

I. INTRODUCTION

The Comprehensive Quality Strategy (CQS) is intended to serve as a blueprint or road map for Vermont and its contracted health plans in assessing the quality of care that beneficiaries receive, as well as for setting forth measurable goals and targets for improvement. In doing so, it sets forth specifications for quality assessment and performance improvement activities that AHS will implement to ensure the delivery of quality health care. In addition, the CQS includes a special focus on MLTSS populations and addresses the following: A self-assessment of MLTSS adherence to state and federal standards of care to include: assessment of existing initiatives designed to improve the delivery of MLTSS (including performance measures or PIPs directed to this population and an examination of processes to identify any potential corrective action steps toward improving the MLTSS system), Person-Centered Planning, Integrated Care Settings, Comprehensive and Integrated Service packages, Qualifications of Providers, and Participant Protections. The plan includes distinctive components for discovery, remediation, and improvement.

a. Managed Care Goals, Objectives and Overview

This section provides a brief description of Medicaid managed care in Vermont, as well as the goals, guiding principles, and objectives of the Medicaid managed care program. The goals align with the three part aim but are more specific in identifying pathways for the state to achieve its goals. This section also includes the identification of priorities, strategic partnerships, and quantifiable performance driven objectives. The objectives reflect the state's priorities and areas of concern for the population covered by the MCE contract. This section also includes the following: a brief history of Vermont's Medicaid (and CHIP, if applicable) managed care programs, an overview of the quality management structure that is in place at the state level, general information about Vermont's decision to contract with an MCE (e.g., to address issues of cost, quality, and/or access), as well as the reasons why the state believes the use of a managed care system will positively impact the quality of care delivered in Medicaid and CHIP.

State and Provider Responsibilities

The section includes state Medicaid agency and any contracted or Medicaid enrolled service providers' responsibilities. The Single State Agency, AHS, retains ultimate authority and accountability for public managed care responsibilities and adherence to the CQS, including monitoring and evaluation of the public managed care model's compliance with requirements specific to the MLTSS assurances identified in STC 1(a)(vii)(2) - as well as the health and welfare of enrollees.

b. Development & Review of Quality Strategy

This section describes how the state developed the quality strategy, subsequently reviews the quality strategy for effectiveness, and the timeline/process for revision of the quality strategy. This section includes a description of how the state obtained the input of beneficiaries and other stakeholders in the development of the quality strategy as well as a description of how the state made (or plans to make) the quality strategy available for public comment before adopting it in final. In addition, this section

includes a timeline for assessing the effectiveness of the quality strategy (e.g., monthly, quarterly, annually) as well as a timeline for modifying or updating the quality strategy.

Public Engagement

The State will solicit and obtain the input of beneficiaries, the Medicaid and Exchange Advisory Board (MEAB), and other stakeholders in its development. This includes making the draft CQS, as well as any significant revisions, available for public comment prior to submission to CMS.

II. ASSESSMENT

a. Quality and Appropriateness of Care

This section summarizes state procedures that assess the quality and appropriateness of care and services furnished to all Medicaid enrollees under the MCE contract, and to individuals with special health care needs. This section also includes the state's definition of special health care needs. In addition, this section details the methods or procedures the state uses to identify the race, ethnicity, and primary language spoken of each Medicaid enrollee. Finally, this section documents efforts or initiatives that the state or MCE has engaged in to reduce disparities in health care.

b. National Performance Measures

This section includes a description of any required national performance measures and levels identified and developed by CMS in consultation with states and other stakeholders. It also indicates whether Vermont plans to voluntarily collect any of the CMS core performance measures for children and adults in Medicaid/CHIP. If so, this section identifies state targets/goals for any of the core measures selected by Vermont for voluntary reporting.

Population Specific Metrics

This section includes information on population specific metrics for each population covered by the Medicaid program, including children, pregnant women, non-disabled adults (including parents), individuals receiving home and community services (HCBS), and individuals receiving long term services and supports (Choices for Care). Metrics are measured at the following levels of aggregation: the state Medicaid agency, specific health care program (such as Choices for Care), and potentially at each direct health services provider. The state will work with CMS to further define metrics, as appropriate, for collection. This section also includes the specific methodology for determining benchmark and target performance on these metrics. Measures include, but are not limited to:

1. HCBS performance measures in the areas of: level of care determinations, person-centered service planning process, outcome of person-centered goals, health and welfare, outcomes, quality of life, effectiveness process, community integration, and assuring there are qualified providers and appropriate HCBS settings.

