State of Vermont
Agency of Human Services

Global Commitment to Health
11-W-00194/1

Section 1115
Demonstration Year: 5
(10/1/2009 – 9/30/2010)

Quarterly Report for the period
October 1, 2009 to December 31, 2009

Submitted Via Email on
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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 Entity. AHS will pay the Managed Care Entity 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 first quarterly report for waiver year five, covering the period from October 1, 2009 to December 30, 2009.***

Enrollment Information and Counts

Please note the table below provides point in time enrollment counts for the Global Commitment to Health Waiver. Due to the nature of the Medicaid program and its beneficiaries, enrollees may become retroactively eligible; move between eligibility groups within a given quarter or after the quarter has closed. Additionally, the Global Commitment to Health Waiver involves the majority of the state's Medicaid program; as such Medicaid eligibility and enrollment in Global Commitment are synonymous, with the exception of the Long Term Care Waiver and SCHIP recipients.

Reports to populate this table are run the Monday after the last day of the quarter. Results yielding less than or equal to a 5% fluctuation quarter to quarter will be considered as illustrating normal deviations reflecting retroactive eligibility determinations and expected terminations. Results reflecting more than a 5% fluctuation between quarters will be reviewed by OVHA and AHS staff for further detail and explanation.

Enrollment counts are person counts, not member months.

Demonstation Population	Current Enrollees Last Day of Qtr 12/31/2009	Previously Reported Enrollees Last Day of Qtr 9/30/2009	Variance 12/31/09 to 9/30/09
Demonstration Population 1:	43,956	43,369	1.35%
Demonstration Population 2:	42,921	42,781	0.33%
Demonstration Population 3:	9,653	9,711	-0.60%
Demonstration Population 4:	N/A	N/A	N/A
Demonstration Population 5:	1,205	1,127	6.92%
Demonstration Population 6:	2,861	2,683	6.63%
Demonstration Population 7:	31,831	30,864	3.13%
Demonstration Population 8:	7,447	7,406	0.55%
Demonstration Population 9:	2,550	2,552	-0.08%
Demonstration Population 10:	N/A	N/A	N/A
Demonstration Population 11:	9,479	8,951	5.90%

Green Mountain Care Outreach / Innovative Activities

During the first quarter, the Office of Vermont Health Access has turned its attention to aligning health care material that consumers receive from the State of Vermont. Significant updates were made to the Green Mountain Care website and a marketing style guide has been initiated and is still in process. The guide has centralized photos, logos, and art files in one location to be easily accessed across departments. It provides boilerplate descriptive language, font, color and logo placement so the look and feel of the program is consistent across state government.

During December, OVHA finalized agreements with the University of Vermont and Champlain College to embark upon a semester-long effort to reach young adults about Green Mountain Care. One group will conduct interviews, focus groups and an on-line survey to determine the best ways in which to reach 18 – 34 year olds, while the other group will develop video for the Green Mountain Care website which will also appeal to this age group.

Enrollment and legislative action: Enrollment in the premium assistance program components of Green Mountain Care (Catamount Health and Employer-Sponsored Insurance) has continued to grow slowly over the quarter. As of the end of December there were 10,804 individuals enrolled.

Vermont submitted a waiver amendment request to CMS in late August to implement two minor changes to eligibility required by Act 61, an omnibus health care reform bill passed during the 2009 legislative session. The two changes to the VHAP and premium assistance eligibility determination process were as follows:

- Depreciation would be allowed as a business expense for self-employed applicants
- Self-employed people who lose their non-group insurance coverage due to no longer being self-employed would not have a 12-month waiting period to enroll in premium assistance.

In the amendment request, Vermont noted that an August 18, 2009 Joint Fiscal Committee decision rescinded the allocated funding to implement these changes. OVHA has submitted a report to the legislature in January on the estimated cost of implementing the depreciation change. The version of the Budget Adjustment bill which has passed the Vermont House has language deferring the changes instead of repealing them. The language in the House-passed version of the bill requires OVHA seek a waiver amendment "upon passage of the FY2012 Budget," and to implement rules in preparation of the eligibility changes upon approval of the waiver amendment, but in no event earlier than July 1, 2011. The Senate has not yet passed the Budget Adjustment Act.

As required by Act 25, An Act Relating to Palliative Care, passed by the legislature during the 2009 session, OVHA submitted a report in November on the programmatic and cost implications of applying for a waiver amendment to provide Medicaid children who have life-limiting illnesses with concurrent palliative and curative care.

Since CMS approved Vermont's waiver request to reduce from 12 months to six months the waiting period required for uninsured people to enroll in VHAP and the premium assistance programs, OVHA will submit a report to the legislature within 60 days on the estimated cost of implementing this change. The legislature will then decide whether to move forward on implementation.

Operational/Policy Developments/Issues

Catamount Health Premium Assistance Programs: The OVHA issues monthly reports on enrollment numbers and demographics, as well as a Catamount Fund financial report. The report that includes the actual enrollment as of the end of December 2009 is included as Attachment 1.

The Dental Dozen: Many Vermonters face challenges in receiving appropriate oral health care due to the limited number of practicing professionals, the affordability of services and a lack of emphasis on the importance of oral health care. Challenges frequently are more acute for low-income Vermonters, including those Vermonters participating in the State's public health care programs. The Dental Dozen recognizes oral health as a fundamental component of overall health and moves toward creating parity between oral health and other health care services.

The OVHA, in conjunction with the Vermont Department of Health (VDH), has implemented 12 targeted initiatives listed below to provide a comprehensive, balanced approach to improve oral health and oral health access for all Vermonters. Updates as of December 31, 2009 are summarized below:

Initiative #1: Ensure Oral Health Exams for School-age Children - The Vermont Department of Health (VDH), the Office of Vermont Health Access (OVHA) and the Department of Education (DOE) collaborated to reinforce the importance of oral health exams and encourage preventive care. Brochures were provided to schools for distribution in October, 2008 to educate parents and children on the importance of fluoride, sealants and regular checkups.

Initiative #2: Increase Dental Reimbursement Rates - The OVHA committed to increase Medicaid reimbursement rates over a three-year period to stabilize the current provider network, encourage new dentists to enroll as Medicaid providers and encourage enrolled dentists to see more Medicaid beneficiaries. Rates were increased by $637,862 in SFY 2008 and by $1,412,441 for SFY 2009. Rates were not increased for SFY 2010 due to budgetary constraints; however, dentists were held harmless from a 2% provider rate reduction experienced by many other Medicaid providers.

Initiative #3: Reimburse Primary Care Physicians for Oral Health Risk Assessments - The OVHA reimburses Primary Care Providers (PCPs) for performing Oral Health Risk Assessments (OHRAs) to promote preventive care and increase access for children from ages 0-3. An action plan has been developed to educate/train physicians on performing OHRA's, including online web links.

Initiative #4: Place Dental Hygienists in Each of the 12 District Health Offices – A successful pilot project resulted in the start of placement of part-time dental hygienists in District Health Offices. Current funding now covers one half-time dental hygienist in the Newport, Vermont District Office.

Initiative #5: Selection/Assignment of a Dental Home for Children - The OVHA introduced the capability to select/assign a primary dentist for a child, allowing for the same continuity of care as assigning a Primary Care Physician (PCP) for health improvement; most new enrollees select a dental home, emphasizing the importance of keeping oral health care on par with regular physicals and health checkups.

Initiative #6: Enhance Outreach - The OVHA and VDH conducted outreach and awareness activities to support understanding of the Dental Dozen and help ensure the success of the initiatives. In SFY 2009, work continued to promote benefits available to dental providers, highlight incentives designed to bring and keep more dentists in Vermont and continue outreach with schools, parents and children. A retired Vermont dentist, with grant assistance, is helping recruit and retain more dentists.

Initiative #7: Codes for Missed Appointments/Late Cancellations - Vermont introduced a code to report missed appointments and late cancellations. The OVHA plans to evaluate this data with the intent of exploring processes to reduce missed appointments and late cancellations in the future.

Initiative #8: Automation of the Medicaid Cap Information for Adult Benefits - The OVHA introduced a system upgrade to allow enrolled dentists to access Medicaid cap information for adult benefits automatically. Currently, the annual cap for adult benefits is set at $495 and the OVHA will track provider use of this upgrade.

Initiative #9: Loan Repayment Program – In SFY 2008, Vermont awarded $195,000 in loan repayment incentives to dentists in return for a commitment to practice in Vermont and serve low income populations; thirteen awards ranged from $5,000 to $20,000. Funding remained at $195,000 for SFY 2009. Funding is targeted to be $97,500 for SFY 2010.

Initiative #10: Scholarships - Scholarships, administered through the Vermont Student Assistance Corporation, are awarded to encourage new dentists to practice in Vermont. The combined allocation of $40,000 for SFY 2008/09 was distributed for the 2008-2009 academic year. The program is scheduled to continue in SFY 2010.

Initiative #11: Access Grants - In SFY 2008, a total of $70,000 was awarded as an incentive for dentists to expand access to Medicaid beneficiaries. Seven grants ranged from $5,000 to $20,000. Funding remained at $70,000 for SFY 2009.

Initiative #12: Supplemental Payment Program – In SFY 2008, the OVHA distributed $292,836 to recognize and reward dentists serving high volumes of Medicaid beneficiaries; 30 dentists qualified for

semi-annual payouts. For SFY 2009, a distribution of $146,418 was made in October, 2008 and another distribution of $146,418 was made in the Spring of 2009; total $292,836. The program has continued in SFY 2010.

Expenditure Containment Initiatives

Vermont Chronic Care Initiative

The goal of the OVHA's Vermont Chronic Care Initiative (VCCI) is to improve health outcomes of Medicaid beneficiaries through addressing the increasing prevalence of chronic illness. Specifically, the program is designed to identify and assist Medicaid beneficiaries with chronic health conditions in accessing clinically appropriate health care information and services; coordinate the efficient delivery of health care to this population by attempting to remove barriers, bridge gaps, and avoid duplication of services; and educate, encourage and empower this population to eventually self-manage their chronic conditions.

The VCCI uses a holistic approach of evaluating both the physical and behavioral conditions, as well as the socioeconomic issues, that often are barriers to health improvement. The OVHA's VCCI 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 room and inpatient utilization. Ultimately, the VCCI aims to improve health outcomes by supporting better self-care and lowering health care expenditures through appropriate utilization of health care services. Through targeting predicted high cost beneficiaries, resources can be allocated where there is the greatest cost savings opportunity. The VCCI focuses on helping beneficiaries understand the health risks of their conditions, engaging them in changing their own behavior, and facilitating their effective communication with their primary care provider. The intention ultimately is to support the person in taking charge of his or her own health care.

The VCCI supports and aligns with other State health care reform efforts, including the Blueprint for Health and the Capitated Office-Based Medically Assisted Treatment (COBMAT) for Opioid Dependence initiative. VCCI staff partner with providers, hospitals, community agencies and other Agency of Human Services (AHS) departments to support a patient-focused model of care committed to enhanced self-management skills, healthcare systems improvement, and efficient coordination of services in a climate of increasingly complex health care needs and scarce resources.

The VCCI focuses on beneficiaries identified as having a specified chronic health condition who are enrolled in Medicaid, VHAP, PCPlus or Dr. Dynasaur under the Vermont Health Access Program with approval by the Centers for Medicaid and Medicare; beneficiaries are not eligible for the VCCI if they receive Medicare or other third party insurance. Those targeted for enrollment in VCCI programs have at least one chronic condition including, but not limited to: Arthritis, Asthma, Chronic Obstructive Pulmonary Disease (COPD), Chronic Renal Failure, Congestive Heart Failure (CHF), Depression, Diabetes, Hyperlipidemia, Hypertension, Ischemic Heart Disease, and Low Back Pain. Eligible beneficiaries are identified and risk stratified by the OVHA's disease management vendor, APS Healthcare, using a proprietary disease identification and stratification system based on Adjusted Clinical Group predictive modeling. Referrals from physicians, hospital, and other community agencies also are accepted. Beneficiaries at highest risk are referred to OVHA care coordinators for intensive face-to-face case management services and those considered to be at lower risk for complications are assigned to APS Healthcare for telephonic disease management provided by an RN health coach. Service level needs are ultimately determined through both predictive modeling and clinical assessment, in accordance with national evidence-based, disease-specific clinical guidelines. The VCCI is designed to enable seamless transition between service tiers as a beneficiary's needs change.

