State of Vermont
Agency of Human Services

2018–2019 External Quality Review Technical Report

for

Department of Vermont Health Access

January 2019

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Introduction

Background

According to 42 Code of Federal Regulations (CFR) §438.340,[1-1] each state Medicaid agency is required to:

I. Draft and implement a written quality strategy for assessing and improving the quality of health care and services furnished by the managed care organization (MCO), prepaid inpatient health plan (PIHP), prepaid ambulatory health plan (PAHP), or primary care case management (PCCM) entity.
II. Make the strategy available for public comment before submitting the strategy to the Centers for Medicare & Medicaid Services (CMS) for review.
III. Review and update the quality strategy as needed, but no less than once every three years. The review must include an evaluation of the effectiveness of the quality strategy conducted within the previous three years.
IV. Submit to CMS a copy of the initial strategy and a copy of the revised strategy whenever significant changes are made to the document.
V. Make the final quality strategy available on the website.

The Vermont Agency of Human Services (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 Health Services Advisory Group, Inc. (HSAG), to conduct the external quality review (EQR) activities beginning in the external quality review organization (EQRO) contract year 2007–2008. This report covers the EQR activities conducted during 2018–2019, the EQRO contract year. The mandatory EQR activities were conducted consistent with the CMS protocols established under 42 CFR §438.352.[1-2]

[1-1] U. S. Government Publishing Office. (2018). *Electronic Code of Federal Regulations.* Available at: https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=0fe554e3f4a6236efe0d8c0aa9319e57&mc=true&n=pt42.4.438&r=PART&ty=HTML#se42.4.438_1340. Accessed on: Sep 10, 2018.

[1-2] U. S. Government Publishing Office. (2017). *Electronic Code of Federal Regulations.* Available at https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=0fe554e3f4a6236efe0d8c0aa9319e57&mc=true&n=pt42.4.438&r=PART&ty=HTML#se42.4.438_1352. Accessed on: Sep 10, 2018.

During the 2018–2019 contract year, and consistent with the applicable CMS protocols, HSAG performed the following EQR activities and provided to AHS and the **Department of Vermont Health Access** (**DVHA**) draft and final reports for each activity:

- Validated **DVHA**'s performance improvement project (PIP)
- Validated a set of **DVHA**'s performance measures
- Reviewed **DVHA**'s compliance with the federal Medicaid managed care standards described at 42 CFR §438.236, §438.242, and §438.330, and the related AHS/**DVHA** intergovernmental agreement (IGA) (i.e., contract) requirements
- Prepared this annual external quality review technical report

Purpose

Under its federal Medicaid demonstration waiver, the State of Vermont uses a managed care model to deliver services and is subject to the Medicaid Managed Care standards/regulations found at 42 CFR §438. This report meets the federal requirement (42 CFR §438.364)[1-3] for preparation of an annual technical report that describes how data from activities conducted in accordance with 42 CFR §438.358 were aggregated and analyzed and how conclusions were drawn as to the quality and timeliness of, and the access to, care furnished by **DVHA**, Vermont's statewide Medicaid managed care model organization.

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

Organization of the Report

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

[1-3] U. S. Government Publishing Office. (2018). *Electronic Code of Federal Regulations.* Available at: https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=0fe554e3f4a6236efe0d8c0aa9319e57&mc=true&n=pt42.4.438&r=PART&ty=HTML%23se42.4.438_1352#se42.4.438_1364. Accessed on: Sep 10, 2018.

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

Section 2—Findings: This section provides contextual information about the federal Medicaid managed care requirements, AHS, and **DVHA**. This section also presents a summary of findings and conclusions about **DVHA**'s strengths and weaknesses, as derived from the EQR activities performed during 2018–2019. Section 2 also includes recommendations and opportunities for improvement in quality, timeliness, and access to care, as provided to **DVHA**. Finally, trends over time are presented as appropriate to the data available.

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

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

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

To fulfill the requirements of 42 CFR §438.358,[1-4] HSAG compiled the overall findings for each EQR activity it conducted and assessed **DVHA**'s strengths, areas requiring improvement, and opportunities to further strengthen its processes, documentation, and/or performance outcomes with respect to the quality and timeliness of, and access to, health care services.

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

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

[1-4] U. S. Government Publishing Office. (2018). *Electronic Code of Federal Regulations.* Available at: https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=0fe554e3f4a6236efe0d8c0aa9319e57&mc=true&n=pt42.4.438&r=PART&ty=HTML%23se42.4.438_1352#se42.4.438_1358. Accessed on: Sep 10, 2018.

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 2018–2019 performance to the results of HSAG's review of the same set of requirements in prior years; and trends in **DVHA**'s performance results across the prior EQR contract years.
- Results from **DVHA**'s follow-up on prior EQR recommendations as validated by HSAG or self-reported by **DVHA**.

Categorizing Results

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

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

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

Validation of the PIP

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

provide a *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 validated rates for a set of performance measures selected by AHS for 2018 reporting. AHS identified the measurement period for all measures as calendar year (CY) 2017. AHS required that the measures be calculated according to the National Committee for Quality Assurance's (NCQA's) *Healthcare Effectiveness Data and Information Set (HEDIS®)*[1-5] *2018, Volume 2, Technical Specifications for Health Plans*. Although most measures were reported using administrative data, **DVHA** was required to report one measure using both administrative and medical record data, known as the hybrid methodology, to ensure that the rates more accurately reflected the services provided to beneficiaries.

Monitoring Compliance With Standards

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

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

[1-5] HEDIS® is a registered trademark of the NCQA.

2. Findings

Background

The Balanced Budget Act of 1997 (BBA), Public Law 105-33,[2-1] and as described in 42 CFR §438.364, requires state Medicaid agencies to contract with an EQRO to prepare an annual report that describes the manner in which data from activities conducted in accordance with 42 CFR §438.358 were aggregated and analyzed.[2-2] The report must also describe how conclusions were drawn as to the quality and timeliness of, and access to, care furnished by the Medicaid MCOs, PIHPs, PAHPs, and PCCM entities. AHS chose to meet this requirement by contracting with HSAG, an EQRO, beginning in contract year 2007–2008 to conduct the three CMS required activities and to prepare the EQR annual technical report bringing together the results from the activities it conducted. This report meets the requirements of 42 CFR §438.364 and does not disclose the identity or other protected health information of any beneficiary.

The Vermont Agency of Human Services (AHS)

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

During the current EQRO contract year (February 2018–February 2019), HSAG conducted three mandatory EQR activities and compared the information to **DVHA**'s performance data from the prior year. The results of HSAG's review are contained in this 2018–2019 EQR technical report.

[2-1] U. S. Government Publishing Office. (1997). *Public Law 105-33* (p. 249). Available at: http://www.gpo.gov/fdsys/pkg/PLAW-105publ33/pdf/PLAW-105publ33.pdf. Accessed on: Sep 7, 2018.

[2-2] U. S. Government Publishing Office. (2017). *External Quality Review Results.* Available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=1a64dceea153294481f0d7b923980163&mc=true&node=se42.4.438_1364&rgn=div8. Accessed on: Sep 7, 2018.

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

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

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

Scope of HSAG's 2018–2019 EQR Activities

HSAG's external quality review in contract year 2018–2019 consisted of conducting the following activities:

- ***Validation of DVHA's performance improvement project (PIP).*** HSAG reviewed **DVHA**'s PIP to ensure that the organization designed, conducted, and reported on the project in a methodologically sound manner, allowing measurement of any real improvements in care and services, and giving confidence in the reported improvements.
- ***Validation of DVHA's performance measures.*** HSAG validated the accuracy of the AHS-required performance measures that were reported by **DVHA**. The validation also determined the extent to which the Medicaid-specific performance measures calculated by **DVHA** followed the HEDIS 2018 specifications.
- ***Review of DVHA's compliance with standards.*** HSAG conducted a review to determine the organization's compliance with performance standards (sets of requirements) described in the federal Medicaid managed care Measurement and Improvement standards (42 CFR §438.236, §438.242, and §438.330) 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 2018–2019 EQR activities and drew conclusions related to the quality and timeliness of, and access to, care and services **DVHA** furnished to its Medicaid beneficiaries. This report describes the results of that process.

Summary of Findings

The following sections summarize HSAG's findings for each of the three activities conducted during 2018–2019.

Validation of the Performance Improvement Project (PIP)

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

The PIP topic addresses the initiation of alcohol and other drug abuse or dependence treatment for adolescent and adult beneficiaries with a new alcohol or other drug abuse or dependence diagnosis. This

[2-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-3.pdf. Accessed on: Dec 19, 2018.

PIP topic represents a key area of focus for improvement by **DVHA**. Members receiving the appropriate care and services for alcohol or other drug abuse or dependence in the recommended time frames is essential to the recovery process. **DVHA** submitted a new baseline result due to the change in HEDIS specifications for the measure related to this PIP *(Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)*. **DVHA** reported new baseline data from 2017 for one study indicator.

