.12 to 12.22 percentage points. Of the 19 measures that showed decreases in performance, none of the rates exhibited an overall decline of more than 7.26 percentage points. The average decline for those indicators was only 1.80 percentage points.

Compliance With Standards Trends

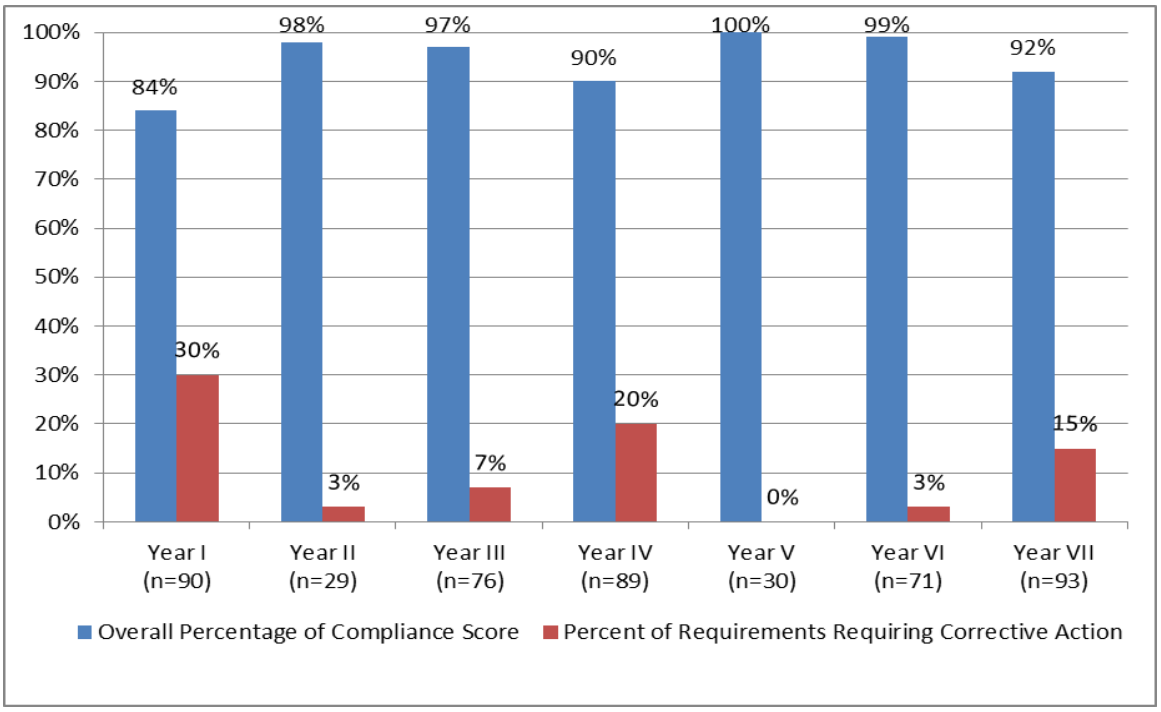
As noted previously, HSAG reviewed a different set of standards for evaluating **DVHA** compliance with federal CMS Medicaid managed care regulations and the associated AHS/**DVHA** IGA requirements during each year within its three-year cycle of reviews. The number and focus of the standards varied for each year's review. For this, the seventh year of reviews, HSAG again reviewed the Structure and Operations standards, the same standards it had reviewed in the first and fourth years of the EQRO contract.

Table 1-6 documents **DVHA**'s performance across seven years of HSAG's compliance reviews.

Table 1-6—Comparison/Trending of DVHA Performance for Compliance with Standards																				
	CY 2008			CY 2009			CY 2010			CY 2011			CY 2012			CY 2013			CY 2014		
Standards Reviewed	Ele-ments	Score	Correc. Action * %	Ele-ments	Score	Correc. Action * %	Ele-ments	Score	Correc. Action * %	Ele-ments	Score	Correc. Action * %	Ele-ments	Score	Correc. Action * %	Ele-ments	Score	Correc. Action * %	Ele-ments	Score	Correc. Action * %
Structure and Operations Standards	90	84%	30%							89	90%	20%							93	92%	15%
Measurement and Improvement Standards				29	98%	3%							30	100%	0%						
Access Standards and Enrollment & Disenrollment							76	97%	7%							71	99%	3%			

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

Figure 1-2—Trends in Performance



The bar graph displays **DVHA**'s overall performance score and the percent of requirements requiring corrective actions for the current and previous six years.

- Year I: 84 percent compliance with 30 percent of the requirements requiring corrective actions
- Year II: 98 percent compliance with 3 percent of the requirements requiring corrective actions
- Year III: 97 percent compliance with 7 percent of the requirements requiring corrective actions
- Year IV: 90 percent compliance with 20 percent of the requirements requiring corrective action
- Year V: 100 percent compliance with none of the requirements requiring corrective action
- Year VI: 99 percent compliance with 3 percent of the requirements requiring corrective action
- Year VII: 92 percent compliance with 15 percent of the requirements requiring corrective action

Quality, Timeliness, and Access to Care Domains

The federal Medicaid managed care regulations state 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."[1-5] CMS has chosen the domains of quality, access, and timeliness as keys to evaluating the performance of MCOs and PIHPs. Definitions HSAG used to evaluate and draw conclusions about **DVHA**'s performance in each of these domains are as follows.

