
State of Vermont
Agency of Human Services

# 2017–2018 External Quality Review Technical Report

*for*

# Department of Vermont Health Access

*January 2018*

HSAG HEALTH SERVICES ADVISORY GROUP

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# 1. Introduction

## Background

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

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

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

To meet requirements established by the federal regulations and described in the AHS quality strategy, AHS contracted with Health Services Advisory Group, Inc. (HSAG), to conduct the external quality review (EQR) activities beginning in the external quality review organization (EQRO) contract year 2007–2008. This report covers the external quality review (EQR) activities conducted during 2017–2018, the EQRO contract year. The mandatory EQR activities were conducted consistent with the CMS protocols established under 42 CFR §438.352.[1-2]

[1-1] U. S. Government Publishing Office. (2017). *Electronic Code of Federal Regulations.* Available at: https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=0fe554e3f4a6236efe0d8c0aa9319e57&mc=true&n=pt42.4.438&r=PART&ty=HTML#se42.4.438_1340. Accessed on: Dec 19, 2017.
[1-2] U. S. Government Publishing Office. (2017). *Electronic Code of Federal Regulations.* Available at https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=0fe554e3f4a6236efe0d8c0aa9319e57&mc=true&n=pt42.4.438&r=PART&ty=HTML#se42.4.438_1352. Accessed on: Dec 19, 2017.

During the 2017–2018 contract year, and consistent with the applicable CMS protocols, HSAG performed the following EQR activities and provided to AHS and the **Department of Vermont Health Access** (**DVHA**) draft and final reports for each activity:

- Validated **DVHA**'s performance improvement project (PIP)
- Validated a set of **DVHA**'s performance measures
- Reviewed **DVHA**'s compliance with the federal Medicaid managed care standards described at 42 CFR §438.10, §438.100, §438.214–230, and the related AHS/**DVHA** intergovernmental agreement (IGA) (i.e., contract) requirements
- Prepared this annual external quality review technical report

## Purpose

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

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

## Organization of the Report

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

[1-3] U. S. Government Publishing Office. (2017). *Electronic Code of Federal Regulations.* Available at: https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=0fe554e3f4a6236efe0d8c0aa9319e57&mc=true&n=pt42.4.438&r=PART&ty=HTML%23se42.4.438_1352#se42.4.438_1364. Accessed on: Nov 30, 2017.

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

**Section 2—Findings:** This section provides contextual information about the federal Medicaid managed care requirements, AHS, and **DVHA**. This section also presents a summary of findings and conclusions about **DVHA**'s strengths and weaknesses, as derived from the EQR activities performed during 2017–2018. Section 2 also includes recommendations and opportunities for improvement in quality, timeliness, and access to care, as provided to **DVHA**. Finally, trends over time are presented as appropriate to the data available.

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

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

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

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

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

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

[1-4] U. S. Government Publishing Office. (2017). *Electronic Code of Federal Regulations.* Available at: https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=0fe554e3f4a6236efe0d8c0aa9319e57&mc=true&n=pt42.4.438&r=PART&ty=HTML%23se42.4.438_1352#se42.4.438_1358. Accessed on: Nov 30, 2017.

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 2017–2018 performance to the results of HSAG's review of the same set of requirements in prior years; and trends in **DVHA**'s performance results across the prior EQR contract years.
- Results from **DVHA**'s follow-up on prior EQR recommendations as validated by HSAG or self-reported by **DVHA**.

## Categorizing Results

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

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

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

### Validation of the PIP

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

provide a *Point of Clarification* to the organization, to assist with improved processes or documentation the next time the PIP is submitted.

### Validation of Performance Measures

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 national Medicaid 90th percentile, as published by the National Committee for Quality Assurance (NCQA). Low performance (area of weakness) was identified as any performance measure rate falling below the national Medicaid 25th 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. Eight standards in this year's compliance review included Structure and Operations requirements, and those eight 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.

# 2. Findings

## Background

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

### *The Vermont Agency of Human Services (AHS)*

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

During the current EQRO contract year (February 2017–February 2018), 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 2017–2018 EQR technical report.

[2-1] U. S. Government Publishing Office. (1997). *Public Law 105-33* (p. 249). Available at: http://www.gpo.gov/fdsys/pkg/PLAW-105publ33/pdf/PLAW-105publ33.pdf. Accessed on: Nov 30, 2017.
[2-2] U. S. Government Publishing Office. (2017). *External Quality Review Results.* Available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=1a64dceea153294481f0d7b923980163&mc=true&node=se42.4.438_1364&rgn=div8. Accessed on: Nov 30, 2017.

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

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

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

## *The Department of Vermont Health Access (DVHA)*

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

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

- 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 2017–2018 EQR Activities

HSAG's external quality review in contract year 2017–2018 consisted of conducting the following activities:

- ***Validation of DVHA's performance improvement project (PIP).*** HSAG reviewed **DVHA**'s PIP to ensure that the organization designed, conducted, and reported on the project in a methodologically sound manner, allowing measurement of any real improvements in care and services, and giving confidence in the reported improvements.
- ***Validation of DVHA's performance measures.*** HSAG validated the accuracy of the AHS-required performance measures that were reported by **DVHA**. The validation also determined the extent to which the Medicaid-specific performance measures calculated by **DVHA** followed the Healthcare Effectiveness Data and Information Set (HEDIS®)[2-3] 2017 specifications.
- ***Review of DVHA's compliance with standards.*** HSAG conducted a review to determine the organization's compliance with performance standards (sets of requirements) described in the federal Medicaid managed care Structure and Operations standards (42 CFR §438.10, §438.100, and §438.214–230) 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 2017–2018 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 2017–2018.

### *Validation of the Performance Improvement Project (PIP)*

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

The topic addresses the initiation of alcohol and other drug dependence treatment for adolescent and adult beneficiaries with a new alcohol or other drug dependence diagnosis. This PIP topic represents a key area of focus for improvement by **DVHA**. Members receiving the appropriate care and services in

[2-3] HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

the recommended time frames is essential to the recovery process. **DVHA** included 2016 data in the PIP for the baseline result.

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

**Table 2-1—2017–2018 PIP Validation Summary Overall Score**

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

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

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

Table 2-2 displays **DVHA**'s performance across all PIP activities. The 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 2-2—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 | 100% (2/2) | 100% (1/1) |
| II. Define the Study Question(s) | 100% (1/1) | 100% (1/1) |
| III. Define the Study Population | 100% (1/1) | 100% (1/1) |
| IV. Select the Study Indicator(s) | 100% (1/1) | 100% (1/1) |
| V. Use Sound Sampling Techniques | *Not Applicable* | *Not Applicable* |
| VI. Reliably Collect Data | 100% (3/3) | 100% (1/1) |
| VII. Analyze Data and Interpret Study Results | 100% (3/3) | 100% (1/1) |

| 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 |
|---|---|---|
| VIII. Implement Intervention and Improvement Strategies | 100% (4/4) | 100% (2/2) |
| IX. Assess for Real Improvement | *Not Assessed* | *Not Assessed* |
| X. Assess for Sustained Improvement | *Not Assessed* | *Not Assessed* |

The validation results indicated an overall score of 100 percent across all applicable evaluation elements. **DVHA** initiated a new PIP, completed the first eight steps of the PIP Summary Form, and reported baseline data. **DVHA** provided all required documentation, and the PIP was a methodologically sound study.

## *Validation of Performance Measures*

HSAG validated a set of performance measures selected by AHS that were calculated and reported by **DVHA**. The methodology HSAG used to validate the performance measures was based on CMS' validation protocol of performance measures.[2-4] The validation findings confirmed that all rates were reportable. Table 2-3 displays the HEDIS 2016 and 2017 performance measure results, the eligible population for each measure (i.e., Number [N]), and the change for each measure rate from HEDIS 2016 to HEDIS 2017. Additionally, the measure results for 2017 were compared to the NCQA's HEDIS Audit Means and Percentiles National Medicaid Health Maintenance Organization (HMO) Percentiles for HEDIS 2016 (the most current rates available).

[2-4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR), Version 2.0*, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Dec 19, 2017.

