CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00128/1**

TITLE: **Maine Medicaid Section 1115 Health Care Reform Demonstration for Individuals with HIV/AIDS**

AWARDEE: **MaineCare Services (OMS)**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Maine HIV/AIDS section 1115(a) Medicaid Demonstration extension (hereinafter "Demonstration"). The parties to this agreement are the Maine Department of Health and Human Services (State) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of Federal involvement in the Demonstration and the State's obligations to CMS during the life of the Demonstration. The STCs are effective July 1, 2010, unless otherwise specified. All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below. This Demonstration renewal is approved through December 31, 2013.

The STCs have been arranged into the following subject areas: Program Description and Objectives; General Program Requirements; Eligibility, Benefits, and Enrollment; Cost Sharing; Delivery Systems; General Reporting Requirements; General Financial Requirements; Monitoring Budget Neutrality; Evaluation of the Demonstration; and, Schedule of State Deliverables for the Demonstration Extension Period.

Additionally, Attachment A has been included to provide supplemental information and guidance for the Quarterly Report.

II. PROGRAM DESCRIPTION AND OBJECTIVES

The HIV/AIDS section 1115(a) Demonstration expands access to certain individuals with HIV/AIDS without health insurance, allows such individuals to become eligible for a targeted benefits package through the Demonstration without having to spend down income or resources, and allows individuals with HIV/AIDS to remain involved in gainful activity. The Demonstration is designed to provide more effective, early treatment of HIV disease by making available a limited but comprehensive package of services, including anti-retroviral therapies. The State believes that early treatment and case management services provided to individuals with HIV/AIDS create efficiencies in the Medicaid program that enable the extension of coverage to certain individuals who would otherwise be without health insurance. The Demonstration includes two groups: "Members" who are MaineCare eligibles identified as HIV-positive individuals who meet the social security definition of "totally disabled" and are below 100 percent of Federal poverty level (FPL); and, "Enrollees" who do not meet the eligibility requirements of MaineCare, but who are HIV-positive and are at or below 250 percent of the FPL.

The State's goal in implementing the Demonstration is to improve the health status of individuals living with HIV/AIDS in Maine by:

- Improving access to continuous health care services;
- Arresting progression of HIV/AIDS status by providing early and optimal care coupled with high quality and cost efficiency; and
- Expanding coverage to additional low-income individuals living with HIV with the savings generated from Disease Prevention and the delayed onset of full-blown AIDS

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The State must comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid Laws, Regulation, and Policy.** All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), must apply to the Demonstration.

3. **Changes in Medicaid Law, Regulation, and Policy.** The State must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in Federal law, regulation, or policy affecting the Medicaid program that occur during this Demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

    a) To the extent that a change in Federal law, regulation, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this Demonstration, the State must adopt, subject to CMS approval, a modified budget neutrality agreement for the Demonstration as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.

    b) If mandated changes in the Federal law require State legislation, the changes must take effect on the day such State legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **State Plan Amendments.** The State will not be required to submit title XIX or title XXI State plan amendments for changes affecting any populations made eligible solely through the Demonstration. If a population eligible through the Medicaid State Plan is affected by a change to the Demonstration, a conforming amendment to the appropriate State Plan may be required, except as otherwise noted in these STCs.

6. **Changes Subject to the Amendment Process**. Changes related to eligibility, enrollment, benefits, cost sharing, sources of non-Federal share of funding, budget neutrality, and other

comparable program elements must be submitted to CMS as amendments to the Demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The State must not implement changes to these elements without prior approval by CMS. Amendments to the Demonstration are not retroactive and FFP will not be available for changes to the Demonstration that have not been approved through the amendment process set forth in paragraph 7 below.

7. **Amendment Process.** Requests to amend the Demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. Amendment requests must include, but are not limited to, the following:

   a) An explanation of the public process used by the State, consistent with the requirements of paragraph 15, to reach a decision regarding the requested amendment;

   b) A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

   c) A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and

   d) If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

8. **Extension of the Demonstration.** No later than 12 months prior to the expiration date of the Demonstration, the chief executive officer of the State must submit to CMS either a Demonstration extension request or a phase-out plan consistent with the requirements of paragraph 9.

   As part of the Demonstration extension request, the state must provide documentation of compliance with the public notice requirements outlined in paragraph 15, as well as include the following supporting documentation:

   a) Demonstration Summary and Objectives: The State must provide a narrative summary of the demonstration project, reiterate the objectives set forth at the time the demonstration was proposed and provide evidence of how these objectives have been met as well as future goals of the program. If changes are requested, a narrative of the changes being requested along with the objective of the change and desired outcomes must be included.

   b) Special Terms and Conditions (STCs): The State must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address any of the following areas, they need not be documented a second time.

c) Waiver and Expenditure Authorities: The State must provide a list along with a programmatic description of the waivers and expenditure authorities that are being requested in the extension.