The OVHA began providing face-to-face intensive care coordination case management services in 2006 to the highest risk, medically complex beneficiaries. Especially among these high risk beneficiaries,

chronic conditions and their management are often complicated by co-occurring mental health and substance abuse conditions, as well as challenges due to financial insecurity such as availability of food, safe and affordable housing, and transportation. The OVHA care coordinators, which include registered nurse case managers and medical social workers, facilitate a medical home, support the primary care provider in achieving the clinical plan of care, facilitate effective communication among service providers, and remove barriers to beneficiary success.

In July 2007, the OVHA considerably expanded operations beyond care coordination to provide a full spectrum of disease management interventions using contracted services from APS Healthcare. At that time, the OVHA VCCI implemented a tiered intervention protocol with services along a continuum from printed education and self-management information to telephonic health coaching and disease management services, to intensive face-to-face care coordination. This sophisticated model includes hospital-based nurses, community-based nurse case managers and medical social workers, as well as centrally located nurse, disease management, and social work staff. All staff shares the same vertically and horizontally integrated chronic care management computer system, APS CareConnection®. In addition to being a case tracking system and repository for information on every beneficiary served, the APS CareConnection® system enables secure communications among staff regarding co-managed beneficiaries, and also is accessible by medical providers as a means to be informed about a patient's activities, goals and progress.

The VCCI provides ongoing outreach, education and support to the primary care providers (PCPs) of participating beneficiaries. OVHA care coordinators or APS nurse health coaches collaborate with the beneficiary and their PCP to develop a customized plan of care (POC), and PCPs are provided periodic updates on patients' progress in completing goals established through the POC. OVHA pays an enhanced rate to PCPs for collaborating with OVHA care coordinators working with their highest risk patients. Participating providers are reimbursed $55 for meeting with care coordination staff when one of their patients is enrolled in care coordination services, $55 for a "discharge" meeting to emphasize the importance of a smooth transition to a less intense level of service, and an enhanced capitated payment rate of $15 per month for each care coordination participant.

During the first two years of expanded operations, some level of intervention services was provided to over 25,000 beneficiaries. Vermont's state budget rescission for State Fiscal Year 2009 included elimination approximately 25% from the funds budgeted for the APS Healthcare contract. As a result, resources were refocused and services changed for some beneficiaries effective October 1, 2008. Specifically, efforts were focused predominantly on very high, high and moderate risk beneficiaries most likely to benefit from face-to-face intensive care coordination services and/or telephonic disease management health coaching. Lower risk individuals are sent information on the program, may request information and educational materials, and are contacted twice each year to assess current needs. During the second full year of operation, from July 1, 2008 through June 30, 2009, 3,189 beneficiaries received face-to-face case management services or telephonic disease management health coaching from a registered nurse. The goal for program year 3 (July 1, 2009 through June 31, 2010) is to provide the same level of services to 4,000 members.

The OVHA contracted with the University of Vermont (UVM) for VCCI program evaluation and identification of quality improvement projects. UVM began a thorough evaluation of VCCI administrative (claims) data and completed a Medical Record Review (MRR) during the first quarter of FFY 2010. 1,001 chart audits were conducted on a randomly selected sample of VCCI beneficiaries with a primary diagnosis of diabetes (N=501) or hypertension (N=500). During the second quarter of FFY 2010, UVM will assist the OVHA with identifying clinical quality measures amenable to performance improvement activities likely to have the greatest impact on the VCCI managed population. UVM will subsequently assist with implementing quality improvement activities and evaluate the VCCI's success at improving clinical and utilization outcomes.

Highlights of the Vermont Chronic Care Initiative for Quarter 1 of FFY 2010

- A provider satisfaction survey was conducted and a draft report completed by APS Healthcare. Improvement action plans are pending.
- UVM completed the MRR of a random sample of VCCI participants.
- OVHA care coordinators developed enhanced collaboration protocols with practices participating in the Blueprint Integrated Pilot sites, including finalization of a Business Associate's Agreement enabling OVHA care coordinators to use the Blueprint's data management and reporting system, DocSite.
- OVHA care coordinators implemented regular meetings and electronic data exchange systems with the emergency departments (EDs) of several hospitals for increased collaboration regarding emergency room utilization among VCCI beneficiaries.
- Utilization and savings trend data are not yet available for program Year 2 (July 1, 2008 through June 30, 2009), due to the requirement for a 6 month claims run out period.
- OVHA Care Coordinators began providing case management to buprenorphine patients from five pilot provider practices. During the first quarter of FFY 2010, 34 buprenorphine patients received case management services from OVHA care coordinators. The APS CareConnection® data management and case tracking system was revised to accommodate buprenorphine measures, and data are transferred monthly from APS to the buprenorphine evaluation team at UVM.
- During the first quarter of FFY 2010, the average monthly program caseload was 2,058. Monthly caseload includes beneficiaries in active outreach by VCCI staff, as well as those successfully engaged and receiving care coordination or health coaching services.
- 1,485 unique beneficiaries were served by either OVHA care coordinators or APS disease management health coaches during the first quarter of FFY 2010. This number includes the 34 buprenorphine patients who received case management services from OVHA care coordinators.

Buprenorphine Program: Many physicians limit the number of opiate dependent patients they treat because of the challenging nature of caring for this population (e.g., missed appointments, diversion, time spent by office staff, complex medical needs). The end result is that most physicians see far fewer patients than they could. The Office of Vermont Health Access (OVHA) aims to increase access for patients to buprenorphine services, increase the number of physicians in Vermont licensed to prescribe buprenorphine and support practices caring for the opiate dependent population.

The OVHA, in collaboration with ADAP, maintains a capitated payment program, the Capitated Program for the Treatment of Opiate Dependency (CPTOD), which increases reimbursement to physicians in a step-wise manner depending on the number of patients treated by a physician enrolled in the program.

The Capitated Payment Methodology is depicted below:

Level	Complexity Assessment	Rated Capitation Payment				Final Capitated Rate (depends on the number of patients per level, per provider)
III.	Induction	$348.97	+	**BONUS**	=	
II.	Stabilization/Transfer	$236.32				
I.	Maintenance Only	$101. 28				

Buprenorphine Program Payment Summary FFY '10	
Oct-09	$ 54,512.45
Nov-09	$ 51,177.27
Dec-09	$ 53,567.75
Total	$ 159,257.47

During the 1st quarter of FFY 2010, the CPTOD as implemented by the OVHA had 32 enrolled providers, approximately 493 patients undergoing opiate addiction treatment, and paid $159,257.47 to the 32 providers. The program continues to be successful at increasing patient access to providers who are licensed to prescribe buprenorphine in Vermont.

In 2009, OVHA began enrolling beneficiaries receiving buprenorphine treatment into case management services provided by OVHA's Chronic Care Initiative care coordinators. Five provider practices participate in this pilot. Beneficiaries eligible for case management include those assigned to treatment complexity levels 3 (Induction) or 2 (Stabilization). Care coordinators provide case management services to support the treating provider in rendering care based on evidence based guidelines and to support the beneficiaries in adherence to care. To support the care coordinators in developing knowledge and skill in working with this challenging population, OVHA holds bi-weekly team meetings with the ADAP medical director and other subject matter experts. At the end of the 1st quarter of FFY 2010, the five pilot practices accounted for approximately 47% (N=230) of the total number of buprenorphine patients enrolled with a capitated provider.

Care coordinators record all data in APS Healthcare's data management system, and APS transfers the data monthly to the University of Vermont (UVM), with which OVHA has an MOU for program evaluation. Additionally, APS provides UVM with monthly data on all beneficiaries in the CPTOD. The second evaluation, which will include the time period of the 1st quarter of FFY 2010, will be completed during the 2nd quarter of FFY 2010. OVHA, ADAP, and UVM meet on a bi-monthly basis to review the work plan and identify areas for improvement in the program. The goal is to provide an optimum environment for Medicaid beneficiaries to receive treatment for opiate addiction while also providing support to the medical offices that care for this challenging population.

During the 1st quarter of FFY 2010, the OVHA in collaboration with ADAP and community subject matter experts revised the *Vermont Buprenorphine Practice Guidelines* to facilitate consistent application of best practice treatment approaches. The *Guidelines* can be accessed through the OVHA website and all providers in the CPTOD will be sent a copy along with their updated contracts.

Mental Health – Vermont Futures Planning

Community System Development

The community-based programs designed to reduce the need for State Hospital services and provide a cost effective alternative to care at Vermont State Hospital are nearly complete. Meadowview - the six-bed community residential recovery program in the Brattleboro area received an occupancy permit and license in December 2009. The program team, in collaboration with the VSH clinical leadership, has identified seven potential residents from patients currently at VSH whose treatment needs exceed the capacities of the ongoing care system. Meadowview is licensed as a Level Three Residential Care Facility, and is the newest program in the Community Rehabilitation and Treatment (CRT) system.

DMH has completed a contract with Vermont Psychiatric Survivors, Inc., to develop a detailed program plan to create a peer-run alternative to traditional crisis stabilization services. The contract will

facilitate the hiring of a project developer and work to create a new 501 C-3 organization for the program.

The consultation to design a care management system has been completed. Working groups are engaged in the following activities:

- Developing consensus medical screening protocols for all hospital emergency departments to use when referring individuals for psychiatric inpatient care
- Designing a Request for Proposals for a vendor to develop a "bed board" to identify inpatient and crisis bed availability state-wide for use by the emergency and inpatient providers.
- Use of a standardized assessment tool (the LOCUS) to describe clinical acuity and to help guide placement dispositions statewide.

Secure Residential Recovery Treatment Program

The planning to develop a 15-bed secure (locked) adult psychiatric treatment and recovery residential program on the grounds of the state office complex in Waterbury described in the FFY 08 annual report and the last quarterly report is proceeding. Local planning and zoning work has begun. The architectural team has finished the design work in consultation with leaders from the VSH, consumers, and family members. The design work on staffing, programming, and architecture will culminate in a Certificate of Need Application in the winter of 2010 (pending legislative approval).

It is expected that the program will be state licensed as a Level III Community Care Home and seek accreditation from the Commission of the Accreditation of Rehabilitation Programs. The program will be state-run, operate independently from other state programs (including Vermont State Hospital) and have its own governance, management team, medical director, clinical team, operating policies and procedures, and business office.

The clinical services provided as part of the 24-hour care will include evidence-based psychiatric rehabilitation services and psychosocial treatment delivered in a positive behavioral support framework to assist individuals to engage in their own recovery and to develop the necessary skills to move to less intensive services and achieve a higher level of independent living. The anticipated length of stay in the program ranges from approximately three months to two years or more. This level of care is unique and not currently available in the Vermont system of care. A request to review the plans for the Secure Residential Recovery program was sent to the CMS regional office at the end of December. As proposed, the program will provide a clinically appropriate lower cost option to hospital-level care and will be included in the Community Rehabilitation and Treatment (CRT) program.

Acute Psychiatric Inpatient Care

Planning for replacing acute inpatient beds has advanced with Rutland Regional Medical Center (RRMC), the Brattleboro Retreat, Springfield Hospital and Dartmouth Medical Center. Throughout fall 2009 the Treasurer's Office, state Finance and Administration, and RRMC pursued a market test to capitalize the development of an expanded capacity for psychiatric inpatient services at RRMC. Unfortunately it does not seem likely that bank financing for the proposed structure can be implemented in the current credit market. DMH, RRMC and Finance and Management are pursuing alternative approaches. A potential collaboration between the Vermont, the Dartmouth Medical College, the Dartmouth Mary Hitchcock Medical Center (DMHC), and the White river Junction Veteran's Administration Hospital to develop a 16-bed inpatient program appears quite promising. In addition, the Brattleboro Retreat in collaboration with Brattleboro Memorial Hospital is exploring the concept of creating a "hospital within a hospital" for up to 16-beds. Finally Springfield Hospital and DMH are actively discussing changes to the current psychiatric inpatient program that may enhance their capability to manage greater patient acuity and DMH is also exploring the development of a 10-bed

medically monitored crisis stabilization program with Springfield Hospital. Fletcher Allen Health Care has indicated a willingness to develop no fewer than 20-psychiatric inpatient beds as part of a larger Master Facilities planning process which could begin planning in 2014 or 2015.

