State of Vermont
Agency of Human Services

Global Commitment to Health
11-W-00194/1

Annual Report
for FFY 07
October 1, 2006 to September 31, 2007

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Background and Introduction

The Global Commitment to Health is a Demonstration Initiative operated under a Section 1115(a) waiver granted by the Centers for Medicare and Medicaid Services, within the Department of Health and Human Services.

The state of Vermont is a national leader in making affordable health care coverage available to low-income children and adults. Vermont was among the first states to expand coverage for children and pregnant women, through the implementation in 1989 of the state-funded Dr. Dynasaur program. In 1992, Dr. Dynasaur became part of the state-federal Medicaid program.

When the federal government introduced the State Children's Health Insurance Program (SCHIP) in 1997, Vermont extended coverage to uninsured and under-insured children living in households with incomes below 300 percent of the Federal Poverty Level (FPL).

In 1995, Vermont implemented an 1115(a) waiver program, the Vermont Health Access Plan (VHAP). That program's primary goal was to expand access to comprehensive health care coverage for uninsured adults with household incomes below 150 percent (later raised to 185 percent) of FPL, through enrollment in managed care. VHAP also included a prescription drug benefit for low-income Medicare beneficiaries who did not otherwise qualify for Medicaid. Both waiver populations pay a modest premium on a sliding scale based on household income.

Implemented October 1, 2005, the Global Commitment converts the Office of Vermont Health Access (OVHA), the state's Medicaid organization, to a public Managed Care Organization (MCO). AHS will pay the MCO a lump sum premium payment for the provision of all Medicaid services in the state (with the exception of the Long-Term Care Waiver, managed separately). A Global Commitment to Health Waiver Amendment, approved October 31st 2007 by CMS, allows Vermont to implement the Catamount Health Premium Subsidy Program with the corresponding commercial Catamount Health Program (implemented by state statute October 1, 2007). The Catamount Plan is a new health insurance product offered in cooperation with Blue Cross Blue Shield of Vermont and MVP Health Care. It provides comprehensive, quality health coverage at a reasonable cost no matter how much an individual earns. The intent of this program is to reduce the number of uninsured citizens of Vermont. Subsidies are available to those who fall at or below 300% of the federal poverty level (FPL). Vermont claims federal financial participation for those uninsured Vermonters who fall at or below 200% of the FPL. For those individuals who fall between 200 and 300% Vermont provides subsidies through general fund revenue. Benefits include doctor visits, check-ups and screenings, hospital visits, emergency care, chronic disease care, prescription medicines and more.

The Global Commitment and its newest amendment provide the state with the ability to be more flexible in the way it uses its Medicaid resources. Examples of this flexibility include new payment mechanisms (e.g., case rates, capitation, combined funding streams) rather than fee-for-service, to pay for services not traditionally reimbursable through Medicaid (e.g., pediatric psychiatric consultation) and investments in programmatic innovations (e.g., the Vermont Blueprint for Health). The managed care model will also encourage inter-departmental collaboration and consistency across programs.

One of the Terms and Conditions of the Global Commitment Waiver requires the State "to submit progress reports 60 days following the end of each quarter. This is the annual report for the second waiver year, fiscal year 2007.

Accomplishments

MCO Work Plan & Requirements: As an MCO, the OVHA must adhere to federal rules for Medicaid MCOs. During the first two waiver years the AHS and OVHA completed almost all activities in its initial work plan to ensure compliance with federal regulations. Accomplishments in the work plan include, but are not limited to;

- Filings, comments, and testimony were completed for MCO grievance and appeal implementation, and rules were effective July 1, 2007.
- Creation of a web based provider directory which includes provider names, locations and telephone numbers for all primary care and specialist providers and hospitals participating in the Medicaid program. This web based directory allows individuals to search by address, provider type, etc.
- Development of three handbooks for three populations; the Health Care Programs [Medicaid, Dr. Dynasaur, Vermont Health Access Plan (VHAP), VHAP-employer-sponsored insurance (ESI), Pharmacy Programs (VHAP-Pharmacy, VScript, VScript expanded, VPharm), and Premium Assistance Programs [Employer-sponsored Insurance (ESI), Catamount Health Premium Assistance]. They were sent to all departments in the MCO and to advocates for comments. The mailing to all households is scheduled for December 2007.
- Establishment of information and direct web page link to statewide information on advanced directives.
- Establishment of a medical advisory task force to provide consultation for clinical practice guideline development and review.
- Development of procedures related to fraud and abuse detection including: designation of a compliance officer in OVHA; completion of a compliance plan to guard against fraud and abuse including standards of conduct and staff training; implementation of a new automated fraud abuse detection system within the MMIS.
- Development of an initial utilization management plan.

Technical Assistance from CMS Regional Office: Vermont has relied on CMS regional staff for technical assistance in areas ranging from quality assurance and evaluation to fiscal reporting processes and formats. Regional staff have been very responsive, timely and helpful in providing technical assistance, supporting materials and helping Vermont understand and implement MCO requirements in the context of a state government system.

Collaborations with the Joint Fiscal Office: The State has continued its collaborative process with which to develop consensus documents and agreements between the Executive and Legislative branches related to Global Commitment budgets, trends and projections. This detailed level of fiscal consensus building is the first of its kind between the branches of state government and has yielded a productive and collaborative discussion of the pressures on our public and private health care delivery systems.

Several notable changes in key AHS leadership were made since the beginning of waiver year two. Patrick Flood was appointed Deputy Secretary of the Agency in June, 2007. James Giffin was appointed as Agency Chief Financial Officer in August, 2007. Monica Light began work as AHS MCO Financial Administrator in April, 2007. Suzanne Santarcangelo, formerly Special Assistant to the Secretary, was hired as Director of AHS Health Care Operations, Compliance and Improvement in Dec 2008. Matt Riven began employment as Assistant Agency CFO in January, 2008.

Despite Vermont's changes in staffing and the challenges of competing healthcare demands, the AHS and MCO made considerable progress in meeting MCO requirements under 42 CFR section 438.

Project Status

During year two the Quality Assurance Performance Improvement Committee drafted a Quality Strategy that identified agency-wide MCO quality standards, performance measures, and a performance improvement project. Prior to drafting the strategy, the committee spent time reviewing Federal Quality Assessment and Performance Improvement Standards, establishing a Quality Framework, and reviewing current AHS-wide Performance Measures and Performance Improvement Projects. The AHS Quality Improvement Manager worked with OVHA and its sub-contracted departments/divisions to continue to develop an inventory of current Performance Measures and Performance Improvement Projects and to identify how and where the MCO standards contained in the CFR are applicable to Vermont's public MCO. The aforementioned quality framework was used as a guide to facilitate committee discussion re: identification of possible performance measures to help inform the written Quality Strategy.