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

Table 2-1—2018–2019 PIP Validation Summary Overall Score

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

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

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

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

Table 2-2—Performance Across All Activities

Stage	Step	Percentage of Applicable Elements		
		Met	***Partially Met***	***Not Met***
Design	I. Select the Study Topic(s)	100% (2/2)	0% (0/2)	0% (0/2)
	II. Define the Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III. Define the Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV. Select the Study Indicator(s)	100% (1/1)	0% (0/1)	0% (0/1)
	V. Use Sound Sampling Techniques	*Not Applicable*		
	VI. Reliably Collect Data	100% (3/3)	0% (0/3)	0% (0/3)
Design Total		**100% (8/8)**	**0% (0/8)**	**0% (0/8)**

Stage	Step	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Implementation	VII. Analyze and Interpret Study Results	100% (3/3)	0% (0/3)	0% (0/3)
	VIII. Implement Intervention and Improvement Strategies	100% (3/3)	0% (0/3)	0% (0/3)
Implementation and Evaluation Total		**100% (6/6)**	**0% (0/6)**	**0% (0/6)**
Outcomes	IX. Assess for Real Improvement	*Not Assessed*		
	X. Assess for Sustained Improvement	*Not Assessed*		
Outcomes Total		***Not Assessed***		
Percentage Score of Applicable Evaluation Elements *Met*		**100% (14/14)**		

The validation results indicated an overall score of 100 percent across all applicable evaluation elements. **DVHA** continued the PIP this year; however, it modified the methodology and results to align with the updated HEDIS specifications for the related *IET* measure. **DVHA** completed the first eight steps of the PIP Summary Form with the reporting of new baseline data. **DVHA** provided all required documentation, and the PIP was a methodologically sound study.

Validation of Performance Measures

HSAG validated a set of performance measures selected by AHS that were calculated and reported by **DVHA**. The methodology HSAG used to validate the performance measures was based on CMS' validation of performance measures protocol.[2-4] The validation findings confirmed that all rates were reportable. Table 2-3 displays the HEDIS 2017 and 2018 performance measure results, the eligible population for each measure (i.e., Number [N]), and the change for each measure rate from HEDIS 2017 to HEDIS 2018. Additionally, the measure results for 2018 were compared to the NCQA's HEDIS Audit Means and Percentiles National Medicaid Health Maintenance Organization (HMO) Percentiles for HEDIS 2017 (the most current rates available).

[2-4] 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: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-2.pdf. Accessed on: Dec 19, 2018.

Table 2-3—DVHA HEDIS 2017 and 2018 Results

Measure	HEDIS 2017		HEDIS 2018		Change From HEDIS 2017 to HEDIS 2018	HEDIS Percentile Ranking
	N	Rate	N	Rate		
*Well-Child Visits in the First 15 Months of Life—0 Visits**	3,045	1.67%	2,841	1.06%	-0.61%	50th–75th
Well-Child Visits in the First 15 Months of Life—1 Visit†	3,045	0.99%	2,841	0.74%	-0.25%	10th–25th
Well-Child Visits in the First 15 Months of Life—2 Visits†	3,045	1.48%	2,841	1.48%	0.00%	5th–10th
Well-Child Visits in the First 15 Months of Life—3 Visits†	3,045	3.05%	2,841	2.85%	-0.20%	5th–10th
Well-Child Visits in the First 15 Months of Life—4 Visits†	3,045	6.11%	2,841	6.51%	+0.40%	10th–25th
Well-Child Visits in the First 15 Months of Life—5 Visits†	3,045	15.07%	2,841	14.85%	-0.22%	25th–50th
Well-Child Visits in the First 15 Months of Life—6 or More Visits	3,045	71.63%	2,841	72.51%	+0.88%	90th–95th
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	12,879	73.97%	12,729	75.24%	+1.27%	50th–75th
Adolescent Well-Care Visits	26,791	50.89%	25,806	50.54%	-0.35%	50th–75th
Adult BMI Assessment	–	–	411	62.53%	NA	10th–25th
Annual Dental Visit—2–3 Years	6,268	49.66%	6,305	56.67%	+7.01%	90th–95th
Annual Dental Visit—4–6 Years	9,690	72.16%	9,543	74.03%	+1.87%	75th–90th
Annual Dental Visit—7–10 Years	13,256	77.66%	13,055	78.70%	+1.04%	95th–100th
Annual Dental Visit—11–14 Years	12,304	74.11%	12,206	75.67%	+1.56%	95th–100th
Annual Dental Visit—15–18 Years	11,448	65.71%	11,296	68.78%	+3.07%	95th–100th
Annual Dental Visit—19–20 Years	4,407	46.36%	3,953	53.10%	+6.74%	95th–100th
Annual Dental Visit—Total	57,373	68.12%	56,538	71.00%	+2.88%	95th–100th
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	3,229	97.96%	3,222	98.08%	+0.12%	90th–95th
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	15,720	91.42%	15,564	92.56%	+1.14%	75th–90th
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	15,481	95.79%	14,830	95.90%	+0.11%	75th–90th
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	21,769	94.99%	20,840	95.49%	+0.50%	90th–95th
Chlamydia Screening in Women—16–20 Years	4,162	47.53%	4,003	49.74%	+2.21%	25th–50th
Chlamydia Screening in Women—21–24 Years	2,852	55.58%	2,575	58.06%	+2.48%	25th–50th
Chlamydia Screening in Women—Total	7,014	50.80%	6,578	52.99%	+2.19%	25th–50th
Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	40,955	78.24%	37,645	79.39%	+1.15%	50th–75th
Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	23,981	83.49%	21,594	85.22%	+1.73%	25th–50th

Measure	HEDIS 2017		HEDIS 2018		Change From HEDIS 2017 to HEDIS 2018	HEDIS Percentile Ranking
	N	Rate	N	Rate		
Adults' Access to Preventive/Ambulatory Health Services—65+ Years	394	72.59%	427	82.44%	+9.85%	25th–50th
Adults' Access to Preventive/Ambulatory Health Services—Total	65,330	80.13%	59,666	81.52%	+1.39%	25th–50th
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up[1]	—	—	1,324	33.91%	NA	NA
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up[1]	—	—	1,324	52.72%	NA	NA
Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment (Initiation)—13–17 Years—Total[1]	—	—	235	35.74%	NA	NA
Initiation and Engagement of AOD Abuse or Dependence Treatment (Initiation)—18+ Years—Total[1]	—	—	4,378	38.21%	NA	NA
Initiation and Engagement of AOD Abuse or Dependence Treatment (Initiation)—Total—Total[1]	—	—	4,613	38.09%	NA	NA
Initiation and Engagement of AOD Abuse or Dependence Treatment (Engagement)—13–17 Years—Total[1]	—	—	235	18.30%	NA	NA
Initiation and Engagement of AOD Abuse or Dependence Treatment (Engagement)—18+ Years—Total[1]	—	—	4,378	19.67%	NA	NA
Initiation and Engagement of AOD Abuse or Dependence Treatment (Engagement)—Total—Total[1]	—	—	4,613	19.60%	NA	NA
Breast Cancer Screening[1]	—	—	6,189	54.26%	NA	NA
Ambulatory Care (Outpatient Visits)—<1 Year[†,2]	36,328	941.04	33,567	905.75	-35.29	90th–95th
Ambulatory Care (Outpatient Visits)—1–9 Years[†,2]	117,053	299.28	112,957	298.10	-1.18	50th–75th
Ambulatory Care (Outpatient Visits)—10–19 Years[†,2]	94,823	246.51	90,621	242.35	-4.16	50th–75th
Ambulatory Care (Outpatient Visits)—20–44 Years[†,2]	176,166	268.48	148,279	261.51	-6.97	10th–25th
Ambulatory Care (Outpatient Visits)—45–64 Years[†,2]	142,090	408.41	124,066	407.84	-0.57	10th–25th
Ambulatory Care (Outpatient Visits)—65–74 Years[†,2]	1,131	313.38	1,223	321.08	+7.70	10th–25th
Ambulatory Care (Outpatient Visits)—75–84 Years[†,2]	405	530.80	438	598.36	+67.56	50th–75th
Ambulatory Care (Outpatient Visits)—85+ Years[†,2]	124	370.15	231	596.90	+226.75	75th–90th
Ambulatory Care (Outpatient Visits)—Total[†,2]	568,120	311.61	511,382	306.94	-4.67	25th–50th
Ambulatory Care (Emergency Department [ED] Visits)—<1 Year[*,2]	2,540	65.80	2,320	62.60	-3.20	90th–95th
Ambulatory Care (ED Visits)—1–9 Years[*,2]	13,428	34.33	13,438	35.46	+1.13	90th–95th
Ambulatory Care (ED Visits)—10–19 Years[*,2]	13,975	36.33	13,539	36.21	-0.12	50th–75th
Ambulatory Care (ED Visits)—20–44 Years[*,2]	37,849	57.68	32,773	57.80	+0.12	75th–90th
Ambulatory Care (ED Visits)—45–64 Years[*,2]	13,628	39.17	12,962	42.61	+3.44	90th–95th