Financial/Budget Neutrality Development/Issues

Effective October 1, 2009, AHS began paying OVHA the PMPM capitation payment per the rates in the IGA for FFY10, in addition to the monthly FFY09 trueup payments. As of January 28, 2010, AHS has not yet received official notification from CMS that the FFY10 rates (submitted to CMS on August 31, 2009) have been approved.

AHS received CMS' approval on December 23, 2009 (effective December 31, 2009) to include three new populations in the GC Waiver: Catamount 200-300% FPL, ESIA 200-300% FPL, and VPharm3. On January 20, 2010, AHS received confirmation from CMS that it is acceptable to pay OVHA the existing PMPMs for these populations. Accordingly, on January 1, 2010, AHS began paying OVHA these expansion populations at the PMPM rates set for the Catamount >=200% FPL, ESIA >=200% FPL, and GlobalRxDual MEGs.

On January 20, 2010, AHS received notification from CMS that the CMS-64 and CMS-21 reporting deadlines for QE1209 has been extended to February 19, 2010, due to the MBES/CBES upgrade. Accordingly, our budget neutrality status for QE1209 will be submitted with the next narrative report (for QE0310).

Member Month Reporting

Demonstration project eligibility groups are not synonymous with Medicaid Eligibility Group reporting in this table. For example, an individuals in the Demonstration population 4 HCBS (home and community based services) and Demonstration Project 10 may in fact be in Medicaid Eligibility Group 1 or 2. Thus the numbers below may represent duplicated population counts.

This report is run the first Monday following the close of month for all persons eligible as of the 15th of the preceding month.

Data reported in the following table is NOT used in Budget Neutrality Calculations or Capitation Payments as information will change at the end of quarter; information in this table cannot be summed across the quarters. All payments are adjusted at the end of the year to reconcile expected population movement between eligibility groups.

Demonstation Population	Month 1 10/15/2009	Month 2 11/15/2009	Month 3 12/15/2009	Total for Quarter Ending 1st Qtr FFY '10	Total for Quarter Ending 4th Qtr FFY '09	Total for Quarter Ending 3nd Qtr FFY '09	Total for Quarter Ending 1st Qtr FFY '09	Total for Quarter Ending 4th Qtr FFY '08	Total for Quarter Ending 3rd Qtr FFY '08	Total for Quarter Ending 2nd Qtr FFY '08	Total for Quarter Ending 1st Qtr FFY '08
Demonstration Population 1:	43,821	43,796	43,896	131,513	129,656	128,203	125,825	123,997	122,281	121,926	120,113
Demonstration Population 2:	43,000	43,095	42,980	129,075	128,698	128,590	122,210	121,981	123,283	122,118	120,309
Demonstration Population 3:	9,858	9,787	9,707	29,352	29,428	28,628	26,555	26,452	25,723	24,676	24,821
Demonstration Population 4:	N/A	N/A	N/A	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Demonstration Population 5:	1,140	1,196	1,210	3,546	3,410	3,568	3,832	3,850	3,767	3,542	3,767
Demonstration Population 6:	2,703	2,748	2,767	8,218	8,088	7,480	8,208	7,428	7,357	6,208	6,084
Demonstration Population 7:	30,343	30,832	31,042	92,217	89,158	87,116	75,277	74,301	73,966	72,336	65,803
Demonstration Population 8:	7,398	7,421	7,435	22,254	21,905	23,165	22,032	21,715	23,100	22,697	22,445
Demonstration Population 9:	2,568	2,558	2,547	7,673	7,634	7,665	7,649	7,626	7,838	7,919	7,929
Demonstration Population 10:	N/A	N/A	N/A	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Demonstration Population 11:	9,142	9,519	9,617	28,278	26,444	24,717	19,465	16,136	12,525	7,997	1,641

Consumer Issues

The AHS and OVHA have several mechanisms whereby consumer issue are tracked and summarized. The first is through the Managed Care Entity, Health Access Member Services. This is a contracted

function for providing information on health care programs, assisting with the eligibility process, and helping beneficiaries to understand the benefits and responsibilities of their particular programs. The complaints received by Member Services are based on anecdotal weekly reports that the contractor provides to OVHA (see Attachment 2). Member services works to resolve the issues raised by beneficiaries, and their data helps OVHA look for any significant trends. The weekly reports are seen by several management staff at OVHA and staff asks for further information on complaints that may appear to need follow-up to ensure that the issue is addressed. When a caller is dissatisfied with the resolution that Member Services offers, the member services representative explains the option of filing a grievance and assists the caller with that process. It is noteworthy that Member Services receives an average approximately 25,000 calls a month. We believe that the low volume of complaints and grievances is an indicator that our system is working well.

The second mechanism to assess trends in consumer issues is the Managed Care Entity Grievance and Appeal report. This report is based on data entered by grievance and appeal coordinators in various locations throughout the Managed Care Entity (see Attachment 3). The unified Managed Care Entity database in which they enter information helps them track the timeframes for responding to the grievances and appeals, as well as assists OVHA and AHS in monitoring compliance and assessing if there are trends that may benefit from a performance improvement project.

The third mechanism to track consumer issues is the report for the Office of Health Care Ombudsman (HCO) is a comprehensive report of all contacts with beneficiaries (see Attachment 4). These include inquiries, requests for information, and requests for assistance. HCO's role is to assist individuals to navigate health care insurance systems, and help to resolve eligibility and coverage problems. The data is not broken down into requests for assistance as opposed to complaints.

Quality Assurance/Monitoring Activity

External Quality Review Organization: During this quarter, the External Quality Review Organization (EQRO) reviewed Managed Care Entity's modified Performance Improvement Project (PIP) submission form and produced a final report. The EQRO conducted the validation consistent with the CMS protocol, *Validating Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities*, final protocol, Version 1.0, May 1, 2002. The validation covered steps I through VI, which involved review of the selected study topic, study questions, and study indicators, and identification of the study population, and data collection procedures. The validation results indicated an overall score of 100 percent across all evaluation elements and a finding of high confidence in the results of the PIP for steps I-VI, which incorporate the study design and implementation phases of a PIP. Also during this quarter, the EQRO produced a final report detailing the findings of their Performance Measure Validation activities. During this year's review, the EQRO validated a set of 13 performance measures calculated by the Managed Care Entity. The 13 measures included 19 clinical indicators (or rates) plus three utilization measures. The EQRO conducted the validation activities as outlined in the CMS publication, *Validating Performance Measures: A Protocol for Use in Conducting External Quality Review Activities*, final protocol, Version 1.0, May 1, 2002. The performance measures were reported and validated for the measurement period of October 1, 2007, and ended September 30, 2008. The performance measure specifications identified by AHS were a modified version of selected HEDIS 2008 measures to account for the state-specific reporting period. All 13 measures were assigned a validation finding of fully compliant with AHS specifications. Also during this quarter, the EQRO produced a final report detailing the findings of their review of compliance with managed care regulations activities. The EQRO conducted a review of Managed Care Entity's compliance with federal Medicaid managed care regulations and their associated AHS IGA/contract requirements in three performance categories (i.e., standards). The EQRO followed the guidelines in the February 11, 2003, CMS protocol, *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A Protocol for Determining Compliance With Medicaid Managed Care Proposed Regulations* at 42 CFR Parts 400, 430, et al, for the pre-on-site and on-site

review activities. For two of the three standards, the Managed Care Entity received a percentage of compliance score of 95 percent for an overall percentage of compliance score of 98 percent. Finally, the EQRO produced a final Technical Report that combines the results of all three external quality review activities and identifies strengths and challenges associated with the three activities as well as making recommendations to improve the timeliness, access, and quality of services provided by the Managed Care Entity. This document was forwarded to CMS.

Quality Assurance Performance Improvement Committee (QAPI): During this quarter, the Quality Assessment and Performance Improvement (QAPI) Committee continued to discuss the scope of next year's Managed Care Entity Compliance Review. The discussion focused on the coverage and authorization of service requirements contained in the Code of Federal Regulations. The Committee reviewed the specific items associated with this requirement including but not limited to the following: written criteria and mechanism to ensure consistent application of criteria. Also during this quarter, the group reviewed a reporting template for the monitoring/oversight of the QAPI activities of the Managed Care Entity. It was agreed that other Managed Care Entity staff would be invited to future meetings to present the results of their work. A schedule was distributed which identifies which specific activity will be discussed during each month. Finally, the group continued to develop a list of sample measures to support an Agency-wide performance management system. This approach appears to be in line with broader State-wide

Quality Strategy: The AHS Quality Improvement Manager and the members of the QAPI committee will review the Quality Strategy on a regular basis and recommend any necessary modifications.

Demonstration Evaluation

During this quarter, the AHS Quality Improvement Manager reviewed the interim evaluation report of the Global Commitment to Health 1115 Waiver prepared by Pacific Health Policy Group (PHPG). Feedback was given and modifications were made to the document. At the end of the quarter, the document accompanied the State's formal waiver extension request to CMS. Once the outcome of the waiver extension request is known, AHS will meet with the PHPG project manager to modify the current evaluation work plan to correspond with the time period agreed upon in CMS's response to the request.

Reported Purposes for Capitated Revenue Expenditures

Provided that OVHA's contractual obligation to the populations covered under the Demonstration is met, any revenue from capitation payments related to the beneficiaries covered under this demonstration may only be used for the following purposes:

- 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; and
- Encourage the formation and maintenance of public-private partnerships in health care.

Please see Attachment 6 for a summary of Managed Care Entity Investments, with applicable category identified, for State fiscal year 2009.

Enclosures/Attachments

Identify by title any attachments along with a brief description of what information the document contains.

Attachment 1: Catamount Health Enrollment Report
Attachment 2: Budget Neutrality Workbook *(CMS-64 submission deadline extended, so no budget neutrality information available for this quarterly report)*
Attachment 3: Complaints Received by Health Access Member Services
Attachment 4: Medicaid Managed Care Entity Grievance and Appeal Reports
Attachment 5: Office of VT Health Access Ombudsman Report
Attachment 6: OVHA Managed Care Entity Investment Summary

State Contact(s)

Fiscal:	Jim Giffin, CFO	
	VT Agency of Human Services	802-241-2949 (P)
	103 South Main Street	802-241-1200 (F)
	Waterbury, VT 05671-0201	jim.giffin@ahs.state.vt.us
Policy/Program:	Suzanne Santarcangelo, Director	
	AHS Health Care Operations, Compliance, and Improvement	
	VT Agency of Human Services	802-241-3155 (P)
	103 South Main Street	802-241-4461 (F)
	Waterbury, VT 05671-0203	suzanne.santarcangel@ahs.state.vt.us
Managed Care Entity:	Susan W. Besio, PhD, Director	
	VT Office of Health Access	802-879-5901 (P)
	312 Hurricane Lane, Suite 201	802-879-5952 (F)
	Williston, VT 05495	susan.besio@ahs.state.vt.us

Date Submitted to CMS: February 22, 2010

ATTACHMENTS

VERMONT

State of Vermont
Agency of Human Services
Office of Vermont Health Access

Office of Vermont Health Access
SFY 10 Catamount Health Actual Revenue and Expense Tracking
Tuesday, January 19, 2010