The committee recommended that the MCO collect and report performance measures that illuminate the following focus areas:

- Preventive care (i.e., immunizations, dental visits, prenatal/postpartum care, well-child and adolescent well-care visits)
- Chronic conditions (i.e., asthma, diabetes, depression), and
- Consumer experience of care (i.e., getting needed care, getting care quickly, customer service, and overall rating of health plan)

HEDIS (*The Health Plan Employer Data and Information Set*) measures are used to assess the first two focus areas while CAHPS (The Consumer Assessment of Healthcare Providers and Systems) measures are used to evaluate the third.

The Quality Assurance Performance Improvement committee also explored competing performance improvement methodologies. Members attended a one-day workshop conducted by Mark Friedman titled "Results Accountability Decision-Making and Budgeting." The morning session provided education and information re: Quality Assurance Performance Improvement methodologies, while the afternoon provided specific feedback to members re: proposed Quality Strategy performance measures and performance improvement projects.

Finally, members of the Quality Assurance Performance Improvement committee recommended a performance improvement project that focused on Preventive Care. The project uses the following performance measures for children and youth entering State custody:

- Adolescent Well-Care Visit (HEDIS®)
- Childhood Immunization Status (HEDIS®)
- Adolescent Immunization Status (HEDIS®)

External Quality Review: A new EQRO contract manager was appointed. Beginning January 2, 2007, the EQRO contract was formally transferred from OVHA to AHS and Cathleen Gent assumed the management responsibilities of the EQRO contract. In addition to changes in the contract manager, modifications were made to deliverable three of the scope of work to broaden the focus of the EQRO from the CRT population to all those enrolled in the Global Commitment (GC) to Health Waiver.

Changes to deliverable three allowed the EQRO to focus their consulting efforts on advancing the GC Quality Strategy as well as the GC Waiver Evaluation. A copy of the original EQRO contract and a copy identifying the agreed upon modifications was set to CMS

Throughout the year, the AHS Quality Improvement Manager attended quarterly meetings with the EQRO. During these meetings, updates on current deliverables were provided and consulting activities re: Global Commitment (GC) Quality Strategy and the GC Waiver Evaluation were discussed. During the last quarter of the year, the EQRO submitted their annual technical report to AHS. After review by AHS, OVHA, and DMH, the EQRO annual technical report was forwarded to CMS.

Also during this year, a no-cost contract extension was agreed to and signed with VPQHC in order to calculate 15 HEDIS performance measures for baseline and year one of the waiver. It is anticipated that the Performance Measure work will be completed by the end of the FFY 2008 Quarter two.

Finally, during this year, a request for proposal (RFP) for the new EQRO was drafted and posted. After a competitive bid process, Health Services Advisory Group (HSAG) was selected as the new Medicaid Managed Care EQRO. The new EQRO will focus on services provided to those individuals enrolled in the Global Commitment to Health Waiver and conduct the three required activities of EQR (i.e., validate performance measures, validate performance improvement projects, and conduct audits to determine Managed Care Organization (MCO) compliance with Federal/State MCO quality standards).

Quality Strategy: The AHS crafted a draft quality strategy. Specifically, time was spent reviewing the CMS standards for access, structure and organization, and measurement and improvement, as well as, CMS approved Quality Strategies from various states. The AHS Quality Improvement Manager worked with the Quality Assurance Performance Improvement committee members to begin identifying possible Performance Measures and areas for Performance Improvement. Specifically, time was spent inventorying performance measures used by various initiatives across the state. In addition to promoting appropriate, safe, effective care aimed at optimum health outcomes, the Quality Strategy will require input of recipients and ensure plan compliance with standards established by the State for quality of care.

The AHS Quality Improvement Manager spent time eliciting feedback from Quality Assurance Performance Improvement committee members, members of the Health Access Oversight Committee, and the OVHA Medicaid Advisory Board on the GC Quality Strategy. Final feedback will be elicited via the public hearing process in the next quarter. Once all feedback has been given, the Quality Strategy will be modified and submitted to CMS for review.

Evaluation Activities: The AHS Quality Improvement Manager worked with AHS staff and the VPQHC Director of Evaluative Sciences to design an evaluation framework for the GC waiver. Activities undertaken to outline the evaluation framework included the following: drafting an evaluation plan (both formative and summative), developing a timeline, identifying goals, objectives, hypotheses, and performance measures and targets, determining the method, procedures, and instruments, as well as, identifying the data analysis plans and report writing requirements. The AHS Quality Improvement Manager examined CMS approved waiver evaluation plans from other states and obtained technical assistance re: general information on evaluations, the broader context of evaluations in terms of CMS policies, general guidelines for evaluations, the relationships between evaluations of demonstrations and other program functions, including evaluation of program quality, and recommended components of a state evaluation plan and of state evaluation reports.

Finally, the AHS Quality Improvement Manager obtained feedback from Quality Assurance Performance Improvement committee members and other agency-wide stakeholders on the revised GC waiver evaluation plan. It was agreed that the measures contained in the Quality Strategy would be transferred to the GC Evaluation plan, while cost and access measures needed further conversation. The Quality Assurance Performance Improvement committee will inventory applicable access and cost measures across the agency, specify appropriate targets, and make recommendations in the next quarter.

