

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
January 1, 2008 to March 31, 2008

Submitted Via Email on
May 21, 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). 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 second quarterly report for waiver year three, covering the period from January 1, 2008 to March 31, 2008.***

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 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 3/31/2008	Previously Reported Enrollees
Demonstration Population 1:	40,716	40,064
Demonstration Population 2:	40,823	39,947
Demonstration Population 3:	8,180	8,087
Demonstration Population 4:	N/A	N/A
Demonstration Population 5:	1,174	1,256
Demonstration Population 6:	2,151	2,102
Demonstration Population 7:	25,399	23,292
Demonstration Population 8:	7,645	7,519
Demonstration Population 9:	2,640	2,642
Demonstration Population 10:	N/A	N/A
Demonstration Population 11:	3,169*	1,273

* Demonstration Population 11 represents the State’s new Catamount Health Premium subsidy . Enrollment numbers are expected to grow throughout the year.

Green Mountain Care Outreach / Innovative Activities

Green Mountain Care, Vermont’s newly rebranded public health care programs are gaining in recognition with the general public. As expected, there was a decrease in inquiries to the Green Mountain Care website and call center during the holiday season. However, calls began to increase in January during the second wave of television and on-line advertising. During this quarter an independent randomized survey was conducted to determine ad recall and Vermonters’ feelings about the State’s health care reform efforts. The results showed over half of Vermonters are aware of Green Mountain Care with 45% saying they have heard of the program before, (which was only launched in November, 2007). Recognition is attributed to a successful television campaign. Sixty-nine percent recalled seeing the Green Mountain Care ads, and the ad caused one in five Vermonters to take some kind of action (i.e. calling the 1-800 number, visiting the website, or telling a friend about the program). Also 58 % reported they were interested in Green Mountain Care. Interest appears to be driven by Vermonters’ general concern about health care and prescription drug costs and worry about losing their own health coverage. Finally, 77 % of Vermonters strongly support the idea of Green Mountain Care and the state’s role in offering such a program.

In addition to the ad campaign, efforts at outreach include:

- Website improvements including making the site accessible to those with limited English proficiency.
- Adding a Green Mountain Care spokesperson to the Department of Labor's (DOL) Rapid Response Team. This team is available whenever there is a lay off in order to educate laid-off employees about programs for which they qualify.
- On-going efforts ensure that Green Mountain Care outreach brochures and posters are visible in places that uninsured individuals seek care, especially in hospital emergency departments and clinics that are part of Vermont's safety net system of care.
- Efforts are underway to update applications and forms to make them more user friendly. We are also asking partner organizations to update their forms with current branding so there is alignment between state agencies and community organizations.

Another promising and proactive outreach effort is targeted at seniors during Graduation Season:

Efforts are underway to encourage college seniors to check out their health insurance options under Green Mountain Care before they graduate. Public and private colleges have shown unprecedented support by allowing outside marketing efforts to occur directly to their seniors. Additionally, college faculty and staff, as well as employees of State government have received an email encouraging them to check out their health insurance options for their dependents who will graduate off their school or parent's plan. Activities scheduled for the next quarter are listed below.

A concert will be hosted by Green Mountain Care in May in partnership with a radio station that targets this demographic. Three weeks of concert promotions will congratulate grads and encourage them to check their health insurance options under Green Mountain Care. Ads will appear in three print publications as well.

During May and June, we will turn our attention to high school seniors through an educational campaign in partnership with the Vermont Bar Association (VBA). The VBA has produced a guide known as, "On Your Own," which addresses the rights and responsibilities of individuals when they enter adulthood. A representative from Green Mountain Care will partner with an attorney to speak directly to 12th graders in schools throughout Vermont. The publication will be completed in the next quarter and already 40 schools have requested training.

Enrollment and legislative action: Enrollment in the new premium assistance program components (Catamount Health and Employer-Sponsored Insurance) has been growing steadily over the quarter. As of the end of March, there were 3640 individuals enrolled. This number falls short of the projections for this point in time; however, growth in enrollment is not slowing down, as had been predicted, so it is still possible that enrollment will reach projections by the end of the fiscal year. The administration will be working with the legislature's Joint Fiscal Office in June to revise enrollment and expenditure projections for the next fiscal year.

In the legislature this year the House Health Care Committee is discussing another health care reform bill that would build on the health care reforms passed during the 2005/2006 legislative session and the enhancements passed in 2006/2007. Many members of the committee wanted to expand Catamount Health, such as subsidizing small businesses to purchase Catamount Health for their employees, but budget projections for the 2009 fiscal year will most likely curtail any expansion efforts.

Act 70 from last year's legislative session 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 took 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, has been developed by OVHA's IT staff. OVHA is currently in negotiation with Bi-State over a grant agreement that will allow Bi-State to add a position on July 1 that will promote the enrollment and tracking tool with health care providers, and will coordinate and train the cadre of outreach assistors in communities across the state.

Operational/Policy Developments/Issues

Catamount Health Premium Assistance Programs: In January OVHA began issuing monthly reports on enrollment numbers and demographics, as well as a Catamount Fund financial report. These reports are required by the health care reform law and are provided to the House and Senate standing committees on health care, the fiscal committees, and the Health Care Reform Commission. See 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), 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 will require a number of years to achieve desired results and measurable improvement. This multi-pronged effort started in SFY '08 and should receive continued emphasis and support through SFY '09 and SFY '10. All but one of the initiatives were introduced or implemented by February, 2008; initiative #1, an educational campaign to ensure oral health exams for school-age children, is being developed by the VDH, the OVHA and the Department of Education for the fall of 2008.

