State of Vermont

Agency of Human Services
(AHS)

2015–2016 External Quality Review Technical Report

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HSAG HEALTH SERVICES ADVISORY GROUP

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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 2007–2008 to conduct the three Centers for Medicare & Medicaid Services (CMS) required activities and to prepare the external quality review (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 beneficiary.

The Vermont Agency of Human Services (AHS)

AHS is the State agency responsible for administrating the Medicaid managed care program in Vermont. In fall 2005, the Vermont Legislature approved implementation of the Global Commitment to Health Waiver, a demonstration initiative operated under an 1115 waiver. The waiver allowed the State to designate the Office of Vermont Health Access (OVHA), now 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 the current EQRO contract year (February 2015–February 2016), HSAG conducted the three mandatory EQR activities and compared the information to **DVHA**'s performance data from the prior year. The results of HSAG's review are contained in this 2015–2016 EQR technical report.

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

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. It is also responsible for (1) state oversight and coordination of Vermont's expansive Health Care Reform initiatives which are designed to increase access, improve quality, and contain the cost of health care for all Vermonters; (2) Vermont's health information technology strategic planning, coordination, and oversight; and (3) the Blueprint for Health.

DVHA's stated mission as the statewide Medicaid managed care model organization is to:

- 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 2015–2016 EQR Activities

HSAG's external quality review in contract year 2015–2016 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 Measurement and Improvement standards at 42 CFR §438.236–242 and with the associated requirements contained in the AHS IGA (i.e., contract) with **DVHA**.
- ***Preparation of the external quality review annual technical report***. HSAG compiled and analyzed all data from its 2015–2016 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 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 IX.

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 ensuring that beneficiaries receive needed care and services. Beneficiaries receiving appropriate follow-up care can reduce the risk of repeat hospitalization. **DVHA**'s goal is to increase the percentage of discharges for beneficiaries six years of age and older who were hospitalized for treatment of selected mental illness diagnoses and had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within seven and 30 days of discharge. **DVHA** used data from calendar year (CY) 2014 for the first remeasurement results.

DVHA's *Follow-up After Hospitalization for Mental Illness* PIP received a score of 90 percent for all applicable evaluation elements scored as *Met*, a score of 90 percent for critical evaluation elements scored as *Met*, and an overall validation status of *Not 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*	90%
Percentage Score of Critical Elements Met**	90%
Validation Status***	***Not 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. The PIP overall score was *Not Met* because the interventions did not result in real improvement in the study indicator results.

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	*Not Applicable*	*Not Applicable*
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	6/6	3/3
IX. Assess for Real Improvement	1/3	0/1
X. Assess for Sustained Improvement	*Not Assessed*	*Not Assessed*

The validation results indicated an overall score of 90 percent across all applicable evaluation elements. **DVHA** provided all of the required documentation, and the PIP was a methodologically sound study. However, the study indicator results did not demonstrate improvement from baseline to Remeasurement 1. As a result, the critical evaluation element in Activity IX related to achieving statistically significant improvement over baseline was scored *Not Met*, which resulted in an overall *Not Met* validation status for the PIP.

Validation of Performance Measures

HSAG validated a set of performance measures selected by AHS that were calculated and reported by **DVHA**. The methodology HSAG used to validate the performance measures was based on CMS' performance measures' validation protocol.[1-2] The validation findings confirmed that all rates were reportable. Table 1-3 below displays the performance measure results, including a comparison to the prior year's rates and the Healthcare Effectiveness Data and Information Set (HEDIS®)[1-3] 2014 national Medicaid percentiles. Measures with no rates displayed, which are denoted with a double-dash (--), were not reported in HEDIS 2014; therefore, trending was not applicable (NA).

Table 1-3—DVHA HEDIS 2015 Results

Performance Measure	HEDIS 2014		HEDIS 2015		Overall Trend	HEDIS Percentile Ranking
	N	Rate	N	Rate	Change	
Well-Child Visits in the First 15 Months of Life—0 Visits¥	3,082	1.59%	3,146	1.53%	-0.06%	25th–50th
Well-Child Visits in the First 15 Months of Life—1 Visit	3,082	0.91%	3,146	0.79%	-0.12%	10th–25th
Well-Child Visits in the First 15 Months of Life—2 Visits	3,082	1.36%	3,146	2.07%	+0.71%	25th–50th
Well-Child Visits in the First 15 Months of Life—3 Visits	3,082	2.60%	3,146	3.46%	+0.86%	10th–25th
Well-Child Visits in the First 15 Months of Life—4 Visits	3,082	5.39%	3,146	6.58%	+1.19%	10th–25th
Well-Child Visits in the First 15 Months of Life—5 Visits	3,082	12.20%	3,146	14.72%	+2.52%	25th–50th
Well-Child Visits in the First 15 Months of Life—6 or More Visits	3,082	75.96%	3,146	70.85%	-5.11%	75th–90th
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	13,170	71.49%	13,219	72.82%	+1.33%	50th–75th
Adolescent Well-Care Visits	22,630	46.97%	25,496	47.35%	+0.38%	25th–50th
Annual Dental Visits—Ages 2–3	6,378	46.47%	6,568	46.80%	+0.33%	75th–90th
Annual Dental Visits—Ages 4–6	9,947	71.61%	9,945	71.42%	-0.19%	75th–90th
Annual Dental Visits—Ages 7–10	12,782	77.85%	12,989	77.24%	-0.61%	75th–90th
Annual Dental Visits—Ages 11–14	12,139	72.19%	11,922	72.68%	+0.49%	90th–95th
Annual Dental Visits—Ages 15–18	10,098	65.64%	11,195	65.36%	-0.28%	>95th
Annual Dental Visits—Ages 19–21	2,664	43.02%	5,379	39.58%	-3.44%	50th–75th
Annual Dental Visits—Combined Rate	54,008	67.72%	57,998	66.07%	-1.65%	75th–90th
Children's and Adolescents' Access to Primary Care Practitioners—12–24 Months	3,453	98.55%	3,572	97.40%	-1.15%	50th–75th
Children's and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	16,077	92.13%	16,221	91.35%	-0.78%	50th–75th
Children's and Adolescents' Access to Primary Care Practitioners—7–11 Years	14,460	94.46%	14,307	95.93%	+1.47%	90th–95th