Healthcare Reforms & Benefit Changes: The Vermont FY07 Budget Act and the Vermont Health Care Affordability Act became effective July 1, 2006. Upon passage of Act 191, OVHA hired a project director to oversee the implementation of the new premium assistance programs. An interdepartmental work group was convened and has been meeting on a weekly basis since that time. The team met daily for several weeks in October of 2006 to develop functional requirements for the information technology (IT) contract, which was awarded in January 2007. Rules were promulgated effective October 1, 2007. New staff members were hired and trained in August and September 2007. At this point all tasks are on schedule for the October 1 implementation date. This legislation contained the following changes regarding cost-sharing amounts, eligibility and benefits:

- *VHAP-ESI* – The new laws propose to implement an Employer Sponsored Insurance (ESI) program for both existing and new VHAP enrollees. Beneficiaries will be held harmless in terms of cost and benefits compared to the regular VHAP program. The savings generated by this initiative will be used to finance coverage for additional low-income, uninsured Vermonters.
- *ESI Premium Assistance Program* – Vermont intends to make coverage more affordable for uninsured individuals with incomes up to 300 percent of FPL. Individuals who have access to coverage through their employers will have the opportunity to participate in the ESI Premium Assistance Program. Public subsidies will be available under this program to help cover the employee share of monthly premiums for employer-sponsored coverage.
- *Catamount Health Assistance Program* – Catamount Health is a broad initiative designed to make affordable commercial coverage accessible to individuals unable to obtain coverage through their employers. Covered benefits will be defined by the State and provided through commercial carriers. Catamount Health will be available to all Vermonters, regardless of income. The Catamount Health Assistance Program would provide for public subsidies toward the premiums paid under Catamount Health. The Catamount Health Assistance Program will be available to low-income uninsured Vermonters with incomes up to 300% of the FPL, who do not have access to employer-sponsored insurance that is more cost-effective for the State.
- *Recertification Requirements* – Vermont previously recertified eligibility for certain groups at six-month intervals, while recertification occurs every twelve months for other eligibility groups. Act 191 passed by the Vermont legislature in 2006 modified the program requirements for VHAP, Dr. Dynasaur and other eligibility groups to require recertification every twelve months. This modification also helps to offset the operational resource demands resulting from the new citizenship verification requirements. This change was implemented in May 2007.
- *VHAP Eligibility Requirements* – Vermont has modified existing rules to extend eligibility to Vermont residents who are college students and have taken medical leave.

Chronic Care Management The OVHA's commitment to a Chronic Care Management Program (CCMP) is supported by legislation (Act 191) which specifically authorizes CCMP. An RFP was issued on August 4, 2006 to develop a population stratification methodology to identify Medicaid beneficiaries who may benefit most from participation in the OVHA's CCMP. This RFP resulted in a

contract with the Center for Health Policy and Research (CHPR) at the University of Massachusetts Medical School. The contract with CHPR began January 24, 2007. CHPR identified 22, 865 Medicaid beneficiaries with one or more of the eleven targeted chronic conditions (arthritis, asthma, chronic obstructive pulmonary disease, congestive heart failure, depression, diabetes, hyperlipidemia, hypertension, ischemic heart disease, and low back pain).

Another RFP was issued on October 5, 2006 for Intervention Services (IVS) and Health Risk Assessment (HRA) administration to complete the implementation of the OVHA's CCMP. This RFP resulted in a contract with APS Healthcare that began June 15, 2007. As the IVS vendor APS Healthcare will:

1) Perform risk stratification to pro-actively identify the specific intervention populations from within the overall target population.
2) Generate and distribute mailings to all eligible beneficiaries with disease-specific, self- care information which complies with established State disease-specific best practice standards (as promoted by the Blueprint for Health) when available.
3) Maintain a call center to provide incoming and outgoing nurse telephone contact with both patients and providers during both business hours and limited extended hours. The call center will be staffed by licensed nurses minimally holding an LPN certification, providing evidence-based clinical advice and counseling.
4) Provide face-to-face interventions for high acuity patients, with the goal of eliminating barriers to optimal self-management of chronic health conditions.
5) Conduct provider outreach and education reaching all statewide Medicaid providers. The content will include current guidelines for prevention and treatment of chronic diseases in support of the Chronic Care Model.
6) Employ a data collection and management system which will enable the Care Coordination Program (CCP) as well as CCMP program staff to securely collect and store relevant patient-level information. The system will incorporate Medicaid claims data, including point-of-sale pharmacy claims and will be compatible with the Blueprint for Health Chronic Care Information System.

As the HRA vendor, APS Healthcare will administer a generic health risk assessment to all beneficiaries with a chronic condition. The HRA will be administered in an impartial manner in electronic, paper, telephonic, or face-to-face format. The results of the HRA will assist in their risk stratification and care plan development, and will be provided to the individual beneficiary's primary care provider.

In further support of these Chronic Care Management goals, the OVHA deployed the Care Coordination Program (CCP) to address the needs of the highest risk Medicaid beneficiaries, using dyads' of nursing and medical social worker teams located in eight geographic districts covering the state. The CCP staff are employed by the OVHA and work in concert with the CCMP teams as described above, to provide seamless transition of chronic care management services based on beneficiary risk level.

Quantitative and Case Study Findings

One initiative utilizing the flexibility granted by the Global Commitment to Health Waiver includes OVHA's Care Coordination Program (CCP). Specifically, OVHA is committed to partnering with primary care providers, hospitals, Agency of Human Services (AHS) departments, and community agencies, and is represented on the Blueprint for Health executive committee (a key component of the

State's overall Health Care Reform initiative) in order to best address the need for enhanced coordination of services in a climate of increasingly complex health care needs and scarce resources.

The CCP facilitates the beneficiary-provider relationship by offering services that assist providers in tending to the intricate medical and social needs of beneficiaries without increasing the administrative burden. The CCP supports providers by providing intensive case management to the beneficiary between visits to enable the plan of care to be successful. Ultimately, the CCP aims to improve health outcomes, decrease inappropriate utilization of services, and increase appropriate utilization of services. Outlined below is a brief description of the CCP, start-up status and accomplishments in waiver year two:

Method: Teams of nurses and social workers assess high risk members to determine beneficiary needs and develop a customized plan of care in collaboration with the primary care provider and the beneficiary, using a holistic approach.

The CCP teams focus on Medicaid's highest risk population with one or more of 11 chronic conditions which include: Arthritis, Asthma, Chronic Obstructive Pulmonary Disease (COPD), Chronic Renal Failure, Congestive Heart Failure (CHF), Depression, Diabetes, Hyperlipidemia, Hypertension, Coronary Artery Disease, or Low Back Pain.

It is well documented that these conditions and their management are further complicated by the often co-occurring conditions of mental health and substance abuse; as well as challenges including food security and the availability of safe and affordable housing and transportation due to financial insecurity. As many as 20 different agencies and service providers have been engaged in OVHAs Care Coordination efforts to successfully address the priority health and security needs of beneficiaries.

As supported by the Chronic Care Model, the CCP emphasizes evidence-based, planned, integrated and collaborative care for beneficiaries who exhibit high-prevalence chronic disease states, high-expense utilization, high medication utilization, and/or high emergency department (ED) and inpatient utilization or, who may be at risk for future utilization of these resources. CCP professionals, working at the local level, facilitate engagement of the Primary Care and other community service providers to support the beneficiary to achieve the sustainable change required for long term health outcomes improvements.

