

# Special Terms and Conditions of Approval

## CENTERS FOR MEDICARE & MEDICAID SERVICES SPECIAL TERMS AND CONDITIONS

**NUMBER:** 11-W-00116/6

**TITLE:** *IndependentChoices*: Arkansas Independence Plus Demonstration

**AWARDEE:** Arkansas Department of Health and Human Services

The following are Special Terms and Conditions for the award amendment of the Arkansas Independence Plus Demonstration, *IndependentChoices*, under a Medicaid section 1115 Demonstration. On August 11, 2006, the State submitted an extension and amendment request to allow demonstration participants to add new self-directed services, eliminate the “new to continuing” ratio and increase the enrollment limit. The Special Terms and Conditions are arranged in five subject areas and three attachments: General Program Requirements and Agreements, General Reporting Requirements, Legislation, Assurances and Operational Protocol, Attachment A: General Financial Requirements, Attachment B: Monitoring Budget Neutrality for the Demonstration, and Attachment C: Summary Schedule of Reporting Items.

Letters, documents, reports, or other materials that are submitted for review or approval must be sent to the Centers for Medicare & Medicaid Services (CMS) Central Office Demonstration Project Officer and the State representative in the CMS Regional Office.

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## I. GENERAL PROGRAM REQUIREMENTS

- 1. Phase-out Plan.** If the State intends to phase out the program it must submit a phase-out plan, which includes provisions for cessation of enrollment, to CMS no later than 6 months prior to the expiration of the demonstration. The phase-out plan will be submitted for CMS to review and consider for approval.
- 2. Cooperation with Federal Evaluators.** The State will fully cooperate with Federal evaluators and their contractor's efforts to conduct an independent federally funded evaluation of the demonstration program.
- 3. CMS Right to Suspend or Preclude the Demonstration During Implementation.** The CMS may suspend or preclude State demonstration implementation and/or service provision to demonstration enrollees whenever it determines that the State has materially failed to comply with the Special Terms and Conditions (STCs) or other terms of the project, and/or if the implementation of the project does not further the goals of the Medicaid program.
- 4. CMS Right to Terminate or Suspend the Demonstration During Operation.** During demonstration operation, CMS may suspend or terminate any project in whole or in part at any time before the date of expiration, whenever it determines that the State has materially failed to comply with any of the terms of the project. CMS will promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date. The State waives none of its rights to challenge CMS' finding that the State materially failed to comply. CMS reserves the right to withhold approval for the demonstration project or withdraw such approval at any time, if it determines that granting or continuing the demonstration project would no longer be in the public interest. If the demonstration project is terminated by action of CMS, CMS will be liable for only normal closeout costs. The State will submit a phase-out plan for CMS to review and consider for approval.
- 5. State Right to Terminate or Suspend Demonstration.** The State may suspend or terminate this demonstration in whole or in part at any time before the date of expiration. The State will promptly notify CMS in writing of the reasons for suspension or termination, together with the effective date. If the demonstration project is terminated by the State, CMS will be liable for only normal closeout costs. The State will submit a phase-out plan for CMS to review and consider for approval.

## II. GENERAL REPORTING REQUIREMENTS

(Attachment C provides a summary of the frequency of required reporting items.)

- 6. Quarterly & Annual Progress Reports.** The State will submit quarterly progress reports that are due 60 days after the end of each quarter. The fourth quarterly report of every calendar year will include an overview of the past year as well as the last quarter, and will serve as the annual progress report. CMS reserves the right to request the annual report in draft. The reports must address, at a minimum:

  - A discussion of events occurring during the quarter (including enrollment numbers, lessons learned, and a summary of expenditures);
  - Notable accomplishments, including findings from Quality Assurance, beneficiary survey and evaluation activities; and
  - Problems/issues that were identified and how they were solved.
- 7. Final Report.** At the end of the demonstration, the State will submit a draft final report to CMS for review and comments. The final report with CMS' comments is due no later than 180 days after the termination of the project.

