State of Vermont
Agency of Human Services

2016–2017 External Quality Review Report of Results

for

Department of Vermont Health Access

March 2017

HSAG HEALTH SERVICES ADVISORY GROUP

Contents

1. Executive Summary

Background

The Balanced Budget Act of 1997 (BBA), Public Law 105-33, and as described in the Code of Federal Regulations (CFR) [42 CFR §438.364], requires state Medicaid agencies to contract with an external quality review organization (EQRO) to prepare an annual report that describes the manner in which data from activities conducted in accordance with 42 CFR §438.358 were aggregated and analyzed. The report must also describe how conclusions were drawn as to the quality and timeliness of, and access to, care furnished by the Medicaid managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs). The Vermont Agency of Human Services (AHS) chose to meet this requirement by contracting with Health Services Advisory Group, Inc. (HSAG), an EQRO, beginning in contract year 2007–2008 to conduct the three Centers for Medicare & Medicaid Services (CMS) required activities and to prepare the external quality review (EQR) annual technical report bringing together the results from the activities it conducted. This report meets the requirements of 42 CFR §438.364 and does not disclose the identity of any beneficiary.

The Vermont Agency of Human Services (AHS)

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

During the current EQRO contract year (February 2016–February 2017), HSAG conducted the three mandatory EQR activities and compared the information to **DVHA**'s performance data from the prior year. The results of HSAG's review are contained in this 2016–2017 EQR technical report.

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

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

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

The Department of Vermont Health Access (DVHA)

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

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

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

Scope of HSAG's 2016–2017 EQR Activities

HSAG's external quality review in contract year 2016–2017 consisted of conducting the following activities:

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

- ***Validation of DVHA's performance measures***. HSAG validated the accuracy of the AHS-required performance measures that **DVHA** reported. The validation also determined the extent to which Medicaid-specific performance measures calculated by **DVHA** followed specifications established by AHS.
- ***Review of DVHA's compliance with standards.*** HSAG conducted a review to determine the organization's compliance with performance standards (sets of requirements) described in the federal Medicaid managed care Access and Enrollment/Disenrollment standards (42 CFR §438.206–210 and §438.226) 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 2016–2017 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 2016–2017.

Validation of the Performance Improvement Project (PIP)

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

The purpose of the study was to improve follow-up after an inpatient stay for selected mental health disorders. Follow-up after discharge is important for continuity of care between treatment settings and ensuring that beneficiaries receive needed care and services. Beneficiaries receiving appropriate follow-up care can reduce the risk of repeat hospitalization. **DVHA**'s goal is to increase the percentage of discharges for beneficiaries six years of age and older who were hospitalized for treatment of selected mental illness diagnoses and had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within seven and 30 days of discharge. **DVHA** used data from calendar year (CY) 2015 for the Remeasurement 2 results.

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR), Version 2.0*, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. Accessed on Dec 20, 2016.

DVHA's *Follow-Up After Hospitalization for Mental Illness* PIP received a score of 85 percent for all applicable evaluation elements scored as *Met*, a score of 90 percent for critical evaluation elements scored as *Met*, and an overall validation status of *Not Met*, as displayed in Table 1-1.

Table 1-1—2016–2017 PIP Validation Summary Overall Score

Percentage Score of Evaluation Elements *Met**	85%
Percentage Score of Critical Elements *Met***	90%
Validation Status***	***Not Met***

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

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

*** For a *Not Met* validation status, 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*.

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

Table 1-2—Performance Across All Activities

Review Activities	Total Number of Evaluation Elements *Met*/Total Number of Applicable Evaluation Elements	Total Number of Critical Elements *Met*/Total Number of Applicable Critical Evaluation Elements
I. Select the Study Topic	2/2	1/1
II. Define the Study Question(s)	1/1	1/1
III. Define the Study Population	1/1	1/1
IV. Select the Study Indicator(s)	1/1	1/1
V. Use Sound Sampling Techniques	*Not Applicable*	*Not Applicable*
VI. Reliably Collect Data	3/3	1/1
VII. Analyze Data and Interpret Study Results	3/3	1/1
VIII. Implement Intervention and Improvement Strategies	5/6	3/3
IX. Assess for Real Improvement	1/3	0/1
X. Assess for Sustained Improvement	*Not Assessed*	*Not Assessed*

The validation results indicated an overall score of 85 percent across all applicable evaluation elements. **DVHA** provided all required documentation, and the PIP was a methodologically sound study. **DVHA** had an opportunity for improvement related to the timeliness of intervention implementation in the current measurement period. In addition, **DVHA** reported Remeasurement 2 results. The assessment for

real improvement determined that although improvement occurred for both study indicators from the first remeasurement, neither study indicator's Remeasurement 2 result demonstrated statistically significant improvement from the baseline. Study Indicator 2's Remeasurement 2 result was lower than the baseline.

Validation of Performance Measures

HSAG validated a set of performance measures selected by AHS that were calculated and reported by **DVHA**. The methodology HSAG used to validate the performance measures was based on CMS' performance measures' validation protocol.[1-2] The validation findings confirmed that all rates were reportable. Table 1-3 below displays the performance measure results and trended results, including a comparison to the prior year's rates and the Healthcare Effectiveness Data and Information Set (HEDIS®)[1-3] 2015 national Medicaid percentiles. Measures with no rates displayed, which are denoted with a double-dash (--), were not reported in the prior year; therefore, trending was not applicable (NA).

Table 1-3—DVHA HEDIS 2015 and 2016 Results

Performance Measure	HEDIS 2015		HEDIS 2016		Overall Trend	HEDIS Percentile Ranking
	Number (N)	Rate	N	Rate	Change	
Well-Child Visits in the First 15 Months of Life—0 Visits¥	3,146	1.53%	3,348	2.09%	+0.56%	25th–50th
Well-Child Visits in the First 15 Months of Life—1 Visit	3,146	0.79%	3,348	1.28%	+0.49%	25th–50th
Well-Child Visits in the First 15 Months of Life—2 Visits	3,146	2.07%	3,348	2.00%	-0.07%	10th–25th
Well-Child Visits in the First 15 Months of Life—3 Visits	3,146	3.46%	3,348	3.38%	-0.08%	10th–25th
Well-Child Visits in the First 15 Months of Life—4 Visits	3,146	6.58%	3,348	7.83%	+1.25%	10th–25th
Well-Child Visits in the First 15 Months of Life—5 Visits	3,146	14.72%	3,348	16.04%	+1.32%	25th–50th
Well-Child Visits in the First 15 Months of Life—6 or More Visits	3,146	70.85%	3,348	67.38%	-3.47%	75th–90th
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	13,219	72.82%	14,183	72.60%	-0.22%	50th–75th
Adolescent Well-Care Visits	25,496	47.35%	29,369	46.85%	-0.50%	25th–50th
Annual Dental Visits—Ages 2–3	6,568	46.80%	7,106	44.67%	-2.13%	50th–75th
Annual Dental Visits—Ages 4–6	9,945	71.42%	10,620	70.16%	-1.26%	75th–90th
Annual Dental Visits—Ages 7–10	12,989	77.24%	14,124	74.88%	-2.36%	75th–90th
Annual Dental Visits—Ages 11–14	11,922	72.68%	13,051	71.04%	-1.64%	90th–95th

[1-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR), Version 2.0*, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. Accessed on: Dec 20, 2016.