[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 2015 Results						
Performance Measure	HEDIS 2014		HEDIS 2015		Overall Trend	HEDIS Percentile Ranking
	N	Rate	N	Rate	Change	
Children's and Adolescents' Access to Primary Care Practitioners—12–19 Years	18,485	93.90%	19,122	94.81%	+0.91%	90th–95th
Chlamydia Screening in Women—16–20 Years	3,092	47.35%	3,977	49.56%	+2.21%	25th–50th
Chlamydia Screening in Women—21–24 Years	2,299	54.85%	2,985	57.25%	+2.40%	25th–50th
Chlamydia Screening in Women—Total	5,391	50.55%	6,962	52.86%	+2.31%	25th–50th
Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	31,658	84.21%	40,215	77.44%	-6.77%	10th–25th
Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	21,700	89.37%	22,030	83.83%	-5.54%	10th–25th
*Adults' Access to Preventive/Ambulatory Health Services—65+ Years***	7,718	94.31%	381	83.20%	-11.11%	25th–50th
Adults' Access to Preventive/Ambulatory Health Services—Total	61,076	87.32%	62,626	79.72%	-7.60%	10th–25th
*Comprehensive Diabetes Care—HbA1c Testing**	6,364	65.07%	548	81.39%	NT	25th–50th
*Comprehensive Diabetes Care—Eye Exam**	6,364	47.03%	548	51.82%	NT	25th–50th
*Comprehensive Diabetes Care—Medical Attention for Nephropathy**	6,364	61.36%	548	70.44%	NT	5th–10th
Follow-Up After Hospitalization for Mental Illness—7-day Follow-up	1,567	41.61%	1,152	42.45%	+0.84%	50th–75th
Follow-Up After Hospitalization for Mental Illness—30-day Follow-up	1,567	61.77%	1,152	59.29%	-2.48%	25th–50th
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation)—13–17 Years	312	42.63%	293	39.59%	-3.04%	50th–75th
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation)—18 Years and Older	5,715	33.88%	5,418	33.04%	-0.84%	10th–25th
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation)—Total	6,027	34.33%	5,711	33.37%	-0.96%	10th–25th
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Engagement)—13–17 Years	312	18.91%	293	17.75%	-1.16%	50th–75th
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Engagement)—18 Years and Older	5,715	13.26%	5,418	13.34%	+0.08%	50th–75th
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Engagement)—Total	6,027	13.56%	5,711	13.57%	+0.01%	50th–75th
Use of Appropriate Medications for People With Asthma—5–11 Years	552	90.04%	545	89.17%	-0.87%	25th–50th
Use of Appropriate Medications for People With Asthma—12–18 Years	501	86.43%	453	82.34%	-4.09%	10th–25th
Use of Appropriate Medications for People With Asthma—19–50 Years	897	75.92%	971	74.97%	-0.95%	25th–50th
Use of Appropriate Medications for People With Asthma—51–64 Years	227	80.62%	243	82.72%	+2.10%	90th–95th

Table 1-3—DVHA HEDIS 2015 Results						
Performance Measure	HEDIS 2014		HEDIS 2015		Overall Trend	HEDIS Percentile Ranking
	N	Rate	N	Rate	Change	
Use of Appropriate Medications for People With Asthma—Total	2,177	82.41%	2,212	80.83%	-1.58%	10th–25th
Antidepressant Medication Management—Effective Acute Phase Treatment	4,161	63.30%	3,225	69.36%	+6.06%	>95th
Antidepressant Medication Management—Effective Continuation Phase Treatment	4,161	44.12%	3,225	52.22%	+8.10%	90th–95th
Breast Cancer Screening	7,543	38.10%	4,211	56.11%	+18.01%	25th–50th
*Controlling High Blood Pressure**	--	--	411	48.18%	NA	10th–25th
*Prenatal and Postpartum Care—Timeliness of Prenatal Care**	--	--	411	82.00%	NA	25th–50th
*Prenatal and Postpartum Care—Postpartum Care**	--	--	411	57.91	NA	25th–50th

¥ A lower rate (decline) indicates better performance for this indicator.
* For HEDIS 2015, this measure was calculated using hybrid methodology.
** Medicare enrollees were removed from the eligible population when calculating this indicator for the *Adults' Access to Preventive/Ambulatory Health Services—65+ Years* measure for HEDIS 2015. This change has resulted in a smaller denominator than in the previous year. Therefore, caution should be exercised when comparing HEDIS 2015 to the previous years' results.
NT = Trending cannot be performed due to the changes in data collection methodologies between years.

DVHA performed well on certain clinical indicators and below the 25th national Medicaid percentile on other clinical indicators. Of the 49 clinical indicators reported, two indicators exceeded the 95th national Medicaid percentile:

- *Annual Dental Visits—Ages 15–18*
- *Antidepressant Medication Management—Effective Acute Phase Treatment*

In addition to the two indicators above, five indicators exceeded the 90th national Medicaid percentile:

- *Annual Dental Visits—Ages 11–14*
- *Children's and Adolescents' Access to Primary Care Practitioners—7–11 Years*
- *Children's and Adolescents' Access to Primary Care Practitioners—12–19 Years*
- *Use of Appropriate Medications for People With Asthma—51–64 Years*
- *Antidepressant Medication Management—Effective Continuation Phase Treatment*

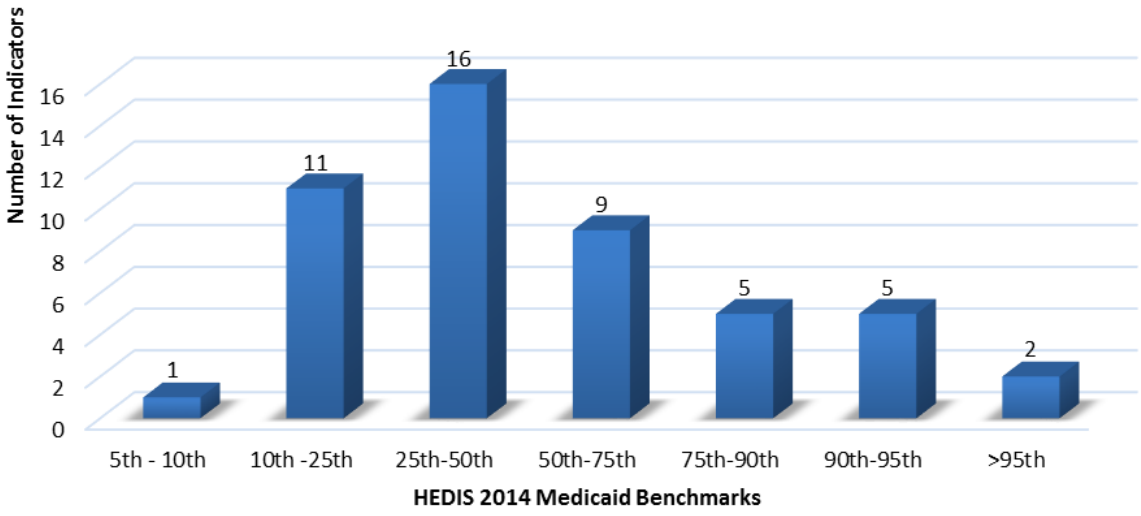
DVHA performed below the 25th national Medicaid percentile on 12 indicators:

- *Well-Child Visits in the First 15 Months of Life—1 Visit*
- *Well-Child Visits in the First 15 Months of Life—3 Visits*
- *Well-Child Visits in the First 15 Months of Life—4 Visits*
- *Adults' Access to Preventive/Ambulatory Health Services—20–44 Years*
- *Adults' Access to Preventive/Ambulatory Health Services—45–64 Years*

- *Adults' Access to Preventive/Ambulatory Health Services—Total*
- *Comprehensive Diabetes Care— Medical Attention for Nephropathy*
- *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation)—18 Years and Older*
- *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation)—Total*
- *Use of Appropriate Medications for People With Asthma—12–18 Years*
- *Use of Appropriate Medications for People With Asthma—Total*
- *Controlling High Blood Pressure*

Figure 1-1 shows the distribution of how the reported indicators compared to the 2014 HEDIS national Medicaid benchmarks.

