*State of Vermont*
*Agency of Human Services*

# Global Commitment to Health
# 11-W-00194/1

**Quarterly Report**
**for the period**
**July 1, 2007 to September 30, 2007**

**Submitted Via Email on**
**November 27, 2007**

## 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.

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 pyschiatric 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. The intent of these reports is to present the State's analysis and the status of the various operational areas." ***This is the fourth quarterly report for waiver year two, covering the period from July 1, 2007 to September 30, 2007.***

## a) Events occurring during the quarter, or anticipated to occur in the near future, that affect health care delivery, enrollment, quality of care, and access that are relevant to the Demonstration, the benefit package, and other operational issues.

***Staffing Changes***

No changes to report.

***MCO Requirements***
All MCO work plan activities are progressing as planned. The OVHA and AHS continue to focus on ensuring requirements under 42 CFR sections 438. See Attachment A for updated work plan timelines and list of task completions through September 30, 2007.

***Benefit Changes***
The Vermont FY07 Budget Act and the Vermont Health Care Affordability Act contain changes regarding cost-sharing amounts, eligibility and benefits including, *VHAP-Employer Sponsored Insurance; Employer Sponsored Insurance Premium Assistance Program; Catamount Health Assistance Program*; *Revised Premium, Recertification & VHAP eligibility requirements*; and a *Chronic Care Management Program.*

Vermont submitted a waiver amendment request to CMS on September 11, 2006 to operate those initiatives that require CMS approval within the framework of our approved Global Commitment to Health 1115(a) Demonstration. That amended was approved, in part, on October 31, 2007. Vermont will continue to seek approval on those elements excluded from the October approval notice. This request continues to be an integral piece of a much larger Health Care Reform plan and critical to our state legislative and budgeting process.

***Financial Administration***
Consistent with 42 CFR section 438, in December 2005 Vermont submitted the actuarial certification report prepared by Milliman Consultants and Actuaries, Inc. to CMS for review. Vermont received feedback from CMS that the methodology used by the actuarial firm is acceptable. The contract with Milliman Consultants and Actuaries, Inc. has been extended to develop the SFY2007 and SFY2008 rates using the same methodology. As per ongoing discussions with CMS the State has opted to set its capitated rates based on a Federal fiscal year. This requires retroactive revisions to the FFY06 and 07 AHS/OVHA Intergovernmental Agreements and additional actuarial consulting services to provide new certified rate ranges based upon Federal fiscal years 2007 and 2008. The State is waiting for updated rate ranges from Milliman and will revise all documents with updated capitated rates for OVHA based on the Federal fiscal year.

***Health plan financial performance, including capitated revenue expenditures.***
The state and CMS collaborated to develop reporting formats and supplemental documentation for the quarterly CMS-64 reports, as well as other financial reports required by the

Demonstration's Special Terms and Conditions. We have submitted our CMS-64 reports using the formatting changes provided by CMS.

## b) Action plans for addressing any policy and administrative issues identified.

See OVHA/MCO Work Plan (Attachment A)

AHS Deputies and Directors continue to review opportunities for programmatic flexibilities within existing budgeted resources. These include the integration of administrative structures for programs serving the same or similar populations, and opportunities to increase access to services by decreasing administrative burdens created by programs operating, (pre-waiver), under separate AHS administrative and Medicaid reimbursement structures. The projects identified to date and their current status is included in the chart below.

| **Project Title** | **Proposal in brief** | **Status** |
|---|---|---|
| *Early Childhood "3 programs into 1" Project & Supportive Child Care* | A streamlined administrative structure and unified plans of care for AHS programs delivering early childhood services. | Pilots started |
| *Children's Personal Care Services* | Offering eligible families choice to receive traditional or flexible benefit package | Implementation plan under development |
| *Unified Service Plans* | Unifying service plans for individuals who receive high tech, developmental services and personal care services | Procedures updated, approved and implemented. |
| *Jump on Board for Success* (MH services for target youth in order to increase stability of jobs, home and health status) | Performance Based Contract Option to replace fee for service billing. | Pilots on hold |
| *Runaway and Homeless Youth* (MH services for target youth in order to stabilize crisis and health status, reunify families and counsel youth) | Performance based Contract Option to replace fee for service billing. | Pilots expected to start October 2007 |