d) Quality: The State must provide summaries of External Quality Review Organization (EQRO) reports, managed care organization (MCO) and State quality assurance monitoring, and any other documentation of the quality of care provided under the demonstration.

e) Compliance with the Budget Neutrality Cap: The State must provide financial data (as set forth in the current STCs) demonstrating the State's detailed and aggregate, historical and projected budget neutrality status for the requested period of the extension as well as cumulatively over the lifetime of the demonstration. CMS will work with the State to ensure that Federal expenditures under the extension of this project do not exceed the Federal expenditures that would otherwise have been made. In doing so, CMS will take into account the best estimate of current trend rates at the time of the extension. In addition, the State must provide up to date responses to the CMS Financial Management standard questions.

f) Draft report with Evaluation Status and Findings: The State must provide a narrative summary of the evaluation design, status (including evaluation activities and findings to date), and plans for evaluation activities during the extension period. The narrative is to include, but not be limited to, describing the hypotheses being tested and any results available.

9. **Demonstration Phase-Out.** The State may suspend or terminate this Demonstration in whole, or in part, at any time prior to the date of expiration. The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date. In the event the State elects to phase out the Demonstration, the State must submit a phase-out plan to CMS at least six months prior to initiating phase-out activities. Consistent with the enrollment limitation requirement in paragraph 10 a phase-out plan shall not be shorter than six months unless such action is necessitated by emergent circumstances. The phase-out plan is subject to CMS approval. If the project is terminated or any relevant waivers suspended by the State, FFP shall be limited to normal closeout costs associated with terminating the Demonstration including services and administrative costs of disenrolling participants.

10. **Enrollment Limitation During Demonstration Phase-Out.** If the State elects to suspend, terminate, or not renew this Demonstration as described in paragraph 9, during the last 6 months of the Demonstration, individuals who would not be eligible for Medicaid under the current Medicaid State plan must not be enrolled unless the Demonstration is extended by CMS. Enrollment must be suspended if CMS notifies the State in writing that the Demonstration will not be renewed.

11. **CMS Right to Terminate or Suspend**. CMS may suspend or terminate the Demonstration (in whole or in part) at any time before the date of expiration, whenever it determines following a hearing that the State has materially failed to comply with 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.

12. **Finding of Non-Compliance.** The State does not relinquish its rights to challenge the CMS finding that the State materially failed to comply.

13. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS will promptly notify the State in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the State an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

14. **Adequacy of Infrastructure.** The State must ensure the availability of adequate resources for implementation and monitoring of the Demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other Demonstration components.

15. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The State must continue to comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) and the tribal consultation requirements pursuant to section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009, when any program changes to the Demonstration, including (but not limited to) those referenced in STC 7, are proposed by the State. In States with Federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the State is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal, amendment and/or renewal of this Demonstration.

16. **FFP.** No Federal matching funds for expenditures for this Demonstration will take effect until the effective date identified in the Demonstration approval letter.

IV. ELIGIBILITY, BENEFITS, AND ENROLLMENT

The Maine HIV/AIDS Demonstration provides a comprehensive set of services to those who are both HIV positive and are at or below 250 percent of the FPL. The Demonstration expands access to those without health insurance and who are otherwise ineligible for MaineCare. Individuals with other insurance may receive this benefit. MaineCare may pay premiums/cost-sharing for this insurance according to current MaineCare rules.

17. Eligibility.

Mandatory State plan groups described below are subject to all applicable Medicaid laws and regulations, except to the extent expressly waived, or listed as not applicable to demonstration exenditures, in the list of waivers and expenditure authorities issued with the award letter for this Demonstration.

Those non-Medicaid eligible groups described below who are made eligible for the Demonstration by virtue of the expenditure authorities expressly granted in this Demonstration

are subject to Medicaid laws or regulations only as specified in the expenditure authorities for this Demonstration.

The eligibility criteria for the HIV/AIDS Demonstration are as follows:

- Positive HIV status;
- Financially eligible;
- Completed information form related to other insurance, i.e., third party liability (TPL);
- Payment of premiums (if applicable); and
- Willingness to sign informed consent that includes;
    - Understanding of requirements of the benefit; and
    - Willingness to comply with treatment recommendations

Demonstration Eligibility Groups	Federal Poverty Level (FPL) and/or Other qualifying Criteria	Eligible Benefit
"Members" State Plan Mandatory Groups*	HIV-positive individuals who meet the Social Security definition of "totally disabled" and are below 100 percent of FPL	Full Medicaid Benefit offered under the State plan
"Enrollees" Expansion Populations**	Positive HIV status and at or below 250 percent of FPL	Targeted Benefit

* These mandated State Plan eligible beneficiaries ("Members") are enrolled in the Demonstration for the benefit of enhanced coordination and to generate savings for Expansion populations listed as "Enrollees" in the Demonstration Eligibility Groups category.

****** These "Enrollee" eligible beneficiaries are expansion populations whose expenditures are paid for solely by savings generated by "Members" enrolled in the Demonstration.

