State of Vermont
Agency of Human Services

2019–2020 External Quality Review Technical Report

for

Department of Vermont Health Access

January 2020

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Introduction and Summary of Findings

Background

The federal Balanced Budget Act of 1997 (BBA), Public Law 105-33, requires state Medicaid agencies to "provide for an annual external independent review conducted by a qualified independent entity of the quality outcomes and timeliness of, and access to, the items and services for which the organization is responsible under the contract."[1-1] Health Services Advisory Group, Inc. (HSAG), is under contract with the Vermont Agency of Human Services (AHS) to perform the external quality review (EQR) activities for the State.

The 2019 Vermont EQR Technical Report for the Vermont AHS (AHS) complies with 42 Code of Federal Regulations (CFR) §438.364,[1-2] which requires the external quality review organization (EQRO) to produce an annual detailed technical report that summarizes findings on access to and quality of care including a description of the manner in which the data from all activities conducted in accordance with 42 CFR §438.358 were aggregated and analyzed, and conclusions were drawn as to the quality and timeliness of, and access to the care furnished by the managed care organization (MCO), prepaid inpatient health plan (PIHP), prepaid ambulatory health plan (PAHP), or primary care case management (PCCM) entity. This report meets the requirements of 42 CFR §438.364 and does not disclose the identity or other protected health information (PHI) of any beneficiary. The AHS quality strategy establishes standards related to access to care, structure and operations, quality measurement and improvement, performance objectives, provisions for external quality review, and mechanisms to monitor compliance with the standards and objectives set forth in the quality strategy.

To meet requirements established by the federal regulations and described in the AHS quality strategy, AHS contracted with HSAG to conduct the EQR activities beginning in the EQRO contract year 2007–2008. This report covers the EQR activities conducted during 2019–2020, the EQRO contract year. HSAG conducted the mandatory EQR activities consistent with the Centers for Medicare & Medicaid Services (CMS) protocols established under 42 CFR §438.352.[1-3]

[1-1] U. S. Government Publishing Office. (1997). *Public Law 105-33* (p. 249). Available at: http://www.gpo.gov/fdsys/pkg/PLAW-105publ33/pdf/PLAW-105publ33.pdf. Accessed on: Sep 4, 2019.

[1-2] U. S. Government Publishing Office. (2018). *Electronic Code of Federal Regulations.* Available at: https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=0fe554e3f4a6236efe0d8c0aa9319e57&mc=true&n=pt42.4.438&r=PART&ty=HTML#se42.4.438_1340. Accessed on: Sep 16, 2019.

[1-3] U. S. Government Publishing Office. (2018). *Electronic Code of Federal Regulations.* Available at: https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=0fe554e3f4a6236efe0d8c0aa9319e57&mc=true&n=pt42.4.438&r=PART&ty=HTML#se42.4.438_1352. Accessed on: Sep 16, 2019.

During the 2019–2020 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 §438.206–438.210 and §438.54–438.56, 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)[1-4] for preparation of an annual technical report that describes how data from activities conducted in accordance with 42 CFR §438.358 were aggregated and analyzed and how conclusions were drawn as to the quality and timeliness of, and the access to, care furnished by **DVHA**, 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.

[1-4] U. S. Government Publishing Office. (2018). *Electronic Code of Federal Regulations.* Available at: https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=0fe554e3f4a6236efe0d8c0aa9319e57&mc=true&n=pt42.4.438&r=PART&ty=HTML%23se42.4.438_1352#se42.4.438_1364. Accessed on: Sep 16, 2019.

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

Section 2—Detailed Findings: This section provides contextual information about the federal Medicaid managed care requirements, AHS, and **DVHA**. This section also presents a summary of findings and conclusions about **DVHA**'s strengths and weaknesses, as derived from the EQR activities performed during 2019–2020. 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. The section also includes 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,[1-5] 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.

[1-5] 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 16, 2019.

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 2019–2020 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 General Comment to the organization, to assist with improved processes or documentation for the next PIP submission.

Validation of Performance Measures

HSAG validated rates for a set of performance measures selected by AHS for 2019 reporting. AHS identified the measurement period for all measures as calendar year (CY) 2018. 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®)*[1-6] *2019, Volume 2, Technical Specifications for Health Plans*. Although most measures were reported using administrative data, **DVHA** was required to report three measures 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. Seven standards in this year's compliance review included Access and Enrollment and Disenrollment requirements, and those seven 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.

[1-6] HEDIS® is a registered trademark of the NCQA.

Opportunities for Improvement

Table 1-1 contains a list of the opportunities for improvement for **DVHA** that includes all EQR tasks described in this 2019–2020 EQR Technical Report. The table also includes contract compliance standards that did not achieve a score of 100 percent and HEDIS measures that did not achieve a rate above the Medicaid 25th percentile. Additional information about the tasks displayed in Table 1-1 is included in the Detailed Findings section of this report.

Table 1-1—Opportunities for Improvement for DVHA

EQR Activity	Measure Standard	MCO Results	Standard
Contract Compliance Review	Availability of Services	93.3%	100%
	Furnishing of Services	69.4%	100%
	Coordination and Continuity of Care	85.0%	100%
	Coverage and Authorization of Services	89.6%	100%
	Emergency and Poststabilization Services	91.7%	100%
	Disenrollment Requirements	80.0%	100%
HEDIS	*Adult BMI Assessment*	Below Medicaid 10th Percentile	Above the Medicaid 25th Percentile
	Adults' Access to Preventive/Ambulatory Health Services—65+ Years	Below Medicaid 25th Percentile	Above the Medicaid 25th Percentile
	Comprehensive Diabetes Care—HbA1c Testing	Below Medicaid 25th Percentile	Above the Medicaid 25th Percentile
	Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)	Below Medicaid 25th Percentile	Above the Medicaid 25th Percentile
	Comprehensive Diabetes Care—HbA1c Control (<8.0%)	Below Medicaid 25th Percentile	Above the Medicaid 25th Percentile
	Comprehensive Diabetes Care—HbA1c (<7.0%) for a Selected Population	Below Medicaid 25th Percentile	Above the Medicaid 25th Percentile
	Comprehensive Diabetes Care—Medical Attention for Nephropathy	Below Medicaid 5th Percentile	Above the Medicaid 25th Percentile

2. Detailed Findings

Background

The BBA, Public Law 105-33,[2-1] and as described in 42 CFR §438.364, requires state Medicaid agencies to contract with an EQRO to prepare an annual report that describes the manner in which data from activities conducted in accordance with 42 CFR §438.358 were aggregated and analyzed.[2-2] The report 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 PHI of any beneficiary.

The Vermont Agency of Human Services (AHS)

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

During the current EQRO contract year (February 2019–February 2020), 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 2019–2020 EQR technical report.

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

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: Dec 3, 2019.

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: Dec 3, 2019.

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 2019–2020 EQR Activities

HSAG's external quality review in contract year 2019–2020 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 2019 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 Access and Enrollment and Disenrollment standards (42 CFR §438.206–438.210 and §438.54–438.56) 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 2019–2020 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 2019–2020.

Validation of the Performance Improvement Project (PIP)

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

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 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.

[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 3, 2019.

