



PARTNERS in CARE

July 2011

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From The Desk of the Medical Director

ACOs – Part 3- Sharing Some of What We Know So Far

This is a continuing dialogue on ACO's and VMC's evaluation of the opportunity. Parts 1 and 2 of the dialogue can be found on the VMC website: www.vermontmanagedcare.org. Click on Providers then ACO Resources.

The much-anticipated accountable care organizations (ACOs) proposed Rule on the Medicare Shared Savings Program was issued by the Centers for Medicare and Medicaid Services (CMS) on March 31st with 429 pages of information. The proposed rule details and seeks comments on many various aspects of the formation of and participation within an ACO. The regulations have a 60 day comment period which concluded at 5pm on June 6th.

VMC has reviewed the current regulations and assessed the benefits and impacts associated with becoming an ACO and subsequently submitted our comments to CMS. The next step is to wait for the publication of the final regulations, which we expect will occur toward the end of July or August. VMC will analyze any changes from the proposed rule, and will then determine if an application will be submitted. Federal regulations dictate that applications be submitted in September for a January 1, 2012, start date.

Main Concepts of ACO Regulations:

- Reimbursement for Medicare beneficiaries will remain as fee for service and the beneficiary will be able “to exercise complete freedom of choice in the physicians and other health care practitioners and suppliers from whom they receive their services”.
- ACOs follow evidence-based medicine and improve care and services over time.
- 65 quality indicators are to be reported to CMS.
- Primary Care Physicians, defined as general practice, family practice, internal medicine and geriatric medicine, can participate in only one ACO.
- Notification to the beneficiary that the provider is practicing within an ACO is required.
- All ACO marketing and communication materials must be approved by CMS before use with beneficiaries to protect and ensure they are not confusing or misleading.
- ACOs must prove Patient Centeredness.

Beneficiary Assignment

Also called patient attribution, beneficiary assignment to ACOs is based on primary care services rendered only by ACO professionals who are physicians. CMS is proposing that beneficiary assignment be based on the plurality of primary care services [Plurality of PCP Services is defined as the beneficiary having received more office or other outpatient evaluation and management services from the PCP than from any other physician.] from those providers within the ACO. These services would be calculated using Medicare total allowed charges.

Shared Savings Determination

CMS has proposed both a one-sided model and a two-sided model for shared savings. The differences between the one sided model and the two sided model is the risk sharing. The one-sided model has no risks for losses and would share in savings only. The two-sided model

We encourage our readers to call or write us with your feedback about our newsletter.

Contact Martita Giard at 847-8161 or email to:
martita.giard@vtmednet.org

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ACOs – Part 3 *continued*

shares in both savings and losses with a higher percentage of reward for savings. During the 3rd year of the contract, all ACOs will become two-sided models.

Both models would require the ACO to have total per capita costs for assigned beneficiaries in the performance year be both above the minimum savings rate of 2% and below the estimated benchmark as well as meet certain quality and performance standards to qualify for the shared savings.

Marketing & Communications

All marketing & communication materials that will be shared with Medicare beneficiaries must be approved by CMS in advance. This is to ensure that materials are clear and not misleading to the beneficiaries.

Primary Care Physicians are responsible for informing their Medicare beneficiaries that they are participating in an ACO. Beneficiaries can opt out of having CMS share their health care information with the ACO, therefore it will be very important for the providers to educate beneficiaries about the need to allow the ACO to receive that information. If beneficiaries decline the option to have their health care information shared with the ACO, the ACO will still be responsible for managing this population's care, meeting financial targets, etc., without the use of claims data to support that function.