18. **Eligibility Exclusions.** The following persons are excluded from the HIV/AIDS Demonstration.

Negative HIV Status
Individuals with HIV over 250 percent of the FPL

19. **Maine HIV/AIDS Demonstration Benefits.** Benefits are based on a disease model with the goal to delay, prevent, and reverse the progression of HIV/AIDS. The HIV/AIDS Demonstration benefit is not an entitlement program. It is a disease management program with defined treatment protocols. A candidate for the benefit must agree to be monitored and participate in medical treatment. Participants must meet certain eligibility requirements and

must follow treatment recommendations after being determined eligible for the program.

a) The 1115 HIV/AIDS Participant "Members" receive all of the medically necessary covered MaineCare services, while "Enrollees" receive a targeted essential set of MaineCare services as listed in the following chart:

The following MaineCare categories of services and respective policies of the MaineCare Benefits Manual (MCBM) ***are included*** in the limited benefit for "Enrollees":

General Category of Service	Specific Services Include
Inpatient	MCBM Chapter II, Section 45, Hospital Services
Psychiatric Facility	MCBM Chapter II, Section 46, Psychiatric Facilities Services
Outpatient	MCBM Chapter II, Section 45, Hospital Services
EPSDT Examinations	MCBM Chapter II, Section 94, Prevention, Health Promotion (Formerly MCBM Chapter V, Section 3, EPSDT Examinations: Physician Services)
Medications	MCBM Chapter II, Section 80, Pharmacy Services
Community Support Services	MCBM Chapter II, Section 17, Community Support Services
Lab & X-ray	MCBM Chapter II, Section 55, Laboratory Services and Section 101, Medical Imaging Services
Transportation	MCBM Chapter II, Section 113, Transportation Services; benefit will only pay for transportation to covered services
Ambulatory Care	MCBM Chapter II, Section 3, Ambulatory Care Clinic Services; Section 4, Ambulatory Surgical Center Services
Case Management	MCBM Chapter II, Section 13.07, Targeted Case Management Services for Persons with HIV Infection; Section 13.06, Case Management Services for Persons with Severe and Disabling Mental Illness
Family Planning	MCBM Chapter II, Section 30, Family Planning Agency Services
Mental Health	MCBM Chapter II, Section 65, Mental Health Services
Ambulance	MCBM Chapter II, Section 5, Ambulance Services
Psychology Services	MCBM Chapter II, Section 100, Psychological Services
Medicare Crossover-A	MCBM Chapter II, Section 45, Hospital Services
VD Screening	MCBM Chapter II, Section 150, VD Screening Clinic
Medicare Crossover-B	MCBM Chapter II, Section 90, Physician Services; Section 31, Federally Qualified Health Center Services; Section 103, Rural Health Clinic Services
Child Health	MCBM Chapter II, Section 90, Physician Services; Section 31, Federally Qualified Health Center Services; Section 103, Rural Health Clinic Services

General Category of Service	Specific Services Include
Physician, Physician Assistant, Advanced Practice Registered Nurse, Certified Nurse Practitioner	When employed in a physician's practice, in addition to providing the following services, may also act as a primary care provider: MCBM Chapter II, Section 90, Physician Services; Section 31, Federally Qualified Health Center Services; Section 103, Rural Health Clinic Services
Advanced Practice Registered Nurse	In addition to providing services under Sections 90, 31, and 103 when employed in a physician's practice, may also provide services in private practice under MCBM Chapter II, Section 14, Advanced Practice Registered Nursing Services
Certified Nurse Practitioner Certified Nurse-Midwife Certified Registered Nurse Anesthetist Certified Clinical Nurse	In addition to providing services under Sections 90, 31, and 103 when employed in a physician's practice, may also provide services when employed by an Advanced Practice Registered Nurse, under MCBM Chapter II, Section 14, Advanced Practice Registered Nursing Services
Early Intervention	MCBM Chapter II, Section 27, Early Intervention Services
Development and Behavioral Clinical Services	MCBM Chapter II, Section 23, Developmental and Behavioral Clinic Services
Substance Abuse Treatment	MCBM Chapter II, Section 111, Substance Abuse Treatment Services

General Category of Service	Specific Services Include
Physician, Advanced Practice Registered Nurse Audiologist Certified Clinical Nurse Specialist Certified Nurse Midwife Certified Nurse Practitioner Certified Registered Nurse Anesthetist Licensed Clinical Professional Counselor Licensed Clinical Social Worker Licensed Master Social Worker Licensed Professional Counselor Nurse Practitioner Occupational Therapist Physician's Assistant Physical Therapist Registered Nurse First Assist	When employed in a physician's practice, MCBM Chapter II, Section 90, Physician Services; Section 31, Federally Qualified Health Center Services; Section 103, Rural Health Clinic Services

The following MaineCare categories of services and respective policies of the MCBM are ***not included*** in the "Enrollee" participant benefit package, which are included for the "Member" groups.

