

State of Vermont
Agency of Human Services

Global Commitment to Health
11-W-00194/1

Section 1115
Demonstration Year: 3
(10/1/2007 – 9/30/2008)

Quarterly Report for the period
October 1, 2007 to December 31, 2007

Submitted Via Email on
February 29, 2008

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).

The Global Commitment provides 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 three, covering the period from October 1, 2007 to December 31, 2007.***

Enrollment Information and Counts

This is the first quarter using the enrollment table below – thus the second column will be populated in the next quarterly report. 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 SCHP 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.

Demonstration Population	Current Enrollees Last Day of Qtr 12/31/2007	Previously Reported Enrollees
Demonstration Population 1:	40,064	N/A
Demonstration Population 2:	39,947	N/A
Demonstration Population 3:	8,087	N/A
Demonstration Population 4:	N/A	N/A
Demonstration Population 5:	1,256	N/A
Demonstration Population 6:	2,102	N/A
Demonstration Population 7:	23,292	N/A
Demonstration Population 8:	7,519	N/A
Demonstration Population 9:	2,642	N/A
Demonstration Population 10:	N/A	N/A
Demonstration Population 11:	1,273	N/A

Outreach/Innovative Activities

As part of Vermont’s health care reform activities, Vermont’s public health care programs were rebranded under the umbrella name “Green Mountain Care” with the tag line, “A Healthier State of Living.”

The new website, www.greenmountaincare.org, was launched on October 1, 2007. The website hosts a high-level screening tool, and allows Vermonters to determine which programs they may be eligible for and enables the download of the appropriate application. The 1-800 number at Health Access Member Services (i.e., Maximus) for Green Mountain Care is found throughout the website and screening tool to allow for phone inquiries.

The Green Mountain Care marketing campaign was launched on November 1, 2007 with a press conference with Governor James Douglas, TV and print/internet ads designed by the Green Mountain Care marketing contractor, GMMB. The response from the public has been overwhelmingly positive, and as a result, the number of visitors to the website increased from 2,960 in October 2007, to 9,423 in November 2007. The number of Catamount Health calls to the 1-800 number at Maximus for Green Mountain Care has also increased.

The OVHA coordinates an Outreach and Enrollment Steering Committee comprised of about 30 stakeholders who function as information conduits to their individual constituency. Some members are directly involved in assisting consumers or they represent the community through a business association such as the Vermont State Chamber and Lake Champlain Chamber of Commerce. The Campaign for Health Care Security is also a member and employs outreach workers to provide direct consumer assistance in the application process. Each member, as well as others in the community, is helping to spread the word about Green Mountain Care through emails, newsletters, and events.

Thousands of uninsured Vermonters have responded to the marketing campaign by calling for more information about Green Mountain Care, visiting the new website, and applying for premium assistance. As of the end of December, 3,319 households have been approved for Catamount Health premium assistance, and 907 households have been approved for ESI premium assistance. Many of these households are still in the process of enrolling in their ESI plans or choosing a Catamount Health plan.

Health care reform requires a proactive outreach system that uses web-based tools and an inquiry tracking system establishing a case file for potential applicants at the first point of contact. The OVHA has taken the lead in creating a work group to implement a tracking tool; the work group includes representatives from the OVHA, DCF/ESD, and Bi-State Primary Care Association. The tracking tool, and the links to outreach specialists who can provide assistance to Vermonters applying for health care programs, will be in place in the spring of 2008.

During December 2007, the following handbooks were finalized, distributed and posted to the OVHA website at www.ovha.vermont.gov: 1) Health Care Programs Handbook, 2) Pharmacy Programs Handbook, 3) Premium Assistance Programs Handbook.

A Vermont Health Access Advisory (October 2007) was produced and distributed to providers. Banner pages are produced and distributed to providers on a weekly basis. Both the Vermont Health Access Advisory and the banner pages are mechanisms to keep providers informed about topics that impact their services, interaction with beneficiaries or claims submission.

Operational/Policy Developments/Issues

Catamount Health: The most significant issue occurring in FFY08 quarter one was the implementation of the Catamount Health Plan on October 1, 2007 and the corresponding Catamount Health Premium Subsidy program on October 31, 2007. The Catamount Plan is a new health insurance 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). A Global Commitment to Health Waiver Amendment, approved October 31st by CMS, allows Vermont to claim 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.

Employer-Sponsored Insurance Premium Assistance: Employer-Sponsored Insurance (ESI) Premium Assistance offers premium assistance to eligible employees to help them enroll in their employer-sponsored health insurance plan if all of the following criteria are met:

- The employee meets the eligibility criteria to enroll in Catamount Health or the Vermont Health Access Plan (VHAP);
- The employee's household income is under \$2,613 a month for one person;
- The employer's plan has comprehensive benefits; and

The cost of providing premium assistance to enroll in an employer's plan is less than the cost of providing premium assistance to enroll in Catamount Health or the VHAP.