Implementation: The high risk beneficiaries who will most benefit from the CCP are selected based upon criteria identified through claims analysis, and in collaboration with the beneficiary and their primary care provider. Selection of this population as well as monitoring assistance is performed by the Center for Health Policy and Research (CHPR) at the University of Massachusetts Medical School, under contract with OVHA.

Regionally-based Care Coordination teams [one Registered Nurse (RN) and one social worker] work with the beneficiary, their primary care and specialty care provider(s), community based organizations, and State entities to devise a plan of care based on assessment of medical and psycho-social needs; as well as gaps and/or barriers in implementation of the clinical treatment plan. Care Coordination teams coordinate resources - including those available through the Vermont Blueprint for Health initiative - which support the beneficiary in developing self-efficacy skills to empower them to become active partners in their own health and well-being.

During the reporting period, OVHA enhanced the CCP operating structure with the addition of two regional supervisor positions to work with the AHS Field Services Director to provide leadership and

oversight for the growing staff of professionals. As of September 31, 2007, the OVHA hired 10 additional staff to support the CCP infrastructure toward development of a statewide presence. In addition to the Field Director and two Regional Supervisors, OVHA added five medical social workers and two nurses to deploy the initiative in seven of eight designated regions throughout the state. These include: Franklin/Grand Isle, Rutland/Addison, Windham/Windsor, Lamoille, Caledonia/Orleans, Washington/Orange and Chittenden Counties. Our last service area, Bennington County, is slated to go live in January 2008. One county - Lamoille - is covered by a single medical social worker due to low beneficiary penetration and utilization data; however, the social worker has supplemental nursing resources available from surrounding areas, depending on the beneficiary location. This configuration will provide the OVHA with statewide coverage. When fully operational, the CCP will have team of 18 professional staff.

The Agency of Human Services (AHS) reorganization recognized the need for coordination of services at the community level. As such, the Care Coordination teams are located primarily at the local district offices to provide a unique and critical aspect of the AHS support network and to establish relationships with primary care providers that are focused on health outcomes. Care Coordination teams are embedded in their communities and well informed of local and statewide quality improvement initiatives and thus are able to assist providers and beneficiaries to access these services.

Consistent with the AHS four key practices, Care Coordination teams focus on customer service, holistic support, strength based relationships and outcomes. Teams work closely with the AHS district field service directors on common beneficiaries and are instrumental in identification of service gaps and barriers critical to successful and effective resolution. Mature CCP teams also engage with the local interagency teams (LITs) as well as the Regional Partnerships. The result of implementing locally-based Care Coordination teams is the opportunity to collaborate creatively and effectively to address the unique needs of an individual beneficiary. To date, this collaboration has been rewarding for both beneficiaries and the OVHA, and supports the existing local infrastructure for our AHS clients in common.

Current Participating Providers, Agencies and Stakeholders: As of September 2007, the CCP has engaged providers, agencies and stakeholders statewide including, but not limited to the following partners:

1) Area Health Education Centers
2) Blueprint for Health – a key component of Vermont's health care reform initiative
3) Department for Children and Families (DCF) - field service districts
4) Department of Disabilities, Aging and Independent Living (DAIL)
5) Department of Mental Health
6) Hospitals and Physician Hospital Organizations (PHO)
7) Planned Parenthood of Northern New England
8) Provider practice groups, including independent practices, hospital owned practices and Federally Qualified Health Centers (FQHCs)
9) Regional Mental Health Service providers
10) Substance Abuse treatment providers
11) Vermont Association of Hospitals & Health Systems (VAHHS)
12) Vermont Department of Health (VDH) and district health offices
13) Visiting Nurse's Association (VNA)
14) Vocational Rehabilitation Services

Integration with the Chronic Care Management Program (CCMP): The OVHA's Care Coordination

Program (CCP), in conjunction with the Chronic Care Management Program (CCMP), exemplifies the Chronic Care Model in action. The CCP and CCMP are the vanguard of a system redesign to improve the health outcomes of Medicaid beneficiaries.

The OVHA's Chronic Care Management Program (CCMP) is designed to address the needs of Medicaid beneficiaries with more moderate needs on a continuum extending downward from the CCP population. Beneficiaries will transition into the CCMP from the CCP when they are no longer in need of intensive case management. It is anticipated that there will be fluidity between the CCP and CCMP as beneficiaries move up and down the health needs continuum and transition between the CCP and CCMP. Transition between programs will be initiated in early 2008 based on case load progress and protocol development to assure seamless transition

Provider Payments As Part Of CCP: A segment of the operating costs for the CCP are set aside for reimbursing participating providers. A strategy has been developed to reimburse the providers with an enhanced capitated payment rate of $15 per month for a CCP patient. To emphasize the importance of developing a plan of care with the primary care provider, the OVHA will also reimburse the provider $55 for meeting with Care Coordination teams when one of their patients is enrolled in the CCP. Providers will also be reimbursed $55 for a "discharge" meeting to emphasize the importance of a smooth transition to CCMP when a participant leaves the CCP. The combination of incentive payments for meetings and an enhanced case management fee, $10 more than the PC Plus case management fee, provides primary care providers with an attractive incentive for participation in the CCP.

Achievements To-Date:

1) Over 600 beneficiaries have received Care Coordination services since inception. With expanded staffing and beneficiaries being actively enrolled statewide, the OVHA anticipates doubling this population in federal fiscal year 2008.
2) Care Coordination teams are receiving education and training on topics to assure skill development including *Medicaid Boot Camp, Bridges out of Poverty* and *Motivational Interviewing* and *De-escalation Techniques.*
3) The OVHA trained 20 CCP and other clinical staff to become certified as Chronic Care Professionals (a nationally recognized certification); with certification due by 12/08. Additional CCP staff will be trained and certified in 2008.
4) Developed and disseminated a brochure for providers which outlines the OVHA's clinical initiatives including the CCP, CCMP and the Buprenorphine Program.
5) Multiple AHS departments and OVHA units have collaborated to ensure the successful implementation of the CCP.
6) The more mature OVHA CCP teams have developed partnerships with AHS field service directors, participate on Local Interagency Teams (LITs) and participate in Regional Partnership team meetings.
7) Community and local outreach to key stakeholders, including AHS departments, non-profit organizations and the physician community, have been completed in 10 of 13 counties, starting with areas with highest need and interest. Orleans, Addison and Orange County stakeholder meetings will be held in early calendar year 2008.
8) Hospital outreach to date has been successful and well received; and is ongoing.
9) A reimbursement strategy is being implemented to encourage providers to participate in the CCP.
10) A CCP Orientation Manual has been completed and is being used as a staff development and implementation tool to facilitate uniform implementation strategies; various additional operating protocols are also in development with PDSA cycles to support tests of change.