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

Performance Measure	HEDIS 2015		HEDIS 2016		Overall Trend	HEDIS Percentile Ranking
	Number (N)	Rate	N	Rate	Change	
Annual Dental Visits—Ages 15–18	11,195	65.36%	12,273	63.89%	-1.47%	90th–95th
*Annual Dental Visits—Ages 19–20**	5,379	39.58%	5,266	41.57%	+1.99%	75th–90th
Annual Dental Visits—Combined Rate	57,998	66.07%	62,440	64.87%	-1.20%	75th–90th
Children's and Adolescents' Access to Primary Care Practitioners—12–24 Months	3,572	97.40%	3,765	97.16%	-0.24%	50th–75th
Children's and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	16,221	91.35%	17,434	90.64%	-0.71%	50th–75th
Children's and Adolescents' Access to Primary Care Practitioners—7–11 Years	14,307	95.93%	16,019	95.11%	-0.82%	75th–90th
Children's and Adolescents' Access to Primary Care Practitioners—12–19 Years	19,122	94.81%	22,617	94.00%	-0.81%	75th–90th
Chlamydia Screening in Women—16–20 Years	3,977	49.56%	4,634	49.63%	+0.07%	25th–50th
Chlamydia Screening in Women—21–24 Years	2,985	57.25%	3,569	56.26%	-0.99%	25th–50th
Chlamydia Screening in Women—Total	6,962	52.86%	8,203	52.52%	-0.34%	25th–50th
Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	40,215	77.44%	52,767	73.24%	-4.20%	10th–25th
Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	22,030	83.83%	28,319	80.55%	-3.28%	10th–25th
Adults' Access to Preventive/Ambulatory Health Services—65+ Years	381	83.20%	403	72.70%	-10.50%	<5th
Adults' Access to Preventive/Ambulatory Health Services—Total	62,626	79.72%	81,489	75.78%	-3.94%	10th–25th
Follow-Up After Hospitalization for Mental Illness—7-day Follow-Up	1,152	42.45%	1,278	43.11%	+0.66%	25th–50th
Follow-Up After Hospitalization for Mental Illness—30-day Follow-Up	1,152	59.29%	1,278	59.55%	+0.26%	25th–50th
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation)—13–17 Years	293	39.59%	265	39.25%	-0.34%	25th–50th
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation)—18 Years and Older	5,418	33.04%	6,068	34.81%	+1.77%	25th–50th
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation)—Total	5,711	33.37%	6,333	34.99%	+1.62%	25th–50th
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Engagement)—13–17 Years	293	17.75%	265	18.11%	+0.36%	50th–75th
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Engagement)—18 Years and Older	5,418	13.34%	6,068	14.16%	+0.82%	50th–75th
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Engagement)—Total	5,711	13.57%	6,333	14.32%	+0.75%	50th–75th
Breast Cancer Screening	4,211	56.11%	5,277	54.22%	-1.89%	25th–50th

Performance Measure	HEDIS 2015		HEDIS 2016		Overall Trend	HEDIS Percentile Ranking
	Number (N)	Rate	N	Rate	Change	
Controlling High Blood Pressure	411	48.18%	411	56.45%	+8.27%	25th–50th
Adult BMI Assessment	--	--	411	74.70%	NA	10th–25th
*Ambulatory Care (Outpatient Visits)—<1 Year***	--	--	37,434	914.23	NA	90th–95th
*Ambulatory Care (Outpatient Visits)—1–9 Years***	--	--	121,434	305.49	NA	50th–75th
*Ambulatory Care (Outpatient Visits)—10–19 Years***	--	--	94,927	245.86	NA	50th–75th
*Ambulatory Care (Outpatient Visits)—20–44 Years***	--	--	183,404	272.12	NA	10th–25th
*Ambulatory Care (Outpatient Visits)—45–64 Years***	--	--	147,319	416.93	NA	10th–25th
*Ambulatory Care (Outpatient Visits)—65–74 Years***	--	--	977	370.78	NA	10th–25th
*Ambulatory Care (Outpatient Visits)—75–84 Years***	--	--	401	481.97	NA	25th–50th
*Ambulatory Care (Outpatient Visits)—85+ Years***	--	--	244	505.18	NA	50th–75th
*Ambulatory Care (Outpatient Visits)—Total***	--	--	586,140	315.84	NA	25th–50th
*Ambulatory Care (ED Visits)—<1 Year¥****	--	--	2,830	69.12	NA	75th–90th
*Ambulatory Care (ED Visits)—1–9 Years¥****	--	--	14,281	35.93	NA	75th–90th
*Ambulatory Care (ED Visits)—10–19 Years¥****	--	--	14,319	37.09	NA	50th–75th
*Ambulatory Care (ED Visits)—20–44 Years¥****	--	--	40,594	60.23	NA	75th–90th
*Ambulatory Care (ED Visits)—45–64 Years¥****	--	--	13,906	39.36	NA	75th–90th
*Ambulatory Care (ED Visits)—65–74 Years¥****	--	--	75	28.46	NA	50th–75th
*Ambulatory Care (ED Visits)—75–84 Years¥****	--	--	18	21.63	NA	50th–75th
*Ambulatory Care (ED Visits)—85+ Years¥****	--	--	16	33.13	NA	50th–75th
*Ambulatory Care (ED Visits)—Total¥****	--	--	86,039	46.36	NA	75th–90th
Medication Management for People With Asthma (Medication Compliance 50%)—5–11 Years	--	--	514	72.18%	NA	>95th
Medication Management for People With Asthma (Medication Compliance 50%)—12–18 Years	--	--	397	64.99%	NA	>95th
Medication Management for People With Asthma (Medication Compliance 50%)—19–50 Years	--	--	1,033	69.51%	NA	90th–95th
Medication Management for People With Asthma (Medication Compliance 50%)—51–64 Years	--	--	293	83.28%	NA	>95th
Medication Management for People With Asthma (Medication Compliance 50%)—Total	--	--	2,237	71.12%	NA	>95th
Medication Management for People With Asthma (Medication Compliance 75%)—5–11 Years	--	--	514	52.53%	NA	>95th
Medication Management for People With Asthma (Medication Compliance 75%)—12–18 Years	--	--	397	45.84%	NA	>95th
Medication Management for People With Asthma (Medication Compliance 75%)—19–50 Years	--	--	1,033	51.21%	NA	>95th

Performance Measure	HEDIS 2015		HEDIS 2016		Overall Trend	HEDIS Percentile Ranking
	Number (N)	Rate	N	Rate	Change	
Medication Management for People With Asthma (Medication Compliance 75%)—51–64 Years	--	--	293	67.58%	NA	>95th
Medication Management for People With Asthma (Medication Compliance 75%)—Total	--	--	2,237	52.70%	NA	>95th

¥ A lower rate (decline) indicates better performance for this indicator.

* For HEDIS 2016, the upper age limit was revised to 20 years of age to align with the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) service guidelines. However, the HEDIS 2015 rate and HEDIS national percentile for this age group were based on ages 19-21 years.

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

NA indicates that trending was not applicable.

DVHA performed well on some clinical indicators and below the 25th national Medicaid percentile on other clinical indicators. Of the 66 clinical indicators reported, nine indicators exceeded the 95th national Medicaid percentile:

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

In addition to the nine indicators above, four indicators exceeded the 90th national Medicaid percentile:

- *Annual Dental Visits—Ages 11–14*
- *Annual Dental Visits—Ages 15–18*
- *Ambulatory Care (Outpatient Visits)—<1 Year*
- *Medication Management for People With Asthma (Medication Compliance 50%)—19–50 Years*

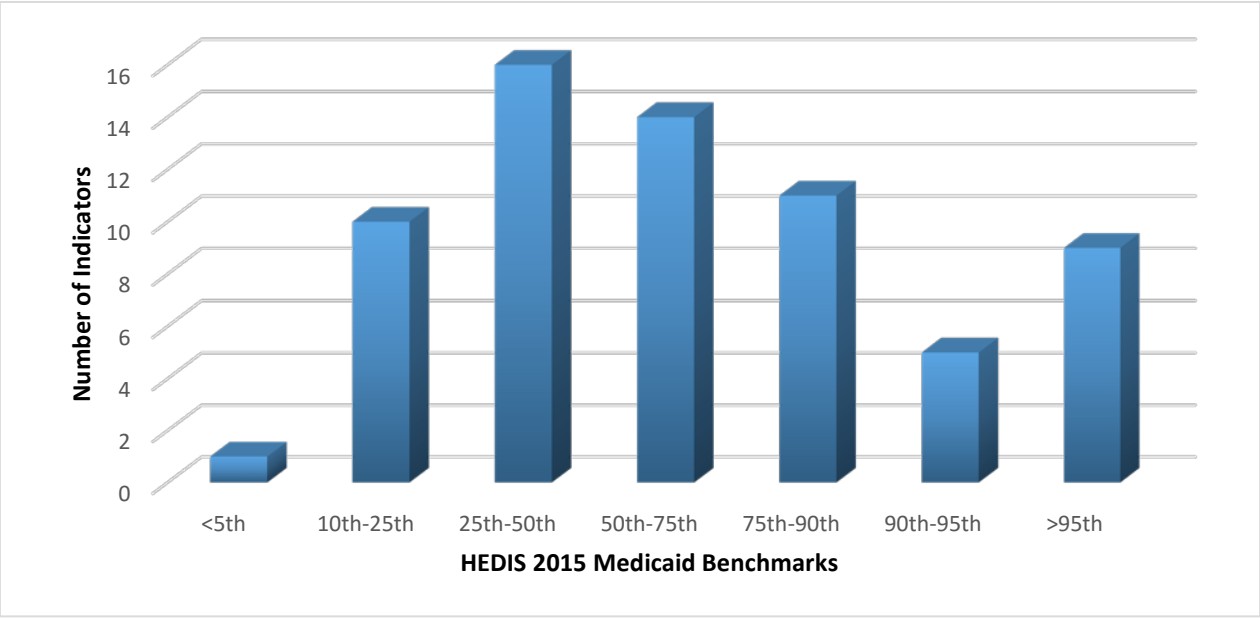
DVHA performed below the 25th national Medicaid percentile on 11 indicators:

- *Well-Child Visits in the First 15 Months of Life—2 Visits*
- *Well-Child Visits in the First 15 Months of Life—3 Visits*
- *Well-Child Visits in the First 15 Months of Life—4 Visits*

- *Adults' Access to Preventive/Ambulatory Health Services—20–44 Years*
- *Adults' Access to Preventive/Ambulatory Health Services—45–64 Years*
- *Adults' Access to Preventive/Ambulatory Health Services—65+ Years*
- *Adults' Access to Preventive/Ambulatory Health Services—Total*
- *Adult BMI Assessment*
- *Ambulatory Care (Outpatient Visits)—20–44 Years*
- *Ambulatory Care (Outpatient Visits)—45–64 Years*
- *Ambulatory Care (Outpatient Visits)—65–74 Years*

Figure 1-1 shows the distribution of how the reported indicators compared to the 2015 HEDIS national Medicaid benchmarks.

Figure 1-1—Number of Indicator Rates Meeting the HEDIS 2015 Medicaid Benchmarks



As shown in the figure above, most indicators were between the 25th and 75th national Medicaid percentiles, indicating that many opportunities for improvement exist.

Review of Compliance With Standards

Under its EQRO contract, AHS requested that HSAG continue to review one of the three sets of federal Medicaid managed care standards during each EQRO contract year. For EQRO contract year 2016–2017, AHS requested that HSAG conduct a review of the Access and Enrollment/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.[1-4] HSAG reviewed **DVHA**'s written operating policies and procedures, program plans, meeting minutes, numerous written reports, and other data and documentation related to **DVHA**'s performance during the review period. Reviewers also conducted staff interviews related to each of the 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 1-4 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.

[1-4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR), Version 2.0*, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. Accessed on: Dec 20, 2016.

Table 1-4—Standards and Compliance Score

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Total Compliance Score
I	Availability of Services	12	12	12	0	0	0	**100%**
II	Furnishing of Services	17	17	14	3	0	0	**91%**
III	Cultural Competence	3	3	3	0	0	0	**100%**
IV	Coordination and Continuity of Care	9	9	9	0	0	0	**100%**
V	Coverage and Authorization of Services	22	22	21	1	0	0	**98%**
VI	Emergency and Poststabilization Services	12	12	12	0	0	0	**100%**
VII	Disenrollment Requirements	5	5	4	1	0	0	**90%**
	Totals	**80**	**80**	**75**	**5**	**0**	**0**	**97%**

***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 1-4 preceding, HSAG reviewed **DVHA**'s performance related to 80 elements across the seven standards. Of the 80 elements, **DVHA** obtained a score of *Met* for 75 of the elements and a score of *Partially Met* for five elements. As a result, **DVHA** obtained a total compliance score of 97 percent across the 80 requirements.

With scores at or above 90 percent in all seven standard areas reviewed, **DVHA** demonstrated numerous performance strengths in meeting the federal measurement and improvement regulations and AHS contract requirements. Four of the seven standards indicated significant areas of strength, with scores of 100 percent. The remaining three standards received a score below 100 percent but at 90 percent or higher: Furnishing of Services, Coverage and Authorization of Services, and Disenrollment Requirements. **DVHA**'s performance represented a change in three element scores from the 2012–2013 review of the same standards. During the prior review, **DVHA** scored 100 percent in all six standards and a 90 percent in Standard V, Coverage and Authorization of Services.

Overall Conclusions and Performance Trending

Performance Trends

Performance Improvement Project Trends

This was the third year **DVHA** conducted its PIP—*Follow-Up After Hospitalization for Mental Illness.* **DVHA**'s performance suggests a continuation of its thorough application of the Design stage. **DVHA**

provided all required documentation for Activities I through VI. HSAG determined that **DVHA** designed a methodologically sound study. The technical design of the PIP continued to be sufficient to measure valid study indicator outcomes. **DVHA** continued to accurately document the data collection methodology, analysis of results, causal/barrier analysis, and process to evaluate the effectiveness of the intervention.

This was the second year that the PIP was assessed for improvement. **DVHA** reported that 62.9 percent of beneficiaries had follow-up after discharge within seven days (Study Indicator 1). This was a non-significant increase of 1.5 percentage points from Remeasurement 1. The result exceeded the goal of 62.6 percent. The Remeasurement 2 result for follow-up after discharge within 30 days was 78.1 percent (Study Indicator 2). This study indicator also demonstrated a non-significant increase of 1.4 percentage points and was just below the goal of 78.3 percent. Compared to the prior year's submission, the PIP did not achieve statistically significant improvement from the baseline for all study indicators either year. The following table displays the baseline and remeasurement data for the two study indicators.

Table 1-5—*Follow-Up After Hospitlization for Mental Illness* PIP

Study Indicators	Baseline (1/1/13–12/31/13)	Remeasurement 1 (1/1/14–12/31/14)	Remeasurement 2 (1/1/15–12/31/15)	Sustained Improvement^
Percentage of discharges for beneficiaries 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge.	62.5%	61.4%	62.9%	NA
Percentage of discharges for beneficiaries 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 30 days of discharge.	79.3%	76.7%	78.1%	NA

^ Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect statistically significant improvement when compared to the baseline results.

NA Statistically significant improvement over baseline and a subsequent measurement must occur before sustained improvement can be assessed.

Performance Measure Trends

DVHA used software, the source code of which had been certified by the National Committee for Quality Assurance (NCQA) to calculate and report the HEDIS 2016 measures. Table 1-6 below displays the rates for measures **DVHA** reported for HEDIS 2013, 2014, 2015, and 2016 and the overall trended rate. The trends displayed are calculated from the first reported rate to the HEDIS 2016 rate. Measures with no rates displayed (--) were not reported in prior years; therefore, trending was not performed (NA).

Table 1-6—HEDIS 2013, 2014, 2015, and 2016 Rates and Trended Results

Performance Measure	HEDIS 2013		HEDIS 2014		HEDIS 2015		HEDIS 2016		Overall Trend
	N	Rate	N	Rate	N	Rate	N	Rate	Change (Percentage Point Difference)
Well-Child Visits in the First 15 Months of Life—0 Visits[¥]	3,109	2.06%	3,082	1.59%	3,146	1.53%	3,348	2.09%	+0.03%
Well-Child Visits in the First 15 Months of Life—1 Visit	3,109	1.29%	3,082	0.91%	3,146	0.79%	3,348	1.28%	-0.01%
Well-Child Visits in the First 15 Months of Life—2 Visits	3,109	1.83%	3,082	1.36%	3,146	2.07%	3,348	2.00%	+0.17%
Well-Child Visits in the First 15 Months of Life—3 Visits	3,109	2.22%	3,082	2.60%	3,146	3.46%	3,348	3.38%	+1.16%
Well-Child Visits in the First 15 Months of Life—4 Visits	3,109	5.40%	3,082	5.39%	3,146	6.58%	3,348	7.83%	+2.43%
Well-Child Visits in the First 15 Months of Life—5 Visits	3,109	11.97%	3,082	12.20%	3,146	14.72%	3,348	16.04%	+4.07%
Well-Child Visits in the First 15 Months of Life—6 or More Visits	3,109	75.23%	3,082	75.96%	3,146	70.85%	3,348	67.38%	-7.85%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	13,186	69.32%	13,170	71.49%	13,219	72.82%	14,183	72.60%	+3.28%
Adolescent Well-Care Visits	22,441	46.27%	22,630	46.97%	25,496	47.35%	29,369	46.85%	+0.58%
Annual Dental Visits—Ages 2–3	6,418	46.96%	6,378	46.47%	6,568	46.80%	7,106	44.67%	-2.29%
Annual Dental Visits—Ages 4–6	9,981	72.78%	9,947	71.61%	9,945	71.42%	10,620	70.16%	-2.62%
Annual Dental Visits—Ages 7–10	12,659	78.02%	12,782	77.85%	12,989	77.24%	14,124	74.88%	-3.14%
Annual Dental Visits—Ages 11–14	12,123	72.76%	12,139	72.19%	11,922	72.68%	13,051	71.04%	-1.72%
Annual Dental Visits—Ages 15–18	9,740	65.56%	10,098	65.64%	11,195	65.36%	12,273	63.89%	-1.67%
*Annual Dental Visits—Ages 19–20**	2,641	44.72%	2,664	43.02%	5,379	39.58%	5,266	41.57%	NT
Annual Dental Visits—Combined Rate	53,562	68.23%	54,008	67.72%	57,998	66.07%	62,440	64.87%	-3.36%