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), is implementing the 12 targeted initiatives listed below to improve oral health for all Vermonters.

- Initiative #1: Ensure Oral Health Exams for School-age Children
- Initiative #2: Increase Dental Reimbursement Rates
- Initiative #3: Reimburse Primary Care Physicians for Oral Health Risk Assessments
- Initiative #4: Place Dental Hygienists in Each of the 12 District Health Offices
- Initiative #5: Selection/Assignment of a Dental Home for Children
- Initiative #6: Enhance Outreach
- Initiative #7: Codes for Missed Appointments/Late Cancellations
- Initiative #8: Automation of the Medicaid Cap Information for Adult Benefits
- Initiative #9: Loan Repayment Program
- Initiative #10: Scholarships
- Initiative #11: Access Grants
- Initiative #12: Supplemental Payment Program

The Dental Dozen initiatives complement and build on one another to form a comprehensive approach for improving oral health in the State. For example, raising reimbursement rates, offering loan repayment and providing scholarship opportunities, help attract and retain Medicaid dental providers. Also, Primary Care Physicians (pediatricians and family physicians) will now have the opportunity to incorporate oral health risk assessments as an integrated component of normal well baby visits. The established goals of the Dental Dozen are to:

- Increase the supply of practitioners providing dental care
- Increase supply of providers serving Medicaid beneficiaries
- Increase access to dental care for Medicaid beneficiaries
- Promote preventive oral health care
- Make dental care more affordable
- Reduce missed appointments and late cancellations

Expenditure Containment Initiatives

Buprenorphine Program: Many physicians limit the number of opiate dependent patients because of the challenging nature of caring for this population (i.e., missed appointments, diversion, time spent by office staff). The end result is that most physicians see far fewer patients than they could. The Office of Vermont Health Access (OVHA), in cooperation with the Vermont Department of Health (VDH) Alcohol & Drug Abuse Program (ADAP), the Department of Corrections (DOC), and the commercial insurers, aims to increase access for patients to Buprenorphine services, increase the number of physicians in Vermont licensed to prescribe Buprenorphine and to support practices caring for the opiate dependent population. The OVHA was appropriated \$500,000 in one-time funds by the legislature to implement the Buprenorphine initiative in 2006. The current plan for the use of these funds, established in a collaborative manner between ADAP and OVHA, is a capitated program that

increases reimbursement in a step-wise manner depending on the number of patients treated by a physician. The Capitated Payment Methodology is depicted below:

	Complexity Assessment	Rated Capitation Payment	+	BONUS	=	Final Capitated Rate (depends on the number of patients per level, per provider)
III.	Induction	\$348.97				
II.	Stabilization/Transfer	\$236.32				
I.	Maintenance Only	\$101.28				

CPTOD 2007 Payment Summary	
May-07	\$ 680.00
Jun-07	\$ 15,595.40
Jul-07	\$ 15,149.40
Aug-07	\$ 20,505.59
Sep-07	\$ 28,315.04
SURVEY	\$ 10,000.00
Oct-07	\$ 27,968.12
Nov-07	\$ 30,492.75
	\$ 148,706.30

As of December 2007, the Capitated Program for the Treatment of Opiate Dependency (CPTOD) as implemented by the OVHA has 30 enrolled providers, 25 of which have active patient rosters and approximately 300 patients undergoing opiate addiction treatment. In the first quarter of SFY '08, the Buprenorphine Program paid \$63,970 in Buprenorphine claims for the 577 patients who received care, and paid a total \$58,507 to 18 enrolled providers. The OVHA will be obtaining rosters for the remaining seven providers and will continue statewide outreach to increase enrollment in the program.

Care Coordination Program: 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 beneficiaries. The OVHA is committed to partnering with primary care providers, hospitals, community agencies, and other Agency of Human Services (AHS) departments, to address the need for enhanced coordination of services in a climate of increasingly complex health care needs and scarce resources by utilizing the flexibility granted by the Global Commitment to Health Waiver.

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 office visits to enable the plan of care (POC) to be successful. Ultimately, the CCP aims to improve health outcomes, decrease inappropriate utilization of services, and increase appropriate utilization of services.

Individuals involved in the CCP 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, Coronary Artery Disease, or Low Back Pain. 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, 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 care coordination efforts to successfully address the priority health and security needs of beneficiaries.

As of December 2007, Care Coordination staff have been deployed in Franklin/Grand Isle, Rutland/Addison, Bennington, Windham/Windsor and Lamoille Counties, which supplement our existing presence in Caledonia/Orleans, Washington/Orange and Chittenden Counties. While the Lamoille County location is covered by a single medical social worker due to low beneficiary penetration and utilization data, the social worker has supplemental resources available with three nursing resources in surrounding district service areas, depending on the beneficiary location. This configuration provides the OVHA with statewide coverage.