[1-5] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Legislative Summary: Balanced Budget Act of 1997 Medicare and Medicaid Provisions.*

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 or PIHP increases the likelihood of desired health outcomes of its recipients through its structural and operational characteristics and through provision of health services that are consistent with current professional knowledge."[1-6]

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."[1-7] NCQA further discusses the intent of this standard to minimize any disruption in the provision of health care. HSAG extends this definition of timeliness to include other managed care provisions that impact services to beneficiaries and that require a timely response by the managed care organization—e.g., processing expedited appeals and providing timely follow-up care.

Access

In the preamble to the federal Medicaid Managed Care Rules and Regulations,[1-8] CMS discusses access to, and the availability of, services to Medicaid beneficiaries as the degree to which MCOs and PIHPs implement the standards set forth by the State to ensure that all covered services are available to beneficiaries. Access includes the availability of an adequate and qualified provider network that reflects the needs and characteristics of the beneficiaries served by the MCO or PIHP.

To draw conclusions about the quality and timeliness of, and access to, care **DVHA** provided, HSAG determined which components of each EQR activity could be used to assess these domains (as indicated in Table 1-7).

[1-6] Department of Health and Human Services Centers for Medicare & Medicaid Services. *Federal Register*. *Code of Federal Regulations*. Title 42, Vol 3, October 1, 2005.
[1-7] National Committee for Quality Assurance. Standards and Guidelines for Health Plans.
[1-8] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*, Vol. 67, No. 115, June 14, 2002.

Table 1-7—EQR Activity Components Assessing Quality, Timeliness, and Access			
PIP	**Quality**	**Timeliness**	**Access**
Follow-up After Hospitalization for Mental Illness	✓	✓	
Performance Measures	**Quality**	**Timeliness**	**Access**
Well-Child Visits in the First 15 Months of Life	✓		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	✓		
Adolescent Well-Care Visits	✓		
Annual Dental Visits	✓		✓
Children's and Adolescents' Access to Primary Care Practitioners			✓
Adults' Access to Preventive/Ambulatory Health Services			✓
Comprehensive Diabetes Care	✓		
Use of Appropriate Medications for People With Asthma	✓		
Antidepressant Medication Management	✓	✓	✓
Chlamydia Screening in Women	✓		
Follow-Up After Hospitalization for Mental Illness	✓	✓	✓
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment			✓
Breast Cancer Screening	✓		
Compliance Review Standards	**Quality**	**Timeliness**	**Access**
Standard I—Provider Selection	✓		✓
Standard II—Credentialing and Recredentialing	✓		
Standard III—Beneficiary Information	✓		
Standard IV—Beneficiary Rights	✓		
Standard V—Confidentiality	✓		
Standard VI—Grievance System: Beneficiary Grievances	✓	✓	
Standard VII—Grievance System: Beneficiary Appeals and State Fair Hearings	✓	✓	
Standard VIII—Subcontractual Relationships and Delegation	✓		

EQR Assessment of DVHA's Strengths and Weaknesses

Performance Improvement Project

DVHA showed strength in conducting its study by receiving *Met* scores for all applicable evaluation elements in Activities I through VIII, demonstrating a sound application of the PIP process. **DVHA**'s strong performance in the Design and Implementation stages indicated that the PIP was designed appropriately to measure outcomes and improvement.

Performance Measures

As in previous years, HSAG found **DVHA**'s electronic claims and eligibility data validity to be of high quality. Staff members were dedicated to positive operational changes to assist in reporting performance measures. Efforts to improve care and outcomes for Medicaid beneficiaries were also seen by the addition of new performance measures, increasing from 35 to 47 indicators this measurement year. Overall, 16 existing indicators have seen positive improvement over the last four years. *Adults' Access to Preventive/Ambulatory Health Services—65+ Years* had the largest increase (12.22 percentage points) over the four-year span.

The indicators for *Comprehensive Diabetes Care* continued to be a challenge for **DVHA**. Three of the four diabetes indicators reported this year performed below the national Medicaid 5th percentile. Although HSAG recommended reporting this measure using hybrid methods, due to insufficient planning time for medical record procurement and abstraction, **DVHA** decided to forgo hybrid reporting for HEDIS 2014. The *Use of Appropriate Medications for People With Asthma—5–11 Years* and several indicators for the *Well-Child Visits in the First 15 Months of Life* measure (i.e., 1, 2, 3, 4, and 5 Visits) also presented opportunities for improvement. For the *Use of Appropriate Medications for People With Asthma—5–11 Years* indicator, the HEDIS 2014 rate showed a decline from HEDIS 2011 of 3.64 percentage points, resulting in a rank below the national Medicaid 25th percentile. Although there have been minor changes in the *Well-Child Visits in the First 15 Months of Life* measure, most of the indicators for this measure ranked below the national Medicaid 25th percentile and have seen a downward trend. Many of the newly added measures are also below the national Medicaid 25th percentile. These measures include *Chlamydia Screening in Women*, *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment*, and *Breast Cancer Screening*.

Compliance With Standards

DVHA had strengthened its organizational structure; management and administrative processes; and the quality, frequency, and level of detail and meaningful information in its written documents, including Operating Principles (i.e., policies and procedures), reports related to numerous activities, and IGAs with partner delegates. It was evident that **DVHA** had enhanced oversight of its partner delegates and contractors/vendors, resulting in 100 percent compliance in standards related to provider selection processes, credentialing and recredentialing, and subcontractors and delegates.

DVHA also performed strongly in administering a compliant grievance system (encompassing processes for beneficiary grievances, appeals, and the State fair hearing). However, **DVHA** was required to initiate corrective actions related to providers' access to complete beneficiary grievance and appeal information, its definition of "action" in policies and manuals, timeliness of appeal acknowledgments, timeliness of appeal resolutions and notices to beneficiaries, and inclusion of a process for members or providers/designated representatives to request reconsiderations.