	SFY '10 Appropriated				Consensus Estimates for SFY to Date				Actuals thru 12/31/09				
	<=200%	*>200% before 1/1/10*	*>200% after 1/1/10*	*Total*	*<=200%*	*>200% before 1/1/10*	*>200% after 1/1/10*	*Total*	*<=200%*	*>200% before 1/1/10*	*>200% after 1/1/10*	*Total*	*% of SFY to-Date*
TOTAL PROGRAM EXPENDITURES													
Catamount Health	30,315,950	3,202,483	11,776,319	45,294,752	14,385,914	3,202,483	3,678,977	21,267,374	14,485,403	6,436,111	-	20,921,514	98.37%
Catamount Eligible Employer-Sponsored Insurance	1,061,694	116,345	427,831	1,605,870	509,175	116,345	138,397	763,916	475,263	239,713	-	714,976	93.59%
Subtotal New Program Spending	31,377,644	3,318,828	12,204,150	46,900,622	14,895,089	3,318,827	3,817,374	22,031,290	14,960,665	6,675,825	-	21,636,490	98.21%
Catamount and ESI Administrative Costs	1,523,958	242,689	899,587	2,666,234	761,979	242,689	299,862	1,304,530	761,979	542,551	-	1,304,530	100.00%
TOTAL GROSS PROGRAM SPENDING	32,901,602	3,561,517	13,103,737	49,566,856	15,657,068	3,561,516	4,117,236	23,335,820	15,722,644	7,218,376	-	22,941,020	98.31%
TOTAL STATE PROGRAM SPENDING	**9,883,641**	**3,561,517**	**3,936,363**	**17,381,521**	**4,703,383**	**3,561,516**	**1,236,818**	**8,264,899**	**4,723,082**	**7,218,376**	**-**	**11,941,458**	**144.48%**
TOTAL OTHER EXPENDITURES													
Immunizations Program	-	625,000	1,875,000	2,500,000	-	625,000	625,000	1,250,000	-	625,000	625,000	1,250,000	100.00%
VT Dept. of Labor Admin Costs Assoc. With Employer	-	98,518	295,554	394,072	-	98,518	98,518	197,036	-	98,518	98,518	197,036	100.00%
Marketing and Outreach	500,000	-	-	500,000	250,000	-	-	250,000	250,000	-	-	250,000	100.00%
Blueprint	-	461,678	1,385,035	1,846,713	-	461,678	461,678	923,357	-	461,678	461,678	923,357	100.00%
TOTAL OTHER SPENDING	500,000	1,185,196	3,555,589	5,240,785	250,000	1,185,196	1,185,196	2,620,393	250,000	1,185,196	1,185,196	2,620,393	100.00%
TOTAL STATE OTHER SPENDING	**150,200**	**1,185,196**	**3,555,589**	**4,890,985**	**75,100**	**1,185,196**	**1,185,196**	**2,445,493**	**75,100**	**1,185,196**	**1,185,196**	**2,445,493**	**100.00%**
TOTAL ALL STATE SPENDING	**10,033,841**	**4,746,713**	**7,491,951**	**22,272,506**	**4,778,483**	**4,746,713**	**2,422,014**	**11,947,210**	**4,798,182**	**8,403,572**	**1,185,196**	**14,386,951**	**120.42%**
TOTAL REVENUES													
Catamount Health Premiums	4,559,808	1,079,635	3,970,083	9,609,526	2,196,734	1,060,686	1,226,832	4,484,252	2,147,485	1,704,249	-	3,851,734	85.89%
Catamount Eligible Employer-Sponsored Insurance P	300,889	82,026	301,629	684,544	148,078	83,739	98,692	330,508	146,388	115,175	-	261,563	79.14%
Subtotal Premiums	4,860,697	1,161,661	4,271,712	10,294,070	2,344,811	1,144,425	1,325,524	4,814,761	2,293,873	1,819,424	-	4,113,297	85.43%
Federal Share of Premiums	(3,400,544)	-	(2,988,490)	(6,389,034)	(1,640,430)	-	(927,337)	(2,567,767)	(1,604,794)	-	-	(1,604,794)	62.50%
TOTAL STATE PREMIUM SHARE	1,460,153	1,161,661	1,283,222	3,905,036	704,381	1,144,425	398,188	2,246,994	689,079	1,819,424	-	2,508,503	111.64%
Cigarette Tax Increase ($.60 / $.80)				9,315,500				4,657,750 -				5,177,631	111.16%
Floor Stock				-				- -				341,858	0.00%
Employer Assessment				7,124,207				3,562,104 -				3,220,000	90.40%
Interest				-				- -				9,217	0.00%
State Fund Transfer due to Enhanced ARRA				(3,635,627)				(2,185,061)				(1,737,352)	79.51%
TOTAL OTHER REVENUE				12,804,080				6,034,793				7,011,354	116.18%
TOTAL STATE REVENUE	**1,460,153**	**1,161,661**	**1,283,222**	**16,709,116**	**704,381**	**1,144,425**		**8,281,787**	**689,079**	**1,819,424**		**9,519,857**	**114.95%**
State-Only Balance				(5,563,390)				(3,665,423)				(4,867,094)	
Carryforward				7,311,891				7,311,891				7,311,891	
(DEFICIT)/SURPLUS				**1,748,501**				**3,646,467**				**2,444,797**	
Reserve Account Funding				-				-				-	
REVISED (DEFICIT)/SURPLUS WITH RESERVE FUNDING				**1,748,501**				**3,646,467**				**2,444,797**	

NOTE: The total program expenditures include both claims and premium costs

Green Mountain Care Enrollment Report

December 2009

TOTAL ENROLLMENT BY MONTH

	Jul-07	Nov-07	Jul-08	Nov-08	Jan-09	Feb-09	Mar 09	Apr 09	May 09	Jun 09	Jul 09	Aug 09	Sep 09	Oct 09	Nov 09	Dec 09
Adults:																
VHAP-ESIA	-	35	672	759	859	900	938	952	948	957	966	955	953	962	959	968
ESIA	-	21	336	499	504	489	519	542	577	578	586	589	633	706	692	698
CHAP	-	320	4,608	6,120	6,407	6,699	7,046	7,538	7,710	7,842	7,988	8,235	8,477	8,802	8,954	9,138
Catamount Health	-	120	697	932	1,011	1,103	1,168	1,220	1,243	1,320	1,339	1,404	1,455	1,516	1,556	1,660
Total	-	376	6,313	8,310	8,781	9,191	9,671	10,252	10,478	10,697	10,879	11,183	11,518	11,986	12,161	12,464

	Jul-07	Nov-07	Jul-08	Nov-08	Jan-09	Feb-09	Mar 09	Apr 09	May 09	Jun 09	Jul 09	Aug 09	Sep 09	Oct 09	Nov 09	
Adults:																
VHAP	23,725	24,849	26,441	26,860	28,038	28,957	29,451	30,064	30,747	30,997	31,270	31,605	31,629	32,469	32,429	33,067
Other Medicaid	69,764	69,969	70,947	35,601	36,893	37,019	37,290	37,331	37,663	37,857	37,930	38,117	38,207	37,625	37,689	38,411
Children:																
Dr Dynasaur	19,738	19,733	19,960	20,511	20,630	20,717	20,649	20,636	20,675	20,798	20,705	20,466	20,525	20,434	20,418	20,472
SCHIP	3,097	3,428	3,396	3,527	3,606	3,105	3,140	3,264	3,290	3,330	3,398	3,412	3,430	3,412	3,446	3,451
Other Medicaid*	Included	Included	Included	34,015	35,672	36,375	36,836	37,035	37,354	37,519	37,671	37,605	37,579	37,212	37,291	38,116
Total	116,324	117,979	120,744	120,514	124,839	126,173	127,366	128,330	129,729	130,501	130,974	131,205	131,370	131,152	131,273	133,517
TOTAL ALL	116,324	118,355	127,057	128,824	133,620	135,364	137,037	138,582	140,207	141,198	141,853	142,388	142,888	143,138	143,434	145,981

KEY:

* Prior to November 2008, the numbers for Other Medicaid included both children and adults enrolled in this eligibility category

VHAP-ESIA = Eligible for VHAP and enrolled in ESI with premium assistance

ESIA = Between 150% and 300% and enrolled in ESI with premium assistance

CHAP = Between 150% and 300% and enrolled in Catamount Health with premium assistance

Catamount Health = Over 300% and enrolled in Catamount Health with no premium assistance

VHAP = Enrolled in VHAP with no ESI that is cost-effective and/or approvable

Dr. Dynasaur = Enrolled in Dr. Dynasaur

SCHIP = Enrolled in SCHIP

Totals do not include programs such as Pharmacy, Choices for Care, Medicare Buy-in

Data on the range and types of ESI plans has not been included in this report, but will be included as soon as the data is available.

Green Mountain Care Enrollment Report

Dec 2009 Demographics

Income	VHAP-ESIA*	ESIA*	CHAP*	TOTAL
0-50%	9	4	449	
50-75%	54	1	88	
75-100%	123	-	135	
100-150%	496	5	448	
150-185%	272	222	3,451	
185-200%	5	219	2,089	
200-225%	8	125	1,226	
225-250%	1	85	737	
250-275%	-	35	391	
275-300%	-	2	124	
Total	968	698	9,138	10,804

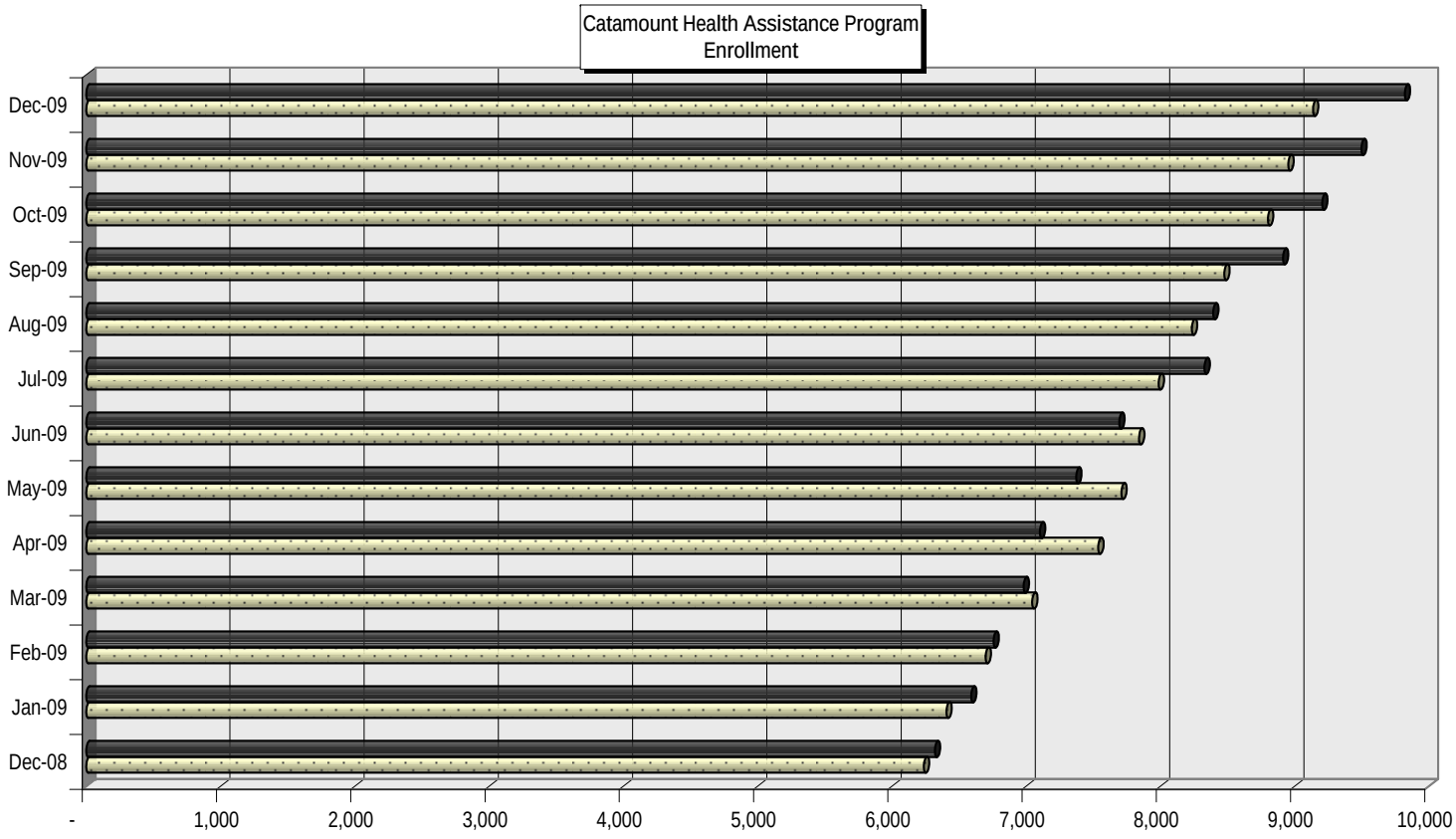
Age	VHAP-ESIA	ESIA	CHAP	TOTAL
18-24	59	68	1,938	
25-35	263	172	1,561	
36-45	373	193	1,473	
46-55	213	188	1,925	
56-64	60	75	2,233	
65+	-	2	8	
Total	968	698	9,138	10,804

