State of Vermont
Agency of Human Services

2023–2024 External Quality Review Technical Report

for

Department of Vermont Health Access

April 2024

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Introduction and Summary of Findings

Background

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

The 2023–2024 Vermont EQR technical report for the AHS complies with Title 42 of the Code of Federal Regulations (CFR) §438.364, which requires the external quality review organization (EQRO) to produce "an annual detailed technical report that summarizes findings on access to and quality of care including a description of the manner in which the data from all activities conducted in accordance with 42 CFR §438.358 were aggregated and analyzed, and conclusions were drawn as to the quality and timeliness of, and access to the care furnished by the managed care organization (MCO), prepaid inpatient health plan (PIHP), prepaid ambulatory health plan (PAHP), or primary care case management (PCCM) entity." [1-2] This report meets the requirements of 42 CFR §438.364 and does not disclose the identity or other protected health information (PHI) of any beneficiary. The AHS quality strategy establishes standards related to access to care, structure and operations, quality measurement and improvement, performance objectives, provisions for external quality review, and mechanisms to monitor compliance with the standards and objectives set forth in the quality strategy.

To meet requirements established by the federal regulations and described in the AHS quality strategy, AHS contracted with HSAG to conduct the EQR activities beginning in the EQR contract year 2007–2008. This report covers the EQR activities conducted during 2023–2024, the EQR contract year. HSAG conducted the mandatory EQR activities consistent with the Centers for Medicare & Medicaid Services (CMS) protocols established under 42 CFR §438.352.[1-3]

During the 2023–2024 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)

[1-1] U. S. Government Publishing Office. (1997). *Public Law 105-33* (p. 249). Available at: http://www.gpo.gov/fdsys/pkg/PLAW-105publ33/pdf/PLAW-105publ33.pdf. Accessed on: Jan 5, 2024.

[1-2] U. S. Government Publishing Office. (2024). *Electronic Code of Federal Regulations.* Available at: eCFR :: 42 CFR 438.358 -- Activities related to external quality review. Accessed on: Jan 5, 2024.

[1-3] U. S. Government Publishing Office. (2024). *Electronic Code of Federal Regulations.* Available at: eCFR :: 42 CFR 438.352 -- External quality review protocols. Accessed on: Jan 5, 2024.

- Validated a set of **DVHA**'s performance measures
- Reviewed **DVHA**'s compliance with the federal Medicaid managed care standards in eight performance categories described at 42 CFR §438.10, §438.12, §438.100, and §438.214–230, and the related AHS/**DVHA** intergovernmental agreement (IGA) (i.e., contract) requirements
- Prepared this annual EQR technical report

Purpose

Under its federal Medicaid demonstration waiver, the State of Vermont uses a managed care model to deliver services and is subject to the Medicaid Managed Care standards/regulations found at 42 CFR §438. This report meets the federal requirement (42 CFR §438.364)[1-4] for preparation of an annual technical report that describes how data from activities conducted in accordance with 42 CFR §438.358 were aggregated and analyzed and how conclusions were drawn as to the quality and timeliness of, and the access to, care furnished by **DVHA**, the single, statewide Medicaid PIHP/managed care entity (MCE) in the State of Vermont.

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.

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

Section 2—Detailed Findings: This section provides contextual information about the federal Medicaid managed care requirements, AHS, and **DVHA**. This section also presents a summary of findings and conclusions about **DVHA**'s strengths and weaknesses, as derived from the EQR activities performed

[1-4] U. S. Government Publishing Office. (2024). *Electronic Code of Federal Regulations.* Available at: eCFR :: 42 CFR 438.364 -- External quality review results. Accessed on: Jan 5, 2024.

during 2023–2024. Section 2 also includes recommendations and opportunities for **DVHA** to improve quality, timeliness, and access to care. Finally, HSAG presents trends over time as appropriate to the data available.

Section 3—EQR Assessment of DVHA's Strengths and Weaknesses and Summary of Quality, Timeliness, and Access: This section describes **DVHA**'s strengths and weaknesses, as identified through the EQR activities performed during 2023–2024. Section 3 also includes a summary of conclusions related to the quality, timeliness, and accessibility of care provided to beneficiaries.

Section 4—Assessment of Vermont's Quality Strategy: This section presents HSAG's review of the Vermont AHS Comprehensive Quality Strategy and describes how the State can target goals and objectives to better support improvement in the ***quality***, ***timeliness***, and ***accessibility of care***. The information also offers conclusions and recommendations pertaining to continuous improvement in the ***quality, timeliness,*** and ***accessibility of care*** provided to beneficiaries.

Section 5—Description of EQR Activities: For each activity HSAG performed, Section 5 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 6—Follow-Up on Prior Year Recommendations: This section presents **DVHA**'s self-reported information concerning the improvement actions the organization took in response to the recommendations HSAG made in the previous year's EQR report. The section also includes the extent to which **DVHA** was successful in improving its performance results.

Opportunities for Improvement

Table 1-1 contains a list of the opportunities for improvement for **DVHA** that includes all EQR tasks described in this contract year 2023–2024 EQR technical report. The table includes contract compliance standards that did not achieve a score of 100 percent and Healthcare Effectiveness Data and Information Set (HEDIS®)[1-5] measures that did not achieve a rate above the Medicaid 50th percentile. Vermont used the 50th percentile national benchmarks for HEDIS measures used to monitor performance in the areas of ***quality***, ***timeliness***, and ***accessibility of care***. Additional information about the tasks displayed in Table 1-1 is included in the Detailed Findings section of this report.

Table 1-1—Opportunities for Improvement for DVHA

EQR Activity	Measure Standard			MCE Results	Standard
	Standard	**42 CFR**	**CFR Standard Name/ Vermont Standard Name**		
Contract Compliance Review	III.	§438.10	Information Requirements/Beneficiary Information	96.0%	100%
	VI.	§438.228	Grievance and Appeal Systems/Grievances	97.7%	100%
	VII.	§438.228	Grievance and Appeal Systems/Appeals and State Fair Hearings	93.0%	100%
	VIII.	§438.230	Subcontractual Relationships and Delegation	98.9%	100%
HEDIS	*Adults' Access to Preventive/Ambulatory Health Services—20–44 Years*			Below the Medicaid 50th Percentile	At or Above the Medicaid 50th Percentile
	Adults' Access to Preventive/Ambulatory Health Services—45–64 Years			Below the Medicaid 50th Percentile	At or Above the Medicaid 50th Percentile
	Adults' Access to Preventive/Ambulatory Health Services—65+ Years			Below the Medicaid 50th Percentile	At or Above the Medicaid 50th Percentile
	Adults' Access to Preventive/Ambulatory Health Services—Total			Below the Medicaid 50th Percentile	At or Above the Medicaid 50th Percentile

[1-5] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

EQR Activity	Measure Standard	MCE Results	Standard
	Breast Cancer Screening	Below the Medicaid 50th Percentile	At or Above the Medicaid 50th Percentile
	Chlamydia Screening in Women—16–20 Years	Below the Medicaid 25th Percentile	At or Above the Medicaid 50th Percentile
	Chlamydia Screening in Women—21–24 Years	Below the Medicaid 25th Percentile	At or Above the Medicaid 50th Percentile
	Chlamydia Screening in Women—Total	Below the Medicaid 25th Percentile	At or Above the Medicaid 50th Percentile
	*Asthma Medication Ratio—5–11 Years**	Below the Medicaid 10th Percentile	At or Above the Medicaid 50th Percentile
	*Asthma Medication Ratio—12–18 Years**	Below the Medicaid 10th Percentile	At or Above the Medicaid 50th Percentile
	Asthma Medication Ratio—19–50 Years	Below the Medicaid 25th Percentile	At or Above the Medicaid 50th Percentile
	Asthma Medication Ratio—Total	Below the Medicaid 25th Percentile	At or Above the Medicaid 50th Percentile
	Prenatal and Postpartum Care—Timeliness of Prenatal Care	Below the Medicaid 25th Percentile	At or Above the Medicaid 50th Percentile
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile—3–11 Years	Below the Medicaid 50th Percentile	At or Above the Medicaid 50th Percentile

EQR Activity	Measure Standard	MCE Results	Standard
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—12–17 Years	Below the Medicaid 25th Percentile	At or Above the Medicaid 50th Percentile
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total	Below the Medicaid 25th Percentile	At or Above the Medicaid 50th Percentile
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—3–11 Years	Below the Medicaid 50th Percentile	At or Above the Medicaid 50th Percentile
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—12–17 Years	Below the Medicaid 25th Percentile	At or Above the Medicaid 50th Percentile
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	Below the Medicaid 50th Percentile	At or Above the Medicaid 50th Percentile
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—12–17 Years	Below the Medicaid 25th Percentile	At or Above the Medicaid 50th Percentile
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	Below the Medicaid 50th Percentile	At or Above the Medicaid 50th Percentile

* Indicates that the indicator scored below the 10th percentile.

2. Detailed Findings

Background

The BBA, Public Law 105-33,[2-1] and as described in 42 CFR §438.364, requires state Medicaid agencies to contract with an EQRO to prepare an annual report that describes the manner in which data from activities conducted in accordance with 42 CFR §438.358 were aggregated and analyzed.[2-2] The report also must 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 an EQR annual technical report that includes the results from the activities it conducted. This report meets the requirements of 42 CFR §438.364 and does not disclose the identity or other PHI of any beneficiary.

The Vermont Agency of Human Services (AHS)

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

During the current EQR contract year (May 15, 2023–May 14, 2024), HSAG conducted three mandatory EQR activities and compared the information to **DVHA**'s performance data from the prior year. This 2023–2024 EQR technical report contains the results of HSAG's review.

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

2-1 U. S. Government Publishing Office. (1997). *Public Law 105-33* (p. 249). Available at: http://www.gpo.gov/fdsys/pkg/PLAW-105publ33/pdf/PLAW-105publ33.pdf. Accessed on: Feb 2, 2024.

2-2 U. S. Government Publishing Office. (2024). *External Quality Review Results.* Available at: eCFR :: 42 CFR 438.358 -- Activities related to external quality review. Accessed on: Feb 2, 2024.

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

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

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

Scope of HSAG's 2023–2024 EQR Activities

HSAG's EQR activities in contract year 2023–2024 consisted of conducting the following:

- ***Validation of DVHA's performance improvement project (PIP).*** HSAG reviewed **DVHA**'s PIP to ensure that the organization designed, conducted, and reported on the project in a methodologically sound manner, allowing measurement of any real improvements in care and services, and giving confidence in the reported improvements.
- ***Validation of DVHA's performance measures.*** HSAG validated the accuracy of the AHS-required performance measures that were reported by **DVHA**. The validation also determined the extent to which the Medicaid-specific performance measures calculated by **DVHA** followed the HEDIS MY 2022 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 regulations described at 42 CFR §438.10 (information requirements), §438.12 (provider discrimination prohibited), §438.100 (enrollee rights), and §438.214–230 (provider selection, confidentiality, grievance and appeal systems, and subcontractual relationships and delegation), 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 2023–2024 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 2023–2024.

Validation of the Performance Improvement Project

HSAG validated **DVHA**'s ongoing PIP, *Managing Hypertension*. HSAG used the Department of Health and Human Services, CMS publication, *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019.[2-3] For future validations, HSAG will use *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023.[2-

[2-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects (PIPs): A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Feb 2, 2024.

[4] HSAG's validation assessed Steps 7 and 8 (data analysis and interpretation of results, improvement strategies and interventions, and outcomes).

The PIP topic addressed the management and control of hypertension and is based on the HEDIS 2022 *Controlling High Blood Pressure (CBP)* measure and technical specifications. HSAG selected the topic after collection and analysis of data and an environmental scan for measure alignment and priority. The target population was Vermont Medicaid members 18 to 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg). The topic selected by **DVHA** addressed CMS' requirements related to quality outcomes—specifically, the ***timeliness*** and ***accessibility*** of care and services.

DVHA's *Managing Hypertension* PIP received a score of 96 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—2023 PIP Validation Summary Overall Score

Percentage Score of Evaluation Elements *Met**	**96%**
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 steps. The third column represents the total number of evaluation elements *Met* compared to the total number of applicable evaluation elements for each activity reviewed, including critical elements.

Table 2-2—Performance Across All Activities

Stage	Step	Percentage of Applicable Elements		
		Met	***Partially Met***	***Not Met***
Design	1. Review the selected PIP Topic	100% (1/1)	0% (0/1)	0% (0/1)
	2. Review the PIP Aim Statement	100% (1/1)	0% (0/1)	0% (0/1)
	3. Review the Identified PIP Population	100% (1/1)	0% (0/1)	0% (0/1)

[2-4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects (PIPs):A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf. Accessed on: Feb 2, 2024.

Stage	Step	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
	4. Review the Sampling Method	100% (5/5)	0% (0/5)	0% (0/5)
	5. Review the Selected Performance Indicator(s)	100% (2/2)	0% (0/2)	0% (0/2)
	6. Review the Data Collection Procedures	100% (3/3)	0% (0/3)	0% (0/3)
Design Total		**100% (13/13)**	**0% (0/13)**	**0% (0/13)**
Implementation*	7. Review Data analysis and Interpretation of Results	100% (3/3)	0% (0/3)	0% (0/3)
	8. Assess the Improvement	100% (6/6)	0% (0/5)	0% (0/5)
Implementation Total		**100% (9/9)**	**0% (0/9)**	**0% (0/9)**
Outcomes	9. Assess for Significant and Sustained Improvement	67% (2/3)	0% (0/0)	33% (1/3)
Outcomes Total		**67% (2/3)**	**0% (0/0)**	**33% (1/3)**
Percentage Score of Applicable Evaluation Elements *Met*		**96% (24/25)**		

The validation results indicate an overall score of 96 percent across all applicable evaluation elements. **DVHA** reported first remeasurement results for the performance indicator this year. **DVHA** continued with using a hybrid data collection process with administrative data from claims/encounters and medical record review using paper medical record abstractions, outpatient medical records, inpatient non-acute records, telephone visits, e-visit or virtual check-ins, or remote monitoring events.

For Remeasurement 1, **DVHA** achieved non-statistically significant improvement with a rate of 52.80 percent. The MCE used a two-tailed Fisher's exact test to conduct statistical testing with a *p* value outcome of 0.8889.

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' *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023.[2-5] The validation findings confirmed that all rates were reportable. Table 2-3 displays the HEDIS measurement year (MY) 2021 and HEDIS MY 2022 performance measure results; the denominator for each measure (i.e., number [N]); and the change for each measure rate from HEDIS MY 2021 to HEDIS MY 2022. Please note that for measures reported using the administrative methodology, the denominator is the eligible population. Additionally, HSAG compared the measure results for HEDIS MY 2022 to the National Committee for Quality Assurance's (NCQA's) HEDIS Audit Means and Percentiles National Medicaid Health Maintenance Organization (HMO) Percentiles (referred to as "percentiles" in this report) for HEDIS MY 2021.

Table 2-3—DVHA HEDIS MY 2021 and MY 2022 Results

Measure	HEDIS MY 2021		HEDIS MY 2022		Change From HEDIS MY 2021 to HEDIS MY 2022	HEDIS Percentile Rank
	N	Rate	N	Rate		
Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	49,753	75.15%	54,705	71.16%	-3.99%	25th–50th
Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	25,404	82.46%	27,289	80.75%	-1.71%	25th–50th
Adults' Access to Preventive/Ambulatory Health Services—65+ Years	453	79.69%	466	77.25%	-2.44%	25th–50th
Adults' Access to Preventive/Ambulatory Health Services—Total	75,610	77.63%	82,460	74.37%	-3.26%	25th–50th
Child and Adolescent Well-Care Visits—3–11 Years	30,015	65.33%	30,012	67.04%	+1.71%	75th–90th
Child and Adolescent Well-Care Visits—12–17 Years	20,101	58.56%	20,648	58.22%	-0.34%	50th–75th
Child and Adolescent Well-Care Visits—18–21 Years	10,530	29.91%	11,655	28.99%	-0.92%	50th–75th
Child and Adolescent Well-Care Visits—Total	60,646	56.93%	62,315	57.00%	+0.07%	50th–75th

[2-5] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Feb 2, 2024.