General Category of Service	Services Do Not Include
Adult Family Care	MCBM Chapter II, Section 2, Adult Family Care Services
Consumer Directed Attendant	MCBM Chapter II, Section 12, Consumer Directed Attendant Services
Home and Community-Based Waiver Services for the Elderly and Adults with Disabilities	MCBM Chapter II, Section 19, Home and Community-Based Waiver Services for the Elderly and for Adults with Disabilities (was Section 18, Home and Community-Based Waiver Services for Adults with Disabilities)
Home and Community-Based Waiver Services for Persons with Mental Retardation Retardation	MCBM Chapter II, Section 21, Home and Community-Based Waiver Services for Persons with Mental Retardation
Private Non-Medical Institution	MCBM Chapter II, Section 97, Private Non-Medical Institution Services
Day Health	MCBM Chapter II, Section26, Day Health Services
Home Health	MCBM Chapter II, Section 40, Home Health Services
Hospice	MCBM Chapter II, Section 43, Hospice Services
Medical Supplies and Durable Medical Equipment	MCBM Chapter II, Section 60, Medical Supplies and Durable Medical Equipment
Nursing Facility	MCBM Chapter II, Section 67, Nursing Facility Services
Optician, Optometrist	MCBM Chapter II, Section 75, Vision Services (Ophthalmologist services are covered if the services are under physician services, Section 90)
Physical Therapy	MCBM Chapter II, Section 85, Physical Therapy Services
Private Duty Nursing and Personal Care	MCBM Chapter II, Section 96, Private Duty Nursing and Personal Care Services

General Category of Service	Services Do Not Include
Primary Care Case Management	MCBM Chapter II, Section 13, Targeted Case Management Services (except Section 13.07, Targeted Case Management Services for Persons with HIV Infection; Section 13.06, Case Management Services for Persons with Severe and Disabling Mental Illness
School Based Rehabilitation	MCBM Chapter II, Section 104, School Based Rehabilitation Services
Speech-Language Pathology	MCBM Chapter II, Section 109, Speech and Hearing Services
Licensed Clinical Social Worker, Licensed Clinical Professional Counselor	MCBM Chapter II, Section 58, Licensed Clinical Social Worker Services (Services are covered if the services are under Physician Services Chapter 90)
Licensed Marriage and Family Therapist	MCBM Chapter II, Section 58, Licensed Clinical Social Worker Services
MaineNET	MCBM Chapter VI, Section 3, MaineNET
Managed Care Initiative	MCBM Chapter VI, Section 2, MaineCare DirigoChoice Initiative
Audiology	MCBM Chapter II, Section 109, Speech and Hearing Services (Services are covered if Physician Services under Chapter 90)
Speech and Hearing Agencies	MCBM Chapter II, Section 109, Speech and Hearing Services (Formerly Section 105, Speech and Hearing Agencies)
Chiropractic	MCBM Chapter II, Section 15, Chiropractic Services
Home/Community-Based Waiver for Physically Disabled	MCBM Chapter II, Section 22, Home and Community-Based Waiver Services for the Physically Disabled
Dental	MCBM Chapter II, Section 25, Dental Services
Hearing Aids and Services	MCBM Chapter II, Section 35, Hearing Aids and Services
Day Treatment	MCBM Chapter II, Section 41, Day Treatment Services
ICF-MR	MCBM Chapter II, Section 50, ICF-MR Services
Genetic Testing and Clinical Genetic Services	MCBM Chapter II, Section 62, Genetic Testing and Clinical Genetic Services
Occupational Therapy	MCBM Chapter II, Section 68, Occupational Therapy Services
Podiatric	MCBM Chapter II, Section 95, Podiatric Services

General Category of Service	Services Do Not Include
Day Habitation Services for Mental Retardation	MCBM Chapter II, Section 24, Day Habitation Services for Persons with Mental Retardation
Rehabilitative Services	MCBM Chapter II, Section 102, Rehabilitative Services

V. COST SHARING

20. **Co-pays.** Demonstration "Enrollees" pay a co-pay for physician services and pharmaceuticals that is higher than MaineCare "Member" participants. For all other services, "Enrollees" pay the same co-pays as MaineCare "Members" (see table below).

Demonstration Co-Pays*

Services	Demonstration "Enrollees"	Demonstration "Members"
Prescription Drugs**	$10.00	$3.00, capped at $30 per month per member
Physician Visits	$10.00	None
Outpatient Hospital Services	$3.00	$3.00
Home Health Services	N/A	$3.00
Durable Medical Equipment	N/A	$3.00
Private Duty Nursing and Personal Care Services	N/A	$3.00
Ambulance Services	$3.00	$3.00
Physical Therapy Services	$2.00	$2.00
Occupational Therapy Services	$2.00	$2.00
Speech Therapy Services	N/A	$2.00
Podiatry Services	N/A	$2.00
Psychologist Services	$2.00	$2.00
Chiropractic Services	N/A	$2.00
Laboratory Services	$1.00	$1.00
Optical Services	N/A	$2.00
Optometric Services	N/A	$3.00
Mental Health Clinic Services	$2.00	$2.00
Substance Abuse Services	$2.00	$2.00
Hospital Inpatient Services	$3.00 per patient day	$3.00 per patient day
Federally Qualified Health Center Services	$3.00 per patient day	$3.00 per patient day
Rural Health Center Services	$3.00 per patient day	$3.00 per patient day