A segment of the operating costs for the CCP are set aside for reimbursing participating providers. A strategy has been implemented to reimburse providers with an enhanced capitated payment rate of \$15 per month for a CCP participant. To emphasize the importance of developing a POC 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 are also reimbursed \$55 for a “discharge” meeting to emphasize the importance of a smooth transition 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.

Chronic Care Management Program (CCMP): The goal of the OVHA’s Chronic Care Management Program (CCMP) is to improve health outcomes and reduce costs for beneficiaries with chronic conditions and to collaborate with providers, hospitals and community agencies to support a patient-focused model of care, committed to healthcare systems improvement and enhanced patient self-management skills. In association with the Blueprint for Health and in partnership with the Care Coordination Program (CCP), which addresses the needs of beneficiaries at the highest risk level, the CCMP addresses the increasing prevalence of chronic illness for the Medicaid population. The CCMP is based on the Chronic Care Model and is designed to take a holistic approach by evaluating physical conditions and socioeconomic issues for Medicaid beneficiaries.

The CCMP focuses on beneficiaries who have been identified as having one of the 11 following chronic illnesses: Arthritis, Asthma, Chronic Obstructive Pulmonary Disease (COPD), Chronic Renal Failure, Congestive Heart Failure (CHF), Depression, Diabetes, Hyperlipidemia (i.e., high cholesterol, high triglycerides), Hypertension, Ischemic Heart Disease (i.e., coronary artery disease) and Low Back Pain. Beneficiaries who are currently enrolled in Medicaid, VHAP, PCPlus and Dr. Dynasaur and who have a chronic illness are eligible for the CCMP. The OVHA estimates that there are approximately 25,000 beneficiaries with at least one of the above-cited diagnoses.

The CCMP is administered by two contracts: 1) the Center for Health Policy and Research (CHPR) at the University of Massachusetts Medical School has provided population selection and program monitoring services since January 24, 2007, and 2) APS Healthcare Services, Inc has provided Health Risk Assessments (HRA) and Intervention Services (IVS) since July 1, 2007.

Based upon a predictive modeling system, CHPR provides OVHA with the 25,000 Medicaid beneficiaries selected for CCMP, who are then uploaded into the APS CareConnection® case tracking system. APS CareConnection® is a proprietary system that documents HRAs and interventions, educational tools and self-management strategies to assist practitioners, beneficiaries and APS health

care professionals in the prevention and treatment of chronic conditions. The 25,000 beneficiaries who are selected for CCMP receive a Member Handbook and welcome letter, which includes contact information and an invitation to call APS to complete an HRA. They also receive a quarterly newsletter with general and disease-specific health information. Risk stratification and intervention services are outlined in the table below.

	LOW	MODERATE	MODERATELY HIGH	HIGH
<u>INTERVENTION SERVICES</u>				
HRA administration	X	X	X	X
Initiate IVS after HRA completion	Within 45 days	Within 30 days	Within 15 days	Within 15 days
Welcome letter	X	X	X	X
Quarterly newsletter with disease-specific insert	X	X	X	X
Access to health coach telephonic support	X	X	X	X
Access to RN support	X	X	X	X
List to primary care providers of patients due for disease specific monitoring	Quarterly	Monthly	Monthly	Monthly
List to primary care providers of patients needing drug related interventions	Quarterly	Monthly	Monthly	Monthly
One-time face-to-face outreach visit to primary care provider		X	X	X
Care plan developed in coordination with primary care provider		X	X	X
Outgoing phone contact or correspondence		Quarterly	Monthly	Bi-weekly
Face-to-face contact			One-time	Monthly

As of December 31, 2007, CCMP staff have outreached to 16 Vermont hospitals, eight hospital affiliates, 20 Family Practices, 12 Pediatricians, 25 Federally Qualified Health Centers (FQHCs), 18 Regional Health Centers, 14 Vermont health organizations (e.g., Vermont Assembly of Home Health Agencies, Vermont Association of Hospitals and Health Systems), and three Vermont chapters of the American Diabetes Association, the American Heart Association, and the American Lung Association. Outreach efforts to beneficiaries and providers will continue as CCMP expands across the state.

- Targeted beneficiaries as of July 1, 2007: **22,865**
- HRAs completed for CCMP and CCP as of January 27, 2008: **9,007**
- Intervention Services (IVS) Assessments completed as of January 20, 2008: **1,430**

Financial/Budget Neutrality Development/Issues

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 is reviewing inconsistencies

in data originally submitted to Milliman 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 can be completed.