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:

Level	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 - 2008 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
Dec-07	\$ 38,872.44
Jan-08	\$ 45,163.01
Feb-08	\$ 40,366.07
Mar-08	\$ 41,590.23
Apr-08	\$ 40,309.54
Total	\$ 355,007.59

As of April 2008, the Capitated Program for the Treatment of Opiate Dependency (CPTOD) as implemented by the OVHA has 34 enrolled providers and approximately 430 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. In the 2nd quarter of SFY '08, the program paid \$97,333.31 in Buprenorphine claims for 1161 patients. In the 3rd quarter of SFY '08, the program paid \$127,119.31 in claims for 1250 patients. The program has been successful at increasing patient access to providers who are licensed to prescribe Buprenorphine in Vermont.

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 to enable the plan of care (POC) to be successful; and supports the beneficiary in setting and achieving self-management goals. 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 by both providers and individual beneficiaries, are further complicated by the often co-occurring conditions of mental health and substance abuse; as well as challenges including procurement of nourishing food, availability of safe and affordable housing and transportation issues due to financial insecurity. The CCP teams partner with various internal Agency of Human Services (AHS) partners as well as external partners such as Home Health Agencies, certified diabetic educators, hospital wellness programs including their community based Healthier Living Workshops and others to facilitate the care management goals of both beneficiaries and the primary care provider. CCP has worked effectively with as many of 20 different agencies and service providers to effectively coordinate services to address priority health and security needs of Medicaid beneficiaries.

To continuously improve assessment and coordination services, the CCP developed a beneficiary assessment tool to help inform and support our work and develop a targeted care plan based on the beneficiary profile. Additionally, CCP provides ongoing training of staff to foster skill development and assure consistent application of procedures. In the January through March reporting period staff received training by a psychiatrist who specializes in substance abuse to further enhance team skill and appropriately address co-occurring conditions of mental health and substance abuse, including drug seeking behaviors, which are common to our population. These conditions pose a unique additional challenge in chronic care management efforts of this high risk population. Ongoing training and case reviews on this important topic are planned with the Department of Mental Health and Department of Health partners engaged in prevention and management of addictive disorders.

By March 2008, the OVHA Care Coordination Program was providing statewide coverage to the highest risk Medicaid beneficiaries in eight district service areas, staffed by a total of seven nurses and eight medical social workers; and a management team consisting of two regional nursing supervisors and a field service director. During the January – March reporting period, the CCP had an active average case load of 335 cases per month, with over 380 active cases by late March.

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

Between January 1, 2008 and March 31, 2008, CCMP staff outreached to 16 Vermont hospitals, eight, 66 Family Practices and hospital affiliates, 6 Pediatricians, 4 Federally Qualified Health Centers (FQHCs), 4 Regional Health Centers, 9 Vermont health organizations (e.g., Vermont Assembly of Home Health Agencies, Vermont Association of Hospitals and Health Systems), and 1 Vermont chapter of a national organization.

Several of these visits (e.g., hospitals, FQHCs, and a few Family Practices) were repeat visits to present to staff members who were not available at the initial outreach meeting.

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 March 31, 2008: **11,677**
- Intervention Services (IVS) Assessments completed as of March 31, 2008: **2,210**

Financial/Budget Neutrality Development/Issues

On March 14, 2008, AHS submitted its IGA with the OVHA to CMS for Global Commitment waiver years one and two. The IGAs included per-member-per-month capitation rates that are within the actuarially certified ranges. On April 30, 2008, AHS received approval from CMS on the waiver year one IGA. Upon receipt of final approval from CMS for the waiver year two IGA and upon agreement with CMS reporting staff, AHS will then amend all CMS-64 submissions for both waiver years to reflect the appropriate costs as allocated to each Medicaid eligibility group.

The State received the actuarial certification for Catamount PMPM capitation rates from Milliman on February 20, 2008. AHS is currently in the final stages of setting PMPM rates for waiver year three.

On April 1, 2008, the State entered into a new contractual arrangement with Aon Consulting for actuarial consulting services for waiver years four and five. This is a two-year agreement, in which Aon will develop actuarially certified rate ranges for FFY09 and FFY10. Aon will deliver the FFY09 rate range certifications to AHS in August, 2008 and the FFY10 rate range certifications to AHS in August, 2009.

Please see Attachment 2 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.

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	Month 2	Month 3	Total for Quarter Ending	Total for Quarter Ending
	1/15/2008	2/15/2008	3/15/2008	2nd Qtr FFY '08	1st Qtr FFY '08
Demonstration Population 1:	40,641	40,611	40,674	121,926	120,113
Demonstration Population 2:	40,295	40,935	40,888	122,118	120,309
Demonstration Population 3:	8,223	8,225	8,228	24,676	24,821
Demonstration Population 4:	N/A	N/A	N/A	N/A	N/A
Demonstration Population 5:	1,262	1,122	1,158	3,542	3,767
Demonstration Population 6:	2,118	2,004	2,086	6,208	6,084
Demonstration Population 7:	23,143	24,518	24,675	72,336	65,803
Demonstration Population 8:	7,476	7,589	7,632	22,697	22,445
Demonstration Population 9:	2,636	2,640	2,643	7,919	7,929
Demonstration Population 10:	N/A	N/A	N/A	N/A	N/A
Demonstration Population 11:	2,090	2,690	3,217	7,997	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, AHS worked with OVHA and the previous EQRO, VPQHC, to calculate 15 performance measures for baseline and year one of the GC to Health Waiver. At the end of the quarter, a draft report was delivered to AHS and OVHA. After review and discussion with VPQHC, it was agreed that some modifications were necessary in order to improve the validity of the measures. It is anticipated that a final report will be issued during the next quarter. Additionally, monthly update calls were initiated with the new EQRO, Health Services Advisory Group, Inc. (HSAG). Standing agenda items were developed around the three required activities of the EQRO and include the following: compliance monitoring, performance measures, and performance improvement projects. In addition to these updates, the AHS Quality Improvement Manager has been working with the new EQRO to develop a Review of Compliance with Standards Documentation Request and Evaluation Form for the MCO. This work has centered on identifying requirements for each of the Structure and Operation Standards found in 42 CFR 438 and the AHS/OVHA IGA. The AHS Quality Improvement Manager met with the MCO to discuss the Year 2 Performance Improvement Project (PIP): Fostering Healthy Families. Agenda items included the following: a description of the project, a review of the CMS Validating PIP Protocol, and a review of the EQRO PIP data collection tool. In addition to this meeting, the AHS Quality Improvement Manager engaged in numerous discussions with HSAG to better understand the relationship between their data collection tool and the CMS protocol.