In addition to looking at AHS programming and opportunities under the waiver, this group continues to be responsible for ensuring that necessary changes in internal operations occur related to the OVHA/MCO work plan (Attachment A), IGA commitments and other relevant state and federal regulations.

*QA/PI Committee*

During this quarter, the QA/PI Committee continued to review Federal Quality Assessment and Performance Improvement Standards, prioritized agency-wide performance measures, and

recommended an agency-wide performance improvement project. The AHS QIM 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. Also during this quarter, the QAPI committee prioritized agency-wide performance measures. Performance measures are used by the MCO to achieve the following goals:

- Measure results/outcomes
- Monitor/evaluate performance over time
- Identify/prioritize areas for improvement
- Establish goals/targets for quality improvement projects
- Facilitate comparisons with self/other Medicaid programs

The MCO is required to collect and report performance measures that illuminate the following focus areas:

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

HEDIS (*The Health Plan Employer Data and Information Set*) measures are used to assess the first two focus areas while CAHPS (The Consumer Assessment of Healthcare Providers and Systems) measures are used to evaluate the third. Finally, members of the QAPI committee recommended a year one performance improvement project that focused on Preventive Care. The project uses the following performance measures for children and youth entering State custody:

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

*Quality Strategy*

During this quarter, the AHS QIM continued to craft a draft quality strategy. Specifically, the AHS QIM spent time eliciting feedback from QAPI committee members, as well as, other key agency-wide stakeholders. After the document has been reviewed, modifications will be made and a draft copy will be submitted to CMS.

## State efforts related to the collection and verification of encounter data.

No new activity to report.

## c) Enrollment data, member month data and budget neutrality monitoring tables

No change has occurred this quarter. The state and CMS currently are collaborating with regard to development of budget neutrality monitoring formats. Enrollment and member month data are in section d) below.

## d) Demonstration program average monthly enrollment for each of the following eligibility groups:[1]

**a. Mandatory State Plan Adults**
**b. Mandatory State Plan Children**
**c. Optional State Plan Adults**
**d. Optional State Plan Children**
**e. VHAP Expansion Adults**
**f. Pharmacy Program Beneficiaries (non-Duals)**
g. **Other Waiver Expansion Adults**

| Population | Age Limit | Jul-07 | Aug-07 | Sep-07 |
|---|---|---|---|---|
| Optional | Under 21 | 39,774 | 39,590 | 38,337 |
| Optional | 21 and Over | 17,301 | 16,979 | 16,424 |
| Mandatory | Thru 18 | 15,049 | 14,936 | 14,697 |
| Mandatory | Over 18 | 24,134 | 24,170 | 23,979 |
| VHAP/Underinsured | Thru 18 | 1,517 | 1,504 | 1,460 |
| VHAP/Underinsured | Over 18 | 22,577 | 22,888 | 22,779 |
| Pharmacy Only/HVP | All | 19,442 | 19,899 | 20,343 |
| SCHIP | All | 3,072 | 3,109 | 3,051 |
| **TOTAL** | | 142,866 | 143,075 | 141,070 |

## e) State's progress toward the Demonstration goals.

*External Quality Review*:

During this quarter, a new request for proposal (RFP) was finalized and posted. The new EQRO contract will broaden the focus of review from those enrolled in the CRT program to those enrolled in the Global Commitment to Health Waiver. The Agency of Human Services Quality Improvement Manager was part of the proposal review committee and reviewed six of the seven proposals. During the end of this quarter, the committee made a recommendation to the AHS Secretary's Office for a new EQRO. The recommendation was accepted. It is anticipated that a new EQRO contract will be in place during the next quarter. Also during this quarter, the current EQRO began calculating 15 performance measures for baseline and year one of the waiver. In order to ensure that this work gets completed by the current EQRO, a no-cost contract extension was agreed to and signed.