Measure	HEDIS MY 2021		HEDIS MY 2022		Change From HEDIS MY 2021 to HEDIS MY 2022	HEDIS Percentile Rank
	N	Rate	N	Rate		
Breast Cancer Screening	6,464	46.16%	7,674	50.86%	+4.70%	25th–50th
Chlamydia Screening in Women—16–20 Years	4,271	41.89%	4,372	41.13%	-0.76%	10th–25th
Chlamydia Screening in Women—21–24 Years	2,704	51.96%	2,831	51.93%	-0.03%	10th–25th
Chlamydia Screening in Women—Total	6,975	45.79%	7,203	45.37%	-0.42%	10th–25th
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—6–17 Years	215	56.74%	241	63.07%	+6.33%	75th–90th
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—18–64 Years	896	43.53%	958	48.12%	+4.59%	75th–90th
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—65+ Years	1	NA	2	NA	NC	NC
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total	1,112	46.04%	1,201	51.12%	+5.08%	75th–90th
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—6–17 Years	215	77.67%	241	81.74%	+4.07%	75th–90th
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—18–64 Years	896	62.95%	958	66.49%	+3.54%	75th–90th
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—65+ Years	1	NA	2	NA	NC	NC
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total	1,112	65.83%	1,201	69.53%	+3.70%	75th–90th
Initiation and Engagement of Substance Use Disorder Treatment (Initiation)—13–17 Years—Total	—	—	222	26.58%	NC	NC
Initiation and Engagement of Substance Use Disorder Treatment (Initiation)—18+ Years—Total	—	—	3,990	40.83%	NC	NC
Initiation and Engagement of Substance Use Disorder Treatment (Initiation)—Total—Total	—	—	4,212	40.08%	NC	NC

Measure	HEDIS MY 2021		HEDIS MY 2022		Change From HEDIS MY 2021 to HEDIS MY 2022	HEDIS Percentile Rank
	N	Rate	N	Rate		
Initiation and Engagement of Substance Use Disorder Treatment (Engagement)—13–17 Years—Total	—	—	222	9.46%	NC	NC
Initiation and Engagement of Substance Use Disorder Treatment (Engagement)—18+ Years—Total	—	—	3,990	17.97%	NC	NC
Initiation and Engagement of Substance Use Disorder Treatment (Engagement)—Total—Total	—	—	4,212	17.52%	NC	NC
Ambulatory Care (Outpatient Visits)—<1 Year[†,1]	31,314	10,612.76	31,842	11,261.35	+648.59	NC
Ambulatory Care (Outpatient Visits)—1–9 Years[†,1]	360,839	3,064.79	358,238	3,361.82	+297.03	NC
Ambulatory Care (Outpatient Visits)—10–19 Years[†,1]	401,015	2,661.51	411,667	2,569.09	-92.42	NC
Ambulatory Care (Outpatient Visits)—20–44 Years[†,1†]	682,370	3,072.97	736,254	2,790.80	-282.17	NC
Ambulatory Care (Outpatient Visits)—45–64 Years[†,1]	411,003	5,211.58	431,760	4,815.73	-395.85	NC
Ambulatory Care (Outpatient Visits)—65–74 Years[†,1]	80,234	6,749.31	92,318	5,968.15	-781.16	NC
Ambulatory Care (Outpatient Visits)—75–84 Years[†,1]	32,790	7,313.45	34,985	6,843.96	-469.49	NC
Ambulatory Care (Outpatient Visits)—85+ Years[†,1]	19,431	6,102.83	18,881	6,249.46	+146.63	NC
Ambulatory Care (Outpatient Visits)—Total[†,1]	2,018,996	3,786.20	2,115,945	3,621.50	-164.70	25th–50th
Ambulatory Care (Emergency Department [ED] Visits)—<1 Year[1]	31,314	607.01	31,842	940.27	+333.26	NC
Ambulatory Care (ED Visits)—1–9 Years[1]	360,839	301.50	358,238	430.94	+129.44	NC
Ambulatory Care (ED Visits)—10–19 Years[1]	401,015	349.54	411,667	403.55	+54.01	NC
Ambulatory Care (ED Visits)—20–44 Years[1]	682,370	590.04	736,254	596.34	+6.30	NC
Ambulatory Care (ED Visits)—45–64 Years[1]	411,003	554.48	431,760	587.22	+32.74	NC

Measure	HEDIS MY 2021		HEDIS MY 2022		Change From HEDIS MY 2021 to HEDIS MY 2022	HEDIS Percentile Rank
	N	Rate	N	Rate		
Ambulatory Care (ED Visits)—65–74 Years[1]	80,234	616.35	92,318	580.91	-35.44	NC
Ambulatory Care (ED Visits)—75–84 Years[1]	32,790	647.03	34,985	690.47	+43.44	NC
Ambulatory Care (ED Visits)—85+ Years[1]	19,431	534.20	18,881	575.82	+41.62	NC
Ambulatory Care (ED Visits)—Total[1]	2,018,996	485.16	2,115,945	534.84	+49.68	50th–75th
Well-Child Visits in the First 30 Months of Life—6 Visits in First 15 Months	2,636	70.03%	2,488	71.54%	+1.51%	>95th
Well-Child Visits in the First 30 Months of Life—2 Visits in 15 Through 30 Months	2,901	79.46%	2,826	80.82%	+1.36%	90th–95th
Asthma Medication Ratio—5–11 Years	439	67.43%	462	67.53%	+0.10%	5th–10th
Asthma Medication Ratio—12–18 Years	430	60.47%	461	58.79%	-1.68%	5th–10th
Asthma Medication Ratio—19–50 Years	1,379	45.76%	1,638	50.00%	+4.24%	10th–25th
Asthma Medication Ratio—51–64 Years	436	61.24%	516	59.88%	-1.36%	50th–75th
Asthma Medication Ratio—Total	2,684	54.17%	3,077	55.61%	+1.44%	10th–25th
Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—6–17 Years	356	85.96%	415	85.06%	-0.90%	>95th
Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—18–64 Years	688	65.41%	695	65.90%	+0.49%	90th–95th
Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—65+ Years	1	NA	1	NA	NC	NC
Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total	1,045	72.44%	1,111	73.00%	+0.56%	>95th
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—6–17 Years	356	89.89%	415	90.84%	+0.95%	>95th
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—18–64 Years	688	72.67%	695	74.82%	+2.15%	90th–95th
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—65+ Years	1	NA	1	NA	NC	NC
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total	1,045	78.56%	1,111	80.74%	+2.18%	>95th
Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—13–17 Years	—	—	34	47.06%	NC	NC
Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—18+ Years	—	—	1,516	44.46%	NC	NC

Measure	HEDIS MY 2021		HEDIS MY 2022		Change From HEDIS MY 2021 to HEDIS MY 2022	HEDIS Percentile Rank
	N	Rate	N	Rate		
Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total	—	—	1,550	44.52%	NC	NC
Follow-Up After ED Visit for Substance Use—30-Day Follow-Up—13–17 Years	—	—	34	58.82%	NC	NC
Follow-Up After ED Visit for Substance Use—30-Day Follow-Up—18+ Years	—	—	1,516	62.14%	NC	NC
Follow-Up After ED Visit for Substance Use—30-Day Follow-Up—Total	—	—	1,550	62.06%	NC	NC
Developmental Screening in the First Three Years of Life—1 Year	2,547	45.82%	2,472	47.61%	+1.79%	NC
Developmental Screening in the First Three Years of Life—2 Years	2,872	53.90%	2,766	54.19%	+0.29%	NC
Developmental Screening in the First Three Years of Life—3 Years	2,884	56.14%	2,984	55.70%	-0.44%	NC
Developmental Screening in the First Three Years of Life—Total	8,303	52.20%	8,222	52.76%	+0.56%	NC
Prenatal and Postpartum Care—Timeliness of Prenatal Care	411	81.75%	411	79.32%	-2.43%	10th–25th
Prenatal and Postpartum Care—Postpartum Care	411	82.97%	411	78.83%	-4.14%	50th–75th
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)—18–64 Years	—	—	407	42.26%	NC	NC
Diabetes Care for People with Serious Mental Illness: HbA1c Poor Control (>9.0%)—65–75 Years	—	—	407	7.13%	NC	NC
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—3–11 Years	254	69.69%	232	74.57%	+4.88%	25th–50th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—12–17 Years	157	64.33%	179	64.80%	+0.47%	10th–25th

Measure	HEDIS MY 2021		HEDIS MY 2022		Change From HEDIS MY 2021 to HEDIS MY 2022	HEDIS Percentile Rank
	N	Rate	N	Rate		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total	411	67.64%	411	70.32%	+2.68%	10th–25th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—3–11 Years	254	70.87%	232	72.84%	+1.97%	25th–50th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—12–17 Years	157	56.05%	179	59.22%	+3.17%	10th–25th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	411	65.21%	411	66.91%	+1.70%	25th–50th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—3–11 Years	254	58.66%	232	68.97%	+10.31%	50th–75th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—12–17 Years	157	56.05%	179	59.22%	+3.17%	10th–25th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	411	57.66%	411	64.72%	+7.06%	25th–50th

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

† Rates for this indicator are presented for information only.

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

— indicates that the measure is a first-year measure for HEDIS MY 2022; therefore, prior year rates are not displayed.

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

NC indicates that a comparison to benchmarks or to the prior year's rates is not appropriate either due to a change in specifications or because HEDIS MY 2022 is the first year this measure is being reported.

Excluding information-only measures, **DVHA** demonstrated strength, with eight measure rates meeting or exceeding the 90th percentile. Of the 43 reportable rates with comparable benchmarks, five rates met or exceeded the 95th percentile:

- *Well-Child Visits in the First 30 Months of Life—6 Visits in First 15 Months*
- *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—6–17 Years*
- *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total*
- *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—6–17 Years*
- *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total*

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

- *Well-Child Visits in the First 30 Months of Life—2 Visits in 15 Through 30 Months*
- *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—18–64 Years*
- *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—18–64 Years*

Excluding information-only measures, **DVHA** demonstrated opportunities for improvement with the following 12 rates falling below the 25th percentile:

- *Chlamydia Screening in Women—16–20 Years*
- *Chlamydia Screening in Women—21–24 Years*
- *Chlamydia Screening in Women—Total*
- *Asthma Medication Ratio—5–11 Years*
- *Asthma Medication Ratio—12–18 Years*
- *Asthma Medication Ratio—19–50 Years*
- *Asthma Medication Ratio—Total*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—12–17 Years*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—12–17 Years*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—12–17 Years*

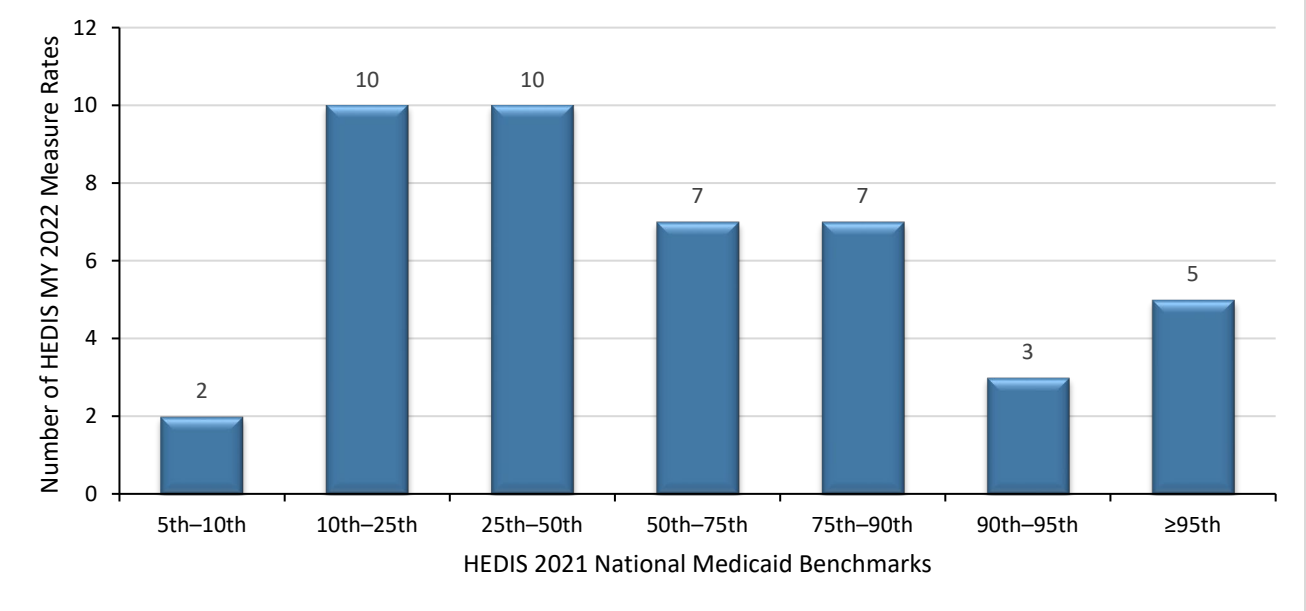
Excluding information-only measures, an additional nine rates fell below the 50th percentile but were at or above the 25th percentile:

- *Adults' Access to Preventive/Ambulatory Health Services—20–44 Years*

- *Adults' Access to Preventive/Ambulatory Health Services—45–64 Years*
- *Adults' Access to Preventive/Ambulatory Health Services—65+ Years*
- *Adults' Access to Preventive/Ambulatory Health Services—Total*
- *Breast Cancer Screening*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—3–11 Years*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—3–11 Years*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total*

Figure 2-1 shows the distribution of how the reported indicators compared to the HEDIS MY 2021 national Medicaid benchmarks.

Figure 2-1—Number of HEDIS MY 2022 Measure Rates Meeting the HEDIS MY 2021 National Medicaid Benchmarks



DVHA performed at or above the 75th percentile for 15 of 44 (34.1 percent) measure rates appropriate for comparison to benchmarks, demonstrating strengths in sufficient child and adolescent care, and 7-day and 30-day follow-up care after hospitalization for mental illness, well-child visits in the first 30 months of life, and 7-day and 30-day follow-up care after ED visits for mental illness. Conversely, excluding information-only measures, 21 of 44 rates (47.7 percent) fell below the 50th percentile, indicating efforts should be focused on ensuring that members have access to breast cancer and chlamydia screenings, ratios of asthma medication, and prenatal care. **DVHA** also should focus on educating members on the importance of

weight assessment including BMI percentile, and counseling for nutrition and physical activity for children and adolescents.

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 EQR contract year. For EQR contract year 2023–2024, AHS requested that HSAG conduct a review of the federal Medicaid managed care standards described at 42 CFR §438.10 (information requirements), §438.12 (provider discrimination prohibited), §438.100 (enrollee rights), and §438.214–230 (provider selection, confidentiality, grievance and appeal systems, and subcontractual relationships and delegation), and the related AHS/**DVHA** IGA (i.e., contract) requirements.

HSAG conducted the review consistent with CMS' *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023.[2-6] HSAG reviewed **DVHA**'s written operating policies and procedures, program plans, meeting minutes, numerous written reports, and other data and documentation related to **DVHA**'s performance during the review period. Reviewers also conducted staff interviews related to each of the eight standards to allow **DVHA** staff members to elaborate on the written information that 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.

[2-6] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Available at: CMS External Quality Review (EQR) Protocols (medicaid.gov). Accessed on: Jan 5, 2024.