DVHA's *Initiation of Alcohol and Other Drug Abuse or 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—2019–2020 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)**
Implementation	VII. Analyze and Interpret Study Results	100% (3/3)	0% (0/3)	0% (0/3)
	VIII. Implement Intervention and Improvement Strategies	100% (6/6)	0% (0/6)	0% (0/6)
Implementation and Evaluation Total		**100% (9/9)**	**0% (0/9)**	**0% (0/9)**

Stage	Step	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Outcomes	IX. Assess for Real Improvement	100% (3/3)	0% (0/3)	0% (0/3)
	X. Assess for Sustained Improvement	*Not Assessed*		
Outcomes Total		**100% (3/3)**	**0% (0/3)**	**0% (0/3)**
Percentage Score of Applicable Evaluation Elements *Met*		**100% (20/20)**		

The validation results indicated an overall score of 100 percent across all applicable evaluation elements. **DVHA** continued the PIP this year and reported first remeasurement results for the study indicator. The improvement from the baseline to the first remeasurement was statistically significant, indicating real improvement in outcomes.

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 2018 and 2019 performance measure results, the denominator for each measure (i.e., Number [N]), and the change for each measure rate from HEDIS 2018 to HEDIS 2019. Please note that for measures reported using the administrative methodology, the denominator is the eligible population. Additionally, the measure results for HEDIS 2019 were compared to the NCQA's HEDIS Audit Means and Percentiles National Medicaid Health Maintenance Organization (HMO) Percentiles for HEDIS 2018 (the most current rates available). NCQA's HEDIS Audit Means and Percentiles National Medicaid HMO Percentiles will be referred to as "percentiles" throughout this report.

[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 3, 2019.

Table 2-3—DVHA HEDIS 2018 and 2019 Results

Measure	HEDIS 2018		HEDIS 2019		Change from HEDIS 2018 to HEDIS 2019	HEDIS Percentile Ranking
	N	Rate	N	Rate		
*Well-Child Visits in the First 15 Months of Life—0 Visits**	2,841	1.06%	2,770	1.23%	+0.17%	25th–50th
Well-Child Visits in the First 15 Months of Life—1 Visit†	2,841	0.74%	2,770	0.76%	+0.02%	10th–25th
Well-Child Visits in the First 15 Months of Life—2 Visits†	2,841	1.48%	2,770	1.84%	+0.36%	10th–25th
Well-Child Visits in the First 15 Months of Life—3 Visits†	2,841	2.85%	2,770	2.42%	-0.43%	5th–10th
Well-Child Visits in the First 15 Months of Life—4 Visits†	2,841	6.51%	2,770	6.57%	+0.06%	25th–50th
Well-Child Visits in the First 15 Months of Life—5 Visits†	2,841	14.85%	2,770	14.19%	-0.66%	25th–50th
Well-Child Visits in the First 15 Months of Life—6 or More Visits	2,841	72.51%	2,770	73.00%	+0.49%	75th–90th
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	12,729	75.24%	12,605	75.34%	+0.10%	50th–75th
Adolescent Well-Care Visits	25,806	50.54%	25,516	52.51%	+1.97%	25th–50th
Adult BMI Assessment	411	62.53%	411	69.10%	+6.57%	5th–10th
Annual Dental Visit—2–3 Years	6,305	56.67%	6,069	57.90%	+1.23%	90th–95th
Annual Dental Visit—4–6 Years	9,543	74.03%	9,498	74.38%	+0.35%	75th–90th
Annual Dental Visit—7–10 Years	13,055	78.70%	12,963	78.85%	+0.15%	90th–95th
Annual Dental Visit—11–14 Years	12,206	75.67%	12,473	75.39%	-0.28%	≥95th
Annual Dental Visit—15–18 Years	11,296	68.78%	11,265	68.75%	-0.03%	≥95th
Annual Dental Visit—19–20 Years	3,953	53.10%	3,535	53.75%	+0.65%	≥95th
Annual Dental Visit—Total	56,538	71.00%	55,803	71.41%	+0.41%	≥95th
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	3,222	98.08%	3,131	98.21%	+0.13%	≥95th
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	15,564	92.56%	15,305	92.42%	-0.14%	75th–90th
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	14,830	95.90%	14,989	96.14%	+0.24%	75th–90th
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	20,840	95.49%	20,903	95.41%	-0.08%	90th–95th
Chlamydia Screening in Women—16–20 Years	4,003	49.74%	3,899	50.83%	+1.09%	25th–50th
Chlamydia Screening in Women—21–24 Years	2,575	58.06%	2,347	59.65%	+1.59%	25th–50th
Chlamydia Screening in Women—Total	6,578	52.99%	6,246	54.15%	+1.16%	25th–50th
Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	37,645	79.39%	37,112	79.40%	+0.01%	50th–75th
Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	21,594	85.22%	20,960	85.61%	+0.39%	25th–50th

Measure	HEDIS 2018		HEDIS 2019		Change from HEDIS 2018 to HEDIS 2019	HEDIS Percentile Ranking
	N	Rate	N	Rate		
Adults' Access to Preventive/Ambulatory Health Services—65+ Years	427	82.44%	381	79.27%	-3.17%	10th–25th
Adults' Access to Preventive/Ambulatory Health Services—Total	59,666	81.52%	58,453	81.63%	+0.11%	50th–75th
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—6–17 Years	—	—	326	45.40%	NC	NC
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—18–64 Years	—	—	1,207	32.56%	NC	NC
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—65+ Years	—	—	0	NA	NC	NC
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total	1,324	33.91%	1,533	35.29%	+1.38%	25th–50th
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—16–17 Years	—	—	326	68.10%	NC	NC
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—18–64 Years	—	—	1,207	46.81%	NC	NC
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—65+ Years	—	—	0	NA	NC	NC
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total	1,324	52.72%	1,533	51.34%	-1.38%	25th–50th
Initiation and Engagement of AOD Abuse or Dependence Treatment (Initiation)—13–17 Years—Total	235	35.74%	214	35.98%	+0.24%	25th–50th
Initiation and Engagement of AOD Abuse or Dependence Treatment (Initiation)—18+ Years—Total	4,378	38.21%	4,038	39.80%	+1.59%	25th–50th
Initiation and Engagement of AOD Abuse or Dependence Treatment (Initiation)—Total—Total	4,613	38.09%	4,252	39.60%	+1.51%	25th–50th
Initiation and Engagement of AOD Abuse or Dependence Treatment (Engagement)—13–17 Years—Total	235	18.30%	214	15.89%	-2.41%	50th–75th
Initiation and Engagement of AOD Abuse or Dependence Treatment (Engagement)—18+ Years—Total	4,378	19.67%	4,038	18.70%	-0.97%	75th–90th
Initiation and Engagement of AOD Abuse or Dependence Treatment (Engagement)—Total—Total	4,613	19.60%	4,252	18.56%	-1.04%	75th–90th
Breast Cancer Screening	6,189	54.26%	5,885	52.90%	-1.36%	25th–50th
Ambulatory Care (Outpatient Visits)—<1 Year[†,1]	33,567	905.75	33,648	960.33	+54.58	90th–95th
Ambulatory Care (Outpatient Visits)—1–9 Years[†,1]	112,957	298.10	111,897	305.38	+7.28	50th–75th
Ambulatory Care (Outpatient Visits)—10–19 Years[†,1]	90,621	242.35	91,496	246.87	+4.52	50th–75th
Ambulatory Care (Outpatient Visits)—20–44 Years[†,1]	148,279	261.51	145,013	266.76	+5.25	25th–50th
Ambulatory Care (Outpatient Visits)—45–64 Years[†,1]	124,066	407.84	121,604	419.45	+11.61	10th–25th