Figure 1-1—Number of Indicator Rates Meeting the HEDIS 2014 Medicaid Benchmarks



As shown in the figure above, a majority of the indicators were between the 10th and 50th national Medicaid percentiles, indicating that many opportunities for improvement exist.

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 2015–2016, AHS requested that HSAG conduct a review of the Measurement and Improvement 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 review period. Reviewers also conducted staff interviews related to each of the three standards to allow **DVHA** staff members to elaborate on the written information HSAG reviewed, to assess the consistency of staff responses given during the interviews against the written documentation, and to clarify any questions reviewers had following the document review.

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

Table 1-4 presents a summary of **DVHA**'s performance results for the three standard areas reviewed. The information includes:

- The total number of elements (i.e., requirements) and the number of applicable elements for each of the standards.
- The number of elements for each of the standards that received a score of *Met*, *Partially Met*, *Not Met*, or a designation of *NA* (not applicable), as well as the totals across the three 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	Practice Guidelines	**11**	**11**	**10**	**0**	**1**	**0**	**90.9%**
II	Quality Assessment and Performance Improvement (QAPI) Program	**11**	**11**	**11**	**0**	**0**	**0**	**100%**
III	Health Information Systems	**9**	**9**	**9**	**0**	**0**	**0**	**100%**
	Totals	**31**	**31**	**30**	**0**	**1**	**0**	**96.8%**

***Total # of Elements*:** The total number of elements in each standard.
***Total # of Applicable Elements*:** The total number of elements within each standard minus any elements that received a score of *NA*.
***Total Compliance Score*:** The overall percentages were calculated by adding the number of elements that received a score of *Met* to the weighted (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 above, HSAG reviewed **DVHA**'s performance related to 31 requirements across the three standards. Of the 31 requirements, **DVHA** obtained a score of *Met* for 30 of the requirements. One element in the Practice Guidelines Standard was scored *Not Met*. As a result **DVHA** obtained a total percentage of compliance score across the 31 requirements of 96.8 percent.

[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.

With scores at or above 90 percent in all three of the standard areas reviewed, **DVHA** demonstrated numerous performance strengths in meeting the federal measurement and improvement regulations and AHS contract requirements. Two of the three standards indicated significant areas of strength, with scores of 100 percent. For the only standard area with a score below 100 percent—Practice Guidelines—**DVHA** scored *Partially Met* on one of the 11 evaluation elements. Targeted opportunities for improvement could be achieved by updating practice guidelines as required by **DVHA**'s policies and procedures.

DVHA's performance represented a change in one element from the 2011–2012 review of the same standards. During the prior review, **DVHA** scored 100 percent in all three standards. This year's review produced scores of 100 percent in two of the standards and 90.9 percent in one standard. The one element found to be noncompliant involved validating that the clinical practice guidelines were reviewed and periodically updated as required by the **DVHA** Evidence-based Clinical Practice Guidelines policy and procedure.

Overall Conclusions and Performance Trending

Performance Trends

Performance Improvement Project Trends

This was the second year **DVHA** conducted its PIP—*Follow-up After Hospitalization for Mental Illness*. **DVHA**'s performance suggests a continuation of its thorough application of the Design stage and the Implementation and Evaluation stage. **DVHA** provided accurate and comprehensive documentation to support a solid study design that was methodologically sound. **DVHA** appropriately collected the necessary data to produce accurate study indicator rates. **DVHA** reported baseline and first remeasurement results, completed causal/barrier analysis, prioritized barriers, and implemented interventions linked with barriers.

This was the first year that the PIP was assessed for improvement. The PIP study indicator results declined from the baseline and did not achieve statistically significant improvement. Since this was the first year in which remeasurement results were included, trending of the results will be included in subsequent reports.

Performance Measure Trends

DVHA used software, the source code of which had been certified by the NCQA to calculate and report the HEDIS 2015 measures. Table 1-5 below displays the rates for measures **DVHA** reported for HEDIS 2012, 2013, 2014, and 2015, and the overall trended rate. The trends displayed are calculated from the first reported rate to the HEDIS 2015 rate. Measures with no rates displayed (--) were not reported in prior years; therefore, trending was not performed (NA).

Table 1-5—HEDIS 2012, 2013, 2014, and 2015 Rates and Trended Results									
Performance Measure	HEDIS 2012		HEDIS 2013		HEDIS 2014		HEDIS 2015		Overall Trend
	N	Rate	N	Rate	N	Rate	N	Rate	Change (Percentage Point Difference)
Well-Child Visits in the First 15 Months of Life—0 Visits[¥]	3,131	1.72%	3,109	2.06%	3,082	1.59%	3,146	1.53%	-0.19
Well-Child Visits in the First 15 Months of Life—1 Visit	3,131	1.05%	3,109	1.29%	3,082	0.91%	3,146	0.79%	-0.26
Well-Child Visits in the First 15 Months of Life—2 Visits	3,131	1.72%	3,109	1.83%	3,082	1.36%	3,146	2.07%	+0.35
Well-Child Visits in the First 15 Months of Life—3 Visits	3,131	3.29%	3,109	2.22%	3,082	2.60%	3,146	3.46%	+0.17
Well-Child Visits in the First 15 Months of Life—4 Visits	3,131	5.94%	3,109	5.40%	3,082	5.39%	3,146	6.58%	+0.64
Well-Child Visits in the First 15 Months of Life—5 Visits	3,131	12.36%	3,109	11.97%	3,082	12.20%	3,146	14.72%	+2.36
Well-Child Visits in the First 15 Months of Life—6 or More Visits	3,131	73.91%	3,109	75.23%	3,082	75.96%	3,146	70.85%	-3.06
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	13,137	69.70%	13,186	69.32%	13,170	71.49%	13,219	72.82%	+3.12
Adolescent Well-Care Visits	22,547	46.17%	22,441	46.27%	22,630	46.97%	25,496	47.35%	+1.18
Annual Dental Visits—Ages 2–3	6,407	47.15%	6,418	46.96%	6,378	46.47%	6,568	46.80%	-0.35
Annual Dental Visits—Ages 4–6	9,857	73.36%	9,981	72.78%	9,947	71.61%	9,945	71.42%	-1.94
Annual Dental Visits—Ages 7–10	12,441	78.05%	12,659	78.02%	12,782	77.85%	12,989	77.24%	-0.81
Annual Dental Visits—Ages 11–14	11,869	73.48%	12,123	72.76%	12,139	72.19%	11,922	72.68%	-0.80
Annual Dental Visits—Ages 15–18	9,841	66.15%	9,740	65.56%	10,098	65.64%	11,195	65.36%	-0.79
Annual Dental Visits—Ages 19–21	3,119	40.53%	2,641	44.72%	2,664	43.02%	5,379	39.58%	-0.95
Annual Dental Visits—Combined Rate	53,534	68.10%	53,562	68.23%	54,008	67.72%	57,998	66.07%	-2.03
Children's and Adolescents' Access to Primary Care Practitioners—12–24 Months	3,487	98.34%	3,423	98.31%	3,453	98.55%	3,572	97.40%	-0.94
Children's and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	16,004	92.18%	16,175	91.70%	16,077	92.13%	16,221	91.35%	-0.83
Children's and Adolescents' Access to Primary Care Practitioners—7–11 Years	13,834	94.54%	14,221	94.48%	14,460	94.46%	14,307	95.93%	+1.39
Children's and Adolescents' Access to Primary Care Practitioners—12–19 Years	17,999	93.56%	18,212	93.73%	18,485	93.90%	19,122	94.81%	+1.25
Chlamydia Screening in Women—16–20 Years	--	--	--	--	3,092	47.35%	3,977	49.56%	NA