For compliance with standards related to beneficiary information, rights, and confidentiality, **DVHA** demonstrated strengths in meeting many of the requirements, but received recommendations or required actions in all three areas. The Beneficiary Information standard received the lowest score of all standards reviewed, and resulted in required actions for **DVHA** to revise its member handbook and include adequate information on confidentiality rights, appeal rights afforded to providers, and the rights and process for requesting disenrollment.

Recommendations and Opportunities for Improvement

Performance Improvement Project

All applicable evaluation elements received *Met* scores; however, there were two *Points of Clarification* identified during HSAG's 2014–2015 validation process.

DVHA received the following recommendations for improving future PIP submissions:

- Activity III: Numerator information and criteria should not be included in the study population definition. The study population should reflect the study indicator denominators. **DVHA** should remove the bulleted information referencing numerator positive hit criteria.
- Activity VI: Much of the documentation in Activity VI focused on the accuracy of administrative data. The documentation should only reflect how complete the data are when pulled and how **DVHA** obtained the percentage of completeness.

Performance Measures

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

- **DVHA** staff should conduct additional root cause analysis on performance measures with low rates and incorporate national/regional benchmarks to manage rates.
- **DVHA** should continue its review practice and enhance it to identify rates that fall below the national 10th percentiles.
- **DVHA** would benefit from monitoring encounters to ensure federally qualified health centers (FQHCs) submit all services rendered in addition to the case rate.
- **DVHA** abstracted data from medical records but did not include the results for this reporting year. **DVHA** is encouraged to report in future years using medical record review for measures

that appear to have incomplete lab data. The hybrid project should be carefully planned next year, requesting auditor's assistance as needed.

- While **DVHA** has integrated some staff members, it is recommended that **DVHA** continue this integration and expand data monitoring and validation activities. This will help to identify declining rates and reasons for the decline.

Compliance With Standards

DVHA was required to ensure that:

- The next revision to the member handbook describes (1) at a high level, the members' right to confidentiality; (2) **DVHA**'s processes for ensuring the members' right to, the process for, and all relevant information needed to enable them to initiate/request disenrollment; and (3) information about the appeal rights that the State of Vermont makes available to providers to challenge **DVHA**'s failure to cover a service.
- It informs members about their right to terminate enrollment and provide enrollment termination procedures.
- Through the provider handbook or other informational materials, it provides substantive written information to network providers about member grievances and related requirements.
- Its policies and procedures, manuals, handbooks, and any other internal documents that define an "action" consistently include the provision regarding the failure to act within time frames as required by 42 CFR: 438.400(b)(1) and State rule.
- Members are provided with a written acknowledgement within five calendar days of receipt of the appeal as required by State rule.
- **A**ppeals are resolved and members receive written notice of the resolution within the maximum time frames for standard and expedited appeals, including any extensions.
- If AHS continues to offer members the option of requesting a reconsideration, **DVHA** reviews and revises its documentation (i.e., notice of decision form, provider manual, and any other relevant documents) to consistently allow for the member, the provider, or designated representative to request a reconsideration as required in the AHS/**DVHA** IGA.

Suggestions for DVHA

While not rising to the level of noncompliance requiring corrective action, HSAG reviewers encouraged **DVHA** to consider:

- Expanding the information it currently provides to members about (1) emergency services and when/how to access them, and (2) what poststabilization services are and how to access them.
- Conducting unannounced visits that include a walk-through of the facilities to determine any visible evidence of failure to protect confidential/privileged information (e.g., confidential documents lying face-up on desks, monitors with confidential information on the screen visible for those passing by or nearby, and confidential information being discussed in rooms with the doors open).

2. Introduction

Background

According to 42 CFR §438.202, each state Medicaid agency is required to:

I. Have a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs.
II. Obtain the input of recipients and other stakeholders in the development of the strategy and make the strategy available for public comment before adopting it.
III. Ensure that MCOs, PIHPs, and prepaid ambulatory health plans (PAHPs) comply with standards established by the State, consistent with this subpart.
IV. Conduct periodic reviews to evaluate the effectiveness of the strategy, and update the strategy periodically as needed.
V. Submit to CMS the following:
    a. A copy of the initial strategy and a copy of the revised strategy whenever significant changes are made.
    b. Regular reports on the implementation and effectiveness of the strategy.

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 set forth in the federal regulations and described in the AHS quality strategy, AHS contracted with HSAG to conduct the EQR activities beginning in EQRO contract year 2007–2008. This report covers the EQR activities conducted during 2014–2015, the EQRO contract year. The mandatory EQR activities were conducted consistent with the CMS protocols established under 42 CFR §438.352.

During the 2014–2015 contract year, and consistent with the applicable CMS protocols, HSAG performed the following EQR activities and provided to AHS and **DVHA** draft and final reports for each activity:

- Validated **DVHA**'s PIP
- Validated a set of **DVHA**'s performance measures
- Reviewed **DVHA**'s compliance with the federal Medicaid managed care standards described at 42 CFR§438.214 through 438.230 and the related AHS/**DVHA** IGA (i.e., contract) requirements
- Prepared this annual external quality review technical report

Purpose

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

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

Organization of the Report

Section 1—Executive Summary: 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 2014–2015. Section 1 also includes recommendations and opportunities for improvement in quality, timeliness, and access to care, as provided to **DVHA**. Finally, trends over time are presented as appropriate to the data available.

Section 2—Introduction: Section 2 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 3—Description of External Quality Review Activities: For each activity HSAG performed, Section 3 provides information related to the objectives of the activity, a description of the data obtained, technical methods of data collection and analysis, and a description of how overall conclusions were drawn related to **DVHA**'s performance.