Measure	HEDIS 2018		HEDIS 2019		Change from HEDIS 2018 to HEDIS 2019	HEDIS Percentile Ranking
	N	Rate	N	Rate		
Ambulatory Care (Outpatient Visits)—65–74 Years†,1	1,223	321.08	1,005	288.96	-32.12	<5th
Ambulatory Care (Outpatient Visits)—75–84 Years†,1	438	598.36	261	446.92	-151.44	25th–50th
Ambulatory Care (Outpatient Visits)—85+ Years†,1	231	596.90	89	NA	NC	NC
Ambulatory Care (Outpatient Visits)—Total†,1	511,382	306.94	505,013	313.68	+6.74	25th–50th
*Ambulatory Care (Emergency Department [ED] Visits)—<1 Year**,1	2,320	62.60	2,326	66.39	+3.79	90th–95th
*Ambulatory Care (ED Visits)—1–9 Years**,1	13,438	35.46	13,069	35.67	+0.21	90th–95th
*Ambulatory Care (ED Visits)—10–19 Years**,1	13,539	36.21	13,176	35.55	-0.66	50th–75th
*Ambulatory Care (ED Visits)—20–44 Years**,1	32,773	57.80	31,829	58.55	+0.75	75th–90th
*Ambulatory Care (ED Visits)—45–64 Years**,1	12,962	42.61	12,828	44.25	+1.64	90th–95th
*Ambulatory Care (ED Visits)—65–74 Years**,1	77	20.22	56	16.10	-4.12	≥95th
*Ambulatory Care (ED Visits)—75–84 Years**,1	26	35.52	10	17.12	-18.40	75th–90th
*Ambulatory Care (ED Visits)—85+ Years**,1	12	31.01	8	NA	NC	NC
*Ambulatory Care (ED Visits)—Total**,1	75,147	45.10	73,302	45.53	+0.43	75th–90th
Medication Management for People With Asthma (Medication Compliance 50%)—5–11 Years	520	77.31%	553	75.23%	-2.08%	≥95th
Medication Management for People With Asthma (Medication Compliance 50%)—12–18 Years	424	72.41%	409	71.64%	-0.77%	≥95th
Medication Management for People With Asthma (Medication Compliance 50%)—19–50 Years	933	70.31%	855	73.80%	+3.49%	75th–90th
Medication Management for People With Asthma (Medication Compliance 50%)—51–64 Years	283	81.98%	278	82.73%	+0.75%	75th–90th
Medication Management for People With Asthma (Medication Compliance 50%)—Total	2,160	73.94%	2,095	74.94%	+1.00%	90th–95th
Medication Management for People With Asthma (Medication Compliance 75%)—5–11 Years	520	56.35%	553	52.98%	-3.37%	≥95th
Medication Management for People With Asthma (Medication Compliance 75%)—12–18 Years	424	50.47%	409	52.32%	+1.85%	≥95th
Medication Management for People With Asthma (Medication Compliance 75%)—19–50 Years	933	53.59%	855	55.20%	+1.61%	90th–95th
Medication Management for People With Asthma (Medication Compliance 75%)—51–64 Years	283	68.20%	278	64.75%	-3.45%	75th–90th
Medication Management for People With Asthma (Medication Compliance 75%)—Total	2,160	55.56%	2,095	55.32%	-0.24%	90th–95th
Comprehensive Diabetes Care—HbA1c Testing	—	—	576	84.38%	NC	10th–25th
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)**	—	—	576	47.74%	NC	10th–25th
Comprehensive Diabetes Care—HbA1c Control (<8.0%)	—	—	576	42.01%	NC	10th–25th

Measure	HEDIS 2018		HEDIS 2019		Change from HEDIS 2018 to HEDIS 2019	HEDIS Percentile Ranking
	N	Rate	N	Rate		
Comprehensive Diabetes Care—HbA1c Control (<7.0%) for a Selected Population	—	—	350	27.71%	NC	10th–25th
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	—	—	576	57.12%	NC	25th–50th
Comprehensive Diabetes Care—Medical Attention for Nephropathy	—	—	576	82.12%	NC	<5th
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	—	576	56.42%	NC	25th–50th
Controlling High Blood Pressure[2]	—	—	411	49.64%	NC	NC

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

† Rates for this indicator are presented for information only.

[1] For the Ambulatory Care indicators, N represents the number of visits instead of the denominator, and the rates displayed are the number of visits per 1,000 member months.

[2] Due to the changes in the technical specifications for this measure in HEDIS 2019, NCQA does not recommend trending between 2019 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks are not performed for this indicator.

— indicates that NCQA recommended a break in trending or the measure is a first-year measure for HEDIS 2019; therefore, prior year rates are not displayed.

NA indicates that a rate could not be reported due to a small denominator.

NC indicates that a comparison to benchmarks or to the prior year's rates is not appropriate either due to a change in specifications or because HEDIS 2019 is the first year this measure is being reported.

Excluding information-only measures, **DVHA** demonstrated strength with 19 measure rates meeting or exceeding the 90th percentile and with only seven measure rates falling below the 25th percentile. Of the 57 reportable rates with comparable benchmarks, 10 rates exceeded the 95th percentile:

- *Annual Dental Visit—11–14 Years*
- *Annual Dental Visit—15–18 Years*
- *Annual Dental Visit—19–20 Years*
- *Annual Dental Visit—Total*
- *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months*
- *Ambulatory Care (ED Visits)—65–74 Years*
- *Medication Management for People With Asthma (Medication Compliance 50%)—5–11 Years*
- *Medication Management for People With Asthma (Medication Compliance 50%)—12–18 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*

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

- *Annual Dental Visit—2–3 Years*
- *Annual Dental Visit—7–10 Years*
- *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%)—Total*
- *Medication Management for People With Asthma (Medication Compliance 75%)—19–50 Years*
- *Medication Management for People With Asthma (Medication Compliance 75%)—Total*

DVHA demonstrated opportunities for improvement, with the following seven rates falling below the 25th percentile:

- *Adult BMI Assessment*
- *Adults' Access to Preventive/Ambulatory Health Services—65+ Years*
- *Comprehensive Diabetes Care—HbA1c Testing*
- *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*
- *Comprehensive Diabetes Care—HbA1c Control (<8.0%)*
- *Comprehensive Diabetes Care—HbA1c Control (<7.0%) for a Selected Population*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