Measure	HEDIS 2017		HEDIS 2018		Change From HEDIS 2017 to HEDIS 2018	HEDIS Percentile Ranking
	N	Rate	N	Rate		
Ambulatory Care (ED Visits)—65–74 Years,[2]*	73	20.23	77	20.22	-0.01	75th–90th
Ambulatory Care (ED Visits)—75–84 Years,[2]*	25	32.77	26	35.52	+2.75	25th–50th
Ambulatory Care (ED Visits)—85+ Years,[2]*	10	29.85	12	31.01	+1.16	50th–75th
Ambulatory Care (ED Visits)—Total,[2]*	81,528	44.72	75,147	45.10	+0.38	75th–90th
Medication Management for People With Asthma (Medication Compliance 50%)—5–11 Years	533	70.92%	520	77.31%	+6.39%	95th–100th
Medication Management for People With Asthma (Medication Compliance 50%)—12–18 Years	399	71.18%	424	72.41%	+1.23%	90th–95th
Medication Management for People With Asthma (Medication Compliance 50%)—19–50 Years	974	77.00%	933	70.31%	-6.69%	75th–90th
Medication Management for People With Asthma (Medication Compliance 50%)—51–64 Years	311	83.92%	283	81.98%	-1.94%	75th–90th
Medication Management for People With Asthma (Medication Compliance 50%)—Total	2,217	75.46%	2,160	73.94%	-1.52%	90th–95th
Medication Management for People With Asthma (Medication Compliance 75%)—5–11 Years	533	51.59%	520	56.35%	+4.76%	95th–100th
Medication Management for People With Asthma (Medication Compliance 75%)—12–18 Years	399	52.38%	424	50.47%	-1.91%	95th–100th
Medication Management for People With Asthma (Medication Compliance 75%)—19–50 Years	974	60.78%	933	53.59%	-7.19%	90th–95th
Medication Management for People With Asthma (Medication Compliance 75%)—51–64 Years	311	68.17%	283	68.20%	+0.03%	95th–100th
Medication Management for People With Asthma (Medication Compliance 75%)—Total	2,217	58.10%	2,160	55.56%	-2.54%	95th–100th

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

† Rates for this indicator are presented for information only.

[1] Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed, and comparisons to benchmarks are not performed for this measure.

[2] For the Ambulatory Care indicators, the rates displayed are the number of visits per 1,000 member months.

— indicates that NCQA recommended a break in trending; therefore, prior year rates are not displayed.

NA indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.

DVHA demonstrated strength with several measure rates meeting or exceeding the national Medicaid 90th percentile, and only one measure rate fell below the 25th percentile (excluding information-only measures). Of the 42 reportable rates with comparable benchmarks, 10 rates exceeded the national Medicaid 95th percentile:

- *Annual Dental Visit—7–10 Years*
- *Annual Dental Visit—11–14 Years*

- *Annual Dental Visit—15–18 Years*
- *Annual Dental Visit—19–20 Years*
- *Annual Dental Visit—Total*
- *Medication Management for People With Asthma (Medication Compliance 50%)—5–11 Years*
- *Medication Management for People With Asthma (Medication Compliance 75%)—5–11 Years*
- *Medication Management for People With Asthma (Medication Compliance 75%)—12–18 Years*
- *Medication Management for People With Asthma (Medication Compliance 75%)—51–64 Years*
- *Medication Management for People With Asthma (Medication Compliance 75%)—Total*

In addition to the 10 rates listed above, 10 rates met or exceeded the national Medicaid 90th percentile:

- *Well-Child Visits in the First 15 Months of Life—6 or More Visits*
- *Annual Dental Visit—2–3 Years*
- *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months*
- *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years*
- *Ambulatory Care (ED Visits)—<1 Year*
- *Ambulatory Care (ED Visits)—1–9 Years*
- *Ambulatory Care (ED Visits)—45–64 Years*
- *Medication Management for People With Asthma (Medication Compliance 50%)—12–18 Years*
- *Medication Management for People With Asthma (Medication Compliance 50%)—Total*
- *Medication Management for People With Asthma (Medication Compliance 75%)—19–50 Years*

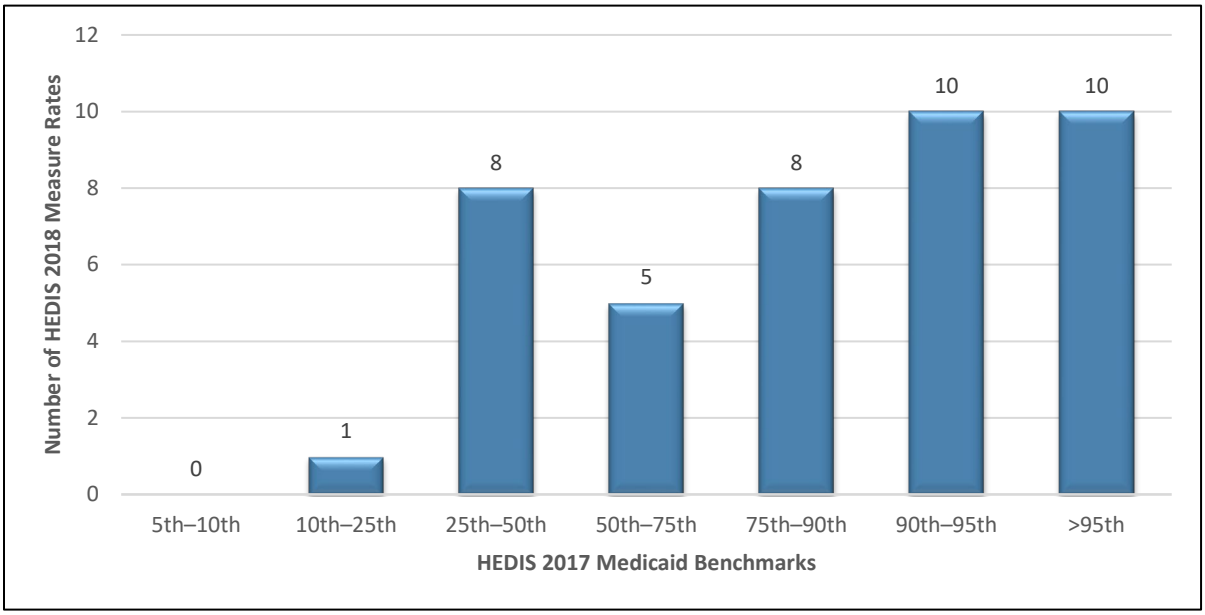
DVHA demonstrated opportunities for improvement, with the following eight rates falling below the national Medicaid 50th percentile:

- *Chlamydia Screening in Women—16–20 Years*
- *Chlamydia Screening in Women—21–24 Years*
- *Chlamydia Screening in Women—Total*
- *Adults' Access to Preventive/Ambulatory Health Services—45–64 Years*
- *Adults' Access to Preventive/Ambulatory Health Services—65+ Years*
- *Adults' Access to Preventive/Ambulatory Health Services—Total*
- *Ambulatory Care (ED Visits)—75–84 Years*
- *Adult BMI [Body Mass Index] Assessment*

DVHA's rate for *Adult BMI Assessment* fell below the national Medicaid 25th percentile.

Figure 2-1 shows the distribution of how the reported indicators compared to the 2017 HEDIS national Medicaid benchmarks.

Figure 2-1—Number of HEDIS 2018 Measure Rates Meeting the HEDIS 2017 Medicaid Benchmarks



DVHA performed at or above the national Medicaid 75th percentile for 28 of 42 (66.7 percent) measure rates appropriate for comparison to benchmarks, demonstrating strengths with ensuring young members have access to care, members of all ages receive dental screenings, and members with asthma remain on their asthma medications. Conversely, nine of 42 rates (21.4 percent) fell below the national Medicaid 50th percentile, indicating efforts should be focused on ensuring older adult members have access to preventive and ambulatory care, adult members receive BMI screenings, and young women are appropriately screened for chlamydia.

Review of Compliance With Standards

AHS requested that HSAG continue to review one of the three sets of federal Medicaid managed care standards during each EQRO contract year. For EQRO contract year 2018–2019, 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.[2-5] HSAG reviewed **DVHA**'s written operating policies and procedures, program plans, meeting minutes, numerous written reports, and other data and documentation related to **DVHA**'s performance during the review period. Reviewers also conducted staff interviews related to each of the three standards to allow **DVHA** staff members to elaborate on the written information HSAG

[2-5] 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: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-1.pdf. Accessed on: Dec 19, 2018.

reviewed, to assess the consistency of staff responses given during the interviews against the written documentation, and to clarify any questions reviewers had following the document review.

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

Table 2-4 presents a summary of **DVHA**'s performance results for the 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 2-4—Standards and Compliance Score

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Total Compliance Score
I	Practice Guidelines	11	11	11	0	0	0	**100%**
II	Quality Assessment and Performance Improvement Program	11	11	11	0	0	0	**100%**
III	Health Information Systems	11	11	11	0	0	0	**100%**
	Totals	**33**	**33**	**33**	**0**	**0**	**0**	**100%**

***Total # of Elements*:** The total number of elements in each standard.

***Total # of Applicable Elements*:** The total number of elements within each standard minus any elements that received a score of *NA*.

***Total Compliance Score*:** The overall percentages were calculated by adding the number of elements that received a score of *Met* to the weighted number (multiplied by 0.50) that received a score of *Partially Met*, then dividing this total by the total number of applicable elements.

As displayed in Table 2-4, HSAG reviewed **DVHA**'s performance related to 33 elements across the three standards. Of the 33 elements, **DVHA** obtained a score of *Met* for all the elements. As a result, **DVHA** obtained a total percentage-of-compliance score across the 33 requirements of 100 percent.