Performance Measure	HEDIS 2013		HEDIS 2014		HEDIS 2015		HEDIS 2016		Overall Trend
	N	Rate	N	Rate	N	Rate	N	Rate	Change (Percentage Point Difference)
Children's and Adolescents' Access to Primary Care Practitioners—12–24 Months	3,423	98.31%	3,453	98.55%	3,572	97.40%	3,765	97.16%	-1.15%
Children's and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	16,175	91.70%	16,077	92.13%	16,221	91.35%	17,434	90.64%	-1.06%
Children's and Adolescents' Access to Primary Care Practitioners—7–11 Years	14,221	94.48%	14,460	94.46%	14,307	95.93%	16,019	95.11%	+0.63%
Children's and Adolescents' Access to Primary Care Practitioners—12–19 Years	18,212	93.73%	18,485	93.90%	19,122	94.81%	22,617	94.00%	+0.27%
Chlamydia Screening in Women—16–20 Years	--	--	3,092	47.35%	3,977	49.56%	4,634	49.63%	NA
Chlamydia Screening in Women—21–24 Years	--	--	2,299	54.85%	2,985	57.25%	3,569	56.26%	NA
Chlamydia Screening in Women—Total	--	--	5,391	50.55%	6,962	52.86%	8,203	52.52%	NA
Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	30,936	84.09%	31,658	84.21%	40,215	77.44%	52,767	73.24%	-10.85%
Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	20,947	88.93%	21,700	89.37%	22,030	83.83%	28,319	80.55%	-8.38%
*Adults' Access to Preventive/Ambulatory Health Services—65+ Years****	7,615	93.04%	7,718	94.31%	381	83.20%	403	72.70%	-20.34%
Adults' Access to Preventive/Ambulatory Health Services—Total	59,498	86.94%	61,076	87.32%	62,626	79.72%	81,489	75.78%	-11.16%
Follow-Up After Hospitalization for Mental Illness—7-day Follow-Up	--	--	1,567	41.61%	1,152	42.45%	1,278	43.11%	NA
Follow-Up After Hospitalization for Mental Illness—30-day Follow-Up	--	--	1,567	61.77%	1,152	59.29%	1,278	59.55%	NA
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation)—13-17 Years	--	--	312	42.63%	293	39.59%	265	39.25%	NA
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation)—18 Years and Older	--	--	5,715	33.88%	5,418	33.04%	6,068	34.81%	NA

Performance Measure	HEDIS 2013		HEDIS 2014		HEDIS 2015		HEDIS 2016		Overall Trend
	N	Rate	N	Rate	N	Rate	N	Rate	Change (Percentage Point Difference)
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation)—Total	--	--	6,027	34.33%	5,711	33.37%	6,333	34.99%	NA
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Engagement)—13–17 Years	--	--	312	18.91%	293	17.75%	265	18.11%	NA
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Engagement)—18 Years and Older	--	--	5,715	13.26%	5,418	13.34%	6,068	14.16%	NA
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Engagement)—Total	--	--	6,027	13.56%	5,711	13.57%	6,333	14.32%	NA
Breast Cancer Screening	--	--	7,543	38.10%	4,211	56.11%	5,277	54.22%	NA
*Controlling High Blood Pressure***	--	--	--	--	411	48.18%	411	56.45%	NA
Adult BMI Assessment	--	--	--	--	--	--	411	74.70%	NA
Ambulatory Care (Outpatient Visits)—<1 Years+*	--	--	--	--	--	--	37,434	914.23	NA
Ambulatory Care (Outpatient Visits)—1–9 Years+*	--	--	--	--	--	--	121,434	305.49	NA
Ambulatory Care (Outpatient Visits)—10–19 Years+*	--	--	--	--	--	--	94,927	245.86	NA
Ambulatory Care (Outpatient Visits)—20–44 Years+*	--	--	--	--	--	--	183,404	272.12	NA
Ambulatory Care (Outpatient Visits)—45–64 Years+*	--	--	--	--	--	--	147,319	416.93	NA
Ambulatory Care (Outpatient Visits)—65–74 Years+*	--	--	--	--	--	--	977	370.78	NA
Ambulatory Care (Outpatient Visits)—75–84 Years+*	--	--	--	--	--	--	401	481.97	NA
Ambulatory Care (Outpatient Visits)—85+ Years+*	--	--	--	--	--	--	244	505.18	NA
Ambulatory Care (Outpatient Visits)—Total+*	--	--	--	--	--	--	586,140	315.84	NA
Ambulatory Care (ED Visits)—<1 Years¥+*	--	--	--	--	--	--	2,830	69.12	NA
Ambulatory Care (ED Visits)—1–9 Years¥+*	--	--	--	--	--	--	14,281	35.93	NA

Performance Measure	HEDIS 2013		HEDIS 2014		HEDIS 2015		HEDIS 2016		Overall Trend
	N	Rate	N	Rate	N	Rate	N	Rate	Change (Percentage Point Difference)
Ambulatory Care (ED Visits)—10–19 Years[¥+]	--	--	--	--	--	--	14,319	37.09	NA
Ambulatory Care (ED Visits)—20–44 Years[¥+]	--	--	--	--	--	--	40,594	60.23	NA
Ambulatory Care (ED Visits)—45–64 Years[¥+]	--	--	--	--	--	--	13,906	39.36	NA
Ambulatory Care (ED Visits)—65–74 Years[¥+]	--	--	--	--	--	--	75	28.46	NA
Ambulatory Care (ED Visits)—75–84 Years[¥+]	--	--	--	--	--	--	18	21.63	NA
Ambulatory Care (ED Visits)—85+ Years[¥+]	--	--	--	--	--	--	16	33.13	NA
Ambulatory Care (ED Visits)—Total[¥+]	--	--	--	--	--	--	86,039	46.36	NA
Medication Management for People With Asthma (Medication Compliance 50%)—5–11 Years	--	--	--	--	--	--	514	72.18%	NA
Medication Management for People With Asthma (Medication Compliance 50%)—12–18 Years	--	--	--	--	--	--	397	64.99%	NA
Medication Management for People With Asthma (Medication Compliance 50%)—19–50 Years	--	--	--	--	--	--	1,033	69.51%	NA
Medication Management for People With Asthma (Medication Compliance 50%)—51–64 Years	--	--	--	--	--	--	293	83.28%	NA
Medication Management for People With Asthma (Medication Compliance 50%)—Total	--	--	--	--	--	--	2,237	71.12%	NA
Medication Management for People With Asthma (Medication Compliance 75%)—5–11 Years	--	--	--	--	--	--	514	52.53%	NA
Medication Management for People With Asthma (Medication Compliance 75%)—12–18 Years	--	--	--	--	--	--	397	45.84%	NA
Medication Management for People With Asthma (Medication Compliance 75%)—19–50 Years	--	--	--	--	--	--	1,033	51.21%	NA

Performance Measure	HEDIS 2013		HEDIS 2014		HEDIS 2015		HEDIS 2016		Overall Trend
	N	Rate	N	Rate	N	Rate	N	Rate	Change (Percentage Point Difference)
Medication Management for People With Asthma (Medication Compliance 75%)—51–64 Years	--	--	--	--	--	--	293	67.58%	NA
Medication Management for People With Asthma (Medication Compliance 75%)—Total	--	--	--	--	--	--	2,237	52.70%	NA

¥ A lower rate (decline) indicates better performance for this indicator.