Quality and Performance Standards

The regulations outline five quality and performance domains containing a total of 65 indicators which will provide focus to ACO quality improvement activity and will serve as the basis for CMS to assess, benchmark, reward, and improve the ACO quality performance. The domains are:

- 1) Patient experience of care (or patient experience and satisfaction survey items)
- 2) Care coordination (information systems and transitions of care)
- 3) Patient safety (hospital acquired infections)
- 4) Preventative health (vaccinations, screenings, etc.)
- 5) At-risk population/frail elderly health (chronic conditions and frail elderly)

Of the 65 indicators, 10 are patient survey questions, 7 are claims data information and 48 are clinical indicators. CMS has tried to combine indicators from incentive or quality programs that are currently in progress such as Meaningful Use and Group Practice Reporting Option (GPRO), a computerized extension of Physician Quality Reporting System (PQRS). They have also added approximately 20 new indicators. However, the final quality indicators are still to be defined.

Patient-Centeredness Criteria

CMS has clearly articulated that patient centeredness is a key focus for ACOs. CMS is proposing that an ACO would be considered patient-centered if it has all of the following in place:

- A beneficiary experience of care survey.
- Patient involvement in ACO governance. CMS is proposing that representation by a Medicare fee for service beneficiary serve on the ACO governing body.
- A process for evaluating the health needs of the ACO's assigned population, including consideration of diversity in their patient populations, and a plan to address the needs of their population.
- Systems to identify high-risk individuals and processes to develop individualized care plans for targeted patient populations, including integration of community resources to address individual needs.

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- A mechanism for the coordination of care (for example use of enabling technologies or care coordinators).
- A process for communicating clinical knowledge/evidence-based medicine to beneficiaries in a way that is understandable to them. This process should allow for beneficiary engagement and shared decision-making that takes into account the beneficiaries' unique needs, preferences, values, and priorities.
- Written standards for beneficiary access and communication and a process for beneficiaries to access their medical record.
- Internal processes for measuring clinical or service performance by physicians across the practices, and using these results to improve care and service over time.

It will be the ACO's responsibility to monitor compliance with the regulations for the network and to report the quality and performance indicators in totality.

In conclusion we at VMC feel that the current standards:

- Do not provide enough upside to make it worthwhile in a high performing network.
- The two-sided model with risk is not a viable option for start up.
- The proposed standards are highly prescriptive, too regulatory in nature and just not appealing.
- We anticipate it would take a fair amount of up front investment that is not guaranteed in the return.
- Our assessment of our ability to meet the entrance criteria of 50% Meaningful Use, and 65 Quality measures in year 1 and 2 is slim.

We at VMC will look to the final ACO regulations with our eye on advocacy for our provider network, and for Medicare patients. If VMC providers are going to be accountable for the quality and cost of healthcare for this population, we look to CMS to provide the "right" amount of regulation so we can truly work collaboratively to improve care for Medicare patients.

ACO Impact Analysis to VMC Providers and Hospitals

The ACO Team at VMC did a thorough analysis of the Proposed Rule to understand how the regulations would impact our network. Our analysis identified many critical areas that would be restrictive, burdensome, and in some cases punitive, to our provider network.

In the CMS proposal, beneficiaries are assigned only to physicians designated as primary care physicians. This would be very limiting for VMC, as our NPs and PAs play a critical role in providing care to our patients, and help to extend the care provided by the physicians. Not including them as an integral part of the care delivery system would be restrictive.

VMC is a data-driven organization. If there are patients who "opt out of data sharing" it would impede our ability to adequately manage their care and improve their outcomes.

The Shared Savings section of the proposed regulations was very disappointing. CMS has proposed both a one-sided and a two-sided model for shared savings. The difference between the one-sided and the two-sided model is the risk sharing. The one-sided model has no risks for losses and would share in savings only. The two-sided model shares in both savings and losses with a higher percentage of reward for savings. During the 3rd year of the contract, all ACOs would become two-sided models. Both models would require the ACO to have total per capita costs for assigned beneficiaries in the performance year be both above the minimum savings rate of 2% and below the standards to qualify for the shared sav-

ings. The concept of the two-sided methodology is laudable, but the details in this version of the regulations are untenable for providers. The concerning factors include a 25% withhold to offset future losses, with no clarity as to how or when it would be paid back.