*No co-payment may be imposed on either "Members" or "Enrollees" with respect to the following services and populations:

- Family planning;
- Individuals under 21 years of age;
- An individual who is an inpatient in a hospital, nursing facility, or other institution, and is required to spend all their income for costs of care, with the exception of a minimal amount of for personal needs;
- Pregnant women, and services furnished during the post-partum phase of maternity care to the extent permitted by federal law;
- Emergency services, as defined by the department;
- Services furnished to an individual by a Health Maintenance Organization, as defined in section 1903(m) of the Social Security Act, in which he/she is enrolled; and
- Any other service or services required to be exempt under the provisions of the Social Security Act, Title XIX and successors to it.

** The AIDS Drug Assistance Program (ADAP), funded by title II, provides coverage for the co-payment of HIV related drugs for "members" and "enrollees" as well as provides premium assistance for certain "enrollees" required to pay a premium under the Demonstration. ADAP is considered a "wrap" around benefit for all demonstration participants. "Members" and "Enrollees" participate in both benefit programs and receive both a MaineCare card and an ADAP card.

21. **Monthly Premiums**. "Enrollees" are responsible for payment of a monthly premium dependent on their income level. When the Demonstration began in 2002, the premiums were:

Income Level	Monthly Premium
Less than 150% of FPL	$0
Between 150%-200% of FPL	$20
Between 200%-250% of FPL	$40

Premiums have been inflated by 5 percent annually, and for the extension period the premiums will be:

Demonstration Year (DY)	Actual Premium, Income level <150% FPL	Actual Premium, Income level 150-200% of FPL	Actual Premium, Income level 200-250% of FPL
DY 9 7/2010-6/2011	$0	$29.56	$59.11
DY 10 7/2011-6/2012	$0	$31.04	$62.07
DY 11 7/2012-12/2013	$0	$32.59	$65.17

22. **Cost Sharing Protections.** In the event demonstration "enrollees" fail to pay premiums by the date on which they are due, the State will provide a reasonable grace period of no less than 30

days during which the "enrollee" may make the payment without termination from the program. During the grace period, the State will notify the "enrollee" of failure to make the required payment and may face termination from the program if the payment is not made. The State will give the individual the right to appeal any adverse actions for failure to pay premiums. In addition, before final disenrollment can occur, the State will perform a Medicaid eligibility determination to ensure that the participant is not eligible for the State plan. If the Medicaid eligibility determination finds that the demonstration "Enrollee" is ineligible for Medicaid, the State will disenroll the participant. The individual may reenroll in the Demonstration as soon as the individual is able to pay the required premium, subject to enrollment limitations.

VI. DELIVERY SYSTEMS

23. **Service Delivery.** Services for the demonstration are provided using the same mechanism as other MaineCare members, including services that require prior authorization and are ordered and prescribed by a physician. Participants will be permitted to choose among participating providers (agencies).

    Individuals with other insurance may be members of this benefit. MaineCare Services may pay premiums/cost-sharing for this insurance according to current Medicaid State Plan rules.

24. **Contracts.** Procurement and the subsequent final contracts developed to implement selective contracting by the State with any provider group shall be subject to CMS approval prior to implementation. Existing contracts with Federally Qualified Health Centers (FQHC) shall continue in force.

    Payments under contracts with public agencies, not competitively bid in a process involving multiple bidders, shall not exceed the documented costs incurred in furnishing covered services to eligible individuals (or a reasonable estimate with an adjustment factor no greater than the annual change in the consumer price index).

VII. GENERAL REPORTING REQUIREMENTS

25. **General Financial Requirements.** The State must comply with all general financial requirements under title XIX set forth in Section VIII.

26. **Compliance with Managed Care Reporting Requirements.** The State does not currently use managed care for this Demonstration. If the State did use managed care the State must comply with all managed care reporting regulations at 42 CFR 438*;* except as expressly identified as not applicable in the expenditure authorities incorporated into these STCs.

27. **Reporting Requirements Related to Budget Neutrality.** The State must comply with all reporting requirements for monitoring budget neutrality set forth in Section IX.

28. **Quarterly Calls.** CMS shall schedule Quarterly conference calls with the State. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the Demonstration. Areas to be addressed include, but are not limited to, health care delivery,

enrollment, cost sharing, quality of care, access, the benefit package, audits, lawsuits, financial reporting and budget neutrality issues, progress on evaluations, State legislative developments, and any Demonstration amendments, concept papers, or relevant State plan amendments the State is considering submitting. CMS shall update the State on any amendments or concept papers under review, as well as Federal policies and issues that may affect any aspect of the Demonstration. The State and CMS shall jointly develop the agenda for the calls.