* For HEDIS 2016, the upper age limit was revised to 20 years of age to align with the EPSDT service guidelines. However, the HEDIS 2013, 2014, and 2015 national percentiles for this age group were based on ages 19–21 years.

** Starting in HEDIS 2015, this measure was calculated using hybrid methodology.

*** Medicare enrollees were removed from the eligible population when calculating this indicator for the *Adults' Access to Preventive/Ambulatory Health Services—65+ Years* measure for HEDIS 2015. This change has resulted in a smaller denominator than in previous years. Therefore, caution should be exercised when comparing HEDIS 2015 and HEDIS 2016 to prior years' results.

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

NT = Trending cannot be performed due to the changes in measure specifications between years.

NA indicates that trending was not applicable.

Overall, nine of the 24 indicators with rates that could be trended showed an increase in performance since HEDIS 2013. Of the 15 measures that showed decreases in performance, the *Adults' Access to Preventive/Ambulatory Health Services* indicators exhibited the largest performance decrease, ranging from 8.38 to 20.34 percentage points.

Compliance With Standards Trends

For the 2016–2017 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 of Services, and Enrollment and Disenrollment) included standards associated with federal Medicaid managed care Access requirements found at CFR §438.206–210 and the enrollment and disenrollment requirements found at CFR §438.226, 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 and focus of the standards vary for each year's review. The three-year cycle consists of the following standards: Year 1, Structure and Operations standards (42 CFR

§438.214–224 and §228–230); Year 2, Measurement and Improvement standards (42 CFR §438.236–242); and Year 3, Access and Enrollment/Disenrollment standards (42 CFR §438.206–210 and §438.226).

For this, the ninth year of reviews, HSAG evaluated the Access and Enrollment/Disenrollment standards, the same standards reviewed by HSAG in 2009–2010 and 2012–2013.

Table 1-7 documents **DVHA**'s performance across eight years of compliance reviews conducted by HSAG.

Table 1-7—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 %*
CY 2008	90	84%	30%						
CY 2009				29	98%	3%			
CY 2010							76	97%	7%
CY 2011	89	90%	20%						
CY 2012				30	100%	0.0%			
CY 2013							71	99%	3%
CY 2014	93	92%	15%						
CY 2015				31	97%	3%			
CY 2016							80	97%	6%

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

The overall scores **DVHA** received for the three years' reviews of the Access and Enrollment/Disenrollment standards ranged from 99 percent to 97 percent. In the CY 2010 review, **DVHA** had five items that required corrective action; and by the CY 2013 review, that number decreased to two items. During the CY 2016 review, five items required corrective action.

During the 2013 review of Standard V, Coverage and Authorization of Services, the denial memo used by the Department of Children and Families (DCF) did not contain five required items: appeal rights, the right to an expedited appeal, the right to request a State fair hearing and information concerning the extension of covered services, the right to request an external review by AHS/**DVHA**, and the circumstances under which a beneficiary may be required to pay for the cost of extending services. During the 2016 review of Standard V, those same elements were again missing from the DCF denial memo. The overall scores from the three reviews (i.e., CY 2010, CY 2013, and CY 2016) of the federal Medicaid managed care Access standards (CFR §438.206–438.210) and the enrollment and disenrollment requirements (§438.226) ranged within two percentage points, from 99 percent to 97 percent. Although the scores indicate a high level of compliance with the federal and State requirements,

AHS and **DVHA** need to ensure that all *Partially Met* and *Not Met* elements are corrected after an HSAG compliance audit.

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

Quality

CMS defines quality in the final rule at 42 CFR §438.320 as follows: "Quality, as it pertains to external quality review, means the degree to which an MCO or PIHP increases the likelihood of desired health outcomes of its recipients through its structural and operational characteristics and through provision of health services that are consistent with current professional knowledge."[1-6]

Timeliness

NCQA defines timeliness relative to utilization decisions as follows: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[1-7] NCQA further discusses the intent of this standard to minimize any disruption in the provision of health care. HSAG extends this definition of timeliness to include other managed care provisions that impact services to beneficiaries and that require a timely response by the managed care organization—e.g., processing expedited appeals and providing timely follow-up care.

Access

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

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

[1-6] Department of Health and Human Services Centers for Medicare & Medicaid Services. *Federal Register*. *Code of Federal Regulations*. Title 42, Vol 3, December 10, 2015.

[1-7] National Committee for Quality Assurance. (2015). Standards and Guidelines for Health Plans.

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

To draw conclusions about the quality and timeliness of, and access to, care **DVHA** provided, HSAG determined which components of each EQR activity could be used to assess these domains (as indicated in Table 1-8).

Table 1-8—EQR Activity Components Assessing Quality, Timeliness, and Access

PIP	Quality	Timeliness	Access
Follow-Up After Hospitalization for Mental Illness	✓	✓	
Performance Measures	**Quality**	**Timeliness**	**Access**
Well-Child Visits in the First 15 Months of Life	✓		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	✓		
Adolescent Well-Care Visits	✓		
Annual Dental Visits	✓		✓
Children's and Adolescents' Access to Primary Care Practitioners			✓
Chlamydia Screening in Women	✓		
Adults' Access to Preventive/Ambulatory Health Services			✓
Follow-Up After Hospitalization for Mental Illness	✓	✓	✓
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment			✓
Breast Cancer Screening	✓		
Controlling High Blood Pressure	✓		
Adult BMI Assessment	✓		
Ambulatory Care			✓
Medication Management for People With Asthma	✓		
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—Enrollment and Disenrollment			✓

EQR Assessment of DVHA's Strengths and Weaknesses

Performance Improvement Project

DVHA's performance on the *Follow-Up After Hospitalization for Mental Illness* PIP suggests a thorough application of providing the necessary documentation requirements to meet CMS' PIP protocol in the Design stage, where 100 percent of the applicable evaluation elements received a *Met* score. **DVHA**'s documentation provided evidence that the PIP had a solid design. These activities ensured that the study properly defined and collected the necessary data to produce accurate study indicator rates. The managed care entity (MCE) appropriately conducted the data collection and analysis activities of the Implementation and Evaluation stage. Additionally, **DVHA** completed a causal/barrier analysis, prioritized barriers, and documented an improvement strategy targeted to overcome one of the barriers. The MCE evaluated its intervention during the 2015 measurement year and provided the ongoing quarterly evaluation results with the PIP submission.

Performance Measures

DVHA continued to expand its quality improvement process to close gaps in care using best practice strategies. The addition and expansion of **DVHA**'s internal abstraction team has helped to improve measure compliance through medical record reviews and documentation. Based on the increase in rates for the performance measures reported using the hybrid methodology, HSAG recommends expanding this effort for additional hybrid measures in future reporting years.

DVHA continued to contract with a software vendor with HEDIS Certified Measures to produce the required performance measures. This has helped to ensure that rates are calculated correctly and that the software vendor provides **DVHA** with the necessary tools and benchmarks to appropriately monitor performance measure rates.

With the assistance of its claims vendor, the volume of electronic claims that **DVHA** captures continued to increase. **DVHA**'s fee-for-service payment structure continued to provide for maximum capture of services as well.

DVHA's quality team reviewed its performance measure rates in detail in an effort to identify mechanisms for improving the quality of care and outcomes for its beneficiaries. This improvement was initially based on prior audit findings, and **DVHA** has continued this excellent process.

DVHA continued to struggle with capturing lab values from external laboratories; therefore, rates for measures that required lab values continued to be low. Remedying this problem will require additional medical record review for measures that rely on lab values or the addition of using supplemental data sources to supplement the administrative rates.

DVHA should continue to incorporate national/regional benchmarks to evaluate and monitor rates.

For all measures, **DVHA** excluded dual-eligible Medicare Primary beneficiaries in the calculation and production of rates. During the previous reporting year, **DVHA** included this population, which resulted in large variations of some rates, most notably *Breast Cancer Screening* and *Adults' Access to Preventive/Ambulatory Health Services*. **DVHA** is not the primary payer for this population; therefore, data associated with many services were not provided to **DVHA** to be included for measure calculation. Additionally, per HEDIS specifications, these beneficiaries may be excluded from reporting. HSAG recommends that **DVHA** only include beneficiaries in the measures when Medicaid is the primary payer, per NCQA guidelines. Dual-eligible beneficiaries should be excluded in future reporting or, at a minimum, separate rates should be reported for dual-eligible beneficiaries.