Table 2-4—Standards and Compliance Score

Standard	Standard Name	Total Elements	Total Applicable Elements	Number of Elements			Score**
				Met	*Partially Met**	*Not Met**	
I	Provider Selection	11	11	11	0	0	100%
	STANDARD I SCORE	11	11	11	0	0	**100%**
II	Credentialing and Recredentialing	4	4	4	0	0	100%
	Provider Enrollment File Review	140	140	140	0	0	100%
	Provider Revalidation File Review	127	127	127	0	0	100%
	STANDARD II SCORE	271	271	271	0	0	**100%**
III	Beneficiary Information	15	15	13	1	1	90.0%
	Beneficiary Handbook Checklist	40	39	38	0	1	97.4%
	New Beneficiary Outreach and Education Checklist	9	9	9	0	0	100%
	STANDARD III SCORE	64	63	60	1	2	**96.0%**
IV	Beneficiary Rights	4	4	4	0	0	100%
	Beneficiary Rights Checklist	11	11	11	0	0	100%
	STANDARD IV SCORE	15	15	15	0	0	**100%**
V	Confidentiality	5	5	5	0	0	100%
	STANDARD V SCORE	5	5	5	0	0	**100%**
VI	Grievance System—Beneficiary Grievances	16	16	13	3	0	90.6%
	Beneficiary Grievances File Review	50	50	50	0	0	100%
	STANDARD VI SCORE	66	66	63	3	0	**97.7%**
VII	Grievance System—Beneficiary Appeals and State Fair Hearings	39	39	35	4	0	94.9%
	Beneficiary Appeals File Review	40	32	29	0	3	90.6%
	STANDARD VII SCORE	79	71	64	4	3	**93.0%**
VIII	Subcontractual Relationships and Delegation	8	8	7	1	0	93.8%
	Subcontractual Relationships and Delegation File Review	36	36	36	0	0	100%
	STANDARD VIII SCORE	44	44	43	1	0	**98.9%**
Standards Total		**555**	**546**	**532**	**9**	**5**	**98.3%**
Percent *Met* (No Action Required)* **					**97.4%**		
Percent *Partially Met* (Action Required)					**1.7%**		
Percent *Not Met* (Action Required)					**0.9%**		

* ***Partially Met*** and ***Not Met*** elements must be addressed in the CAP (Appendix C).

** A *Met* score equals 1.0 point; a *Partially Met* score equals 0.5 points; and a *Not Met* score equals 0.0 points.

***Due to rounding, the sum of the Percent *Met,* Percent *Partially Met,* and Percent *Not Met* scores may equal slightly less than or slightly greater than 100 percent.

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

***Total 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 546 elements across the eight standards. Of the 546 elements, **DVHA** obtained a score of *Met* for 532 elements (97.4 percent), a *Partially Met* score for nine elements (1.7 percent), and a *Not Met* score for five elements (0.9 percent). As a result, **DVHA** obtained a total percentage-of-compliance score across the 546 elements of 98.3 percent.

Overall Conclusions and Performance Trending

Performance Trends

Performance Improvement Project Trends

DVHA continued its PIP topic, *Managing Hypertension*, in contract year 2023. **DVHA** performed well across all validated steps of the PIP. HSAG determined that **DVHA** designed a methodologically sound improvement project, accurately reported and interpreted Remeasurement 1 results, and conducted appropriate QI activities and interventions.

Table 2-5 outlines the performance indicator for the PIP.

Table 2-5—*Managing Hypertension* PIP Performance Indicator

PIP Title	Performance Indicator
Managing Hypertension	The percentage of Vermont Medicaid members 18 to 85 years of age with a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg).

Table 2-6—*Managing Hypertension* PIP for Department of Vermont Health Access

PIP—Managing Hypertension			
Performance Indicator	**Baseline (1/1/2021—12/31/2021)**	**Remeasurement 1 (1/1/2022–12/31/2022)**	**Remeasurement 2 (1/1/2023–12/31/2023)**
The percentage of Vermont Medicaid members 18 to 85 years of age with a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg).	52.07%	52.80%	TBD

The baseline rate for the eligible members was 52.07 percent. **DVHA** used a hybrid data collection process with administrative data from claims/encounters and medical record review using paper medical record abstractions, outpatient medical records, inpatient nonacute records, telephone visits, e-visits or virtual check-ins, or remote monitoring events.

For Remeasurement 1, **DVHA** continued with the same data collection methodology and achieved non-statistically significant improvement with a rate of 52.80 percent. The MCE used a two-tailed Fisher's exact test to conduct statistical testing with a *p* value outcome of 0.8889.

Table 2-7 displays the barriers and interventions as documented by **DVHA**.

Table 2-7—Interventions Implemented/Planned for the *Managing Hypertension* PIP

Barriers	Interventions
Members do not have blood pressure monitors to use at home.	Improved members' access to automatic blood pressure cuffs by expanding Medicaid coverage for blood pressure cuffs for additional hypertension diagnoses and ensuring pharmacy coverage for blood pressure cuffs. **DVHA** added pharmacy staff to its PIP team. This provided needed resources that helped communicate changes to local pharmacies and develop an educational provider webinar. The webinar detailed the proper clinical procedure for prescribing blood pressure monitors as well as development of self-monitoring blood pressure programs.
Lack of referral options for community programming.	Developed a community connection that provides referral support to the system of care (connecting with the Coordinator of Health Coaches for hypertension self-management and self-monitoring program for individuals diagnosed with hypertension). **DVHA**'s PIP team established a data flow with the workshop coordinator during the first remeasurement period and indicated that the results were promising. For each cohort, average systolic and diastolic blood pressure metrics decreased over the course of the eight-week program. **DVHA** reported that this intervention presented limited opportunities for its team to engage in additional change ideas given the capacity of the workshop coordinators during this reporting period.
No simple resource tool for providers.	Initially, **DVHA** developed a one-page tool that both **DVHA** and OneCare will use for communication with and education of providers. The one-page tool includes background and tips associated with improving performance and member engagement on the HEDIS *CBP* measure. During the first remeasurement period, this intervention was revised. **DVHA** continued to work on the one-page tip sheet but revised its placement focus. **DVHA** reported that the e-learn platform did not receive the administrative support necessary to maintain it as a robust provider resource, resulting in the MCE changing the methods to promote it. The MCE also made updates to the tip sheet. The updates included measure specification clarification and an added focus on the importance of appropriate cuff sizing. These updates were also incorporated into the Hypertension Management webinar for providers.

Performance Measure Trends

DVHA used a vendor with HEDIS Certified Measures[SM,2-7] to calculate and report the HEDIS MY 2022 performance measure rates. Table 2-8 below displays the rates for measures **DVHA** reported for HEDIS MY 2019, MY 2020, MY 2021, and MY 2022; the denominator (i.e., N); and the change for each measure rate from HEDIS MY 2019 to HEDIS MY 2022.

Table 2-8—HEDIS MY 2019, MY 2020, MY 2021, and MY 2022 Results

Measure	HEDIS MY 2019		HEDIS MY 2020		HEDIS MY 2021		HEDIS MY 2022		Change From HEDIS MY 2019 to HEDIS MY 2022
	N	Rate	N	Rate	N	Rate	N	Rate	
Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	32,793	81.22%	39,397	76.25%	49,753	75.15%	54,705	71.16%	-10.06%
Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	19,101	86.80%	21,350	82.48%	25,404	82.46%	27,289	80.75%	-6.05%
Adults' Access to Preventive/Ambulatory Health Services—65+ Years	170	92.35%	298	83.22%	453	79.69%	466	77.25%	-15.10%
Adults' Access to Preventive/Ambulatory Health Services—Total	52,064	83.30%	61,045	78.46%	75,610	77.63%	82,460	74.37%	-8.93%
Child and Adolescent Well-Care Visits—3–11 Years	—	—	28,846	62.61%	30,015	65.33%	30,012	67.04%	NC
Child and Adolescent Well-Care Visits—12–17 Years	—	—	18,849	54.56%	20,101	58.56%	20,648	58.22%	NC
Child and Adolescent Well-Care Visits—18–21 Years	—	—	8,704	28.64%	10,530	29.91%	11,655	28.99%	NC
Child and Adolescent Well-Care Visits—Total	—	—	56,399	54.68%	60,646	56.93%	62,315	57.00%	NC
Breast Cancer Screening	5,461	52.33%	5,796	48.57%	6,464	46.16%	7,674	50.86%	-1.47%
Chlamydia Screening in Women—16–20 Years	3,590	48.75%	3,821	41.48%	4,271	41.89%	4,372	41.13%	-7.62%
Chlamydia Screening in Women—21–24 Years	2,014	60.53%	2,289	54.78%	2,704	51.96%	2,831	51.93%	-8.60%
Chlamydia Screening in Women—Total	5,604	52.98%	6,110	46.46%	6,975	45.79%	7,203	45.37%	-7.61%

[2-7] HEDIS Certified Measures[SM] is a service mark of the NCQA.

Measure	HEDIS MY 2019		HEDIS MY 2020		HEDIS MY 2021		HEDIS MY 2022		Change From HEDIS MY 2019 to HEDIS MY 2022
	N	Rate	N	Rate	N	Rate	N	Rate	
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—6–17 Years	291	46.74%	239	56.90%	215	56.74%	241	63.07%	+16.33%
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—18–64 Years	1,137	36.68%	873	41.81%	896	43.53%	958	48.12%	+11.44%
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—65+ Years	0	NA	0	NA	1	NA	2	NA	NC
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total	1,428	38.73%	1,112	45.05%	1,112	46.04%	1,201	51.12%	+12.39%
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—6–17 Years	291	72.16%	239	75.31%	215	77.67%	241	81.74%	+9.58%
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—18–64 Years	1,137	57.52%	873	61.86%	896	62.95%	958	66.49%	+8.97%
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—65+ Years	0	NA	0	NA	1	NA	2	NA	NC
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total	1,428	60.50%	1,112	64.75%	1,112	65.83%	1,201	69.53%	+9.03%
Initiation and Engagement of Substance Use Disorder Treatment (Initiation)—13–17 Years—Total	—	—	—	—	—	—	222	26.58%	NC
Initiation and Engagement of Substance Use Disorder Treatment (Initiation)—18+ Years—Total	—	—	—	—	—	—	3,990	40.83%	NC

Measure	HEDIS MY 2019		HEDIS MY 2020		HEDIS MY 2021		HEDIS MY 2022		Change From HEDIS MY 2019 to HEDIS MY 2022
	N	Rate	N	Rate	N	Rate	N	Rate	
Initiation and Engagement of Substance Use Disorder Treatment (Initiation)—Total—Total	—	—	—	—	—	—	4,212	40.08%	NC
Initiation and Engagement of Substance Use Disorder Treatment (Engagement)—13–17 Years—Total	—	—	—	—	—	—	222	9.46%	NC
Initiation and Engagement of Substance Use Disorder Treatment (Engagement)—18+ Years—Total	—	—	—	—	—	—	3,990	17.97%	NC
Initiation and Engagement of Substance Use Disorder Treatment (Engagement)—Total—Total	—	—	—	—	—	—	4,212	17.52%	NC
Ambulatory Care (Outpatient Visits)—<1 Year[†,1]	34,073	11,882.02	32,814	10,083.74	31,314	10,612.76	31,842	11,261.35	-620.67
Ambulatory Care (Outpatient Visits)—1–9 Years[†,1]	351,175	3,733.85	351,069	2,755.70	360,839	3,064.79	358,238	3,361.82	-372.03
Ambulatory Care (Outpatient Visits)—10–19 Years[†,1]	362,956	2,955.99	373,915	2,336.68	401,015	2,661.51	411,667	2,569.09	-386.90
Ambulatory Care (Outpatient Visits)—20–44 Years[†,1]	543,335	3,444.84	580,531	2,980.18	682,370	3,072.97	736,254	2,790.80	-654.04
Ambulatory Care (Outpatient Visits)—45–64 Years[†,1]	353,408	5,830.97	367,855	5,043.36	411,003	5,211.58	431,760	4,815.73	-1,015.24
Ambulatory Care (Outpatient Visits)—65–74 Years[†,1]	59,767	8,244.01	65,264	6,788.98	80,234	6,749.31	92,318	5,968.15	-2,275.86
Ambulatory Care (Outpatient Visits)—75–84 Years[†,1]	30,558	8,279.99	31,789	6,925.41	32,790	7,313.45	34,985	6,843.96	-1,436.03
Ambulatory Care (Outpatient Visits)—85+ Years[†,1]	20,476	6,214.49	20,206	5,452.44	19,431	6,102.83	18,881	6,249.46	+34.96
Ambulatory Care (Outpatient Visits)—Total[†,1]	1,755,742	4,325.44	1,823,443	3,581.55	2,018,996	3,786.20	2,115,945	3,621.50	-703.94
Ambulatory Care (Emergency Department [ED] Visits)—<1 Year[1]	34,073	847.71	32,814	511.98	31,314	607.01	31,842	940.27	+92.56
Ambulatory Care (ED Visits)—1–9 Years[1]	351,175	434.04	351,069	259.13	360,839	301.50	358,238	430.94	-3.10
Ambulatory Care (ED Visits)—10–19 Years[1]	362,956	430.73	373,915	300.16	401,015	349.54	411,667	403.55	-27.18

Measure	HEDIS MY 2019		HEDIS MY 2020		HEDIS MY 2021		HEDIS MY 2022		Change From HEDIS MY 2019 to HEDIS MY 2022
	N	Rate	N	Rate	N	Rate	N	Rate	
Ambulatory Care (ED Visits)—20–44 Years[1]	543,335	750.52	580,531	572.00	682,370	590.04	736,254	596.34	-154.18
Ambulatory Care (ED Visits)—45–64 Years[1]	353,408	687.76	367,855	539.40	411,003	554.48	431,760	587.22	-100.54
Ambulatory Care (ED Visits)—65–74 Years[1]	59,767	762.16	65,264	647.77	80,234	616.35	92,318	580.91	-181.25
Ambulatory Care (ED Visits)—75–84 Years[1]	30,558	781.07	31,789	584.35	32,790	647.03	34,985	690.47	-90.60
Ambulatory Care (ED Visits)—85+ Years[1]	20,476	598.36	20,206	481.05	19,431	534.20	18,881	575.82	-22.54
Ambulatory Care (ED Visits)—Total[1]	1,755,742	609.52	1,823,443	450.28	2,018,996	485.16	2,115,945	534.84	-74.68
Well-Child Visits in the First 30 Months of Life—6 Visits in First 15 Months	—	—	2,607	70.35%	2,636	70.03%	2,488	71.54%	NC
Well-Child Visits in the First 30 Months of Life—2 Visits in 15 Through 30 Months	—	—	2,572	83.32%	2,901	79.46%	2,826	80.82%	NC
Asthma Medication Ratio—5–11 Years	—	—	511	74.95%	439	67.43%	462	67.53%	NC
Asthma Medication Ratio—12–18 Years	—	—	445	65.17%	430	60.47%	461	58.79%	NC
Asthma Medication Ratio—19–50 Years	—	—	1,199	49.96%	1,379	45.76%	1,638	50.00%	NC
Asthma Medication Ratio—51–64 Years	—	—	340	60.88%	436	61.24%	516	59.88%	NC
Asthma Medication Ratio—Total	—	—	2,495	59.28%	2,684	54.17%	3,077	55.61%	NC
Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—6–17 Years	429	89.04%	284	88.73%	356	85.96%	415	85.06%	-3.98%
Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—18–64 Years	705	67.23%	653	63.09%	688	65.41%	695	65.90%	-1.33%
Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—65+ Years	0	NA	0	NA	1	NA	1	NA	NC
Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total	1,134	75.49%	937	70.86%	1,045	72.44%	1,111	73.00%	-2.49%

Measure	HEDIS MY 2019		HEDIS MY 2020		HEDIS MY 2021		HEDIS MY 2022		Change From HEDIS MY 2019 to HEDIS MY 2022
	N	Rate	N	Rate	N	Rate	N	Rate	
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—6–17 Years	429	91.84%	284	91.90%	356	89.89%	415	90.84%	-1.00%
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—18–64 Years	705	75.60%	653	71.67%	688	72.67%	695	74.82%	-0.78%
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—65+ Years	0	NA	0	NA	1	NA	1	NA	NC
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total	1,134	81.75%	937	77.80%	1,045	78.56%	1,111	80.74%	-1.01%
Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—13–17 Years	—	—	—	—	—	—	34	47.06%	NC
Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—18+ Years	—	—	—	—	—	—	1,516	44.46%	NC
Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—Total	—	—	—	—	—	—	1,550	44.52%	NC
Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—13–17 Years	—	—	—	—	—	—	34	58.82%	NC
Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—18+ Years	—	—	—	—	—	—	1,516	62.14%	NC
Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Total	—	—	—	—	—	—	1,550	62.06%	NC
Developmental Screening in the First Three Years of Life—1 Year	2,649	49.83%	2,578	43.52%	2,547	45.82%	2,472	47.61%	-2.22%
Developmental Screening in the First Three Years of Life—2 Years	2,762	62.13%	2,651	57.56%	2,872	53.90%	2,766	54.19%	-7.94%

Measure	HEDIS MY 2019		HEDIS MY 2020		HEDIS MY 2021		HEDIS MY 2022		Change From HEDIS MY 2019 to HEDIS MY 2022
	N	Rate	N	Rate	N	Rate	N	Rate	
Developmental Screening in the First Three Years of Life—3 Years	2,884	59.78%	2,840	57.61%	2,884	56.14%	2,984	55.70%	-4.08%
Developmental Screening in the First Three Years of Life—Total	8,295	57.38%	8,069	53.09%	8,303	52.20%	8,222	52.76%	-4.62%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	411	69.59%	411	84.67%	411	81.75%	411	79.32%	+9.73%
Prenatal and Postpartum Care—Postpartum Care	411	65.45%	411	77.37%	411	82.97%	411	78.83%	+13.38%
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)—18–64 Years	—	—	—	—	—	—	407	42.26%	NC
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)—65–75 Years	—	—	—	—	—	—	407	7.13%	NC
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—3–11 Years	—	—	—	—	254	69.69%	232	74.57%	NC
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—12–17 Years	—	—	—	—	157	64.33%	179	64.80%	NC
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total	—	—	—	—	411	67.64%	411	70.32%	NC
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—3–11 Years	—	—	—	—	254	70.87%	232	72.84%	NC

Measure	HEDIS MY 2019		HEDIS MY 2020		HEDIS MY 2021		HEDIS MY 2022		Change From HEDIS MY 2019 to HEDIS MY 2022
	N	Rate	N	Rate	N	Rate	N	Rate	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—12–17 Years	—	—	—	—	157	56.05%	179	59.22%	NC
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	—	—	—	—	411	65.21%	411	66.91%	NC
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—3–11 Years	—	—	—	—	254	58.66%	232	68.97%	NC
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—12–17 Years	—	—	—	—	157	56.05%	179	59.22%	NC
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	—	—	—	—	411	57.66%	411	64.72%	NC

† Rates for this indicator are presented for information only.