Overall Conclusions and Performance Trending

Performance Trends

Performance Improvement Project Trends

DVHA submitted its PIP topic, *Initiation of Alcohol and Other Drug Abuse or Dependence Treatment*, for the second time in 2018–2019. **DVHA**'s performance suggests a thorough application of the Design and Implementation stages.

DVHA provided all required documentation for Steps I through VIII. HSAG determined that **DVHA** designed a methodologically sound study. The technical design of the PIP was valid to measure reliable study indicator outcomes. **DVHA** accurately documented the data collection methodology and causal/barrier analysis.

For the new 2017 baseline measurement period, **DVHA** reported that 46.6 percent of members 13 years of age and older with a new episode of AOD abuse or dependence had initial treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication assisted treatment (MAT) within 14 days of the diagnosis. **DVHA** reported the denominator result, which included the total eligible population as 5,060, and the numerator result for members who received the services within the recommended time frame as 2,357. The health plan set a Remeasurement 1 goal of 48.5 percent.

HSAG has not yet identified performance trends in the PIP results since the health plan reported a new baseline result. The following table displays the baseline result for the study indicator.

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

PIP—*Initiation of Alcohol and Other Drug Abuse or Dependence Treatment*				
Study Indicator	**Baseline (1/1/17–11/14/17)**	**Remeasurement 1 (1/1/18–11/14/18)**	**Remeasurement 2 (1/1/19–11/14/19)**	***Sustained Improvement**
The percentage of Vermont Medicaid members 13 years of age and older with a new episode of alcohol or other drug (AOD) abuse or dependence who have initial treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication assisted treatment (MAT) within 14 days of the diagnosis.	46.6%			Not Applicable

* Step X for sustained improvement is not assessed until the PIP achieves statistically significant improvement from the baseline and reports a subsequent measurement result.

Performance Measure Trends

DVHA used a vendor with HEDIS Certified Measures[SM, 2-6] to calculate and report the HEDIS 2018 performance measure rates. Table 2-6 below displays the rates for measures **DVHA** reported for HEDIS 2015, 2016, 2017, and 2018; the eligible population (i.e., N); and the change for each measure rate from HEDIS 2015 to HEDIS 2018.

Table 2-6—HEDIS 2015, 2016, 2017, and 2018 Results

Performance Measure	HEDIS 2015		HEDIS 2016		HEDIS 2017		HEDIS 2018		Change From HEDIS 2015 to HEDIS 2018
	N	Rate	N	Rate	N	Rate	N	Rate	
*Well-Child Visits in the First 15 Months of Life—0 Visits**	3,146	1.53%	3,348	2.09%	3,045	1.67%	2,841	1.06%	-0.47%
Well-Child Visits in the First 15 Months of Life—1 Visit†	3,146	0.79%	3,348	1.28%	3,045	0.99%	2,841	0.74%	-0.05%
Well-Child Visits in the First 15 Months of Life—2 Visits†	3,146	2.07%	3,348	2.00%	3,045	1.48%	2,841	1.48%	-0.59%
Well-Child Visits in the First 15 Months of Life—3 Visits†	3,146	3.46%	3,348	3.38%	3,045	3.05%	2,841	2.85%	-0.61%
Well-Child Visits in the First 15 Months of Life—4 Visits†	3,146	6.58%	3,348	7.83%	3,045	6.11%	2,841	6.51%	-0.07%
Well-Child Visits in the First 15 Months of Life—5 Visits†	3,146	14.72%	3,348	16.04%	3,045	15.07%	2,841	14.85%	+0.13%
Well-Child Visits in the First 15 Months of Life—6 or More Visits	3,146	70.85%	3,348	67.38%	3,045	71.63%	2,841	72.51%	+1.66%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	13,219	72.82%	14,183	72.60%	12,879	73.97%	12,729	75.24%	+2.42%
Adolescent Well-Care Visits	25,496	47.35%	29,369	46.85%	26,791	50.89%	25,806	50.54%	+3.19%
Adult BMI Assessment	–	–	411	74.70%	–	–	411	62.53%	NA
Annual Dental Visit—2–3 Years	6,568	46.80%	7,106	44.67%	6,268	49.66%	6,305	56.67%	+9.87%
Annual Dental Visit—4–6 Years	9,945	71.42%	10,620	70.16%	9,690	72.16%	9,543	74.03%	+2.61%
Annual Dental Visit—7–10 Years	12,989	77.24%	14,124	74.88%	13,256	77.66%	13,055	78.70%	+1.46%
Annual Dental Visit—11–14 Years	11,922	72.68%	13,051	71.04%	12,304	74.11%	12,206	75.67%	+2.99%
Annual Dental Visit—15–18 Years	11,195	65.36%	12,273	63.89%	11,448	65.71%	11,296	68.78%	+3.42%
Annual Dental Visit—19–20 Years[1]	5,379	39.58%	5,266	41.57%	4,407	46.36%	3,953	53.10%	NT
Annual Dental Visit—Total[1]	57,998	66.07%	62,440	64.87%	57,373	68.12%	56,538	71.00%	+4.93%
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	3,572	97.40%	3,765	97.16%	3,229	97.96%	3,222	98.08%	+0.68%

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

Performance Measure	HEDIS 2015		HEDIS 2016		HEDIS 2017		HEDIS 2018		Change From HEDIS 2015 to HEDIS 2018
	N	Rate	N	Rate	N	Rate	N	Rate	
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	16,221	91.35%	17,434	90.64%	15,720	91.42%	15,564	92.56%	+1.21%
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	14,307	95.93%	16,019	95.11%	15,481	95.79%	14,830	95.90%	-0.03%
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	19,122	94.81%	22,617	94.00%	21,769	94.99%	20,840	95.49%	+0.68%
Chlamydia Screening in Women—16–20 Years	3,977	49.56%	4,634	49.63%	4,162	47.53%	4,003	49.74%	+0.18%
Chlamydia Screening in Women—21–24 Years	2,985	57.25%	3,569	56.26%	2,852	55.58%	2,575	58.06%	+0.81%
Chlamydia Screening in Women—Total	6,962	52.86%	8,203	52.52%	7,014	50.80%	6,578	52.99%	+0.13%
Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	40,215	77.44%	52,767	73.24%	40,955	78.24%	37,645	79.39%	+1.95%
Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	22,030	83.83%	28,319	80.55%	23,981	83.49%	21,594	85.22%	+1.39%
Adults' Access to Preventive/Ambulatory Health Services—65+ Years	381	83.20%	403	72.70%	394	72.59%	427	82.44%	-0.76%
Adults' Access to Preventive/Ambulatory Health Services—Total	62,626	79.72%	81,489	75.78%	65,330	80.13%	59,666	81.52%	+1.80%
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up[2]	—	—	—	—	—	—	1,324	33.91%	NA
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up[2]	—	—	—	—	—	—	1,324	52.72%	NA
Initiation and Engagement of AOD Abuse or Dependence Treatment (Initiation)—13-17 Years—Total[2]	—	—	—	—	—	—	235	35.74%	NA
Initiation and Engagement of AOD Abuse or Dependence Treatment (Initiation)—18+ Years—Total[2]	—	—	—	—	—	—	4,378	38.21%	NA
Initiation and Engagement of AOD Abuse or Dependence Treatment (Initiation)—Total—Total[2]	—	—	—	—	—	—	4,613	38.09%	NA
Initiation and Engagement of AOD Abuse or Dependence Treatment (Engagement)—13–17 Years—Total[2]	—	—	—	—	—	—	235	18.30%	NA
Initiation and Engagement of AOD Abuse or Dependence Treatment (Engagement)—18+ Years—Total[2]	—	—	—	—	—	—	4,378	19.67%	NA