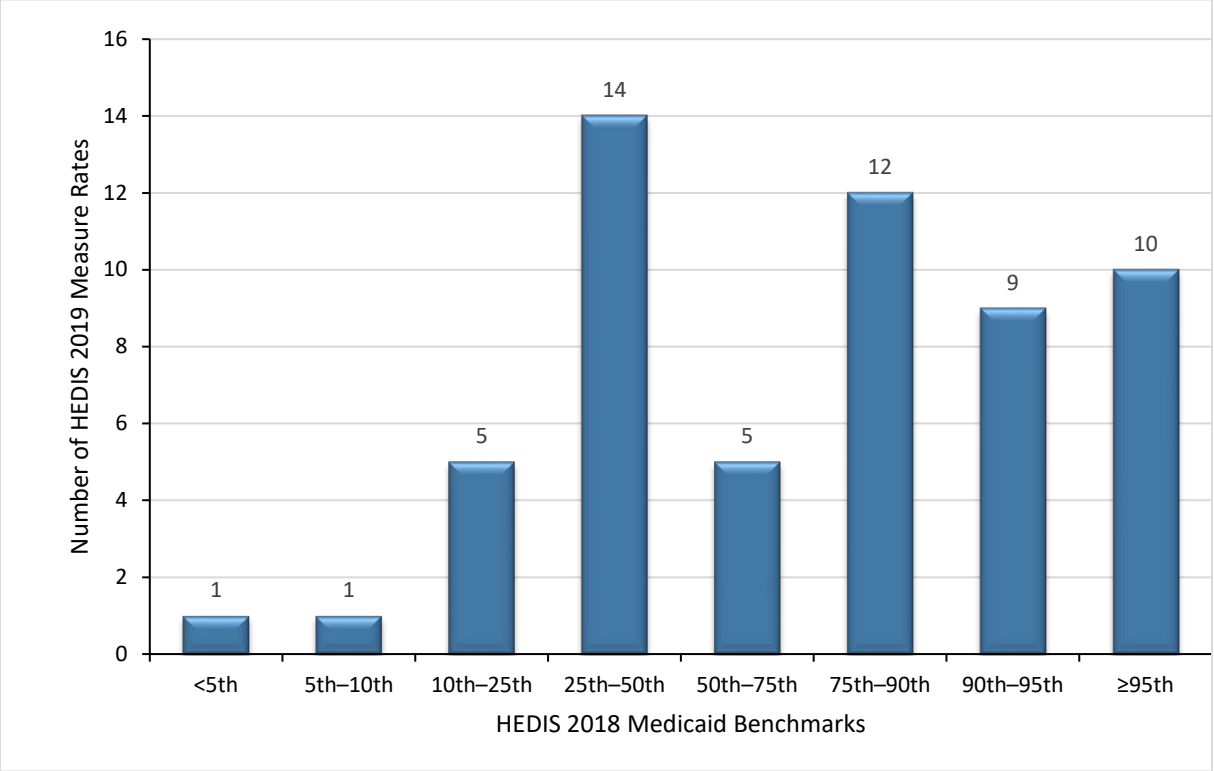
An additional 14 rates fell below the 50th percentile but were at or above the 25th percentile:

- *Well-Child Visits in the First 15 Months of Life—0 Visits*
- *Adolescent Well-Care Visits*
- *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*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total*
- *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total*
- *Initiation and Engagement of AOD Abuse or Dependence Treatment (Initiation)—13–17 Years—Total*
- *Initiation and Engagement of AOD Abuse or Dependence Treatment (Initiation)—18+ Years—Total*
- *Initiation and Engagement of AOD Abuse or Dependence Treatment (Initiation)—Total—Total*

- *Breast Cancer Screening*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*

Figure 2-1 shows the distribution of how the reported indicators compared to the 2018 HEDIS national Medicaid benchmarks.

Figure 2-1—Number of HEDIS 2019 Measure Rates Meeting the HEDIS 2018 Medicaid Benchmarks



DVHA performed at or above the 75th percentile for 31 of 57 (54.4 percent) measure rates appropriate for comparison to benchmarks, demonstrating strengths with ensuring access to primary care and dental screenings for children and adolescents, appropriate ED utilization, and appropriate management of medications for members with asthma. Conversely, 21 of 57 rates (36.8 percent) fell below the 50th percentile, indicating efforts should be focused on ensuring older adult members have access to preventive and ambulatory care, young children and adolescents are receiving necessary well-child/well-care visits, young women are appropriately screened for chlamydia, women are appropriately screened for breast cancer, and members with diabetes receive appropriate care.

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 2019–2020, AHS requested that HSAG conduct a review of the Access and Enrollment and Disenrollment 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 seven standards to allow **DVHA** staff members to elaborate on the written information HSAG reviewed, to assess the consistency of staff responses given during the interviews against the written documentation, and to clarify any questions reviewers had following the document review.

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

Table 2-4 presents a summary of **DVHA**'s performance results for the seven standard areas reviewed. The information includes:

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

Table 2-4—Standards and Compliance Score

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Total Compliance Score
I	Availability of Services	15	15	14	0	1	0	**93.3%**
II	Furnishing of Services	18	18	11	3	4	0	**69.4%**
III	Cultural Competence	3	3	3	0	0	0	**100%**

[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 3, 2019.

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Total Compliance Score
IV	Coordination and Continuity of Care	10	10	7	3	0	0	**85.0%**
V	Coverage and Authorization of Services	24	24	20	3	1	0	**89.6%**
VI	Emergency and Poststabilization Services	12	12	10	2	0	0	**91.7%**
VII	Disenrollment Requirements	5	5	3	2	0	0	**80.0%**
	Totals	**87**	**87**	**68**	**13**	**6**	**0**	**85.6%**

***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 87 elements across the seven standards. Of the 87 elements, **DVHA** obtained a score of *Met* for 68 elements (78.2 percent) and a *Partially Met* score for 13 elements (14.9 percent). **DVHA** obtained a *Not Met* score for six elements (6.9 percent). As a result, **DVHA** obtained a total percentage-of-compliance score across the 87 elements of 85.6 percent.

Overall Conclusions and Performance Trending

Performance Trends

Performance Improvement Project Trends

DVHA continued its PIP topic, *Initiation of Alcohol and Other Drug Abuse or Dependence Treatment*, in 2019–2020. **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** reported that it revisited the fishbone diagram and provided results for the substance abuse treatment provider survey. **DVHA** determined that the highest-priority barrier was timely access to treatment. The intervention for the PIP to address the barrier was promoting telemedicine visits for substance abuse disorder treatment.

For outcomes in Step IX, **DVHA** reported a first remeasurement result of 46.7 percent, a statistically significant improvement from the baseline result. Sustained improvement and performance trends will be assessed for the next annual validation when **DVHA** reports Remeasurement 2 results.

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.	44.2%	46.7%		Not Assessed

* 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 2019 performance measure rates. Table 2-6 below displays the rates for measures **DVHA** reported for HEDIS 2016, 2017, 2018, and 2019; the denominator (i.e., N); and the change for each measure rate from HEDIS 2016 to HEDIS 2019.