The state will have issues identified, with resulting plans of action in place, for the submission of the second quarter FFY08 report to CMS. The state is in the process of selecting a vendor for the FFY2009 – 2010 period and will make its announcement of the selected bidder no later then Feb 15, 2008, after which time contract negotiation will commence. Contract effective date is expected to be April 1, 2008.

Please see Attachment 1 for current budget neutrality workbook.

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. See Attachment 2 crosswalk for illustrative purposes.

This report is run the first Monday following the close of month for all persons eligible as of the 15th of the preceding month. Upon implementation of prospective capitation rate payment, AHS will use the enrollment data as of the 15th of the month to pay OVHA’s per member, per month capitation payment on the 1st of the following 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.

Demonstration Population	Month 1 10/15/2007	Month 2 11/15/2007	Month 3 12/15/2007	Total for Quarter Ending Dec 31, 2007 1st Qtr FFY '08
Demonstration Population 1:	40,103	39,986	40,024	120,113
Demonstration Population 2:	40,130	40,171	40,008	120,309
Demonstration Population 3:	8,369	8,300	8,152	24,821
Demonstration Population 4:	N/A	N/A	N/A	N/A
Demonstration Population 5:	1,254	1,250	1,263	3,767
Demonstration Population 6:	1,948	2,076	2,060	6,084
Demonstration Population 7:	21,238	21,962	22,603	65,803
Demonstration Population 8:	7,432	7,503	7,510	22,445
Demonstration Population 9:	2,641	2,645	2,643	7,929
Demonstration Population 10:	N/A	N/A	N/A	N/A
Demonstration Population 11:	-	357	1,284	1,641

Consumer Issues *A summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences. Also discuss feedback received from the other consumer groups.*

The AHS and OVHA have several mechanisms whereby consumer issue are tracked and summarized. The first is through the MCO, 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 3). 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 MCO Grievance and Appeal report. This report is based on data entered by grievance and appeal coordinators in various locations throughout the MCO (see Attachment 4). The unified MCO 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 5). 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.

In addition to these activities the MCO and its IGA partners routinely assess consumer satisfaction with various aspects of care. Future reports will contain results as available of these targeted surveys and feedback forums.

Quality Assurance/Monitoring Activity

External Quality Review Organization: During this quarter, a new External Quality Review Organization (EQRO) contract was put in place. After a competitive bid process, Health Services Advisory Group (HSAG) was retained 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. The EQRO will 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). Also during this quarter, the AHS Quality Improvement Manager participated in a two-day EQRO site-visit. These meetings covered the following topics: an overview of HSAG's history and experience, key steps and HSAG's approach to the validation of performance improvement projects (PIPs) and validation of performance measures, key steps and HSAG's approach to the monitoring of MCO compliance with the BBA and the associated state-specified standards for quality program operations, and the content and purpose of the annual EQR technical report. In addition, the AHS staff attended a HSAG sponsored Performance

Improvement Project (PIP) training session. The group discussed how to incorporate the existing initiative into the CMS-defined PIP activities. The proposed approach is to develop and document the study design components of the CMS PIP activities (i.e., identification of study topic, study question, study indicator(s), and eligible population). Finally, AHS continued to work with the MCO and the previous EQRO to calculate 15 performance measures for baseline and year one of the GC to Health Waiver. It is anticipated that the Performance Measures work will be completed by February 1, 2008.

Quality Assurance /Performance Improvement Committee: During this quarter, the committee continued to review Federal Quality Assessment and Performance Improvement Standards, prioritized agency-wide performance measures, and reviewed the VT Medicaid Managed Care Quality Strategy. The AHS and MCO staff continued to work with agency-wide representatives to identify how and where the MCO standards contained in the CFR are applicable to Vermont's public MCO. This involved completing templates for each standard (i.e., access, structure & operations, and measurement & improvement) that identified the following items: the key elements contained in the CFR for each standard, how and where the elements were relevant to each Department/Division, information regarding monitoring and oversight activities, and specific contact information for all applicable elements. This activity will lead to the development of a MCO Quality Plan. Also during this quarter, the QAPI committee continued to prioritize agency-wide performance measures. The goal of this activity is to make recommendations for MCO measures by June 2008. Finally, HSAG attended a committee meeting to present an overview of their role and responsibility as the new EQRO. Their presentation included the following topics: an overview of HSAG's history and experience, key steps and HSAG's approach to the validation of performance improvement projects (PIPs) and validation of performance measures, and key steps and HSAG's approach to the monitoring of MCO compliance with BBA and the associated state-specified standards for quality program operations.

Quality Strategy: During this quarter, the AHS and OVHA continued to craft a draft quality strategy. Specifically, AHS staff spent time eliciting feedback from QAPI committee members, members of the Health Access Oversight Committee, and the Medicaid Advisory Board. 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.