DVHA continued to use medical record review to ensure that maximum efforts were made to complete numerator gaps. **DVHA** should continue to expand its internal medical records staff and look for innovative ways to collect data for the hybrid measures.

Compliance With Standards

DVHA maintained IGAs with each of its partner delegates that included provisions concerning meeting all AHS requirements regarding beneficiaries' access to services. **DVHA** provided direct access to women's healthcare for both routine and preventive healthcare services. The MCE's member handbook included information indicating that women's healthcare was a covered Medicaid service and did not require a referral from a primary care provider (PCP). **DVHA** also established a process to ensure that beneficiaries with special healthcare needs had direct access to a specialist. **DVHA** operated under a policy of free choice and maintained an open provider network as required in the State plan.

DVHA used provider surveys, complaints, and grievances to monitor compliance with timely access requirements. Interviews with staff confirmed that **DVHA** has taken corrective action to require compliance with timely access requirements as a result of the responses received on the provider survey.

DVHA promoted the delivery of culturally competent services to Global Commitment to Health Waiver beneficiaries consistent with 42 CFR and the AHS/**DVHA** IGA. **DVHA** produced several resource documents for staff regarding how to access both interpreter and translation services, and information regarding interpreter services was available to providers on the Vermont Medicaid website. **DVHA** contracted with Maximus to produce beneficiary materials and required that the documents be written at a fifth-grade reading level to ensure readability.

Extensive interviews with **DVHA** staff revealed that **DVHA** and its IGA partner delegates assist beneficiaries in the coordination of services through the Vermont Chronic Care Initiative (VCCI). The VCCI targeted Medicaid beneficiaries at risk for adverse health outcomes and provided short-term, holistic, intensive case management and social support services for individuals. The IGA partners employed the continuous quality improvement process during management of the cases provided for review during the on-site visit. The reassessments, treatment plans, and contact notes indicated that monitoring occurred to evaluate the beneficiary's current status and progress toward the stated goals, and modification to the goals occurred when priorities changed in the health management of the beneficiary.

DVHA maintained several guides, manuals, and desktop protocols that provided staff direction in the handling of service authorizations. The MCE used standardized clinical criteria including McKesson-InterQual and other nationally recognized, evidence-based criteria to guide authorization decisions. **DVHA** also required that staff consult with the referring provider as needed to gather sufficient information to make informed utilization review decisions.

The **DVHA** Health Care Programs Handbook—Green Mountain Care explained an emergency condition in simple terms and included examples of conditions that would require immediate medical attention. A review of the handbook also confirmed that **DVHA** educates individuals at the time of enrollment concerning services and how to access them, the importance of selecting a PCP, the role and responsibilities of the PCP, and the importance of building and maintaining a relationship with the PCP.

Recommendations and Opportunities for Improvement

Performance Improvement Project

While both study indicators demonstrated improvement from the first remeasurement to the second remeasurement, neither study indicator demonstrated statistically significant improvement from the baseline to the second remeasurement. It appears the PIP needs more robust interventions to facilitate statistically significant improvement from the baseline. In addition, **DVHA** should be cognizant of the timing of interventions. Interventions implemented too late in a measurement period may not allow ample time to impact the results.

Recommendations

HSAG recommends that **DVHA** continue to evaluate interventions, determine if interventions are having the desired impact, and implement additional interventions to address high-priority barriers. If the interventions are not having the desired impact, changes should be made before the measurement year has concluded. **DVHA** should consider conducting small tests of change using a rapid-cycle approach such as Plan-Do-Study-Act (PDSA) and expand successful changes to a larger scale.

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

- Revisit the causal/barrier analysis frequently to determine if new barriers exist. Consider using additional quality methods and tools to examine processes and failures related to the PIP topic. Information gained from completing this analysis should be used to develop interventions.
- Continue to pursue active interventions that target the identified high-priority barriers.
- Continue to review and analyze interim study indicator results in addition to the annual evaluation. Conducting interim measurements and evaluating the results could assist **DVHA** in identifying and eliminating barriers that impede improvement in addition to gauging the progress of the PIP before an entire measurement year has passed.

- Identify any disparate subgroup within the study population, continue to use data mining; subgroup analysis; and knowledge of beneficiary characteristics, utilization statistics, and provider practice patterns. Interventions should be tailored to target a specific barrier for the disparate subgroup, if one is identified.
- Continue collaboration with external partnerships for the PIP. Continued teamwork may provide assistance and synergy in the quality improvement process, result in further system improvements, and ultimately lead to improvement in beneficiary health outcomes.

Performance Measures

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

- Increase staff efforts to develop protocols for capturing lab values. This may be accomplished through additional hybrid review or through the creation of supplemental data sources.
- Include beneficiaries in the measures when Medicaid is the primary payer only, according to NCQA guidelines. Dual-eligible beneficiaries should be excluded in future reporting or, at a minimum, separate rates should be maintained for dual-eligible beneficiaries.

Compliance With Standards

The CY 2016 compliance review included 80 elements in seven standards. **DVHA** *Met* 75 elements and *Partially Met* five elements. The *Partially Met* elements included three elements in Standard II—Furnishing Services, one element in Standard V—Coverage and Authorization of Services, and one element in Standard VII—Enrollment and Disenrollment requirements.

The recommendations for Standard II included ensuring that physical rehabilitative services and laboratories meet the requirement of being within 60 minutes of each beneficiary's residence. To monitor that requirement, **DVHA** must include physical rehabilitative services and laboratories in the entities evaluated through the use of a geographic mapping program. **DVHA** also must ensure that maps showing provider-to-beneficiary ratios for PCPs and specialists in the network are sent to AHS quarterly.

The recommendations for Standard V included ensuring that written notice of action (NOA) forms used by the MCO and each of its partner delegates meet all content requirements described in 42 CFR §438.404(b) and in the AHS/**DVHA** IGA. Specifically, the DCF documentation needs to include:

- The beneficiary's or provider's right to file an appeal and procedures for doing so.
- Circumstances under which an expedited resolution is available and how to request one.
- The beneficiary's right at any time to request a State fair hearing for covered services and how to request that covered services be extended.

- The beneficiary's right to request external review by AHS/**DVHA** for covered services (as applicable to Medicaid eligibility) or alternative services.
- The circumstances under which the beneficiary may be required to pay the cost of these services pending the outcome of a State fair hearing or external review by AHS/**DVHA**.

A new requirement added to this year's review in Standard VII involved sending information to beneficiaries in the Choices for Care Program. **DVHA** must ensure that beneficiaries in the Choices for Care Program are informed about systems to prevent, detect and report, investigate, and remediate abuse, neglect, and exploitation.

Suggestions for DVHA

While Standard IV and Standard VII did not rise to the level of requiring corrective action, HSAG reviewers encourage **DVHA** to consider the following.

Standard IV—Coordination and Continuity of Care

Concerning the services available through the VCCI, HSAG recommends that **DVHA**:

- Add a statement to the member handbook and provider manual indicating that services are available to assist beneficiaries in coordinating their healthcare needs.
- Require that program manuals contain a section concerning Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements.
- Provide a more prominent display in the treatment plan of the names of the PCPs and specialists involved in treating the beneficiaries.
- Ensure that PCPs and specialists receive a copy of the beneficiary's treatment plan by documenting the date that the plan was sent to the providers in the treatment plan.
- Document time-delimited goals in the treatment plan to assist beneficiaries and case managers in assessing the progress toward meeting the goals.

Standard VII—Enrollment and Disenrollment

Concerning enrollment and disenrollment HSAG recommends that **DVHA**:

- Ensure that a good faith effort is made to provide notice of termination of a contracted provider within 15 days after receipt or issuance of a termination notice to each beneficiary who received his or her primary care from (or was regularly seen by) the terminated provider and documents the process used to provide this notice. Interviews with staff confirmed that in the two instances of provider terminations during the review year, **DVHA** and Maximus contacted beneficiaries within the 15-day requirement to ensure that they were advised of the termination and that the beneficiaries selected a new PCP.
- Create documentation to ensure that disenrollment is not considered for the four reasons listed in the CFR and IGA. Section 2.2.4 of the AHS/**DVHA** IGA stipulates that **DVHA** not disenroll individuals

due to an adverse change in the beneficiary's status, utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs.

2. Introduction

Background

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

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

The AHS quality strategy establishes standards related to access to care, structure and operations, quality measurement and improvement, performance objectives, provisions for external quality review, and mechanisms to monitor compliance with the standards and objectives set forth in the quality strategy.