29. **Quarterly Reports:** The State must submit progress reports in the format specified in Attachment A no later than 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. These quarterly reports must include, but are not limited to:

    a) An updated budget neutrality monitoring spreadsheet;

    b) Events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including but not limited to:

        1. Systems and Reporting Issues;
        2. Approval and contracting with new health plans;
        3. Benefits;
        4. Enrollment;
        5. Grievances;
        6. Quality of care;
        7. Access;
        8. Health plan financial performance that is relevant to the Demonstration;
        9. Pertinent legislative activity; and
        10. Other operational issues.

    c) Action plans for addressing any policy and administrative issues identified;

    d) The number of individuals enrolled in the HIV/AIDS Demonstration by eligibility group (EG) and disease-stage-specific category, as well as in total; and

    e) Evaluation activities and interim findings.

    Quarterly report for the quarter ending September 30 is due **November 30**
    Quarterly report for the quarter ending December 31 is due **February 28**
    Quarterly report for the quarter ending March 31 is due **May 31**
    Quarterly report for the quarter ending June 30 is due **August 31**

30. **Annual Report.** The State must submit a draft annual report documenting accomplishments, project status (including disease-stage-specific enrollment and per member per month (PMPM), quantitative and case study findings, interim evaluation findings, utilization data, progress on implementing cost containment initiatives (if relevant), policy and administrative difficulties in the operation of the Demonstration, and systems and reporting issues. The State must submit the draft annual report no later than 120 days after the end of each Demonstration year (October 31st). Within 30 days of receipt of comments from CMS, a final annual report must be submitted, and posted to the CMS Web site with prior permission.

VIII. GENERAL FINANCIAL REQUIREMENTS

31. **Quarterly Reports.** The State must provide quarterly expenditure reports using Form CMS-64 to separately report total expenditures for services provided under the Medicaid program, including those provided through the Demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the Demonstration period. CMS shall provide FFP for allowable Demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in section IX**.**

32. AIDS Drug Assistance Program (ADAP). By August 15, 2010, the State will submit for CMS approval a proposed methodology to provide aggregate ADAP information on subsidies provided to "members" and "enrollees". ADAP is a separate Federal program for which CMS does not provide Federal match. The State will begin to report this information with the quarterly report due November 30, 2010, and will continue to report this information on each quarterly report with a summary provided on the annual report.

33. **Reporting Expenditures Subject to the Budget Neutrality Cap.** The following describes the reporting of expenditures subject to the budget neutrality cap:

a) In order to track expenditures under this Demonstration, Maine must 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 and Section 2115 of the State Medicaid Manual. All Demonstration expenditures claimed under the authority of title XIX of the Act must be reported each quarter 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 DY in which services were rendered or for which capitation payments were made). For monitoring purposes, cost settlements must be recorded on Line 10.b, in lieu of Lines 9 or 10.C. 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.

b) For each demonstration year, separate forms CMS-64.9 Waiver and/or 64.9P Waiver will be submitted reporting expenditures for individuals enrolled in the demonstration and subject to the budget neutrality cap. The State must complete separate forms for the following two enrollment categories:

- **"Members"** who are MaineCare eligibles identified as HIV-positive individuals who meet the Social Security definition of "totally disabled" and are below 100 percent of FPL

- **"Enrollees"** who do not meet the eligibility requirements of MaineCare, but who are HIV positive and are at or below 250 percent of the FPL.

The sum of the quarterly expenditures for both waiver name categories for all demonstration years will represent the expenditures subject to the budget neutrality cap

c) For purposes of this section, the term "expenditures subject to the budget neutrality cap"

shall include all Medicaid expenditures on behalf of the individuals who are enrolled in this Demonstration (as described in item 35 and who are receiving the services subject to the budget neutrality cap). All expenditures that are subject to the budget neutrality cap are considered demonstration expenditures and shall be reported on forms CMS-64.9 waiver and/or 64.9P waiver.

d) Premiums and other applicable cost sharing contributions from "Enrollees" that are collected by the State from "Enrollees" under the Demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet line 9.D, columns A and B. Additionally, the total amounts that are attributable to the Demonstration must be separately reported on the CMS-64Narr by Demonstration year.

e) 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. All administrative costs will be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver.

f) All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the Demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 Demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

34. Reporting Member Months.

The following describes the reporting of member months subject to the budget neutrality gap:

a) The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member months to the total. Two individuals who are eligible for 2 months each contribute 2 eligible member months to the total, for a total of 4 eligible member months.

b) For the purposes of this Demonstration, the term "Demonstration eligibles" excludes unqualified aliens and refers to the Demonstration Populations described below:

- **"Members"** who are MaineCare members identified as HIV-positive individuals who meet the Social Security definition of "totally disabled" and are below 100 percent of the FPL; and

- **"Enrollees"** who do not meet the eligibility requirements of MaineCare, but who are HIV positive and are at or below 250 percent of the FPL.

c) For the purpose of calculating the budget neutrality expenditure cap and for other purposes, the State must provide to CMS, as part of the quarterly report required under paragraph 28, the actual number of eligible member months for the Demonstration Populations defined in

paragraph 35(b). The State must submit a statement accompanying the quarterly report, which certifies the accuracy of this information.