[1] Note: CMS and AHS have agreed that the eligibility groups should be reported as identified in the table rather than in the initial Special Terms and Conditions.

## f) State's evaluation activities.

During this quarter, a revised GC waiver evaluation plan was shared with QAPI committee members and other agency-wide stakeholders. Performance measures were discussed and need to be recommended in three major areas: access, cost, and quality. It was agreed that the measures contained in the Quality Strategy would be transferred to the GC Evaluation plan, while cost and access measures needed further conversation. The QAPI committee will inventory applicable access and cost measures across the agency, specify appropriate targets, and make recommendations in the next quarter. Once the document has been reviewed by all appropriate parties, the revised evaluation plan will be submitted to CMS.

# ATTACHMENT A

# MCO WORKPLAN
# UPDATED 09/30/2007

| MCO Work Plan (revised 12/31/06)<br>**AREA/ DESCRIPTION** | **TASKS** | **TIMELINE** |
|---|---|---|
| **MEMBER SERVICES** | | |
| **Interpreter Services** | | |
| *Oral interpreter services must be provided free of charge to non-English speaking enrollees who request assistance. [438.10(c)(4)]* | Arrange for vendor to provide services as needed | Completed |
| **Provider Directory** | | |
| *A directory must be compiled and maintained. The directory must list the name, location and telephone numbers for all primary care and specialist providers and hospitals participating in the Medicaid program. The directory must also identify any languages other than English spoken by the provider and must include an indicator to identify those who are accepting new patients. [438.10(e)(2)(ii)(D)]* | Develop web-based directory with ability to search by address, provider type, etc. | Completed: |
| | Survey providers on language capacity and open panel issues | Completed |
| | Develop process for periodic updates (web-based format allows for immediate updates). | Completed |
| **Notification of Terminating Providers** | | |
| *OVHA must notify an enrollee whose PCP terminates their participation in Medicaid within 15 days of the provider's notice to the state. Enrollees who are regularly seeing a provider who is not their PCP must also be similarly noticed. [438.10(f)(5)]* | Develop process for identification of terminating providers | Completed |
| | Draft notice to enrollees | Completed |
| | Identify process for determining which enrollees have been "regularly treated" by any terminating provider | Completed |
| | Print and mail notices within 15 days to affected enrollees | Completed |
| **Enrollee Handbook** | | |
| *Develop and maintain a current enrollee handbook which covers how to access care, enrollee rights and responsibilities, procedures for obtaining benefits, what to do in a medical emergency and how to file a grievance or appeal. Handbooks must be distributed to new enrollees within 45 days of enrollment. Handbooks must be available in languages other than English if five (5) percent or more of Demonstration enrollees speak that language. [438.10]* | Assess need for languages other than English (documentation for CMS) | Completed |
| | Draft handbook | |
| | Disseminate for input, finalize based on comments received | |
| | Print a supply for initial distribution | |
| | Develop and execute handbook distribution process on an ongoing basis | |
| | Post handbook on website | |
| **Advance Directives** | | |
| *OVHA must prepare and make available information on Advance Directives. [438.6(h)(2)(i)]* | Identify materials related to new 2005 state statute regarding Advance Directives | Completed: Link to new statewide information on EDS and OVHA web-page; Providers notified, also sent to enrollees on request. |
| | Obtain a supply of forms for distribution upon request | |
| | Post information on website | |
| | Draft informational notice on Advance Directives and distribute for posting in physicians' offices (EDS Newsletter) | |