11) The Care Connection® data management and tracking system [a proprietary system of APS - the OVHA vendor for the Chronic Care Management Program (CCMP)] is being used by CCP staff to assure service coordination between CCP and CCMP.
12) Metrics for programmatic monitoring and evaluation have been established in partnership with CHPR.
13) The OVHA has taken the lead on development of clinical guidelines for Hypertension, Asthma, Hyperlipidemia and Congestive Heart Failure (CHF), working with the Vermont Blueprint for Health initiative to facilitate and assure alignment.
14) The OVHA is a key member of the newly formed Institute for Healthcare Improvement (IHI) 'Triple Aim' team, lead by the Blueprint for Health. IHI is an internationally recognized leader in healthcare quality improvement.

Utilization Data

The Office of Vermont Health Access (OVHA) has been designated, as the office with primary responsibility for program integrity. A unique unit was formed in 2005 as the *Surveillance and Utilization Review Unit* (SURS) and renamed in 2006 as *The Program Integrity Unit* (PI). OVHA'S Program Integrity (PI) unit has oversight responsibility for the detection of fraud, abuse, waste and misuse. Efforts to detect prevent, and control fraud and abuse rely on a partnership with departments, across the Agency of Human Services.

Program Integrity is central to program management and ensuring a program's effectiveness and efficiency. Each state has primary responsibility for protecting its Medicaid program's integrity. This includes, but is not limited, to provision of medically necessary, appropriate and evidenced based healthcare service, accurate reimbursement to qualified providers, efficient administration, and prevention of inappropriate services and reimbursement. Vermont is taking several steps to meet this challenge and understands it's obligation to ensure the program integrity. This is a complex undertaking that involves all aspects of program management, from policy development to day-to-day operations.

This unit is supervised by an OVHA Deputy Director, a PI Manager and a Program Operations Administrator. Staffing consist of Program Operations Auditor's, a Nurse Case Manager, Medicaid Fiscal Analyst's and Health Data Analyst's.

PI has brought together the representatives from departments across *The Agency of Human Services* (AHS) to use the collective resources and knowledge across the agencies departments to address program integrity issues. The *Fraud Abuse Control Team* (FACT) team a cross agency collaborative is in its development phase for the purpose of sharing data in an effort to identify patterns of aberrant billing practices. Building cooperative and collaborative relationships, across departments who, in turn, have established cooperative relationships with providers, consumers, and law enforcement will strengthen the capacity in which to conduct utilization management activities.

Utilization Review Processes: A goal of the PI unit is to monitor consistent adherence to the compliance with State and Federal regulatory standards. The PI unit has established procedures and monitoring activities towards formal utilization review processes. These utilization review processes, include but may not be limited to, the following random and/or focused review categories,

- Pre-service Review
- Concurrent Review
- Post Service Review

Utilization Management Approaches:

- Decision Support System(DSS) Selection Process
- Provider Profile Reporting
- Beneficiary Profile Reporting

Enhancements 2007-2008:

- OVHA uses Milliman ,nationally accredited, Clinical Criteria
- OVHA has purchased a license to access Hayes – a medical research Company
- Procured a vendor to conduct Post Payment Review
- Have reviewed for implementation additional Claims Check prepayment edit and audits– prepayment audit software

Utilization data for FFY07 relative to emergency room, inpatient services and preventative medicine services is outlined below.

Vermont's Global Commitment to Health
Federal Fiscal Year (FFY) 2007

	Total Visits	Average Members	p/1000
ER Visits	63,911	98,520	648.71
Inpatient Days	59,938	98,520	608.38
Inpatient Admissions	10,481	98,520	106.38
Preventive Medicine Services	55,035	98,520	558.62

* Average members exclude Dual Eligibles

Vermont's Global Commitment to Health
Federal Fiscal Year (FFY) 2007

	Average Members	ER Visits p/1,000	Days p/1,000	Admissions p/1000	Average Length of Stay	Preventive Medicine Services p/1,000
ABD - Non-Medicare - Adult	11,386	1,240.44	1,512.68	210.60	7.18	262.51
ABD - Non-Medicare - Child	3,430	785.99	1,019.10	121.59	8.38	443.21
ANFC - Non-Medicare - Adult	9,227	1,595.83	1,318.91	352.76	3.74	208.62
ANFC - Non-Medicare - Child	50,780	414.50	279.48	44.80	6.24	817.26
GlobalExp	22,532	684.20	568.27	94.31	6.03	298.83

* Excludes Optional and Dual Eligibles

The data in the above chart represents a non-specific count, rather than a true HEDIS measure based accounting. Therefore, in the future reports, HEDIS measures will replace this generalized measure.

Policy and Administrative Difficulties

Fiscal & Operational Management: Development of the financial aspects of the waiver continued to receive significant attention during waiver year two. In addition to waiver start up issues, the State and Federal fiscal years associated with waiver rate setting were not in alignment. The State and CMS agreed on using a federal fiscal year to set the actuarially certified PMPM capitation rates paid to OVHA by AHS. This created the need for an overall review of actuarial work and revised rate setting in order to move all relevant fiscal and data reporting to the Federal fiscal year alignment. During

Vermont's work to convert the actuarial certifications and rate ranges to the federal fiscal year from the state fiscal year, anomalies in the data were discovered. The state spent considerable time reviewing inconsistencies in data originally submitted to our actuary in order to determine the significance of the data issues and the resulting impact on the rate ranges for FFY06, 07 and 08.

Compounding this analysis is the interplay between the State's Long Term Waiver and Global Commitment. During the final Long Term Care wavier approval process, CMS required the State to include acute care services for persons receiving LTC services in the LTC waiver. The reporting mechanism for identification of acute care costs associated with persons receiving LTC 1115 waiver services was finalized a year ago and did not exist in any automated fashion prior to the receipt of the LTC waiver. The State needs to ensure that the appropriate GC MEGs exclude the acute care costs with the LTC waiver. This has not been a simple task. Once the state is confident that the information is complete, additional actuary work will be completed. Additionally, the State received approval to for the Catamount program on October 31, 2007; subsequently, the State solicited additional actuarial consulting to develop PMPM rate ranges for the three new MEGs for FFY08. We expect to have all updates and revisions to IGA and rates for 06, 07 and 08 by the end of the first quarter of wavier year three.