### III. LEGISLATION

- 8. Changes in the Enforcement of Laws, Regulations, and Policy Statements.** All requirements of the Medicaid program expressed in laws, regulations, and policy statements, not expressly waived or identified as not applicable in the award letter (of which these STCs are part), will apply to the demonstration. To the extent that changes in the enforcement of such laws, regulations, and policy statements would have affected State spending in the absence of the demonstration in ways not explicitly anticipated in this agreement, CMS will incorporate such effects into a modified budget limit for the Demonstration. The modified budget limit would be effective upon enforcement of the law, regulation, or policy statement.

If the law, regulation, or policy statement cannot be linked specifically with program components that are or are not affected by the demonstration (e.g., all disallowances involving provider taxes or donations), the effect of enforcement on the State's budget limit will be proportional to the size of the demonstration in comparison to the State's entire Medicaid program (as measured in aggregate medical assistance payments).

- 9. Changes in Federal Law Affecting Medicaid Expenditures.** The State must, within the time frame specified in law, come into compliance with any changes in Federal law affecting the Medicaid program that occur after the demonstration award date. To the extent that a change in Federal law, which does not exempt State section 1115 demonstrations, would affect State Medicaid spending in the absence of the demonstration, CMS will incorporate such changes into a modified budget limit for the demonstration. The modified budget limit will be effective upon implementation of the change in Federal law, as specified in law.

If the new law cannot be linked specifically with program components that are or are not affected by the demonstration (e.g., laws affecting sources of Medicaid funding), the State must submit its methodology to CMS for complying with the change in law. If the methodology were consistent with Federal law and in accordance with Federal projections of the budgetary effects of the new law in the State, CMS would approve the methodology. Should CMS and the State, working in good faith to ensure State flexibility, fail to develop within 90 days a methodology to revise the without waiver baseline that is consistent with Federal law and in accordance with Federal budgetary projections, a reduction in Federal payments will be made according to the method applied in non-demonstration States.

- 10. Amending the Demonstration.** The State may submit for CMS consideration a request for an amendment to the demonstration to request exemption from changes in law occurring after the demonstration award date. The cost to the Federal Government of such an amendment must be offset to ensure that total projected expenditures under a modified demonstration do not exceed projected expenditures in the absence of the demonstration (assuming full compliance with the change in law).

## IV. ASSURANCES

Acceptance of the STCs of Approval constitutes the State's assurance that the following will be met:

**11. Voluntary Program.** The program is voluntary for all demonstration participants.

**12. Financial Management Services.** Financial management services will be available to all demonstration participants.

**13. Required Elements of Self-Direction.** As a State Medicaid program that presents individuals with the option to control and direct Medicaid funds through individual budgets, the State will meet the requirements CMS has determined are necessary to operate a successful self-directed program. The State will address in the Operational Protocol how it will satisfy the following requirements:

- **Person-Centered Planning.** A process, directed by the participant, intended to identify the strengths, capacities, preferences, needs, and desired outcomes of the participant.
- **Employer Authority.** The participant direction opportunity by which the participant exercises choice and control over individuals who furnish their demonstration services authorized in the service plan. Under the employer authority, the participant may function as the co-employer or the common law employer of workers who furnish direct services and supports to the participant.
- **Budget Authority.** The participant direction opportunity by which the participant exercises choice and control over a specified amount of funds in a participant-directed budget. Under the budget authority, the participant has decision-making authority regarding who will provide a service, when the service will be provided, and how the service will be provided consistent with the demonstration program's requirements. The participant has the authority to make changes in the distribution of funds among the self-directed services included in the participant-directed budget.
  - **Individual Budget.** An individual budget is developed using a person-centered planning process; based on actual service utilization and cost data and derived from reliable sources; developed using a consistent methodology to calculate the resources available to each participant that is open to public inspection; and reviewed according to a specified method and frequency.
- **Information and Assistance in Support of Participant Direction.** Activities that are undertaken to assist a demonstration participant to direct and manage their self-directed services and budgets. Such activities include information, training and assistance, including counseling/support broker services and financial management services.
  - **Counseling/Support Broker:** A support that includes, but is not limited to, assistance in locating and accessing needed services and supports, and counseling about employer responsibilities and budget development and monitoring.
  - **Financial Management Services.** A support that is provided to demonstration participants that includes, but is not limited to, operating a payroll service for

participant-employed workers, making required payroll withholdings, paying invoices for demonstration services and goods and tracking expenditures against the participant-directed budget.