One of the burdensome aspects of the proposed legislation is that all marketing materials, communications, and activities related to the ACO must be pre-approved by Medicare. Not only would this be very time consuming for providers, it could result in a lack of timely information for patients due to providers second guessing themselves when communicating with their patients.

Another restrictive aspect of the proposal is that providers may not add ACO physician participants during the 3-year ACO agreement. This would be very difficult in a rural state such as Vermont. This section of the proposal then turns punitive as the regulations add that "changes such as this may result in termination of the 3-year agreement and forfeiture of the 25% withhold of shared savings earned by the original ACO participants."

Our review of the Proposed Rule indicated many areas of opportunity for CMS to make revisions in the final regulations that will be more provider-friendly. CMS has solicited comments, and we hope that our comments and concerns will be thoughtfully considered, and fully addressed in their final regulations.

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CHCB Construction Update



Construction on the expanded Community Health Center of Burlington (CHCB) facility is full speed ahead and excitement is growing as the building takes shape. The building’s LEED certification ensured stewardship of resources and green-building practices during construction and will result in natural light in 90% of the space, improved indoor air quality and dramatically improved energy efficiency. With site improvements, many rooms in the new facility will have Vermont views of the rolling hills and scenic vistas surrounding Burlington. Even more importantly, the new building will double in size, bringing additional access to care for the region with new medical, dental and behavioral health rooms and more capacity for newly-expanded services. With this expansion, CHCB estimates that an additional 6,500 community residents can be served. CHCB currently serves about 13,000 community residents a year.

With siding installation, sheet rock-ing and painting in progress, CHCB staff is gearing up for their first major move of the project. Phase One will be completed in July and the medical and behavioral

health staff will move into the new space in back of the current facility. After that first move, construction can begin on the last, final phase of the construction, slated to be fully complete by March 2012. Major funding for the project is coming from a national HRSA grant, but community support will be critical to complete the project. The Heart of Health Care Capital Campaign is currently underway to raise the final dollars needed.

CHCB is Chittenden County’s sole Federally Qualified Health Center and all members of the community are welcome for care. Special programs that support access include a sliding-fee scale for all services for low-income, uninsured community residents, the Safe Harbor Clinic for adults and families experiencing homelessness, the Pearl Street Clinic for youth up to age 26, and a school-based dental clinic serving low-income schoolchildren of the Burlington School District.

For more information about the project or the Heart of Health Care Capital Campaign, please contact Alison Calderara at (802) 264-8190.

Events & Notices

VMC Employee News

Over the past several months, VMC has had several staff changes. We would like to congratulate those who have recently been promoted.



Employee Promotions:

- Terry Burbo, CPCS, was promoted from Supervisor, Credentialing and Enrollment to Manager, Credentialing and Enrollment
- Karl Zygarowski, was promoted from Technical Specialist/Information Analyst to Senior Technical Specialist, Analytics & Reporting
- Leah Fullem, was promoted from Supervisor, Data Management & Reporting to Manager, Analytics & Reporting.

In addition the name of the Data Management & Reporting department has changed to Analytics & Reporting.

Credentialing

In an effort to create efficiencies and improve credentialing processes for providers, the Fletcher Allen Health Care Credentialing Staff has been integrated with the Vermont Managed Care Credentialing Department led by Manager, Terry Burbo. Vermont Managed Care will be responsible for the credentialing and recredentialing functions for all providers in the VMC Network as well as the credentialing functions for providers on the Medical/Associate staff of Fletcher Allen Health Care and all state and federal program enrollment for FAHC. Velinda Russo and the Medical Staff Office will remain at the main FAHC campus. Velinda will continue to be responsible for Medical Staff Services including all privileging, OPPE/FPPE, CME, provider mandatories and policy/standards maintenance for TJC and CMS for FAHC, she can be reached at 847-2702.