The metrics are aligned with the Medicaid and CHIP adult and child core measures, and also align with other existing Medicare and Medicaid federal measure sets where possible and appropriate. In addition, the metrics go beyond HEDIS and CAHPS data, and reflect cost of care.

c. Monitoring, Compliance, and Evaluation

This section includes methods and procedures the state will use to monitor MCE compliance with Federal regulations. It includes procedures that account for the regular monitoring and evaluation of MCE compliance with the standards of subpart D (access, structure and operations, and measurement and improvement standards) including, but not limited to the following: member or provider surveys, HEDIS results, reporting of performance measures and performance improvement projects, grievance and appeals. Special focus is placed on long term care services and supports (CFC) populations and addresses the following:

1. A self-assessment of CFC adherence to state and federal standards of care to include:
 - i. Assessment of existing initiatives designed to improve the delivery of CFC, including performance measures or Performance Improvement Projects (PIPs) directed to this population.
 - ii. Examination of processes to identify any potential corrective action steps toward improving the CFC system.
2. Person-Centered Planning and Integrated Care Settings
3. Comprehensive and Integrated Service packages
4. Qualifications of Providers
5. Participant Protections

This section also includes specific plans for continuous quality improvement, which includes transparency of performance on metrics and structured learning, as well as a rigorous and independent evaluation of the demonstration, as described in STC 63.

d. External Quality Review (EQR)

This section includes a description of the state's arrangements for an annual, external independent quality review of the quality, access, and timeliness of the services covered under the MCE contract. In addition, this section identifies the entity that performs the EQR and for what period of time. Since the state has not contracted with its External Quality Review Organization (EQRO) to perform any optional EQR activities – this section only includes a description of mandatory activities.

III. STATE STANDARDS

a. Access Standards

This section includes a discussion of the standards that the state has established in the MCE contract for access to care, as required by 42 C.F.R. Part 438, subpart D (i.e., *availability of services, assurances of adequate capacity and services, coordination and continuity of care, and coverage and authorization of services*). These standards relate to the overall goals and objectives listed in the quality strategy's introduction (see Section I above). This section also provides a summary description of the contract provisions.

b. Structure and Operations Standards

This section includes a discussion of the standards that the state has established in the MCE contract for structure and operations, as required by 42 C.F.R. Part 438, subpart D (i.e., *provider selection, enrollee information, confidentiality, enrollment and disenrollment, grievance systems, and sub contractual relationships and delegation*). These standards relate to the overall objectives listed in the quality strategy's introduction (see Section I above). This section also provides a summary description of the contract provisions.

c. Measurement and Improvement Standards

This section includes a discussion of the standards that the state has established in the MCE contract for measurement and improvement, as required by 42 C.F.R. Part 438, subpart D (i.e., *practice guidelines, quality assessment and performance improvement program, and health information systems*). All Performance Improvement Project (PIP) topics, tied to specific goals, are included in the CQS. These standards relate to the overall objectives listed in the quality strategy's introduction (see Section I above). This section also provides a summary description of the contract provisions.

IV. IMPROVEMENT & INTERVENTIONS

This section describes how the state will attempt to improve the quality of care delivered by the MCE through interventions including, but not limited to the following: Cross-state agency collaborative; Grants; and Disease management programs.

a. Intermediate Sanctions

This section details how the state will appropriately use intermediate sanctions that meet the requirements of 42 C.F.R. Part 438, subpart I. In addition, this section specifies the state's methodology for using intermediate sanctions as a vehicle for addressing identified quality of care problems.

b. Health Information Technology

This section details how the state's information system supports initial and ongoing operation and review of the state's quality strategy. In addition, it describes any innovative health information technology (HIT) initiatives that will support the objectives of the state's quality strategy and ensure the state is progressing toward its stated goals.

V. DELIVERY SYSTEM REFORMS

This section includes information on delivery system reforms such as incorporating long-term services and supports into a managed care delivery system. It describes the reasons for incorporating this population/service into managed care and includes a definition of this population and methods of

identifying enrollees in this population. It also lists applicable performance measures to this population/service, as well as the reasons for collecting these performance measures. In addition, this section lists any performance improvement projects that are tailored to this population/service and includes a description of the interventions associated with the performance improvement projects. Finally, any assurances required in the state's Special Terms and Conditions (STCs), if applicable, are addressed in this section.

VI. CONCLUSIONS & OPPORTUNITIES

This section includes a description of the following: the identification of successes that the state considers to be best or promising practices; a discussion of the ongoing challenges the state faces in improving the quality of care for beneficiaries; a discussion of challenges or opportunities with data collection systems, such as registries, claims or enrollment reporting systems, pay-for-performance tracking or profiling systems, electronic health record (EHR) information exchange, regional health information technology collaborative, telemedicine initiatives, grants that support state HIT/EHR development or enhancement, etc.; recommendations that the state has for ongoing Medicaid and CHIP quality improvement activities in the state; and highlight grants received that support improvement of the quality of care received by managed care enrollees.