Demonstration Evaluation

GC Evaluation Plan: During this quarter, AHS staff continued to work with QAPI committee members and other agency-wide stakeholders to revise the GC waiver evaluation plan. Performance measures were discussed and need to be recommended in three major areas: access, cost, and quality. During this quarter, measures contained in the Quality Strategy were cross walked into the GC Evaluation plan, while cost and access measures need further conversation. The QAPI committee continued to inventory applicable access and cost measures across the agency and specify appropriate targets. During the next quarter, the QAPI committee will make recommendations regarding cost and access measures. Once the document has been reviewed by all appropriate parties, the revised evaluation plan will be submitted to CMS. Also during this quarter, a new request for proposal (RFP) for the evaluation of the GC Waiver was initiated. This document is a request by the Vermont Agency of Human Services (AHS) for proposals from qualified entities to conduct an evaluation of the "Global Commitment to Health" Waiver. The evaluation will answer four fundamental questions:

1. To what degree did the demonstration achieve its purposes, aims, objectives, goals, and quantified performance targets?
2. What lessons were learned as a result of the demonstration? What would the state recommend to other states which may be interested in implementing a similar demonstration?
3. In what ways, and to what extent, were outcomes for enrollees, providers, and payers changed as a result of the demonstration?

4. Did the reallocation of resources in the demonstration generate greater “value” for the state’s program expenditures?

While many of the above questions cannot be answered until the end of the demonstration period, the evaluation plan includes on-going information on the incremental progress of the demonstration. The State intends to use the results of the evaluation to inform its future policy decisions with respect to the evolution of its healthcare system and policy planning efforts.

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 MCO investments by category.

Enclosures/Attachments

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

Attachment 1: Global Commitment Expenditure Tracking

Attachment 2: Global Commitment Waiver Medicaid Population/Reporting Crosswalk

Attachment 3: Complaints Received by Health Access Member Services

Attachment 4: Medicaid MCO Legislative and Choices For Care Grievance and Appeal Reports

Attachment 5: Office of VT Health Access Quarterly Report

Attachment 6: OVHA MCO Investment Summary Listing

State Contact(s)

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MCO:	Joshua Slen, Director VT Office of Health Access 312 Hurricane Lane, Suite 201 Williston, VT 05495	802-879-5901 (P) 802-879-5952 (F) joshua.slen@ahs.state.vt.us

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ATTACHMENTS

Global Commitment Expenditure Tracking

QE	Quarterly Expenditures	PQA: WY1	PQA: WY2	Net Program PQA	Net Program Expenditures as reported on 64	non-MCO Admin Expenses	Total columns J:K for Budget Neutrality calculation	Cumulative Waiver Cap	Variance to Cap under/(over)
1205	\$ 178,493,793			\$ -	\$ 178,493,793				
0306	\$ 189,414,365	\$ 14,472,838		\$ 14,472,838	\$ 203,887,203				
0606	\$ 209,647,618	\$ (14,172,165)		\$ (14,172,165)	\$ 195,475,453				
0906	\$ 194,437,742	\$ 133,350		\$ 133,350	\$ 194,571,092				
WY1 SUM	\$ 771,993,518	\$ 434,023	\$ -	\$ 434,023	\$ 782,145,128	\$ 3,996,628	\$ 786,141,756	\$ 1,015,000,000	\$ 228,858,244
1206	\$ 203,444,640	\$ 8,903		\$ 8,903	\$ 203,453,543				
0307	\$ 203,804,330	\$ 8,894,097		\$ 8,894,097	\$ 212,698,427				
0607	\$ 186,458,403	\$ 814,587	\$ (68,408)	\$ 746,179	\$ 187,204,582				
0907	\$ 225,219,267			\$ -	\$ 225,219,267				
WY2 SUM	\$ 818,926,640	\$ 9,717,587	\$ (68,408)	\$ 9,649,179	\$ 819,868,580	\$ 5,930,799	\$ 825,799,379	\$ 1,936,000,000	\$ 324,058,865
Cumulative							\$ 1,611,941,135	\$ 1,936,000,000	\$ 324,058,865
1207	\$ 213,871,059		\$ 1,010,348						
0308									
0608									
0908									
WY3 SUM	\$ 213,871,059	\$ -	\$ 1,010,348	\$ -	\$ 213,871,059	\$ 1,234,012	\$ 215,105,071	\$ 2,848,000,000	\$ 1,020,953,795
Cumulative							\$ 1,827,046,205	\$ 2,848,000,000	\$ 1,020,953,795
1208									
0309									
0609									
0909									
WY4 SUM	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 3,779,000,000	\$ 1,951,953,795
Cumulative							\$ 1,827,046,205	\$ 3,779,000,000	\$ 1,951,953,795
1209									
0310									
0610									
0910									
WY5 SUM	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 4,700,000,000	\$ 2,872,953,795
Cumulative							\$ 1,827,046,205	\$ 4,700,000,000	\$ 2,872,953,795
		\$ 10,151,610	\$ 941,940						