For any questions regarding credentialing, recredentialing or FAHC state and federal enrollment please feel free to contact any of the credentialing staff listed below:

- Terry Burbo, CPCS - Manager of Credentialing and Enrollment 847-8199
- Jodie Couture - Senior Credentialing Coordinator. 847-8056
- Kelley Roy – Credentialing Coordinator 847-6242
- Ana Anderson – Credentialing Coordinator. 847-4244
- Dona Marcotte – Credentialing Coordinator 847-8411
- Nancy Iredale – Medical Staff Coordinator 847-5222
- Holly Turner – Medical Staff Coordinator 847-5996
- Kari Bierbaum – Medical Staff Coordinator. 847-4303
- Beth Elkins – Medical Staff Coordinator 847-1882

Provider Email Addresses – Bounce Backs

Communicating with you to keep you informed of current events and information is very important to VMC and important for you. We want to be sure that you have the information you need in a timely, effective and efficient manner. In an effort to be more “green”, VMC would like to begin using email to send our providers information when appropriate.

One of the items that we will be sending to our providers on a quarterly basis is the VMC Provider Newsletter. We would ask that you set your email filters to accept emails from vmcnewsletter@vtmednet.org. This can typically be accomplished by accessing your email filter settings and adding this address to your “safe senders” or “approved senders” list. We have received many email bounce backs from providers in the past and want to prevent it in the future. By accepting emails from VMC this will allow prompt delivery of important information to your practice.

If you have questions or concerns please contact your Provider Relations Representative, Elizabeth Roach or Carrie Germaine at, 847-8161 or toll free at 1-800-639-3881.

Network Brag Board

Lowrey Sullivan, MD, Named NMC's Chief Medical Officer

St. Albans, Vt.-- In an effort to ensure an even closer working relationship between the physicians and the hospital, Dr. Lowrey Sullivan has accepted the position of Chief Medical Officer on Northwestern Medical Center's Leadership Team. He will begin his new part-time role at the hospital on or about June 1.

"I am very pleased that Dr. Sullivan has accepted the position of Chief Medical Officer," said Jill Bowen, NMC's Chief Executive Officer. "This is a challenging role with many competing priorities and imperatives. Having a physician who already has the respect of our medical staff provides a strong foundation for the success of this position."

Dr. Sullivan, a Board-Certified Obstetrician & Gynecologist with Green Mountain OB/GYN, will maintain his clinical practice while serving in the part-time position for the hospital. Dr. Sullivan earned his Bachelors degree from Middlebury College and his Medical Degree from the University of Vermont. He did his Internship and Residency training at the Albany College of Medicine.

"I'm very excited to be assuming this new role," said Dr. Sullivan. "With the changing healthcare environment, it's even more critical for physicians in private practice and employed physicians to work together with hospital administration to optimize patient care in our community."



2011 MVP Quality Award

Aesculapius Medical Center won a 2011 Quality Award from MVP Health Care for providing outstanding care to diabetes patients. Providers who were recognized by MVP ensured that patients received the medical services recommended by the American Diabetes Association to gain good control of the disease. Aesculapius was the only Vermont practice in the MVP network to receive a Quality Award for diabetes care.

The 2011 award categories reflect the focus of Vermont's Blueprint for Health, including helping patients stay healthy and managing existing illnesses, using systems in place at the primary care practice level, coordinating care within a team of health care professionals both internally and within the community, and focusing on the full range of care for patients. Vermont Managed Care serves as MVP's contracted representative to review quality reports with providers in their network.



VMC Reimbursement – A Follow Up to our 2010 Provider Survey

In our 2010 Provider Survey, there was a question asking if our network felt VMC's reimbursement levels were adequate. We received a score of 2.5 out of 5. We felt it was important to provide some education around this topic, specifically related to the withhold return which is part of the overall reimbursement. Providers have told us when they review the VMC reimbursement terms, they have not factored in the actual withhold return amount. It is important to factor in the withhold to obtain an accurate level of reimbursement.