To permit full recognition of "in-process" eligibility, reported counts of member months may be subject to revisions after the end of each quarter. Member month counts may be revised retrospectively as needed.

35. **Standard Medicaid Funding Process.** The standard Medicaid funding process shall be used during the demonstration. Maine must estimate matchable Medicaid expenditures on the quarterly form CMS-37. In addition, the estimate of matchable Demonstration expenditures (total computable and Federal share) subject to the budget neutrality cap must be separately reported by quarter for each Federal fiscal year (FFY) on the form CMS-37.12 for both the medical assistance program and administrative costs. CMS shall make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

36. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-Federal share of funding, CMS shall provide FFP at the applicable Federal matching rates for the Demonstration as a whole as outlined below, subject to the limits described in Section IX:

    a) Administrative costs, including those associated with the administration of the Demonstration; and

    b) Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid State plan; and

    c) Net medical assistance expenditures made under section 1115 Demonstration authority under the HIV/AIDS Demonstration.

37. **Sources of Non-Federal Share.** The State certifies that matching the non-Federal share of funds for the Demonstration are State/local monies. The State further certifies that such funds shall not be used to match for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.

    a) CMS shall review the sources of the non-Federal share of funding for the Demonstration at any time. The State agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

    b) Any amendments that impact the financial status of the program shall require the State to provide information to CMS regarding all sources of the non-Federal share of funding.

38. **State Certification of Funding Conditions.** The State must certify that the following conditions for non-Federal share of Demonstration expenditures are met:

    a) Units of government, including governmentally operated health care providers, may certify that State or local tax dollars have been expended as the non-Federal share of funds under the Demonstration.

    b) To the extent the State utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the State would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.

    c) To the extent the State utilizes CPEs as the funding mechanism to claim Federal match for payments under the Demonstration, governmental entities to which general revenue funds are appropriated must certify to the State the amount of such tax revenue (State or local) used to satisfy Demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the State's claim for Federal match.

    d) The State may use intergovernmental transfers to the extent that such funds are derived from State or local tax revenues and are transferred by units of government within the State. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-Federal share of title XIX payments. Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between health care providers and State and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, (including health care provider-related taxes), fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

39. **Monitoring the Demonstration.** The State will provide CMS with information to effectively monitor the Demonstration, upon request, in a reasonable time frame.

IX. MONITORING BUDGET NEUTRALITY

40. **Limit on Federal Title XIX funding.** Maine 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 STCs specify the aggregate financial cap on the amount of Federal title XIX funding that the State may receive on expenditures subject to the budget neutrality cap as defined in paragraph 44 of section IX of this document. The aggregate financial cap is determined by applying the President's 2010 Budget trend rate to the Demonstration year 8 annual budget limits to obtain annual budget limits for Demonstration year 9, 10 and 11 (the 3-year renewal period). In the State's modeling for the renewal period annual budget limits based on disease-stage-specific PMPMs. The budget neutrality cap will be for the total computable cost of $145,194,877 million for the life of the Demonstration.

41. **Impermissible DSH, Taxes or Donations**. The CMS reserves the right to adjust the budget neutrality ceiling in order to be consistent with enforcement of impermissible provider payments, health care related taxes, new Federal statutes, or with 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 section 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.

42. **How the Limit will be Applied.** The limit calculated above will apply to actual expenditures for the Demonstration, as reported by the State under section VIII. 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 3-year period, the budget neutrality test will be based on the time period through the termination date.

Enforcement of Budget Neutrality. CMS shall enforce budget neutrality over the life of the Demonstration rather than on an annual basis. However, if the State's expenditures exceed the calculated cumulative budget neutrality expenditure cap by the percentage identified below for any of the Demonstration years, the State must submit a corrective action plan to CMS for approval.

Year	Without Waiver	Allowed Margin
DY 01 (2003)	$8,706,056	8 percent
DY 02 (2004)	$10,243,192	3 percent
DY 03 (2005)	$11,758,699	1 percent
DY 04 (2006)	$13,229,739	0.5 percent
DY 05 (2007)	$ 14,633,870	0 percent
DY 06 (2008)	$ 8,811,261	1 percent
DY 07 (2009)	$11,582,977	.5 percent
DY 08 (2010)	$14,289,233	0 percent
DY09 (2011)	$11,181,494	1 percent
DY10 (2012)	$14,472,654	.5 percent
DY11 (2013)	$ 17,313,754	0 percent
DY12 (2014)	$8,971,948*	1 percent

*** DY12 (2014) Without Waiver reflected for time period 06/30/2013 to 12/31/2013**

43. **Exceeding Budget Neutrality.** If, at the end of this Demonstration period, the cumulative budget neutrality expenditure cap has been exceeded, the excess Federal funds must be returned to CMS. If the Demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision shall be based on the time elapsed through the termination date.