To meet requirements established by the federal regulations and described in the AHS quality strategy, AHS contracted with HSAG to conduct the EQR activities beginning in EQRO contract year 2007–2008. This report covers the EQR activities conducted during 2016–2017, the EQRO contract year. The mandatory EQR activities were conducted consistent with the CMS protocols established under 42 CFR §438.352.

During the 2016–2017 contract year, and consistent with the applicable CMS protocols, HSAG performed the following EQR activities and provided to AHS and **DVHA** draft and final reports for each activity:

- Validated **DVHA**'s PIP
- Validated a set of **DVHA**'s performance measures
- Reviewed **DVHA**'s compliance with the federal Medicaid managed care standards described at 42 CFR §438.206–210, §438.226, and the related AHS/**DVHA** IGA (i.e., contract) requirements
- Prepared this annual external quality review technical report

Purpose

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

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

Organization of the Report

Section 1—Executive Summary: This section provides contextual information about the federal Medicaid managed care requirements, AHS, and **DVHA**. This section also presents a summary of findings and conclusions about **DVHA**'s strengths and weaknesses, as derived from the EQR activities performed during 2016–2017. Section 1 also includes recommendations and opportunities for improvement in quality, timeliness, and access to care, as provided to **DVHA**. Finally, trends over time are presented as appropriate to the data available.

Section 2—Introduction: Section 2 outlines the purpose and organization of the report. This section also describes the methodology HSAG used to develop the EQR annual technical report, to categorize the results, and to draw conclusions regarding **DVHA**'s performance results related to each EQR activity.

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

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

Methodology for Preparing the EQR Technical Report

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

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

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

Data Sources

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

- Results of HSAG's validation of **DVHA**'s PIP.
- Results of HSAG's validation of **DVHA**'s performance measures and **DVHA**'s performance measure rates and trending of prior years' results.
- Results of HSAG's monitoring of **DVHA**'s compliance with the selected standards in the Medicaid managed care regulations and the associated AHS/**DVHA** IGA/contract requirements; a comparison of **DVHA**'s 2016–2017 performance to the results of HSAG's review of the same set of requirements in prior years; and trends in **DVHA**'s performance results across the prior EQR contract years.
- Results from **DVHA**'s follow-up on prior EQR recommendations as validated by HSAG or self-reported by **DVHA**.

Categorizing Results

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

Identifying DVHA's Strengths and Opportunities for Improvement

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

Validation of PIP

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

Validation of Performance Measures

HSAG analyzed the performance measure data with respect to the performance levels. For each performance measure for which **DVHA** reported results, HSAG identified a high and a low performance level based on a comparison of **DVHA**'s rate to the distribution of national Medicaid percentiles. High performance (a strength) was identified as any performance measure rate meeting or exceeding the most recent (2015) 90th national Medicaid HEDIS percentile, as published by NCQA. In past years, HSAG used the 10th percentile as the threshold for determining areas of weakness for the HEDIS measures. Because **DVHA** has improved the rates generated for the HEDIS measures over the years, HSAG increased the performance level for determining areas of weakness beginning in the 2015–2016 EQR Technical Report to the 25th national Medicaid HEDIS percentile.

Monitoring Compliance With Standards

HSAG determined which information, documentation, and data reflected specific aspects of care and services **DVHA** provided related to each of the standards HSAG reviewed. HSAG then analyzed and drew conclusions about the results of the compliance review with respect to the domains of quality, timeliness, and access. Seven standards in this year's compliance review included requirements from Access and Enrollment/Disenrollment, 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.

3. Description of External Quality Review Activities

Validation of Performance Improvement Project

During the 2016–2017 EQRO contract year with AHS, HSAG validated one PIP conducted by **DVHA**. This section describes the processes HSAG used to complete the validation activities. HSAG described the details related to its approach, methodologies, and findings from the PIP validation activities in its Performance Improvement Project Validation Report—*Follow-Up After Hospitalization for Mental Illness* for **DVHA** provided to AHS and **DVHA**.

Objectives and Background Information

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

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

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

Description of Data Obtained

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

Technical Methods of Data Collection/Analysis

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

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

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

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

of the PIP); however, enhanced documentation would demonstrate a stronger application of the CMS protocols for completing a PIP.

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

Determining Conclusions

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

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

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

- *Met:* High confidence/confidence in reported PIP results. All critical evaluation elements were *Met*, and 80 to 100 percent of all evaluation elements were *Met* across all activities.
- *Partially Met:* Low confidence in reported PIP results. All critical evaluation elements were *Met*, and 60 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*.

Validation of Performance Measures

Validation of performance measures is one of three mandatory EQR activities required by CMS. 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 may perform this validation. HSAG, the EQRO for AHS, conducted the validation activities. HSAG conducted the validation activities following CMS' *EQR Protocol 2*: *Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012. HSAG described the details related to its approach, methodologies, and findings from the performance measures activities in its Validation of Performance Measures for **DVHA** Report for **DVHA** provided to AHS and **DVHA**.

Objectives and Background Information

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

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

AHS selected 14 HEDIS measures, totaling 66 indicators, for HSAG's validation. The measurement period addressed in this report was CY 2015.

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. Since all the performance measures under the scope of this validation were approved by NCQA under

the measure certification program, **DVHA** continued to contract with a software vendor to calculate the measures. HSAG did not perform additional source code review.

Technical Methods of Data Collection/Analysis

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

Pre-On-Site Activities:

- HSAG reviewed the completed Roadmap and flagged areas for on-site follow-up. The review team used the Roadmap to determine if the systems' capabilities were sufficient to report the HEDIS measures. **DVHA** was also required to complete the "Medical Record Review" section within the Roadmap.
- HSAG reviewed all supporting documents, including prior performance measure reports, data flow diagrams, data integration logic, medical record review hybrid tools and instructions, training materials for medical record staff members, policies and procedures for monitoring the accuracy of medical record reviews, and NCQA's measure certification report for the selected vendor.
- HSAG provided AHS and **DVHA** with an agenda for the on-site visit. The agenda included a brief description of each session's purpose and discussion items.
- HSAG conducted a pre-on-site conference call with **DVHA** to discuss any outstanding Roadmap questions and preparations for the on-site visit.

On-Site Review Activities:

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

- HSAG conducted a closing conference to summarize 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 2015 national Medicaid benchmarks.

Determining Conclusions

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

Monitoring of Compliance With Standards

Monitoring compliance with federal Medicaid managed care regulations and the applicable state contract requirements is one of the three mandatory activities a State must conduct. AHS contracted with HSAG to perform the **DVHA** compliance review. HSAG followed the guidelines in the CMS protocol, *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. HSAG described the details related to its approach, methodologies, and findings from the compliance activities in its External Quality Review of Compliance with Standards Report for **DVHA** provided to AHS and **DVHA**.

Objectives and Background Information

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

- Continued to ensure that its IGA with **DVHA** included the applicable CMS Medicaid managed care requirements and that they were at least as stringent as the CMS requirements.
- Contracted with HSAG as its EQRO to conduct reviews to assess **DVHA**'s performance in complying with the federal Medicaid managed care regulations and AHS' associated IGA with **DVHA**.
- 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/Disenrollment standards described at 42 CFR §438.206–210, §438.226, 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 §438.206–210 and §438.226.

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 two prior audits, CY 2010 and CY 2013, HSAG evaluated **DVHA**'s current performance and performed a comparison to the earlier review of these same standards.

Description of Data Obtained

Table 3-1—Description of DVHA's Data Sources

Data Obtained	Time Period to Which the Data Applied
Documentation **DVHA** submitted for HSAG's desk review and additional documentation available to HSAG during the on-site review	July 16, 2015–July 26, 2016
Information from interviews conducted on-site	July 27 and 28, 2016

Technical Methods of Data Collection/Analysis

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

- Developing the compliance review tool HSAG used to document its findings from the review of policies, procedures, reports, and additional plan documents. The compliance tool also included sections to insert findings from the on-site interviews conducted with **DVHA** staff members.
- Preparing and forwarding to **DVHA** a customized desk review request form and instructions for submitting the requested documentation to HSAG for its desk review. The form provided information about HSAG's compliance review activities and the timelines/due dates for each.
- Developing and providing to **DVHA** the detailed agenda for the two-day on-site review.
- Responding to any questions **DVHA** had about HSAG's desk- and on-site review activities and the documentation required from **DVHA** for HSAG's desk review.
- Conducting a pre-on-site desk review of **DVHA**'s key documents and other information obtained from AHS. The desk review enabled HSAG reviewers to increase their knowledge and understanding of **DVHA**'s operations, identify areas needing clarification, and begin compiling and documenting preliminary findings and interview questions before the on-site review.