Why withhold is incorporated in VMC's reimbursement methodology -

VMC is a non-profit PHO (Physician Hospital Organization), governed by a board of directors including Vermont community health care providers as well as physicians and other individuals affiliated with Fletcher Allen Health Care, VMC's sole corporate member. It contracts with payors to arrange health care services for enrolled individuals through a network of participating physicians, hospitals and suppliers. Its contracts with payors tend to be based on a capitation or risk model, under which VMC shares significant responsibility for the costs of health care services to patients who receive care from VMC contracted providers. Use of withholds and incentive terms in con-

tracts with providers is sound business management for a provider-sponsored organization such as VMC that assumes responsibility for the cost of health care to an enrolled population. Also, withhold and incentive risk provisions help align our network providers' interest in working together to pursue both quality improvement and cost effectiveness in the care of patients. These features also help enable VMC to achieve the integration in health care delivery that is key to the lawful operation of PHO organizations such as VMC in accordance with guidelines of the Federal Trade Commission and Department of Justice Antitrust Division.

VMC's Aggregate withhold return rate from 2005-2009

Year	Aggregate WH Returned*
2005	119.7%
2006	110.1%
2007	95.4%
2008	80.3%
2009	96.2%

We are currently in the process of reconciling the 2010 withhold return to be distributed to our network by the end of July.

* Aggregate WH Return includes both professionals and facilities in the VMC network. It also includes all VMC risk contract products with MVP, TVHP, Fletcher Allen Preferred self-insured plan, and Copley self-insured plan.

Other General Reimbursement Facts

PCP Chronic Care Enhancement

Pilot Program - VMC recognizes the work involved in managing the care of chronically ill members. By way of this pilot which has recently been approved by the VMC Board to be rolled out as a program later this year, we have provided additional reimbursement to PCP's in the pilot for the past two years.

Care Management Reimbursement

Amount - VMC recognizes that the PCP's in our network are asked to perform an array of administrative tasks in managing their patient panel. For the past several years, VMC has provided a per member per month amount to account for this work.

Annual Reimbursement Increases -

Over the past several years VMC has consistently provided annual increases. These increases have occurred during years when reimbursement terms were held flat by other health plans.

If you have questions about the withhold or any part of the VMC reimbursement terms, we would be happy to talk with you. Please contact your VMC External Provider Relations Representative at 800-639-3881.

Fletcher Allen Preferred and Preferred Plus Members Drug Co-Pay Assistance Program

A Fletcher Allen Health Care Employee and/or family member enrolled in the Fletcher Allen Preferred or Preferred Plus Medical Program may qualify for a program that covers the co-pay for certain high value medications. The Program is open to all Fletcher Allen Preferred and Preferred Plus Medical Plan subscribers and dependents. Eligibility is based on both financial and clinical eligibility.

Examples of eligible clinical conditions include:

- Hypertension
- Diabetes
- Asthma
- Mood Disorders
- Hyperlipidemia
- Congestive Heart Failure
- Coronary Heart Disease
- Chronic Obstructive Pulmonary Disease
- Deep Vein Thrombosis/Pulmonary Embolism

Members of the Fletcher Allen Preferred and Preferred Plus Health Plans may call the Fletcher Allen Health Care Health Assistance Program at 802-847-6984 to apply for the program. After a short intake process, the member will be asked to provide supporting financial documentation prior to having their prescription filled at either the UHC or Fanny Allen Pharmacy.

The Program is sponsored by Vermont Managed Care on behalf of the Fletcher Allen Preferred Medical Plan. If you have a patient who is struggling to fill their medications, please contact us for additional information. Brief informational cards about the program are also available. Providers may call their VMC External Provider Relations Representative at 800-639-3881 for further information.

Do You Have Contractual Documents You Need to Return to VMC?

We recognize that as busy practicing physicians and providers, you deal with a multitude of information each and every day. Sometimes, things like contractual documents get pushed to the middle or even the bottom of the pile. Our Provider Relations staff are here to help you address any questions so you can sign and return these documents ensuring you are participating in the appropriate health plan products in a timely manner. In the future, we will be stamping all contractual documents on the delivery envelope as such to help you easily identify these materials when they arrive. If you would like to talk with us about your VMC contract and riders, please contact your VMC External Provider Relations Representative at 800-639-3881.