Operational Challenges: Challenges experienced in waiver year two have been related to infrastructure and operational aspects of the Global Commitment to Health wavier. This is primarily in the areas of data and fiscal reporting; ensuring key fiscal and policy staff understand the rate setting methodology and its impact on the state budget process and information technology systems. Specifically, staff responsible for creating various reports often struggled with inconsistencies in data, in attempting to resolve these inconsistencies it became clear that the Special Terms and Conditions of the Vermont wavier contain requirements for up to five different (and at times conflicting) reporting schemas. After discovering variations in reporting, the fiscal and data staff at AHS and OVHA spent time cross walking the schemas into one consistent framework. This framework was shared with CMS and Vermont has proposed that all reporting be based on the crosswalk (See Attachment 1).

Issues confounding the reporting problems include the interplay and reconciliation of the States two 1115 waivers, the Long Term Care and the Global Commitment to Health mentioned above. This causes considerable complexity in reconciliations between GC and LTC waivers. Adding to the complexity of this reporting is the structure of Vermont's IT system. The IT structure supporting the AHS Healthcare programs was established in 1983 for eligibility and 1992 for the MMIS.

- Changes are cumbersome and limited to a very small number of staff who have specific knowledge of the legacy system
- While changes are occurring on one aspect of policy (for example, Catamount Health implementation) changes literally cannot occur to implement another policy changes. Due to the nature of the system it must be linear and one project cannot start until another is completed.
- Given the inter-relatedness of the data, I.T. changes must proceed with caution to ensure that coding and programming changes do not create inaccuracies or unintended consequences in other required State or Federal reports.

The Agency is in the process of an extensive MITA self assessment relative to modernizing the healthcare information technology.

Cost Incurred But Not Reported (IBNR). The Global Commitment financial model relies on managed care capitation payments as the vehicle for funding Medicaid-covered services. Under a traditional

managed care approach, the MCO receives prospective capitation payments in exchange for assuming the financial risk for payment of services rendered during the contract period. Services rendered prior to the start of the contract period would not be the responsibility of the MCO. Therefore, the MCO would accumulate a reserve in order to pay for claims incurred during the contract period, but paid after the contract period (i.e., "run out claims"). Capitation payments under Global Commitment began on October 1, 2006. However, OVHA, as the public MCO, used the capitation revenues to pay for claims incurred prior to October 1st. Ideally, the MCO would not have been obligated to use capitation revenues to pay for services rendered prior to the contract period and would have been permitted to build a reserve to cover any claims tail at the end of the contract period. This approach would have required the State to make "double payments" to pay for previously incurred claims as well as the prospective capitation payments. However, the State of Vermont was not in a position fiscally that would enable the Legislature to appropriate funds necessary to support both payments. Further, we did not believe that the Vermont Legislature would permit the public MCO to carry a large reserve for several years in order to cover the claims tail at the conclusion of the waiver. We believe that given the public and statewide nature of our Demonstration project, the approach taken was the most viable. However we also recognize that as we move forward with renewal discussions, the State believes that these issues warrant clarification and will work with CMS to resolve these issues.

Developing MCO compliance, quality standards and other activities in the context of State Government Agencies. In most cases meeting the MCO requirements involve changes in internal procedures under the control of AHS or its member departments. In other areas, such as grievance and appeals, the revisions involve state regulatory/rulemaking processes which can be more lengthy and involved within the state government and legislative systems. Both processes can be inherently time consuming.

Financial planning and budgeting has been particularly challenging. Pre-waiver, many programs operated under separate and discrete waivers or other appropriations. Budgets were historically built by individual departments and combined into one overall AHS budget. Post waiver, all Global Commitment related expenditures and projections need to be combined into a single agency wide global commitment budget and the entirety of the budget needs to be built before prioritization across the agency and with individual departments can occur. The Global Commitment budget is then overlaid into the non-Global Commitment budget, cross walked with historical categories of individual departments and one total AHS budget created. Additional complexities are created by overlapping State and Federal fiscal years and the statutorily required separation of the State's "Catamount Fund" from other Medicaid funds.

Just as AHS needs to view Global Commitment across all departments as one budget, so does the rest of state government and the legislature. Work with the State Finance and Management Office as well as Vermont's Legislative Joint Fiscal Office pre-Global Commitment involved individual departmental budgets, appropriations, trends and projections. Post Global Commitment a process has been put into place to develop consensus documents and agreements between the Executive and Legislative branches on whole of Global Commitment. This detailed level of consensus building is the first of its kind between the branches of state government, and while initially a more consuming process, has yielded a much more productive and collaborative discussion of the pressures on our public and private health care delivery systems.

The inter-relationships and flexibilities that are created under Global Commitment have the potential to streamline or potentially eliminate the multiple billing and documentation requirements that currently exist. Developing more streamlined fiscal and management strategies align closely with principals of reorganization which included, in part, that the Agency structure and practices:

- support a holistic approach to serving individuals and families and ensure the coordination of services when multiple interrelated needs exist.
- ensure the efficient and effective allocation of financial and staff resources;
- establish effective data collection systems to support ongoing assessment of service quality and enhance continual organizational improvement;
- ensure maximum communication and collaborative planning when more than one service is being provided to a single consumer or family.
- provide a continuum of services capable of adapting and responding to changing needs and unique situations, including transitional stages.

The Agency continues to promote a unified management approach as we facilitate a variety of senior leadership and management meetings and ad hoc work groups to work on cross-cutting operational, fiscal, quality improvement and outcome issues. Managers are being held accountable for identifying and recommending changes that can be implemented across the agency to:

- create more efficient administrative processes and requirements;
- identify and eliminate duplicative business processes, program monitoring and reporting requirements;
- create more efficient funding mechanisms and contractual options (e.g., capitated rates, pay-for-performance and/or outcome based contracts);
- prioritize program development or expansion initiatives;
- ensure compliance with federal MCO and other waiver requirements.

Capitated Revenue Spending

The final per member per month rates as set for waiver two are listed below. Investments made by the MCO in waiver year two totaled an estimated $55,669,485 which represents actual spending for three quarters of State fiscal year 2007 and one quarter of State fiscal year 2008. Areas of capitated spending and the associated categories are outlined in Attachment 2.