Table 1-5—HEDIS 2012, 2013, 2014, and 2015 Rates and Trended Results									
Performance Measure	HEDIS 2012		HEDIS 2013		HEDIS 2014		HEDIS 2015		Overall Trend
	N	Rate	N	Rate	N	Rate	N	Rate	Change (Percentage Point Difference)
Chlamydia Screening in Women—21–24 Years	--	--	--	--	2,299	54.85%	2,985	57.25%	NA
Chlamydia Screening in Women—Total	--	--	--	--	5,391	50.55%	6,962	52.86%	NA
Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	30,444	81.39%	30,936	84.09%	31,658	84.21%	40,215	77.44%	-3.95
Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	20,393	83.59%	20,947	88.93%	21,700	89.37%	22,030	83.83%	+0.24
*Adults' Access to Preventive/Ambulatory Health Services—65+ Years***	7,488	79.49%	7,615	93.04%	7,718	94.31%	381	83.20%	+3.71
Adults' Access to Preventive/Ambulatory Health Services—Total	58,325	81.92%	59,498	86.94%	61,076	87.32%	62,626	79.72%	-2.20
*Comprehensive Diabetes Care—HbA1c Testing**	6,073	63.84%	6,152	64.19%	6,364	65.07%	548	81.39%	NT
*Comprehensive Diabetes Care—Eye Exam**	6,073	45.69%	6,152	46.68%	6,364	47.03%	548	51.82%	NT
*Comprehensive Diabetes Care—Medical Attention for Nephropathy**	6,073	59.72%	6,152	60.27%	6,364	61.36%	548	70.44%	NT
Follow-Up After Hospitalization for Mental Illness—7-day Follow-up	--	--	--	--	1,567	41.61%	1,152	42.45%	NA
Follow-Up After Hospitalization for Mental Illness—30-day Follow-up	--	--	--	--	1,567	61.77%	1,152	59.29%	NA
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation)—13-17 Years	--	--	--	--	312	42.63%	293	39.59%	NA
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation)—18 Years and Older	--	--	--	--	5,715	33.88%	5,418	33.04%	NA
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation)—Total	--	--	--	--	6,027	34.33%	5,711	33.37%	NA
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Engagement)—13–17 Years	--	--	--	--	312	18.91%	293	17.75%	NA
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Engagement)—18 Years and Older	--	--	--	--	5,715	13.26%	5,418	13.34%	NA

Table 1-5—HEDIS 2012, 2013, 2014, and 2015 Rates and Trended Results									
Performance Measure	HEDIS 2012		HEDIS 2013		HEDIS 2014		HEDIS 2015		Overall Trend
	N	Rate	N	Rate	N	Rate	N	Rate	Change (Percentage Point Difference)
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Engagement)—Total	--	--	--	--	6,027	13.56%	5,711	13.57%	NA
Use of Appropriate Medications for People With Asthma—5–11 Years	632	92.72%	621	88.24%	552	90.04%	545	89.17%	-3.55
Use of Appropriate Medications for People With Asthma—12–18 Years	523	87.57%	518	88.42%	501	86.43%	453	82.34%	-5.23
Use of Appropriate Medications for People With Asthma—19–50 Years	823	79.10%	857	79.93%	897	75.92%	971	74.97%	-4.13
Use of Appropriate Medications for People With Asthma—51–64 Years	185	81.62%	202	84.65%	227	80.62%	243	82.72%	+1.10
Use of Appropriate Medications for People With Asthma—Total	2,163	85.34%	2,198	84.71%	2,177	82.41%	2,212	80.83%	-4.51
Antidepressant Medication Management—Effective Acute Phase Treatment	2,147	68.42%	2,578	68.81%	4,161	63.30%	3,225	69.36%	+0.94
Antidepressant Medication Management—Effective Continuation Phase Treatment	2,147	54.54%	2,578	51.98%	4,161	44.12%	3,225	52.22%	-2.32
Breast Cancer Screening	--	--	--	--	7,543	38.10%	4,211	56.11%	NA
*Controlling High Blood Pressure**	--	--	--	--	--	--	411	48.18%	NA
*Prenatal and Postpartum Care—Timeliness of Prenatal Care**	--	--	--	--	--	--	411	82.00%	NA
*Prenatal and Postpartum Care—Postpartum Care**	--	--	--	--	--	--	411	57.91	NA

¥ A lower rate (decline) indicates better performance for this indicator.
* For HEDIS 2015, this measure was calculated using hybrid methodology.
** Medicare enrollees were removed from the eligible population when calculating this indicator for the *Adults' Access to Preventive/Ambulatory Health Services—65+ Years* measure for HEDIS 2015. This change has resulted in a smaller denominator than in previous years. Therefore, caution should be exercised when comparing HEDIS 2015 to prior years' results.
NT = Trending cannot be performed due to the changes in data collection methodologies between years.

Overall, 13 of the 31 indicators with rates that could be trended showed an increase in performance since HEDIS 2012. Of the 18 measures that showed decreases in performance, the *Use of Appropriate Medications for People with Asthma* indicators (with the exception of the 51–64 year olds) exhibited the largest performance decrease, ranging from 3.55 to 5.23 percentage points.

Compliance With Standards Trends

For the 2015–2016 review, the second year of HSAG's three-year cycle of compliance reviews, HSAG performed a desk review of **DVHA**'s documents and an on-site review that included reviewing additional documents and conducting interviews with key **DVHA** staff members. HSAG evaluated the degree to which **DVHA** complied with federal Medicaid managed care regulations and the associated AHS IGA in three performance categories (i.e., standards). The three standards (i.e., Practice Guidelines, Quality Assessment and Performance Improvement Program, and Health Information Systems) included requirements associated with federal Medicaid Measurement and Improvement standards found at CFR §438.236–242.

HSAG reviews 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 a three-year cycle of reviews. The number and focus of the standards vary for each year's review. The three-year cycle consists of the following standards: Year 1, Structure and Operations standards (42 CFR §438.214–224 and 228–230); Year 2, Measurement and Improvement standards (42 CFR §438.236–242); and Year 3, Access and Enrollment/Disenrollment standards (42 CFR §438.206–210 and 42 CFR §438.226).