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

— indicates that the measure is a first-year measure for HEDIS MY 2022; therefore, prior year rates are not displayed.

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

NC indicates that a comparison to benchmarks or to the prior year's rates is not appropriate either due to a change in specifications or because HEDIS MY 2022 is the first year this measure is being reported.

Overall, eight of the 35 (22.8 percent) measure rates that could be trended showed an improvement in performance since HEDIS MY 2019 (excluding information-only measures). The *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—6–17 Years* rates improved by over 15 percentage points. The *Prenatal and Postpartum Care—Postpartum Care*, *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—18–64 Years*, and *Follow-Up After*

Hospitalization for Mental Illness—7-Day Follow-Up—Total rates all improved by more than 10 percentage points from HEDIS MY 2019 to HEDIS MY 2022. Of the 26 measure rates that showed a decline in performance, the *Adults' Access to Preventive/Ambulatory Health Services—65+ Years* rate declined by more than 15 percentage points.

Compliance With Standards Trends

The 2023–2024 review was the first year of HSAG's three-year cycle of compliance reviews. Due to the travel restrictions and stay-at-home orders in many states in response to the coronavirus disease 2019 (COVID-19), AHS, HSAG, and **DVHA** agreed to perform this year's compliance review virtually. HSAG performed a desk review of **DVHA**'s documents, and the virtual review 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 requirements associated with the federal Medicaid managed care standards found at 42 CFR §438.10, §438.12, §438.100, and §438.214–§438.230.

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—Beneficiary Information (42 CFR §438.10); Provider Discrimination Prohibited (42 CFR §438.12); Enrollee Rights (42 CFR §438.100); Provider Selection, Confidentiality, Grievance and Appeal Systems, and Subcontractual Relationships and Delegation requirements (42 CFR §438.214–§438.230)
- Year 2—Practice Guidelines, Health Information Systems, and Quality Assessment and Performance Improvement (QAPI) Program standards (42 CFR §438.236, §438.242, and §438.330)
- Year 3—Access (42 CFR §438.206, §438.207, §438.208, and §438.210); Emergency and Poststabilization Services (42 CFR §438.114); and Managed Care Enrollment and Disenrollment Requirements and Limitations (§438.54–§438.56)

For this year (2023–2024—the sixteenth year of review), HSAG evaluated the 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 standards, the same standards it reviewed in 2008, 2011, 2014, 2017, and 2020.

Table 2-9 documents **DVHA**'s performance across 16 years of compliance reviews conducted by HSAG.

Table 2-9—Comparison/Trending of Scores Achieved During Compliance Reviews

Year of the Review	Year 1 Standards			Year 2 Standards			Year 3 Standards		
	Elements	Score	Corrective Action %*	Elements	Score	Corrective Action %*	Elements	Score	Corrective Action %*
2008	90	84%	30%						
2009				29	98%	3%			
2010							76	97%	7%
2011	89	90%	20%						
2012				30	100%	0%			
2013							71	99%	3%
2014	93	92%	15%						
2015				31	97%	3%			
2016							80	97%	6%
2017	84	90%	19%						
2018				33	100%	0%			
2019							68	86%	22%
2020	88	94%	11%						
2021				24	96%	4%			
2022							111	82%	28%
2023	546**	98%	3%						

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

**The increase in the total number of elements resulted from assigning individual scores to each file review and checklist element and adding those elements to the applicable standard.

For the Year 1 standards, the overall scores **DVHA** received across the six years ranged from 84 percent to 98 percent, with the overall corrective action percentages ranging from 3 percent to 30 percent. During the prior review in 2020, **DVHA** scored 94 percent across the eight standards.

Recommendations and Opportunities for Improvement

Performance Improvement Project

DVHA demonstrated proficiency in reporting and interpreting Remeasurement 1 data as well as implementing QI activities and interventions. The MCE achieved improvement in the performance

indicator, although the improvement was not statistically significant. The following are HSAG's recommendations to **DVHA** based on validation of **DVHA**'s PIP:

- **DVHA** should continue to apply lessons learned and knowledge gained during the PIP to make changes and revisions to QI processes and activities as the PIP progresses into the second remeasurement.
- **DVHA** should continue to revisit its causal/barrier analysis and QI processes frequently to ensure that it does not need to revise current interventions or develop and initiate new interventions.
- **DVHA** should seek technical assistance from HSAG as needed.

Performance Measures

HSAG offers the following recommendations related to improving **DVHA**'s performance rates of quality, timeliness, and access-related measures; data collection; and reporting processes:

- With 21 of 44 rates (47.7 percent) falling below the 50th percentile, **DVHA** should consider focusing efforts on ensuring that adults have ***access*** to preventive and ambulatory care services, breast cancer and chlamydia screenings, asthma medication ratios, and prenatal care. **DVHA** also should focus on child and adolescent measures likes weight assessment and counseling for nutrition, physical activity, and BMI percentiles.
- **DVHA** should monitor progress on Vermont's updated clinical repository, operated by Vermont Information Technology Leaders (VITL). VITL is scheduled to officially launch within the next few years, and **DVHA** should stay informed about its progress in order to identify the areas they may improve utilizing VITL.

Compliance With Standards

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

- **DVHA** must include language in its Member Handbook regarding how beneficiaries are to report suspected fraud or abuse as required in 42 CFR §438.10 and the AHD/**DVHA** IGA. Informing members could assist in improving the ***quality of care*** furnished to beneficiaries.
- **DVHA** must include formulary information that is readily accessible to beneficiaries on its website as required in 42 CFR §438.10(i)(1–3). Readily accessible formulary information could assist with improving the ***quality and accessibility of care*** furnished to beneficiaries.
- **DVHA** and its IGA partners must develop and implement uniform grievances policies and procedures and ensure that any proposed changes to the written grievances policies and procedures receive AHS approval. Developing and implementing uniform grievances policies and procedures for **DVHA** and its IGA partners could assist in improving the ***quality of care*** furnished to beneficiaries.

- **DVHA** must inform providers about a beneficiary's right to request continuation of benefits during an appeal or State fair hearing filing, and that if **DVHA**'s action is upheld in a hearing, the beneficiary may be liable for the cost of any continued benefits. **DVHA** also must inform providers about any State-determined provider appeal rights to challenge the failure of the organization to cover a service. Informing providers of a beneficiary's right to request continuation of benefits during an appeal or State fair hearing filing, and that if **DVHA**'s action is upheld in a hearing, the beneficiary's potential liability for the cost of any continued benefits could impact the ***quality, timeliness,*** and ***accessibility of care*** furnished to beneficiaries.
- **DVHA** must ensure that IGA partners, including designated agencies (DAs) and specialized service agencies (SSAs), adhere to appeals and State fair hearing policies. Formal oversight monitoring of IGA partners, including DAs and SSAs, could identify inconsistent practices across departments, allow for timely intervention to correct inconsistent practices, and improve the ***quality, timeliness,*** and ***accessibility of care*** furnished to beneficiaries.
- **DVHA** must implement a process to ensure that providers and representatives of the beneficiary, acting on behalf of the enrollee, may file an appeal with the enrollee's written consent. This process could assist to improve the ***quality, timeliness,*** and ***accessibility of care*** furnished to beneficiaries.
- **DVHA** must ensure that, when a beneficiary requests an expedited appeal, **DVHA** contacts the beneficiary by telephone to inform the individual that all evidence and allegations of fact or law must be presented as soon as possible within the 72-hour resolution period. This process could positively impact the ***quality, timeliness,*** and ***accessibility of care*** furnished to beneficiaries.
- **DVHA** must ensure through oversight and monitoring that IGA partners comply with the requirements of the IGA regarding written acknowledgment of an appeal. The Medicaid program or department that receives the appeal must notify the beneficiary in writing to acknowledge receipt of the appeal within five calendar days of receipt. This process could assist to improve the ***quality, timeliness,*** and ***accessibility of care*** furnished to beneficiaries.
- **DVHA** must ensure that the maximum total time period for the standard resolution of an internal appeal, including any extension requested by the beneficiary or based on **DVHA**'s determination that additional information is needed, and that the delay is in the best interest of the enrollee, is 44 days. This practice could assist to improve the ***timeliness*** and ***accessibility of care*** furnished to beneficiaries.
- **DVHA** and its IGA partners must ensure that all appeal resolution notices include required information. This practice could assist to improve the ***quality, timeliness,*** and ***accessibility of care*** furnished to beneficiaries.
- **DVHA** and its IGA partners should develop a mechanism to include the appeals resolution notices and other pertinent member information in the appeal file and capture the dissemination of the required information within the appeals database. This practice could assist to improve the ***quality, timeliness,*** and ***accessibility of care*** furnished to beneficiaries.
- **DVHA** must ensure, as required in 42 CFR §438.230(c)(3), that its written agreements with IGA partners, vendors, and providers include right to audit language specifically stating that the right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

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

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."[3-1] CMS has chosen the domains of quality, access, and timeliness as keys to evaluating the performance of MCOs, PIHPs, PAHPs, and PCCMs.

The following subsections include information concerning the objective of each activity included in this report, the technical methods of data collection and analysis, the description of data obtained, and how conclusions were drawn. The categorization of how HSAG formulated conclusions according to the quality, timeliness, or accessibility of care are based on the following definitions:

Quality

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

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

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."[3-3] 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.

[3-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Legislative Summary: Balanced Budget Act of 1997 Medicare and Medicaid Provisions.* Available at: https://innovation.cms.gov/files/migrated-medicare-demonstration-x/cc_section4016_bba_1997.pdf. Accessed on: Feb 2, 2024.

[3-2] U. S. Government Publishing Office. (2024). *Electronic Code of Federal Regulations*. Available at: eCFR :: 42 CFR 438.320 -- Definitions. Accessed on: Feb 2, 2024.

[3-3] National Committee for Quality Assurance. (2023). *Standards and Guidelines for Health Plans*.

Access

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

> Access, as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under §438.68 (Network adequacy standards) and §438.206 (Availability of services).[3-4]

The CFR also requires that the EQR results include a description of how the data from all activities conducted in accordance with §438.358 were aggregated and analyzed and conclusions were drawn as to the quality, timeliness, and accessibility of care furnished by the MCO, PIHP, PAHP, or PCCM entity in §438.364(a)(1).[3-5] HSAG follows a three-step process to aggregate and analyze data collected from all EQR activities and draw conclusions about the ***quality, timeliness,*** and ***accessibility of care*** furnished by the MCE as well as the program overall.

First, HSAG analyzes the quantitative results obtained from each EQR activity for the MCE to identify strengths and weaknesses in each domain of quality, timeliness, and accessibility of services furnished by the MCE for the EQR activity. Second, from the information collected, HSAG identifies common themes and the salient patterns that emerge across EQR activities for each domain, and HSAG draws conclusions about the overall quality and timeliness of, and access to care and services furnished by the MCE. Lastly, HSAG identifies any patterns and commonalities that exist across the program to draw aggregated conclusions about the ***quality***, ***timeliness***, and ***accessibility of care*** for the program.

The following subsections of the report include the strengths and opportunities for improvement and provide an assessment and evaluation of the ***quality, timeliness,*** and ***access to care*** and services of the MCE by task. That information is followed by a subsection which identifies common themes and patterns that emerged across the EQR activities for the MCE and includes conclusions about the quality and timeliness of, and access to care and services for the Vermont Medicaid beneficiaries.

Conclusions Related to the Performance Improvement Project

To draw conclusions about the ***quality***, ***timeliness***, and ***accessibility of care*** **DVHA** provided, HSAG determined which components of the *Managing Hypertension* PIP activity could be used to assess these domains. Table 3-1 illustrates the ***quality, timeliness,*** and ***access*** domains related to the *Managing Hypertension* PIP.

Table 3-1—PIP Activity Components Assessing Quality, Timeliness, and Access

PIP	Quality	Timeliness	Access
Managing Hypertension	✓	✓	✓

[3-4] U. S. Government Publishing Office. (2024). *Electronic Code of Federal Regulations*. Available at: eCFR :: 42 CFR 438.320 -- Definitions. Accessed on: Feb 1, 2024.

[3-5] U. S. Government Publishing Office. (2024). *Electronic Code of Federal Regulations*. Available at: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-E/section-438.364. Accessed on: Feb 1, 2024.

DVHA's *Managing Hypertension* PIP submission documentation provided evidence that the PIP was a scientifically sound project supported by use of key research principles, and the MCE reported and interpreted Remeasurement results accurately and conducted appropriate QI processes and interventions. **DVHA** demonstrated strengths by achieving 96 percent of CMS' Protocol 1 requirements across all steps validated.

DVHA's performance indicator was based on HEDIS technical specifications and focused on measuring the rate of Vermont Medicaid members 18 to 85 years of age with a diagnosis of hypertension whose blood pressure was adequately controlled (<140/90 mm Hg). **DVHA** specified that a systematic hybrid data collection method following HEDIS technical specifications will be used for collecting baseline and remeasurement data.

Conclusions Related to Performance Measures

To draw conclusions about the ***quality***, ***timeliness***, and ***accessibility of care*** **DVHA** provided, HSAG determined which components of each performance measure could be used to assess these domains. Table 3-2 illustrates the ***quality***, ***timeliness***, and ***access*** domains related to the performance measures included in this report. Items marked not applicable (NA) are measures evaluating utilization of services.