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

Methodology for Preparing the EQR Technical Report

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

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

1. Reliability: Reliable data consistently identify the event targeted for measure, and the results are reproducible.
2. Validity: Valid data make sense logically and capture the intended aspects of care.
3. Comparability: The data have comparable data sources and data collection methods, as well as precise specifications.
4. Meaningfulness: The data used are meaningful to the AHS, **DVHA**, beneficiaries, providers, IGA partners/vendors, and other interested stakeholders.
5. Controllability: The data used measure an aspect of care that is within AHS' and **DVHA**'s control.

Data Sources

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

- Results of HSAG's validation of **DVHA**'s PIP.
- Results of HSAG's validation of **DVHA**'s performance measures.
- **DVHA**'s performance measure rates and trending of the prior year's results.
- Results of HSAG's monitoring of **DVHA**'s compliance with the selected standards in the Medicaid managed care regulations and the associated AHS/**DVHA** IGA/contract requirements; a comparison of **DVHA**'s 2014–2015 performance to the results of HSAG's review of the same set of requirements in contract year 2010–2011; and trends in **DVHA**'s performance results across the eight HSAG EQR contract years.

Categorizing Results

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

Identifying DVHA's Strengths and Opportunities for Improvement

For each of the three EQR activities, HSAG conducted a thorough review and analysis of the data. Because the activities varied in terms of the types of data HSAG collected and used, the

methodology for identifying strengths and weaknesses was designed to accommodate the data available for and specific to each activity.

Validation of PIP

HSAG considers a PIP that has achieved an overall *Met* validation status and improved study indicator outcomes an area of strength. For *Partially Met* or *Not Met* evaluation components, HSAG considers these areas of weakness and makes recommendations for improvement. In addition, for any component of the PIP activities (including *Met* elements) evaluated by HSAG during its validation, HSAG may provide a *Point of Clarification* to the organization, to assist with improved processes or documentation the next time the PIP is submitted.

Validation of Performance Measures

HSAG analyzed the performance measure data with respect to the performance levels. For each performance measure for which **DVHA** reported results, HSAG identified a high and a low performance level based on a comparison of **DVHA**'s rate to the distribution of national Medicaid percentiles. High performance (a strength) was identified as any performance measure rate meeting or exceeding the most recent (2013) national Medicaid HEDIS 90th percentile, as published by NCQA. Low performance (a weakness) was identified as any performance measure rate at or below the 2013 national Medicaid HEDIS 10th percentile.

Monitoring Compliance With Standards

HSAG determined which information, documentation, and data reflected specific aspects of care and services **DVHA** provided related to each of the standards HSAG reviewed. HSAG then analyzed and drew conclusions about the results of the compliance review with respect to the domains of quality, timeliness, and access. In reviewing specific documents and reported data and in considering **DVHA** staff responses to specific interview questions, which focused on each of the standards, HSAG recognized that information will often not be specific to only one domain but may provide insight into **DVHA**'s performance across multiple domains.

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

Validation of Performance Improvement Project

During the seventh year of its EQRO contract with AHS, HSAG validated one PIP that **DVHA** conducted. This section describes the processes HSAG used to complete the validation activities. HSAG described the details related to its approach, methodologies, and findings from the PIP validation activities in its Performance Improvement Project Validation Report—*Follow-up After Hospitalization for Mental Illness* for the Department of Vermont Health Access provided to AHS and **DVHA**.

Objectives and Background Information

The AHS quality strategy required **DVHA** to conduct a PIP in accordance with 42 CFR §438.240. The purpose of a PIP is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical or nonclinical areas. This structured method of assessing and improving the Medicaid managed care model organizations' processes is expected to have a favorable effect on health outcomes and beneficiary satisfaction. AHS contracted with HSAG as the EQRO to meet the federal Medicaid managed care requirement for validating **DVHA**'s PIP. Validation of PIPs is one of the three CMS mandatory activities.

The primary objective of HSAG's PIP validation was to determine **DVHA**'s compliance with requirements set forth in 42 CFR §438.240(b)(1), including:

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

Description of Data Obtained

HSAG reviewed the documentation **DVHA** submitted for the one PIP validated by HSAG. The PIP was submitted using HSAG's PIP Summary Form, which HSAG developed to collect all required data elements for the PIP validation process. **DVHA** completed the PIP Summary Form following instructions provided by the HSAG PIP Review Team regarding the level of documentation required to address each PIP evaluation element. **DVHA** was also instructed to submit any supporting documentation that could provide further details and background information. HSAG provided technical assistance to **DVHA** before the PIP submission to answer **DVHA**'s questions. After HSAG validated the PIP, **DVHA** had the opportunity to incorporate HSAG's recommendations and resubmit the PIP for a final validation.

Technical Methods of Data Collection/Analysis

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

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

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

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

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

Determining Conclusions

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

The PIP validation process was designed so that a well-planned, strategically conducted, fully documented, and valid PIP could score 100 percent on HSAG's PIP Validation Tool. PIPs scoring at least 80 percent produce appropriately valid and generalizable results for improving the health, functional status, or outcomes for beneficiaries. HSAG's validation process accommodates for each PIP's stage of development for scoring purposes. As a result, the process does not penalize PIPs for being partially completed.

HSAG assessed the PIP's findings based on the validity and reliability of the results as follows:

- *Met*: High confidence/confidence in the reported PIP results
- *Partially Met*: Low confidence in the reported PIP results
- *Not Met*: Reported PIP results were not credible

Validation of Performance Measures

Validation of performance measures is one of three CMS mandatory activities. As set forth in 42 CFR §438.358, states are required to ensure that their contracted MCOs and PIHPs collect and report performance measures annually using standardized, state-required measures. AHS identified a set of performance measures calculated and reported by **DVHA** for validation. HSAG conducted

the validation activities following CMS' *EQR Protocol 2*: *Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012.