Pre-Approval Changes for Fletcher Allen Preferred Medical Plan

Effective August 1, 2011, pre-approval will be required for head CT and MRI for Fletcher Allen Preferred Medical Plan Members.

Additional clarifications for services that continue to require pre-approval have been incorporated on the revised pre-approval form. These include: Skilled Nursing Facility Admissions, Neuropsychological Evaluation and Testing, Infertility Correction, Orthognatic Surgery Related to TMJ, MRS, Video EEG Monitoring, Speech Therapy, Genzyme, Cerazyme, Ocular Prostheses, and All Rental DME Equipment. As has been historically the case, participating providers and facilities are financially liable for failure to

obtain pre-approval for the following: Diagnostic Laparoscopy, Hysterectomy, Septoplasty, Sinus Surgery/FESS Procedure, Breast MRI, Cardiac MRI, Head, Cervical, Lumbar and Sacral CT and MRI's, Myelograms, Pet Scans, MRS.

Effective immediately, the following items no longer require pre-approval: Skin Endpoint Titration, Respiratory Therapy, and Meningitis Vaccine. Travel Immunizations are also being removed as they are a non-covered benefit. Also being removed from the pre-approval list are deluxe equipment items which are not covered when standard equipment meets medical need. Convenience items are also non-covered and have been removed: Removable

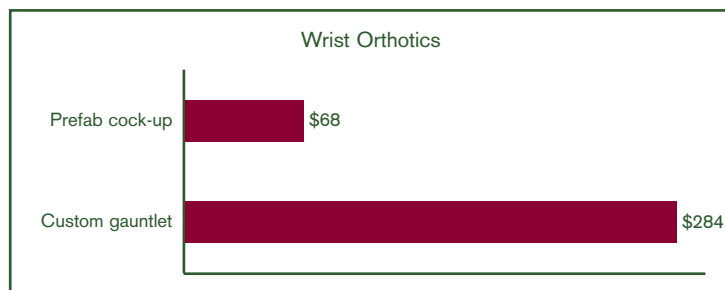
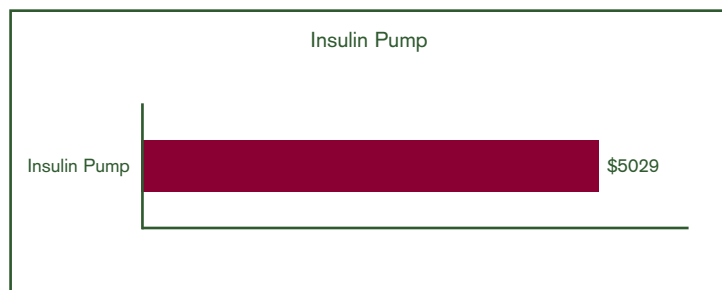
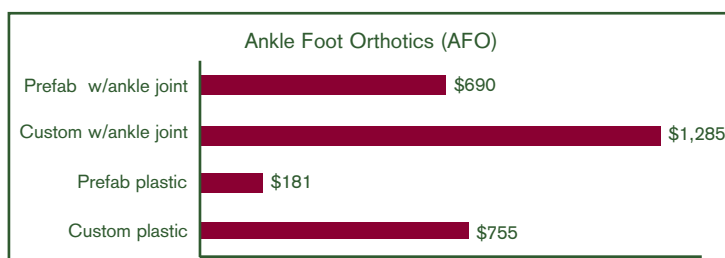
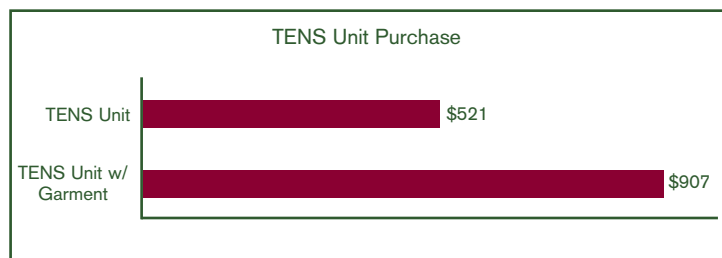
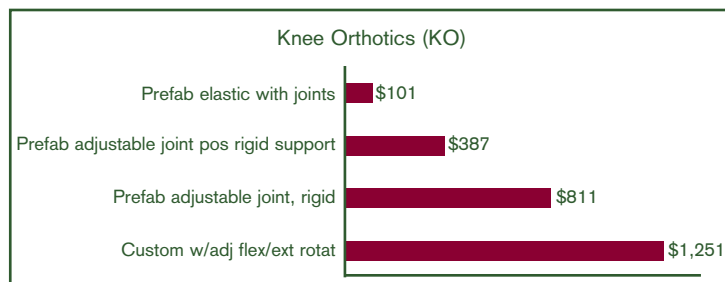
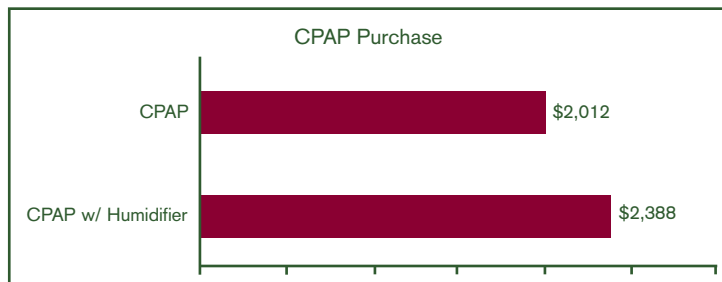
Soft Interface related to DME, Oxygen Accessory (wheeled cart, battery pack, battery charger, DC power adapter), Electronic Spirometer, and Functional Electrical Stimulator.