Table 3-2—Performance Measure Activity Components Assessing Quality, Timeliness, and Access

Performance Measure	Quality	Timeliness	Access
Adults' Access to Preventive/Ambulatory Health Services			✓
Child and Adolescent Well-Care Visits	✓	✓	✓
Breast Cancer Screening	✓	✓	✓
Chlamydia Screening in Women	✓	✓	✓
Follow-Up After Hospitalization for Mental Illness	✓	✓	✓
Initiation and Engagement of AOD Abuse or Dependence Treatment	✓	✓	✓
Ambulatory Care	NA	NA	NA
Well Child Visits in the First 30 Months of Life	✓	✓	✓
Asthma Medication Ratio	✓		✓
Follow-Up After ED Visit for Mental Illness	✓	✓	✓
Follow-Up After ED Visit for AOD Abuse or Dependence	✓	✓	✓
Developmental Screening in the First 3 Years of Life	✓	✓	✓
Prenatal and Postpartum Care	✓	✓	✓
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	✓	✓	✓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	✓		

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

DVHA staff used trending mechanisms to monitor claims submissions which ensured data completeness prior to rate production. **DVHA** also refreshed administrative data frequently to ensure inclusion of the most recent claim information available for measure calculation. [***Quality***]

DVHA partnered with Gainwell Technologies (formerly DXC Technologies) to manage its core systems. **DVHA**'s oversight of Gainwell ensured that Gainwell met the requirements for data capture and HEDIS reporting. Gainwell actively participated in quality meetings and participated in **DVHA**'s virtual review. ***[Quality, Access*]**

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 the ***quality***, ***timeliness***, and ***accessibility of care*** demonstrated strengths by meeting or exceeding the 90th percentile, including *Well-Child Visits in the First 30 Months of Life—6 Visits in First 15 Months* and *2 Visits in 15 Through 30 Months*, *Follow-Up After ED Visit for Mental Illness—7-Day* and *30-Day Follow-Up—6–17 Years, 18–64 Years*, and *Total.*

DVHA should continue to pursue all available data sources to supplement its data captured via claims. **DVHA** may benefit from the use of data from Vermont's clinical repository operated by VITL. The VITL repository, which retains patient information in a standardized format, could be used as an additional data source for future measure production. This will enhance measure rates by identifying additional values for numerator compliance. Using the VITL repository will impact the ***quality***, ***timeliness***, and ***accessibility of care*** received by beneficiaries. **DVHA** should begin to utilize data captured from electronic health records (EHRs) from providers. EHR sources would complement administrative capture and reduce reliance on hybrid abstraction. **[*Quality*]**

Conclusions Related to Compliance With Standards

To draw conclusions about the ***quality***, ***timeliness***, and ***accessibility of care*** **DVHA** provided, HSAG determined which components of each compliance review standard could be used to assess these domains. Table 3-3 illustrates the ***quality***, ***timeliness***, and ***access*** domains related to the compliance review standards.

HSAG evaluated the standards reviewed during 2023–2024 and determined the following conclusions concerning the domains of ***quality***, ***timeliness***, and ***access***. Table 3-3 illustrates the ***quality***, ***timeliness***, and ***access*** domains related to the compliance review standards.

Table 3-3—Compliance Review Standards Components Assessing Quality, Timeliness, and Access

Compliance Review Standards	Quality	Timeliness	Access
Standard I—Provider Discrimination Prohibited/Provider Selection	✓		✓
Standard II—Provider Selection/Credentialing and Recredentialing	✓		✓
Standard III—Information Requirements/Beneficiary Information	✓	✓	✓
Standard IV—Enrollee Rights/Beneficiary Rights	✓	✓	
Standard V—Confidentiality	✓		
Standard VI—Grievance and Appeal Systems/Grievances	✓	✓	✓
Standard VII—Grievance and Appeal Systems/Appeals and State Fair Hearings	✓	✓	✓
Standard VIII—Subcontractual Relationships and Delegation	✓		

Each of the compliance review standards included elements representing the domains of ***quality***, ***timeliness***, and/or ***access***. *Met* elements in the standards reviewed this year addressed all three domains. HSAG offered the following conclusions and recommendations for continued performance improvement.

- **DVHA** must include language in its Member Handbook regarding how beneficiaries are to report suspected fraud and abuse as required in 42 CFR §438.10(g)(2)(xv) and in the AHS-**DVHA** IGA. HSAG also listed this as a finding in the 2020–2021 compliance review.
- Although providers could access **DVHA**'s medication formulary on the **DVHA** website, beneficiaries could not access the formulary. **DVHA** must include formulary information that is readily accessible to beneficiaries on its website as required in 42 CFR §438.10(i)(1–3).
- **DVHA** must ensure that the department and IGA partner delegates adhere to uniform grievance rules. **DVHA** also must submit to AHS for approval any proposed changes to the rules and policies.
- **DVHA** must inform providers about a beneficiary's right to request continuation of benefits during an appeal or State fair hearing, and that if **DVHA**'s action is upheld in a hearing, the beneficiary may be liable for the cost of any continued benefits.
- **DVHA** must ensure that, if the grievance decision constitutes an action adverse to the beneficiary, the grievance review process does not delay or inhibit a beneficiary's ability to request a State fair hearing.
- **DVHA** must inform providers about any state-determined provider appeal rights to challenge the failure of the organization to cover a service.
- **DVHA** must ensure that the failure to provide a clinically indicated, covered service when the provider is a DA or SSA is included in the definition of "adverse benefit determination."
- **DVHA** must develop and implement uniform AHS-approved appeals policies and ensure that IGA partners, including DAs and SSAs, adhere to the policies and procedures.
- **DVHA** must ensure that providers and representatives of the beneficiary may file an appeal on the beneficiary's behalf with the beneficiary's written consent.

- **DVHA** must obtain and document within the appeals database a beneficiary's written consent for a provider and/or representative to file an appeal on the beneficiary's behalf.
- **DVHA** and IGA partners must resolve appeals and provide beneficiaries with written notice within the maximum time frames for standard and expedited appeals, including any extensions.
- **DVHA** must ensure that when a beneficiary requests an expedited appeal, **DVHA** contacts the beneficiary by telephone to inform the individual that all evidence and allegations of fact or law must be presented as soon as possible within the 72-hour resolution period.
- **DVHA** must ensure that it furnishes members with information regarding the appeal process and the right to participate, and that appeal resolution letters include information pertaining to members' rights to request a State fair hearing.
- **DVHA** must ensure that written agreements with IGA partners, vendors, and providers include right to audit language specifically stating that the right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

DVHA Aggregated Conclusions Concerning Strengths and Weaknesses in the Quality, Timeliness, and Access Domains

Table 3-4—Aggregated Conclusions Regarding DVHA Strengths in the Quality, Timeliness, and Access Domains

Quality	Timeliness	Access	Strengths
✓	✓	✓	The compliance review revealed that **DVHA** informed members about additional resources and programs designed to support child health and promote improved health care (e.g., Children's Integrated Services [CIS] for children from birth to age six and Children's Integrated Services–Early Intervention [CIS–EI] for children under age three who have disabilities or developmental delays). These additional programs and resources contributed to **DVHA**'s *Well-Child Visits in the First 30 Months of Life—6 Visits in First 15 Months* performance measure indicator score that met or exceeded the 95th percentile. This measure's strength provides **DVHA** with the opportunity to impact the ***quality***, ***timeliness***, and ***accessibility of care*** furnished to beneficiaries.

Table 3-5—Aggregated Conclusions Regarding DVHA Weaknesses in the Quality, Timeliness, and Access Domains

Quality	Timeliness	Access	Weaknesses
✓	✓	✓	**DVHA** scored below the 10th percentile for the following preventive care HEDIS measures: *Asthma Medication Ratio—5–11 Years*, *12–18 Years*, *19–50 Years*, and *Total*. The 2023 compliance review revealed that the Member Handbook informed members that some medications required prior authorization, that providers know which medications require prior authorization, and that providers will request the prior authorizations for members. The Member Handbook also specified that members have the responsibility to take care of their health. A review of the **DVHA** website revealed that beneficiaries could not access the formulary through the Member Information page on the **DVHA** website, which was the pathway to all beneficiary-related information on the site. Without access to the formulary, members are unable to identify which medications require prior authorization and actively participate in their health care, which could affect the ***quality***, ***timeliness***, and ***accessibility of care*** furnished to beneficiaries. **Recommendation: DVHA** must ensure that members have easy access to the formulary. **DVHA** should consider developing mechanisms to increase members' knowledge regarding health conditions and related medication authorization requirements to allow for increased participation in health care plans and decisions. This activity could positively impact the ***quality***, ***timeliness***, and ***accessibility of care*** furnished to beneficiaries.

4. Assessment of Vermont's Quality Strategy

Background

The Agency of Human Services developed the Vermont Medicaid Comprehensive Quality Strategy (CQS) and Statewide Transition Plan, dated October 11, 2021, as required by 42 CFR §438.340. CMS, Department of Health and Human Services, published the final rule in the Federal Register on May 6, 2016, and according to the Summary found at the beginning of the CFR, the final rule:

> *…modernizes the Medicaid managed care regulations to reflect changes in the usage of managed care delivery systems. The final rule aligns, where feasible, many of the rules governing Medicaid managed care with those of other major sources of coverage, including coverage through Qualified Health Plans and Medicare Advantage plans; implements statutory provisions; strengthens actuarial soundness payment provisions to promote the accountability of Medicaid managed care program rates; and promotes the quality of care and strengthens efforts to reform delivery systems that serve Medicaid and Children's Health Insurance Plan (CHIP) beneficiaries. It also ensures appropriate beneficiary protections and enhances policies related to program integrity. This final rule also implements provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) and addresses third party liability for trauma codes.*[4-1]

As specified in 42 CFR §438.340(b)(2), a State's quality strategy must include goals and objectives for continuous QI, which must be measurable and take into consideration the health status of all populations served. The CQS listed the following *Global Commitment to Health Demonstration* goals: *to increase access to care, contain health care cost, improve the quality of care, and eliminate institutional bias.*

The October 2021 CQS defined measures and baseline rates using NCQA's Quality Compass[4-2] national Medicaid HMO percentiles for HEDIS. Also, the CQS specified CY 2016 (MY 2017) as the baseline rates. Vermont established the 50th percentile annually as the benchmark for access to care and quality of care measures.

Findings

The Vermont Medicaid Managed Care Program Objectives included in the CQS identified priority areas, established performance targets, and offered time frames for achieving the objectives. The CQS goals

4-1 National Archives and Records Administration. *The Federal Register.* May 6, 2016. Available at: https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-chi ldrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered. Accessed on: Mar 15, 2024.

4-2 Quality Compass® is a registered Trademark of the National Committee for Quality Assurance (NCQA).

specified an end target date of December 31, 2021, however, the CQS did not include updated time frames for achieving performance measure goals.

Vermont requires **DVHA** to report performance measures. **DVHA** collects, analyzes, and reports on the following sets of measures: *Global Commitment to Health* Core Measure Set/HEDIS, CMS Adult Core Measure Set, CMS Child Core Measure Set, and Experience of Care and Health Outcomes[4-3] measures (i.e., Consumer Assessment of Healthcare Providers and Systems [CAHPS®][4-4] survey). The Vermont Medicaid *Global Commitment to Health* waiver program selected performance targets and metrics, including preventive care and annual care measures.

HSAG created Table 4–1 to include the most recent (MY 2022) performance scores and percentile rankings. Table 4-1 also displays the performance measures and previous five-year goals listed in the quality strategy. The table compares the MY 2020 score with the MY 2021 and MY 2022 performance scores for those measures. The table also identifies the percentile achieved for MY 2021 and MY 2022.

Table 4-1—Quality Strategy Goals Comparison of MY 2020, MY 2021, and MY 2022 Performance Rates

Quality Strategy Goal (1/1/2017—12/31/2021)	Performance Measure	MY 2020 Performance Score	MY 2021 Performance Score	MY 2021 Percentile Rank	MY 2022 Performance Score	MY 2022 Percentile Rank
AHS will maintain its performance in preventive/ambulatory care visits of Adult Medicaid managed care beneficiaries over the next five years **[*Quality* and *Access*]**	*Adults' Access to Preventive/ Ambulatory Health Services—Total*	78.46%	77.63%	25th–50th	74.37%	25th–50th
AHS will demonstrate an improvement in enrollee breast cancer screening over the next five years **[*Quality*, *Timeliness*, and *Access*]**	*Breast Cancer Screening*	48.57%	46.16%	5th–10th	50.86%	25th–50th
AHS will demonstrate an improvement in enrollee chlamydia screening in women ages 16–24 years over the next five years **[*Quality*, *Timeliness*, and *Access*]**	*Chlamydia Screening in Women—Total*	46.46%	45.79%	10th–25th	45.37%	25th–50th

4-3 ECHO® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
4-4 CAHPS® is a registered trademark of the AHRQ.

Quality Strategy Goal (1/1/2017—12/31/2021)	Performance Measure	MY 2020 Performance Score	MY 2021 Performance Score	MY 2021 Percentile Rank	MY 2022 Performance Score	MY 2022 Percentile Rank
AHS will demonstrate an improvement in follow-up after hospitalization for mental illness (7 day) over the next five years **[*Quality*, *Timeliness*,** and ***Access*]**	*Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total*	45.05%	46.04%	50th–75th	51.12%	75th–90th
AHS will demonstrate an improvement in follow-up after hospitalization for mental illness (30 day) over the next five years **[*Quality*, *Timeliness*,** and ***Access*]**	*Follow-Up After Hospitalization for Mental Illness—30-day Follow-Up—Total*	64.75%	65.83%	50th–75th	69.53%	75th–90th

In comparison to MY 2021 percentile rankings, **DVHA** demonstrated improvement in four of the five measures listed in Table 4-1. During MY 2022, three measures achieved the 25th–50th percentile and two measures achieved or exceeded the 75th percentile rank.

Recommendations

It is possible that COVID-19 impacted performance rates due to the public health emergency and temporary closing of providers' offices. Improvement in behavioral health performance measures could have been positively impacted by increased access to telehealth services.

To improve preventive care and access-related performance measures, AHS should consider focusing improvement efforts on the recommendations listed below.

- AHS should evaluate the prior established CQS goals to evaluate year-over-year performance rates to determine whether modification of current goals or the development of new goals and performance metrics are necessary to improve the ***quality***, ***timeliness***, and ***accessibility of care*** provided to beneficiaries.
- The Vermont CQS maintained that AHS' monitoring activities included requiring **DVHA** and the Departments to provide evidence of having adopted clinical practice guidelines (CPGs) for the treatment of at least two acute or chronic health conditions. To strengthen the CQS, AHS should consider requiring the adoption of additional CPGs for performance areas that have demonstrated a decreased performance rate or have not achieved the target performance rate, such as controlling high blood pressure, breast cancer screening, and chlamydia screening. Including CPGs for these performance areas could improve the ***quality***, ***timeliness***, and ***accessibility of care*** provided to beneficiaries.

- AHS should consider requiring **DVHA** to identify health care disparities within the preventive care and access-related performance measure data to focus its QI and PIP efforts on disparate populations. Improvement efforts in these areas could impact the ***quality***, ***timeliness***, *and* ***accessibility of care*** provided to beneficiaries.
- Periodically, HEDIS measures may be retired, or performance measure specifications may be modified. AHS should consider reviewing the CQS priority areas and associated objectives and performance targets to ensure these objectives and performance targets align with current HEDIS performance measure specifications. Periodic review of priority areas, objectives, and performance targets could impact the ***quality***, ***timeliness***, and ***accessibility of care*** provided to beneficiaries.
- To strengthen the CQS, AHS could consider establishing specific objectives, quantifiable performance targets, and interventions associated with continuous QI efforts to improve and sustain optimal performance rates. Once specific objectives and interventions have been established for performance measures, AHS could review performance indicator rates and identify opportunities for improvement in the ***quality***, ***timeliness***, and ***accessibility of care***. After identifying opportunities for improvement, AHS may prioritize areas of low performance and define quantifiable improvement targets to indicators so that **DVHA** and other key stakeholders know the level of achievement that is expected in future years. AHS also could consider evaluating whether the 50th percentile benchmark is appropriate for all measures.
- AHS could establish a methodology for reducing the gap between the performance measure rates and achieving the established goals. For example, AHS could recommend reducing the gap between the actual rate and the performance measure goal by 10 percent annually. Identifying the desired improvement percentages and specifying improvement targets based on the current rates for each measure could impact the ***quality***, ***timeliness***, and ***accessibility of care*** for beneficiaries.
- **DVHA** could conduct telephone outreach or virtual member focus groups to determine barriers to care that exist for beneficiaries eligible to receive mammograms or chlamydia screenings with Pap smears (e.g., lack of telephone to schedule appointments, lack of transportation, lack of childcare, and homelessness). This could improve the ***timeliness*** and ***accessibility of care***.
- **DVHA** also could implement measures to ensure appointment availability to primary care providers (PCPs) and obstetricians/gynecologists for access to breast cancer and chlamydia screenings. This could improve the ***timeliness*** and ***accessibility of care***.
- AHS/**DVHA** also could create beneficiaries' incentive payments for preventive care visits, which could improve the ***timeliness*** and ***accessibility of care***, and impact preventive care performance rates.
- AHS/**DVHA** also could develop a formal oversight and monitoring program for IGA partners to improve the consistency in coordination and continuity of care. This effort could improve the ***quality***, ***timeliness***, and ***accessibility of care*** for beneficiaries.
- AHS/**DVHA** could establish specific goals and benchmarks related to initial health screenings of all newly enrolled beneficiaries within 90 days of enrollment. This effort could enhance the identification of beneficiary special health care needs, impact the ED visit performance rates, and improve the ***quality*** and ***accessibility of care*** for beneficiaries.