PQA = Prior Quarter Adjustments

ATTACHMENT 2

Commitment Waiver Medicaid Population/Reporting Crosswalk

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
<u>Traditional Medicaid-Eligible Populations</u>		
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
<u>Expansion Populations</u>		
3. Uninsured children with income between 225 and 300 percent of FPL who are not otherwise eligible for Medicaid or SCHIP	6	3. ABD Dual
4. Adults with children with income between 150 and including 185 percent of FPL	6, 7	4. ANFC Adult
5. Childless adults with income up to and including 150 percent of FPL	6, 7	5. ANFC Child
6. Medicare beneficiaries with income at or below 150 percent of FPL, not otherwise categorically eligible	8	6. Global Expansion (VHAP)
7. Medicare beneficiaries with income above 150 percent and less than 200 percent of FPL, not otherwise categorically eligible	8	7. Global Rx Non-Medicare
8. Individuals with persistent mental illness with income up to 150 percent of FPL	N/A	8. Global Rx Dual
9. ESI Premium Assistance	10	9. Optional Expansion
a. Adults with children with incomes between 185 and including 200 percent of FPL		10. VHAP ESI
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

<u>MEGs for Capitation Rate Payment</u>	<u>CMS-64 Reporting Categories</u>
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 3

**Complaints Received by Health Access Member Services
October 1, 2007 – December 31, 2007**

Catamount Health rules	7
Provider issues (perceived rudeness, refusal to provide service) (variety of provider types)	7
Catamount Health Assistance Program premiums and process	6
Use of social security numbers as identifiers	5
Citizenship and Identity eligibility process	4
Eligibility letters received unsealed	2
Eligibility forms or process	2
VHAP-Employer Sponsored Insurance Assistance process	2
General premium complaints	2
Service not available	1
Acupuncture not covered	1
Member services representative rudeness	1
Total	40

Memo to: House Committee on Human Services
House Committee on Health Care
Senate Committee on Health and Welfare

From: Joshua Slen, Director, Office of Vermont Health Access
Joan Senecal, Commissioner, Department of Disabilities, Aging and Independent Living

Re: Medicaid MCO Legislative Grievance and Appeal Report: July 1, 2007 – December 31, 2007
Choices For Care Grievance and Appeal Report: July 1, 2007 – December 31, 2007

Date: January 15, 2008

The Office of Vermont Health Access became the first state-wide publically run Managed Care Organization (MCO) under the Global Commitment to Health waiver. The Grievance and Appeal process is a federal requirement under MCO regulations [42 C.F.R. 438.408]. In addition, the Choices for Care (CFC) program, operated within DAIL, utilizes the MCO Grievance and Appeals database to track grievances and appeals, bringing all public health care programs into alignment with one standard process. Following the direction of Act 65 of the 2007 legislative session, AHS is pleased to present to you our first semi-annual report on the implementation of the Grievance and Appeal process.

Act 65, Sec. 111a. Global Commitment; Grievance And Appeal Rules: Beginning January 1, 2008 and every six months thereafter, the secretary of the agency of human services or designee shall report on the implementation of the grievance and appeal rules for Global Commitment for health and for Choices for Care, including the number and types of grievances, internal appeals, and appeals to the human services board, and the number of internal appeals that were reversed by the independent decision-maker.

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 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 has at least one assigned grievance and appeal coordinator who enters data into the MCO database. This report is based on data compiled from the centralized database.

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 the first report period (July 1, 2007 – December 31, 2007), there were 22 grievances filed with the MCO. The grievance and appeal coordinator analyzes the content of each grievance and categorizes each grievance into one or more topic areas. Approximately half of these grievances related to quality of service. The breakdown of topic areas is in the attached data summary.

During the first report period (July 1, 2007 – December 31, 2007), there were no grievances filed for the DAIL Choices for Care program.

- Appeals: Medicaid rule M180.1 defines actions that an 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 the first report period (July 1, 2007 – December 31, 2007), there were 17 appeals filed with the MCO. Of the 17 appeals, 12 were resolved within the first reporting period (71%). In nine cases (75% of those resolved), the original decision was upheld by the hearing officer. There were no cases reversed or modified from the original decision, two were withdrawn (17%) and one was approved as a result of the information received at the appeal meeting (8%).