Quality Assurance /Performance Improvement Committee: During this quarter, the Committee spent time reviewing the Review of Compliance with Standards Documentation Request and Evaluation Form created by HSAG. In addition to reviewing the MCO Federal Quality Assessment and Performance Improvement Standards contained in the CFR, the group also reviewed the related State standards. The committee continued to prioritize agency-wide performance measures and Performance Improvement Projects. It is anticipated that during the next quarter, the group will recommend Year 3 Performance Measures and Performance Improvement Projects. The QAPI Committee began to define its role in monitoring the QAPI activities of the MCO. For example, the group reviewed a sample grievance, appeal, and State fair hearing report to determine the types of information that it should receive on a regular basis in order to determine the quality of care provided to MCO enrollees. As this oversight/monitoring role evolves, the committee will need to identify additional functions and reports to be reviewed. Finally, the QAPI Committee continued to develop a MCO Quality Plan.

Quality Strategy: During this quarter, the AHS elicited final feedback on the Quality Strategy via a public hearing process. Final modifications were made to the document and a copy was submitted to CMS for review. A copy of this document is attached to this report (see Attachment 6).

Demonstration Evaluation

The AHS Quality Improvement Manager continued to work with QAPI committee members and other agency-wide stakeholders to revise the GC waiver evaluation plan. Performance measures for quality were adopted from the Quality Strategy while measures for access and cost were recommended. A new request for proposal (RFP) for the evaluation of the GC Waiver was developed and posted. 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. During the next quarter, AHS and MCO staff will be involved in reviewing responses to the RFP and working with AHS to select the most appropriate applicant to conduct the evaluation. It is anticipated that the AHS Quality Improvement Manager will work with the selected party to further refine the content of the GC Evaluation Plan.

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 7 for a draft summary of MCO investments by category for State fiscal year 2008.

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: Global Commitment Budget Neutrality workbook
- 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: AHS Quality Strategy
- Attachment 7: OVHA MCO Investment Summary

State Contact(s)

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Date Submitted to CMS: May 21, 2008

Attachment 1

Monthly Reports on Enrollment Numbers and Demographics
and Catamount Fund Financial Report

Office of Vermont Health Access
 SFY '08 Catamount Health Actual Revenue and Expense Tracking
 Tuesday, April 15, 2008

	SFY '08 Revised Appropriated			Consensus Estimates for SFY to Date			Actuals thru 3/31/08			
	<=200%	>200%	Total	<=200%	>200%	Total	<=200%	>200%	Total	% of SFY to-Date
TOTAL PROGRAM EXPENDITURES										
Catamount Health	6,317,850	6,881,030	13,198,880	2,634,448	2,873,672	5,508,120	1,386,499	1,398,292	2,784,791	50.56%
Catamount Eligible Employer-Sponsored Insurance	88,278	96,147	184,424	27,021	29,430	56,451	42,670	51,716	94,386	167.20%
Subtotal New Program Spending	6,406,128	6,977,177	13,383,304	2,661,469	2,903,102	5,564,571	1,429,169	1,450,009	2,879,177	51.74%
Catamount and ESI Administrative Costs	1,688,833	1,839,378	3,528,211	1,055,521	1,149,611	2,205,132	844,417	919,689	1,764,105	80.00%
TOTAL GROSS PROGRAM SPENDING	8,094,961	8,816,554	16,911,515	3,716,990	4,052,713	7,769,703	2,273,585	2,369,697	4,643,283	59.76%
TOTAL STATE PROGRAM SPENDING	3,318,125	8,816,554	12,134,679	1,523,594	4,052,713	5,576,307	931,943	2,369,697	3,301,640	59.21%
TOTAL OTHER EXPENDITURES										
Immunizations Program	-	4,000,000	4,000,000	-	3,000,000	3,000,000	-	3,000,000	3,000,000	100.00%
VT Dept. of Labor Admin Costs Assoc. With Employer Assess.	-	394,072	394,072	-	295,554	295,554	-	295,554	295,554	100.00%
Marketing and Outreach	1,316,167	-	1,316,167	987,125	-	987,125	987,125	-	987,125	100.00%
Blueprint	-	1,846,713	1,846,713	-	1,385,035	1,385,035	-	1,385,035	1,385,035	100.00%
TOTAL OTHER SPENDING	1,316,167	6,240,785	7,556,952	987,125	4,680,589	5,667,714	987,125	4,680,589	5,667,714	100.00%
TOTAL STATE OTHER SPENDING	539,497	6,240,785	6,780,282	404,623	4,680,589	5,085,211	404,623	4,680,589	5,085,211	100.00%
TOTAL ALL STATE SPENDING	3,857,621	15,057,339	18,914,960	1,928,217	8,733,301	10,661,518	1,336,565	7,050,286	8,386,851	78.66%
TOTAL REVENUES										
Catamount Health Premiums	964,287	2,012,969	2,977,257	402,093	840,661	1,242,754	183,489	295,910	479,399	38.58%
Catamount Eligible Employer-Sponsored Insurance Premiums	48,371	100,976	149,347	14,806	30,908	45,714	14,065	23,004	37,069	81.09%
Subtotal Premiums	1,012,659	2,113,945	3,126,604	416,899	871,569	1,288,468	197,554	318,914	516,468	40.08%
Federal Share of Premiums	(597,570)	-	(597,570)	(246,012)	-	(246,012)	(116,577)	-	(116,577)	47.39%
TOTAL STATE PREMIUM SHARE	415,089	2,113,945	2,529,034	170,887	871,569	1,042,456	80,977	318,914	399,891	38.36%
Cigarette Tax Increase (\$.60 / \$.80)			9,052,000			6,789,000			6,520,704	96.05%
Floor Stock			-			-			29,329	0.00%
Employer Assessment			7,500,000			5,625,000			4,119,791	73.24%
Interest			161,625			121,219			136,296	112.44%
TOTAL OTHER REVENUE			16,713,625			12,535,219			10,806,121	86.21%
TOTAL STATE REVENUE	415,089	2,113,945	19,242,659	170,887	871,569	13,577,675	80,977	318,914	11,206,012	82.53%
State-Only Balance			327,699			2,916,157			2,819,161	
Carryforward			4,617,848			4,617,848			4,617,848	
(DEFICIT)/SURPLUS			4,945,547			7,534,005			7,437,009	
Reserve Account Funding			3,500,000			3,500,000			3,500,000	
REVISED (DEFICIT)/SURPLUS WITH RESERVE FUNDING			8,445,547			11,034,005			10,937,009	