Table 2-6—HEDIS 2016, 2017, 2018, and 2019 Results

Measure	HEDIS 2016		HEDIS 2017		HEDIS 2018		HEDIS 2019		Change From HEDIS 2016 to HEDIS 2019
	N	Rate	N	Rate	N	Rate	N	Rate	
*Well-Child Visits in the First 15 Months of Life—0 Visits**	3,348	2.09%	3,045	1.67%	2,841	1.06%	2,770	1.23%	-0.86%
Well-Child Visits in the First 15 Months of Life—1 Visit†	3,348	1.28%	3,045	0.99%	2,841	0.74%	2,770	0.76%	-0.52%
Well-Child Visits in the First 15 Months of Life—2 Visits†	3,348	2.00%	3,045	1.48%	2,841	1.48%	2,770	1.84%	-0.16%

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

Measure	HEDIS 2016		HEDIS 2017		HEDIS 2018		HEDIS 2019		Change From HEDIS 2016 to HEDIS 2019
	N	Rate	N	Rate	N	Rate	N	Rate	
Well-Child Visits in the First 15 Months of Life—3 Visits†	3,348	3.38%	3,045	3.05%	2,841	2.85%	2,770	2.42%	-0.96%
Well-Child Visits in the First 15 Months of Life—4 Visits†	3,348	7.83%	3,045	6.11%	2,841	6.51%	2,770	6.57%	-1.26%
Well-Child Visits in the First 15 Months of Life—5 Visits†	3,348	16.04%	3,045	15.07%	2,841	14.85%	2,770	14.19%	-1.85%
Well-Child Visits in the First 15 Months of Life—6 or More Visits	3,348	67.38%	3,045	71.63%	2,841	72.51%	2,770	73.00%	+5.62%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	14,183	72.60%	12,879	73.97%	12,729	75.24%	12,605	75.34%	+2.74%
Adolescent Well-Care Visits	29,369	46.85%	26,791	50.89%	25,806	50.54%	25,516	52.51%	+5.66%
Adult BMI Assessment	411	74.70%	—	—	411	62.53%	411	69.10%	-5.60%
Annual Dental Visit—2–3 Years	7,106	44.67%	6,268	49.66%	6,305	56.67%	6,069	57.90%	+13.23%
Annual Dental Visit—4–6 Years	10,620	70.16%	9,690	72.16%	9,543	74.03%	9,498	74.38%	+4.22%
Annual Dental Visit—7–10 Years	14,124	74.88%	13,256	77.66%	13,055	78.70%	12,963	78.85%	+3.97%
Annual Dental Visit—11–14 Years	13,051	71.04%	12,304	74.11%	12,206	75.67%	12,473	75.39%	+4.35%
Annual Dental Visit—15–18 Years	12,273	63.89%	11,448	65.71%	11,296	68.78%	11,265	68.75%	+4.86%
Annual Dental Visit—19–20 Years	5,266	41.57%	4,407	46.36%	3,953	53.10%	3,535	53.75%	+12.18%
Annual Dental Visit—Total	62,440	64.87%	57,373	68.12%	56,538	71.00%	55,803	71.41%	+6.54%
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	3,765	97.16%	3,229	97.96%	3,222	98.08%	3,131	98.21%	+1.05%
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	17,434	90.64%	15,720	91.42%	15,564	92.56%	15,305	92.42%	+1.78%
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	16,019	95.11%	15,481	95.79%	14,830	95.90%	14,989	96.14%	+1.03%
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	22,617	94.00%	21,769	94.99%	20,840	95.49%	20,903	95.41%	+1.41%
Chlamydia Screening in Women—16–20 Years	4,634	49.63%	4,162	47.53%	4,003	49.74%	3,899	50.83%	+1.20%

Measure	HEDIS 2016		HEDIS 2017		HEDIS 2018		HEDIS 2019		Change From HEDIS 2016 to HEDIS 2019
	N	Rate	N	Rate	N	Rate	N	Rate	
Chlamydia Screening in Women—21–24 Years	3,569	56.26%	2,852	55.58%	2,575	58.06%	2,347	59.65%	+3.39%
Chlamydia Screening in Women—Total	8,203	52.52%	7,014	50.80%	6,578	52.99%	6,246	54.15%	+1.63%
Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	52,767	73.24%	40,955	78.24%	37,645	79.39%	37,112	79.40%	+6.16%
Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	28,319	80.55%	23,981	83.49%	21,594	85.22%	20,960	85.61%	+5.06%
Adults' Access to Preventive/Ambulatory Health Services—65+ Years	403	72.70%	394	72.59%	427	82.44%	381	79.27%	+6.57%
Adults' Access to Preventive/Ambulatory Health Services—Total	81,489	75.78%	65,330	80.13%	59,666	81.52%	58,453	81.63%	+5.85%
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—6–17 Years	—	—	—	—	—	—	326	45.40%	NC
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—18–64 Years	—	—	—	—	—	—	1,207	32.56%	NC
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—65+ Years	—	—	—	—	—	—	0	NA	NC
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total	—	—	—	—	1,324	33.91%	1,533	35.29%	NC
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—16–17 Years	—	—	—	—	—	—	326	68.10%	NC
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—18–64 Years	—	—	—	—	—	—	1,207	46.81%	NC

Measure	HEDIS 2016		HEDIS 2017		HEDIS 2018		HEDIS 2019		Change From HEDIS 2016 to HEDIS 2019
	N	Rate	N	Rate	N	Rate	N	Rate	
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—65+ Years	—	—	—	—	—	—	0	NA	NC
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total	—	—	—	—	1,324	52.72%	1,533	51.34%	NC
Initiation and Engagement of AOD Abuse or Dependence Treatment (Initiation)—13–17 Years—Total	—	—	—	—	235	35.74%	214	35.98%	NC
Initiation and Engagement of AOD Abuse or Dependence Treatment (Initiation)—18+ Years—Total	—	—	—	—	4,378	38.21%	4,038	39.80%	NC
Initiation and Engagement of AOD Abuse or Dependence Treatment (Initiation)—Total—Total	—	—	—	—	4,613	38.09%	4,252	39.60%	NC
Initiation and Engagement of AOD Abuse or Dependence Treatment (Engagement)—13–17 Years—Total	—	—	—	—	235	18.30%	214	15.89%	NC
Initiation and Engagement of AOD Abuse or Dependence Treatment (Engagement)—18+ Years—Total	—	—	—	—	4,378	19.67%	4,038	18.70%	NC
Initiation and Engagement of AOD Abuse or Dependence Treatment (Engagement)—Total—Total	—	—	—	—	4,613	19.60%	4,252	18.56%	NC
Breast Cancer Screening	—	—	—	—	6,189	54.26%	5,885	52.90%	NC
Ambulatory Care (Outpatient Visits)—<1 Year[†,1]	37,434	914.23	36,328	941.04	33,567	905.75	33,648	960.33	+46.10
Ambulatory Care (Outpatient Visits)—1–9 Years[†,1]	121,434	305.49	117,053	299.28	112,957	298.10	111,897	305.38	-0.11