Green Mountain Care Enrollment Report (continued)

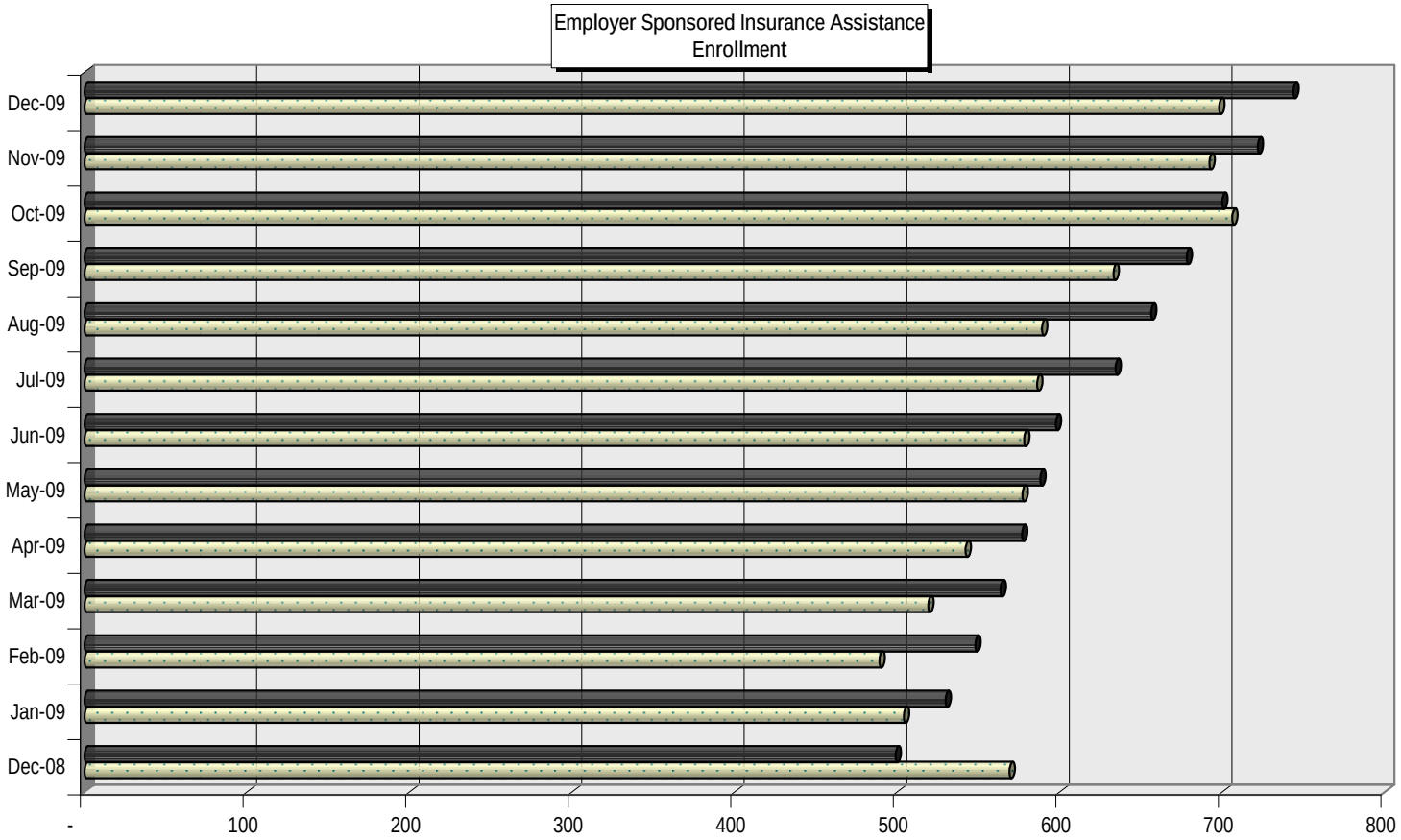
Dec 2009 Demographics

Gender	VHAP-ESIA	ESIA	CHAP	TOTAL
Male	347	256	4,000	
Female	621	442	5,138	
Total	968	698	9,138	10,804

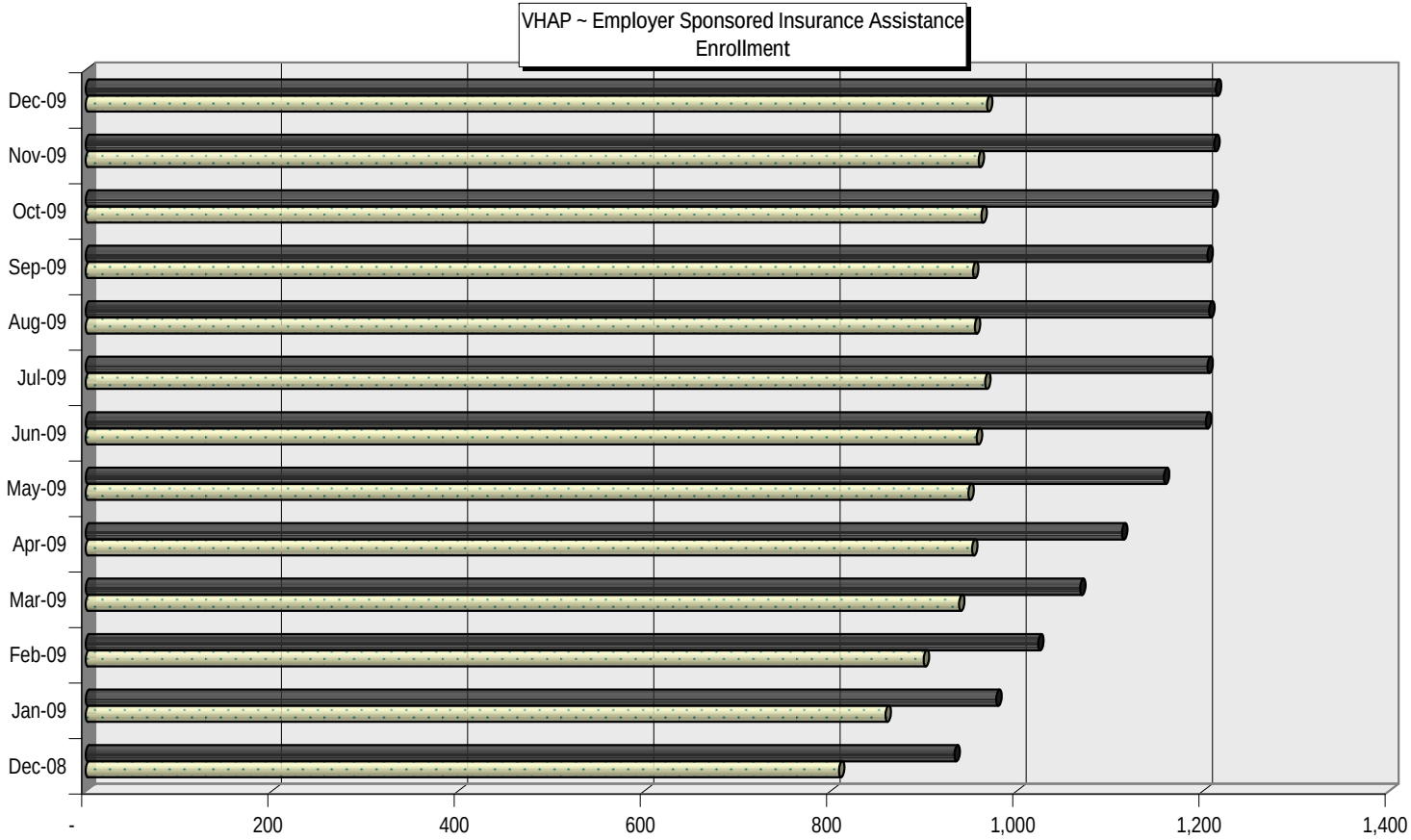
County	VHAP-ESIA	ESIA	CHAP	TOTAL
Addison	59	37	573	
Bennington	78	67	553	
Caledonia	42	25	549	
Chittenden	183	147	1,761	
Essex	9	4	111	
Franklin	103	49	612	
Grand Isle	9	8	112	
Lamoille	58	46	461	
Orange	48	31	471	
Orleans	56	40	534	
Other	-	1	3	
Rutland	113	81	925	
Washington	76	50	911	
Windham	56	45	739	
Windsor	78	67	823	
Total	968	698	9,138	10,804



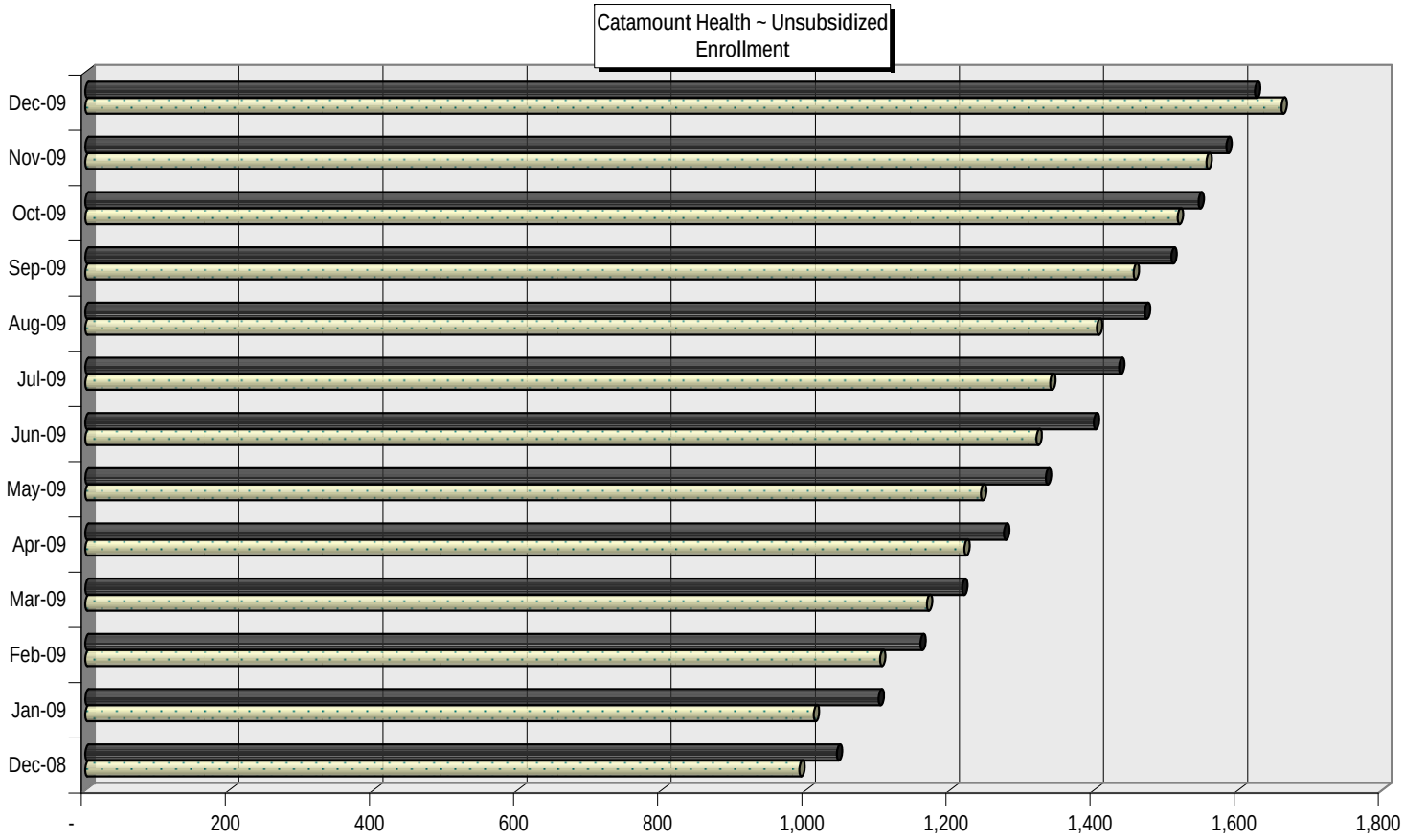
	Dec-08	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09
Projected	6,321	6,592	6,758	6,983	7,103	7,374	7,694	8,329	8,394	8,914	9,206	9,498	9,822
Actual	6,239	6,407	6,699	7,046	7,538	7,710	7,842	7,988	8,235	8,477	8,802	8,954	9,138