**Table 2-3—DVHA HEDIS 2016 and 2017 Results**

| Measure | HEDIS 2016 | | HEDIS 2017 | | Change From HEDIS 2016 to HEDIS 2017 | HEDIS Percentile Ranking |
|---|---|---|---|---|---|---|
| | Number (N) | Rate | N | Rate | | |
| *Well-Child Visits in the First 15 Months of Life—0 Visits** | 3,348 | 2.09% | 3,045 | 1.67% | -0.42% | 50th – 75th |
| *Well-Child Visits in the First 15 Months of Life—1 Visit* | 3,348 | 1.28% | 3,045 | 0.99% | -0.29% | 10th – 25th |
| *Well-Child Visits in the First 15 Months of Life—2 Visits* | 3,348 | 2.00% | 3,045 | 1.48% | -0.52% | 10th – 25th |
| *Well-Child Visits in the First 15 Months of Life—3 Visits* | 3,348 | 3.38% | 3,045 | 3.05% | -0.33% | 10th – 25th |
| *Well-Child Visits in the First 15 Months of Life—4 Visits* | 3,348 | 7.83% | 3,045 | 6.11% | -1.72% | 10th – 25th |
| *Well-Child Visits in the First 15 Months of Life—5 Visits* | 3,348 | 16.04% | 3,045 | 15.07% | -0.97% | 25th – 50th |
| *Well-Child Visits in the First 15 Months of Life—6 or More Visits* | 3,348 | 67.38% | 3,045 | 71.63% | +4.25% | 75th – 90th |
| *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* | 14,183 | 72.60% | 12,879 | 73.97% | +1.37% | 50th – 75th |
| *Adolescent Well-Care Visits* | 29,369 | 46.85% | 26,791 | 50.89% | +4.04% | 50th – 75th |
| *Annual Dental Visit—Ages 2–3* | 7,106 | 44.67% | 6,268 | 49.66% | +4.99% | 75th – 90th |
| *Annual Dental Visit—Ages 4–6* | 10,620 | 70.16% | 9,690 | 72.16% | +2.00% | 75th – 90th |
| *Annual Dental Visit—Ages 7–10* | 14,124 | 74.88% | 13,256 | 77.66% | +2.78% | 90th – 95th |
| *Annual Dental Visit—Ages 11–14* | 13,051 | 71.04% | 12,304 | 74.11% | +3.07% | >95th |
| *Annual Dental Visit—Ages 15–18* | 12,273 | 63.89% | 11,448 | 65.71% | +1.82% | >95th |
| *Annual Dental Visit—Ages 19–20* | 5,266 | 41.57% | 4,407 | 46.36% | +4.79% | 90th – 95th |
| *Annual Dental Visit—Combined Rate* | 62,440 | 64.87% | 57,373 | 68.12% | +3.25% | 90th – 95th |
| *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months* | 3,765 | 97.16% | 3,229 | 97.96% | +0.80% | 90th – 95th |
| *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years* | 17,434 | 90.64% | 15,720 | 91.42% | +0.78% | 75th – 90th |
| *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* | 16,019 | 95.11% | 15,481 | 95.79% | +0.68% | 75th – 90th |
| *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years* | 22,617 | 94.00% | 21,769 | 94.99% | +0.99% | 90th – 95th |
| *Chlamydia Screening in Women—16–20 Years* | 4,634 | 49.63% | 4,162 | 47.53% | -2.10% | 25th – 50th |
| *Chlamydia Screening in Women—21–24 Years* | 3,569 | 56.26% | 2,852 | 55.58% | -0.68% | 25th – 50th |
| *Chlamydia Screening in Women—Total* | 8,203 | 52.52% | 7,014 | 50.80% | -1.72% | 25th – 50th |
| *Adults' Access to Preventive/Ambulatory Health Services—20–44 Years* | 52,767 | 73.24% | 40,955 | 78.24% | +5.00% | 25th – 50th |
| *Adults' Access to Preventive/Ambulatory Health Services—45–64 Years* | 28,319 | 80.55% | 23,981 | 83.49% | +2.94% | 25th – 50th |

| Measure | HEDIS 2016 | | HEDIS 2017 | | Change From HEDIS 2016 to HEDIS 2017 | HEDIS Percentile Ranking |
|---|---|---|---|---|---|---|
| | Number (N) | Rate | N | Rate | | |
| *Adults' Access to Preventive/Ambulatory Health Services—65+ Years* | 403 | 72.70% | 394 | 72.59% | -0.11% | 5th – 10th |
| *Adults' Access to Preventive/Ambulatory Health Services—Total* | 81,489 | 75.78% | 65,330 | 80.13% | +4.35% | 25th – 50th |
| *Follow-Up After Hospitalization for Mental Illness—7-day Follow-Up* | 1,278 | 43.11% | 1,274 | 40.42% | -2.69% | 25th – 50th |
| *Follow-Up After Hospitalization for Mental Illness—30-day Follow-Up* | 1,278 | 59.55% | 1,274 | 57.85% | -1.70% | 25th – 50th |
| *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation)—13–17 Years* | 265 | 39.25% | 209 | 39.23% | -0.02% | 25th – 50th |
| *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation)—18 Years and Older* | 6,068 | 34.81% | 5,910 | 34.35% | -0.46% | 25th – 50th |
| *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation)—Total* | 6,333 | 34.99% | 6,119 | 34.52% | -0.47% | 25th – 50th |
| *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Engagement)—13–17 Years* | 265 | 18.11% | 209 | 11.48% | -6.63% | 25th – 50th |
| *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Engagement)—18 Years and Older* | 6,068 | 14.16% | 5,910 | 15.06% | +0.90% | 75th – 90th |
| *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Engagement)—Total* | 6,333 | 14.32% | 6,119 | 14.94% | +0.62% | 75th – 90th |
| *Breast Cancer Screening* | 5,277 | 54.22% | 6,682 | 55.10% | +0.88% | 25th – 50th |
| *Ambulatory Care (Outpatient Visits)—<1 Year*[1] | 37,434 | 914.23 | 36,328 | 941.04 | +26.81 | 90th – 95th |
| *Ambulatory Care (Outpatient Visits)—1–9 Years*[1] | 121,434 | 305.49 | 117,053 | 299.28 | -6.21 | 50th – 75th |
| *Ambulatory Care (Outpatient Visits)—10–19 Years*[1] | 94,927 | 245.86 | 94,823 | 246.51 | +0.65 | 50th – 75th |
| *Ambulatory Care (Outpatient Visits)—20–44 Years*[1] | 183,404 | 272.12 | 176,166 | 268.48 | -3.64 | 25th – 50th |
| *Ambulatory Care (Outpatient Visits)—45–64 Years*[1] | 147,319 | 416.93 | 142,090 | 408.41 | -8.52 | 10th – 25th |
| *Ambulatory Care (Outpatient Visits)—65–74 Years*[1] | 977 | 370.78 | 1,131 | 313.38 | -57.40 | 10th – 25th |
| *Ambulatory Care (Outpatient Visits)—75–84 Years*[1] | 401 | 481.97 | 405 | 530.80 | +48.83 | 50th – 75th |
| *Ambulatory Care (Outpatient Visits)—85+ Years*[1] | 244 | 505.18 | 124 | 370.15 | -135.03 | 25th – 50th |
| *Ambulatory Care (Outpatient Visits)—Total*[1] | 586,140 | 315.84 | 568,120 | 311.61 | -4.23 | 25th – 50th |
| *Ambulatory Care (Emergency Department Visits)—<1 Year**[1] | 2,830 | 69.12 | 2,540 | 65.80 | -3.32 | 75th – 90th |
| *Ambulatory Care (Emergency Department Visits)—1–9 Years**[1] | 14,281 | 35.93 | 13,428 | 34.33 | -1.60 | 90th – 95th |
| *Ambulatory Care (Emergency Department Visits)—10–19 Years**[1] | 14,319 | 37.09 | 13,975 | 36.33 | -0.76 | 50th – 75th |
| *Ambulatory Care (Emergency Department Visits)—20–44 Years**[1] | 40,594 | 60.23 | 37,849 | 57.68 | -2.55 | 75th – 90th |

| Measure | HEDIS 2016 | | HEDIS 2017 | | Change From HEDIS 2016 to HEDIS 2017 | HEDIS Percentile Ranking |
|---|---|---|---|---|---|---|
| | Number (N) | Rate | N | Rate | | |
| *Ambulatory Care (Emergency Department Visits)—45–64 Years*[1]* | 13,906 | 39.36 | 13,628 | 39.17 | -0.19 | 90th – 95th |
| *Ambulatory Care (Emergency Department Visits)—65–74 Years*[1]* | 75 | 28.46 | 73 | 20.23 | -8.23 | 75th – 90th |
| *Ambulatory Care (Emergency Department Visits)—75–84 Years*[1]* | 18 | 21.63 | 25 | 32.77 | +11.14 | 50th – 75th |
| *Ambulatory Care (Emergency Department Visits)—85+ Years*[1]* | 16 | 33.13 | 10 | 29.85 | -3.28 | 50th – 75th |
| *Ambulatory Care (Emergency Department Visits)—Total*[1]* | 86,039 | 46.36 | 81,528 | 44.72 | -1.64 | 75th – 90th |
| *Medication Management for People With Asthma (Medication Compliance 50%)—5–11 Years* | 514 | 72.18% | 533 | 70.92% | -1.26% | 90th – 95th |
| *Medication Management for People With Asthma (Medication Compliance 50%)—12–18 Years* | 397 | 64.99% | 399 | 71.18% | +6.19% | >95th |
| *Medication Management for People With Asthma (Medication Compliance 50%)—19–50 Years* | 1,033 | 69.51% | 974 | 77.00% | +7.49% | 90th – 95th |
| *Medication Management for People With Asthma (Medication Compliance 50%)—51–64 Years* | 293 | 83.28% | 311 | 83.92% | +0.64% | 90th – 95th |
| *Medication Management for People With Asthma (Medication Compliance 50%)—Total* | 2,237 | 71.12% | 2,217 | 75.46% | +4.34% | 90th – 95th |
| *Medication Management for People With Asthma (Medication Compliance 75%)—5–11 Years* | 514 | 52.53% | 533 | 51.59% | -0.94% | >95th |
| *Medication Management for People With Asthma (Medication Compliance 75%)—12–18 Years* | 397 | 45.84% | 399 | 52.38% | +6.54% | >95th |
| *Medication Management for People With Asthma (Medication Compliance 75%)—19–50 Years* | 1,033 | 51.21% | 974 | 60.78% | +9.57% | >95th |
| *Medication Management for People With Asthma (Medication Compliance 75%)—51–64 Years* | 293 | 67.58% | 311 | 68.17% | +0.59% | 90th – 95th |
| *Medication Management for People With Asthma (Medication Compliance 75%)—Total* | 2,237 | 52.70% | 2,217 | 58.10% | +5.40% | >95th |