X. EVALUATION OF THE DEMONSTRATION

44. State Must Evaluate the Demonstration. As outlined in subparagraphs (a), the outcomes from the evaluation component must be integrated into a programmatic summary that describes whether the State met the Demonstration goal, with recommendations for future efforts regarding both components**.** The State must submit to CMS for approval a draft evaluation design no later than October 1, 2010. The evaluation must outline and address evaluation questions for both of the following:

The HIV/AIDS Demonstration. At a minimum, the draft design must include a discussion of the goals, objectives, and evaluation questions specific to the entire Demonstration. The draft design must discuss the outcome measures that will be used in evaluating the impact of the Demonstration during the period of approval, particularly among the target population. It must discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the Demonstration shall be isolated from other initiatives occurring in the State. The draft design must identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation. The evaluation report must be submitted to CMS by February 28, 2014 that encompasses the outcomes since the beginning of the demonstration.

45. Final Evaluation Plan and Implementation. CMS shall provide comments on the draft designs within 60 days of receipt, and the State must submit a final plan for the overall evaluation of the Demonstration described in paragraph 47, within 60 days of receipt of CMS comments. The State must implement the evaluation designs and report its progress on each in the quarterly reports. The State must submit to CMS a draft evaluation report 120 days prior to the expiration of the Demonstration. CMS shall provide comments within 60 days of receipt of the report. The State must submit the final report prior to the expiration date of the Demonstration.

46. **Cooperation with CMS Evaluators.** Should CMS conduct an independent evaluation of any component of the Demonstration the State will cooperate fully with CMS or the independent evaluator selected by CMS. The State will submit the required data to the contractor or CMS as requested.

XI. SCHEDULE OF STATE DELIVERABLES FOR THE DEMONSTRATION EXTENSION PERIOD

Date - Specific	Deliverable	STC Reference
08/15/2010	Proposed methodology to provide aggregate ADAP information on subsidies provided to "members" and "enrollees"	Section VIII, paragraph 33
10/01/2010	Submit Draft Evaluation Plan, including Evaluation Designs for the Maine HIV/AIDS	Section X, paragraph 47

	demonstration	
02/28/2014	Submit Draft Evaluation Report, including preliminary analysis and recommendations related to the Maine HIV/AIDS demonstration	Section X, paragraph 47
09/01/2013	Submit Final Evaluation Report	Section X, paragraph 48

	Deliverable	**STC Reference**
Annual	By October 31st Draft Annual Report	Section VII, paragraph 31
Each Quarter		
	Quarterly Operational Reports	Section VII, paragraph 30
	CMS-64 Reports	Section VIII, paragraph 34
	Disease-Stage Specific Eligible Member Months	Section VIII, paragraph 35

ATTACHMENT A
Quarterly Report Content and Format

Under Section VII, paragraph 31, the State is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the State. A complete quarterly progress report must include an updated budget neutrality monitoring workbook. The State will submit an electronic copy of the report narrative, as well as the Microsoft Excel workbook for budget neutrality.

NARRATIVE REPORT FORMAT:

Title Line One – Maine HIV/AIDS Demonstration

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:
For example:
Demonstration Year: 6 (07/01/2010 – 06/31/2011)
Federal Fiscal Quarter: 01/2008 (10/01/2010 - 12/31/2010)

Introduction

Information describing the goal of the demonstration, what it does, and key dates of approval /operation. (This should be the same for each report.)

Enrollment Information

Please complete the following table that outlines all enrollment activity under the demonstration. The State should indicate "N/A" where appropriate. If there was no activity under a particular enrollment category, the State should indicate that by "0".

Enrollment Counts

Note: Enrollment counts should be person counts, not member months

Demonstration Populations (as hard coded in the CMS-64)	**Current "Enrollees"** (to date)	
"Enrollees": Demonstration "Enrollees"		
"Members": HIV Positive and MaineCare eligible		

Outreach/Innovative Activities

Summarize outreach activities and/or promising practices for the current quarter.

Operational/Policy Developments/Issues
Identify all significant program developments/issues/problems that have occurred in the current quarter, including but not limited to approval and contracting with new plans, benefit changes, and legislative activity.

Financial/Budget Neutrality Development/Issues
Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS-64 reporting for the current quarter. Identify the State's actions to address these issues.

Member Month Reporting
Enter the member months for each of the EGs for the quarter.

A. For Use in Budget Neutrality Calculations

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
"Enrollees"				
"Members"				

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.

Quality Assurance/Monitoring Activity
Identify any quality assurance/monitoring activity in current quarter.

Demonstration Evaluation
Discuss progress of evaluation design and planning.

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

State Contact(s)
Identify individuals by name, title, telephone, facsimile, and address that CMS may contact should any questions arise.

Date Submitted to CMS