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 13 HEDIS measures, totaling 47 indicators, for HSAG's validation. The measurement period addressed in this report was calendar year 2013.

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 **Information Systems Capabilities Assessment Tool (ISCAT),** which was completed by **DVHA**. The ISCAT provides background information on **DVHA**'s policies, processes, system capabilities, and data in preparation for the on-site 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 performance measure results,** which were obtained from **DVHA**.
- **On-site 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. Since all the performance measures under the scope of this validation were approved by NCQA under the measure certification program, **DVHA** continued to contract with a software vendor to calculate the measures. 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-On-Site Activities:

- HSAG reviewed the completed ISCAT and flagged areas for on-site follow-up. The review team used the ISCAT to determine if the systems' capabilities were sufficient to report the HEDIS measures.

- HSAG reviewed all supporting documents, including prior performance measure reports, data flow diagrams, data integration logic, and NCQA's measure certification report for the selected vendor.
- HSAG provided AHS and **DVHA** with an agenda for the on-site visit. The agenda included a brief description of each session's purpose and discussion items.
- HSAG conducted a pre-on-site conference call with **DVHA** to discuss any outstanding ISCAT questions and preparations for the on-site visit.

On-Site Review Activities:

- HSAG completed an opening meeting to review the purpose, required documentation, basic meeting logistics, and queries to be performed.
- HSAG observed the data systems and processing functions, focusing on the processing of claims and encounters, Medicaid eligibility data, and provider data.
- HSAG led verbal discussions related to the ISCAT and supporting documentation, including a review of processes used for collecting, storing, validating, and reporting the performance measure data. This interactive session with key staff members allowed HSAG to obtain a complete picture of the degree of compliance with written documentation. HSAG conducted interviews to confirm findings from the document review, expand or clarify outstanding issues, and determine if **DVHA** used and followed written policies and procedures in daily practice.
- HSAG completed an overview of data integration and control procedures, including discussion and observation of programming logic and a review of how all data sources were combined. HSAG and **DVHA** discussed the processes for extracting and submitting data to the certified software vendor. HSAG also performed primary source verification, which further validated the output files; reviewed backup documentation on data integration; and addressed data control and security procedures during this session.
- HSAG conducted a closing conference to summarize its preliminary findings based on the review of the ISCAT and on-site activities, including any measure-specific concerns, and discussed follow-up actions.

Post-On-Site Activities:

- HSAG evaluated follow-up documentation **DVHA** provided to address measure-specific issues.
- HSAG evaluated **DVHA**'s performance measure results and compared them to the prior year's performance and HEDIS 2013 national Medicaid benchmarks.

Determining Conclusions

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

Monitoring of Compliance With Standards

Monitoring compliance with federal Medicaid managed care regulations and the applicable state contract requirements is one of the three mandatory activities a State must conduct. AHS contracted

with HSAG to conduct the compliance review of **DVHA**. HSAG followed the guidelines in the 2012 CMS protocol, *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.

Objectives and Background Information

According to 42 CFR §438.358, a review to determine an MCO's or a PIHP's compliance with state standards must be conducted within a three-year period by a state Medicaid agency, its agent, or an EQRO. Based on 42 CFR §438.204(g), these standards must be as stringent as the federal Medicaid managed care standards described in 42 CFR §438—Managed Care, which address requirements related to access, structure and operations, and measurement and improvement. To meet these requirements, AHS:

- Continued to ensure that its IGA with **DVHA** included most of 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**.
- 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 allows **DVHA** time to focus its improvement efforts and implement new initiatives. For the review covered by this report, AHS requested that HSAG review the CMS Structure and Operations standards described at 42 CFR 438.214–230 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 on-site review activities and timelines, and on-site review agenda.
- Collect data and documents from AHS and **DVHA** and review them before and during the on-site review.
- Conduct the on-site review.
- Aggregate and analyze the data and information collected.
- Prepare the report of its findings and any recommendations or suggestions for improvement.

HSAG prepared and submitted to AHS, for its review and approval, a data collection tool to assess and document **DVHA**'s compliance with the Medicaid managed care regulations, State rules, and the associated AHS/**DVHA** IGA requirements. The review tool included requirements that addressed eight performance areas associated with the CMS Medicaid managed care regulations described at 42 CFR 438.214–230.

I. Provider Selection

II. Credentialing and Recredentialing

III. Beneficiary Information

IV. Beneficiary Rights

V. Confidentiality

VI. Grievance System—Beneficiary Grievances

VII. Grievance System—Beneficiary Appeals and State Fair Hearings

VIII. Subcontractual Relationships and Delegation

As these same standards were reviewed in 2010–2011, HSAG was able to evaluate **DVHA**'s current performance and perform a comparison to the earlier review of these same standards.

Description of Data Obtained

Table 3-1—Description of DVHA's Data Sources	
Data Obtained	**Time Period to Which the Data Applied**
Documentation **DVHA** submitted for HSAG's desk review and additional documentation available to HSAG during the on-site review	May 15, 2014–July 19, 2014
Information from interviews conducted on-site	July 17–19, 2014
HSAG's review of a sample of **DVHA**'s and/or its IGA partners' processing of beneficiary appeals and grievances	October 1, 2013–January 31, 2014

Technical Methods of Data Collection/Analysis

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

- Developing the compliance review tool and the record review tools HSAG used to document its findings from the review of a sample of **DVHA**'s documentation related to (1) beneficiary or provider appeals of **DVHA**'s denials of provider or beneficiary requests for services or **DVHA**'s

reductions/suspensions and terminations of previously authorized services, and (2) beneficiary grievances filed with **DVHA** or an IGA partner delegate and **DVHA**'s/IGA partner's responses to the beneficiaries.