	Dec-08	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09
Projected	499	530	548	564	577	588	597	634	656	678	700	722	744
Actual	569	504	489	519	542	577	578	586	589	633	706	692	698



	Dec-08	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09
Projected	933	978	1,023	1,068	1,113	1,158	1,203	1,205	1,207	1,205	1,210	1,212	1,214
Actual	809	859	900	938	952	948	957	966	955	953	962	959	968



	Dec-08	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09
Projected	1,043	1,101	1,159	1,217	1,275	1,333	1,400	1,435	1,471	1,507	1,545	1,584	1,623
Actual	991	1,011	1,103	1,168	1,220	1,243	1,320	1,339	1,404	1,455	1,516	1,556	1,660

VERMONT

Office of Vermont Health Access
312 Hurricane Lane Suite 201
Williston, VT 05495-2086
www.ovha.state.vt.us
[phone] 802-879-5900

Agency of Human Services

Complaints Received by Health Access Member Services
October 1, 2009 – December 31, 2009

Eligibility forms, notices, or process	42
Catamount Health/Premium Assistance Programs premiums, process, ads, plans	5
Use of social security numbers as identifiers	8
General premium complaints	10
Green Mountain Care website	0
Provider issues (perceived rudeness, refusal to provide service, prices) (variety of provider types)	0
Member services	0
Eligibility rules	4
Eligibility local office	16
Prescription drug plan issues	0
Pharmacy coverage	0
Coverage rules	3
Chiropractic coverage change	0
Copays/service limit	1
Provider enrollment issues	1
OVHA	0
Total	**90**

VERMONT

Agency of Human Services

Grievance and Appeal Quarterly Report
Medicaid MCO All Departments Combined Data
October 1, 2009 – December 31, 2009

The MCO is composed of various administrative areas within the Agency of Human Services (AHS). These include: the Office of Vermont Health Access (OVHA), the Department for Children and Families (DCF), the Department of Mental Health (DMH), the Department of Disabilities, Aging and Independent Living (DAIL), and the Department of Health (VDH). Also included in the MCO are the Designated Agencies (DA) and Specialized Service Agencies (SSA) that provide service authorizations for DMH and DAIL. Each entity should have at least one assigned grievance and appeal coordinator who enters data into the MCO database. This report is based on data compiled on January 15, 2010, from the centralized database for grievances and appeals that were filed from October 1, 2009 through December 31, 2009.

Grievances: A grievance is an expression of dissatisfaction about any matter that is not an action taken by the MCO. It includes a request for a written response.

During this quarter, there were twenty-two grievances filed with the MCO. Fourteen were addressed during the quarter, none were withdrawn and eight were still pending at the end of the quarter. Grievances must be addressed within 90 days of filing, so having pending cases at the end of the quarter is to be expected. The grievances were addressed in an average of 21 days. Acknowledgement letters of the receipt of a grievance must be sent within five days, and as the MCO, we averaged only two days, although two of those letters were sent late. Of the grievances filed, 86% were filed by beneficiaries, 9% were filed by a representative of the beneficiary and 5% were filed by someone else at the request of the beneficiary. Of the twenty-two grievances filed, DMH had 91%, and OVHA had 9%. There were no grievances filed for the DCF, the DAIL, or the VDH during this quarter.

On the last quarterly report, it was reported that there were seventeen grievances pending. In actuality, there were only sixteen. The DAIL case had been addressed, but that information had not been entered into the database in time to be accurately reflected in the last quarterly report. Of the sixteen actual cases that were pending at the end of the last quarter, twelve were resolved this quarter, with 75% addressed within the required timeframes. The other three cases had all exceeded the timelines. There are still four grievances outstanding, and all four are from the HowardCenter. As of December 31, 2009, two cases have been pending for 191 days, one for 231 days, and the last for 246 days.

There was one Grievance Review filed this quarter through the DMH. Acknowledgement letters of the receipt of a grievance review must be sent within five days, and it was sent in four days. The three Grievance Reviews that were filed in previous quarters have not been addressed yet. Two are with Rutland Mental Health, one with Clara Martin Center, and the last with HowardCenter.

Appeals: Medicaid rule 7110.1 defines actions that a MCO entity makes that are subject to an internal appeal. These actions are:

1. denial or limitation of authorization of a requested covered service or eligibility for service, including the type, scope or level of service;
2. reduction, suspension or termination of a previously authorized covered service or a service plan;
3. denial, in whole or in part, of payment for a covered service;
4. failure to provide a clinically indicated, covered service, when the MCO provider is a DA/SSA;
5. failure to act in a timely manner when required by state rule;
6. denial of a beneficiary's request to obtain covered services outside the network.

During this quarter, there were thirty-five appeals filed with the MCO, of which fifteen requested an expedited decision, and only one met the criteria. Of these 35 appeals, twenty-three were resolved (66% of filed appeals), two were withdrawn (6%), and ten appeals were still pending (28%). In fourteen cases (61% of those resolved), the original decision was upheld by the person hearing the appeal, one case (4% of those resolved) was reversed, three were modified (13% of those resolved), and five were approved by the department/DA/SSA before the appeal meeting (22% of those resolved).

Of the twenty-three appeals that were resolved this quarter 100% were resolved within the statutory time frame of 45 days. In addition, 91% of the resolved appeals were resolved within 30 days. The average number of days it took to resolve these 23 cases was 17 days. Acknowledgement letters of the receipt of an appeal must be sent within five days, and as the MCO, we averaged only one day, although two of those letters were sent late.

Of the 35 appeals filed, twenty-two were filed by beneficiaries (63%), eleven were filed by a representative of the beneficiary (31%), two were filed by a provider (6%), and none were filed by someone else at the request of the beneficiary. Of the 35 appeals filed, OVHA had 77%, DAIL had 20%, and DMH had 3%. There were no appeals filed for the Department of Health (neither ADAP nor CSHN), or the Department for Children and Families during this quarter.

As each appeal was received the grievance and appeal coordinator assigned it to an action category that related to the content of the appeal as defined in rule 7110 (see above). There were 26 appeals for a denial or limitation of authorization of a requested service or eligibility for service (74%), eight were for a reduction/suspension/termination of a previously authorized covered service or service plan (23%), and one was for a denial, in whole or in part, of payment for a covered service (3%).

There were one DAIL, two DMH, and three OVHA cases filed between April 1, 2009, and June 30, 2009 that were still pending at the beginning of this quarter. In addition, there were four DAIL cases that were still pending from before April 1, 2009. Of those ten pending cases, only four were resolved this quarter. 50% of these cases were upheld (one each for DMH & OVHA), none were reversed; 25% were modified (one for OVHA), none were withdrawn, and 25% were approved before the appeal hearing (one for OVHA). 50% of the cases were resolved within thirty days, 75% in forty-five days, and 100% within fifty-nine days (DHM case was extended). On December 31, 2009 there were six cases still pending; one for DMH DA HowardCenter for 157 days; one for DAIL's Attendant Services Program for 118 days; two for DAIL's Children's Personal Care program for 325 & 476 days, and two for DAIL's DS program through NKHS for 345 days.

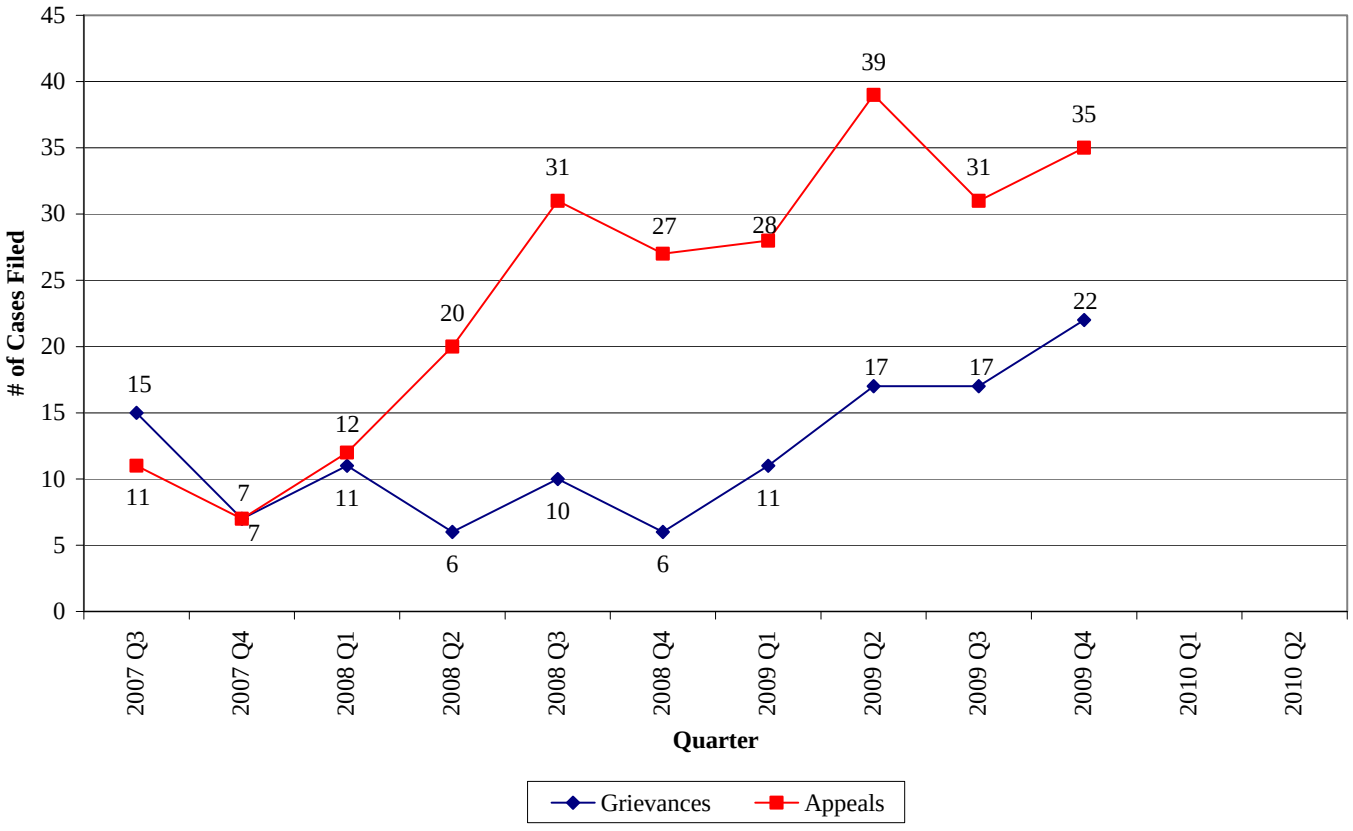
Individuals can file an appeal and a fair hearing at the same time, and they can file a fair hearing if their appeal is not decided in their favor. There were six fair hearings filed this quarter; one for DAIL and five for OVHA. Two were filed concurrently with the appeal, while the other four were filed subsequent to the appeal decision. Four cases are still pending, with one OVHA case being dismissed and another being withdrawn. There were nineteen fair hearings that were pending from previous quarters. Four of them was resolved (three OVHA cases and one DAIL case were withdrawn) so there are a total of nineteen fair hearings still pending, seven for DAIL and twelve for OVHA.

Other Information:

There is one SSA that has refused to be trained in the G&A process (Sterling Area Services) and that DAIL was going to contact them to ensure that an individual was identified and trained. That has still not happened after two years.