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

ESI and CATAMOUNT HEALTH PREMIUM ASSISTANCE PROGRAM REPORT March 2008

TOTAL ENROLLMENT BY MONTH

	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08
VHAP-ESIA	-	-	-	-	35	131	287	411	542	-	-	-
ESIA	-	-	-	-	21	69	127	169	242	-	-	-
CHAP	-	-	-	-	320	1,186	1,834	2,419	3,033	-	-	-
Catamount Health	-	-	-	-	120	165	268	345	361	-	-	-
Total	-	-	-	-	376	1,551	2,516	3,344	4,178	-	-	-

	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08
VHAP	23,725	23,767	23,870	24,245	24,849	25,295	25,899	26,150	26,301	-	-	-
Dr. Dynasaur	19,738	19,664	19,475	19,629	19,733	19,781	19,822	19,977	20,210	-	-	-
SCHIP	3,097	3,137	3,173	3,355	3,428	3,481	3,479	3,170	3,166	-	-	-
Total	46,560	46,568	46,518	47,229	48,010	48,557	49,200	49,297	49,677	-	-	-

TOTAL ALL	46,560	46,568	46,518	47,229	48,386	50,108	51,716	52,641	53,855	-	-	-
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KEY:

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

ESI and CATAMOUNT HEALTH PREMIUM ASSISTANCE PROGRAM REPORT (continued)
March 2008 Demographics

Income	VHAP-ESIA*	ESIA*	CHAP*	TOTAL
0-50%	11	4	110	
50-75%	27	1	28	
75-100%	74	-	38	
100-150%	281	7	157	
150-185%	141	53	801	
185-200%	2	38	394	
200-225%	1	58	627	
225-250%	3	38	387	
250-275%	2	24	283	
275-300%	-	19	208	
Total	542	242	3,033	3,817

Age	VHAP-ESIA	ESIA	CHAP	TOTAL
18-24	27	22	500	
25-35	163	73	501	
36-45	213	61	627	
46-55	111	60	713	
56-64	28	26	684	
65+	-	-	8	
Total	542	242	3,033	3,817

ESI and CATAMOUNT HEALTH PREMIUM ASSISTANCE PROGRAM REPORT (continued)
March 2008 Demographics

Gender	VHAP-ESIA	ESIA	CHAP	TOTAL
Male	190	85	1,332	
Female	352	157	1,701	
Total	542	242	3,033	3,817

County	VHAP-ESIA	ESIA	CHAP	TOTAL
Addison	27	15	197	
Bennington	52	19	160	
Caledonia	28	9	201	
Chittenden	94	55	525	
Essex	4	3	38	
Franklin	56	27	197	
Grand Isle	13	1	42	
Lamoille	30	10	180	
Orange	19	6	179	
Orleans	49	12	195	
Other	-	1	3	
Rutland	67	28	338	
Washington	41	20	267	
Windham	28	20	230	
Windsor	34	16	281	
Total	542	242	3,033	3,817

RANGE & TYPE OF ESI PLANS

Number of individuals who enrolled in an ESI plan 10/07-3/08:

1004

Number of employers:

400
Deductibles

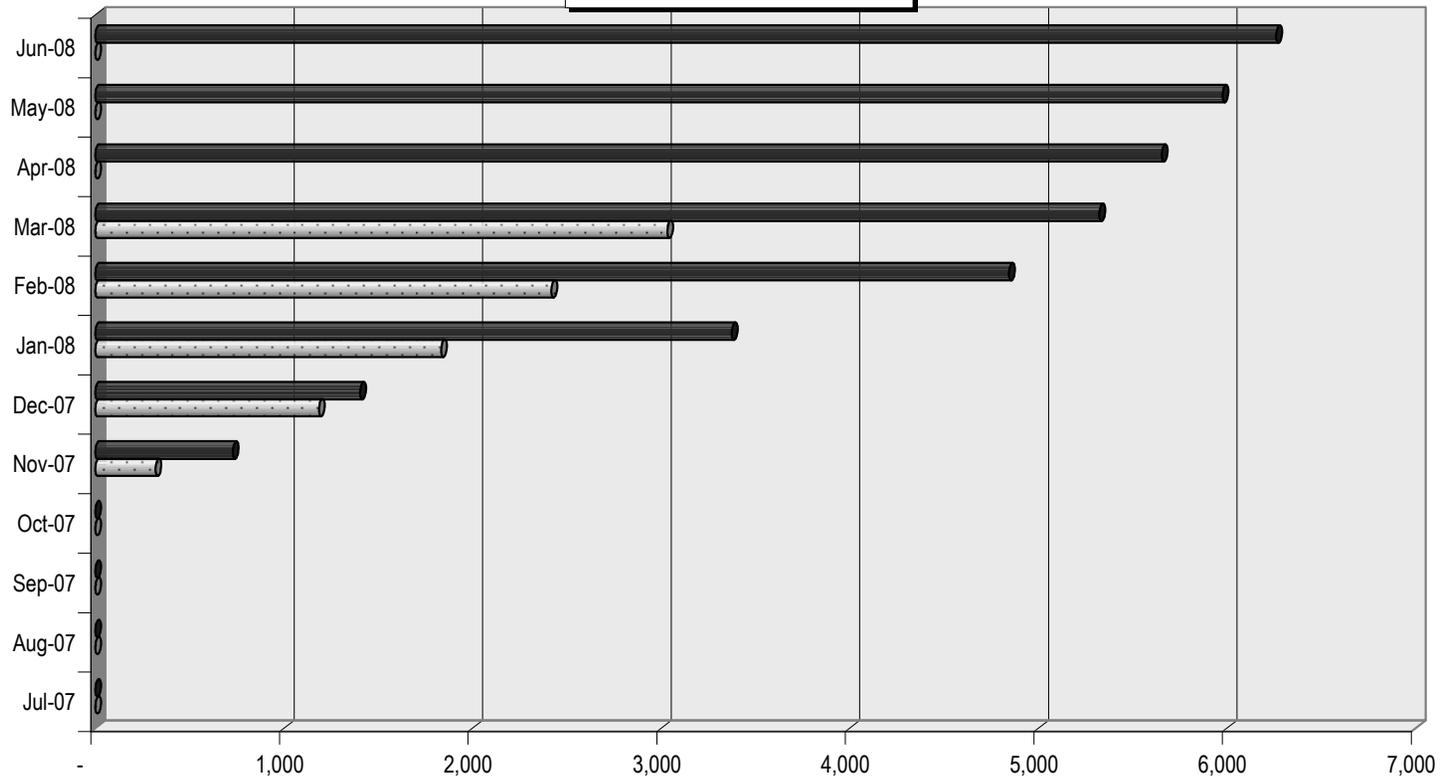
	Single	Couple
0	303	145
1-100	21	3
101-200	39	7
201-300	56	7
301-400	11	11
401-500	88	22
501-750		12
751-1000		36
1001-1500		
1501-2000		
2001-3000		
3001+		
Total # plans	518	243
Average	\$130	\$257
Median	\$0	\$0
Mode	\$0	\$0

Premium
Employee's share

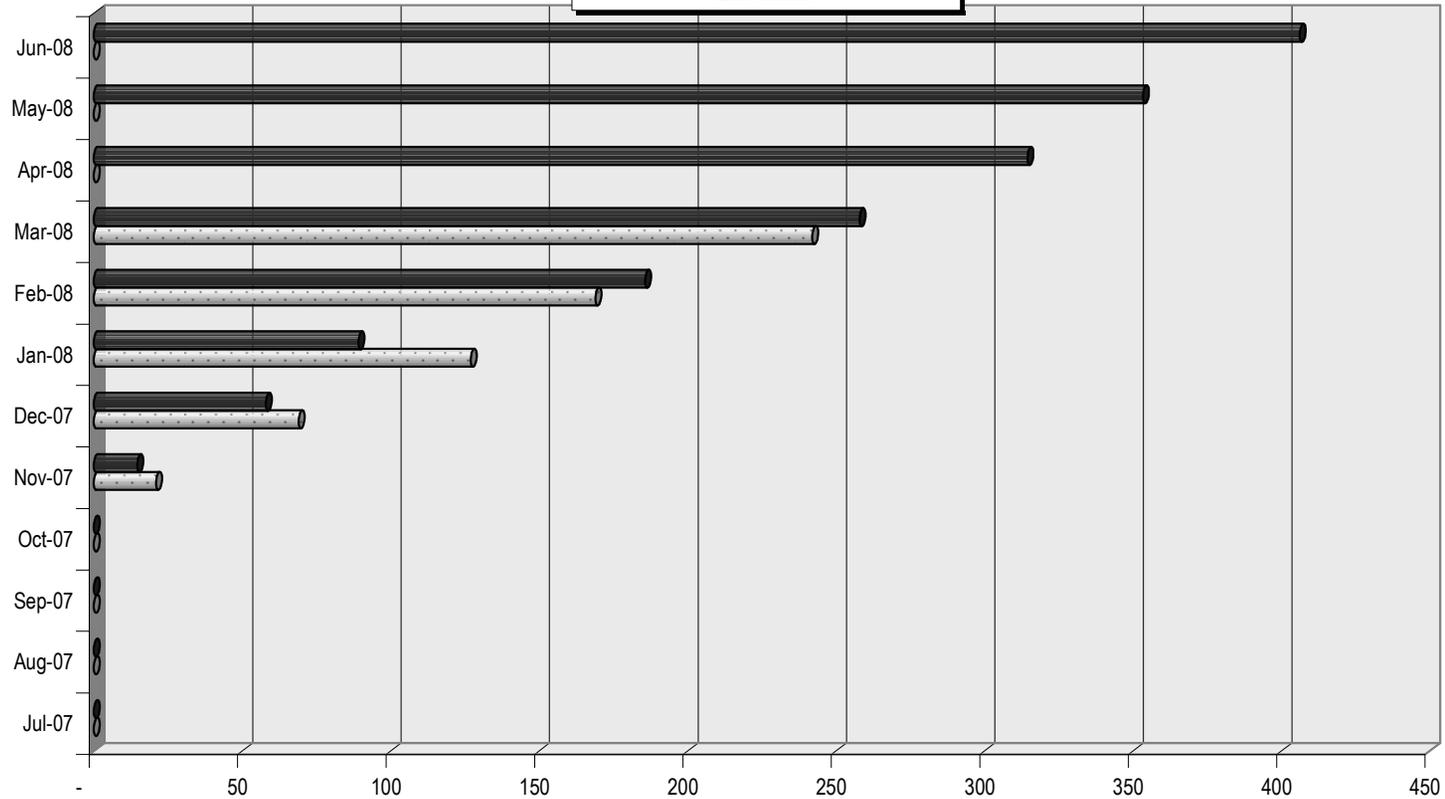
	Single	Couple
\$0-50	40	2
51-100	161	15
101-150	85	25
151-200	101	40
201-250	74	15
251-300	37	23
301-350	10	29
351-400	5	18
401-450	2	16
451-500	2	15
500+	1	45
Total # plans	518	243
Average	\$145.67	\$326.36
Median	\$128.00	\$305.50

