DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-03-17
Baltimore, Maryland 21244-1850

State Demonstrations Group

December 8, 2017

Stefanie Nadeau
Director, Office of MaineCare Services
Department of Health and Human Services
11 State House Station
Augusta, ME 04333

Dear Ms. Nadeau:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) has approved a twelve month temporary extension of Maine's section 1115(a) Medicaid demonstration (Project Number 11-W-00128/1) for individuals with human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) in order to not disrupt such coverage as the state continues to consider other coverage options. This demonstration expands health care access to individuals who are HIV-positive and who have incomes that are at or below 250 percent of the federal poverty level. It is designed to provide more effective and earlier treatment of HIV disease by making available a targeted benefits package including anti-retroviral therapies. This demonstration is now set to expire on December 31, 2018.

CMS' approval is conditioned upon the state's continued compliance with the Special Terms and Conditions (STCs) defining the nature, character, and extent of anticipated federal involvement in the project. The current STCs, waiver, and expenditure authorities will continue to apply during the temporary extension of this demonstration until December 31, 2018.

Your project officer for this demonstration is Emmett Ruff. He is available to answer any questions concerning your section 1115 demonstration. Mr. Ruff's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mail Stop: S2-03-17
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-4252
E-mail: emmett.ruff@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Mr. Ruff and Mr. Richard McGreal, Associate Regional Administrator, in our Boston Regional Office. Mr. McGreal's contact information is as follows:

Mr. Richard McGreal
Associate Regional Administrator
Division of Medicaid and Children Health Operations
Centers for Medicare & Medicaid Services
JFK Federal Building
15 New Sudbury Street, Room 2325
Boston, MA 02203-0003
Email: Richard.McGreal@cms.hhs.gov

If you have additional questions, please contact me at (410) 786-9686.

Sincerely,

/s/

Judith Cash
Acting Director

cc: Richard McGreal, Associate Regional Administrator, Boston Regional Office

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

State Demonstrations Group

September 26, 2016

Stefanie Nadeau
Director, Office of MaineCare Services
Department of Health and Human Services
221 State Street
Augusta, ME 04333

Dear Ms. Nadeau:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) has approved a one-year temporary extension of Maine's section 1115(a) Medicaid demonstration (Project Number 11-W-00128/1) for individuals with human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) in order to not disrupt such coverage as the state continues to consider other coverage options. This demonstration expands health care access to individuals who are HIV-positive and who have incomes that are at or below 250 percent of the federal poverty level. It is designed to provide more effective and earlier treatment of HIV disease by making available a targeted benefits package including anti-retroviral therapies. This demonstration is now set to expire on December 31, 2017.

CMS' approval is conditioned upon the state's continued compliance with the Special Terms and Conditions (STCs) defining the nature, character, and extent of anticipated federal involvement in the project. The current STCs, waiver, and expenditure authorities will continue to apply during the temporary extension of this demonstration until December 31, 2017.

Your project officer for this demonstration is Patricia Hansen. She is available to answer any questions concerning your section 1115 demonstration. Ms. Hansen's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-4252
E-mail: Patricia.Hansen1@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Hansen and Mr. Richard McGreal, Associate Regional Administrator, in our Boston Regional Office. Mr. McGreal's contact information is as follows:

Mr. Richard McGreal
Associate Regional Administrator
Division of Medicaid and Children Health Operations
Centers for Medicare & Medicaid Services
JFK Federal Building
15 New Sudbury Street, Room 2325
Boston, MA 02203-0003
Email: Richard.McGreal@cms.hhs.gov

If you have additional questions, please contact me at (410) 786-9686.

Sincerely,

/s/

Eliot Fishman
Director

cc: Richard McGreal, Associate Regional Administrator, Boston Regional Office

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

State Demonstrations Group

December 21, 2015

Stefanie Nadeau
Director, Office of MaineCare Services
Department of Health and Human Services
221 State Street
Augusta, ME 04333

Dear Ms. Nadeau:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) has approved a one-year temporary extension of Maine's section 1115(a) Medicaid demonstration (Project Number 11-W-00128/1) for individuals with human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) in order to not disrupt such coverage as the state continues to consider other coverage options. This demonstration expands health care access to individuals who are HIV-positive and who have incomes that are at or below 250 percent of the federal poverty level. It is designed to provide a more effective, early treatment of HIV disease by making available a targeted benefits package including anti-retroviral therapies. This demonstration is now set to expire on December 31, 2016.