Measure	HEDIS 2016		HEDIS 2017		HEDIS 2018		HEDIS 2019		Change From HEDIS 2016 to HEDIS 2019
	N	Rate	N	Rate	N	Rate	N	Rate	
Ambulatory Care (Outpatient Visits)—10–19 Years†,1	94,927	245.86	94,823	246.51	90,621	242.35	91,496	246.87	+1.01
Ambulatory Care (Outpatient Visits)—20–44 Years†,1	183,404	272.12	176,166	268.48	148,279	261.51	145,013	266.76	-5.36
Ambulatory Care (Outpatient Visits)—45–64 Years†,1	147,319	416.93	142,090	408.41	124,066	407.84	121,604	419.45	+2.52
Ambulatory Care (Outpatient Visits)—65–74 Years†,1	977	370.78	1,131	313.38	1,223	321.08	1,005	288.96	-81.82
Ambulatory Care (Outpatient Visits)—75–84 Years†,1	401	481.97	405	530.8	438	598.36	261	446.92	-35.05
Ambulatory Care (Outpatient Visits)—85+ Years†,1	244	505.18	124	370.15	231	596.90	89	NA	NC
Ambulatory Care (Outpatient Visits)—Total†,1	586,140	315.84	568,120	311.61	511,382	306.94	505,013	313.68	-2.16
*Ambulatory Care (Emergency Department [ED] Visits)—<1 Year**,1	2,830	69.12	2,540	65.80	2,320	62.60	2,326	66.39	-2.73
*Ambulatory Care (ED Visits)—1–9 Years**,1	14,281	35.93	13,428	34.33	13,438	35.46	13,069	35.67	-0.26
*Ambulatory Care (ED Visits)—10–19 Years**,1	14,319	37.09	13,975	36.33	13,539	36.21	13,176	35.55	-1.54
*Ambulatory Care (ED Visits)—20–44 Years**,1	40,594	60.23	37,849	57.68	32,773	57.80	31,829	58.55	-1.68
*Ambulatory Care (ED Visits)—45–64 Years**,1	13,906	39.36	13,628	39.17	12,962	42.61	12,828	44.25	+4.89
*Ambulatory Care (ED Visits)—65–74 Years**,1	75	28.46	73	20.23	77	20.22	56	16.10	-12.36
*Ambulatory Care (ED Visits)—75–84 Years**,1	18	21.63	25	32.77	26	35.52	10	17.12	-4.51
*Ambulatory Care (ED Visits)—85+ Years**,1	16	33.13	10	29.85	12	31.01	8	NA	NC
*Ambulatory Care (ED Visits)—Total**,1	86,039	46.36	81,528	44.72	75,147	45.10	73,302	45.53	-0.83
Medication Management for People With Asthma (Medication Compliance 50%)—5–11 Years	514	72.18%	533	70.92%	520	77.31%	553	75.23%	+3.05%

Measure	HEDIS 2016		HEDIS 2017		HEDIS 2018		HEDIS 2019		Change From HEDIS 2016 to HEDIS 2019
	N	Rate	N	Rate	N	Rate	N	Rate	
Medication Management for People With Asthma (Medication Compliance 50%)—12–18 Years	397	64.99%	399	71.18%	424	72.41%	409	71.64%	+6.65%
Medication Management for People With Asthma (Medication Compliance 50%)—19–50 Years	1,033	69.51%	974	77.00%	933	70.31%	855	73.80%	+4.29%
Medication Management for People With Asthma (Medication Compliance 50%)—51–64 Years	293	83.28%	311	83.92%	283	81.98%	278	82.73%	-0.55%
Medication Management for People With Asthma (Medication Compliance 50%)—Total	2,237	71.12%	2,217	75.46%	2,160	73.94%	2,095	74.94%	+3.82%
Medication Management for People With Asthma (Medication Compliance 75%)—5–11 Years	514	52.53%	533	51.59%	520	56.35%	553	52.98%	+0.45%
Medication Management for People With Asthma (Medication Compliance 75%)—12–18 Years	397	45.84%	399	52.38%	424	50.47%	409	52.32%	+6.48%
Medication Management for People With Asthma (Medication Compliance 75%)—19–50 Years	1,033	51.21%	974	60.78%	933	53.59%	855	55.20%	+3.99%
Medication Management for People With Asthma (Medication Compliance 75%)—51–64 Years	293	67.58%	311	68.17%	283	68.20%	278	64.75%	-2.83%
Medication Management for People With Asthma (Medication Compliance 75%)—Total	2,237	52.70%	2,217	58.10%	2,160	55.56%	2,095	55.32%	+2.62%
Comprehensive Diabetes Care—HbA1c Testing	—	—	—	—	—	—	576	84.38%	NC
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)**	—	—	—	—	—	—	576	47.74%	NC
Comprehensive Diabetes Care—HbA1c Control (<8.0%)	—	—	—	—	—	—	576	42.01%	NC

Measure	HEDIS 2016		HEDIS 2017		HEDIS 2018		HEDIS 2019		Change From HEDIS 2016 to HEDIS 2019
	N	Rate	N	Rate	N	Rate	N	Rate	
Comprehensive Diabetes Care—HbA1c Control (<7.0%) for a Selected Population	—	—	—	—	—	—	350	27.71%	NC
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	—	—	—	—	—	—	576	57.12%	NC
Comprehensive Diabetes Care—Medical Attention for Nephropathy	—	—	—	—	—	—	576	82.12%	NC
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	—	—	—	—	—	—	576	56.42%	NC
Controlling High Blood Pressure[2]	—	—	—	—	—	—	411	49.64%	NC

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

† Rates for this indicator are presented for information only.

[1] For the Ambulatory Care indicators, N represents the number of visits instead of the denominator, and the rates displayed are the number of visits per 1,000 member months.

[2] Due to changes in the technical specifications for this measure in HEDIS 2019, NCQA does not recommend trending between 2019 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks are not performed for this indicator.

— indicates that NCQA recommended a break in trending or the measure is a first-year measure for HEDIS 2019; therefore, prior year rates are not displayed

NA indicates that a rate could not be reported due to a small denominator.

NC indicates that a comparison to benchmarks or to the prior year's rates is not appropriate either due to a change in specifications or because HEDIS 2019 is the first year this measure is being reported.

Overall, 37 of the 41 (90.2 percent) measure rates that could be trended showed an improvement in performance since HEDIS 2016 (excluding information-only measures). Further, the *Annual Dental Visits–2–3 Years* and the *Annual Dental Visit—19–20 Years* measure indicator rates improved by more than 10 percentage points from HEDIS 2016 to HEDIS 2019, and the *Ambulatory Care (ED Visits)—65–74 Years* measure indicator rate improved by more than 12 visits per 1,000 member months. Of the four measure rates that showed a decline in performance, the *Adult BMI Assessment* measure was the only measure that declined by more than 5 percentage points from HEDIS 2016 to HEDIS 2019. Additionally, the *Ambulatory Care (ED Visits)—45–64 Years* measure indicator rate demonstrated a decline in performance of nearly five visits per 1,000 member months.

Compliance With Standards Trends

For the 2019–2020 review, the third 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 seven performance categories (i.e., standards). The seven standards (i.e., Availability of Services, Furnishing of Services, Cultural Competence, Coordination and Continuity of Care, Coverage and Authorization of Services, Emergency and Poststabilization Services, and Disenrollment Requirements) included requirements associated with the federal Medicaid managed care Access Standards found at 42 CFR §438.206–§438.210 and the enrollment and disenrollment requirements (§438.54–§438.56), which are part of the CMS' Structure and Operations standards.

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–§438.230); 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–§438.210 and §438.54–§438.56).

For this year (2019—the 12th year of review), HSAG evaluated the Access and Enrollment/ Disenrollment standards, the same standards it reviewed in 2010, 2013, and 2016.

Table 2-7 documents **DVHA**'s performance across 12 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%			
2013							71	99%	3%
2014	93	92%	15%						
2015				31	97%	3%			
2016							80	97%	6%
2017	84	90%	19%						
2018				33	100%	0%			
2019							68	86%	22%

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

For the Access and Enrollment/Disenrollment standards, the overall scores **DVHA** received across the four years these standards were reviewed ranged from 86 percent to 99 percent, with the overall corrective action percentages ranging from 3 percent to 22 percent.

During the prior review, **DVHA** scored 97 percent across the seven 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.