- **Type of Living Arrangement.** Self-directed services will be provided to participants in their own private residence, the residence of their families, or in a living arrangement where services are furnished to fewer than four persons unrelated to the proprietor.
- **Independent Advocacy.** An independent advocate/advocacy system is available to all participants in the demonstration program and participants are informed of how to access the independent advocate/advocacy system. This function is performed by individuals or entities that do not provide direct services, perform assessments, or have monitoring, oversight or fiscal responsibilities for the demonstration.

**14. Quality Assurance and Quality Improvement (QA/QI).** The State Department of Health and Human Services (DHS) will design and implement a QA/QI Plan that effectively assures the health and welfare of program participants and includes a plan for discovery of critical incidents, remediation, and improvement.

**15. Evaluation.** The State will conduct an evaluation of the program and will cooperate with an independent evaluation contractor CMS may procure.

**16. Public Notice Requirements.** The State will comply with public notice requirements as published in 59 *Federal Register* 49249, dated September 27, 1994, and CMS requirements regarding Native American Tribe consultation.

**17. Preparation and Approval of Operational Protocol.** The State will revise its Operational Protocol Document, which represents all policies and operating procedures applicable to this demonstration, and will submit the revised Operational Protocol to CMS for approval prior to implementation. The State acknowledges that CMS reserves the right not to approve an Operational Protocol in the event that it does not comply with the STCs of Approval. *Requirements and required contents of the Operational Protocol are outlined in Section V of these STCs.*

**18. Adequacy of Infrastructure.** This demonstration will provide adequate resources to support participants in directing their own care. The support assures, but is not limited to, participant's compliance with laws pertaining to employer responsibilities, provision for back-up attendants as needs arise, and the performance of background checks on employees and guidance to participants on the results of checks. Adequate resources for implementation, monitoring activities, and compliance to the terms and conditions of approval of the demonstration will be provided by the State.

**19. Assistance of a Proxy.** This demonstration is designed to assist individuals who are capable of directing their own care. Individuals not capable of directing their own care will not be deliberately excluded from participating in the demonstration. Specifically, persons who require the assistance of others for care planning, or for whom authorization for care must be obtained from a proxy (e.g., a parent or legal guardian/representative) will not be excluded from program participation.

- 20. Supplant Services.** Cash payments provided under this demonstration program do not supplant informal care services that have routinely and previously been available to project participants. Such ongoing informal care services will be identified as a part of each participant's care plan.
- 21. Contract Approval.** Any Fiscal Management Services contract(s) will be reviewed and approved by CMS prior to the State's requesting Federal financial payments for expenditures incurred under the contract(s).
- 22. Federal Financial Participation (FFP) Availability.** FFP for Fiscal Management Services as "medical assistance" at the FMAP rate is available for the extension year, February 1, 2007, through January 31, 2008.
- 23. Coordination with section 1915(c) Elder Choices waiver.** FFP for the new self-directed demonstration service of companion services will not be available unless and until CMS approves companion services under the section 1915(c) Elder Choices waiver amendment.

## V. OPERATIONAL PROTOCOL

**24. Operational Protocol Timelines and Requirements.** The revised Operational Protocol will be submitted to CMS no later than 30 days after the amendment/extension approval. CMS will respond within 30 days of receipt of the protocol regarding any issues or areas for which clarification is needed in order to fulfill the terms and conditions of approval.

Subsequent changes to the demonstration program and the Operational Protocol that are the result of major changes in policy or operating procedures, including changes to cost-sharing amounts or subsidy amounts, including adjustments for inflation, must be submitted for review by CMS. The State must submit a request to CMS for these changes no later than 90 days prior to the date of implementation of the change(s).