For this, the eighth year of reviews, HSAG reviewed the Measurement and Improvement standards, the same standards it had reviewed in 2008–2009 and 2011–2012.

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

Table 1-6—Comparison/Trending of Scores Achieved During Compliance Reviews

Year of the Review	Structure and Operations Standards			Measurement and Improvement Standards			Access and Enrollment/Disenrollment Standards		
	Elements	Score	Corrective Action %*	Elements	Score	Corrective Action %*	Elements	Score	Corrective Action %*
CY 2008	90	84%	30%						
CY 2009				29	98%	3%			
CY 2010							76	97%	7%
CY 2011	89	90%	20%						
CY 2012				30	100%	0.0%			
CY 2013							71	99%	3%
CY 2014	93	92%	15%						
CY 2015				31	96.8%	3%			

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

The scores **DVHA** received for the three years' review of the Measurement and Improvement standards ranged from 100 percent to 96.8 percent. In the CY 2008 review, **DVHA** had one item that required corrective action concerning the communication to providers about the use and application of the practice guidelines. By the CY 2012 review, **DVHA** had corrected this

deficiency. During the CY 2015 review, HSAG found a different item that did not meet the requirements in the clinical practice guideline standard. **DVHA** did not update the guidelines as required in its policies and procedures.

The scores generated from the annual compliance reviews show a steady improvement in the three-year cycle rates with the exception of the scores for the Measurement and Improvement standards from CY 2012 to CY 2015. In the Practice Guidelines standard, HSAG found one element to be noncompliant during the CY 2015 review. The element involved validating that the clinical practice guidelines were reviewed and periodically updated as required by **DVHA**'s Evidence-based Clinical Practice Guidelines policy and procedure. All other elements reviewed during CY 2015 met the federal and State requirements.

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.

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.

[1-5] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Legislative Summary: Balanced Budget Act of 1997 Medicare and Medicaid Provisions.*
[1-6] Department of Health and Human Services Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Vol 3, December 10, 2015.
[1-7] National Committee for Quality Assurance. (2015). Standards and Guidelines for Health Plans.

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).

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			✓
Chlamydia Screening in Women	✓		
Adults' Access to Preventive/Ambulatory Health Services			✓
Comprehensive Diabetes Care	✓		
Follow-Up After Hospitalization for Mental Illness	✓	✓	✓
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment			✓
Use of Appropriate Medications for People With Asthma	✓		
Antidepressant Medication Management	✓	✓	✓
Breast Cancer Screening	✓		
Controlling High Blood Pressure	✓		
Prenatal and Postpartum Care	✓	✓	✓
Compliance Review Standards	**Quality**	**Timeliness**	**Access**
Standard I—Practice Guidelines	✓		
Standard II—Quality Assessment and Performance Improvement Program	✓	✓	✓
Standard III—Health Information Systems	✓	✓	✓

[1-8] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*, Vol. 67, No. 115, June 14, 2002.

EQR Assessment of DVHA's Strengths and Weaknesses

Performance Improvement Project

DVHA's performance on the PIP suggests a thorough application of providing all of the necessary documentation requirements to meet CMS' PIP protocol. In the Design stage and the Implementation and Evaluation stage, 100 percent of the applicable evaluation elements received a *Met* score. **DVHA**'s documentation provided evidence that the PIP had a solid design. These activities ensured that the study properly defined and collected the necessary data to produce accurate study indicator rates. The managed care entity (MCE) appropriately conducted the data collection and analysis activities of the Implementation and Evaluation stage. **DVHA** also documented improvement strategies targeted to overcome barriers identified by the MCE. In addition, **DVHA** has a process to evaluate the effectiveness of interventions and added a new intervention to address a second barrier.

Performance Measures

As in previous years, HSAG found **DVHA**'s electronic claims and eligibility data validity to be of high quality. **DVHA** continued to strive to improve care and outcomes for Medicaid beneficiaries; 13 existing indicators exhibited positive improvement trends over the last four years, down slightly from 16 improving indicators discussed in last year's report.

One of **DVHA**'s strengths was demonstrated in its *Annual Dental Visits* measure results among children, performing between the 75th and 90th national Medicaid percentiles for ages 2 to 10, between the 90th and 95th percentiles for ages 11 to 14, and above the 95th percentile for ages 15 to 18 years.

The *Well-Child Visits in the First 15 Months of Life—Six or More Visits* measure demonstrated high performance by **DVHA**. Although this indicator exhibited a decrease compared to prior years, it still remains high, falling between the 75th and 90th national Medicaid percentiles.

In addition, the *Children's and Adolescents' Access to Primary Care Practitioners—7–11 and 12–19 Years* indicators were between the 90th and 95th national Medicaid percentiles. Conversely, the *Adults' Access to Preventive/Ambulatory Health Services* measure presented a significant challenge to **DVHA**, with three of four indicators scoring between the 10th and 25th national Medicaid percentiles.

Results for the *Antidepressant Medication Management* measure were excellent. The two indicators of effective care during the acute and continuation phases of treatment with antidepressant medications exceeded the 90th national Medicaid percentile.

DVHA employed hybrid reporting for the *Comprehensive Diabetes Care* measure indicators for the first time. Although trending could not be performed for these indicators due to this change in methodology, the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* indicator was

between the 5th and 10th national Medicaid percentiles, indicating an area of low performance and opportunity for improvement.

DVHA staff members continue to be dedicated to quality improvement and have made positive operational changes to assist in reporting the performance measures, including using hybrid methodology this year to report some measures. Based on the increase in rates due to the hybrid collection methodology, HSAG recommends continuing this effort in future reporting years.

Compliance With Standards

DVHA produced two clinical practice guidelines that were adopted and approved at the time of the on-site review: diabetes and buprenorphine. At the time of the on-site review, the Managed Care Medical Committee (MCMC) also considered adopting a clinical practice guideline for applied behavioral analysis (ABA). The ABA was a new benefit scheduled to begin July 1, 2015, and the sister department representatives and **DVHA** staff expressed concern about the variations in practice of ABA among current providers in the State.

DVHA maintained a comprehensive quality management plan and work plan that detailed the structure, scope, and purpose of the Quality Assessment and Performance Improvement (QAPI) Program, and described the performance improvement framework used by the MCE to evaluate the quality of services provided to Global Commitment to Health Waiver beneficiaries. **DVHA** had three PIPs in place at the time of the review, including CMS' required study aimed at improving the percentage of beneficiaries who received a follow-up appointment within seven days and 30 days of hospital discharge for mental illness.

DVHA maintained a Medicaid Management Information Systems (MMIS) that collected, analyzed, integrated, and reported data concerning services received by Medicaid beneficiaries. The documentation sent by **DVHA** for the pre-on-site review and interviews with staff during the on-site review confirmed that **DVHA** and Hewlett Packard (HP) employed numerous system edits and State activities to ensure that the claims data were accurate, timely, and complete. The health information systems also compiled information concerning the grievances and appeals received by **DVHA**.