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.

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 3, 2019.

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*.

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 N/A relate to utilization of services.

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

PIP	Quality	Timeliness	Access
Initiation of Alcohol and Other Drug Abuse or 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	✓		✓
Adult BMI Assessment	✓		
Annual Dental Visit			✓
Children and Adolescents' Access to Primary Care Practitioners			✓
Chlamydia Screening in Women	✓		
Adults' Access to Preventive/Ambulatory Health Services			✓
Follow-Up After Hospitalization for Mental Illness	✓	✓	✓
Initiation and Engagement of AOD Abuse or Dependence Treatment	✓	✓	✓
Breast Cancer Screening	✓		
Ambulatory Care	N/A	N/A	N/A
Medication Management for People With Asthma	✓		
Comprehensive Diabetes Care	✓		
Controlling High Blood Pressure	✓		

[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: Dec 3, 2019.

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

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 result. **DVHA** met 100 percent of the requirements for data analysis and improvement strategies. For outcomes, the improvement from the baseline to the first remeasurement was statistically significant.

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 either quality of care or access to care demonstrated strengths by meeting or exceeding the 90th percentile, including *Annual Dental Visit*, *Children and Adolescents' Access to Primary Care Practitioners*, and *Medication Management for People With Asthma.* No performance measures related to timeliness of care exceeded the 90th 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 and timeliness of, and/or access to care. *Met* elements in standards I–VII addressed quality and timeliness of, and access to care. HSAG noted the following strengths.

DVHA maintained written agreements with both its IGA partner delegates and network providers that addressed all AHS requirements regarding network sufficiency including access to care for beneficiaries with limited English proficiency (LEP) and/or physical or mental disabilities. **DVHA** had a process in place to ensure that beneficiaries with special health care needs (SHCN) had direct access to specialists, and **DVHA** also provided direct access to women's routine and preventive healthcare services without a referral.

A review of reports and interviews with staff members confirmed that, in addition to provider surveys and telephone calls to providers' offices to determine compliance with access to care standards, **DVHA** used grievances and appeals, ombudsman reports, client satisfaction surveys, and information from member services' calls to monitor the network for timely access to services. A review of the Prepaid Inpatient Health Plan (PIHP) Quality Committee Minutes dated January 18, 2019, confirmed that the committee received a report of the 2018 grievances and appeals and discussed any trends noted in the report.

DVHA promoted the delivery of culturally competent services to Global Commitment to Health Demonstration beneficiaries consistent with 42 CFR and the AHS/**DVHA** IGA. **DVHA** contracted with Maximus to produce beneficiary materials and required that the documents be written at a fifth-grade reading level to ensure readability. Maximus also could provide beneficiary materials in several languages and in alternative formats including large print upon request. **DVHA** incentivized providers to make interpreter services available using a procedure code that facilitated additional reimbursement to the provider for in-person interpreter services for beneficiaries who spoke a language other than English as a first language or were hearing impaired.

DVHA used the Johns Hopkins Adjusted Clinical Group (ACG) predictive modeling system to identify enrollees who may benefit from case management and care coordination services. **DVHA** also accepted case management referrals from providers, community health agencies, hospital discharge planners, social service organizations, community assistance organizations, and enrollee self-referrals.

DVHA had mechanisms in place to conduct comprehensive health needs assessments for enrollees referred to the VCCI for case management services. When **DVHA** identified an enrollee as having SHCN, the VCCI case manager referred the enrollee to the appropriate IGA partner for coordination of care and services. **DVHA** made early and periodic screening, diagnostic and treatment (EPSDT) services available to beneficiaries under age 21 through the EPSDT program.

The Maximus contract required Maximus to perform member services activities to include updating the computer system with eligibility information, operating a call center to assist enrollees who have questions about covered services, verifying third party liability information, assisting with the selection of providers, answering questions about prior authorizations and billing, and handling any other issues to assist enrollees in understanding their coverage with Green Mountain Care.

Recommendations and Opportunities for Improvement

Performance Improvement Project

DVHA has demonstrated proficiency in designing and implementing a PIP. Additionally, the study indicator results demonstrated statistically significant improvement for the first remeasurement, indicating real improvement in the outcomes.

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

- **DVHA** should continue its quality improvement efforts to sustain improvement in the study indicator rate.
- **DVHA** should continue to evaluate the intervention for effectiveness and add additional interventions 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

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

During the on-site review, **DVHA** presented the Vermont Access to Care Plan for review that included results from monitoring the mileage and travel times for enrollees to access PCPs from 2015–2017. **DVHA** indicated that geographic access reports for the current survey period to determine the travel distance for enrollees to a PCP had not been generated. **DVHA** must ensure that, when establishing and maintaining an adequate network, consideration is given for the geographic location of providers and Global Commitment to Health Demonstration enrollees regarding distance, travel time, and the means of transportation ordinarily used by Medicaid enrollees, as required by the IGA §2.7.1 and the CFR.

The Access to Care Plan for **DVHA** also established geographic access standards (i.e., miles and minutes) for travel to PCPs, hospitals, general optometry providers, and lab and x-ray services. During the on-site review, **DVHA** indicated that geographic access reports were not generated during the review period (i.e., August 1, 2018–July 16, 2019). To ensure that the network providers meet the standards required in the IGA and Access to Care Plan, **DVHA** must generate geographic access reports showing the distance or time traveled between enrollees and PCPs, hospitals, general optometry providers, and lab and x-ray services.

The IGA §2.7.5 contained a link to the Access to Care Plan for **DVHA**, and the plan included appointment wait time requirements for urgent, nonurgent, and preventive care for primary care and specialty providers. **DVHA** listed those requirements in the Vermont Medicaid PCP Manual; however, there were no appointment wait time requirements found in the general provider manual for specialist providers. **DVHA** must ensure that appointment wait time requirements are disseminated to all primary care and specialty providers in the Green Mountain Care provider network.

DVHA staff members reported that although the enrollee was asked to identify his or her personal goals while enrolled in case management and care coordination services, there was no evidence to support that the care plan was developed in conjunction with the enrollee's approval.

DVHA staff member interviews confirmed that an enrollee's PCP was not furnished a copy of the case management care plan. Rather, providers were mailed a letter summarizing the results of the VCCI comprehensive health needs assessment, primary case management issues, and notification of referrals to external agencies. However, the VCCI Case Management Workflow Guidelines specified that the Plan of Care letter to the PCP was to be used in conjunction with furnishing the PCP with a copy of the care treatment plan. **DVHA** must ensure that care plans are developed with the participation of the enrollee's PCP and enrollee, in consultation with any specialists caring for the enrollee, and sent to the PCP.

Interviews with case management staff members revealed that, during the comprehensive health needs assessment, enrollees were asked about any care being received by specialist physicians. If an enrollee indicated that a specialist provider also furnished care, the case manager should capture the name of the specialist in the database. **DVHA** must ensure that the treatment plan identifies specialist services that may be accessed directly by the enrollee as appropriate for that enrollee's condition and identified needs.

DVHA staff members reported that **DVHA**'s IGA partner delegate, the Department of Families and Children (DCF), was no longer providing written notice of adverse action to beneficiaries in cases involving decisions to deny an authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. **DVHA** must ensure that its IGA partner delegates provide written notice of adverse action to beneficiaries and ensure that the written notice of action forms used by **DVHA** and by its IGA partner delegates meet all content requirements described in 42 CFR §438.404(b) and in the AHS/**DVHA** IGA. This finding was also noted in the 2016–2017 review for this standard.