FINAL FFY 2007

	PREMIUM RATE	**MEMBER MONTHS**	**PER MEG**
ABD - Non-Medicare - Adult	$ 1,187.30	182,711	$ 216,933,612.71
ABD - Non-Medicare - Child	$ 2,095.44	41,425	$ 86,803,505.40
ABD - Dual	$ 851.74	182,808	$ 155,704,876.94
ANFC - Non-Medicare - Adult	$ 501.49	109,718	$ 55,021,970.55
ANFC - Non-Medicare - Child	$ 319.18	609,267	$ 194,467,518.01
GlobalExp	$ 431.59	269,559	$ 116,337,915.74
GlobalRx - Non-Medicare	$ 214.24	611	$ 130,897.77
GlobalRx - Dual	$ 2.79	136,918	$ 382,527.58
OptionalExp	$ 190.84	13,976	$ 2,667,141.12
TOTALS		**1,546,993**	**$ 828,449,965.82**

.

Attachments

Attachment 1

Global Commitment Waiver Medicaid Population/Reporting Crosswalk

Current MEGs for capitation rate payment

Used to set PMPM capitation payments. Each GC enrollee is counted uniquely within one MEG.

1. ABD Non-Medicare Adult
2. ABD Non-Medicare Child
3. ABD Dual
4. ANFC Adult
5. ANFC Child
6. Global Expansion (VHAP)
7. Global Rx Non-Medicare
8. Global Rx Dual
9. Optional Expansion
10. VHAP ESI
11. Catamount ESI up to 200% of FPL
12. Catamount Premium Subsidy up to 200% of FPL

Eligible GC populations per STCs[1]

Used only to determine specific allowability for enrollee inclusion under the GC waiver. Vermont may only include individuals as specified below (and in further detail in the STCs) under the GC waiver. No direct correlation exists between the below list with either the capitation rate setting or expenditure reporting processes. Individuals in populations 1, 2, 9 and 10 below are unduplicated; it is possible for individuals in populations 3-8 to be counted within multiple groups.

Traditional Medicaid-Eligible Populations

1. Mandatory Categorically Needy
2. Optional Categorically Needy

Expansion Populations

3. Uninsured children with income between 225 and 300 percent of FPL who are not otherwise eligible for Medicaid or SCHIP
4. Adults with children with income between 150 and including 185 percent of FPL
5. Childless adults with income up to and including 150 percent of FPL
6. Medicare beneficiaries with income at or below 150 percent of FPL, not otherwise categorically eligible
7. Medicare beneficiaries with income above 150 percent and less than 200 percent of FPL, not otherwise categorically eligible
8. Individuals with persistent mental illness with income up to 150 percent of FPL
9. ESI Premium Assistance
    a. Adults with children with incomes between 185 and including 200 percent of FPL
    b. Childless adults and non custodial parents with income between 150 and including 200 percent of FPL
10. Catamount Premium Assistance
    a. Adults with children with incomes between 185 and including 200 percent of FPL
    b. Childless adults and non custodial parents with income between 150 and including 200 percent of FPL

CMS-64 expenditure reporting categories[2]

Used to track and monitor expenditures subject to GC budget neutrality by categories i-vi below, as reported on the CMS-64. Additionally, the STCs specify that the State detail actual CRT expenditures on the CMS-64. This reflects the capitation payment (less CRT actuals) stratified across reporting categories i, ii, iii, iv, & vi. Admin expenditures for GC are included within the capitation payment and not broken out separately.

i. ABD	i. Populations 1 & 2
ii. ANFC	ii. Populations 1 & 2
iii. Optional Expansions	iii. Population 2
iv. VT Global Rx	iv. Population 6 & 7
v. Admin Expenditures	v. N/A
vi. VT Global Expansion	vi. Populations 3, 4, 5, 9, 10
vii. CRT Group	vii. Population 8

PMPM Rate x Enrollment by MEG = Capitation Payment Amount TOTAL ⟷ Capitation Payment Amount TOTAL = CMS-64 Reported Expenditures Total (i-vii above)

GC Populations per new quarterly report specifications

The below population format does not tie to the MEG groups, the STCs, or the CMS-64 categories.

Traditional Medicaid-Eligible Populations

1. *Mandatory Categorically Needy*
2. *Optional Categorically Needy*
3. *Medically Needy*
4. *HCBS (home and community based services; individuals who were previously covered under a separate 1915(c) Waiver*

Expansion Populations

5. *Children with income between 225 and 300 percent of FPL who are not otherwise eligible for Medicaid or SCHIP*
6. *Adults with children with income between 150 and including 185 percent of FPL*
7. *Adults with income up to and including 150 percent of FPL*
8. *Medicare beneficiaries with income at or below 150 percent of the FPL*
9. *Medicare beneficiaries with income above 150 percent and less than 200 percent of FPL*
10. *Individuals with persistent mental illness with income up to 150 percent of FPL*
11. *Premium assistance expansion group (either through ESI or the Catamount Health Plan)*
    a. Adults with children with incomes between 185 and including 200 percent of FPL
    b. Childless adults and non custodial parents with income between 150 and including 200 percent of FPL

Estimated Eligible Enrollment Projections per CMS-37 reporting categories

The below categories do not tie to the MEG groups, the STCs, the CMS-64 categories, or the new quarterly report specifications.

1. Blind and Disabled
2A. Aged 65 and Over (Non-Disabled) Qualified Medicare Beneficiaries only
2B. Aged 65 and Over (Non-Disabled) Other Aged
3A. Other Adults (Non-Disabled/Non-Aged). Pregnancy Benefit Adults
3B. Other Adults (Non-Disabled/Non-Aged). Non-Pregnancy Benefit Adults
4A. Non-Disabled Children. Age less than 1-year.
4B. Non-Disabled Children. Age 1 to 5.
4C. Non-Disabled Children. Other Children.

[1] Pages 7-8 of STCs dated 10/31/07
[2] Pages 28-30 of STCs dated 10/31/07

Notes on CRT/HCBS:
The population who receives CRT and HCBS services enrolls through other programs (VHAP, ABD, etc.).
Expenditures for CRT services (category of service 0916) were built into the capitated rate ranges by Milliman.
CRT/HCBS are services obtained by enrollees; people do not enroll solely in a "CRT program" or "HCBS program". CRT/HCBS participants receive other services as well (acute/primary care, etc.).
CRT costs for LTC waiver enrollees are included within GC.
CRT/HCBS expenditures are subject to the GC budget neutrality cap and included in both sides of the equation (capitation rate setting and expenditure reporting).