| | | |
|---|---|---|
| **Member Helpline** | | |
| *OVHA must maintain a toll-free member hotline during normal business hours to answer enrollee inquiries and to accept verbal grievances or appeals. [438.406(a)(1)]* | | Completed |
| **GRIEVANCES & APPEALS** | | |
| **Notice of Adverse Action** | | |
| *OVHA must provide a written Notice of Adverse Action to each enrollee and their requesting provider of any decision to deny a services authorization request or to authorize a service in an amount, duration or scope that is less than requested. The notice must be sent within 14 days of the receipt of the request for services, unless that timeframe might, in the opinion of the requesting provider, seriously jeopardize the enrollee's health. In the latter event, the notice must be sent within three (3) business days of the request. [438.210I]* | Develop one Agency Policy for all GC enrollees | New policy drafted; finalized and approved by CMS |
| | Change administrative rules to reflect new policy | Rulemaking in development |
| | Draft notice to include appeal rights, information on the continuation of benefits, and how to request an expedited appeal | Completed |
| | Develop policies and procedures for processing requests | |
| | Design notice inserts that describe the various reasons for the denial or reduction in services (e.g., not medically necessary, not a covered service, etc) | |
| **Acknowledgement of Appeal** | | |
| *Grievances and appeals must be acknowledged in writing (typical standard is within five business days).* | Develop notices | Completed |
| | Develop policies and procedures for ensuring notices are sent timely | |
| | Develop process and assign staff to assist enrollees in filing grievances and appeals | |
| | Assign staff to receive, date stamp and log in all grievances and appeals | |
| **Resolution of Grievances and Appeals** | | |
| *OVHA must have a formal process for resolving all grievances and appeals. Providers must be permitted to file grievances or appeals on behalf of their patients if so requested. The following definitions apply:* ***An Action means –*** *1) The denial or limited authorization of a requested service, including the type or level of services; 2) The reduction, suspension or termination of a previously authorized service; 3) The denial, in whole or in part, of payment for a service; 4) The failure to provide services in a timely manner (as defined by the state); 5) The failure of the public MCO to act within prescribed timeframes.* ***An Appeal means –*** *Any request for a review of an action.* ***A Grievance is –*** *An expression of dissatisfaction with any matter other than an action (e.g., quality of care) [438.400(b)]. Resolution Timeframes: Standard* | Develop policies and procedures for the receipt, acknowledgement and resolution of grievances and appeals | Completed |
| | Develop a system for logging and tracking grievances and appeals (type, days to resolution, outcome) | |
| | Develop a system for automated reporting on grievances and appeals | |
| | Assign staff to process all grievances and appeals | |
| | Design resolution notices | |