- 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 each day of the 2½-day on-site review.
- Responding to any questions **DVHA** had about HSAG's desk- and on-site review activities and the documentation required from **DVHA** for HSAG's desk review.
- Conducting a pre-on-site 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 on-site review.

For the on-site review activities, two HSAG reviewers conducted the 2½-day on-site review, which included:

- An opening conference, with introductions; **DVHA** staff members' overview of **DVHA** and its relationship with its IGA partners, providers, and any subcontractors; **DVHA** updates on any changes and challenges occurring since HSAG's previous review; a review of the agenda and logistics for HSAG's on-site activities; HSAG's overview of the process it would follow in conducting the on-site review; and, the tentative timelines for providing to **DVHA** and AHS its draft report for AHS' and **DVHA**'s review and comment.
- Review of the documents HSAG requested that **DVHA** have available on-site.
- 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.
- Review of a sample of files/records related to **DVHA**'s or its IGA partners' processing of beneficiary appeals and grievances.
- 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 had the potential to 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 data collection (compliance review) tool. The tool served as a comprehensive record of HSAG's findings, the performance scores it assigned to **DVHA**'s performance for each requirement, and a limited number of required corrective actions. While not requiring formal corrective action, HSAG also made suggestions to further strengthen and drive continued improvement in **DVHA**'s performance. The completed tool was included as one section of HSAG's compliance report. Table 3-1 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 3-2 presents a more detailed, chronological description of the above activities that HSAG performed during its review.

Table 3-2—The Compliance Review Activities HSAG Performed	
Step 1:	**Established the review schedule.**
	Before the review, HSAG coordinated with AHS and **DVHA** to set the schedule and assigned HSAG reviewers to the review team.
Step 2:	**Prepared the data collection tool for review of the eight standards 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 the federal Medicaid managed care regulations described at 42 CFR 438, with revisions issued June 14, 2002, and effective August 13, 2002. Additional criteria used in developing the monitoring tool included applicable Vermont and federal requirements. Prior to finalizing the tool, HSAG submitted the draft 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 it submit specific information and documents to HSAG within a specified number of days of the request. The form included instructions for organizing and preparing the documents related to the review of the eight standards, submitting documentation for HSAG's desk review, and having additional documents available for HSAG's on-site 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 an agenda for each review day and submitted the agendas to DVHA.**
	HSAG developed the agendas to assist **DVHA** staff members in their planning to participate in HSAG's on-site review, assembling requested documentation, and addressing logistical issues. HSAG considers this step essential to performing an efficient and effective on-site review and minimizing disruption to the organization's day-to-day operations. An agenda sets the tone and expectations for the on-site review so that all participants understand the process and time frames.

Table 3-2—The Compliance Review Activities HSAG Performed	
Step 6:	**Provided technical assistance.**
	As requested by **DVHA**, and in collaboration with AHS, HSAG staff members responded to any **DVHA** questions about the requirements for which HSAG would evaluate its performance and about the required **DVHA** documentation.
Step 7:	**Received DVHA's documents for HSAG's desk review and evaluated the information before conducting the on-site review.**
	HSAG compiled and organized the information and documentation, and reviewers used the documentation **DVHA** submitted for HSAG's desk review to gain insight into areas such as **DVHA**'s structure and relationship with its IGA partners, providers, and delegates; information provided to beneficiaries and providers; processes for responding to appeals and grievances; and **DVHA**'s operations, resources, and delegated functions. Reviewers then: ◆ Documented in the review tool their preliminary findings after reviewing the materials **DVHA** submitted as evidence of its compliance with the requirements. ◆ Identified any information not found in the desk review documentation in order to request it prior to the on-site review. ◆ Identified areas and questions requiring further clarification or follow-up during the on-site interviews.
Step 8:	**Conducted the on-site portion of the review.**
	During the 2½-day on-site review, HSAG: ◆ Conducted an opening conference that included introductions, HSAG's overview of the on-site 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. ◆ Conducted interviews with **DVHA**'s staff members. 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. ◆ Reviewed additional documentation. HSAG reviewed additional documentation while on-site and used the review tool to identify relevant information sources and document its review findings. HSAG summarized findings on the last day of the on-site portion of the review. As the final on-site review activity, HSAG reviewers conducted a closing conference to provide **DVHA** staff members and AHS participants with a high-level summary of HSAG's preliminary findings. For each of the eight standards, the findings included HSAG's assessment of **DVHA**'s strengths; any areas requiring corrective action; and any HSAG suggestions for further strengthening **DVHA**'s processes, performance results, and/or documentation.

Table 3-2—The Compliance Review Activities HSAG Performed	
Step 9:	**Documented reviewer findings in the Documentation Request & Evaluation Tool**
	Beginning prior to and continuing through the on-site review, HSAG reviewers documented their preliminary findings related to **DVHA**'s performance for each requirement. Following the on-site review, the reviewers completed their documentation in the tool and finalized their documentation of **DVHA**'s strengths; required corrective actions; and any suggestions for further strengthening **DVHA**'s performance related to its written documentation and to providing accessible, timely, and quality services to beneficiaries.
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 eight 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 eight standards, HSAG calculated a percentage-of-compliance score and then an overall percentage-of-compliance score across the eight standards.
Step 11:	**Prepared a draft and final report.**
	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 it assigned for each requirement within the eight standards, and HSAG's assessment of **DVHA**'s strengths. HSAG also documented any areas requiring **DVHA** corrective action, as well as HSAG's suggestions for further strengthening **DVHA**'s performance results, processes, and/or documentation. HSAG forwarded the report to AHS and **DVHA** for their review and comment. Following AHS' final approval of the draft, HSAG issued the final report to AHS and **DVHA**.