DVHA displayed strong performance in creating clinical practice guidelines, monitoring, and assessing the QAPI Program, and maintaining MMIS. **DVHA** staff members did an outstanding job of preparing, organizing, and sending the pre-on-site documents with the information needed to support the requirements in the HSAG compliance tool. **DVHA** staff members participating in this year's compliance review also thoroughly understood the federal and State EQR requirements. Their knowledge about practice guidelines, the quality program, and the State's health MMIS was evident as they described processes and answered questions during the on-site interviews.

Recommendations and Opportunities for Improvement

Performance Improvement Project

DVHA documented all PIP requirements completely and accurately; however, both study indicators demonstrated declines for the first remeasurement period. While HSAG determined that **DVHA** was proficient in documenting the PIP requirements, the MCE had opportunities for improvement in the Outcomes stage. The intervention implemented for the PIP did not produce the desired results.

Recommendations

The two *Not Met* scores in Activity IX were related to documenting improvement that met the goal and demonstrating statistically significant improvement over baseline. HSAG recommends that **DVHA** continue to evaluate and determine if the interventions are having the desired impact. Based on the interim evaluation results, **DVHA** should determine if modifying current interventions or implementing new interventions is necessary to improve results. If the interventions are not having the desired impact, changes should be made before the measurement year has concluded. If possible, **DVHA** should conduct small tests of change using a rapid-cycle approach such as Plan-Do-Study-Act.

DVHA determined that there may not have been enough time for the intervention to facilitate change in the study indicator results. As the intervention progresses, **DVHA** should continue to monitor to determine if more time is needed for the impact of the intervention to be realized or if modifications should be made.

The following are HSAG's recommendations to assist **DVHA** with its quality improvement processes:

- **DVHA** should continue to review and analyze interim study indicator results in addition to the annual evaluation. Conducting interim measurements and evaluating the results could assist **DVHA** in identifying and eliminating barriers that impede improvement in addition to gauging the progress of the PIP before an entire measurement year has passed.
- **DVHA** should continue to use data mining; subgroup analysis; and its knowledge of beneficiary characteristics, utilization statistics, and provider practice patterns to identify any disparate subgroup within the study population. Interventions should be tailored to target a specific barrier for the disparate subgroup, if one is identified.
- **DVHA** should continue its collaboration with the hospital staff and accountable care organizations (ACOs). External partnerships for the PIP appear to have already led to process improvements. Continued teamwork may provide assistance and synergy in the quality improvement process, result in further system improvements, and ultimately lead to improvement in beneficiary health outcomes.
- **DVHA** should consider using rapid-cycle improvement techniques to pilot small changes and then expand successful changes to a larger scale. HSAG is available to provide technical assistance concerning rapid-cycle improvement methods, if needed.

Performance Measures

HSAG offers 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 to monitor its rates on an ongoing basis, acting promptly to address falling indicators.
- While **DVHA** has integrated some staff members into its quality improvement activities, 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.
- **DVHA** should only include beneficiaries in the measures when Medicaid is the primary payer, according to NCQA guidelines. Dual-eligible beneficiaries should be excluded in future reporting, or at a minimum, separate rates should be reported for dual-eligible beneficiaries.

Compliance With Standards

DVHA had only one element that did not meet the requirements in the three standards (Practice Guidelines, QAPI Program, and Health Information Systems) that were reviewed during CY 2015. The clinical practice guidelines are to be updated periodically, and **DVHA**'s Evidence-based Clinical Practice Guidelines policy and procedure requires the update to be performed at least every two years. During the on-site review, HSAG could not validate that the practice guidelines had been reviewed during the previous two years. **DVHA** must ensure that the clinical practice guidelines are updated as frequently as required in the established policy and procedure.

Suggestions for DVHA

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

- Adopting additional clinical practice guidelines based on the needs of the Medicaid beneficiaries.
- Updating the Utilization Management Plan dated 2011 to include information concerning the processes used to detect underutilization and overutilization of covered services.
- Ensuring that the MMIS has the capability to include demographic fields to capture beneficiary language information.

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 established by 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 2015–2016, the EQRO contract year. The mandatory EQR activities were conducted consistent with the CMS protocols established under 42 CFR §438.352.

During the 2015–2016 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 §438.236–§438.242 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 2015–2016. 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 and **DVHA**'s performance measure rates and trending of prior years' results.
- Results of HSAG's monitoring of **DVHA**'s compliance with the selected standards in the Medicaid managed care regulations and the associated AHS/**DVHA** IGA/contract requirements; a comparison of **DVHA**'s 2015–2016 performance to the results of HSAG's review of the same set of requirements in prior years; and trends in **DVHA**'s performance results across the prior EQR contract years.
- Results from **DVHA**'s follow-up on prior EQR recommendations as validated by HSAG or self-reported by **DVHA**.

Categorizing Results

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

Identifying DVHA's Strengths and Opportunities for Improvement

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

Validation of 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 (2014) 90th national Medicaid HEDIS percentile, as published by NCQA. In past years, HSAG used the 10th percentile as the threshold for determining areas of weakness for the HEDIS measures. Because **DVHA** has improved the rates generated for the HEDIS measures over the years, HSAG increased the performance level for determining areas of weakness this year to the 25th national Medicaid HEDIS 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. The three standards included in this year's compliance review (i.e., Practice Guidelines, Quality Assessment and Performance Improvement Program, and Health Information Systems) contained elements related to all three domains.

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

3. Description of External Quality Review Activities

Validation of Performance Improvement Project

During the 2015–2016 EQRO contract year with AHS, HSAG validated one PIP conducted by **DVHA**. This section describes the processes HSAG used to complete the validation activities. HSAG described the details related to its approach, methodologies, and findings from the PIP validation activities in its Performance Improvement Project Validation Report—*Follow-up After Hospitalization for Mental Illness* for DVHA provided to AHS and **DVHA**.

Objectives and Background Information

The AHS quality strategy required **DVHA** to conduct a PIP in accordance with 42 CFR §438.240. 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(d)(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 was available to provide technical assistance to **DVHA** before the PIP submission to answer questions. After HSAG validated the PIP, **DVHA** had the opportunity to incorporate HSAG's recommendations and resubmit the PIP for a final validation. For this year's validation, the only opportunities for improvement were related to the study indicator outcomes, which would not change in a resubmission; therefore, **DVHA** did not resubmit the PIP.

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.[3-1] HSAG, with AHS' input and approval, developed the PIP Validation Tool to ensure uniform and consistent validation of the PIP. Using this tool, HSAG determined the overall methodological validity of the PIP, as well as the overall success in achieving improved study indicator outcomes, and evaluated the following CMS protocol activities:

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

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

- HSAG reviewed the PIP submission documentation to ensure that all required documentation was received. 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

[3-1] 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.

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 in the scoring process. 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 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.[3-2] HSAG described the details related to its approach, methodologies, and findings from the performance measures activities in its Validation of Performance Measures for DVHA Report for DVHA provided to AHS and **DVHA**.

Objectives and Background Information

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

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

AHS selected 15 HEDIS measures, totaling 49 indicators, for HSAG's validation. The measurement period addressed in this report was CY 2014.