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

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

**DVHA** demonstrated strength with several measure rates meeting or exceeding the national Medicaid 90th percentile, while falling below the 25th percentile on other measure rates. Of the 64 reportable rates, seven rates exceeded the national Medicaid 95th percentile:

- *Annual Dental Visit—Ages 11–14*
- *Annual Dental Visit—Ages 15–18*

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

In addition to the seven rates above, 13 rates met or exceeded the national Medicaid 90th percentile:

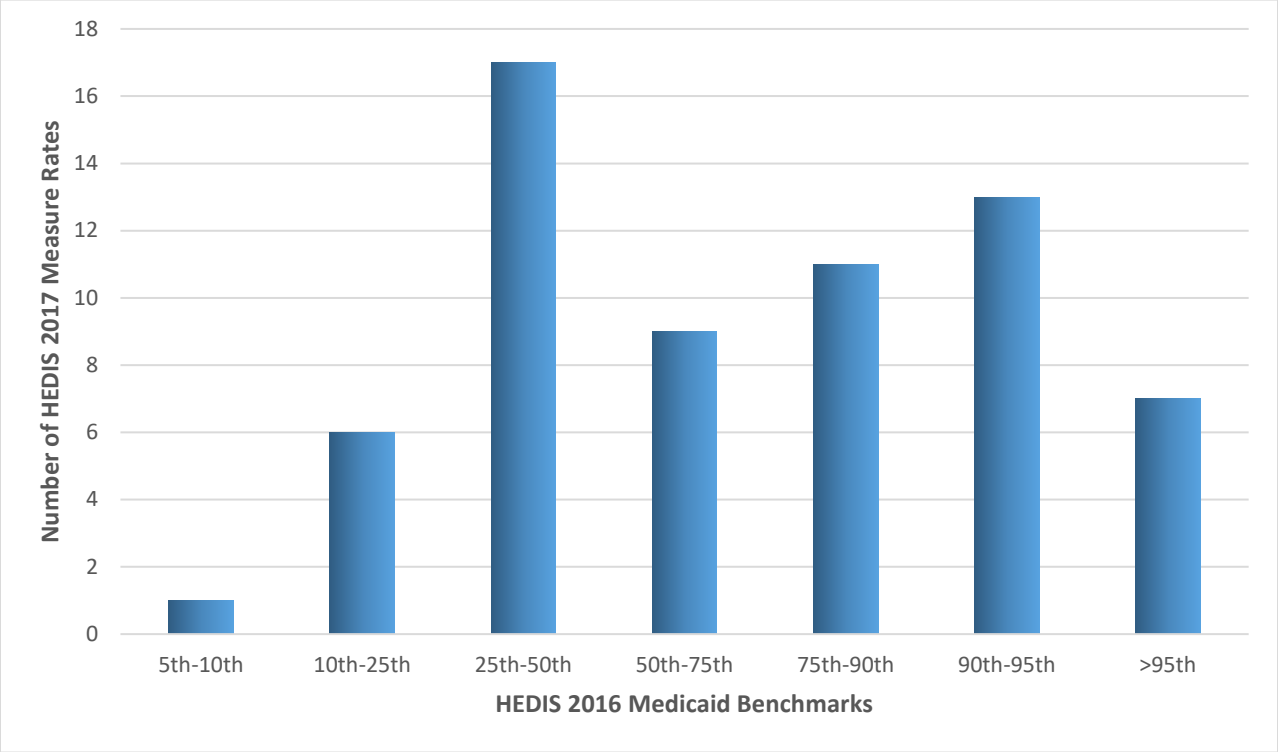
- *Annual Dental Visit—Ages 7–10*
- *Annual Dental Visit—Ages 19–20*
- *Annual Dental Visit—Combined Rate*
- *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months*
- *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years*
- *Ambulatory Care (Outpatient Visits)—<1 Year*
- *Ambulatory Care (ED Visits)—1–9 Years*
- *Ambulatory Care (ED Visits)—45–64 Years*
- *Medication Management for People With Asthma (Medication Compliance 50%)—5–11 Years*
- *Medication Management for People With Asthma (Medication Compliance 50%)—19–50 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%)—51–64 Years*

**DVHA**'s rates fell below the national Medicaid 25th percentile for the following seven rates:

- *Well-Child Visits in the First 15 Months of Life—1 Visit*
- *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—65+ Years*
- *Ambulatory Care (Outpatient Visits)—45–64 Years*
- *Ambulatory Care (Outpatient Visits)—65–74 Years*

Figure 2-1 shows the distribution of how the reported indicators compared to the 2016 HEDIS national Medicaid benchmarks.

**Figure 2-1—Number of HEDIS 2017 Measure Rates Meeting the HEDIS 2016 Medicaid Benchmarks**




As shown in the figure above, nearly half of **DVHA**'s 64 rates ranked at or above the national Medicaid 75th percentile, indicating positive performance during the measurement period. Conversely, 17 rates ranked at or above the national Medicaid 25th percentile but below the 50th percentile, indicating opportunities to improve members' care.

## *Review of Compliance With Standards*

AHS requested that HSAG continue to review one of the three sets of federal Medicaid managed care standards during each EQRO contract year. For EQRO contract year 2017–2018, AHS requested that HSAG conduct a review of the Structure and Operations standards.

HSAG conducted the review consistent with CMS' *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012.[2-5] HSAG reviewed **DVHA**'s written operating policies and procedures, program plans, meeting minutes, numerous written reports, and other data and documentation related to

[2-5] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR), Version 2.0*, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Dec 19, 2017.

**DVHA**'s performance during the review period. Reviewers also conducted staff interviews related to each of the eight standards to allow **DVHA** staff members to elaborate on the written information HSAG reviewed, to assess the consistency of staff responses given during the interviews against the written documentation, and to clarify any questions reviewers had following the document review.

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

Table 2-4 presents a summary of **DVHA**'s performance results for the eight 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 eight standards.
- The total compliance score for each of the standards.
- The overall compliance score across all standards.

**Table 2-4—Standards and Compliance Score**

| Standard # | Standard Name | Total # of Elements | Total # of Applicable Elements | # *Met* | # *Partially Met* | # *Not Met* | # *Not Applicable* | Total Compliance Score |
|---|---|---|---|---|---|---|---|---|
| I | Provider Selection | 11 | 11 | 10 | 1 | 0 | 0 | **95%** |
| II | Credentialing and Recredentialing | 4 | 4 | 3 | 0 | 1 | 0 | **75%** |
| III | Beneficiary Information | 9 | 9 | 8 | 1 | 0 | 0 | **94%** |
| IV | Beneficiary Rights | 3 | 3 | 2 | 1 | 0 | 0 | **83%** |
| V | Confidentiality | 5 | 5 | 5 | 0 | 0 | 0 | **100%** |
| VI | Grievance System–Beneficiary Grievances | 16 | 16 | 9 | 7 | 0 | 0 | **78%** |
| VII | Grievance System–Beneficiary Appeals and State Fair Hearings | 31 | 31 | 28 | 3 | 0 | 0 | **95%** |
| VIII | Subcontractual Relationships and Delegation | 5 | 5 | 3 | 2 | 0 | 0 | **80%** |
| | **Totals** | **84** | **84** | **68** | **15** | **1** | **0** | **90%** |

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

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

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

As displayed in Table 2-4, HSAG reviewed **DVHA**'s performance related to 84 elements across the eight standards. Of the 84 elements, **DVHA** obtained a score of *Met* for 68 of the elements, a score of *Partially Met* for 15 elements, and a score of *Not Met* for one element. As a result, **DVHA** obtained a total percentage-of-compliance score across the 84 requirements of 90 percent.

For the 2017–2018 compliance review, HSAG developed and incorporated the use of checklists for elements that have multiple requirements for an area or a document. For instance, AHS required that **DVHA** include items in the member handbook (e.g., a description of covered benefits, how to access services in urgent and emergent situations, the beneficiary's right to change providers, etc.). After reviewing **DVHA**'s member handbook, HSAG used the checklist to determine if **DVHA**'s member handbook contained the required items.

The three checklists contained elements that HSAG included in the scoring for Standard III, Beneficiary Information (i.e., checklists for Beneficiary Handbook and Beneficiary Rights), and Standard IV, Beneficiary Rights (i.e., checklist for New Beneficiary Outreach and Education).

With scores at or above 90 percent in four standard areas reviewed, **DVHA** demonstrated numerous performance strengths in meeting the federal structure and operations regulations and AHS contract requirements. One of the eight standards, Confidentiality, indicated a significant area of strength, with a score of 100 percent. Three additional standards received scores greater than 90 percent: Provider Selection, Beneficiary Information, and Grievance System—Beneficiary Appeals and State Fair Hearings.

The remaining four standards received scores greater than 75 percent but below 90 percent: Credentialing and Recredentialing, Beneficiary Rights, Grievance System—Beneficiary Grievances, and Subcontractual Relationships and Delegation. These standards represent areas that need to be strengthened to meet all federal and State requirements.

# Overall Conclusions and Performance Trending

## *Performance Trends*

### Performance Improvement Project Trends

**DVHA** submitted its PIP topic, *Initiation of Alcohol and Other Drug Dependence Treatment*, for the first time in 2017–2018. **DVHA**'s performance suggests a thorough application of the Design stage.