Determining Conclusions

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

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

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

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

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

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

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

From the scores it assigned to **DVHA**'s performance for each of the requirements, HSAG calculated a total percentage of compliance score for each of the eight standards and an overall percentage of compliance score across the standards. HSAG calculated the total score for each standard by summing the weighted scores for the requirements in the standard—*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 compliance score across the eight 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 them by the total number of applicable requirements).

4. 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 select federal Medicaid managed care regulations and associated AHS IGA requirements in select performance areas. **DVHA**'s responses were self-reported and, at the time this report was published, not all of them had yet been validated by AHS or HSAG.

Validation of Performance Improvement Project

During the previous EQRO contract year (2013–2014), HSAG validated **DVHA**'s PIP related to its Chronic Care Initiative, *Increasing Adherence to Evidence-Based Pharmacy Guidelines for Members Diagnosed With Congestive Heart Failure*. The validation process included **DVHA**'s submission of the PIP and HSAG's completion of the validation tool. For the 10 review activities **DVHA** completed and HSAG assessed, **DVHA**'s percentage of evaluation elements receiving a score of *Met* was 96 percent.

Table 4-1—Performance Improvement Project—Recommendations/Suggestions and DVHA Responses

HSAG Recommendations	DVHA Response/Actions/Outcomes
In its report of findings provided to **DVHA** and AHS, HSAG recommended that **DVHA** should: ◆ If it has not already done so, conduct further drill-down analysis to ensure that the barriers identified were specific to the population and that targeted interventions are implemented which directly address the barriers.	Based on information collected from pharmacy claims and direct report from members engaged in Vermont Chronic Care Initiative (VCCI) services, care managers continue to find that members generally are compliant with taking medications prescribed by their physicians. Therefore, interventions regarding evidence-based medications have continued to focus more heavily on the prescribers than the members. Using lessons learned from previous PIPs, recommendations from HSAG, and feedback from consultants, **DVHA** staff members continue to improve their skills in conducting PIPs. For **DVHA**'s current PIP, *Follow-up After Hospitalization for Mental Illness*, the PIP team conducted a barrier analysis using the fishbone technique and will conduct further drill-down analysis upon reviewing the first interim data analysis.

Table 4-1—Performance Improvement Project—Recommendations/Suggestions and DVHA Responses	
HSAG Recommendations	**DVHA Response/Actions/Outcomes**
◆ Continue to review interim evaluations of results in addition to the annual evaluation.	Medication adherence for heart failure is assessed periodically through the patient health registries focused on this condition, and annually for year-end reporting. For its current PIP, **DVHA** has developed interim measures to evaluate the progress of the PIP.
◆ Use data mining/analysis techniques and **DVHA**'s knowledge of member characteristics, utilization statistics, and provider practice patterns to identify any disparate subgroup within the study population and implement interventions that target a specific barrier or the disparate subgroup, if one is identified.	During meetings with providers to review patient health registries on heart failure, **DVHA**'s care management staff members discuss historical trends within the practice. The current vendor contract is being rebid, and a planned enhancement that will be made with the new vendor will be to show practices how their adherence rates compare with the rates in other practices. **DVHA** has developed a data management plan for the current PIP which included a significant amount of work on data clean-up for the first year. As the PIP moves forward, **DVHA** will use this recommendation as it considers both provider and beneficiary interventions.
◆ Having not sustained improvement, investigate the data collected to ensure that **DVHA** has correctly identified the barriers and implemented appropriate and effective interventions; and if **DVHA** has not done so, revise interventions and collect additional data to remeasure and evaluate outcomes for improvement, thereby creating a cyclical process until **DVHA** has sustained statistically significant improvement.	**DVHA** has continued to address identified barriers and evaluate progress; however, statistical analyses have not yet been completed. **DVHA** has identified the finding that heart failure diagnoses are more reliable when two claims with this diagnosis are required, rather than just one. The incidence of members reporting that they were inaccurately included in the intervention population now appears to be negligible. As **DVHA**'s current PIP is in year 2 and its first intervention has been implemented, the team has begun discussions of data analysis and the possibility of the need to revise interventions. The team will use quality improvement (QI) tools to identify barriers and possible revised interventions.

Validation of Performance Measures

HSAG validated performance measures for nine areas of performance (with one diabetes measure including four indicators) for a total of 12 indicators. HSAG auditors determined that all 12 were compliant with AHS' specifications and the rates could be reported. As a result of HSAG's desk review and on-site audit, HSAG described the following areas for improvement.