Performance Measure	HEDIS 2015		HEDIS 2016		HEDIS 2017		HEDIS 2018		Change From HEDIS 2015 to HEDIS 2018
	N	Rate	N	Rate	N	Rate	N	Rate	
Initiation and Engagement of AOD Abuse or Dependence Treatment (Engagement)—Total—Total[2]	—	—	—	—	—	—	4,613	19.60%	NA
Breast Cancer Screening[2]	—	—	—	—	—	—	6,189	54.26%	NA
Ambulatory Care (Outpatient Visits)—<1 Year[†,3]	—	—	37,434	914.23	36,328	941.04	33,567	905.75	NA
Ambulatory Care (Outpatient Visits)—1–9 Years[†,3]	—	—	121,434	305.49	117,053	299.28	112,957	298.1	NA
Ambulatory Care (Outpatient Visits)—10–19 Years[†,3]	—	—	94,927	245.86	94,823	246.51	90,621	242.35	NA
Ambulatory Care (Outpatient Visits)—20–44 Years[†,3]	—	—	183,404	272.12	176,166	268.48	148,279	261.51	NA
Ambulatory Care (Outpatient Visits)—45–64 Years[†,3]	—	—	147,319	416.93	142,090	408.41	124,066	407.84	NA
Ambulatory Care (Outpatient Visits)—65–74 Years[†,3]	—	—	977	370.78	1,131	313.38	1,223	321.08	NA
Ambulatory Care (Outpatient Visits)—75–84 Years[†,3]	—	—	401	481.97	405	530.8	438	598.36	NA
Ambulatory Care (Outpatient Visits)—85+ Years[†,3]	—	—	244	505.18	124	370.15	231	596.9	NA
Ambulatory Care (Outpatient Visits)—Total[†,3]	—	—	586,140	315.84	568,120	311.61	511,382	306.94	NA
*Ambulatory Care (ED Visits)—<1 Year**[,3]	—	—	2,830	69.12	2,540	65.8	2,320	62.6	NA
*Ambulatory Care (ED Visits)—1–9 Years**[,3]	—	—	14,281	35.93	13,428	34.33	13,438	35.46	NA
*Ambulatory Care (ED Visits)—10–19 Years**[,3]	—	—	14,319	37.09	13,975	36.33	13,539	36.21	NA
*Ambulatory Care (ED Visits)—20–44 Years**[,3]	—	—	40,594	60.23	37,849	57.68	32,773	57.8	NA
*Ambulatory Care (ED Visits)—45–64 Years**[,3]	—	—	13,906	39.36	13,628	39.17	12,962	42.61	NA
*Ambulatory Care (ED Visits)—65–74 Years**[,3]	—	—	75	28.46	73	20.23	77	20.22	NA
*Ambulatory Care (ED Visits)—75–84 Years**[,3]	—	—	18	21.63	25	32.77	26	35.52	NA
*Ambulatory Care (ED Visits)—85+ Years**[,3]	—	—	16	33.13	10	29.85	12	31.01	NA
*Ambulatory Care (ED Visits)—Total**[,3]	—	—	86,039	46.36	81,528	44.72	75,147	45.1	NA

Performance Measure	HEDIS 2015		HEDIS 2016		HEDIS 2017		HEDIS 2018		Change From HEDIS 2015 to HEDIS 2018
	N	Rate	N	Rate	N	Rate	N	Rate	
Medication Management for People With Asthma (Medication Compliance 50%)—5–11 Years	—	—	514	72.18%	533	70.92%	520	77.31%	NA
Medication Management for People With Asthma (Medication Compliance 50%)—12–18 Years	—	—	397	64.99%	399	71.18%	424	72.41%	NA
Medication Management for People With Asthma (Medication Compliance 50%)—19–50 Years	—	—	1,033	69.51%	974	77.00%	933	70.31%	NA
Medication Management for People With Asthma (Medication Compliance 50%)—51–64 Years	—	—	293	83.28%	311	83.92%	283	81.98%	NA
Medication Management for People With Asthma (Medication Compliance 50%)—Total	—	—	2,237	71.12%	2,217	75.46%	2,160	73.94%	NA
Medication Management for People With Asthma (Medication Compliance 75%)—5–11 Years	—	—	514	52.53%	533	51.59%	520	56.35%	NA
Medication Management for People With Asthma (Medication Compliance 75%)—12–18 Years	—	—	397	45.84%	399	52.38%	424	50.47%	NA
Medication Management for People With Asthma (Medication Compliance 75%)—19–50 Years	—	—	1,033	51.21%	974	60.78%	933	53.59%	NA
Medication Management for People With Asthma (Medication Compliance 75%)—51–64 Years	—	—	293	67.58%	311	68.17%	283	68.20%	NA
Medication Management for People With Asthma (Medication Compliance 75%)—Total	—	—	2,237	52.70%	2,217	58.10%	2,160	55.56%	NA

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

† Rates for this indicator are presented for information only.

[1] To align with the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) service guidelines, the upper age limit was revised from 21 to 20 in HEDIS 2016. Therefore, exercise caution when comparing HEDIS 2016 rates to prior years.

[2] Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed.

[3] For the Ambulatory Care indicators, the rates displayed are the number of visits per 1,000-member months.

NT Indicates trending cannot be performed due to the changes in measure specifications between years.

NA Indicates that trending was not applicable.

— Indicates the plan was not required to report this measure during the specified measurement period or NCQA recommended a break in trending; therefore, no prior year rates are displayed.

Overall, 19 of the 21 (90.5 percent) measure rates that could be trended showed an improvement in performance since HEDIS 2015. Further, the *Annual Dental Visit—2–3 Years* measure indicator rate increased nearly 10 percentage points from HEDIS 2015 to HEDIS 2018. Of the two measure rates that showed a decline in performance, the change was less than 1 percentage point, ranging from a decrease of 0.03 to 0.76 percentage points from HEDIS 2015 to HEDIS 2018. Of note, for the 20 measures that were new in HEDIS 2016, performance improved from HEDIS 2016 to HEDIS 2018 for 16 of the 20 (80.0 percent) measures.

Compliance With Standards Trends

For the 2018–2019 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, and Health Information Systems) included standards associated with federal Medicaid Measurement and Improvement Standards found at 42 CFR §438.236, §438.242, and §438.330.

HSAG reviews a different set of standards to evaluate **DVHA**'s compliance with federal CMS Medicaid managed care regulations and the associated AHS/**DVHA** IGA requirements during each year within a three-year cycle of reviews. The number of standards reviewed each year varies, as does the focus of the review. The three-year cycle consists of the following standards: Year 1, Structure and Operations standards (42 CFR §438.10, §438.100, and §438.214–230); Year 2, Measurement and Improvement standards (42 CFR §438.236, §438.242, and §438.330); and Year 3, Access and Enrollment/Disenrollment standards (42 CFR §438.206–210 and §438.226).

For this year (2018—the 11th year of review), HSAG evaluated the Measurement and Improvement standards, the same standards it reviewed in 2009, 2012, and 2015.

Table 2-7 documents **DVHA**'s performance across 11 years of compliance reviews conducted by HSAG.

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

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

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 %*
2013							71	99%	3%
2014	93	92%	15%						
2015				31	97%	3%			
2016							80	97%	6%
2017	84	90%	19%						
2018				33	100%	0%			

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

For the Measurement and Improvement standards, the overall scores **DVHA** received across the four years these standards were reviewed ranged from 97 percent to 100 percent, with the overall corrective action percentages ranging from 0 percent to 3 percent.

DVHA's performance represented a positive change in one element from the 2015 review of the same standards. During the prior review, **DVHA** scored 97 percent across the three standards. The one element found to be noncompliant involved validating that the clinical practice guidelines (CPGs) were reviewed and periodically updated as required by the **DVHA** Evidence-based Clinical Practice Guidelines policy and procedure. During the current review, **DVHA** corrected the noncompliant item and scored 100 percent in all three standards.

Quality, Timeliness, and Access to Care Domains

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

[2-6] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Legislative Summary: Balanced Budget Act of 1997 Medicare and Medicaid Provisions.* Available at: https://innovation.cms.gov/files/migrated-medicare-demonstration-x/cc_section4016_bba_1997.pdf. Accessed on: Dec 19, 2018.

Quality

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

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

Timeliness

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

Access

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

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

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

[2-7] Department of Health and Human Services Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Vol 81, May 6, 2016.
[2-8] National Committee for Quality Assurance. (2016). *Standards and Guidelines for Health Plans*.
[2-9] Federal Register. *Code of Federal Regulations, Title 42, Volume 4*, May 6, 2016. Available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=fa076676cc95c899c010f8abe243e97e&mc=true&node=se42.4.438_1320&rgn=div8.Accessed on: Sep 7, 2018.

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

PIP	Quality	Timeliness	Access
Initiation of Alcohol and Other Drug Dependence Treatment	✓	✓	✓
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 Visit		✓	✓
Children and Adolescents' Access to Primary Care Practitioners			✓
Performance Measures	**Quality**	**Timeliness**	**Access**
Chlamydia Screening in Women	✓		
Adults' Access to Preventive/Ambulatory Health Services			✓
Follow-Up After Hospitalization for Mental Illness	✓	✓	✓
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment			✓
Breast Cancer Screening	✓		
Adult BMI Assessment	✓		
Ambulatory Care	NA	NA	NA
Medication Management for People With Asthma	✓		
Compliance Review Standards	**Quality**	**Timeliness**	**Access**
Standard I—Practice Guidelines	✓	✓	✓
Standard II—Quality Assessment and Performance Improvement Program	✓	✓	✓
Standard III—Health Information Systems	✓	✓	✓

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

Performance Improvement Project

DVHA's *Initiation of Alcohol and Other Drug Abuse or Dependence Treatment* PIP submission documentation, representing quality, timeliness, and access to care, provided evidence that the PIP was a scientifically sound project supported by use of key research principles. **DVHA**'s PIP met demonstrated strengths by achieving 100 percent of CMS' protocol requirements in the Design stage. The technical design of the PIP was sufficient to measure and monitor PIP outcomes.

HSAG determined that **DVHA** accurately documented the data collection methodology and analysis of the baseline result. **DVHA** met 100 percent of the requirements for data analysis and improvement strategies. **DVHA** revisited the causal/barrier analysis, prioritized barriers, and is analyzing provider survey results related to a high-priority barrier regarding timely access to treatment.