### **25. Required Contents of Operational Protocol:**

- a. Organization and Structural Administration.** A description of the organizational and structural administration that will be in place to implement, monitor, and operate the demonstration, and the tasks each organizational component will perform.
- b. Reporting Items.** A description of the content and frequency of each of the reporting items as listed in Section II and Attachments A and C of this document.
- c. Benefits.** Descriptions or listings of:
  - procedures for determining the plan of care;
  - methodology for establishing the budget for the plan of care;
  - how purchasing plans are developed;
  - procedures and mechanisms to be used to review and adjust payments for the plan of care; and,
  - services which will be cashed out.
- d. Outreach/Marketing/Education.** A description of the State's outreach, marketing, education, and staff training strategy. *NOTE: All marketing materials must be reviewed and approved by CMS prior to use.* Include in the description:
  - information that will be communicated to enrollees, participating providers, and State outreach/education/intake staff (such as social services workers and caseworkers);
  - types of media to be used;
  - specific geographical areas to be targeted;
  - locations where such information will be disseminated;
  - staff training schedules, schedules for State forums or seminars to educate the public; and,
  - the availability of bilingual materials/interpretation services and services for individuals with special needs. Include a description of how eligibles will be informed of cost sharing responsibilities.

- e. Eligibility/Enrollment.** A description of the population of individuals eligible for the demonstration (and eligibility exclusions) and population phase-in and the following:
- eligibility determination;
  - annual redetermination;
  - intake, enrollment, and disenrollment;
  - procedures for determining the existence and scope of a demonstration applicant's existing third party liability;
  - the State agency that will be responsible for each of the above processes.
- f. Enrollment Ceiling.** Description of the enrollment ceiling. This description shall include the process for amending the enrollment ceiling.
- g. Quality Assurance and Quality Improvement (QA/QI).** Description of an overall quality assurance and quality improvement plan that includes, but is not limited to the following:
- quality indicators to be employed to monitor service delivery under the demonstration and the system to be put in place so that feedback from quality monitoring will be incorporated into the program;
  - the mechanisms the State will utilize to assure that the care needs of vulnerable populations participating in this demonstration (i.e., the elderly and disabled) are satisfied, and that funds provided to these beneficiaries are used appropriately;
  - the system the State will operate by which it receives, reviews, and acts upon critical events or incidents, with a description of the critical events or incidents;
  - case management staff for purposes of monitoring participant health and welfare;
  - quality monitoring surveys to be conducted, and the monitoring and corrective action plans to be triggered by the surveys;
  - plans to report survey results, service utilization, and general quality assurance findings to CMS as part of the quarterly and annual reports;
  - procedures for assuring quality of care and participant safeguards;
  - procedures for insuring against duplication of services and payment between the demonstration, fee-for-service and home and community-based services programs; and,
  - fraud control provisions and monitoring.
- h. Information and Assistance in Support of Participant Direction.** Descriptions of the following topics will be included:
- procedures for ensuring sufficient availability of information, training, counseling/supports brokerage, fiscal/employer agent (if any), financial management services, and other support services;
  - procedures for training opportunities and support services available for participants of the demonstration who require assistance with their fiscal and legal responsibilities;

- procedures for conducting participant background checks on potential providers and informing participants of the results of the criminal background checks;
- the State’s relationships and arrangements with organizations providing enrollment/assessment, information, training, counseling/supports brokerage, fiscal/employer agent (if any), financial management services, and other support services;
- the procurement mechanism, standards, scope of work and payment process for the enrollment/assessment, information, training, counseling/supports brokerage, fiscal/employer agent, (if any), financial management services, and other support services;
- procedures to assure that participants and their families or representatives have the requisite information and/or tools to direct and manage their care, including, but not limited to, how the participant and/or representative are informed of: the methodology used to calculate the individual budget, the total dollar value of the services authorized, any policies that apply to the participant’s management of the individual budget, the procedures that he/she must follow in order to request an adjustment of the individual budget, and the amount and the methodology used to calculate any discount applied to the individual budget; and employer-related services such as training in managing the caregivers, assistance in locating caregivers, as well as completing and submitting paperwork associated with billing, payment, and taxation;
- procedures for how the State assures that an individualized back-up plan is developed during the service planning process that includes the identification and discussion of critical services, if unavailable to the participant, would likely place each participant at risk of harm, including the failure of the participant's care provider to show up, and the development of a plan to manage identified risks;
- procedures for how the State will work with families who expend their individualized budget in advance of the re-determination date to assure that services needed to avoid out-of-home placement and the continuation of the health and welfare of the individual are available;
- procedures for how decisions will be made regarding unexpended resources at the time of budget re-determination; and, the
- process by which the State makes available to participants, at no cost, provider qualification/background checks.