ESI and CATAMOUNT HEALTH PREMIUM ASSISTANCE PROGRAM REPORT (continued)
March 2008 Demographics
Employer's percent

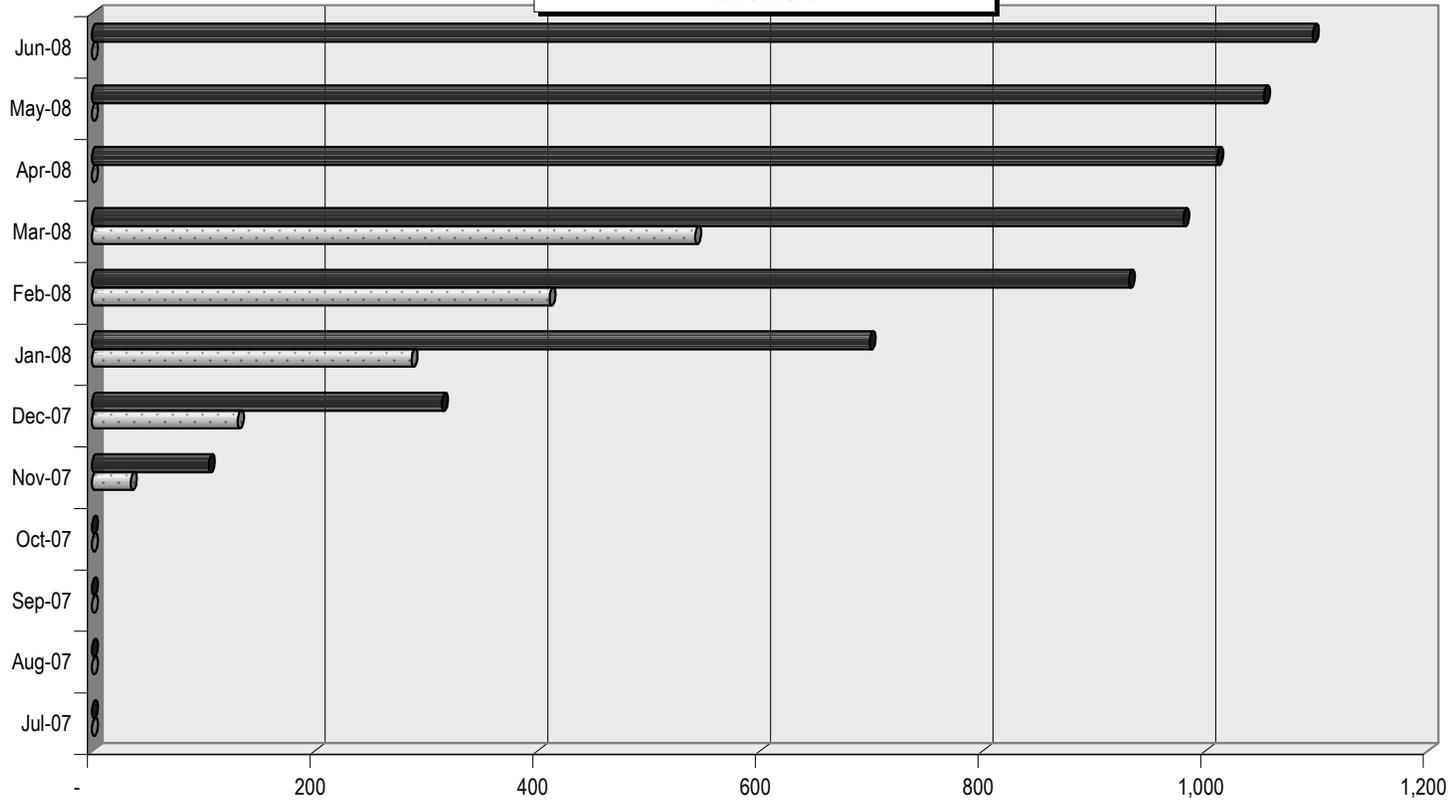
	Single	Couple	
90-100%	33		9
80-90%	161		61
70-80%	74		35
60-70%	41		23
50-60%	101		47
<50%	51		48
Unknown	57		20
Total	518		243