Performance Measures

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

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

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

DVHA staff continued to review performance measures to identify areas for improvement and to identify mechanisms for improving outcomes for its beneficiaries. Several performance measures representing quality, timeliness of care, and access to care demonstrated strengths by meeting or exceeding the national Medicaid 90th percentile, including *Well-Child Visits in the First 15 Months of Life*, *Annual Dental Visit (ages 2–3, 7–10, 11–14, 15–18, 19–20,* and *Total)*, *Children and Adolescents' Access to Primary Care Practitioners (12–24 Months* and *12–19 Years)*, and *Medication Management for People With Asthma (*Age groups exceeding the national Medicaid 90th percentile: *50% Medication Compliance for ages 5–11, 12–18, and Total;* and *75% Medication Compliance for all age groups and Total).* No additional measures related to timeliness of care could be compared to national percentiles due to changes in the technical specifications. Improvement efforts should focus on the one measure representing quality, *Adult BMI Assessment*, that fell below the national Medicaid 25th percentile.

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

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

Compliance With Standards

Each of the compliance review standards included elements representative of quality, timeliness of, and/or access to care. *Met* elements in Standards I, II, and III addressed quality, timeliness of, and access to care. **DVHA** scored 100 percent in each of the three standards included in this review, and HSAG noted the following strengths:

DVHA produced CPGs that were adopted and approved at the time of the on-site review, including Substance Use Disorder MAT, Diabetes, Applied Behavioral Analysis, Developmental Screening for Young Children, Pediatric Palliative Care, and Transcranial Magnetic Stimulation. The Managed Care Medical Committee (MCMC) minutes from the February 14, 2018, meeting included the review of and discussions concerning the MAT and Developmental Screening for Young Children CPGs.

The **DVHA** Evidence-based Clinical Practice Guidelines policy and procedure indicated that the MCMC will identify, develop, adopt, disseminate, and continuously evaluate relevant CPGs based on valid, reliable evidence or a consensus of healthcare professionals. The Developmental Screening for Young Children CPG included standardized developmental and autism screening tools for providers resulting from collaborative efforts of **DVHA** and the Vermont Child Health Improvement Program. The diabetes CPGs fully endorsed the American Diabetes Association's Clinical Practice Recommendations.

DVHA maintained a comprehensive quality management plan and workplan that detailed the structure, scope, and purpose of the QAPI program and described the performance improvement framework used by the managed care entity (MCE) to evaluate the quality of services provided to Global Commitment to Health Waiver beneficiaries. The MCE also had adequate mechanisms in place to share quality data throughout the organization and with its IGA partners.

At the conclusion of the 2015–2016 compliance review, HSAG recommended that **DVHA** consider updating the Utilization Management Plan and strengthening language in the document regarding the detection of under- and overutilization of covered services.

During the current review, **DVHA** submitted the Managed Care Entity Utilization Management Plan, dated October 2016. This plan, which incorporated monitoring of quality, timeliness of, and access to care, furnished detailed information concerning mechanisms to detect under- and overutilization of covered services, as shown below:

- The Quality Improvement and Clinical Integrity Unit conducts analyses of claims data to identify providers who have prescribed unusual drug combinations or quantities for patients.
- The Clinical Utilization Review Board (CURB) conducts retrospective examination of medical claims data for high-cost, high-utilization services; identifies potential areas for improvement; and recommends evidence-based coverage guidelines and appropriate utilization control mechanisms.
- **DVHA**'s Program Integrity Unit, using the Decision Support System (DSS), monitors utilization of services by analyzing claims using factors such as provider type, member, emergency department, inpatient/outpatient services, and selected hospital admissions.

DVHA published the *2017 Vermont Medicaid Global Commitment to Health (GC) Core Measure Set* report, which included a description of the MCE's performance on a variety of standard quality measures. The report detailed year-over-year trending of various quality measures to serve as an indicator of the overall health of Medicaid beneficiaries.

DVHA executed a contract from January 1, 2017, through December 31, 2019, with HP Enterprise Services (i.e., DXC) to continue to maintain the Medicaid Management Information System (MMIS) for **DVHA**. The contract specified the work to be performed to include beneficiary, provider, operation, financial, and plan management. The State determined Medicaid eligibility for the beneficiaries and transferred the eligibility data to DXC daily. DXC also performed provider credentialing, maintained provider information, and handled provider communications.

The **DVHA** Utilization Management Plan, dated October 2016, emphasized that the Vermont Chronic Care Initiative would provide care coordination, case management, and health coaching services to high-cost, high-risk Medicaid beneficiaries based on medical complexity and healthcare service utilization. A review of the Managed Care Medical Committee Work Plan indicated that the committee assisted in the development of a scorecard (i.e., dashboard) to evaluate utilization of services. The workplan also indicated that the Utilization Committee reviewed HEDIS measures results annually. The MMIS system received and paid claims for Medicaid services in Vermont, and interviews with staff members confirmed that **DVHA** used the information generated by the MMIS to monitor over- and underutilization of services.

To ensure that Medicaid beneficiaries received the services billed, the Program Integrity Unit prepared and mailed Explanation of Medicaid Benefits (EOMBs) quarterly to Medicaid beneficiaries. The random sample size selected for each service was 30 cases; however, if the Program Integrity Unit identified fewer than 30 cases, the mailing included 100 percent of the claims. Beneficiaries were to acknowledge receipt of services and send back the information requested within 30 days. At the end of the 30-day period, the Program Integrity Unit reviewed the responses, and any cases that needed follow-up were sent to Program Integrity Unit management. The Program Integrity Unit prepared a summary of the project each quarter and included the findings from the survey on the EOMB Summary Sheet.

HSAG continued to experience AHS' and **DVHA**'s commitment to providing health care that demonstrates quality, timely access, and accessible services for Medicaid beneficiaries. Interviews with staff members confirmed that **DVHA** encourages and supports beneficiary-focused care for participants in the Vermont Global Commitment to Health Waiver.

Recommendations and Opportunities for Improvement

Performance Improvement Project

DVHA has demonstrated a thorough application of the Design stage (Steps I through VI), documenting the methodology for the PIP in alignment with the HEDIS specifications. **DVHA** provided a new baseline result for the PIP that aligns with the updated *IET* measure HEDIS specifications. This will ensure that baseline to remeasurement comparisons are valid.

DVHA has been progressing with the barrier analysis and intervention components of the PIP process that are critical to achieving improvement in the study indicator outcomes. **DVHA** must continue this momentum and ensure that a change is implemented with enough time to impact the remeasurement results. Additionally, the health plan will need to evaluate each initiated intervention and provide data in next year's annual PIP submission that support whether the change has been effective and any decisions that were made as a result (e.g., modified, discontinued, standardized, continued monitoring).

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

- Make the correction in Step III to address the *Point of Clarification.*
- For an additional *Point of Clarification* in Step VIII, initiate at least one intervention to address the high-priority barrier regarding timely access to treatment, allowing enough time to impact the Remeasurement 1 results from 2018. HSAG also recommends that the health plan initiate additional interventions.
- Reference the PIP Completion Instructions annually to ensure all requirements for each completed step have been addressed.
- Continue to reach out to HSAG for PIP technical assistance as often as needed.

Performance Measures

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

- Explore additional external data sources available to enhance the administrative measure rates. Using supplemental data for measures would be beneficial since some relevant details are not available via claims data.
- Continue the process of monitoring and trending claims submissions.
- Explore the use of Vermont's Clinical Repository. Operated by VITL, the repository retains patient information in a standardized format and could be used for future measure production.

Compliance With Standards

Suggestions for DVHA

While not rising to the level of requiring a corrective action, the items below were noted by HSAG reviewers. HSAG encourages **DVHA** to consider the following:

DVHA could consider adopting additional CPGs based on the needs of Medicaid beneficiaries for both preventive care and chronic diseases. Adding CPGs developed by reputable sources, such as the American College of Physicians or the United States Preventive Services Task Force, that address prevalent conditions may be beneficial in assisting providers to more effectively manage members' conditions.

The following suggestion, also included in the 2015 Compliance Report, is offered to further strengthen **DVHA**'s processes, performance, and documentation:

The current MMIS does not have the capability of capturing the language spoken by the beneficiaries due to limitations in the established data fields for beneficiary demographics. **DVHA** should ensure that future enhancements to the MMIS include a demographic field to capture beneficiary language information.

3. Description of External Quality Review Activities

Validation of Performance Improvement Project

During the 2018–2019 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—*Initiation of Alcohol and Other Drug Abuse or Dependence Treatment* for **DVHA** provided to AHS and **DVHA**.

Objectives and Background Information

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

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

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

Description of Data Obtained

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

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.
- 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

[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: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-3.pdf. Accessed on: Dec 19, 2018.

N/A designation for situations in which the evaluation element did not apply to the PIP. HSAG used the *Not Assessed* scoring designation when the PIP had not progressed to the remaining activities. HSAG used a *Point of Clarification* when documentation for an evaluation element included the basic components to meet the requirements for the evaluation element (as described in the narrative of the PIP); however, enhanced documentation would demonstrate a stronger application of the CMS protocols for completing a PIP.

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

Determining Conclusions

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

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

Validation of Performance Measures

Validation of performance measures is a CMA mandatory EQR activity required by the BBA. State Medicaid agencies must ensure that performance measures reported by their MCOs are validated. The state, its agent that is not an MCO, or an EQRO, can perform this validation. HSAG, the EQRO for AHS, conducted the validation activities. For CY 2017, AHS' **DVHA** provided physical, mental, and behavioral health services to Medicaid-eligible recipients. HSAG validated a set of performance measures selected by AHS that were calculated and reported by DVHA. HSAG conducted the validation activities as outlined in the Centers for Medicare & Medicaid Services (CMS) publication, *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 1, 2012.