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

For the baseline measurement period, **DVHA** reported that 45.3 percent of its members 13 years of age and older with a new episode of alcohol or drug dependence had initial treatment through an inpatient admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of diagnosis. **DVHA** set a Remeasurement 1 goal of 47.2 percent.

HSAG has not yet identified performance trends in the PIP results since this was a first-year submission with only a baseline measurement. The following table displays the baseline result for the study indicator.

**Table 2-5—*Initiation of Alcohol and Other Drug Dependence Treatment* PIP**

| Study Indicators | Baseline (1/1/16–12/31/16) | Remeasurement 1 (1/1/17–12/31/17) | Remeasurement 2 (1/1/18–12/31/18) | Sustained Improvement^ |
|---|---|---|---|---|
| The percentage of Vermont Medicaid members 13 years of age and older with a new episode of alcohol or drug dependence (AOD) who have an initial treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of diagnosis. | 45.3% | | | |

^ 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.

## Performance Measure Trends

**DVHA** used software, the source code of which had been certified by NCQA, to calculate and report the HEDIS 2017 measures. Table 2-6 below displays the rates for measures **DVHA** reported for HEDIS 2014, 2015, 2016, and 2017; the eligible population (i.e., N); and the change for each measure rate from HEDIS 2014 to HEDIS 2017. Measures with no rates displayed (—) were not reported in prior years; therefore, trending of rates between HEDIS 2014 and HEDIS 2017 was not performed and is displayed as NA.

**Table 2-6—HEDIS 2014, 2015, 2016, and 2017 Results**

| Performance Measure | HEDIS 2014 | | HEDIS 2015 | | HEDIS 2016 | | HEDIS 2017 | | Change From HEDIS 2014 to HEDIS 2017 |
|---|---|---|---|---|---|---|---|---|---|
| | N | Rate | N | Rate | N | Rate | N | Rate | |
| *Well-Child Visits in the First 15 Months of Life—0 Visits** | 3,082 | 1.59% | 3,146 | 1.53% | 3,348 | 2.09% | 3,045 | 1.67% | -0.08% |
| *Well-Child Visits in the First 15 Months of Life—1 Visit* | 3,082 | 0.91% | 3,146 | 0.79% | 3,348 | 1.28% | 3,045 | 0.99% | +0.08% |

| Performance Measure | HEDIS 2014 | | HEDIS 2015 | | HEDIS 2016 | | HEDIS 2017 | | Change From HEDIS 2014 to HEDIS 2017 |
|---|---|---|---|---|---|---|---|---|---|
| | N | Rate | N | Rate | N | Rate | N | Rate | |
| *Well-Child Visits in the First 15 Months of Life—2 Visits* | 3,082 | 1.36% | 3,146 | 2.07% | 3,348 | 2.00% | 3,045 | 1.48% | +0.12% |
| *Well-Child Visits in the First 15 Months of Life—3 Visits* | 3,082 | 2.60% | 3,146 | 3.46% | 3,348 | 3.38% | 3,045 | 3.05% | +0.45% |
| *Well-Child Visits in the First 15 Months of Life—4 Visits* | 3,082 | 5.39% | 3,146 | 6.58% | 3,348 | 7.83% | 3,045 | 6.11% | +0.72% |
| *Well-Child Visits in the First 15 Months of Life—5 Visits* | 3,082 | 12.20% | 3,146 | 14.72% | 3,348 | 16.04% | 3,045 | 15.07% | +2.87% |
| *Well-Child Visits in the First 15 Months of Life—6 or More Visits* | 3,082 | 75.96% | 3,146 | 70.85% | 3,348 | 67.38% | 3,045 | 71.63% | -4.33% |
| *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* | 13,170 | 71.49% | 13,219 | 72.82% | 14,183 | 72.60% | 12,879 | 73.97% | +2.48% |
| *Adolescent Well-Care Visits* | 22,630 | 46.97% | 25,496 | 47.35% | 29,369 | 46.85% | 26,791 | 50.89% | +3.92% |
| *Annual Dental Visit—Ages 2–3* | 6,378 | 46.47% | 6,568 | 46.80% | 7,106 | 44.67% | 6,268 | 49.66% | +3.19% |
| *Annual Dental Visit—Ages 4–6* | 9,947 | 71.61% | 9,945 | 71.42% | 10,620 | 70.16% | 9,690 | 72.16% | +0.55% |
| *Annual Dental Visit—Ages 7–10* | 12,782 | 77.85% | 12,989 | 77.24% | 14,124 | 74.88% | 13,256 | 77.66% | -0.19% |
| *Annual Dental Visit—Ages 11–14* | 12,139 | 72.19% | 11,922 | 72.68% | 13,051 | 71.04% | 12,304 | 74.11% | +1.92% |
| *Annual Dental Visit—Ages 15–18* | 10,098 | 65.64% | 11,195 | 65.36% | 12,273 | 63.89% | 11,448 | 65.71% | +0.07% |
| *Annual Dental Visit—Ages 19–20*[1] | 2,664 | 43.02% | 5,379 | 39.58% | 5,266 | 41.57% | 4,407 | 46.36% | NT |
| *Annual Dental Visit—Combined Rate* | 54,008 | 67.72% | 57,998 | 66.07% | 62,440 | 64.87% | 57,373 | 68.12% | +0.40% |
| *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months* | 3,453 | 98.55% | 3,572 | 97.40% | 3,765 | 97.16% | 3,229 | 97.96% | -0.59% |
| *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years* | 16,077 | 92.13% | 16,221 | 91.35% | 17,434 | 90.64% | 15,720 | 91.42% | -0.71% |
| *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* | 14,460 | 94.46% | 14,307 | 95.93% | 16,019 | 95.11% | 15,481 | 95.79% | +1.33% |
| *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years* | 18,485 | 93.90% | 19,122 | 94.81% | 22,617 | 94.00% | 21,769 | 94.99% | +1.09% |
| *Chlamydia Screening in Women—16–20 Years* | 3,092 | 47.35% | 3,977 | 49.56% | 4,634 | 49.63% | 4,162 | 47.53% | +0.18% |
| *Chlamydia Screening in Women—21–24 Years* | 2,299 | 54.85% | 2,985 | 57.25% | 3,569 | 56.26% | 2,852 | 55.58% | +0.73% |
| *Chlamydia Screening in Women—Total* | 5,391 | 50.55% | 6,962 | 52.86% | 8,203 | 52.52% | 7,014 | 50.80% | +0.25% |
| *Adults' Access to Preventive/Ambulatory Health Services—20–44 Years* | 31,658 | 84.21% | 40,215 | 77.44% | 52,767 | 73.24% | 40,955 | 78.24% | -5.97% |
| *Adults' Access to Preventive/Ambulatory Health Services—45–64 Years* | 21,700 | 89.37% | 22,030 | 83.83% | 28,319 | 80.55% | 23,981 | 83.49% | -5.88% |

| Performance Measure | HEDIS 2014 | | HEDIS 2015 | | HEDIS 2016 | | HEDIS 2017 | | Change From HEDIS 2014 to HEDIS 2017 |
|---|---|---|---|---|---|---|---|---|---|
| | N | Rate | N | Rate | N | Rate | N | Rate | |
| *Adults' Access to Preventive/Ambulatory Health Services—65+ Years*[2] | 7,718 | 94.31% | 381 | 83.20% | 403 | 72.70% | 394 | 72.59% | -21.72% |
| *Adults' Access to Preventive/Ambulatory Health Services—Total* | 61,076 | 87.32% | 62,626 | 79.72% | 81,489 | 75.78% | 65,330 | 80.13% | -7.19% |
| *Follow-Up After Hospitalization for Mental Illness—7-day Follow-Up* | 1,567 | 41.61% | 1,152 | 42.45% | 1,278 | 43.11% | 1,274 | 40.42% | -1.19% |
| *Follow-Up After Hospitalization for Mental Illness—30-day Follow-Up* | 1,567 | 61.77% | 1,152 | 59.29% | 1,278 | 59.55% | 1,274 | 57.85% | -3.92% |
| *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation)—13-17 Years* | 312 | 42.63% | 293 | 39.59% | 265 | 39.25% | 209 | 39.23% | -3.40% |
| *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% | 5,910 | 34.35% | +0.47% |
| *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation)—Total* | 6,027 | 34.33% | 5,711 | 33.37% | 6,333 | 34.99% | 6,119 | 34.52% | +0.19% |
| *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Engagement)—13–17 Years* | 312 | 18.91% | 293 | 17.75% | 265 | 18.11% | 209 | 11.48% | -7.43% |
| *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% | 5,910 | 15.06% | +1.80% |
| *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Engagement)—Total* | 6,027 | 13.56% | 5,711 | 13.57% | 6,333 | 14.32% | 6,119 | 14.94% | +1.38% |
| *Breast Cancer Screening* | 7,543 | 38.10% | 4,211 | 56.11% | 5,277 | 54.22% | 6,682 | 55.10% | +17.00% |
| *Ambulatory Care (Outpatient Visits)—<1 Years*[3] | — | — | — | — | 37,434 | 914.23 | 36,328 | 941.04 | NA |
| *Ambulatory Care (Outpatient Visits)—1–9 Years*[3] | — | — | — | — | 121,434 | 305.49 | 117,053 | 299.28 | NA |
| *Ambulatory Care (Outpatient Visits)—10–19 Years*[3] | — | — | — | — | 94,927 | 245.86 | 94,823 | 246.51 | NA |
| *Ambulatory Care (Outpatient Visits)—20–44 Years*[3] | — | — | — | — | 183,404 | 272.12 | 176,166 | 268.48 | NA |
| *Ambulatory Care (Outpatient Visits)—45–64 Years*[3] | — | — | — | — | 147,319 | 416.93 | 142,090 | 408.41 | NA |
| *Ambulatory Care (Outpatient Visits)—65–74 Years*[3] | — | — | — | — | 977 | 370.78 | 1,131 | 313.38 | NA |