Catamount Health Assistance Program Enrollment


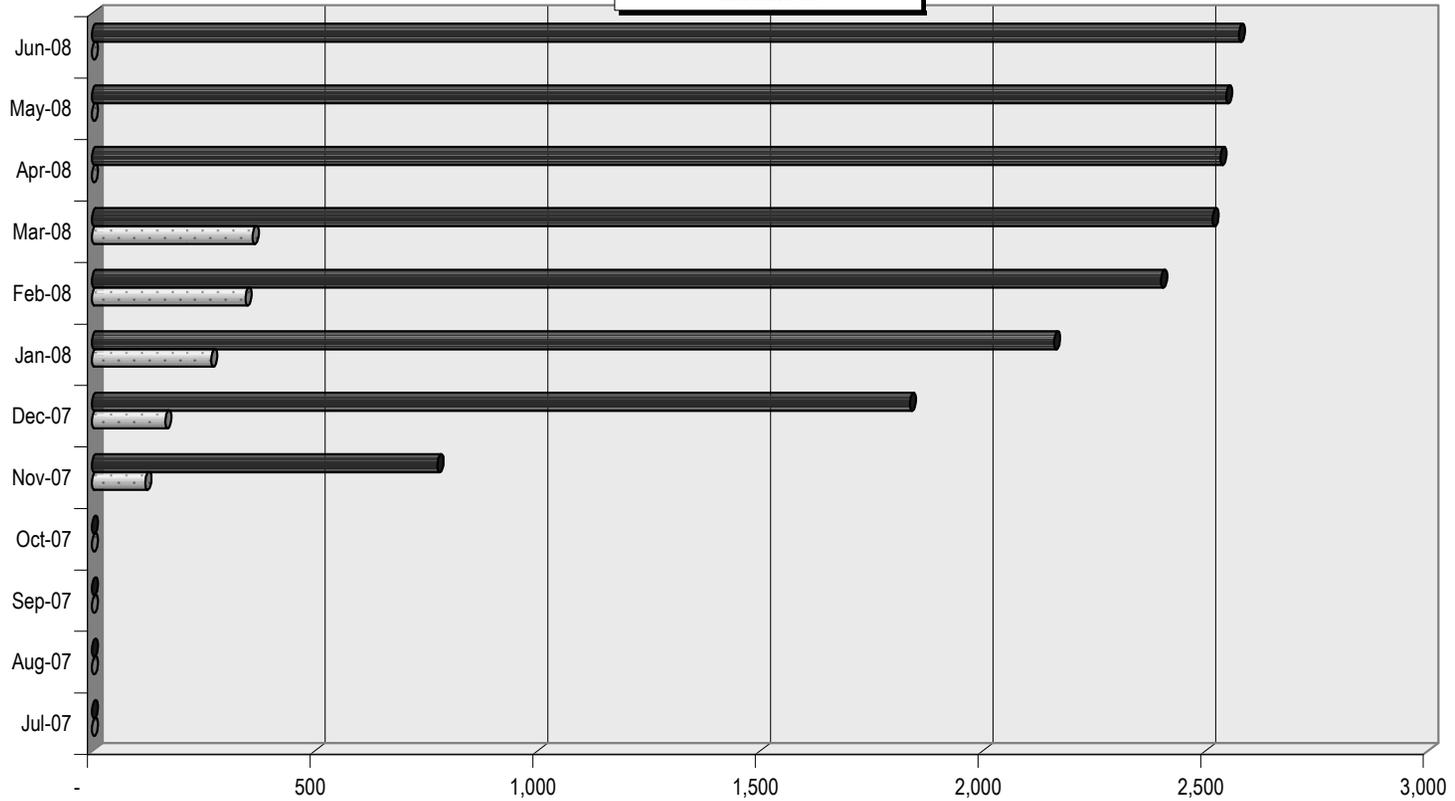
	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08
■ Projected	-	-	-	-	730	1,405	3,375	4,845	5,324	5,655	5,978	6,262
▨ Actual	-	-	-	-	320	1,186	1,834	2,419	3,033	-	-	-

Employer Sponsored Insurance Assistance Enrollment


	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08
■ Projected	-	-	-	-	15	58	89	186	258	315	353	406
□ Actual	-	-	-	-	21	69	127	169	242	-	-	-

VHAP ~ Employer Sponsored Insurance Assistance Enrollment


	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08
■ Projected	-	-	-	-	105	314	699	931	980	1,011	1,053	1,097
□ Actual	-	-	-	-	35	131	287	411	542	-	-	-

Catamount Health ~ Unsubsidized Enrollment


	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08
■ Projected	-	-	-	-	776	1,837	2,161	2,401	2,517	2,535	2,547	2,576
▨ Actual	-	-	-	-	120	165	268	345	361	-	-	-

Attachment 2

Budget Neutrality Workbook

Global Commitment Expenditure Tracking

QE	Quarterly Expenditures	PQA: WY1	PQA: WY2	PQA: WY3	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	\$ 4,239,569	\$ 786,384,697	\$ 1,015,000,000	\$ 228,615,303
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	\$ 6,464,439	\$ 826,333,018	\$ 1,936,000,000	\$ 323,282,285
Cumulative								\$ 1,612,717,715	\$ 1,936,000,000	\$ 323,282,285
1207	\$ 213,871,059	\$ -	\$ 1,010,348		\$ 1,010,348	\$ 214,881,406				
0308	\$ 162,921,830	\$ -	\$ -	\$ -	\$ -	\$ 162,921,830				
0608										
0908										
WY3 SUM	\$ 376,792,889	\$ -	\$ 1,010,348		\$ 1,010,348	\$ 376,792,889	\$ 3,093,668	\$ 379,886,557		
Cumulative								\$ 1,992,604,273	\$ 2,848,000,000	\$ 855,395,727
1208										
0309										
0609										
0909										
WY4 SUM	\$ -	\$ -	\$ -		\$ -	\$ -	\$ -	\$ -		
Cumulative								\$ 1,992,604,273	\$ 3,779,000,000	\$ 1,786,395,727
1209										
0310										
0610										
0910										
WY5 SUM	\$ -	\$ -	\$ -		\$ -	\$ -	\$ -	\$ -		
Cumulative								\$ 1,992,604,273	\$ 4,700,000,000	\$ 2,707,395,727
		\$ 10,151,610	\$ 941,940	\$ -						