As each appeal was received the grievance and appeal coordinator assigned it to an action category that related to the content of the appeal. There were 13 appeals for a denial or limitation of authorization of a requested service or eligibility for service (76%), one was for a reduction/suspension/termination of a previously authorized covered service or service plan (6%), two were for a denial, in whole or in part, of payment for a covered service (12%), and one case has not had its category entered yet (6%).

During the first report period (July 1, 2007 – December 31, 2007), there were seven appeals filed in the Choices for Care program. There were no requests for an expedited appeal. Of those seven appeals, none have been resolved within this first reporting period. The Choices for Care program also assigns one of the MCO action categories to each appeal, bringing all public health care programs into alignment with one standard process. Of the seven appeals, five were for a denial or limitation of authorization of a requested service or eligibility for service (71%), and two were for a reduction/suspension/termination of a previously authorized covered service or service plan (29%).

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. Although there have been nine appeals that have not been decided in the individual's favor for the MCO, none of these have gone to a fair hearing yet. Of the two cases that have gone to fair hearing, one was filed simultaneously with the appeal and the other was filed after the appeal was withdrawn. For the Choices for Care program, during this period there were no fair hearings filed with the appeals.

Medicaid MCO Legislative Grievance and Appeal Report
 Data Summary
 July 1, 2007 – December 31, 2007

 Number of Grievances filed: 22

Number by Category:

Staff/Contractor:	<u>7</u>
Program Concern:	<u>3</u>
Management:	<u>1</u>
Policy or Rule Issue:	<u>2</u>
Quality of Service:	<u>11</u>
Service Accessibility:	<u>6</u>
Timeliness of Service Response:	<u>6</u>
Service Not Offered/Available:	<u>4</u>
Other:	<u>4</u>

Since more than one category can be chosen for each grievance or appeal, total number by category may exceed total number filed.

 Number of Appeals Filed: 17

Regular Appeals:	<u>17</u>
Expedited (met criteria) Appeals:	<u>0</u>

The number of resolved appeals may not add up to the number filed, since an appeal may span two report periods.

 Number Resolved: 12

Number Upheld:	<u>9</u>
Number Reversed:	<u>0</u>
Number Modified:	<u>0</u>
Number Withdrawn:	<u>2</u>
Number Approved by Dept/DA/SSA:	<u>1</u>

"Approved by Dept/DA/SSA" is when additional information received allowed the department/DA/SSA that made the original decision to reverse itself without a decision from the person hearing the internal appeal.

Number by "Action" Category:

Denial or limitation of authorization of a requested service or eligibility for service:	<u>13</u>
Reduction/suspension/termination of a previously authorized covered service or service plan:	<u>1</u>
Denial, in whole or in part, of payment for a covered service:	<u>2</u>
Failure to provide clinically indicated covered service when the MCO provider is a DA/SSA:	<u>0</u>
Denial of a beneficiary request to obtain covered services outside the network:	<u>0</u>
Failure to act in a timely manner when required by state rule:	<u>0</u>

 Number of Fair Hearings Filed with an Appeal: 2

(these are fair hearings filed during this reporting period that have also had an appeal filed for the same action)

 Number of Pending Fair Hearings with an Appeal: 2

The number of pending and resolved fair hearings may not add up to the number filed, since a fair hearing may span two report periods.

 Number of Resolved Fair Hearings with an Appeal: 0

Number Upheld:	<u>0</u>
Number Reversed:	<u>0</u>
Number Modified:	<u>0</u>
Number Withdrawn:	<u>0</u>

Choices for Care Legislative Grievance and Appeal Report
 Data Summary
 July 1, 2007 – December 31, 2007

 Number of Grievances filed: 0

Number by Category:

Staff/Contractor:	<u> 0 </u>
Program Concern:	<u> 0 </u>
Management:	<u> 0 </u>
Policy or Rule Issue:	<u> 0 </u>
Quality of Service:	<u> 0 </u>
Service Accessibility:	<u> 0 </u>
Timeliness of Service Response:	<u> 0 </u>
Service Not Offered/Available:	<u> 0 </u>
Other:	<u> 0 </u>

Since more than one category can be chosen for each grievance or appeal, total number by category may exceed total number filed.

 Number of Appeals Filed: 7

Regular Appeals:	<u> 7 </u>
Expedited (met criteria) Appeals:	<u> 0 </u>

The number of resolved appeals may not add up to the number filed, since an appeal may span two report periods.

 Number Resolved: 0

Number Upheld:	<u> 0 </u>
Number Reversed:	<u> 0 </u>
Number Modified:	<u> 0 </u>
Number Withdrawn:	<u> 0 </u>
Number Approved by Dept/DA/SSA:	<u> 0 </u>

"Approved by Dept/DA/SSA" is when additional information received allowed the department/DA/SSA that made the original decision to reverse itself without a decision from the person hearing the internal appeal.