Table 4-2—Performance Measure—Recommendations/Suggestions and DVHA Responses

HSAG Recommendations	DVHA Response/Actions/Outcomes
◆ **DVHA** should use prior year utilization figures to identify gaps or trends in service categories, such as laboratory (lab) and pharmacy data. As also recommended in the prior year, **DVHA** should aggressively pursue options for obtaining Logical Observation Identifiers, Names, and Codes (LOINC) data from Hewlett-Packard (HP), as it was apparent that some lab providers were reporting LOINC codes, but HP was not retaining or using them for payment purposes.	Lab information is currently not retained by HP when the information is presented on the claim. **DVHA** will not be able to address this until the new MMIS is implemented in calendar year (CY) 2017.
◆ **DVHA** should integrate its quality improvement staff into all areas related to performance measure reporting in order to coordinate data analysis efforts and prepare for future PMV activities. It would be beneficial for **DVHA**'s Information Technology (IT) staff to consider all data sources and bring content experts/stakeholders to regular HEDIS team meetings so that everyone understands the flow of data.	The **DVHA** Data Unit and Quality Unit have been able to improve on integration with the addition of quality staff. A staff person from the data unit has been identified as the primary contact for the Quality Unit. The two units now work closely on producing performance measures and on performance improvement projects. The Quality Unit is the lead for training staff to perform chart extractions for the hybrid measures. Quality Unit staff members participate in the calls with their HEDIS vendor, Verisk Health.
◆ As **DVHA** becomes more familiar with HEDIS and PMV processes, it may be beneficial to consider alternative methods for reviewing data (for example, reviewing per member per month [PMPM] or per member per hybrid reporting) and make use of all available resources and industry experts in order to ensure a successful outcome. **DVHA** is encouraged to carefully plan its hybrid project for next year.	**DVHA** has worked with a contractor to train staff on performing chart reviews for the hybrid measures. Staff members are also working with **DVHA**'s HEDIS vendor and attending several trainings on how to use the tools to perform the extractions. The Quality Unit has developed a manual which outlines procedures to ensure consistency and staff members have been identified to be trainers for clinical reviewers.
◆ HSAG encourages **DVHA** to provide an organizational overview PowerPoint presentation for next year's audit highlighting its performance improvement project work, system or processes changes, and any other quality-related initiatives or outreach efforts. ◆ **DVHA** is encouraged to actively pursue	This recommendation will be considered during preparation for the next audit. **DVHA** has been working closely with its HEDIS vendor, Verisk Health, with hybrid implementation.

Table 4-2—Performance Measure—Recommendations/Suggestions and DVHA Responses	
HSAG Recommendations	**DVHA Response/Actions/Outcomes**
acquiring these data for 2013 if possible, in order to administratively increase rates for measures that do not incorporate hybrid methodology.	
◆ Because of its ambitious plans, **DVHA** should carefully plan the hybrid project (for HEDIS 2014) to include *Controlling High Blood Pressure* and *Prenatal* and *Postpartum Care* to ensure success. HSAG recommends **DVHA** obtain guidance from subject matter experts and other industry resources as it begins these efforts.	**DVHA** contracted for training of staff to perform the hybrid chart reviews. Staff members are also participating in ongoing trainings with **DVHA**'s HEDIS vendor on performing chart extractions.

Monitoring Compliance With Standards

HSAG evaluated **DVHA**'s performance related to seven standards (groups of related requirements). The standards included requirements in the following performance areas: Availability of Services, Furnishing of Services, Cultural Competency, Coverage and Authorization of Services, Emergency and Post Stabilization Services, and Enrollment and Disenrollment.

Table 4-3—Monitoring Compliance With Standards—Recommendations/Suggestions and DVHA Responses	
HSAG Recommendations	**DVHA Responses/Actions/Outcomes**
◆ In the area of coverage and authorization of services, specifically related to the content of notices of actions, **DVHA**'s notices did not consistently include all required information. **DVHA** must ensure that written notice of action from the MCE, and those of its partner delegates, meet all content requirements described in 42 CFR 438.404(b) and in the AHS-**DVHA** IGA.	**DVHA** reported that its notices now contain standardized language designed to comply with the AHS-DVHA IGA and 42 CFR 438.404(b). Furthermore, a new e-mail group was formed to quickly review changes in notice letter templates to ensure clarity and compliance.
◆ Related to the requirements for coverage and authorization of services, **DVHA** must ensure that a written notice of action is provided to the beneficiary at the time of denial of claims payment for covered services. (Note: This requirement to notify the beneficiary does not apply to payment denials based on procedural issues [e.g., the provider was not billing the services on time or the provider used the incorrect procedure code]). ◆ It is also recommended that **DVHA** modify its Notice of Action Policy to conform to these requirements.	**DVHA**'s MMIS does not currently support this capability, but it is being added to **DVHA**'s new MMIS, which is still under procurement. **DVHA** members are protected from financial liability in that the provider agreement forbids any provider from billing a member for a service that was billed to Medicaid (even if the claim is denied).
◆ Related to Emergency and Post Stabilization	These changes have been incorporated into **DVHA**'s

Table 4-3—Monitoring Compliance With Standards—Recommendations/Suggestions and DVHA Responses	
HSAG Recommendations	**DVHA Responses/Actions/Outcomes**
Services, and while not rising to the level of requiring corrective action, **DVHA** is encouraged to consider adding to the provider manual and the member handbooks that **DVHA** does not limit or define what constitutes an emergency medical condition based on a list of diagnoses or symptoms.	next printing of the member handbook (which it will begin mailing out by 2/28/15).
◆ Also in the area of Emergency and Post Stabilization Services, HSAG encourages **DVHA** to ensure that providers were fully informed about the changes to requirements related to billing and reimbursement for emergency and poststabilization services provided to members.	**DVHA** added language to its provider manual to address this recommendation (see Section 7.3.1 on page 50).
◆ Related to requirements for enrollment and disenrollment, HSAG encouraged **DVHA** to consider using other wording in the member handbook addressing "excessive" no shows without prior cancellations, and to consider only member in-office behaviors that were inappropriate and not due to diminished mental or emotional capabilities.	**DVHA** removed the language about disenrollment due to "no-shows" and replaced it with language reminding members that they are responsible for keeping appointments. See page 20 of the member handbook.