For the on-site review activities, two HSAG reviewers conducted the 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 on any changes and challenges occurring since HSAG's previous review; a review of the agenda and logistics for HSAG's on-site activities; HSAG's overview of the process it would follow in conducting the on-site review; and, the tentative timelines for providing **DVHA** and AHS a draft report for AHS' and **DVHA**'s review and comment.
- Review of the documents HSAG requested that **DVHA** have available on-site.
- Interviews with **DVHA**'s key administrative and program staff members. Separate interviews were scheduled and conducted for each of the standards included in the review tool.

- A closing conference during which HSAG reviewers summarized their preliminary findings. For each standard, the findings included HSAG's assessment of **DVHA**'s performance strengths; any anticipated required corrective actions and reviewers' suggestions that could further enhance **DVHA**'s processes; documentation; performance results; and the quality, access to, and timeliness of services provided to beneficiaries.

HSAG reviewers documented their findings in the compliance review tool. The tool served as a comprehensive record of the pre-on-site and on-site review activities and the performance scores achieved by **DVHA**. Five items in this year's review required corrective action. HSAG also made suggestions to **DVHA** to further strengthen and drive continued improvement in **DVHA**'s performance. The completed tool was included as one section of HSAG's compliance report. Table 3-2 lists the major data sources HSAG used in determining **DVHA**'s performance in complying with requirements and the time period to which the data applied. Table 3-2 also presents a more detailed, chronological description of the above activities that HSAG performed during its review.

Table 3-2—The Compliance Review Activities HSAG Performed

Step 1:	**Established the review schedule.**
	Before the review, HSAG coordinated with AHS and **DVHA** to develop the compliance review timeline and assigned HSAG reviewers to the review team.
Step 2:	**Prepared the data collection tool for the standards included in this year's review and submitted it to AHS for review and comment.**
	To ensure that all applicable information was collected, HSAG developed a compliance review tool consistent with CMS protocols. HSAG used the requirements in the IGA between AHS and **DVHA** to develop the standards (groups of requirements related to broad content areas) to be reviewed. HSAG also used version 2 of the federal Medicaid managed care protocols effective September 1, 2012. Additional criteria used in developing the monitoring tool included applicable State and federal requirements. Prior to finalizing the tool, HSAG submitted the draft 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 services and the associated documentation related to coverage and authorization of services; and **DVHA**'s operations, resources, information systems, quality programs, and delegated functions. Reviewers then: • Documented in the review tool their preliminary findings after reviewing the materials **DVHA** submitted as evidence of its compliance with the requirements. • Identified any information not found in the desk review documentation in order to request it prior to the on-site review. • Identified areas and questions requiring further clarification or follow-up during the on-site interviews.
Step 8:	**Conducted the on-site portion of the review.**
	During the on-site review, staff members from **DVHA** were available to answer questions and to assist the HSAG review team in locating specific documents or other sources of information. HSAG's activities completed during the on-site review included the following: • Conducting an opening conference that included introductions, HSAG's overview of the on-site review process and schedule, **DVHA**'s overview of its structure and processes, and a discussion about any changes needed to the agenda and general logistical issues. • Conducting interviews with **DVHA**'s staff. HSAG used the interviews to obtain a complete picture of **DVHA**'s compliance with the federal Medicaid managed care regulations and associated AHS IGA requirements, explore any issues not fully addressed in the documents that HSAG reviewed, and increase HSAG reviewers' overall understanding of **DVHA**'s performance. • Reviewing additional documentation. HSAG reviewed additional documentation while on-site, and used the review tool to identify relevant information sources and document its review findings. Items reviewed on-site included, but were not limited to, written policies and procedures, minutes of key committee or other group meetings, and data and reports across a broad range of areas. While on-site, **DVHA** staff members also discussed the organization's information system data collection process and reporting capabilities related to the standards HSAG reviewed. • Summarizing findings at the completion of the on-site portion of the review. As a final step, HSAG conducted a closing conference to provide **DVHA**'s staff members and AHS 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.

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

Determining Conclusions

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

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

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

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

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

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

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

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

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

4. Follow-Up on Prior EQR Recommendations

Introduction

This section presents **DVHA**'s responses and a description of actions it took or is taking to address HSAG's recommendations made in the prior year's EQR report. The report included HSAG's recommendations to improve **DVHA**'s performance related to HSAG's findings from validation of **DVHA**'s performance improvement project and performance measures, and the review of its performance in complying with the federal Medicaid managed care regulations and associated AHS IGA requirements.

Validation of Performance Improvement Project

During the previous EQRO contract year (2015–2016), HSAG validated **DVHA**'s PIP, *Follow-Up After Hospitalization for Mental Illness*. The validation process included **DVHA**'s submission of the PIP and HSAG's completion of the validation tool. For the nine review activities that **DVHA** completed and HSAG assessed, **DVHA**'s 90 percent of evaluation elements received a score of *Met*. The two *Not Met* scores in Activity IX of the 2015–2016 validation related to not meeting the goal and not achieving statistically significant improvement from the baseline. Both evaluation elements received the same comment as documented in the table below.

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

HSAG Recommendations	DVHA Response/Actions/Outcomes
Both study indicators demonstrated declines for the first remeasurement.	**HSAG findings from 2016–2017 review:** In the 2016–2017 PIP submission, **DVHA** reported that Study Indicator 1's result (follow-up within seven days) met the goal for Remeasurement 2. Study Indicator 2's result (follow-up within 30 days) did not meet the goal for Remeasurement 2. Neither study indicator achieved statistically significant improvement from the baseline to the Remeasurement 2. Although the rate for Study Indicator 2 demonstrated an increase from Remeasurement 1 to Remeasurement 2, it still fell below the baseline. **DVHA Response:**

Validation of Performance Measures

HSAG validated 14 performance measures during the previous EQRO contract year (2015–2016). HSAG auditors determined that all 14 were compliant with AHS' specifications and that the rates could be reported. As a result of HSAG's desk review and on-site audit, HSAG described the following areas for improvement.

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

HSAG Recommendations	DVHA Response/Actions/Outcomes
During the 2015 audit, HSAG recommended that **DVHA** only include beneficiaries in the measures when Medicaid is the primary payer, per the NCQA guidelines. Dual-eligible beneficiaries should be excluded in future reporting or, at a minimum, separate rates should be reported for dual-eligible beneficiaries.	**HSAG findings from 2016–2017 review:** For 2016 reporting, **DVHA** had not excluded the dual beneficiaries prior to the on-site visit; however, **DVHA** did remove the dual-eligible beneficiaries during the final rate reporting. HSAG recommended that **DVHA** continue to remove dual-eligible beneficiaries from future reporting. **DVHA Response:**
For the 2015 audit, HSAG recommended that **DVHA** examine the medical records collected during the audit process to identify whether the documentation issues are random or systemic and then explore the possibility of working with providers, if needed, to enhance the information captured in the medical records.	**HSAG findings from 2016–2017 review:** For 2016 reporting, **DVHA** was not able to achieve the recommendation; but the recommendation remains an important step toward improving medical record data collected and reported by providers. **DVHA Response:**

Monitoring Compliance With Standards

During the 2015 compliance audit, HSAG evaluated **DVHA**'s performance related to the three standards (groups of related requirements) included in the Medicaid Measurement and Improvement Standards found in CFR §438.236–242. The standards included requirements in the following performance areas: Practice Guidelines, Quality Assessment and Performance Improvement, and Health Information Systems. HSAG determined that one element did not meet the requirements as noted below.

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

HSAG Recommendations	DVHA Responses/Actions/Outcomes
DVHA must ensure that the review of clinical practice guidelines occurs periodically, at a time that is no longer than a two-year interval, as stipulated in the **DVHA** Evidence-based Clinical Practice Guidelines policy and procedure.	**HSAG findings from 2016–2017 review: DVHA** is implementing a process to ensure that clinical practice guidelines are reviewed as stipulated in the Evidence-based Clinical Practice Guidelines policy and procedure. **DVHA Response:**