Two of the 10 records in the utilization review denial sample did not meet the requirement that standard authorization decisions be made, and notice provided to the beneficiary and the provider within 14 calendar days of the request. **DVHA** must ensure that the MCE and its IGA partner delegates meet the timelines established for standard authorization decisions and notifications as required in 42 CFR §438.210(d)(1).

DVHA's Clinical Operations Unit Procedure Manual incorrectly indicated that **DVHA** must make an expedited decision and provide notice as expeditiously as the beneficiary's health condition requires and no later than three working days after the receipt of the request. **DVHA** must ensure that expedited authorization decisions be made, and notice provided consistent with the 72-hour time frame requirement in 42 CFR §438.210(d)(2)(i). **DVHA** must review and revise all MCE and IGA partner delegate documents to conform to this requirement.

One element required **DVHA** to ensure that emergency coverage is available to enrollees 24 hours a day, seven days a week. The PCP Manual included the requirement that PCPs arrange for 24 hour-a-day, seven-day-a-week coverage; however, there was no indication of this requirement in the general provider manual. **DVHA** must inform all network providers about the requirement to make services included in the IGA contract available 24 hours a day, seven days a week.

The **DVHA** Health Care Programs Handbook—Green Mountain Care informed enrollees to go to the nearest emergency room or hospital for emergency care right away. The following statement concerning out-of-network emergency care was found on page 11 of the handbook: "Please note that Green Mountain Care cannot guarantee that out-of-state or out-of-network providers will choose to accept your Green Mountain Care insurance and you may have to pay for services yourself." **DVHA** must delete or revise the statement to ensure that enrollees are advised that Green Mountain Care is responsible to pay for emergency services rendered in or out of network.

DVHA must ensure that enrollees in the Choices for Care Program receive education about systems to prevent, detect, report, investigate, and remediate abuse, neglect, and exploitation. This finding was also noted in the 2016–2017 review for this standard.

One element in this standard requires **DVHA** to make a good faith effort to provide notice of termination of a contracted provider within 15 days after receipt or issuance of a termination notice. The general provider manual included the statement that providers must give enrollees 30 days' notice prior to termination. The PCP Manual stipulated that PCPs must notify DXC of their intention to withdraw from participation, in writing, at least 90 days prior to the termination date. **DVHA** must ensure that a notice of termination of a contracted provider is furnished to enrollees who receive their primary care from that provider or were seen regularly by the terminated provider, within 15 days after receipt or issuance of a termination notice.

3. Description of External Quality Review Activities

Validation of Performance Improvement Project

During the 2019–2020 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. **DVHA** achieved all validation criteria with the first submission, and a resubmission was not necessary.

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 General Comment 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 CMS mandatory EQR activity required by the BBA. State Medicaid agencies must ensure that performance measures reported by their MCOs are validated. The state, its agent that is not an MCO, or an EQRO, can perform this validation. HSAG, the EQRO for AHS, conducted the validation activities. For CY 2018, 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 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, cited earlier in this report.

Objectives and Background Information

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

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

AHS selected 15 HEDIS measures for HSAG's validation. The measurement period addressed in this report was CY 2018.

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 with HEDIS Certified Measures for HEDIS 2019 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 2018 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, cited earlier in this report. HSAG described the details related to its approach, methodologies, and findings from the compliance activities in its *2018–2019 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: Dec 3, 2019.

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

I. Availability of Services
II. Furnishing of Services
III. Cultural Competence
IV. Coordination and Continuity of Care
V. Coverage and Authorization of Services
VI. Emergency and Poststabilization Services
VII. Disenrollment Requirements

As these same standards were reviewed during three prior audits, 2010, 2013 and 2016, 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	August 1, 2018–July 16, 2019
Information from interviews conducted on-site	July 17, 2019–July 18, 2019

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, three HSAG reviewers conducted the two-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 concerning 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**. HSAG made recommendations for any element that was scored as *Partially Met* or *Not Met,* and offered suggestions to **DVHA** to further strengthen and drive continued improvement in **DVHA**'s performance. 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; covered services, including emergency and poststabilization services available to beneficiaries; processes for responding to requests for service and the associated documentation related to coverage and authorization of services; coordination and continuity of care; cultural competence; disenrollment requirements; 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** answered 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: • Convening 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 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 (2018–2019), HSAG validated **DVHA**'s PIP, *Initiation of Alcohol and Other Drug Abuse or 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, two *Points of Clarification* were identified.

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

HSAG Recommendations	DVHA Response/Actions/Outcomes
Step III: Under Inclusions, the health plan should indicate "a new episode of AOD abuse or dependence."	**DVHA response:** **DVHA** updated the Inclusions to indicate a new episode of AOD abuse or dependence.
Step VIII: An intervention was not yet started for the #1 ranked barrier (timely access to treatment). The health plan reported that it completed a survey to collect data regarding this barrier before proceeding. The health plan should start an intervention to address the barrier with enough time to impact the Remeasurement 1 results from 2018.	**DVHA response:** **DVHA** implemented a timely intervention to impact the first remeasurement result.

Validation of Performance Measures

HSAG validated 15 performance measures during the previous EQRO contract year (2018–2019). HSAG auditors determined that all 15 were compliant with AHS' specifications and that the rates could be reported. As a result of HSAG's review of provided documentation and 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** strive to improve its medical record completion rate by at least 5 percent to 10 percent, as this will significantly improve **DVHA**'s numerator compliance.	**DVHA response: DVHA** has started collaboration with our Blueprint for Health initiative to access both lab data and medical records via the VITL partnership that manages Vermont healthcare medical records/lab data retentions system. Access to the Vermont Health Information Exchange (VHIE) data, maintained by VITL, is still being built and configured, so it will be a number of years before we will be able to interact with the system to gain access to medical records and lab data via this State partner for HEDIS processes.
HSAG recommended that **DVHA** continue to work with lab vendors to ensure appropriate capture of lab claims and results, as this will enhance rates for numerator compliance.	**DVHA response: DVHA** has started collaboration with our Blueprint for Health initiative to access both lab data and medical records via the VITL partnership that manages Vermont healthcare medical records/lab data retentions system. Access to the VHIE data, maintained by VITL, is still being built and configured, so it will be a number of years before we will be able to interact with the system to gain access to medical records and lab data via this State partner for HEDIS processes.

Monitoring Compliance With Standards

During the 2018–2019 compliance audit, HSAG evaluated the degree to which **DVHA** complied with federal Medicaid managed care regulations and the associated AHS-DVHA IGA (i.e., contract requirements) in three performance categories (i.e., standards). The three standards included requirements associated with federal Medicaid Measurement and Improvement standards found at 42 CFR §438.236, §438.242, and §438.330. The standards HSAG evaluated were those related to Practice Guidelines, Quality Assessment and Performance Improvement, and Health Information Systems. HSAG reviewed **DVHA**'s performance related to 33 elements across the three standards. Of the 33 requirements, **DVHA** obtained a score of *Met* for all requirements. As a result, **DVHA** obtained a total percentage of compliance across the 33 requirements of 100 percent with no recommendations.