| Performance Measure | HEDIS 2014 | | HEDIS 2015 | | HEDIS 2016 | | HEDIS 2017 | | Change From HEDIS 2014 to HEDIS 2017 |
|---|---|---|---|---|---|---|---|---|---|
| | N | Rate | N | Rate | N | Rate | N | Rate | |
| *Ambulatory Care (Outpatient Visits)—75–84 Years*[3] | — | — | — | — | 401 | 481.97 | 405 | 530.80 | NA |
| *Ambulatory Care (Outpatient Visits)—85+ Years*[3] | — | — | — | — | 244 | 505.18 | 124 | 370.15 | NA |
| *Ambulatory Care (Outpatient Visits)—Total*[3] | — | — | — | — | 586,140 | 315.84 | 568,120 | 311.61 | NA |
| *Ambulatory Care (Emergency Department Visits)—<1 Years**[3] | — | — | — | — | 2,830 | 69.12 | 2,540 | 65.80 | NA |
| *Ambulatory Care (Emergency Department Visits)—1–9 Years**[3] | — | — | — | — | 14,281 | 35.93 | 13,428 | 34.33 | NA |
| *Ambulatory Care (Emergency Department Visits)—10–19 Years**[3] | — | — | — | — | 14,319 | 37.09 | 13,975 | 36.33 | NA |
| *Ambulatory Care (Emergency Department Visits)—20–44 Years**[3] | — | — | — | — | 40,594 | 60.23 | 37,849 | 57.68 | NA |
| *Ambulatory Care (Emergency Department Visits)—45–64 Years**[3] | — | — | — | — | 13,906 | 39.36 | 13,628 | 39.17 | NA |
| *Ambulatory Care (Emergency Department Visits)—65–74 Years**[3] | — | — | — | — | 75 | 28.46 | 73 | 20.23 | NA |
| *Ambulatory Care (Emergency Department Visits)—75–84 Years**[3] | — | — | — | — | 18 | 21.63 | 25 | 32.77 | NA |
| *Ambulatory Care (Emergency Department Visits)—85+ Years**[3] | — | — | — | — | 16 | 33.13 | 10 | 29.85 | NA |
| *Ambulatory Care (Emergency Department Visits)—Total**[3] | — | — | — | — | 86,039 | 46.36 | 81,528 | 44.72 | NA |
| *Medication Management for People With Asthma (Medication Compliance 50%)—5–11 Years* | — | — | — | — | 514 | 72.18% | 533 | 70.92% | NA |
| *Medication Management for People With Asthma (Medication Compliance 50%)—12–18 Years* | — | — | — | — | 397 | 64.99% | 399 | 71.18% | NA |
| *Medication Management for People With Asthma (Medication Compliance 50%)—19–50 Years* | — | — | — | — | 1,033 | 69.51% | 974 | 77.00% | NA |
| *Medication Management for People With Asthma (Medication Compliance 50%)—51–64 Years* | — | — | — | — | 293 | 83.28% | 311 | 83.92% | NA |
| *Medication Management for People With Asthma (Medication Compliance 50%)—Total* | — | — | — | — | 2,237 | 71.12% | 2,217 | 75.46% | NA |

| Performance Measure | HEDIS 2014 | | HEDIS 2015 | | HEDIS 2016 | | HEDIS 2017 | | Change From HEDIS 2014 to HEDIS 2017 |
|---|---|---|---|---|---|---|---|---|---|
| | N | Rate | N | Rate | N | Rate | N | Rate | |
| *Medication Management for People With Asthma (Medication Compliance 75%)—5–11 Years* | — | — | — | — | 514 | 52.53% | 533 | 51.59% | NA |
| *Medication Management for People With Asthma (Medication Compliance 75%)—12–18 Years* | — | — | — | — | 397 | 45.84% | 399 | 52.38% | NA |
| *Medication Management for People With Asthma (Medication Compliance 75%)—19–50 Years* | — | — | — | — | 1,033 | 51.21% | 974 | 60.78% | NA |
| *Medication Management for People With Asthma (Medication Compliance 75%)—51–64 Years* | — | — | — | — | 293 | 67.58% | 311 | 68.17% | NA |
| *Medication Management for People With Asthma (Medication Compliance 75%)—Total* | — | — | — | — | 2,237 | 52.70% | 2,217 | 58.10% | NA |

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

[1] For HEDIS 2016 and 2017, 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 2014 and 2015 national percentiles for this age group were based on ages 19–21 years.

[2] 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, 2016, and 2017 to prior years' results.

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

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

NA Indicates that trending was not applicable.

— Indicates the plan was not required to report this measure during the specified measurement period.

Overall, 22 of the 35 measure rates that could be trended showed an increase in performance since HEDIS 2014. Of note, the *Breast Cancer Screening* measure rate increased 17 percentage points from HEDIS 2014 to HEDIS 2017. Of the 13 measure rates that showed decreases in performance, the four *Adults' Access to Preventive/Ambulatory Health Services* measure rates exhibited the largest performance decrease, ranging from 5.88 to 21.72 percentage points from HEDIS 2014 to HEDIS 2017.

## Compliance With Standards Trends

For the 2017–2018 review, the first 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 eight performance categories (i.e., standards). The eight standards (i.e., Provider Selection, Credentialing and Recredentialing, Beneficiary Information, Beneficiary Rights, Confidentiality,

Grievance System—Beneficiary Grievances, Grievance System—Beneficiary Appeals and State Fair Hearings, and Subcontractual Relationships and Delegation) included standards associated with federal Medicaid managed care Structure and Operations requirements found at CFR §438.10, §438.100, and §438.214–230.

HSAG reviews a different set of standards to evaluate **DVHA**'s compliance with federal CMS Medicaid managed care regulations and the associated AHS/**DVHA** IGA requirements during each year within a three-year cycle of reviews. The number of standards reviewed each year varies, as does the focus of the review. The three-year cycle consists of the following standards: Year 1, Structure and Operations standards (42 CFR §438.10, §438.100, and §438.214–230); Year 2, Measurement and Improvement standards (42 CFR §438.236–242); and Year 3, Access and Enrollment/Disenrollment standards (42 CFR §438.206–210 and §438.226).

For this, the 10th year of reviews, HSAG evaluated the Structure and Operations standards, the same standards reviewed by HSAG in 2008–2009, 2011–2012, and 2014–2015.

Table 2-7 documents **DVHA**'s performance across 10 years of compliance reviews conducted by HSAG.

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

| Year of the Review | Structure and Operations Standards | | | Measurement and Improvement Standards | | | Access and Enrollment/Disenrollment Standards | | |
|---|---|---|---|---|---|---|---|---|---|
| | Elements | Score | Corrective Action %* | Elements | Score | Corrective Action %* | Elements | Score | Corrective Action %* |
| 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% |
| CY 2017 | 84 | 90% | 19% | | | | | | |

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

For the Structure and Operations standards, the overall scores **DVHA** received across the four years these standards were reviewed ranged from 84 percent to 92 percent, with the overall Corrective Action percentages ranging from 15 percent to 30 percent.

During the 2014 review of Standard III, Beneficiary Information, it was discovered that the member handbook did not address beneficiary disenrollment rights; the same information was again determined to be missing from the member handbook during the 2017 review of Standard III.

During the 2014 file review relative to Standard VII, Grievance System—Beneficiary Appeals and State Fair Hearings, reviewers determined that two areas required corrective action: (1) ensuring that beneficiaries are provided with a written acknowledgement within five calendar days of receipt of an appeal, and (2) ensuring that appeals are resolved and that members are provided with written notice within the maximum time frames for standard and expedited appeals. In the 2017 review of Standard VII, the same two elements were identified as areas requiring corrective action.

**DVHA**'s performance represented a change in seven scores from the 2014–2015 review of the same standards. The score for one standard remained the same (i.e., Standard V), the scores for two standards improved (i.e., Standard III and Standard VII), and the scores for five standards declined from the prior review (i.e., Standards I, II, IV, VI, and VIII).

The overall scores from the four reviews (i.e., CY 2008, CY 2011, CY 2014, and CY 2017) of the federal Medicaid managed care Structure and Operations standards (CFR §438.10, §438.100, and §438.214–230) increased from 84 percent in CY 2008 to 90 percent in CY 2017. Although the scores indicate a high level of compliance with federal and State requirements, AHS and **DVHA** need to ensure that all *Partially Met* and *Not Met* elements are corrected after each 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."[2-6] CMS has chosen the domains of quality, access, and timeliness as keys to evaluating the performance of MCOs, PIHPs, PAHPs, and PCCMs. Definitions HSAG used to evaluate and draw conclusions about **DVHA**'s performance in each of these domains are as follows.