**i. Evaluation Design.** A description of the State’s evaluation design. The description will include the following:

- discussion of the demonstration hypotheses that will be tested;
- outcome measures that will be included to evaluate the impact of the demonstration;
- what data will be utilized;
- methods of data collection;
- effects of the demonstration will be isolated from those other initiatives occurring in the State;

- any other information pertinent to the State's evaluative or formative research via the demonstration operations; and
- plans to include interim evaluation findings in the quarterly and annual progress reports (primary emphasis on reports of services being purchased and participant satisfaction.)

**ATTACHMENT A**  
**GENERAL FINANCIAL REQUIREMENTS**

1. The State will provide quarterly expenditure reports using the Form CMS-64 to report total expenditures for services provided under the Medicaid program and those provided under IndependentChoices: Arkansas Cash and Counseling Demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. The CMS will provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits as specified in Attachment B (Monitoring Budget Neutrality for the demonstration).
  
2.
  - a. In order to track expenditures under this demonstration, the State will report demonstration expenditures through the Medicaid and State Children’s Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual. All expenditures subject to the budget neutrality cap will be reported on separate Forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the demonstration year in which services were rendered). For monitoring purposes, cost settlements must be recorded on Line 10.b, in lieu of Lines 9 or 10c. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10.c, as instructed in the State Medicaid Manual. The term "expenditures subject to the budget neutrality cap" is defined below in item 2.c.
  
  - b. For each demonstration year, a Form CMS-64.9 WAIVER and/or 64.9P WAIVER will be submitted reporting expenditures subject to the budget neutrality cap. All expenditures subject to the budget neutrality ceiling for demonstration eligibles must be reported. The sum of the expenditures, for all demonstration years reported during the quarter, will represent the expenditures subject to the budget neutrality cap (as defined in 2.c.).
  
  - c. For the purpose of this section, the term “expenditures subject to the budget neutrality cap” will include all Medicaid expenditures on behalf of demonstration participants and will be reported under the waiver name **Independence Plus**. The services subject to budget neutrality include the following categories as they appear on the CMS-64.9 WAIVER and/or 64.9P WAIVER forms: Self-directed demonstration services of Personal Care and Companion Services; and impacted services of Home Health, Community-Based Waiver Services, Targeted Case Management, Hospice Benefits, Non-Emergency Transportation, and Durable Medical Equipment.

Administrative costs will not be included in the budget neutrality limit, but the State must separately track and report additional administrative costs that are directly attributable to the demonstration. Procedures regarding the tracking and reporting of administrative costs will be described in the Operational Protocol to be submitted by the State to CMS under terms specified in Section V.



- c. Net medical assistance expenditures made under section 1115 demonstration authority, including those made in conjunction with the demonstration.
- 6. The State will certify State/local monies used as matching funds for the IndependentChoices program and will further certify that such funds will not be used as matching funds for any other Federal grant or contract, except as permitted by Federal law.

**ATTACHMENT B**  
**MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION**

The following describes the method by which budget neutrality will be assured under the IndependenceChoices demonstration. The demonstration will be subject to a limit on the amount of Federal title XIX funding that the State may receive on selected Medicaid expenditures during the demonstration period.

The budget neutrality limit will be calculated using a per capita cost method. Under this methodology, the State will be at risk for the per capita cost for demonstration participants, but not at risk for the number of participants. By placing the State at risk for the per capita costs of all demonstration participants, CMS assures that demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.