Description of Data Obtained

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

- The **Record of Administration, Data Management, and Processes (Roadmap),** which was completed by **DVHA**. The Roadmap provides background information concerning **DVHA**'s policies, processes, system capabilities, and data in preparation for the 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.

[3-2] 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.

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 Roadmap and flagged areas for on-site follow-up. The review team used the Roadmap to determine if the systems' capabilities were sufficient to report the HEDIS measures. **DVHA** was also required to complete the "Medical Record Review" section within the Roadmap.
- HSAG reviewed all supporting documents, including prior performance measure reports, data flow diagrams, data integration logic, medical record review hybrid tools and instructions, training materials for medical record staff members, policies and procedures for monitoring the accuracy of medical record reviews, 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 Roadmap 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 evaluated 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 Roadmap 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 concerning 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 Information Systems Capabilities Assessment Tool (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 2014 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 perform the **DVHA** compliance review. HSAG followed the guidelines in the 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.[3-3] HSAG described the details related to its approach, methodologies, and findings from the compliance activities in its External Quality Review of Compliance with Standards Report for DVHA provided to AHS and **DVHA**.

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 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**.

[3-3] 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.

- Maintained its focus on encouraging and supporting **DVHA** in targeting areas for continually improving its performance in providing quality, timely, and accessible care to beneficiaries.
- Requested that, as allowed by CMS, HSAG continue its three-year cycle of reviewing **DVHA** performance in complying with the federal Medicaid managed care regulations. This gives **DVHA** time to focus its improvement efforts and implement new initiatives. For the review covered by this report, AHS requested that HSAG review the CMS Measurement and Improvement standards described at 42 CFR §438.236–242 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 three performance areas associated with the CMS Medicaid managed care regulations described at 42 CFR §438.236–242.

I. Practice Guidelines

II. Quality Assessment and Performance Improvement (QAPI) Program

III. Health Information Systems

As these same standards were reviewed during two prior audits in 2008–2009 and 2011–2012, HSAG evaluated **DVHA**'s current performance and performed 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	July 15, 2014–July 14, 2015
Information from interviews conducted on-site	July 15, 2015

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 HSAG used to document its findings from the review of policies, procedures, reports, and additional plan documents. The compliance tool also included sections to insert findings from the on-site interviews conducted with **DVHA** staff members.
- Preparing and forwarding to **DVHA** a customized desk review request form and instructions for submitting the requested documentation to HSAG for its desk review. The form provided information about HSAG's compliance review activities and the timelines/due dates for each.
- Developing and providing to **DVHA** the detailed agenda for the one-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 one-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 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 **DVHA** and AHS a 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.
- A closing conference during which HSAG reviewers summarized their preliminary findings. For each standard, the findings included HSAG's assessment of **DVHA**'s performance

strengths; any anticipated required corrective actions and reviewers' suggestions that could further enhance **DVHA**'s processes; documentation; performance results; and the quality, access to, and timeliness of services provided to beneficiaries.

HSAG reviewers documented their findings in the compliance review tool. The tool served as a comprehensive record of the pre-on-site and on-site review activities and the performance scores achieved by **DVHA**. One item in this year's review required corrective action. HSAG also made suggestions to **DVHA** to further strengthen and drive continued improvement in **DVHA**'s performance. The completed tool was included as one section of HSAG's compliance report. Table 3-2 lists the major data sources HSAG used in determining **DVHA**'s performance in complying with requirements and the time period to which the data applied. Table 3-2 also 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 develop the compliance review timeline and assigned HSAG reviewers to the review team.
Step 2:	**Prepared the data collection tool for the standards included in this year's review and submitted it to AHS for review and comment.**
	To ensure that all applicable information was collected, HSAG developed a compliance review tool consistent with CMS protocols. HSAG used the requirements in the IGA between AHS and **DVHA** to develop the standards (groups of requirements related to broad content areas) to be reviewed. HSAG also used version 2 of the federal Medicaid managed care protocols effective September 1, 2012. Additional criteria used in developing the monitoring tool included applicable State 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 **DVHA** submit specific information and documents to HSAG within a specified number of days of the request. The desk review form included instructions for organizing and preparing the documents related to the review of the standards, submitting documentation for HSAG's desk review, and having additional documents available for HSAG's 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 on-site review agenda and submitted the agenda to DVHA.**
	HSAG developed the agenda to assist **DVHA** staff members in their planning to participate in HSAG's 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

Table 3-2—The Compliance Review Activities HSAG Performed	
	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 allotted for the reviews.
Step 6:	**Provided technical assistance.**
	As requested by **DVHA**, and in collaboration with AHS, HSAG staff members responded to any **DVHA** questions concerning the requirements HSAG used to evaluate its performance.
Step 7:	**Received DVHA's documents for HSAG's desk review and evaluated the information before conducting the on-site review.**
	HSAG reviewers used the documentation received from **DVHA** to gain insight into the organization's structure, services, operations, resources, information systems, quality program, and delegated functions; and to begin compiling the information and preliminary findings before the on-site portion of the review. During the desk review process, reviewers: ◆ Documented findings from the review of the materials **DVHA** submitted as evidence of its compliance with the requirements. ◆ Determined areas and issues requiring further clarification or follow-up during the on-site interviews. ◆ Identified information not found in the desk review documentation to be requested during the on-site review.
Step 8:	**Conducted the on-site portion of the review.**
	During the on-site review, staff members from **DVHA** were available to answer questions and to assist the HSAG review team in locating specific documents or other sources of information. HSAG's activities completed during the on-site review included the following: ◆ Conducting 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. ◆ Conducting interviews with **DVHA**'s staff. HSAG used the interviews to obtain a complete picture of **DVHA**'s compliance with the federal Medicaid managed care regulations and associated AHS IGA requirements, explore any issues not fully addressed in the documents that HSAG reviewed, and increase HSAG reviewers' overall understanding of **DVHA**'s performance. ◆ Reviewing additional documentation. HSAG reviewed additional documentation while on-site, and used the review tool to identify relevant information sources and document its review findings. Documents reviewed on-site included, but were not limited to, written policies and procedures, minutes of key committee or other group meetings, and data and reports across a broad range of areas. While on-site, **DVHA** staff members also discussed the organization's information system data collection process and reporting capabilities related to the standards HSAG reviewed. ◆ Summarizing findings at the completion of the on-site portion of the review. As a final step, HSAG conducted a closing conference to provide **DVHA**'s staff members and AHS with a high-level summary of HSAG's preliminary findings. For each of the standards, the findings included HSAG's assessment of **DVHA**'s strengths; if applicable, any areas requiring corrective actions; and HSAG's suggestions for further strengthening **DVHA**'s processes, performance results, and/or documentation.