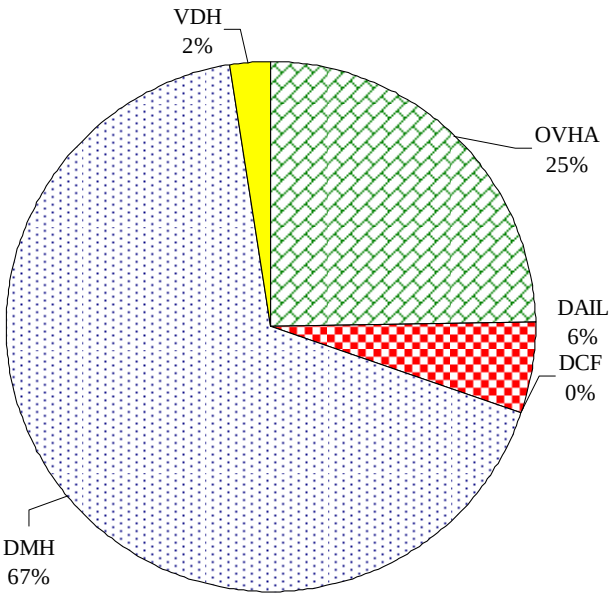
DCF has not yet implemented the MCO Grievance and Appeal process; however, DCF has relied to date on previous internal grievance and appeal processes to handle matters when they arise, and is working towards implementation. There are two persons in the DCF Commissioner's Office who have been trained in the MCO Grievance & Appeal process, although front-line DCF staff have not been identified or trained. The MCO Grievance and Appeal Coordinator has agreed to provide all the necessary training to the Department of Children & Families' staff.

Medicaid MCO Grievances & Appeals

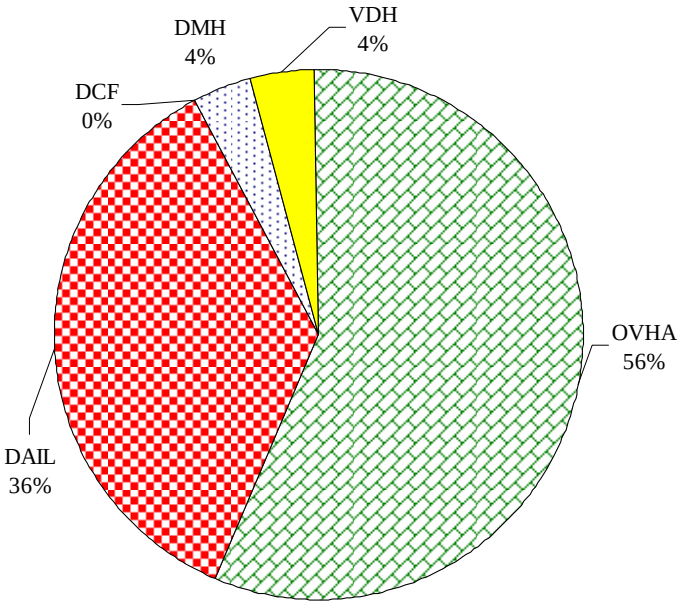


MCO Grievance & Appeals by Department from July 1, 2007 through December 31, 2009

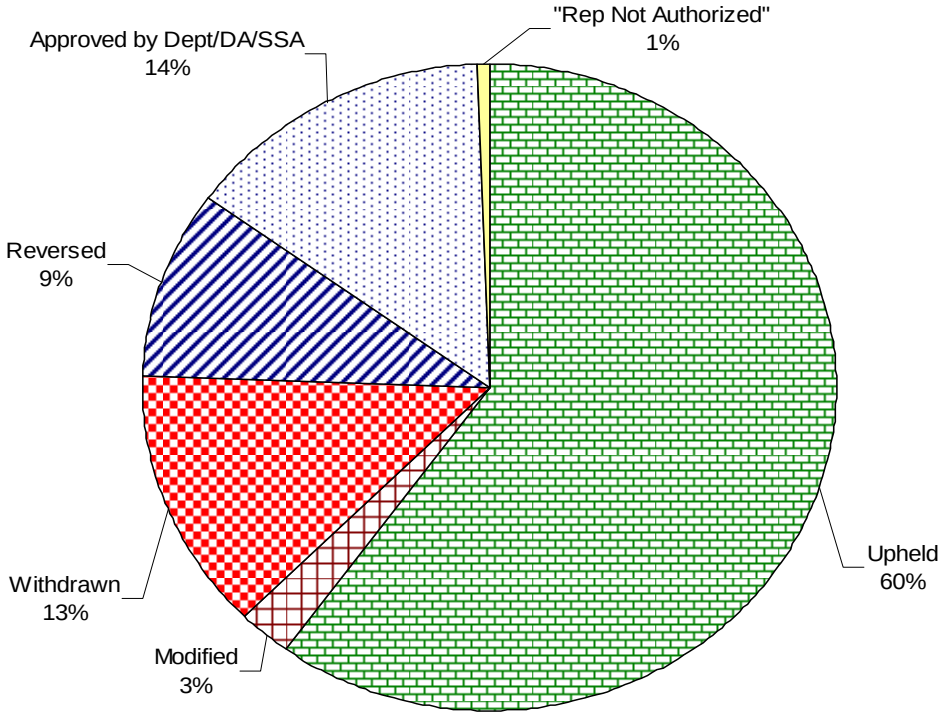
Grievances



Appeals



MCO Appeal Resolutions from July 1, 2007 through September 30, 2009



Grievance and Appeal Quarterly Report
Medicaid MCO All Departments Combined Data
for the period: October 1, 2009 – December 31, 2009

Grievances

Total number of grievances filed: 22

Number pending: 8 *DMH-8*

Number withdrawn: 0

Number addressed: 14 *DMH-12; OVHA-2*
- Within 90 days: 100%
- Exceeding 90 days: 0%

Number of grievances filed too late: 0

Average number of days from "pertinent issue" to filing grievance: 12

Average number of days from filing to entering into database: 7

Average number of days from filing to being addressed: 21

Average number of days to send acknowledgement letter: 2

Number of late acknowledgement letters: 2 *DMH*

Number of grievance reviews requested: 1 *DMH*

Average number of days to send grievance review acknowledgement letter: 4

Number of late grievance review acknowledgement letters: 0

Number of grievance reviews addressed: 0

Source of grievance request:

Beneficiary:	19	86%
Beneficiary Representative:	2	9%
Other:	1	5%

Number related to:

OVHA:	2	9%
DAIL:	0	0%
DCF:	0	0%
DMH:	20	91%
VDH:	0	0%

Top services grieved:
1. Mental Health Services (13)
2. Case Management (4)

Number by category: [Check ALL that apply]

Staff/Contractor:	10
Program Concern:	3
Management:	0
Policy or Rule Issue:	4
Quality of Service:	6
Service Accessibility:	2
Timeliness of Service Response:	1
Service Not Offered/Available:	0
Other:	6
Enrollee Rights:	2
Adverse Effect/Exercising Rights:	0

* * * * * *

Number pending from all previous quarters: 16
*DMH-13; OVHA-3 *Note: One case for DAIL was listed on the last report as pending. It was addressed last quarter, but the data entry was late.]*

Number that were pending in previous quarters and withdrawn this quarter: 0

Number that were pending in previous quarters and addressed this quarter: 12
- Within 90 days: 75% *DMH-6; OVHA-3*
- Exceeding 90 days: 25% *DMH-3*

Number of grievances still pending at the end of this quarter: 4 *DMH [HowardCenter-4: 191, 191, 231 & 246 days]*

Number of grievance reviews pending from all previous quarters: 4 *DMH [RMH-2; CMC;1; HowardCenter-1]*

Number of pending grievance reviews addressed this quarter: 0

Data as of: 01/15/10

Appeals

Number of appeals filed: 35

Number pending: 10 *DAIL-4; OVHA-6*

Number withdrawn: 2 *DAIL-1; OVHA-1*

Number resolved: 23

Upheld:	14	61%	*DAIL-2; OVHA-19*
Reversed:	1	4%	*DAIL-1*
Modified:	3	13%	*OVHA-3*
Approved by Dept/DA/SSA:	5	22%	*OVHA-5*

Number of cases extended: 0

Resolved time frames

Within 30 days:	91%	*DAIL-2; OVHA-19*
Within 45 days:	100%	*DAIL-2; DMH-1; OVHA-20*

Number of appeals filed too late: 0

Average number of days from NOA to filing appeal: 16

Average number of days from filing to entering data into database: 2

Average number of days from filing to resolution: 17

Average number of days to send acknowledgement letter: 1

Number of late acknowledgement letters: 2 *DAIL-1; OVHA-1 (holiday weekend)*

Average number of days from filing to withdrawing: 7

Average number of days to send withdrawal letter: same day

Number of late withdrawal letters: 0

Source of appeal request:

Beneficiary:	22	63%
Beneficiary Representative:	11	31%
Provider:	2	6%
Other:	0	0%

Number related to:

OVHA:	27	77%
DAIL:	7	20%
DCF:	0	0%
DMH:	1	3%
VDH:	0	0%

Top services appealed:

1. Transportation	(11)
2. Personal Care Services	(7)
3. Prescriptions	(7)
4. Surgical Services	(4)
5. Orthodontic	(3)

Number of beneficiaries that requested that their services be continued: 2 6%

Of those that requested their services be continued:

Number that met criteria:	2	100%
Number that did not meet criteria:	0	0%

Number by category:

1. Denial or limitation of authorization of a requested service or eligibility for service:	26
2. Reduction/suspension/termination of a previously authorized covered service or service plan:	8
3. Denial, in whole or in part, of payment for a covered service:	1
4. Failure to provide clinically indicated covered service when the MCO provider is a DA/SSA:	0
5. Denial of a beneficiary request to obtain covered services outside the network:	0
6. Failure to act in a timely manner when required by state rule:	0

Expedited Appeals

Number of expedited appeals filed: 15

Number of expedited appeals that:

Met criteria:	1
Did not meet criteria:	14

For those MEETING criteria

Number pending:0

Number of expedited appeals filed too late: 0

Number resolved: 1

Number upheld:	0	0%
Number reversed:	0	0%
Number modified:	1	100%
Number approved by Dept/DA/SSA:	0	0%

Average number of days from Notice of Action to filing expedited appeal: 6

Average number of days from filing to entering data into database: 6

Average number of days from filing to resolution: 3

Source of appeal:

Beneficiary:	1	100%
Beneficiary Representative:	0	0%
Provider:	0	0%
Other:	0	0%

Service appealed: Prescriptions (1)

Number related to:

OVHA:	1	100%
DAIL:	0	0%
DCF:	0	0%
DMH:	0	0%
VDH:	0	0%

Number by category:

1. Denial or limitation of authorization of a requested service or eligibility for service:	0
2. Reduction/suspension/termination of a previously authorized covered service or service plan:	1
3. Denial, in whole or in part, of payment for a covered service:	0
4. Failure to provide clinically indicated covered service when the MCO provider is a DA/SSA:	0
5. Denial of a beneficiary request to obtain covered services outside the network:	0
6. Failure to act in a timely manner when required by state rule:	0

NOT meeting criteria:

Average number of business days to orally notify beneficiary of not meeting criteria: 2

Average number of business days to notify beneficiary in writing of not meeting criteria: 2

Number late letters: 0

* * * * * *

Number pending from last quarter: 6 *DAIL-1; DMH-2; OVHA-3*

Number pending from previous quarters: 4 *DAIL-4*

Total pending from ALL quarters: 10 *DAIL-5; DMH-2, OVHA-3*

Number of total pending that were resolved this quarter: 4

Number upheld:	2	50%	*DMH-1; OVHA-1*
Number reversed:	0	0%	
Number modified:	1	25%	*OVHA-1*
Number approved by Dept/DA/SSA:	1	25%	*OVHA-1*
Number withdrawn:	0	0%	

Resolution time frames for resolving above cases:

Within 30 days:	50%	*OVHA-2*
Within 45 days:	75%	*OVHA-3*
Within 59 days:	100%	*OVHA-3; DMH-1*

Extended (1) vs. Late (0)

Number of appeals still pending from all previous quarters: 6 *DMH-1 (HowardCenter - 157 days); DAIL-5 (Attendant Services - 118 days; Children's Personal Care Services - 325 & 476 days; Developmental Services - NKHS - 2 cases each at 345 days)*

Fair Hearings

Total number of Fair Hearings filed: 6 *DAIL-1; OVHA-5*

Number of Fair Hearings filed with a concurrent appeal: 2 *OVHA-2*

Number of Fair Hearings filed after appeal resolution: 4 *DAIL-1; OVHA-3*

Number pending: 4 *DAIL-1; OVHA-3*

Number resolved: 2

Number upheld:	0	
Number reversed:	0	
Number modified:	0	
Number dismissed:	1	*OVHA*
Number withdrawn:	1	*OVHA*

Average number of days for resolution: 28

* * * * *

Number of pending Fair Hearings from previous quarters: 19 *DAIL-7; OVHA-12*

Number of pending Fair Hearings from previous quarters resolved this quarter: 4

Number upheld:	0	
Number reversed:	0	
Number modified:	0	
Number dismissed:	0	
Number withdrawn:	4	*DAIL-1; OVHA-3*

Average number of days for resolution for pending Fair Hearings from previous quarters: 159

Number of pending Fair Hearings at the end of this quarter: 19 *DAIL-7; OVHA-12*

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QUARTERLY REPORT
October 1, 2009 – December 31, 2009

OFFICE OF VERMONT HEALTH ACCESS

I. Overview

This is the Office of Health Care Ombudsman's (HCO) report to the Office of Vermont Health Access (OVHA) for the quarter October 1, 2009 through December 31, 2009. We received 190 calls (35%) from OVHA program beneficiaries this quarter, down from 244 (40%) last quarter.