For the purpose of calculating the overall expenditure limit for the demonstration, separate budget estimates will be calculated for each year on a DY basis. The annual estimates will then be added together to obtain an overall expenditure limit for the entire demonstration period. The Federal share of this estimate will represent the maximum amount of FFP that the State may receive during the 1-year extension period for the types of Medicaid expenditures described below. For each DY, the Federal share will be calculated using the Federal Medical Assistance Percentage rate(s) applicable to that year.

**Projecting Service Expenditures**

Each demonstration year budget estimate of Medicaid service expenditures will be calculated as the product of the trended monthly per person cost (MPPC) times the actual number of member months as reported to CMS by the State under the guidelines set forth in Attachment A number 3. The trended costs by DY are the following:

<b>Demonstration Year</b>	<b>Time Period</b>	<b>Trended Monthly Per Person Cost</b>
DY 2007	2/01/07 – 1/31/08	\$ 1,022

**Impermissible DSH, Taxes, or Donations**

The CMS reserves the right to adjust the budget neutrality ceiling to be consistent with enforcement of impermissible provider payments, health care related taxes, new Federal statutes, or policy interpretations implemented through letters, memoranda, or regulations. CMS reserves the right to make adjustments to the budget neutrality cap if any health care related tax that was in effect during the base year, or provider related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of 1903(w) of the Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

**Revising the Trended Monthly Per Person Cost**

In demonstration programs where participation is voluntary and the participation rate represents a minority percentage of the population eligible to participate, a revision to the trended MPPC in specified DY(s) may be considered by the state and CMS when the State implements provider

fee increases that: 1) are irregular in nature; 2) materially exceed the agreed upon trend rate in the year the fee is implemented; and, 3) are implemented through the State Plan and affect the cost of those services included in the demonstration budget neutrality cap on a statewide basis.

The intent of this provision is to protect the State from statewide fee increases that are: 1) pending at time of award but could not be reasonably assessed prior to award or undefined at the time of award; 2) are not included in the historical State experience used in determining the agreed upon budget neutrality cap; and, 3) are not specifically targeted to the demonstration population.

The State, when requesting revision to the MPPC, must provide the following information to CMS on: 1) the full budget effect of the fee increase, including the amount and implementation dates of the current and past fee increases for all services in the MPPC; 2) the MPPC disaggregated by major service categories and number of services for each category, demonstrating the affect with and without the new rate increase; and, 3) the current assessment and projections of with and without waiver costs.

### **How the Limit will be Applied**

The limit calculated above will apply to actual expenditures for long-term care services, as reported by the State under Attachment A. If at the end of the demonstration period the budget neutrality provision has been exceeded, the excess Federal funds will be returned to CMS. There will be no new limit placed on the FFP that the State can claim for expenditures for recipients and program categories not listed. If the demonstration is terminated prior to the approved extension period, the budget neutrality test will be based on the time period through the termination date.

### **Expenditure Review**

The CMS shall enforce budget neutrality over the life of the demonstration, rather than on an annual basis. However, no later than 6 months after the end of each DY, CMS will calculate an annual expenditure target for the completed year. This amount will be compared with the actual FFP claimed by the State under budget neutrality. As this extension is for a 1 year period, the demonstration must continue to be budget neutral through this period as enforced over the life of the demonstration.

**ATTACHMENT C  
SUMMARY SCHEDULE OF REPORTING ITEMS**

<b>Item</b>	<b>Timeframe for Item</b>	<b>Frequency of Item</b>
<b>Operational Protocol</b>	Due to CMS 30 days after amendment/extension approval. CMS comments due 30 days after submission.	One revised Operational Protocol. Changes to the Operational Protocol must be submitted and approved by CMS.
<b>Quarterly/Annual Progress Reports</b>	Due to CMS 60 days after the end of a quarter.	One quarterly report per Federal Fiscal Year quarter during operation of the demonstration; the report for the fourth quarter of each year will serve as the annual progress report.
<b>Final Report</b>	Due to CMS 180 days after the end of the demonstration.	One final report.