5. Description of External Quality Review Activities

Validation of Performance Improvement Project

During the 2023 EQR 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 *Managing Hypertension* PIP validation activities in its Performance Improvement Projects Validation Report for **DVHA**. HSAG provided this report 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(b)(1). The purpose of a PIP is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical and nonclinical areas. This structured method of assessing and improving the Medicaid managed care model organizations' processes is expected to have a favorable effect on health outcomes and beneficiary satisfaction. AHS contracted with HSAG as the EQRO to meet the federal Medicaid managed care requirement for validating **DVHA**'s PIP. Validation of PIPs is a CMS mandatory activity.

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

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

Description of Data Obtained

HSAG reviewed the documentation that **DVHA** submitted for the one PIP validated by HSAG. **DVHA** submitted the PIP using HSAG's PIP Submission Form, which HSAG developed to collect all required data elements for the PIP validation process. **DVHA** completed and updated the PIP Submission Form following instructions provided by the HSAG PIP Team regarding the level of documentation required to address each PIP evaluation element. **DVHA** also submitted any supporting documentation that could provide further details and background information. HSAG was available to provide technical assistance throughout the PIP process. **DVHA** achieved all validation criteria except for achieving statistically significant improvement with the first submission; therefore, a resubmission was not necessary.

Technical Methods of Data Collection/Analysis

Data Collection Methods

Table 5-1—PIP Topics, HEDIS Measure, and Data Source for DVHA

PIP Topic	HEDIS Measure	Data Source
Managing Hypertension	*CBP*	*Hybrid*

HSAG conducted the validation consistent with the CMS publication, *Protocol 1: Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity,* October 2019, cited earlier in this report. 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, and in future submissions, will determine the overall success in achieving significant and sustained improvement. Over the course of the PIP, HSAG will validate the following CMS Protocol 1 steps:

- Step 1—Review the Selected PIP Topic
- Step 2—Review the PIP Aim Statement
- Step 3—Review the Identified PIP Population
- Step 4—Review the Sampling Method
- Step 5—Review the Selected PIP Indicator(s)
- Step 6—Review the Data Collection Procedures
- Step 7—Review Data Analysis and Interpretation of Results
- Step 8—Assess the Improvement Strategies
- Step 9—Assess for Significant and Sustained Improvement

HSAG's PIP validation process consisted of two independent validations that included a validation by team members with expertise in statistics, PIP 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 receipt of all required documentation.
- HSAG conducted the validation and completed the PIP Validation Tool.
- HSAG reconciled the scores by a secondary review. If the two reviewers produced scoring discrepancies, the PIP team discussed the discrepancies and reached a consensus for the final evaluation element score(s).
- Each required CMS Protocol 1 step consisted of evaluation elements necessary to complete the validation of that activity. The PIP team scored the evaluation elements within each activity as *Met*, *Partially Met*, *Not Met*, *Not Applicable* (*NA*), or *Not Assessed*. To ensure a valid and reliable review, HSAG designated some of the elements as critical elements. All critical elements must receive a *Met* score to produce valid and reliable results. The scoring methodology included the *NA* designation for

situations in which the evaluation element did not apply to the PIP. HSAG used the *Not Assessed* scoring designation when the PIP had not progressed to the remaining activities. HSAG used a General Comment when documentation for an evaluation element included the basic components to meet the requirements for the element (as described in the narrative of the PIP); however, enhanced documentation would demonstrate a stronger application of the CMS Protocol 1.

- 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 (NA):* Elements designated *NA* (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, HSAG prepared the draft and final **DVHA** Performance Improvement Projects Validation Report for AHS and **DVHA**.

Determining Conclusions

To draw conclusions about the ***quality***, ***timeliness***, and ***accessibility of care*** **DVHA** provided, HSAG determined which components of the PIP could be used to assess these domains. During contract year 2023, the **DVHA** PIP completed and updated Steps 7 and 8, reported Remeasurement 1 data, and conducted QI processes and interventions. For Remeasurement 1, **DVHA** continued with the same data collection methodology and achieved non-statistically significant improvement in the performance indicator.

Validation of Performance Measures

Validation of performance measures is a CMS mandatory EQR activity required by the BBA. State Medicaid agencies must ensure that performance measures reported by their MCOs are validated. The state, its agent that is not an MCO, or an EQRO, can perform this validation. HSAG, the EQRO for AHS, conducted the validation activities. For MY 2022, **DVHA** provided physical, mental, and behavioral health services to Medicaid-eligible recipients. HSAG validated a set of performance measures selected by AHS and calculated and reported by **DVHA**. HSAG conducted the validation activities as outlined in the CMS publication, *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023, cited earlier in this report.

Objectives and Background Information

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

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

AHS selected 15 HEDIS measures for HSAG's validation. The measurement period addressed in this report was MY 2022.

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)**, completed by **DVHA**. The Roadmap provides background information concerning **DVHA**'s policies, processes, system capabilities, and data in preparation for the virtual review 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**, obtained from **DVHA**.
- **Virtual review interviews and demonstrations**, 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 HEDIS measures. Since all the performance measures under the scope of this validation were approved by NCQA in 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-Virtual Review Activities:

- **DVHA** submitted a completed Roadmap to HSAG. HSAG performed a cursory review of the Roadmap to ensure completion of each section and that all applicable attachments were present. The review team used the Roadmap to determine if the systems' capabilities were sufficient to report the HEDIS measures.
- **DVHA** completed the medical record review (MRR) section within the Roadmap. In addition, HSAG requested and reviewed the following attachments: medical record hybrid tools and instructions, training materials for MRR staff members, and policies and procedures outlining the processes for monitoring the accuracy of the reviews performed by the review staff members. To ensure the accuracy of the hybrid data being abstracted by **DVHA**, HSAG requested that **DVHA** participate in the review of a convenience sample.
- **DVHA** used a software vendor with HEDIS Certified Measures for HEDIS MY 2022 calculation and reporting. All performance measures under the scope of this review were certified by NCQA for HEDIS MY 2022; therefore, **DVHA** was not required to submit source code.
- HSAG reviewed previous years' validation of performance measures reports to assess for trending patterns and rate reasonability.

Virtual Review Activities:

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

- HSAG conducted a closing conference to summarize preliminary findings based on the review of the Roadmap and virtual review activities (including any measure-specific concerns) and discussed follow-up actions.

Post-Virtual Review 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 years' performance and national Medicaid benchmarks.

Determining Conclusions

To draw conclusions about the ***quality***, ***timeliness***, and ***accessibility of care*** that **DVHA** provided, HSAG determined which components of each performance measure could be used to assess these domains. Upon HSAG's evaluation of the performance measure results, HSAG assigned a validation finding to each performance measure.

Monitoring of Compliance With Standards

Monitoring compliance with federal Medicaid managed care regulations and the applicable State contract requirements is one of the CMS mandatory activities. AHS contracted with HSAG to perform the **DVHA** compliance review. HSAG followed the guidelines in CMS' *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023, cited earlier in this report.

Objectives and Background Information

According to 42 CFR §438.358,[5-1] 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. 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 to continually improve its performance in providing quality, timely, and accessible care to beneficiaries.

[5-1] U. S. Government Publishing Office. (2024). *Electronic Code of Federal Regulations.* Available at: eCFR :: 42 CFR 438.358 -- Activities related to external quality review. Accessed on: Feb 2, 2024.

- 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 requirements described at 42 CFR §438.10, §438.12, §438.100, and §438.214–230, and the associated AHS IGA requirements. The primary objective of HSAG's review was to provide meaningful information to AHS and **DVHA** to use to:
  - Evaluate the quality and timeliness of, and access to, care and services **DVHA** and its IGA partners furnished to beneficiaries.
  - Identify, implement, and monitor interventions to continue to drive performance improvement for these aspects of care and services.

HSAG 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, §438.12, §438.100, and §438.214–230.

I. Provider Discrimination Prohibited/Provider Selection
II. Provider Selection/Credentialing and Recredentialing
III. Information Requirements/Beneficiary Information
IV. Enrollee Rights/Beneficiary Rights
V. Confidentiality
VI. Grievance and Appeal Systems/Grievances
VII. Grievance and Appeal Systems/Appeals and State Fair Hearings
VIII. Subcontractual Relationships and Delegation

As these same standards were reviewed during four prior audits (i.e., 2008, 2011, 2014, 2017, and 2020), HSAG evaluated **DVHA**'s current performance and compared the results to those from the earlier reviews of these same standards.

Description of Data Obtained

Table 5-2—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 virtual review	January 1—December 31, 2022
Information obtained through interviews with **DVHA** staff members	July 19–20, 2023

To assess **DVHA**'s compliance with federal regulations, State rules, and contract requirements, HSAG obtains information from a wide range of written documents produced by **DVHA**, including, but not limited to, the following for the SFY 2023 compliance review:

- Committee meeting agendas, minutes, and handouts
- Written policies, procedures, and other plan documents with creation or revision dates prior to the end of the review period (i.e., December 31, 2022)
- The Member Handbook, newsletters, and additional documents sent to members
- The Provider Manual, newsletters, and other **DVHA** communication to providers/subcontractors
- The automated member website
- The automated provider portal and directory
- Narrative and/or data reports across a broad range of performance and content areas
- MCE Questionnaire sent to the MCE with the pre-site documents

HSAG obtains additional information for the compliance review through interactive discussions and interviews with **DVHA**'s key staff members.

Technical Methods of Data Collection/Analysis

Using the AHS-approved data collection tool, HSAG performed a desk review of **DVHA**'s documents and a virtual review that included reviewing additional documents and conducting interviews with key **DVHA** staff members. Pre-virtual 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 virtual interviews conducted with **DVHA** staff members.
- Preparing and forwarding to **DVHA** a customized desk review request form and instructions for submitting the requested documentation to HSAG for its desk review. The form provided information about HSAG's compliance review activities and the timelines/due dates for each.
- Developing and providing to **DVHA** the detailed agenda for the one and one-half days virtual review.
- Responding to any questions **DVHA** had about HSAG's desk- and virtual review activities and the documentation required from **DVHA** for HSAG's desk review.
- Conducting a pre-virtual 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 virtual review.

For the review activities, three HSAG reviewers conducted the one and one-half days virtual review, which included:

- An opening conference, with introductions; **DVHA** staff members' overview of **DVHA** and its relationship with its IGA partners, providers, and subcontractors; **DVHA** updates concerning any

changes and challenges occurring since HSAG's previous review; a review of the agenda and logistics for HSAG's virtual activities; HSAG's overview of the process it would follow in conducting the virtual 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 during the virtual review.
- Interviews with **DVHA**'s key administrative and program staff members. HSAG scheduled and conducted separate interviews 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***, ***timeliness***, and ***accessibility of care*** provided to beneficiaries.

HSAG reviewers documented their findings in the compliance review tool. The tool served as a comprehensive record of the desk review and virtual review activities and the performance scores achieved by **DVHA**. HSAG made recommendations for any element that was scored as *Partially Met* or *Not Met* and offered suggestions to **DVHA** to further strengthen and drive continued improvement in **DVHA**'s performance. HSAG included the completed tool as one section of the compliance report. Table 5-3 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 5-3 also presents a more detailed, chronological description of the above activities that HSAG performed during its review.

Table 5-3—Protocol 3 Activities Performed for the Review of Compliance With Managed Care and State Regulations

Activity 1:	Establish Compliance Thresholds
	• Determine the timeline and agendas for conducting the compliance reviews with AHS • Begin developing the compliance review tool consistent with CMS protocols approximately six months prior to the review date • Collect information from AHS concerning state-specific requirements found in the Vermont AHS/**DVHA** IGA • Define scoring mechanisms used as benchmarks to quantify results from the compliance activities • Send draft compliance tool to AHS for review and comment • Receive approval of draft compliance tool from AHS • Determine the point of contact for the compliance review from **DVHA** and schedule the review • Send the compliance tool and additional pre-site documents to **DVHA** with details concerning the preliminary data needed from **DVHA**, the timeline for posting the information, and the secure website address for posting the information • Conduct webinars with **DVHA** if requesting additional information about the compliance review activities • Respond to **DVHA**'s questions concerning the requirements established to evaluate MCE performance during the compliance reviews

Activity 2:	Perform Preliminary Review
	• Receive requested pre-site documents and data files from **DVHA** • Begin completing compliance tool with information obtained from the pre-site documents • Evaluate **DVHA**'s information to gain insight into its ***quality of care***, ***timeliness of care***, and ***access to care***, and the organizations' structure, services, operations, resources, IS, quality program, and delegated functions • Determine preliminary findings before the site visit from documents submitted by **DVHA** • Specify areas and issues requiring further clarification or follow-up during the review to ensure receipt of information concerning the identified gaps in the documentation sent with the pre-site information
Activity 3:	**Conduct the Compliance Review**
	• Conduct an opening conference that includes introductions, HSAG's overview of the compliance review process and schedule, **DVHA**'s overview of its structure and processes, and a discussion concerning any changes needed to the agenda and general logistical issues • Conduct interviews with **DVHA**'s staff to obtain complete information concerning the MCE's compliance with the federal Medicaid managed care regulations and associated State contract requirements, explore any issues not fully addressed in the pre-site documents, and increase HSAG reviewers' overall understanding of **DVHA**'s performance • Collect additional documents required for the compliance review including, but not limited to, written policies and procedures, minutes of key committee or other group meetings, and data and reports across a broad range of areas • Discuss the organization's IS data collection process and reporting capabilities related to the standards included in the review • Summarize findings at a closing conference to provide **DVHA**'s staff members and AHS with a high-level summary of HSAG's preliminary findings • Provide information concerning next steps and the projected date that **DVHA** will receive the draft compliance report
Activity 4:	**Compile and Analyze Findings**
	• Complete compliance tools with findings from interviews and documents received during the virtual review • Evaluate and analyze **DVHA**'s performance complying with the requirements in each of the standards contained in the review tool • Delineate findings and designate scores (e.g., *Met*, *Partially Met*, *Not Met*, or *Not Applicable*) to document the degree **DVHA** complies with each of the requirements • Calculate a percentage of compliance rate for each individual standard and an overall percentage of compliance score across all standards

Activity 5:	Report Results to the State
	• Prepare a draft report describing HSAG's compliance review findings to include: – Scores assigned for each element within each standard – Assessments of **DVHA**'s strengths and areas requiring corrective action – Identification of best practices to share with AHS – Suggested ways to further enhance **DVHA**'s performance • Forward the draft report to AHS for review and comment • Receive approval of the draft report from AHS • Send the draft report to **DVHA** for comment • Respond to any comments made by **DVHA** • Issue a final report that includes an appendix with the compliance tool and an appendix with elements included in the corrective action plan (CAP) • Collaborate with AHS and **DVHA** to correct all elements scoring below 100 percent compliance until the revisions meet the requirements

Determining Conclusions

While the focus of a compliance review is to evaluate if **DVHA** correctly implemented the federal and State requirements, the results of the review can also determine areas of strength and weakness for **DVHA** related to the ***quality***, ***timeliness***, and ***accessibility of care***. Once HSAG calculates the scores for each standard, the reviewers evaluate each element scoring *Met, Partially Met*, and *Not Met* to determine how the elements relate to the three domains as defined on page 3-1. At that point, HSAG can draw conclusions for **DVHA** concerning the ***quality***, ***timeliness***, and ***accessibility of care*** from the results of the compliance review.