PQA = Prior Quarter Adjustments

Attachment 3

Member Services Complaint Report

**Complaints Received by Health Access Member Services
January 1, 2008 – March 31, 2008**

Catamount Health Assistance Program premiums, process, ads	20
Use of social security numbers as identifiers	12
Provider issues (perceived rudeness, refusal to provide service, prices) (variety of provider types)	8
Eligibility rules	7
Eligibility local office	6
Eligibility forms or process	3
General premium complaints	6
Member services	2
Copays/service limit	2
Prescription drug plan complaint	1
PBM complaint	1
Total	68

Attachment 4

MCO Grievance and Appeals Report

Grievance and Appeal Quarterly Report
 Medicaid MCO All Departments Combined Data
 for the period: January 1, 2008 – March 31, 2008

Grievances

Total Number of Grievances Filed: 11

Number Pending: 3	Source of Grievance Request:		
Number Withdrawn: 0	Beneficiary:	10	91%
Number Addressed: 8	Beneficiary Representative:	1	9%
Average number of days from "pertinent issue" to filing grievance: 11	Other:	0	0%
Average number of days from filing to entering into database: 2	Number Related To:		
Average number of days from filing to being addressed: 12	OVHA: 4	36%	
Average number of days to send acknowledgement letter: 1	DAIL: 0	0%	
Number of late acknowledgement letters: 1	DCF: 0	0%	
Number of Grievances filed too late: 0	DMH: 6	55%	
Number of Grievance Reviews Requested: 1	VDH: 1	9%	
Number of Grievance Reviews Addressed: 0	Top Services Grieved:		
Average number of days to send Grievance Review acknowledgement letter: 2	1. Mental Health/Psychiatric	(6)	
Number of late Grievance Review acknowledgement letters: 0	2. Transportation	(2)	
	3. Inpatient/Outpatient Hospital	(2)	
	4. Substance Abuse	(1)	
	Number by Category: [Check ALL that apply]		
	Staff/Contractor:	9	
	Program Concern:	1	
	Management:	1	
	Policy or Rule Issue:	4	
	Quality of Service:	2	
	Service Accessibility:	2	
	Timeliness of Service Response:	1	
	Service Not Offered/Available:	2	
	Other:	2	

* * * * *

Number Pending from last quarter: 1

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

Number that were pending in previous quarters and addressed this quarter: 1

Within 90 days: 1

Exceeding 90 days: 0

Grievance and Appeal Quarterly Report
 Medicaid MCO All Departments Combined Data
 for the period: January 1, 2008 – March 31, 2008

Appeals

Number of Appeals Filed: 12

Number Pending: 7	Average number of days from filing to resolution when extended: 55
Number Withdrawn: 1	Average number of days to send acknowledgement letter: 1
Number Resolved: 4	Number of late acknowledgement letters: 0
Number Upheld: 3 75%	Average number of days from filing to withdrawing: 39
Number Reversed: 1 25%	Average number of days to send withdrawal letter: 0 = same day
Number Modified: 0 0%	Number of late withdrawal letters: 0
Number Approved by Dept/DA/SSA: 0 0%	Source of Appeal Request:
Number of Cases Extended: 1	Beneficiary: 6 50%
By Beneficiary: 1	Beneficiary Representative: 5 42%
By MCO: 0	Provider: 0 0%
Resolved Time Frames	Other: 1 8%
Within 30 days: 75%	Number Related To:
Within 45 days: 75%	OVHA: 6 50%
Within 59 days: 100%	DAIL: 6 50%
Over 59 days: 0%	DCF: 0 0%
Number of Appeals filed too late: 0	DMH: 0 0%
Average number of days from NOA to filing appeal: 32	VDH: 0 0%
Average number of days from filing to entering data into database: 3	Top Services Appealed:
Average number of days from filing to resolution: 14	1. Long-Term Care (3)
	2. Miscellaneous Choices (7)
	3. No Answer (2)
Number of Beneficiaries that requested that their services be continued: 3 43%	
Of those that requested their services be continued:	
Number that met criteria: 1 33%	
Number that did not meet criteria: 2 67%	

Number by Category:

1. Denial or limitation of authorization of a requested service or eligibility for service:	8
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
No Choice Made:	3

Number Pending from last quarter: 4 1- DAIL, 3 - OVHA

Number that were pending last quarter and withdrawn this quarter: 1 OVHA

Number of cases extended last quarter and resolved this quarter: 0

Number that were pending last quarter and resolved this quarter: 2

Number Upheld:	2	100%	OVHA
Number Reversed:	0	0%	
Number Modified:	0	0%	
Number Approved by Dept/DA/SSA:	0	0%	

Number that were pending last quarter and are still pending: 1 DAIL-NKHS

Number that were pending last quarter and were resolved this quarter, but the time to resolve *exceeded* rule timeframes: 0

Resolved Time Frames for last quarter's pending:

Within 30 days:	0%
Within 45 days:	100%
Within 59 days:	0%
Over 59 days:	0%

Expedited Appeals

Number of Expedited Appeals Filed: 3

Number of Expedited Appeals that:

Met Criteria:	0
Did Not Meet Criteria:	3

Average number of business days to orally notify beneficiary of not meeting criteria: 1

Average number of business days to notify beneficiary in writing of not meeting criteria: 1

Number late letters: 0

Fair Hearings

Total number of Fair Hearings filed (either simultaneously with or subsequent to an appeal): 2

Number of Appeals with a concurrent Fair Hearing: 2

Number of Appeals that went to a Fair Hearing after appeal resolution: 0

Number Pending: 2

Number Resolved: 0

Number of pending Fair Hearings from previous quarters: 2

Number of pending Fair Hearings from previous quarters resolved this quarter: 0

Number of pending Fair Hearings from previous quarters withdrawn this quarter: 1

Number of pending Fair Hearings from previous quarters still pending at the end of this quarter: 1