### Quality

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

> Quality, as it pertains to external quality review, means the degree to which an MCO, PIHP, PAHP, or PCCM entity (described in §438.310(c)(2)) increases the likelihood of desired health outcomes of its enrollees through its (1) structural and operational

[2-6] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Legislative Summary: Balanced Budget Act of 1997 Medicare and Medicaid Provisions.*

> characteristics, (2) the provision of services that are consistent with current professional, evidence-based-knowledge, and (3) interventions for performance improvement.[2-7]

### Timeliness

NCQA defines "timeliness" relative to utilization decisions as follows: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[2-8] NCQA further discusses the intent of this standard to minimize any disruption in the provision of health care. HSAG extends this definition of timeliness to include other managed care provisions that impact services to beneficiaries and that require a timely response by the managed care organization—e.g., processing expedited appeals and providing timely follow-up care.

### Access

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

> Access, as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under §438.68 (Network adequacy standards) and §438.206 (Availability of services).[2-9]

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

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

| PIP | Quality | Timeliness | Access |
|---|---|---|---|
| *Initiation of Alcohol and Other Drug Dependence Treatment* | | ✓ | ✓ |
| **Performance Measures** | **Quality** | **Timeliness** | **Access** |
| *Well-Child Visits in the First 15 Months of Life* | ✓ | ✓ | ✓ |
| *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* | ✓ | ✓ | ✓ |
| *Adolescent Well-Care Visits* | ✓ | ✓ | ✓ |
| *Annual Dental Visit* | | ✓ | ✓ |
| *Children and Adolescents' Access to Primary Care Practitioners* | | | ✓ |

[2-7] Department of Health and Human Services Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Vol 81, May 6, 2016.
[2-8] National Committee for Quality Assurance. (2016). *Standards and Guidelines for Health Plans.*
[2-9] Federal Register. *Code of Federal Regulations, Title 42, Volume 4*, May 6, 2016. Available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=fa076676cc95c899c010f8abe243e97e&mc=true&node=se42.4.438_1320&rgn=div8.Accessed on: Jan 02, 2018.

| Performance Measures | Quality | Timeliness | Access |
|---|---|---|---|
| *Chlamydia Screening in Women* | ✓ | | |
| *Adults' Access to Preventive/Ambulatory Health Services* | | | ✓ |
| *Follow-Up After Hospitalization for Mental Illness* | ✓ | ✓ | ✓ |
| *Initiation and Engagement of Alcohol and Other Drug 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—Provider Selection | ✓ | | ✓ |
| Standard II—Credentialing and Recredentialing | ✓ | ✓ | ✓ |
| Standard III—Beneficiary Information | ✓ | | ✓ |
| Standard IV—Beneficiary Rights | ✓ | ✓ | |
| Standard V—Confidentiality | ✓ | ✓ | |
| Standard VI—Grievance System–Beneficiary Grievances | ✓ | ✓ | ✓ |
| Standard VII—Grievance System–Beneficiary Appeals and State Fair Hearings | ✓ | ✓ | ✓ |
| Standard VIII—Subcontractual Relationships and Delegation | ✓ | | |

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

## *Performance Improvement Project*

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

HSAG determined that **DVHA** accurately documented the data collection methodology and analysis of the baseline result. **DVHA** met 100 percent of the requirements for data analysis and improvement strategies. **DVHA** completed a causal/barrier analysis, identified a priority barrier, and implemented a system-level intervention that was logically linked to the associated barrier.

## Performance Measures

**DVHA** continued to use an external, NCQA-approved, certified software vendor to produce the HEDIS measures under review. Utilizing an NCQA-approved vendor ensured that **DVHA**'s rates were calculated in accordance with the HEDIS specifications and that the measures met standards set forth by NCQA.

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

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

**DVHA** staff continued to review performance measures to identify areas for improvement and to identify mechanisms for improving outcomes for its beneficiaries. Several performance measures representing quality, timeliness of care, and access to care demonstrated strengths by meeting or exceeding the national Medicaid 90th percentile, including *Annual Dental Visit*, *Children and Adolescents' Access to Primary Care Practitioners*, *Ambulatory Care ED Visits*, *Ambulatory Care (Outpatient Visits)–<1 Year)*, and *Medication Management for People With Asthma.*

Quality, timeliness of care, and access to care measures that scored below the national Medicaid 25th percentile, representing opportunities for improvement, included *Well-Child Visits in the First 15 Months of Life*, *Adults' Access to Preventive/Ambulatory Health Services–65+ Years*, and *Ambulatory Care (Outpatient Visits)—45–64 Years* and *65–74 Years*.

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

**DVHA** should continue to work with laboratory vendors to ensure appropriate capture of laboratory claims and results. This will enhance measure rates that use laboratory values for numerator compliance.

**DVHA** may benefit from using supplemental data for some measures. **DVHA** should explore all external sources available, including data from health information exchanges (HIEs), to enhance the administrative measure rates. During the on-site audit, as a result of discussions regarding supplemental data sources, it was identified that potential, untapped supplemental data may exist in external HIEs.

## Compliance With Standards

**DVHA** had a detailed Provider Enrollment Unit Manual that included the expectations and obligations of DXC, explaining the step-by-step processes and time frames for entering provider information into the Medicaid Management Information System (MMIS) and the implementation of automated edit and audit checks to ensure compliance with licensure/certification requirements.

**DVHA** participated in a state-led, nationally recognized initiative focused on transforming health care delivery and payments, the Vermont Blueprint for Health, resulting in the production of reports concerning quality and utilization measures. The reports contained comparisons of provider practice results to local peer practices as well as provider results and State average comparisons.

**DVHA** maintained a provider services call center, operated by DXC, that included an automated voice response system and provider services representatives to allow providers to inquire about beneficiary eligibility, verify claims, and receive assistance with submission of claims and with preparation and submittal of monthly encounter data.

**DVHA** staff members understood the requirements of 42 CFR §438.602(b), and they closely monitored the process used by DXC to review the credentials of the Medicaid providers.

**DVHA**'s member handbook included a description of each beneficiary's right under State law to make decisions regarding his or her medical care and instructions for beneficiaries regarding how to file a written complaint regarding a provider who failed to follow Vermont laws related to the handling of advance directives.

**DVHA** addressed beneficiary rights in its Exercise of Rights and Enrollee Bill of Rights policies and had processes in place to ensure that staff members, IGA partners, vendors, and providers take beneficiary rights into account when furnishing services to beneficiaries.

**DVHA** provided training to staff regarding confidentiality and conducted walkthroughs of **DVHA**'s facilities to help ensure the security and confidentiality of documents containing protected health information (PHI).

**DVHA** provided a copy of the business associates agreement used with its IGA partners, vendors, and contracted providers, which required that disclosure of PHI occur in conformance with the Health Insurance Portability and Accountability Act (HIPAA) privacy rules and stipulated that the contractual relationship may be terminated if disclosure violations occurred.

The **DVHA** Global Commitment to Health Managed Care Entity (MCE) Grievance & Appeals Technical Assistance Manual contained detailed requirements for processing grievances.

**DVHA**'s grievance and appeals database had the capability to allow users to query various reports including the number of appeals by service and the timeliness of resolution.

**DVHA**'s appeals process included written materials for members regarding the appeals process, including the Notice of Decision (NOD) form and form letters.

**DVHA** used predelegation readiness tools with new vendors and had a process in place for ongoing monitoring of subcontractor key performance indicators.

HSAG continued to experience AHS' and **DVHA**'s commitment to providing health care that demonstrates quality, timely access, and accessible services for Medicaid beneficiaries. Interviews with

staff members confirmed that **DVHA** encourages and supports beneficiary-focused care for participants in the Vermont Global Commitment to Health Waiver.

Each of the compliance review standards included elements representative of quality, timeliness of, and/or access to care. *Met* elements in Standard I and Standard III addressed quality and access to care. *Met* elements in Standard II, Standard VI, and Standard VII addressed quality, timeliness of, and access to care. *Met* elements in Standard IV and Standard V represented quality and timeliness of care domains. Quality also was represented by *Met* elements in Standard VIII.

## Recommendations and Opportunities for Improvement

### *Performance Improvement Project*

The strong performance on this PIP suggests a thorough application of the Design stage (Steps I through VI). A sound study design created the foundation for **DVHA** to progress to subsequent PIP stages—collecting baseline data and implementing a system-level intervention that has the potential to impact study indicator outcomes.

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

- **DVHA** should address all *Points of Clarification* documented in the PIP Validation Tool prior to the next annual submission. *Points of Clarification* are associated with *Met* validation scores.
- **DVHA**'s efforts in the Implementation stage should support the development of active interventions and sound measurement results leading to improved outcomes.
- **DVHA** should reference the PIP Completion Instructions annually to ensure that all requirements for each completed step have been addressed.

### *Performance Measures*

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

- Explore additional external sources available, including data from HIEs, to enhance the administrative measure rates. Using supplemental data for measures would be beneficial since some relevant details are not available via claims data.
- Continue the process of monitoring and trending claims submissions.
- Continue to work with laboratory vendors to ensure appropriate capture of laboratory claims and results.

## Compliance With Standards

The recommendations for Standard I included creating written policies and procedures for selection and retention of providers, and ensuring that those policies or operating principles include, at a minimum, the requirements of the CFR and the contract between **DVHA** and AHS. Those revisions may impact quality and access to care.