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 *NA* 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). If requested, HSAG also assists in the review of CAPs from **DVHA** to determine if the proposed corrections will meet the intent of the requirements that were scored *Partially Met* or *Not Met*.

Standards Required by CMS to Be Included in EQR Compliance Reviews

CMS established the required activities that must be monitored by EQROs during the review, conducted within the previous three-year period, to determine the MCE's compliance with the standards, and validation of network adequacy (pending the publications of the protocols for that activity). The topics required to be included in the compliance reviews are defined in 42 CFR §438 Subpart D, §438.10, 438.12, 438.100, and 438.214–230 of the BBA, and the State contractual requirements.[5-2,5-3] Those requirements are shown in Table 5-4. The 2023–2024 compliance review included standards for Year 1 of the three-year cycle.

AHS elected to establish a cycle of reviewing one-third of the compliance review standards each fiscal year. HSAG and AHS established the three-year cycle in 2007–2008, the first year that HSAG operated as the EQRO for Vermont. That same cycle has been maintained for the compliance reviews throughout the years. The cycle was established to ensure that the HSAG reviewed the required CFR elements at least every three years. Table 2-9 lists the overall scores achieved during the compliance reviews each

[5-2] U.S. Government Publishing Office. (2024). *Code of Federal Regulations.* Available at: eCFR :: 42 CFR Part 438 Subpart D -- MCO, PIHP and PAHP Standards. Accessed on Mar 18, 2024.

[5-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care*, §15, page 72818, Nov 2020. Available at: https://www.federalregister.gov/documents/2020/11/13/2020-24758/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care. Accessed on: Mar 18, 2024.

year. Table 5-4 includes the location of the requirements in the Vermont compliance tool and the year those requirements are included in the compliance review.

Table 5-4—CMS Requirements, Location of Requirements in the Vermont Compliance Tool, and Year Requirements Are Reviewed

CFR	CMS Standard	Standard in Vermont Compliance Tool	Year the Requirements Are Reviewed in Vermont		
			Year 2 2021–2022	Year 3 2022–2023	Year 1 2023–2024
§438.10	Information Requirements	Standard III—Cultural Competence		X	
§438.56	Disenrollment: Requirements and Limitations	Standard VII—Disenrollment Requirements		X	
§438.100	Enrollee Rights	Standard IV—Beneficiary Rights			X
§438.114	Emergency and Poststabilization Services	Standard VI—Emergency and Poststabilization Services		X	
§438.206	Availability of Services	Standard I—Availability of Services		X	
		Standard III–Beneficiary Information			X
§438.207	Assurances of Adequate Capacity and Services	Standard II—Assurances of Adequate Capacity and Services		X	
§438.208	Coordination and Continuity of Care	Standard IV—Coordination and Continuity of Care		X	
§438.210	Coverage and Authorization of Services	Standard V—Coverage and Authorization of Services		X	
§438.214	Provider Selection	Standard I—Provider Selection			X
		Standard II—Credentialing and Recredentialing			X
§438.224	Confidentiality	Standard V—Confidentiality			X
§438.228	Grievance and Appeals System	Standard VI—Grievance System—Beneficiary Grievances			X
		Standard VII—Grievance System—Beneficiary Appeals and State Fair Hearings			X
§438.230	Subcontractual Relationships and Delegation	Standard VIII—Subcontractual Relationship and Delegation			X

CFR	CMS Standard	Standard in Vermont Compliance Tool	Year the Requirements Are Reviewed in Vermont		
			Year 2 2021–2022	Year 3 2022–2023	Year 1 2023–2024
§438.236	Practice Guidelines	Standard I—Practice Guidelines	X		
§438.242	Health Information Systems	Standard III—Health Information Systems	X		
§438.330	Quality Assessment and Performance Improvement Program	Standard II—Quality Assessment and Performance Improvement Program	X		

6. 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 PIP 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 EQR contract year (2022–2023), HSAG validated **DVHA**'s PIP, *Managing Hypertension*. The validation process included **DVHA**'s submission of the PIP and HSAG's completion of the validation tool. For the validation of the Implementation stage, Steps 7 and 8, HSAG assessed that **DVHA** received a score of *Met* for 100 percent of the evaluation elements. **DVHA** met 100 percent of the requirements and reported its baseline rate and the QI activities conducted. The MCE completed a causal/barrier analysis, prioritized the identified barriers, and initiated interventions that have the potential to impact the performance indicator. **DVHA** also developed processes to evaluate the effectiveness of each intervention. There were no recommendations included in the PIP validation tool; however, HSAG provided the following recommendations in the annual PIP validation report.

Table 6-1—Performance Improvement Project—HSAG Recommendations/Suggestions and DVHA Actions/Outcomes

HSAG Recommendations	DVHA Actions/Outcomes
DVHA should consider shorter testing/evaluation periods for its current interventions. The testing/evaluation of interventions should allow the MCE to quickly gather data and make data-driven decisions on the status of an intervention. If the intervention is not having the desired impact, new strategies and interventions should be initiated.	**DVHA** evaluated its interventions timely and made data-driven decisions regarding the status of the intervention.
DVHA should apply lessons learned and knowledge gained during the PIP to make changes and revisions to QI processes and activities.	**DVHA** made decisions or changes to interventions and QI activities based on lessons learned through evaluating the effectiveness of each intervention.
DVHA should ensure that it addresses HSAG's validation feedback in the next annual submission.	**DVHA** addressed the validation feedback provided in the 2022 PIP validation tool, made the necessary changes, and updated its documentation.

HSAG Recommendations	DVHA Actions/Outcomes
DVHA should ensure that it references the PIP Completion Instructions throughout the PIP process to ensure that all documentation requirements have been addressed prior to the annual validation submission.	**DVHA** met all documentation requirements for each validated step of the PIP process.
DVHA should seek technical assistance from HSAG as needed.	**DVHA** did not seek technical assistance; however, the performance of the PIP and the validation status indicated that the MCE did not require assistance. HSAG communicated to **DVHA** that technical assistance is available if the MCE has any questions or requests guidance.

Validation of Performance Measures

HSAG validated 15 performance measures during the previous EQR contract year (2021–2022). HSAG auditors determined that all 15 were compliant with AHS' specifications and that the rates could be reported. As a result of HSAG's review of provided documentation and a Webex audit, HSAG described the following areas for improvement.

Table 6-2—Performance Measure—HSAG Recommendations/Suggestions and DVHA Actions/Outcomes

HSAG Recommendations	DVHA Actions/Outcomes
HSAG continues to recommend that **DVHA** monitor progress on Vermont's clinical repository, operated by VITL. VITL is scheduled to officially launch within the next few years, and **DVHA** should stay informed about its progress in order to identify the areas that may be improved by utilizing supplemental data from VITL.	**DVHA** continued to identify areas for improvement using supplemental data. There are, however, limitations to this process since many provider groups do not use electronic medical records (EMRs) and/or are not using the same type of EMR.

Monitoring Compliance With Standards

During the 2022–2023 compliance audit, HSAG evaluated the degree to which **DVHA** complied with federal Medicaid managed care regulations and the associated AHS-**DVHA** IGA (i.e., contract requirements) in seven performance categories (i.e., standards). The three standards included requirements associated with federal Medicaid managed care access standards (42 CFR §438.206–438.210), enrollment and disenrollment requirements (42 CFR §438.54–§438.56), and emergency and poststabilization services (42 CFR §438.114). The standards HSAG evaluated were those related to the following:

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

HSAG reviewed this same set of standards during the 2010, 2013, 2016, 2019, and 2022 compliance reviews.

The standards included, but were not limited to, performance requirements for **DVHA**'s processes and related documentation for:

- Having processes and tools to ensure the availability of an adequate network of providers for beneficiaries, including specialists, and as needed, out-of-network providers.
- Ensuring a network of providers sufficient to provide timely appointment and geographic access to medically necessary services, and to comply with AHS' IGA requirements for the maximum distance or time beneficiaries travel to appointments, by provider type.
- Participating in AHS' cultural competency programs and activities.
- Ensuring that beneficiaries had access to written materials in prevalent, non-English languages and free interpreter services, and providing information to beneficiaries about how they could access these materials/services.
- Ensuring that each beneficiary had an ongoing source of primary services and designating the beneficiary's PCP as responsible for coordinating beneficiary care across and among all individual and organizational providers serving the beneficiary.
- As applicable to beneficiaries' needs, enrolling specialists as PCPs.
- Providing all medically necessary services to beneficiaries in the amount, duration, and scope needed to achieve the purpose for which they were provided.
- Ensuring that **DVHA** and its IGA partners did not deny, limit, or reduce services based solely on the beneficiary's diagnosis or type of condition/illness.

- Ensuring that care provided was consistent with generally accepted practice, and that the medical director and/or his or her qualified designee(s) made all medical/clinical determinations.
- Having and, as applicable, ensuring that its IGA partners had written policies and procedures for processing and responding to requests in a timely manner for initial and ongoing services.
- Using qualified health care professionals, reviewing and meeting CMS/AHS requirements for timely processing, and responding to beneficiary and provider requests for services.
- Meeting CMS/AHS timelines and requirements for providing timely notice of adverse actions related to requests for services/continuation of services.
- Including all required information in the notices of actions sent to providers and beneficiaries, including any decisions to extend the associated timelines for making decisions, as applicable.
- Ensuring that **DVHA** and its IGA partners did not compensate individuals or entities conducting utilization review (UR) activities so as to provide incentives to deny, limit, or discontinue medically necessary services.
- Ensuring the availability of emergency services 24 hours a day, seven days a week; applying the "prudent layperson" criteria in defining "emergency services"; not limiting or defining "emergency services" based on a list of diagnoses or symptoms; and complying with CMS/AHS requirements related to coverage and payment of emergency services.
- Ensuring that **DVHA** and its IGA partners covered and paid for medically necessary poststabilization services and adhered to applicable requirements related to any cost for the beneficiaries.
- Providing all CMS/AHS-required information to new beneficiaries.
- Ensuring that **DVHA** and its enrollment broker did not disenroll beneficiaries based on any of the CMS/AHS prohibited reasons for disenrollment.

HSAG reviewed **DVHA**'s performance related to 111 elements across the seven standards. Of the 111 requirements, **DVHA** obtained a score of *Met* for 78 elements, a score of *Partially Met* for 25 elements, and a score of *Not Met* for eight elements. As a result, **DVHA** obtained a total percentage of compliance across the 111 requirements of 81.5 percent, for which HSAG offered suggestions to **DVHA** to further strengthen its processes, performance, and documentation.

Table 6-3—Monitoring Compliance With Standards—HSAG Recommendations/Suggestions and DVHA Actions/Outcomes

HSAG Recommendations	DVHA Actions/Outcomes
DVHA must ensure that in establishing and maintaining the provider network consideration is given to the geographic location of providers and Global Commitment to Health Demonstration enrollees related to distance, travel time, and the means of transportation ordinarily used by Medicaid enrollees as required by IGA §2.10.1 and 42 CFR §438.68(c)(1)(vi).	HSAG closed this element after receiving written confirmation from AHS' Director of Healthcare Policy that AHS is removing time/distance requirements from State code. AHS also confirmed that the department considered distance, travel time, and the means of transportation ordinarily used by Medicaid enrollees when developing the newly established ratio requirements. **DVHA** began monitoring beneficiary-to-provider ratios using AHS-developed network adequacy standards.
DVHA must ensure that if the contracted network is unable to provide medically necessary services covered under the AHS IGA to a particular enrollee, **DVHA** adequately and in a timely manner covers these services out of network for the enrollee for as long as the entity is unable to provide them.	**DVHA** developed a standard operating procedure (SOP) to address this requirement and planned revisions to the Member Handbook to include out-of-network information.
DVHA must include information in plan documents to address the requirement that **DVHA** and its IGA partner delegates do not charge the enrollee more for services obtained out of the network than the enrollee would be charged if he or she had obtained the services through an in-network provider.	**DVHA** planned revisions to the Member Handbook to include information pertaining to out-of-network charges to beneficiaries.
DVHA must develop and implement an Access to Care Plan that meets all AHS requirements outlined in the AHS/**DVHA** IGA.	HSAG closed this element after receiving written confirmation from AHS' Director of Healthcare Policy that AHS is removing time/distance requirements from State code. AHS also confirmed that the department considered distance, travel time, and the means of transportation ordinarily used by Medicaid enrollees when developing the newly established ratio requirements. AHS will work with **DVHA** to ensure that providers meet established requirements for access to care and services.
DVHA must develop plan documents that include information for providers regarding timely access to care requirements based on the beneficiary's urgency of need.	HSAG closed this element after receiving written confirmation from AHS' Director of Healthcare Policy that AHS is removing time/distance requirements from State code. AHS also confirmed that the department considered distance, travel time, and the means of transportation ordinarily used by Medicaid enrollees when developing the newly established ratio requirements. AHS will work with **DVHA** to ensure that providers meet established requirements for access to care and services. **DVHA** developed Network Adequacy Reports to demonstrate monitoring of member access to provider ratios.

HSAG Recommendations	DVHA Actions/Outcomes
DVHA must ensure that network providers comply with the timely access requirements.	HSAG closed this element after receiving written confirmation from AHS' Director of Healthcare Policy that AHS is removing time/distance requirements from State code. AHS also confirmed that the department considered distance, travel time, and the means of transportation ordinarily used by Medicaid enrollees when developing the newly established ratio requirements. AHS will work with **DVHA** to ensure that network providers comply with established access requirements.
DVHA must ensure that urgent care access standards are disseminated to all PCPs and specialist providers in the provider network.	HSAG closed this element after receiving written confirmation from AHS' Director of Healthcare Policy that AHS is removing time/distance requirements from State code. AHS also confirmed that the department considered distance, travel time, and the means of transportation ordinarily used by Medicaid enrollees when developing the newly established ratio requirements. AHS will work with **DVHA** to ensure that providers maintain timely access to urgent care services within 24 hours.
DVHA must ensure that access standards for non-urgent, non-emergent conditions are disseminated to all PCPs and specialist providers in the provider network.	HSAG closed this element after receiving written confirmation from AHS' Director of Healthcare Policy that AHS is removing time/distance requirements from State code. AHS also confirmed that the department considered distance, travel time, and the means of transportation ordinarily used by Medicaid enrollees when developing the newly established ratio requirements. AHS will work with **DVHA** to ensure that providers maintain timely access to care for non-urgent, non-emergent conditions within 14 days.
DVHA must ensure that access standards for preventive care are disseminated to all PCPs and specialist providers in the provider network.	HSAG closed this element after receiving written confirmation from AHS' Director of Healthcare Policy that AHS is removing time/distance requirements from State code. AHS also confirmed that the department considered distance, travel time, and the means of transportation ordinarily used by Medicaid enrollees when developing the newly established ratio requirements. AHS will work with **DVHA** to ensure that providers maintain timely access to preventive care within 90 days.

HSAG Recommendations	DVHA Actions/Outcomes
DVHA must generate geographic access reports to determine if the requirement for beneficiaries to access PCP services within 30 miles is met.	HSAG closed this element after receiving written confirmation from AHS' Director of Healthcare Policy that AHS is removing time/distance requirements from State code. AHS also confirmed that the department considered distance, travel time, and the means of transportation ordinarily used by Medicaid enrollees when developing the newly established ratio requirements. AHS will work with **DVHA** to ensure that members have timely access to PCPs.
DVHA must generate geographic access reports to determine if the requirement for beneficiaries to access hospital services within 30 minutes is met.	HSAG closed this element after receiving written confirmation from AHS' Director of Healthcare Policy that AHS is removing time/distance requirements from State code. AHS also confirmed that the department considered distance, travel time, and the means of transportation ordinarily used by Medicaid enrollees when developing the newly established ratio requirements. AHS will work with **DVHA** to ensure that members have access to hospital services.
DVHA must generate geographic access reports to determine if the requirement for beneficiaries to access ophthalmology/optometry services within 60 miles is met.	HSAG closed this element after receiving written confirmation from AHS' Director of Healthcare Policy that AHS is removing time/distance requirements from State code. AHS also confirmed that the department considered distance, travel time, and the means of transportation ordinarily used by Medicaid enrollees when developing the newly established ratio requirements. AHS will work with **DVHA** to ensure that providers meet access requirements for ophthalmology/optometry services.
DVHA must generate geographic access reports to determine if the requirement for beneficiaries to access lab and advanced imaging services within 60 miles is met.	HSAG closed this element after receiving written confirmation from AHS' Director of Healthcare Policy that AHS is removing time/distance requirements from State code. AHS also confirmed that the department considered distance, travel time, and the means of transportation ordinarily used by Medicaid enrollees when developing the newly established ratio requirements. AHS will work with **DVHA** to ensure that providers meet access requirements for lab and advanced imaging services.