POPULATION COUNT CROSSWALK

Eligible GC populations per STCs	Found in MEGs	Current MEGs for capitation rate payment
Traditional Medicaid-Eligible Populations		
1. Mandatory Categorically Needy	*1, 2, 3, 4, 5*	*1. ABD Non-Medicare Adult*
2. Optional Categorically Needy	*1, 2, 3, 4, 5, 9*	*2. ABD Non-Medicare Child*
Expansion Populations		*3. ABD Dual*
3. Uninsured children with income between 225 and 300 percent of FPL who are not otherwise eligible for Medicaid or SCHIP	*6*	*4. ANFC Adult*
4. Adults with children with income between 150 and including 185 percent of FPL	*6, 7*	*5. ANFC Child*
5. Childless adults with income up to and including 150 percent of FPL	*6, 7*	*6. Global Expansion (VHAP)*
6. Medicare beneficiaries with income at or below 150 percent of FPL, not otherwise categorically eligible	*8*	*7. Global Rx Non-Medicare*
7. Medicare beneficiaries with income above 150 percent and less than 200 percent of FPL, not otherwise categorically eligible	*8*	*8. Global Rx Dual*
8. Individuals with persistent mental illness with income up to 150 percent of FPL	*N/A*	*9. Optional Expansion*
9. ESI Premium Assistance	*10*	*10. VHAP ESI*
a. Adults with children with incomes between 185 and including 200 percent of FPL		
b. Childless adults and non custodial parents with income between 150 and including 200 percent of FPL		
10. Catamount Premium Assistance	*11, 12*	*11. Catamount ESI up to 200% of FPL*
a. Adults with children with incomes between 185 and including 200 percent of FPL		
b. Childless adults and non custodial parents with income between 150 and including 200 percent of FPL		*12. Catamount Premium Subsidy up to 200% of FPL*

EXPENDITURE REPORTING CROSSWALK

MEGs for Capitation Rate Payment	CMS-64 Reporting Categories
ABD Non-Medicare Adult……..	ABD
ABD Non-Medicare Child……..	ABD
ABD Dual……..……..	ABD
ANFC Adult……..……..	ANFC
ANFC Child……..……..	ANFC
Global Expansion (VHAP) ……..……..	VT Global Expansion
Global Rx Non-Medicare……..……..	VT Global Rx
Global Rx Dual……..……..	VT Global Rx
Optional Expansion……...……..	Optional Expansion
VHAP ESI……..……..	VT Global Expansion
Catamount ESI up to 200% of FPL……...……..	VT Global Expansion
Catamount Premium Subsidy up to 200% of FPL……..	VT Global Expansion
	CRT Group
	Admin Expenditures

Attachment 2

State of Vermont - Office of Vermont Health Access
Summary Listing - MCO Investments
State Fiscal Year 2008: draft

	Dept.	Investment Description	Reduce the rate of uninsured and/or underinsured in Vermont	Increase the access of quality health care to uninsured, underinsured, and Medicaid beneficiaries	Provide public health approaches to improve the health outcomes and the quality of life for Medicaid-eligible individuals in Vermont	Encourage the forma and maintenance public-private partnerships in hea care
	Department of Education	School Health Services		●		
	BISHCA	Health Care Administration	●		●	●
	VITL	Vermont Information Technology Leaders			●	●
	VVH	Vermont Veterans Home		●		
	Vermont State Colleges	Health Professional Training		●		
	University of Vermont Medical School	Vermont Physician Training		●		
	VDH	Emergency Medical Services		●	●	
	VDH	TB Medical Services		●		
	VDH	Epidemiology			●	
	VDH	Health Research and Statistics	●	●		
	VDH	Health Laboratory			●	
	VDH	Tobacco Cessation			●	
	VDH	Family Planning		●	●	
	VDH	Physician/Dentist Loan Repayment Program		●	●	
	VDH	Renal Disease		●		
	VDH	Newborn Screening		●	●	
	VDH	WIC Coverage		●	●	
	VDH	Substance Abuse Treatment		●		
	VDH	Recovery Centers		●		
	VDH	Maple Leaf		●		
	VDH	Grace House		●		
	VDH	Vermont Blueprint for Health		●		●
	VDH	Vermont Area Health Education Centers		●	●	●
	VDH	Community Clinics	●	●		
	VDH	FQHC Lookalike			●	●
	VDH	Patient Safety			●	●
	VDH	CHAMPPS		●		
	DMH	Emergency Mental Health for Children and Adults		●	●	
	DMH	Respite Services for Youth with SED and their Families		●		
	DMH	Special Payments for Medical Services		●		
	DMH	MH Outpatient Services for Adults		●		
	DMH	Mental Health Elder Care		●		
	DMH	Mental Health Consumer Support Programs		●		●
	DMH	Mental Health CRT Community Support Services		●		
	DMH	Mental Health Children's Community Services		●		
	DMH	CRT Staff Secure Transportation		●		
	DMH	Peer Supports - FUTURES		●		
	DMH	Recovery Housing		●		
	OVHA	Buy-In	●	●		
	OVHA	HIV Drug Coverage		●		
	OVHA	Civil Union	●	●		
	DCF	Family Infant Toddler Program			●	
	DCF	Medical Services		●		
	DCF	Residential Care for Youth/Substitute Care		●		
	DCF	Aid to the Aged, Blind and Disabled CCL Level III		●		
	DCF	Aid to the Aged, Blind and Disabled Res Care Level III		●		
	DCF	Aid to the Aged, Blind and Disabled Res Care Level IV		●		
	DCF	Essential Person Program		●		
	DCF	GA Medical Expenses		●		
	DCF	VCRHYP		●		
	DDAIL	Mobility Training/Other Svcs.-Elderly Visually Impaired		●		
	DDAIL	DS Special Payments for Medical Services		●		
	DDAIL	Flexible Family/Respite Funding		●		
	DDAIL	Quality Review of Home Health Agencies		●	●	●
	DDAIL	Caregiver Registry		●	●	
	DOC	Return House		●		
	DOC	Intensive Substance Abuse Program (ISAP)		●		
	DOC	Intensive Sexual Abuse Program		●		
	DOC	Intensive Domestic Violence Program		●		
	DOC	Women's Health Program (Tapestry)		●		
	DOC	Community Rehabilitative Care		●		