CMS' approval is conditioned upon the state's continued compliance with the Special Terms and Conditions (STCs) defining the nature, character, and extent of anticipated federal involvement in the project. The current STCs, waiver, and expenditure authorities will continue to apply during the temporary extension of this demonstration until December 31, 2016.

Your project officer for this demonstration is Lina Gomez Valencia. She is available to answer any questions concerning your section 1115 demonstration. Ms. Gomez Valencia's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-4433
E-mail: Lina.Gomezvalencia@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Gomez Valencia and Mr. Richard McGreal, Associate Regional Administrator, in our Boston Regional Office. Mr. McGreal's contact information is as follows:

Mr. Richard McGreal
Associate Regional Administrator
Division of Medicaid and Children Health Operations
Centers for Medicare & Medicaid Services
JFK Federal Building
15 New Sudbury Street, Room 2325
Boston, MA 02203-0003
Email: Richard.McGreal@cms.hhs.gov

If you have additional questions, please contact me at (410) 786-9686.

Sincerely,

/S/

Eliot Fishman
Director

Enclosures

cc: Richard McGreal, Associate Regional Administrator, Boston Regional Office

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

November 25, 2014

Stefanie Nadeau
Director
MaineCare Services
Department of Health and Human Services
11 State House Station
Augusta, ME 04333-0011

Dear Ms. Nadeau:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) has approved a one-year temporary extension of Maine's section 1115 demonstration (Project Number 11-W-00128/1) for individuals with human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) in order to not disrupt such coverage as the state continues to consider other coverage options. This demonstration expands health care access to individuals who are HIV-positive and who have incomes that are at or below 250 percent of the federal poverty level. It is designed to provide a more effective, early treatment of HIV disease by making available a targeted benefits package including anti-retroviral therapies. This demonstration is now set to expire on December 31, 2015.

The CMS approval of this demonstration is conditioned upon continued compliance with the special terms and conditions (STCs) defining the nature, character, and extent of anticipated federal involvement in the project. The award is subject to our receiving your written acknowledgement of the award and acceptance of these STCs within 30 days of the date of this letter. The current STCs, waiver, and expenditure authorities will continue to apply during the temporary extension of this demonstration until December 31, 2015.

Your project officer for this demonstration is Wakina Scott. She is available to answer any questions concerning your section 1115 demonstration. Ms. Scott's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-0921
E-mail: Wakina.Scott@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Scott and Mr. Richard McGreal, Associate Regional Administrator in our Boston Regional Office. Mr. McGreal's contact information is as follows:

Mr. Richard McGreal
Associate Regional Administrator
Division of Medicaid and Children Health Operations
Centers for Medicare & Medicaid Services
JFK Federal Building
15 New Sudbury Street, Room 2325
Boston, MA 02203-0003
Email: Richard.McGreal@cms.hhs.gov

If you have additional questions, please contact Mr. Eliot Fishman, Director, Children and Adults Health Programs Group (CAHPG), Center for Medicaid and CHIP Services (CMCS) at (410) 786-5647.

Sincerely,

/s/

Cindy Mann
Director

Enclosures

cc: Richard McGreal, Associate Regional Administrator, Boston Regional Office

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

December 9, 2013

Stephanie Nadeau
Director
MaineCare Services
Department of Health and Human Services
11 State House Station
Augusta, ME 04333-0011

Dear Ms. Nadeau:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) has approved a one-year temporary extension of Maine's section 1115 demonstration (Project Number 11-W-00128/1) for individuals with human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) in order to not disrupt such coverage as the state continues to consider other coverage options. This demonstration expands health care access to individuals who are HIV-positive and who have incomes that are at or below 250 percent of the federal poverty level. It is designed to provide a more effective, early treatment of HIV disease by making available a targeted benefits package including anti-retroviral therapies. This demonstration is now set to expire on December 31, 2014.