HSAG Recommendations	DVHA Actions/Outcomes
DVHA must generate geographic access reports to determine if the requirement for beneficiaries to access pharmacy and dental services within 60 miles is met.	HSAG closed this element after receiving written confirmation from AHS' Director of Healthcare Policy that AHS is removing time/distance requirements from State code. AHS also confirmed that the department considered distance, travel time, and the means of transportation ordinarily used by Medicaid enrollees when developing the newly established ratio requirements. AHS will work with **DVHA** to ensure that providers meet access requirements for pharmacy and dental services.
DVHA must generate geographic access reports to determine whether travel distance and travel time requirements are met. This finding was also noted in the SFY 2019–2020 review of this standard.	HSAG closed this element after receiving written confirmation from AHS' Director of Healthcare Policy that AHS is removing time/distance requirements from State code. AHS also confirmed that the department considered distance, travel time, and the means of transportation ordinarily used by Medicaid enrollees when developing the newly established ratio requirements. AHS will work with **DVHA** to ensure that providers meet established access requirements.
DVHA must monitor IGA partners' performance through a formal review according to a periodic schedule established by the State, consistent with industry standards or State laws and regulations. HSAG recommended during the 2019 compliance review of this standard that **DVHA** develop a formal monitoring process to ensure that IGA partners' case management care plans and care coordination activities are conducted and documented in compliance with established rules and IGA requirements.	**DVHA** began developing SOPs to include monitoring and oversight activities. The process is still in development. **DVHA** will work with AHS to ensure compliance with oversight and monitoring requirements related to IGA partners' case management care plans. **DVHA** will monitor these elements through home- and community-based services (HCBS) quality assurance performance management activities. Care coordination activities will be conducted and documented in compliance with established rules and IGA requirements.
DVHA must ensure that oversight and monitoring activities are documented to support compliance with established rules and IGA requirements.	**DVHA** began developing SOPs to include monitoring and oversight activities. The process is still in development. **DVHA** will work with AHS to ensure compliance with oversight and monitoring requirements related to IGA partners' case management care plans. Care coordination activities will be conducted and documented in compliance with established rules and IGA requirements.

HSAG Recommendations	DVHA Actions/Outcomes
DVHA must develop processes and implement mechanisms to ensure that beneficiaries with special health care needs are assessed and have a treatment plan that is: (a) developed by appropriate health care professionals, and (b) developed by the enrollee's PCP with enrollee participation, and in coordination with any specialists caring for the enrollee.	This element has been deleted from the CAP due to the revisions in the IGA between AHS and **DVHA**. **DVHA** is aware that 42 CFR §438.208 requires that the MCE produce a treatment plan or service plan for enrollees who require long-term services and supports (LTSS), and if the State requires, for enrollees with special health care needs that are determined through assessment to need a course of treatment or regular care monitoring. The treatment plans must be developed by the appropriate health care professional with enrollee participation, and in consultation with any providers caring for the enrollee, as outlined in the federal requirements.
DVHA must ensure that care coordination treatment plans identify specialist services that may be accessed directly by the enrollee as appropriate for that enrollee's condition and identified needs.	This element has been deleted from the CAP due to the revisions in the IGA between AHS and **DVHA**. **DVHA** is aware that 42 CFR §438.208(c)(4) requires enrollees with special health care needs, as determined through an assessment to need a course of treatment or regular care monitoring, the MCE must have a mechanism in place to allow enrollees to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs.
DVHA must ensure that care coordination treatment plans for enrollees with special health care needs conform to the State's quality assurance and UR standards.	**DVHA** will monitor this element by using four home- and HCBS quality measures: comprehensive assessment and update, comprehensive care plan and update, shared care plan with PCP, and reassessment or care plan update after inpatient discharge. HSAG suggested that **DVHA** develop a written process to explain how each HCBS quality measure will be used to ensure that treatment plans conform to quality assurance and UR standards. The written process also should furnish details on the responsible party/department, frequency of monitoring, actions to be taken based on monitoring findings, etc.
DVHA must ensure that there is a unified treatment plan for enrollees with special health care needs to prevent enrollees from receiving duplicative case management/care coordination services.	This element has been deleted from the CAP due to the revisions in the IGA between AHS and **DVHA**. **DVHA** is aware that 42 CFR §438.208(b)(4) requires that the MCE share with the State or other entities serving the enrollee the results of any identification and assessment of an enrollee's needs to prevent duplication of those activities.

HSAG Recommendations	DVHA Actions/Outcomes
DVHA and its IGA partners must ensure that in the process of coordinating care, each enrollee's privacy is protected in accordance with the privacy requirements in 45 CFR §160 and 164 Subparts A and E, as applicable.	**DVHA** proposed language to be inserted in partner departments' memorandums of understanding (MOUs) regarding the requirements for ensuring the privacy of member information in accordance with Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy laws.
DVHA and its IGA partners must document and ensure that written processes to ensure compliance with HIPAA privacy rules are approved by the Compliance Committee.	**DVHA** proposed language to be inserted in partner departments' MOUs regarding expectations of a formal monitoring process related to privacy procedures to ensure adherence to the standards. Partner departments must submit annual attestations to the AHS Privacy Officer that the privacy practices were followed and disclosure of any cases where the privacy practices were not followed. The AHS Privacy Officer reports a summary of attestations and disclosures annually to the **DVHA** Quality Committee.
DVHA and its IGA partners must provide best efforts to conduct an initial screening of each enrollee's needs, within 90 days of the effective date of enrollment for all new enrollees, including subsequent attempts if the initial attempt to contact the enrollee is unsuccessful.	**DVHA** revised the New to Medicaid Outreach Workflow diagram to include the requirement to make best efforts to conduct an initial screening of each enrollee's needs, within 90 days of the effective date of enrollment for all new enrollees. **DVHA** must include subsequent attempts if the initial attempt to contact the enrollee is unsuccessful to comply with 42 CFR §438.208(b)(3). **DVHA** also developed a performance measure that is used as a monitoring tool.
DVHA must ensure that the contract with each IGA partner properly reflects the partner's responsibility for approving prior authorizations.	**DVHA** conducted education and training for the Clinical Operations team related to expedited authorization decisions and notifications as required by the CFR. **DVHA** also required newly hired employees to review the process within the first two weeks of employment, and all Clinical Operations staff members to review the procedure annually. **DVHA** developed proposed language to be inserted in partner departments MOUs with AHS to include 42 CFR §438.210 requirements related to authorizations of services; a requirement for a formal monitoring process to ensure adherence to the standards; and annual submission of an attestation to the **DVHA** Quality Committee.

HSAG Recommendations	DVHA Actions/Outcomes
DVHA must ensure that Vermont Department of Health documents its prior authorization processes and that the written processes are approved by the **DVHA** Compliance Committee.	**DVHA** developed proposed language to be inserted in partner departments' MOUs with AHS to include 42 CFR §438.210 requirements related to authorizations of services, a requirement for a formal monitoring process to ensure adherence to the standards, and annual submission of an attestation to the **DVHA** Quality Committee. The annual submission must stipulate that the authorization processes were followed and include the disclosure of any deviations from the procedures. The Vermont Department of Health (VDH) created an SOP for Children's Personal Care Services, in which program eligibility and authorization of services is outlined. This SOP is an example of the authorization process for services delegated to partner delegees and providers.
DVHA must ensure that the MCE meets the timelines established for standard authorization decisions and notifications as required in 42 CFR §438.210(d)(1).	**DVHA** developed report dashboards for the Percentage of Initial Prior Authorization Requests with a Decision Rendered within 14- and 28-Days. The monthly dashboard allows **DVHA** to monitor and track trends in prior authorization decisions and modify internal processes as necessary to meet compliance requirements.
DVHA must provide education for all staff responsible for making authorization decisions regarding the specific federal time frame requirements for making expedited authorization decisions as described in **DVHA**'s Clinical Operations Unit Procedure Manual.	**DVHA** provided staff education to the Clinical Operations team on January 19, 2023, concerning the expedited authorization decisions and notifications as required in the CFR. Newly hired employees must review the process within the first two weeks of employment, and all Clinical Operations staff members must review the procedure manual annually.
DVHA must create plan documents to confirm that **DVHA** and its IGA partner delegates do not limit or define what constitutes an emergency medical condition based on a list of diagnoses or symptoms.	**DVHA** proposed revisions to the Member Handbook to acknowledge that **DVHA** and its IGA partner delegates do not limit or define what constitutes an emergency medical condition based on a list of diagnoses or symptoms.
DVHA must develop plan documents to confirm that **DVHA** and its IGA partner delegates do not refuse to cover emergency services based on a failure on the part of the emergency room provider, hospital, or fiscal agent to notify the enrollee's provider, the responsible department, or **DVHA** of the beneficiary's screening and treatment within 10 calendar days of the enrollee's presentation for emergency services.	**DVHA** updated the Vermont Medicaid General Billing and Forms Manual to specify that **DVHA** does not require the emergency room provider, hospital, or fiscal agent to notify the enrollee's provider or **DVHA** of the enrollee's screening and treatment within 10 calendar days of the enrollee's presentation for emergency services.

HSAG Recommendations	DVHA Actions/Outcomes
DVHA must create plan documents to confirm that **DVHA** and its IGA partner delegates do not refuse to cover and pay for emergency services when the enrollee is instructed by **DVHA** or an IGA partner delegate representative to seek emergency services, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of emergency medical condition.	**DVHA** proposed revisions to the Member Handbook to address the requirements that **DVHA** and its IGA partner delegates do not refuse to cover and pay for emergency services when the enrollee is instructed by **DVHA** or an IGA partner delegate representative to seek emergency services, including cases in which the absence of immediate medication attention would not have had the outcomes specified in the definition of emergency medical condition.
DVHA must create plan documents to support the requirement that **DVHA** and its IGA partner delegates do not refuse to cover and pay for emergency services when an enrollee has an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the federal regulations and the AHS/**DVHA** IGA when defining emergency medical condition.	**DVHA** proposed revisions to the Member Handbook to address the requirements that **DVHA** and its IGA partner delegates do not refuse to cover and pay for emergency services when an enrollee has an emergency medical condition. This includes cases in which the absence of immediate medication attention would not have had the outcomes specified in the federal regulations and the AHS/**DVHA** IGA when defining emergency medical condition.
DVHA's plan documents must include information concerning the requirement that **DVHA**/its IGA partner delegates are financially responsible/pay for poststabilization services obtained from any provider, regardless of whether the provider is within or outside **DVHA**'s provider network, that are not prior authorized by a **DVHA**/IGA partner delegate provider or representative but are administered to maintain, improve, or resolve the enrollee's stabilized condition if: a) **DVHA** or an IGA partner delegate does not respond to the provider's request for precertification or prior authorization within one hour. b) **DVHA**/an IGA partner delegate cannot be contacted. c) **DVHA**'s/an IGA partner delegate's representative and the attending physician cannot agree concerning the enrollee's care/treatment and a **DVHA**/IGA partner physician is not available for consultation. In this situation, **DVHA**/the IGA partner delegate allows the treating physician to continue with care of the enrollee until a **DVHA**/IGA partner delegate plan physician is reached or the enrollee/patient is discharged.	**DVHA** developed the Emergency and Post Stabilization Services SOP to document **DVHA**'s understanding of the federal regulation and how **DVHA** operates to comply with the requirements.

HSAG Recommendations	DVHA Actions/Outcomes
DVHA's plan documents must include information concerning the requirement that **DVHA** and its IGA partner delegates retain financial responsibility for poststabilization services they have not approved until one of the following occurs: a) An in-network provider with privileges at the treating hospital assumes responsibility for the enrollee's care. b) An in-network provider assumes responsibility for the enrollee's care through transfer. c) **DVHA**'s/the IGA partners' delegate representative and the treating physician reach an agreement concerning the enrollee's care. d) The enrollee is discharged.	**DVHA** developed the Emergency and Post Stabilization Services SOP to document **DVHA**'s understanding of the federal regulation and how **DVHA** operates to comply with the requirements.
DVHA must create documentation to confirm that, in the event the enrollee receives poststabilization services from a provider outside of **DVHA**'s network, **DVHA** limits charges to the member to an amount no greater than what **DVHA** would charge if he or she had obtained the services through an in-network provider.	**DVHA** updated the General Billing Forms Manual to include language to address the requirements that if an enrollee receives poststabilization services from a provider outside of **DVHA**'s network, **DVHA** must limit charges to the member to an amount no greater than what **DVHA** would charge if the member obtained the services through an in-network provider.
DVHA must monitor the contents and mailing of Member Handbooks to ensure that every newly enrolled beneficiary receives notification concerning enrollee rights, appeal and State fair hearing rights, confidentiality rights, availability of the Healthcare Ombudsman, and enrollee-initiated disenrollment.	**DVHA** added language in the contract amendment with Maximus to specify the time frame by which the subcontractor must mail Member Handbooks to new enrollees. **DVHA** also developed a monitoring tool to capture data from three different reports. The reports will be used to reconcile the number of new enrollees with the number of handbooks mailed each week. This reconciliation will be rolled up into a reported 13-week quarter and captured in a new scorecard. Additionally, **DVHA** developed a new monitoring tool to ensure all new members receive a handbook and thereby receive notification concerning enrollee rights, appeal and State fair hearing rights, confidentiality rights, availability of the Healthcare Ombudsman, and enrollee-initiated disenrollment.
DVHA must have documentation to support the requirement to make a good faith effort to provide notice of termination of a contracted provider within 15 days after receipt or issuance of a termination notice, and monitoring to ensure that each enrollee who received his or her primary care from, or was seen regularly by, the terminated provider receives the notice.	**DVHA** proposed the addition of language to the Maximus contract amendment regarding the requirements to notify Medicaid members of terminating providers. **DVHA** also created the Beneficiary Notification of Provider Termination and a Provider Terminations letter template that contained language to address the requirements of this element.

HSAG Recommendations	DVHA Actions/Outcomes
DVHA's documentation concerning disenrollment must include a list of prohibited disenrollment to include an adverse change in the enrollee's status, utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs.	**DVHA** created a Prohibited Reasons for Disenrollment DVHA.pdf document that addressed the list of prohibited reasons for disenrollment. The reasons included an adverse change in the enrollee's status, utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from an enrollee's special needs.
DVHA must create plan documents to define the process to review individuals who lose eligibility in the Global Commitment to Health Demonstration by comparing, at least monthly, the active Global Commitment to Health Demonstration enrollee list with the Economic Services Division's eligibility list to confirm Medicaid status for all Global Commitment to Health Demonstration enrollees.	Based on changes to the requirements of the AHS/**DVHA** IGA, **DVHA** is no longer responsible for reviewing individuals who lose eligibility in the Global Commitment to Health Demonstration. Past requirements included comparing, at least monthly, the active Global Commitment to Health Demonstration enrollee list with the Economic Services Division's eligibility list to confirm Medicaid status for all Global Commitment to Health Demonstration enrollees.
DVHA must develop plan documents to explain the process used to ensure that it makes a good faith effort to provide notice of termination of a contracted provider within 15 days after receipt or issuance of a termination notice to each enrollee who received his or her primary care from, or was seen regularly by, the terminated provider.	**DVHA** implemented the Beneficiary Notification of Provider Termination SOP and developed a Provider Terminations letter template that contained language to address the requirements of this element.