The recommendations for Standard II included creating a uniform credentialing policy to ensure that the processing of initial credentialing and recredentialing files meets the requirements established by **DVHA** and approved by AHS, establishing an approval process for the Provider Enrollment Unit Manual, and approving any revisions made to that document by DXC. **DVHA** also must ensure that every file processed for initial credentialing or recredentialing includes verification of Drug Enforcement Administration (DEA) certification, when applicable; malpractice insurance; and Medicare/Medicaid sanctions. The processing of recredentialing files must occur within the five-year time limit as defined in 42 CFR §455.414.[2-10] **DVHA** also must include proof of Provider Enrollment, Chain and Ownership System (PECOS) verification in the provider file, and the proof should contain the provider's PECOS enrollment date to ensure that the provider was in the PECOS database on the date **DVHA** received the application for reenrollment in Vermont Medicaid. Those changes could impact quality and access to care.

The recommendations for Standard III and Standard IV, representative of quality, timeliness, and access included ensuring that written information contained in the member handbook describes the beneficiary's right to terminate enrollment in the Medicaid program.

The recommendations for Standard VI included providing written evidence that AHS approved the grievance and appeals processes and policies implemented by **DVHA** and its IGA partners. Additionally, any proposed changes to the rules, procedures, and policies also must be submitted to AHS for approval. Additional recommendations included:

- **DVHA** must include information about providing beneficiaries reasonable assistance in filing grievances and providing interpreter services to include Teletypewriter (TTY)/Telecommunications Device for the Deaf (TDD).
- **DVHA** must ensure that an acknowledgement letter is sent within five calendar days of receiving the grievance unless the grievance decision is made within five days.
- **DVHA** must ensure that all documents sent to the IGAs concerning grievances contain information about the beneficiary's ability to withdraw a grievance and ensuring acknowledgment of the withdrawal in writing within five calendar days.

[2-10] U. S. Government Publishing Office. (2017). *Electronic Code of Federal Regulations.* Available at: https://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title42/42cfr455_main_02.tpl. Accessed on: Jan 03, 2018.

- **DVHA** must ensure that all documents sent to the IGAs concerning grievances contain information about ensuring that individuals who make decisions on grievances were not involved in any previous level of review or decision-making.
- **DVHA** must ensure that all grievances are addressed within 90 calendar days of receipt of the grievance. Written notices also must contain a summary of the grievance, information considered in making the grievance decision, the grievance disposition, as well as information about the individuals who may conduct a grievance review. If the response is adverse to the beneficiary, the notice also must inform the beneficiary of the right to initiate a grievance review and how to initiate the review. Those actions may impact quality, timeliness of, and access to care.

The recommendations for Standard VII included the development and implementation of uniform AHS-approved rules and policies in accordance with applicable appeals rules and State fair hearing rules, ensuring that the department which receives the appeal mails written acknowledgment of the appeal within five calendar days of receipt, and ensuring that processing and resolution of beneficiary appeals occurs within 45 days of receipt of the appeal. These changes may impact quality, timeliness of, and access to care.

The recommendations for Standard VIII, representative of quality, included defining delegated activities and reporting responsibilities of the subcontractor and adding provisions regarding the use of a corrective action process to address problem performance in **DVHA**'s IGAs with the Department of Disabilities, Aging and Independent Living (DAIL), Department for Children and Families (DCF), and Department of Mental Health (DMH).

### Suggestions for DVHA

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

#### Standard II—Credentialing and Recredentialing

- The date on the provider application was the date used to enroll the provider in Vermont Medicaid. Verification of the credentials, however, took up to six months or longer after the date on the Vermont Medicaid Disclosure Form (provider application). The gap between the date on the disclosure form and the date the information was verified could represent a critical gap in the credentials verification process. Except in emergency situations, **DVHA** should consider implementing a procedure ensuring that providers cannot treat Medicaid beneficiaries until the application process is completed. The date of enrollment could then be the date **DVHA** certifies that the verification of provider credentials is complete.
- **DVHA** could consider using a nationally recognized, standard application as the enrollment application for Vermont Medicaid. Valuable information about the background of providers could also be obtained during the credentialing process from such data sources as the National Practitioner Data Bank.
- Because recredentialing occurs at least every five years, **DVHA** could include a review of data representing the quality of health care furnished by the provider (utilization review data,

performance measure data, grievance and appeals data, etc.). **DVHA** should consider using quality data to assess providers who are being recredentialed to ensure that the network of Vermont Medicaid providers includes health care practitioners who have been providing quality care to the Medicaid beneficiaries.

**Standard VI—Grievance System—Beneficiary Grievances**

- A State fair hearing may be initiated for a grievance if the grievance "is not acted upon with reasonable promptness" as stipulated in 3 V.S.A. [Vermont Statutes Annotated] §3091(a)[2-11]. HSAG could not find evidence of beneficiaries being informed of the right to initiate a State fair hearing during the grievance process. **DVHA** may consider notifying beneficiaries about requesting a State fair hearing if the decision is not rendered within 90 days in the grievance acknowledgement letters.

[2-11] Justia Legal Resources. (2016). *2016 Vermont Statutes, Title 3–Executive, Chapter 53–Human Services.* Available at: https://law.justia.com/codes/vermont/2016/title-3/chapter-53/. Accessed on: Jan 03, 2018.

# 3. Description of External Quality Review Activities

## Validation of Performance Improvement Project

During the 2017–2018 EQRO contract year with AHS, HSAG validated one PIP conducted by **DVHA**. This section describes the processes HSAG used to complete the validation activities. HSAG described the details related to its approach, methodologies, and findings from the PIP validation activities in its Performance Improvement Project Validation Report—*Initiation of Alcohol and Other Drug Dependence Treatment* for **DVHA** provided to AHS and **DVHA**.

### *Objectives and Background Information*

The AHS quality strategy required **DVHA** to conduct a PIP in accordance with 42 CFR §438.330. The purpose of a PIP is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical or nonclinical areas. This structured method of assessing and improving the Medicaid managed care model organizations' processes is expected to have a favorable effect on health outcomes and beneficiary satisfaction. AHS contracted with HSAG as the EQRO to meet the federal Medicaid managed care requirement for validating **DVHA**'s PIP. Validation of PIPs is 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 §438.330(d)(2)(i-iv), 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*: High confidence/confidence in reported PIP results. All critical evaluation elements were *Met*, and 80 percent to 100 percent of all evaluation elements were *Met* across all activities.
  - *Partially Met:* Low confidence in reported PIP results. All critical elements were *Met* and 60 percent to 79 percent of all evaluation elements were *Met* across all activities; or one or more critical evaluation elements were *Partially Met.*
  - *Not Met:* All critical evaluation elements were *Met* and less than 60 percent of all evaluation elements were *Met* across all activities; or one or more critical evaluation elements were *Not Met.*
  - *Not Applicable (N/A):* Elements designated *N/A* (including critical elements) were removed from all scoring.
  - *Not Assessed*: Elements (including critical elements) were removed from all scoring.
- In addition to a validation status (e.g., *Met*), HSAG gave the PIP an overall percentage score for all evaluation elements (including critical elements), which was calculated by dividing the total elements *Met* by the sum of all applicable elements that were assessed (as *Met*, *Partially Met*, and *Not Met*). A critical element percentage score was then calculated by dividing the total critical elements *Met* by the sum of the applicable critical elements that were assessed (as *Met*, *Partially Met*, and *Not Met*).
- After completing the validation review, HSAG prepared the draft and final **DVHA** Performance Improvement Project Validation Report—*Initiation of Alcohol and Other Drug Dependence Treatment* for AHS and **DVHA**.

## Determining Conclusions

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

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

# Validation of Performance Measures

Validation of performance measures is 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 12 HEDIS measures, totaling 64 indicators, for HSAG's validation. The measurement period addressed in this report was CY 2016.

## *Description of Data Obtained*

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

- The **Record of Administration, Data Management, and Processes (Roadmap)**, which was completed by **DVHA**. The Roadmap provides background information concerning **DVHA**'s policies, processes, system capabilities, and data in preparation for the on-site validation activities.
- **Supporting documentation**, including file layouts, system flow diagrams, system log files, policies and procedures, data collection process descriptions, and file consolidations logic or extracts.
- **Current and prior years' performance measure results**, which were obtained from **DVHA**.
- **On-site interviews and demonstrations**, which were conducted by HSAG. Information was obtained through interaction, discussion, and formal interviews with key **DVHA** staff members, as well as observation of data processing functions and demonstrations.

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

## Technical Methods of Data Collection/Analysis

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

### Pre-On-Site Activities:

- 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.
- HSAG reviewed all supporting documents, including prior performance measure reports, data flow diagrams, data integration logic, 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 2016 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,[3-1] a review to determine an MCO's, PIHP's, PAHP's, or PCCM's compliance with state standards must be conducted within a three-year period by a state Medicaid agency, its agent, or an EQRO. These standards must be as stringent as the federal Medicaid managed care standards described in 42 CFR §438—Managed Care, which address requirements related to access, structure and operations, and measurement and improvement. To meet these requirements, AHS:

- Continued to ensure that its IGA with **DVHA** included the applicable CMS Medicaid managed care requirements and that they were at least as stringent as the CMS requirements.
- 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 Structure and Operations standards described at 42 CFR §438.10, §438.100, and §438.214–230, and the associated AHS IGA requirements. The

[3-1] U. S. Government Publishing Office. (2017). *Electronic Code of Federal Regulations.* Available at: https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=0fe554e3f4a6236efe0d8c0aa9319e57&mc=true&n=pt42.4.438&r=PART&ty=HTML#se42.4.438_1358. Accessed on: Dec 19, 2017.