| | | |
|---|---|---|
| *Grievance – 45 days from date of receipt ([438.408(b)(1)] =90days); Standard Appeal – 45 days from date of receipt [438.408(b)(2)]; Expedited Appeal – Three (3) business days from date of receipt [438.408(b)(3)]* | | |
| **Fair Hearings** | | |
| *OVHA must ensure that enrollees have the right to request a fair hearing within no less than 20 days or more than 90 days from the date of the notice of resolution of the grievance or appeal. [438.408(f)]. AHS, as the oversight entity, must ensure that the fair hearing is conducted in accordance with all applicable state and federal regulations including timeframes for the conduct of the hearing and the enrollee's due process rights.* | Develop policies and procedures for coordinating between the Grievance and Appeals process and the state Fair Hearing process | Completed |
| | Develop a system for notifying enrollees at the time of the resolution of their grievance or appeal of their right to a fair hearing | |
| | Develop reporting system to track number, types, timeliness and resolution of fair hearings | |
| **QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT (QAPI)** | | |
| **QAPI Plan** | | |
| *AHS must develop a strategy and plan which incorporates procedures that: 1) Assess the quality and appropriateness of care and services furnished to all Medicaid enrollees, including those with special health care needs [438.204(b)(1)]; 2) Identify the race, ethnicity and primary language spoken by each Demonstration enrollee [438.204(b)(2)]; 3) Provide for an annual, external independent review of the quality outcomes and timeliness of, and access to, the covered services under the Demonstration [438.204(d)]* | 1) Develop inventory of all QA/QI activities currently underway within OVHA and sub-contracted departments; Develop workgroup to identify new priorities;<br>2) Summarize into comprehensive QAPI Plan for CMS review | Completed<br>Draft completed and in internal routing and review prior to submission to CMS |
| | 3) Ensure that information is available in ACCESS eligibly system | December, 2007 |
| | 4) Expand EQRO focus beyond CRT program | Completed |
| **Source of Primary Care** | | |
| *OVHA must ensure that each Demonstration enrollee has an ongoing source of primary care. [438.208(b)(1)] It must further implement mechanisms to identify persons with special health care needs. [438.208(b)(4)(c)] The quality strategy must specify these mechanisms. [438.208(b)(4)(c)(i)]* | Identification of beneficiaries not already participating through PCPLus | In process |
| | Develop policies and procedures for the selection of a PCP by each Demonstration enrollee | Completed for current PCPlus |
| | Design information system capacity to capture the PCP information for each enrollee | Completed |
| | Develop a mechanism for tracking PCP caseload | Completed |
| **Practice Guidelines** | | |
| *OVHA must adopt practice guidelines that are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field, and which are adopted in consultation with contracting health care professionals. [438.236(b)]* | Establish a medical advisory task force of contracting professionals to provide consultation on the guidelines to be adopted for physical health issues | Completed |
| | Select key areas where guidelines are to be developed | Completed |
| | Research evidence-based guidelines and protocols for each of the key areas | Completed |

| | | |
|---|---|---|
| | Adopt the appropriate guidelines after consultation with the task force | Completed for existing guidelines; on-going identification of new national practice guidelines |
| | Distribute guidelines to appropriate network providers | Completed |
| **Measuring Performance Improvement** | | |
| *AHS must operate its QAPI program on an ongoing basis and conduct performance improvement projects designed to achieve, through ongoing measurement and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. Procedures must be in place to collect and use performance measurement data and to detect both under- and over-utilization of services. Mechanisms must also be in place to assess the quality and appropriateness of care furnished to enrollees with special health care needs. [438.240(a), (b), (c), & (d)]* | Develop inventory of all QA/QI activities currently underway within OVHA and sub-contracted departments; | Completed |
| | Develop workgroup to identify new priorities; | Completed |
| | Summarize into comprehensive QAPI Plan for CMS review | Draft completed and in internal routing and review prior to submission to CMS |
| **PROGRAM INTEGRITY** | | |
| **Actuarial Certification of Capitation Rates** | | |
| *AHS must provide CMS with an actuarial certification of the capitation rates that will be used as the basis of payment of Medicaid funds to the health plan. The rates must be certified by an actuary who meets the standards established by the American Academy of Actuaries. [438.6(c)(4)(i)]* | Develop database for actuaries | Completed |
| | Establish capitation rates by MEG | Completed |
| | Obtain written certification from qualified actuary | Completed |
| | Submit rates to CMS | Revision in progress for Year 1, 2, & 3 rates |
| **Compliance Plan** | | |
| *OVHA must also have administrative and management arrangements and/or procedures, including a mandatory compliance plan, that is designed to guard against fraud and abuse. This includes written policies, procedures and standards of conduct. A compliance officer must be designated and a compliance committee formed that is accountable to senior management. An effective training and education program must be developed and implemented for the compliance officer and other VHAP employees. [438.608(a) &(b)]* | Appoint compliance officer | In substantial compliance with major expansion of activities planned |
| | Develop written compliance plan | |
| | Develop policies and procedures for program integrity | |
| | Develop written standards of conduct | |
| | Design staff training program | |
| | Conduct staff training | |
| **MONITORING** | | |
| **Utilization** | | |
| *OVHA must monitor the program to identify potential areas of over- and under-utilization. Where such over- or under-utilization is identified, OVHA shall develop a Corrective Action Plan (CAP) for review by the AHS. [438.240(b)(3)]* | Develop an overall utilization management plan for the Demonstration | Completed with ongoing activities through new Program Integrity Unit and FADS |
| | Identify key areas for monitoring (e.g., inpatient days, emergency visits, etc) | |