An updated pre-approval form can be found on the VMC website at www.vermontmanagedcare.org by clicking on Providers, then on Forms or by calling your External Provider Relations Representative at 800-639-3881.

Average Durable Medical Equipment (DME) Vendor Charge Per Unit

In health care, one of the things that have been historically difficult to pinpoint, is how much something costs. It is typical that the ordering provider is unaware of the associated cost for the item they have requested for their patient. We thought it would be interesting to share with you the average charge per unit for durable medical equipment by in-network DME vendors. Again, these are average vendor charges per unit.

Average DME Vendor Charge Per Unit for Commonly-Ordered DME and Orthotics



Primary Care Chronic Care Enhancement Pilot Program

The VMC Care Management Committee reviewed the results of the two-year Chronic Care Enhancement (PCP CCE) Pilot Program at its March 2011 meeting. The recommendation to move from a pilot status to a program was presented to the Board of Directors at their April 2011 meeting and was approved.

The effective date of the program is targeted for October 1, 2011. Between now and then, we will be preparing for the transition and will send out additional communication to primary care physicians in our core service area.

The following criteria modifications made by the Board will be incorporated into the permanent program as of October 1, 2011:

1. Cap program enrollment to 800 members
2. Continue to require an initial care plan
3. Require an attestation at 6 month intervals for re-enrollment
4. Modify the payment cycle to twice per year
5. Require on annual comprehensive preventive exam and at least one other E&M visit in a 12 month period by the PCP for payment

Should you have any questions please contact your VMC External Provider Relations Representative at 800-639-3881.



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Internal Medicine |

* Board Officers

Vermont Managed Care Contact Numbers



Phone #	Phone # FAP	Fax #
Main		
802-847-8161		802-847-6214

Customer Service (CS) / Case Managers (CM)		
802-847-8369 (CS)	802-847-4862 (CS)	802-847-6213 (CS)
800-639-3881 (CS & CM)	866-582-6836 (CM)	802-847-6213 (CM)

Provider Enrollment (PE) / Provider Relations (PR) / Credentialing		
802-847-8161 or		802-847-3427 (PE)
800-639-3881		802-847-6214 (PR)
		802-847-6254 (CRED)

A complete phone list of all staff is available in the VMC Provider Manual available online at www.vermontmanagedcare.org.