Objectives and Background Information

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

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

AHS selected 13 HEDIS measures for HSAG's validation. The measurement period addressed in this report was CY 2017.

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 and prior years' performance measure results**, which were obtained from **DVHA**.
- **On-site interviews and demonstrations**, which were conducted by HSAG. Information was obtained through interaction, discussion, and formal interviews with key **DVHA** staff members, as well as observation of data processing functions and demonstrations.

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

Technical Methods of Data Collection/Analysis

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

Pre-On-Site Activities:

- **DVHA** was required to submit a completed Roadmap to HSAG. HSAG performed a cursory review of the Roadmap to ensure that each section was complete and that all applicable attachments were present. The review team used the Roadmap to determine if the systems' capabilities were sufficient to report the HEDIS measures.
- **DVHA** was responsible for completing the medical record review (MRR) section within the Roadmap. In addition, HSAG requested and reviewed the following attachments: medical record hybrid tools and instructions, training materials for MRR staff members, and policies and procedures outlining the processes for monitoring the accuracy of the reviews performed by the review staff members. To ensure the accuracy of the hybrid data being abstracted by **DVHA**, HSAG requested that **DVHA** participate in the review of a convenience sample.
- **DVHA** used a software vendor whose measures were certified by NCQA for HEDIS 2018 calculation and reporting. All performance measures under the scope of this review were certified by NCQA for HEDIS 2018; therefore, **DVHA** was not required to submit source code.
- HSAG reviewed previous years' validation of performance measures reports to assess for trending patterns and rate reasonability.

On-Site Review Activities:

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

- HSAG conducted a closing conference to summarize preliminary findings based on the review of the Roadmap and 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 2017 national Medicaid benchmarks.

Determining Conclusions

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

Monitoring of Compliance With Standards

Monitoring compliance with federal Medicaid managed care regulations and the applicable state contract requirements is one of the CMS mandatory activities a State must conduct. AHS contracted with HSAG to perform the **DVHA** compliance review. HSAG followed the guidelines in 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. 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,[3-2] a review to determine an MCO's, PIHP's, PAHP's, or PCCM's compliance with state standards must be conducted within a three-year period by a state Medicaid agency, its agent, or an EQRO. These standards must be as stringent as the federal Medicaid managed care standards described in 42 CFR §438—Managed Care, which address requirements related to access, structure and operations, and measurement and improvement. To meet these requirements, AHS:

- Continued to ensure that its IGA with **DVHA** included the applicable CMS Medicaid managed care requirements and that they were at least as stringent as the CMS requirements.

[3-2] U. S. Government Publishing Office. (2018). *Electronic Code of Federal Regulations.* Available at: https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=0fe554e3f4a6236efe0d8c0aa9319e57&mc=true&n=pt42.4.438&r=PART&ty=HTML#se42.4.438_1358. Accessed on: Sep 10, 2018.

- Contracted with HSAG as its EQRO to conduct reviews to assess **DVHA**'s performance in complying with the federal Medicaid managed care regulations and AHS' associated IGA with **DVHA**.
- Maintained its focus on encouraging and supporting **DVHA** in targeting areas for continually improving its performance in providing quality, timely, and accessible care to beneficiaries.
- Requested that, as allowed by CMS, HSAG continue its three-year cycle of reviewing **DVHA** performance in complying with the federal Medicaid managed care regulations. This 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, §438.242, and §438.330, 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 compiled and submitted to AHS, for its review and approval, a data collection tool to assess and document **DVHA**'s compliance with the Medicaid managed care regulations, State rules, and the associated AHS/**DVHA** IGA requirements. The review tool included requirements that addressed three performance areas associated with the CMS Medicaid managed care regulations described at 42 CFR §438.236, §438.242, and §438.330.

I. Practice Guidelines

II. Quality Assessment and Performance Improvement

III. Health Information Systems

As these same standards were reviewed during three prior audits, 2009, 2012 and 2015, HSAG evaluated **DVHA**'s current performance and compared the results to those from the earlier review of these same standards.

Description of Data Obtained

Table 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 21, 2017–July 17, 2018
Information from interviews conducted on-site	July 18, 2018

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 two-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** had 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**. **DVHA** scored 100 percent in each standard included in this review. HSAG 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 report to AHS for its review and comments.
Step 3:	**Prepared and submitted the Desk Review Form to DVHA.**
	HSAG prepared and forwarded a desk review form to **DVHA** and requested that **DVHA** submit specific information and documents to HSAG within a specified number of days of the request. The desk review form included instructions for organizing and preparing the documents related to the review of the standards, submitting documentation for HSAG's desk review, and having additional documents available for HSAG's 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 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 compiled and organized the information and documentation, and reviewers used the documentation **DVHA** submitted for HSAG's desk review to gain insight into areas such as **DVHA**'s structure and relationship with its IGA partners; information provided to beneficiaries and providers; composition and accessibility of the provider network; clinical practice guidelines, the Quality Assessment and Performance Improvement program, and health information systems; and **DVHA**'s operations, resources, information systems, quality programs, and delegated functions. Reviewers then: • Documented in the review tool their preliminary findings after reviewing the materials **DVHA** submitted as evidence of its compliance with the requirements. • Identified any information not found in the desk review documentation in order to request it prior to the on-site review. • Identified areas and questions requiring further clarification or follow-up during the on-site interviews.

Step 8:	Conducted the on-site portion of the review.
	During the 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. Items 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 participants with a high-level summary of HSAG's preliminary findings. For each of the standards, the findings included HSAG's assessment of **DVHA**'s strengths; if applicable, any areas requiring corrective actions; and HSAG's suggestions for further strengthening **DVHA**'s processes, performance results, and/or documentation. • **DVHA** staff members were readily available throughout the on-site review to answer HSAG's review questions and to assist in locating specific documents or other sources of information.
Step 9:	**Documented reviewer findings in the Documentation Request & Evaluation Tool.**
	Beginning prior to and continuing through the on-site review, HSAG reviewers documented their preliminary findings related to **DVHA**'s performance for each requirement. Following the on-site review, the reviewers completed the documentation in the tool and finalized the documentation of **DVHA**'s strengths; required corrective actions; and any suggestions for further strengthening **DVHA**'s performance related to the written documentation and to providing accessible, timely, and quality services to enrollees.

Step 10:	Calculated the individual scores and determined the overall compliance score for performance.
	HSAG evaluated and analyzed **DVHA**'s performance in complying with the requirements in each of the standards contained in the review tool. HSAG used *Met*, *Partially Met*, and *Not Met* scores to document the degree to which **DVHA** complied with each of the requirements. A designation of *NA* was used if an individual requirement did not apply to **DVHA** during the period covered by the review. For each of the standards, HSAG calculated a percentage of compliance score and then an overall percentage of compliance score across all the standards.
Step 11:	**Prepared a report of findings and if required, corrective actions.**
	After completing the documentation of findings and scoring for each of the standards, HSAG prepared a draft report that described HSAG's compliance review findings; the scores assigned for each requirement within the standards; HSAG's assessment of **DVHA**'s strengths; any areas requiring corrective action; and HSAG's suggestions for further enhancing **DVHA**'s performance results, processes, and documentation. HSAG forwarded the report to AHS and **DVHA** for their review and comment. Following AHS' approval of the draft, HSAG issued the final report to AHS and **DVHA**.

Determining Conclusions

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

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

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

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

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

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

- No documentation is present and staff members have little or no knowledge of processes or issues addressed by the regulatory provisions.

- For a provision with multiple components, key components of the provision could be identified and any findings of *Not Met* or *Partially Met* would result in an overall finding of noncompliance for the provision, regardless of the findings noted for the remaining components.

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

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

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.

Validation of the Performance Improvement Project

During the previous EQRO contract year (2017–2018), HSAG validated **DVHA**'s PIP, *Initiation of Alcohol and Other Drug Dependence Treatment*. The validation process included **DVHA**'s submission of the PIP and HSAG's completion of the validation tool. For the eight review activities that **DVHA** completed and HSAG assessed, **DVHA** received a score of *Met* for 100 percent of the evaluation elements. Although all applicable evaluation elements received *Met* scores, three *Points of Clarification* were identified.

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

HSAG Recommendations	DVHA Response/Actions/Outcomes
Activity VII: The health plan needs to update its measurement period dates in the data table prior to the next annual submission. The baseline still reflects 2015, and it should reflect 2016.	**HSAG findings: DVHA** updated the measurement period dates. The information provided in the data table was accurate and clear.
Activity VIII: It was noted that one barrier was identified and listed in Activity VIII. In the future, if more priority barriers are listed in the PIP, the health plan must describe its process for prioritizing these barriers.	**HSAG findings: DVHA** identified additional barriers and prioritized the barriers based on data and quality improvement processes.
Activity VIII: The health plan indicated that it would use the results from the *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)* HEDIS measure to determine the success of its interventions. This method is insufficient in measuring the success of individual interventions. The health plan must develop a method or process to evaluate the effectiveness of each individual intervention and report the results in the PIP. Decisions to continue, revise, or discontinue an intervention should be based on the outcomes of the evaluation.	**HSAG findings: DVHA** submitted a new baseline result for the *Initiation of Alcohol and Other Drug Abuse or Dependence Treatment* PIP due to updated HEDIS specifications and had not progressed to the point of evaluating the effectiveness of each intervention.