| | | |
|---|---|---|
| | Establish thresholds for evaluating potentially inappropriately high or low levels of utilization by MEG | |
| **Provider and Enrollee Characteristics** | | |
| *OVHA's health information system must track certain characteristics of its network providers and enrollees (e.g., enrollees with special health care needs; providers with accommodations for the disabled in their offices) [438.242]* | Identify outstanding issues in ACCESS and/other systems related to capturing required enrollee characteristics | Completed |
| | Ensure that Provider survey captures required information and is in on-line directory | |
| **Enrollee Rights** | | |
| *Establish policies and procedures on enrollee rights consistent with the requirements of Part 438.100 of 42 CFR.* | Expand existing PCP and CRT policies and procedures | Completed for PCP and CRT enrollees; available through enrollee handbook for all enrollees by September, 2007 |
| **Encounter Data Validation** | | |
| *OVHA must put in place a process for validating encounter data and for reporting information on encounters/ claims by category of service. [438.242]* | Expand existing processes to include sub-contracted departments. | Completed |
| | Implement new Fraud and Abuse Detection Decision Support System (FADS) | |
| **ENROLLEE ACCESS & PROVIDER NETWORK** | | |
| **Availability of Services** | | |
| *OVHA must ensure that an adequate network of providers to provide access to all covered services is under contract to the state. This includes an assessment of geographic location of providers, considering distance and travel time, the means of transportation ordinarily used by Medicaid enrollees and whether the location provides for physical access for enrollees with disabilities. The assessment must also consider the number of network providers who are NOT accepting new Medicaid patients. OVHA must also ensure that network providers offer hours of operation that are no less than those offered to other patients. OVHA must also subcontract with other selected AHS departments that will provide services to Demonstration enrollees. [438.206]* | Conduct geo-access analysis of current network | on-going |
| | Identify any existing gaps | |
| | Recruit additional providers as needed | |
| | Develop process and procedures for provider site visits if warranted | |
| | Develop ongoing monitoring plan for the provider network | |
| | Design process for collecting info on providers with closed panels (no new patients accepted) and those with access/accommodations for the physically disabled | Survey completed; information available in on-line provider directory |
| | Develop contracts (IGAs) with other departments | Completed. |
| **CMS REPORTING** | | |
| **General Financial Requirements** | | |
| *AHS/OVHA shall comply with all general financial requirements under Title XIX. AHS must maintain financial records, including the following: 1) Monthly comparisons of projected vs actual expenditures; 2) Monthly report of OVHA revenues and expenses for Demonstration program; 3) Monthly comparisons of projected vs actual caseload, 4) Quarterly analysis of expenditures by service type; 5) Monthly financial statements; 6) All reports and data necessary to support waiver reporting requirements [IGA 2.12.2]* | Document any modifications to current report formats that will be required | On-going |
| | Assign staff responsible for the production and submission of the required reports | Completed |

| **Budget Neutrality Reporting** | | |
|---|---|---|
| *For the purpose of monitoring budget neutrality, within 60 days after the end of each quarter, the state shall provide to CMS a report identifying actual expenditures under the Demonstration. [STC pg. 20]* | Obtain report format from CMS | Completed |
| | Make any necessary changes to reporting processes and procedures to accommodate the CMS-specified report formats | Still under discussion |
| | Assign staff responsible for the production of the reports | Completed |
| | Develop policies and procedures for the development of corrective action plans if actual expenditures exceed the levels permissible under the Demonstration STCs (by year) | Under development |