The CMS approval of this demonstration is conditioned upon continued compliance with the special terms and conditions (STCs) defining the nature, character, and extent of anticipated federal involvement in the project. The award is subject to our receiving your written acknowledgement of the award and acceptance of these STCs within 30 days of the date of this letter. A copy of the STCs, waivers and expenditure authorities are enclosed.

Your project officer for this demonstration is Wakina Scott. She is available to answer any questions concerning your section 1115 demonstration. Ms. Scott's contact information is as follows:

> Centers for Medicare & Medicaid Services
> Center for Medicaid and CHIP Services
> Mail Stop S2-01-16
> 7500 Security Boulevard
> Baltimore, MD 21244-1850
> Telephone: (410) 786-0921
> E-mail: Wakina.Scott@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Scott and Mr. Richard McGreal, Associate Regional Administrator in our Boston Regional Office. Mr. McGreal's contact information is as follows:

Mr. Richard McGreal
Associate Regional Administrator
Division of Medicaid and Children Health Operations
Centers for Medicare & Medicaid Services
JFK Federal Building
15 New Sudbury Street, Room 2325
Boston, MA 02203-0003
Email: Richard.McGreal@cms.hhs.gov

If you have additional questions, please contact Mr. Eliot Fishman, Director, Children and Adults Health Programs Group (CAHPG), Center for Medicaid and CHIP Services (CMCS) at (410) 786-5647.

Sincerely,

/s/

Cindy Mann
Director

Enclosures

cc:

Richard McGreal, Associate Regional Administrator, Boston Regional Office

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 human immunodeficiency virus/acquired immunodeficiency syndrome (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 as of the date of the approval letter, through December 31, 2014, unless otherwise specified. All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below.

The STCs have been arranged into the following subject areas:

I. Preface
II. Program Description and Objectives
III. General Program Requirements
IV. Eligibility, Benefits, and Enrollment
V. Cost Sharing
VI. Delivery Systems
VII. General Reporting Requirements
VIII. General Financial Requirements
IX. Monitoring Budget Neutrality
X. Evaluation of the Demonstration; and
XI. Schedule of State Deliverables during the Demonstration

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 and Children's Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs 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, including the protections for Indians pursuant to section 5006 of the American Recovery and Reinvestment Act of 2009.

3. **Changes in Medicaid and CHIP Law, Regulation, and Policy (e.g. CHIPRA).** 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 or CHIP programs 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. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required reports and other deliverables in a timely fashion according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:

   a) Demonstration of Public Notice 42 CFR Section 431.408 and Tribal Consultation: The state must provide documentation of the state's compliance with public notice process as specified in 42 CFR section 431.408 and documentation that the tribal consultation requirements outlined in paragraph 14 have been met;

   b) Demonstration Amendment Summary and Objectives: The state must provide a detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation, the objective of the change and desired outcomes including a conforming title XIX and/or title XXI state plan amendment, if necessary;

   c) Waiver and Expenditure Authority: The state must provide a list along with a programmatic description of the waivers and expenditure authorities that are being requested for the amendment;

d) A data analysis worksheet, which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis must 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;

e) An up-to-date CHIP allotment neutrality worksheet, if necessary; and

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

8. **Extension of the Demonstration.**

   a) States that intend to request demonstration extensions under sections 1115(a), 1115(e) or 1115(f) must submit an extension request no later than 6 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.

   b) Compliance with Transparency Requirements 42 CFR Section 431.412:

      Effective April 27, 2012, as part of demonstration extension requests, the state must provide documentation of compliance with the transparency requirements 42 CFR Section 431.412 and the public notice and tribal consultation requirements outlined in paragraph 14 as well as include the following supporting documentation:

      i. Historical Narrative Summary of the demonstration Project: 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.

      ii. 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.

iii. 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.