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 eight performance areas associated with the CMS Medicaid managed care regulations described at 42 CFR §438.10, §438.100, and §438.214–230.

I. Provider Selection
II. Credentialing and Recredentialing
III. Beneficiary Information
IV. Beneficiary Rights
V. Confidentiality
VI. Grievance System—Beneficiary Grievances
VII. Grievance System—Beneficiary Appeals and State Fair Hearings
VIII. Subcontractual Relationships and Delegation

As these same standards were reviewed during three prior audits, CY 2008, CY 2011 and CY 2014, HSAG evaluated **DVHA**'s current performance and compared the results to those from the earlier review of these same standards.

## Description of Data Obtained

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

| Data Obtained | Time Period to Which the Data Applied |
|---|---|
| Documentation **DVHA** submitted for HSAG's desk review and additional documentation available to HSAG during the on-site review | July 27, 2016–July 20, 2017 |
| Information from interviews conducted on-site | July 19 and 20, 2017 |

## Technical Methods of Data Collection/Analysis

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

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

For the on-site review activities, three HSAG reviewers conducted the two-day on-site review, which included:

- An opening conference, with introductions; **DVHA** staff members' overview of **DVHA** and its relationship with its IGA partners, providers, and subcontractors; **DVHA** updates on any changes and challenges occurring since HSAG's previous review; a review of the agenda and logistics for HSAG's on-site activities; HSAG's overview of the process it would follow in conducting the on-site review; and, the tentative timelines for providing **DVHA** and AHS a draft report for AHS' and **DVHA**'s review and comment.
- Review of the documents HSAG requested that **DVHA** had available on-site.
- Interviews with **DVHA**'s key administrative and program staff members. Separate interviews were scheduled and conducted for each of the standards included in the review tool.

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

HSAG reviewers documented their findings in the compliance review tool. The tool served as a comprehensive record of the pre-on-site and on-site review activities and the performance scores achieved by **DVHA**. Sixteen 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.<br>Reviewers then:<br>• Documented in the review tool their preliminary findings after reviewing the materials **DVHA** submitted as evidence of its compliance with the requirements.<br>• Identified any information not found in the desk review documentation in order to request it prior to the on-site review.<br>• 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:<br>• 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.<br>• 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.<br>• Reviewing additional documentation. HSAG reviewed additional documentation while on-site, and used the review tool and checklists to identify relevant information sources and document its review findings. Items reviewed on-site included, but were not limited to (1) written policies and procedures, minutes of key committee or other group meetings, and data and reports across a broad range of areas; (2) a sample of initial provider credentialing and recredentialing files; (3) a sample of **DVHA**-IGA partner records of beneficiary or provider appeals of **DVHA**'s denials of provider or beneficiary requests for services or **DVHA**'s reductions/suspensions or terminations of previously authorized services; (4) a sample of records of beneficiary grievances filed with **DVHA** or an IGA partner delegate and responses of **DVHA**'s IGA partner to the beneficiaries; and (5) a sample of **DVHA**'s documentation of the date each grievance was submitted, the actions taken and respective dates, and the response provided to the individual submitting the grievance. 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.<br>• Summarizing findings at the completion of the on-site portion of the review. As a final step, HSAG conducted a closing conference to provide **DVHA**'s staff members and AHS participants with a high-level summary of HSAG's preliminary findings. For each of the standards, the findings included HSAG's assessment of **DVHA**'s strengths; if applicable, any areas requiring corrective actions; and HSAG's suggestions for further strengthening **DVHA**'s processes, performance results, and/or documentation.<br>• **DVHA** staff members were readily available throughout the on-site review to answer HSAG's review questions and to assist in locating specific documents or other sources of information. |
| **Step 9:** | **Documented reviewer findings in the Documentation Request & Evaluation Tool** |
| | Beginning prior to and continuing through the on-site review, HSAG reviewers documented their preliminary findings related to **DVHA**'s performance for each requirement. Following the on-site review, the reviewers completed the documentation in the tool and finalized the documentation of **DVHA**'s strengths; required corrective actions; and any suggestions for further strengthening **DVHA**'s performance related to the written documentation and to providing accessible, timely, and quality services to enrollees. |

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

## Determining Conclusions

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

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

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

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

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

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

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

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

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

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

# 4. Follow-Up on Prior EQR Recommendations

## Introduction

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

## Validation of the Performance Improvement Project

During the previous EQRO contract year (2016–2017), HSAG validated **DVHA**'s PIP, *Follow-Up After Hospitalization for Mental Illness (FUH)*. 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** received a score of *Met* for 85 percent of the evaluation elements. The PIP received a *Partially Met* score in Activity VIII for interventions that were implemented in a timely manner to allow for impact of study indicator outcomes. In Activity IX, the PIP received a *Partially Met* score because only one study indicator's result met the goal. In addition, the PIP received a *Not Met* score in Activity IX because neither study indicator demonstrated statistically significant improvement from the baseline to the second remeasurement.

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

| HSAG Recommendations | DVHA Response/Actions/Outcomes |
|---|---|
| Based on the declines in both study indicators, HSAG anticipated that the MCE would implement an additional intervention to impact the Remeasurement 2 results. | **HSAG findings: DVHA** submitted a new topic, *Initiation of Alcohol and Other Drug Dependence Treatment.* The MCE implemented the intervention in a timely manner, and it had the potential to impact study indicator outcomes.<br>**DVHA response:** During this past year, the **DVHA** Quality Unit continued to work on the *FUH* topic, though not as a formal PIP lead. Instead, the Quality Improvement (QI) administrator is participating on a joint payer QI project being led by VPQHC, or Vermont Program for Quality in Health Care. The study design and results of the **DVHA** *FUH* PIP were shared with this multi-payer team at the outset of our participation. |
| The study indicator results did not meet the goal for Remeasurement 2. | **HSAG findings: DVHA** submitted a new topic, *Initiation of Alcohol and Other Drug Dependence Treatment.* In the submission, **DVHA** provided baseline data. Future submissions will include a remeasurement.<br>**DVHA response:** Please see above response. |

## Validation of Performance Measures

HSAG validated 12 performance measures during the previous EQRO contract year (2016–2017). HSAG auditors determined that all 12 were compliant with AHS' specifications and that the rates could be reported. As a result of HSAG's review of provided documentation and on-site audit, HSAG described the following areas for improvement.

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

| HSAG Recommendations | DVHA Response/Actions/Outcomes |
|---|---|
| HSAG recommended that **DVHA** explore all external sources available, including data from HIEs, to enhance the administrative rates. | **DVHA response:** During the past year, **DVHA** explored all external sources available, including data from HIEs, to enhance the administrative rates. |
| HSAG recommended that **DVHA** continue the process of monitoring and trending claims submissions throughout the year. | **DVHA response:** During the past year, **DVHA** continued the process of monitoring and trending claims submissions throughout the year. |
| HSAG recommended that **DVHA** continue to work with laboratory vendors to ensure appropriate capture of laboratory claims and results. This will enhance rates that use laboratory values for numerator compliance. | **DVHA response:** During the past year, **DVHA** explored the feasibility of accessing lab data from the Vermont Information Technology Leaders, Inc. (VITL) clinical repository to ensure appropriate capture of laboratory claims and results. This may take several years to implement. |

## Monitoring Compliance With Standards

During the 2016–2017 compliance audit, HSAG evaluated **DVHA**'s performance related to the three standards (groups of related requirements) included in the Medicaid Access and Enrollment/Disenrollment Standards found in CFRs §438.206–210 and §438.226, and with the associated requirements contained in the AHS IGA (i.e., contract) with **DVHA**. The standards included requirements in the following performance areas: 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. HSAG determined that five elements 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 produce reports to ensure monitoring of the 60-minute transport time to physical rehabilitative services. | **DVHA response:** During the past year, **DVHA** has added mapping reports to ensure monitoring of the 60-minute transport time to physical rehabilitative services. The element will be included in the next network map. |
| **DVHA** must generate reports to monitor the transport time to laboratories to ensure that beneficiaries can access services within a transport time of one hour. | **DVHA response:** During the past year, **DVHA** has added mapping reports to monitor the transport time to laboratories to ensure that beneficiaries can access services within a transport time of one hour. The element will be included in the next network map. |

| HSAG Recommendations | DVHA Responses/Actions/Outcomes |
|---|---|
| **DVHA** must send maps that show provider-to-beneficiary ratios for PCPs and specialists in the network to AHS quarterly. | **DVHA response:** During the past year, **DVHA** has added mapping reports that show provider-to-beneficiary ratios for PCPs and specialists in the network. The element will be included in the next network map and made available to AHS quarterly. |
| **DVHA** must ensure that written Notice of Action (NOA) forms used by the MCE and each of its partner delegates meet all content requirements described in 42 CFR §438.404(b) and in the AHS/**DVHA** IGA. | **DVHA response:** During the past year, **DVHA** reviewed the documents used by DCF staff and found that they DO include all the required language. The version submitted during document review was outdated. |
| **DVHA** needs to ensure that beneficiaries in the Choices for Care Program receive education about systems to prevent, detect and report, investigate, and remediate abuse, neglect, and exploitation. | **DVHA response:** During the past year, **DVHA** worked with DAIL to determine how best to provide this information. At this time, the details have not yet been finalized. At a minimum, this information will be included in the next printing of the member handbook. |