Number by "Action" Category:

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

 Number of Fair Hearings Filed with an Appeal: 0

(these are fair hearings filed during this reporting period that have also had an appeal filed for the same action)

 Number of Pending Fair Hearings with an Appeal: 0

The number of pending and resolved fair hearings may not add up to the number filed, since a fair hearing may span two report periods.

 Number of Resolved Fair Hearings with an Appeal: 0

Number Upheld:	<u> 0 </u>
Number Reversed:	<u> 0 </u>
Number Modified:	<u> 0 </u>
Number Withdrawn:	<u> 0 </u>

ATTACHMENT 5
QUARTERLY REPORT: October 1, 2007 - December 31, 2007
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 for the quarter October 1, 2007 through December 31, 2007.

We received 277 OVHA-related calls this quarter, down from 304 last quarter. Call volume was higher in October than November or December, which is consistent with past years. Our total call volume for all calls this quarter was 621, down slightly from 627 last quarter. Thus, this quarter OVHA-related calls were 45% of the total call volume, also down slightly percentage-wise from last quarter (48 %), which was down (52%) from the previous quarter.

We saw a significant drop in OVHA-related prescription drug and Medicare Part D calls as compared to the same quarter last year. This year we had 60 calls in October, November and December. In 2006 we had 104.

However, this year we had the new health care reform programs beginning this quarter. The state began processing applications for the new programs on October 1, 2007, with coverage beginning November 1, 2007. We had 80 calls related to Catamount, including billing issues, consumer education, and eligibility questions about the premium assistance programs. We are working on what issues we should be tracking for these new programs.

II. Disposition of cases

We closed 265 OVHA cases this quarter.

- 56 % (149) of the calls were resolved by advising or referring the client after analyzing the problem;
- 35 % (92 calls) required direct intervention on the caller's behalf, including advocacy with OVHA and providers, writing letters, gathering medical information, and representation in fair hearings.

III. Issues

- 30% (80 calls) involved access to care, up from 20% (61 calls) last quarter;
- 22% (58 calls) involved billing or coverage problems, about the same as last quarter;
- 24 % (64 calls) were eligibility issues, down from 29% (89 calls) last quarter in which we saw a spike due to many Medicare Savings Program terminations;
- 6 cases were coded as OVHA consumer education.
- 14% (36 calls) of the OVHA-related calls involved Medicare Part D or related Medicare Modernization Act issues.

A. Access to Care

We received 80 OVHA-related access to care calls.

- 30 % (24 calls) of these involved prescription drugs, not including Part D calls, compared to 21% (13 calls) last quarter;
- 5 % (4 calls) involved access to DME supplies, significantly down from 18% (11 calls) in the previous quarter;
- 19% (15 calls) involved dental care including orthodontics, an increase from 15% (9 calls) calls last quarter;
- 25% (20 calls) involved specialty care, such as surgical care, almost triple the calls received last quarter, which were 11% (7 calls).

B. Billing/Coverage

We received 58 calls in this category.

- 52% (30 calls) involved Medicaid/VHAP managed care billing, as compared to 49% (33 calls) calls last quarter;
- 19% (11 calls) involved hospital billing problems, as compared to 21% (14 calls) calls last quarter.

C. Eligibility

We received 64 calls in this category.

- 47 % (30 calls) of the eligibility calls involved Medicaid eligibility, significantly down from the 70% (62 calls), last quarter which included a large number of calls related to Buy In program terminations;
- 23 % (15 calls) involved VHAP eligibility, as compared to 19% (17 calls) last quarter;
- 20% (13 calls) were related to the new premium assistance programs and Catamount Health.

D. Medicare Part D/Prescription Drug Problems

- We received 36 calls from OVHA beneficiaries with problems primarily related to Medicare Part D, up from 28 last quarter. This increase was expected because of the annual changes in Part D plans and the open enrollment period.
- 22 % (60 calls) of the OVHA calls dealt with prescription coverage, if the Part D calls are viewed together with the calls coded as access to drugs/pharmacy, vs. 15% (47 calls) last quarter;
- The number of Good Cause and Hardship exceptions from the State (for Medicare beneficiaries who are also on Medicaid or VPharm) we have sought has gone down as we continue to seek ways to resolve these matters quickly for callers who are at risk of going without their medication.

IV. Uninsured Callers

In addition to the 277 OVHA-related calls, the HCO received an additional 71 (up from 67) calls from uninsured Vermonters. We discussed the new Catamount and premium assistance programs with many of these callers. We received 80 Catamount-related calls this quarter.

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 formation and maintenance of public-private partnerships in health care
Department of Education	School Health Services		●		
BISHCA	Health Care Authority	●		●	●
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	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 & Nursing Homes		●	●	
DDAIL	Caregiver Registry		●	●	
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		●		