The total number of all cases/all coverages that we opened this quarter was 547, compared to 616 last quarter, a 13% decrease. We had a drop in call volume in November and December for unknown reasons. This compares to 643 calls in the last quarter of 2008, and 622 in 2007. Still, 2009 was our busiest year ever, but only by twelve calls.

The HCO began using a new case management system at the start of this quarter. It enables us to add to the data we want to record and in particular allows us to track more issues, and multiple issues per case. Each case is categorized with a "primary" issue which we use to determine the total number of calls. With this new database, we now can indicate if the case also raised other issues. For example, somebody calling about eligibility for Catamount Health might also have a pre-existing condition that would not be covered by Catamount, and we can now track that as a secondary issue. Or, someone could call about access to pain management and also have access to a primary care provider as a secondary and related issue.

A. Eligibility

The percentage of calls related to eligibility for state programs continues to rise. This quarter we received 154 calls related to eligibility or 28.15% of all calls. Of these, 51 were from current OVHA beneficiaries, 43 were uninsured, and 23 had commercial insurance. We did not get the insurance status from the others. Despite the downturn in the economy, the number of callers who are uninsured is not going up (just 59 this quarter compared to 70 last quarter, and59 the previous one). When they do call, almost 74% are calling about eligibility for state programs.

Notably, we are seeing a significant increase in problems related to eligibility determinations. A look at all issues, not just the primary issues of callers, reveals some serious problems with eligibility determinations. Of the 154 calls about eligibility, five involved application processing delays, eleven involved DCF mistakes, and nine involved lost paperwork. This number of

problems with state processing is unprecedented. It used to be very rare for us to hear that DCF lost paperwork, for example. We'd get maybe one or two a year. To have nine such cases in one quarter is of great concern. When we contact the state to resolve these problems we are hearing of eligibility workers carrying impossibly high caseloads. Some have told us, with great distress in their voices, that they are unable to keep up with their work loads. This is clearly having an impact on applicants and beneficiaries. We are also getting more comments on our consumer satisfaction questionnaires about poor service from the state. One commenter described the service as "wretched."

B. Access to Care

This quarter we had a total of 157 calls related to access issues or 28.7% of all calls. Of these, 70 (45%) were from OVHA beneficiaries. In the previous quarter we had 158 total Access calls, with 85 (54%) coming from OVHA beneficiaries. Since only 35% of our total calls were from OVHA callers, this is a comparatively high percentage of calls regarding access issues, and remains a cause of some concern. The percentage of calls from OVHA beneficiaries about access issues consistently runs about 35%. For beneficiaries of commercial carriers it usually runs about 20-25%. There has been about a 16% increase in calls regarding access from OVHA beneficiaries since 2008.

C. Hybrid programs

We received 59 calls related to the hybrid programs involving both government and commercial insurance, which is about 11% of our total calls. We received 17 calls about federal Medicare Modernization Act (Medicare Part C, Medicare Part D and VPharm) issues, compared to 30 calls last quarter. For the state hybrid programs (Catamount Health and the Premium Assistance programs), we received 42 calls this quarter, compared to 58.

D. Pain Management

The number of calls related to pain management has steadily dropped. This quarter we received eight calls involving this issue, down from sixteen last quarter. Once again most of these calls were from state program beneficiaries, six out of the eight. No one on commercial insurance called about access to pain management treatment.

E. Mental Health

We received only five calls from OVHA beneficiaries about mental health treatment. One involved access to treatment for an eating disorder, which was the primary issue. One involved substance abuse as a secondary issue. The other three were about access to mental health treatment as secondary issues. Compare these figures to the total of twelve calls we received regarding access to mental health and five calls about billing problems.

Disposition of cases

We closed 197 OVHA cases this quarter, compared to 266 last quarter:

- About 2% (3 calls) from OVHA beneficiaries were resolved in the initial call, compared to 6% (15 calls) last quarter;
- 59% (117 calls) were resolved by advice or referral, after an analysis of the problem. Last quarter 54% (143 calls) were resolved in this manner;
- 20% (39 calls) were resolved by direct intervention on the caller's behalf, including advocacy with OVHA and providers, writing letters, gathering medical information, and representation at fair hearings. Last quarter 20% (52 calls) were resolved in this manner;
- About 5% (9 calls) were considered complex intervention, which involves complex analysis and more than two hours of an advocate's time, compared to 7% (19 calls) last quarter.

II. Issues

We opened 190 cases from OVHA beneficiaries, compared to 244 last quarter. Of these:

- 36.84% (70 calls) involved Access to Care, compared to 34.84% (85 calls) last quarter;
- 26.84% (51 calls) involved Eligibility, compared to 28.28% (69 calls) last quarter;
- 21.58% (41 calls) involved Billing/Coverage, compared to 12.70% (31 calls) last quarter;
- 7.37% (14 calls) involved Other issues, compared to 18.03% (44 calls) last quarter, which includes Medicare Part D calls; and
- 5.79% (11 calls) were coded as Consumer Education, compared to 5.33% (13 calls) last quarter.

A. Access to Care

We received 70 OVHA Access to Care calls, compared to 84 last quarter. The top call volume issues within this category were:

- 12 involved access to Prescription Drugs (with none about VPharm Therapeutic Substitution), down from 16 last quarter;
- 12 involved Specialty Care, compared to 10 last quarter;
- 8 involved Transportation, compared to 9;
- 7 involved Dental or Orthodontics, compared to 6.
- 6 involved Pain Management, compared to 12 last quarter; and
- 3 involved Durable Medical Equipment, Supplies or Wheelchairs, compared to 10.

B. Billing/Coverage

We received 41 OVHA calls in this category, compared to 31 last quarter:

- 17 involved Medicaid/VHAP Managed Care, compared to 15 last quarter; and
- 8 involved Hospital Billing, compared to 9 last quarter.

C. Eligibility

We received 51 OVHA calls in this category, compared to 69 last quarter:

- 16 involved Medicaid eligibility, compared to 23 last quarter;
- 16 involved VHAP, compared to 19;
- 5 involved the Buy In Programs, aka Medicare Savings Programs; and
- 2 involved Catamount Health and Premium Assistance, compared to 15. This count only includes callers who were already on OVHA plans when they called us. Many callers who call about Catamount are either uninsured or on commercial plans.

III. Tables on All Calls, Catamount and Medicare Part D, by month and year

All Cases							
	2003	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**
January	241	252	178	313	280	309	240
February	187	188	160	209	172	232	255
March	177	257	188	192	219	229	256
April	161	203	173	192	190	235	213
May	234	210	200	235	195	207	213
June	252	176	191	236	254	245	276
July	221	208	190	183	211	205	225
August	189	236	214	216	250	152	173
September	222	191	172	181	167	147	218
October	241	172	191	225	229	237	216
November	227	146	168	216	195	192	170
December	226	170	175	185	198	214	161
Total	2578	2409	2200	2583	2560	2604	2616

Catamount Health & Premium Assistance			
	2007	**2008**	**2009**
January		39	24
February		21	19
March		29	21
April		22	11
May		17	19
June		29	21
July		20	20
August		14	17
September		17	20
October	27	25	20
November	30	12	11
December	23	23	11
Total	80	268	214

Medicare Modernization Act--Part D, Part C (added 6/08) & VPharm				
	2006	**2007**	**2008**	**2009**
January	118	64	32	21
February	28	20	35	16
March	29	27	18	23
April	43	28	19	9
May	83	25	15	18
June	80	26	18	22
July	43	19	15	16
August	39	28	7	4
September	25	17	9	30
October	32	14	13	7
November	37	25	15	9
December	35	21	16	5
Total	592	314	212	180

Investment Criteria #	Rationale	ATTACHMENT 6
1	Reduce the rate of uninsured and/or underinsured in Vermont	
2	Increase the access of quality health care to uninsured, underinsured, and Medicaid beneficiaries	
3	Provide public health approaches to improve the health outcomes and the quality of life for Medicaid-eligible individuals in Vermont	
4	Encourage the formation and maintenance of public-private partnerships in health care.	

SFY09 Final Managed Care Entity Investments

1/26/10

Investment Criteria #	Department	Investment Description
2	DOE	School Health Services
4	AOA	Blueprint Director
2	BISHCA	Health Care Administration
4	DII	Vermont Information Technology Leaders
2	VVH	Vermont Veterans Home
2	VSC	Health Professional Training
2	UVM	Vermont Physician Training
4	AHSCO	Vermont 2-1-1 Service
2	VDH	Emergency Medical Services
2	VDH	TB Medical Services
3	VDH	Epidemiology
3	VDH	Health Research and Statistics
2	VDH	Health Laboratory
4	VDH	Tobacco Cessation: Community Coalitions
3	VDH	Statewide Tobacco Cessation
2	VDH	Family Planning
4	VDH	Physician/Dentist Loan Repayment Program
2	VDH	Renal Disease
3	VDH	WIC Coverage
4	VDH	Vermont Blueprint for Health
4	VDH	Area Health Education Centers (AHEC)
4	VDH	Community Clinics
4	VDH	FQHC Lookalike
4	VDH	Patient Safety - Adverse Events
4	VDH	Coordinated Health Activity, Motivation & Prevention Programs (CHAMPPS)
2	VDH	Substance Abuse Treatment
4	VDH	Recovery Centers
2	VDH	Immunization
2	VDH	DMH Investment Cost in CAP
2	DMH	Special Payments for Treatment Plan Services
2	DMH	MH Outpatient Services for Adults
4	DMH	Mental Health Consumer Support Programs
2	DMH	Mental Health CRT Community Support Services
2	DMH	Mental Health Children's Community Services
2	DMH	Emergency Mental Health for Children and Adults
2	DMH	Respite Services for Youth with SED and their Families
1	OVHA	Buy-In
1	OVHA	HIV Drug Coverage
1	OVHA	Civil Union
1	OVHA	Vpharm
2	DCF	Family Infant Toddler Program
2	DCF	Medical Services
2	DCF	Residential Care for Youth/Substitute Care
2	DCF	Aid to the Aged, Blind and Disabled CCL Level III
2	DCF	Aid to the Aged, Blind and Disabled Res Care Level III
2	DCF	Aid to the Aged, Blind and Disabled Res Care Level IV
2	DCF	Essential Person Program
2	DCF	GA Medical Expenses
2	DCF	CUPS/Early Childhood Family Mental Health
2	DCF	HBKF/Healthy Babies, Kids & Families
1	DCF	Catamount Administrative Services
2	DCF	Therapeutic Child Care
2	DCF	Lund Home
2	DAIL	Mobility Training/Other Svcs.-Elderly Visually Impaired
2	DAIL	DS Special Payments for Medical Services
2	DAIL	Flexible Family/Respite Funding
4	DAIL	Quality Review of Home Health Agencies
2	DOC	Intensive Substance Abuse Program (ISAP)
2	DOC	Intensive Sexual Abuse Program
2	DOC	Intensive Domestic Violence Program
2	DOC	Women's Health Program (Tapestry)
2	DOC	Community Rehabilitative Care
2	DOC	Return House