Validation of Performance Measures

HSAG validated 12 performance measures during the previous EQRO contract year (2017–2018). HSAG auditors determined that all 12 were compliant with AHS' specifications and that the rates could be reported. As a result of HSAG's review of provided documentation 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
HSAG recommended that **DVHA** explore all external sources for using available supplemental data, including data from health information exchanges (HIEs), to enhance the administrative rates.	**DVHA response: DVHA** explored the use of HIE data to enhance administrative rates, and it has been determined that the HIE is not mature enough to use as a source for supplemental data.
HSAG recommended that **DVHA** continue the process of monitoring and trending claims submissions throughout the year.	**DVHA response: DVHA** continued the process of monitoring and trending claims submissions throughout the year.
HSAG recommended that **DVHA** continue to work with laboratory vendors to ensure appropriate capture of laboratory claims and results, as this will enhance rates for numerator compliance.	**DVHA response:** Once the HIE is more robust and mature, **DVHA** will look to acquire laboratory information from this source.

Monitoring Compliance With Standards

During the 2017–2018 compliance audit, HSAG evaluated the degree to which **DVHA** complied with federal Medicaid managed care regulations and the associated AHS-DVHA IGA (i.e., contract requirements) in eight performance categories (i.e., standards). The eight standards included requirements associated with federal Medicaid managed care and structure and operation standards found at 42 CFR §438.214–230. The standards HSAG evaluated were those related to 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 lists HSAG's recommendations for performance areas that received a score of *Partially Met* or *Not Met* for a required compliance element.

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

HSAG Recommendations	DVHA Responses/Actions/Outcomes
DVHA must create written policies and procedures for selection and retention of providers, and those policies or operating principles must include, at a minimum, the requirements of 42 CFR §438.214 and the requirements found in Section 2.5.4 of the contract between **DVHA** and AHS.	**DVHA response:** This language will be drafted into a policy by April 1, 2019.
DVHA must create a uniform credentialing policy to ensure that the processing of initial credentialing and recredentialing files meets the requirements established by **DVHA** and approved by AHS.	**DVHA response: DVHA**'s Provider and Member Relations Unit, in conjunction with its fiscal agent, recently implemented a comprehensive new process for provider credentialing and recredentialing. **DVHA** acknowledges that its process still has room to expand on the definition of "credentialing," but the new process does comply with all **DVHA** requirements.
DVHA needs to establish an approval process for the Provider Enrollment Unit Manual and approve any revisions made to that document by DXC. (The process delineated in the Provider Enrollment Unit Manual developed by DXC was very complete, but no evidence was produced to verify that the process was approved by **DVHA**.)	**DVHA response: DVHA**'s Provider and Member Relations Unit, in conjunction with its fiscal agent, recently implemented a comprehensive new process for provider enrollment. This process included new policies and procedures for DXC and included sign-off by **DVHA**.
DVHA must ensure that every file processed for initial credentialing or recredentialing includes verification of the DEA certification, when applicable; malpractice insurance; and Medicare/Medicaid sanctions. Recredentialing files must be processed within the five-year time limit as defined in 42 CFR §455.414.	**DVHA response: DVHA**'s Provider and Member Relations Unit, in conjunction with its fiscal agent, recently implemented a comprehensive new process for provider credentialing that addressed the issue during this project.
DVHA should investigate discrepancies when providers attest to board certification but the information is not found on the LexisNexis report.	**DVHA response: DVHA**'s Provider and Member Relations Unit, in conjunction with its fiscal agent, recently implemented a comprehensive new process for provider credentialing that addressed the issue during this project.
DVHA should consider adding the approval date to the checklist found in each of the initial credentialing and recredentialing files.	**DVHA response: DVHA**'s Provider and Member Relations Unit, in conjunction with its fiscal agent, recently implemented a comprehensive new process for provider credentialing that addressed the issue during this project.

HSAG Recommendations	DVHA Responses/Actions/Outcomes
DVHA must include proof of PECOS [Provider Enrollment, Chain, and Ownership System] verification in the provider file, and the proof should include the provider's PECOS enrollment date to ensure that the provider was listed in the PECOS database on the date **DVHA** received the application for enrollment in Vermont Medicaid.	**DVHA response: DVHA**'s Provider and Member Relations Unit, in conjunction with its fiscal agent, recently implemented a comprehensive new process for provider credentialing that addressed the issue during this project.
DVHA must ensure that written information included in the member handbook describes the beneficiary's right to terminate enrollment in the Medicaid program.	**DVHA response: DVHA** will complete the addition of this language by January 1, 2019.
DVHA must provide written evidence that AHS approves the grievance processes and policies implemented by **DVHA** and its IGA partners. Any proposed changes to the rules, procedures, and policies also must be submitted to AHS for approval.	**DVHA response:** Since this audit, **DVHA** has implemented many improvements to its G&A [grievance and appeals] processes, and these will be submitted to AHS through **DVHA**'s Compliance Committee by June 2019.
DVHA should consider endorsing only the Global Commitment to Health MCE Grievance & Appeals Technical Assistance Manual as the document to follow when processing grievances. If there are procedures the apply to specific IGA partners, **DVHA** could include an appendix in the manual that lists those specific requirements.	**DVHA response:** A single manual is now used for all grievances and appeals.
DVHA must ensure that all documents sent to the IGAs concerning grievances contain information about the beneficiary's ability to withdraw a grievance and that the withdrawal must be acknowledged in writing within five calendar days.	**DVHA response:** Since this audit, **DVHA** has implemented many improvements to its G&A processes, and this requirement is now in place.
DVHA must ensure that all grievances are addressed within 90 calendar days of receipt of the grievance. Written notices also must contain a brief summary of the grievance, information considered in making the grievance decision, and the position. If the response is adverse to the beneficiary, the notice also must inform the beneficiary of the right to initiate a grievance review and how to initiate the review.	**DVHA response:** Since this audit, **DVHA** has implemented many improvements to its G&A processes, and this requirement is now in place.
DVHA must ensure that all documents sent to the IGAs concerning grievances contain information about the individuals who may conduct a grievance review.	**DVHA response:** Since this audit, **DVHA** has implemented many improvements to its G&A processes, and this requirement is now in place.
DVHA must ensure that all documents sent to the IGAs concerning grievances contain information about ensuring that individuals who make decisions on grievances were not involved in any previous level of review or decision making.	**DVHA response:** Since this audit, **DVHA** has implemented many improvements to its G&A processes, and this requirement is now in place.

HSAG Recommendations	DVHA Responses/Actions/Outcomes
DVHA must include information about providing beneficiaries reasonable assistance in filing grievances, completing forms, and taking other procedural steps, such as providing interpreter services and toll-free numbers that have adequate Teletypewriter (TTY)/Telecommunications Device for the Deaf (TDD) and interpreter services.	**DVHA response:** This language will be included in the member handbook by April 2019.
DVHA must ensure that an acknowledgement letter is sent within five calendar days of receiving the grievance. All documents sent to the IGAs concerning grievances also must contain information indicating that sending an acknowledgement letter if the grievance decision is made within the five-day time frame is not necessary.	**DVHA response:** Since this audit, **DVHA** has implemented many improvements to its G&A processes, and this requirement is now in place.
DVHA must ensure the development and implementation of uniform, AHS-approved rules and policies in accordance with applicable appeals rules and hearing rules, as promulgated separately by the Human Services Board fair hearing rules.	**DVHA response:** Since this audit, **DVHA** has implemented many improvements to its G&A processes and this requirement is now in place.
DVHA must ensure that its IGA partners, including designated agencies and specialized service agencies acting within the delegated authority of **DVHA**/Department of Mental Health (DMH) adhere to the policies and procedures.	**DVHA response:** Since this audit, **DVHA** has implemented many improvements to its G&A processes, and this requirement is now in place.
DVHA must ensure that the department that receives the appeal mails written acknowledgment of the appeal within five calendar days of receipt as required by State rule.	**DVHA response:** Since this audit, **DVHA** has implemented many improvements to its G&A processes, and this requirement is now in place.
DVHA must ensure that appeals are resolved and that members are provided with written notice within the maximum time frames for standard and expedited appeals, including any extensions.	**DVHA response:** Since this audit, **DVHA** has implemented many improvements to its G&A processes, and this requirement is now in place.
DVHA's IGAs with DAIL [Department of Disabilities, Aging and Independent Living], Department for Children and Families (DCF), and DMH must define delegated activities and reporting responsibilities of the subcontractor.	**DVHA response:** Since this audit, **DVHA** has implemented many improvements to its G&A processes, and this requirement is now in place.
DVHA's IGAs with DAIL, DCF, and DMH also must include contract provisions regarding the use of a corrective action process to address problem performance.	**DVHA response:** Since this audit, **DVHA** has implemented many improvements to its G&A processes, and this requirement is now in place.