Table 3-2—The Compliance Review Activities HSAG Performed	
Step 9:	**Calculated the individual scores and determined the overall compliance score for performance.**
	HSAG evaluated and analyzed **DVHA**'s performance in complying with the requirements in each of the standards contained in the review tool. HSAG used *Met*, *Partially Met*, and *Not Met* scores to document the degree to which **DVHA** complied with each of the requirements. A designation of *NA* was used if an individual requirement did not apply to **DVHA** during the period covered by the review. For each of the standards, HSAG calculated a percentage of compliance score and then an overall percentage of compliance score across all the standards.
Step 10:	**Prepared a report of findings and if required, corrective actions.**
	After completing the documentation of findings and scoring for each of the standards, HSAG prepared a draft report that described HSAG's compliance review findings; the scores assigned for each requirement within the standards; HSAG's assessment of **DVHA**'s strengths; any areas requiring corrective action; and HSAG's suggestions for further enhancing **DVHA**'s performance results, processes, and documentation. HSAG forwarded the report to AHS and **DVHA** for their review and comment. Following AHS' approval of the draft, HSAG issued the final report to AHS and **DVHA**.

Determining Conclusions

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

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

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

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

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

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

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

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

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

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 federal Medicaid managed care regulations and associated AHS IGA requirements. For the follow-up to the prior year's compliance review, **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 (2014–2015), HSAG validated **DVHA**'s PIP, *Follow-Up After Hospitalization for Mental Illness*. 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 100 percent. Although all applicable evaluation elements received *Met* scores, there were two *Points of Clarification* identified that **DVHA** addressed in this year's submission.

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

HSAG Recommendations	DVHA Response/Actions/Outcomes
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.	**DVHA** accurately and completely defined the study population. The numerator information and criteria were removed from Activity III.
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.	**DVHA** documented how complete the data were when pulled and how the percentage of completeness was obtained.

Validation of Performance Measures

HSAG validated 15 performance measures during the previous EQRO contract year (2014–2015). HSAG auditors determined that all 15 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
During the 2014 audit, HSAG recommended that **DVHA** 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.	**DVHA** was not able to achieve the recommendation for 2015 reporting, but the recommendation remains an important step toward improving rates for measures requiring lab results.
For the 2014 audit, **DVHA** decided to forego "official" hybrid reporting. However, **DVHA** collected and abstracted data from medical records but did not include these results in the rates it reported. HSAG encouraged **DVHA** to report using medical record review for measures that appear to have incomplete lab data.	For 2015 reporting, **DVHA** decided to report performance measure rates using the hybrid process. Based on the results derived from medical record review for the 2015 audit, the rates improved as much as 20 percentage points for several measures. HSAG recommends that **DVHA** continue to use the hybrid reporting method for future reporting.
During the 2014 audit, it appeared that **DVHA** had begun the integration of its information technology (IT) and quality improvement (QI) staff but did not appear to be effectively monitoring data and rates. HSAG recommended that **DVHA** continue this integration but expand the data monitoring and validation activities. **DVHA** should be aware when rates decline and be able to potentially identify reasons for those declines.	For the 2015 audit, HSAG observed that **DVHA** was aware of its current rates and how they compared to the national Medicaid HEDIS 2014 percentiles. **DVHA** was also aware of the increases in rates due to the additional medical record review process for the performance measures that were being reported using hybrid methodology.

Monitoring Compliance With Standards

During the 2014 compliance audit, HSAG evaluated **DVHA**'s performance related to the eight standards (groups of related requirements) included in the Structure and Operation Standards (42 CFR §438.214–224 and 228–230). The standards included requirements in the following performance areas: Provider Selection, Credentialing and Recredentialing, Beneficiary Information, Beneficiary Rights, Confidentiality, Grievance System—Beneficiary Grievances, Grievance System—Beneficiary Appeals and State Fair Hearings, and Subcontractual Relationships and Delegation.

Table 4-3—Monitoring Compliance With Standards—Recommendations/Suggestions and DVHA Responses

HSAG Recommendations	DVHA Responses/Actions/Outcomes
Related to the area of beneficiary information, **DVHA** must ensure that the next revision to the member handbook describes (1) at a high level, the beneficiaries' right to confidentiality; (2) **DVHA**'s processes for ensuring their 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.	(1) In the member handbook, p. 18, under the "Notice of Privacy Practices" section, the following language will be in our next revision at the beginning of this section: "We know how important it is to protect your personal and medical information, and there are laws and rules that limit how and when we can share your private information." (2) In the member handbook, p. 5, in our next revision, a new section will be added under the "Welcome to Your Green Mountain Care Program" section called "How to Leave or Disenroll From a Program." The section will read: "Having health insurance is very important to your overall health. Without health insurance, you may not be able to access the healthcare services you need. Before you make any decisions about dropping your health insurance, you should carefully consider the impact this decision might have on your health and your personal finances. If you wish to leave any of our programs, you may do so by contacting our Vermont Health Connect and Green Mountain Care Customer Support Center at 1-800-250-8427. You may be required to follow up with a written request." (3) In the member handbook, p. 20, under the "Appeal" section (at the end of the section), our next revision will add the following language: "In addition to this process, your provider also has the right to directly appeal certain decisions we make. For more information about this process, please contact your provider."

Table 4-3—Monitoring Compliance With Standards—Recommendations/Suggestions and DVHA Responses	
HSAG Recommendations	**DVHA Responses/Actions/Outcomes**
Related to the area of beneficiary rights, **DVHA** must ensure that it informs beneficiaries about their right to terminate enrollment and provide enrollment termination procedures.	In the member handbook, p. 5, in our next revision, a new section will be added under the "Welcome to Your Green Mountain Care Program" section called "How to Leave or Disenroll From a Program." The section will read: "Having health insurance is very important to your overall health. Without health insurance, you may not be able to access the healthcare services you need. Before you make any decisions about dropping your health insurance, you should carefully consider the impact this decision might have on your health and your personal finances. If you wish to leave any of our programs, you may do so by contacting our Vermont Health Connect and Green Mountain Care Customer Support Center at 1-800-250-8427. You may be required to follow up with a written request."
Related to the grievance system, **DVHA** must ensure that, through the provider handbook or other informational materials, it furnishes substantive written information to network providers about beneficiary grievances and related requirements.	The provider manual now has two sections addressing this issue: 4.9 "Member Grievances" and 4.10 "Member Appeals."
◆ Related to beneficiary appeals and State fair hearings, **DVHA** must review and revise its policies and procedures, manuals, handbooks, and any other internal documents to ensure that the definition for the term "action" consistently includes the provision regarding the failure to act within time frames as required by 42 CFR: §438.400(b)(1) and State rule.	The provider manual and member handbook now use consistent definitions for "action" and include the failure to act in a timely manner.
◆ **DVHA** must ensure that beneficiaries are provided with a written acknowledgement within five calendar days of receipt of the appeal as required by State rule.	This has been corrected in our appeal procedures.
◆ **DVHA** must ensure that appeals are resolved and that beneficiaries are provided with written notice within the maximum time frames for standard and expedited appeals, including any extensions.	This has been corrected in our appeal procedures.
◆ If AHS continues to offer beneficiaries the option of requesting a reconsideration, **DVHA** must review and revise its Notice of Decision form, provider manual, and any other relevant documents to ensure that they consistently allow for either the beneficiary, the provider, or designated representative to request a reconsideration as required in the AHS/**DVHA** IGA.	**DVHA** is still discussing this with AHS and will have the issue resolved by the end of the first calendar quarter of 2016.