iv. Quality: The state must provide summaries of External Quality Review Organization (EQRO) reports; managed care organization (MCO) reports; state quality assurance monitoring; and any other documentation that validates of the quality of care provided or corrective action taken under the demonstration.

v. Financial Data: 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. If Title XXI funding is used in the demonstration, a CHIP Allotment Neutrality worksheet must be included.

vi. Evaluation Report: 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.

vii. Documentation of Public Notice 42 CFR section 431.408: The state must provide documentation of the state's compliance with public notice process as specified in 42 CFR section 431.408 including the post-award public input process described in 431.420(c) with a report of the issues raised by the public during the comment period and how the state considered the comments when developing the demonstration extension application.

9. **Demonstration Phase-Out.** The state may suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.
   a) Notification of Suspension or Termination: The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The state must submit its notification letter and a draft phase-out plan to CMS no less than 6 months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the state must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation state plan amendment. Once the 30-day public comment period has ended, the state must

provide a summary of each public comment received the state's response to the comment and how the state incorporated the received comment into a revised phase-out plan.

The state must obtain CMS's approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.

b) Phase-out Plan Requirements: The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

c) Phase-out Procedures: The state must comply with all notice requirements found in 42 CFR sections 431.206, 431.210, and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR sections 431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR section 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed at 42 CFR section 435.916.

d) Exemption from Public Notice Procedures 42.CFR Section 431.416(g): CMS may expedite the federal and state public notice requirements in the event it determines that the objectives of title XIX and XXI would be served or under circumstances described in 42 CFR section 431.416(g).

e) Federal Financial Participation (FFP): 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. **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.

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

12. **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.

13. **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.

14. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The state must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009 and the tribal consultation requirements contained in the state's approved state plan, when any program changes to the demonstration, including (but not limited to) those referenced in paragraph 6, are proposed by the state.

    In states with federally recognized Indian tribes, consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001, letter or the consultation process in the state's approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers (42 C.F.R. section 431.408(b)(2)).

    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, and/or renewal of this demonstration (42 C.F.R. section 431.408(b)(3)). The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment.

15. **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.

16. **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 expenditures, 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 populations listed as "Enrollees" in the demonstration eligibility groups category.

** These "Enrollee" eligible beneficiaries are expansion populations who would not otherwise be eligible for medical assistance.

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

demonstration.

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

18. **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.

    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 chart below. Services may also be provided by a qualified provider employed by a Federally Qualified Health Center, Rural Health Center or Indian Health Center.

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	Services*
Inpatient	MCBM Section 45, Hospital Services
Psychiatric Facility	MCBM Section 46, Psychiatric Facilities Services
Outpatient	MCBM Section 45, Hospital Services
EPSDT Examinations	MCBM Section 94, Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT), Section 90, Physician Services
Medications	MCBM Section 80, Pharmacy Services
Community Support Services	MCBM Section 17, Community Support Services
Lab & X-ray	MCBM Section 55, Laboratory Services and Section 101, Medical Imaging Services
Transportation	MCBM Section 113, Non-Emergency Transportation Services; benefit will only pay for transportation to and from MaineCare covered services; MCBM, Section 5, Ambulance Services
Ambulatory Care	MCBM Section 3, Ambulatory Care Clinic Services
Case Management	MCBM Section 13.04, Targeted Case Management Services for Persons with HIV Infection
Family Planning	MCBM Section 30, Family Planning Agency Services
Mental Health	MCBM Section 65, Behavioral Health Services (including Psychological Services)
Psychology Services	MCBM Section 65, Psychological Services
Medicare Crossover-A	MCBM Section 45, Hospital Services
STD Testing/VD Screening	MCBM Section 30, Family Planning Services; MCBM, Section 90, Physician Services
Medicare Crossover-B	MCBM Section 90, Physician Services; Section 31, Federally Qualified Health Center Services; Section 103, Rural Health Clinic Services

General Category of Service	Services*
Physician, Physician Assistant, Advanced Practice Registered Nurse, Certified Nurse Practitioner	MCBM Section 90, Physician Services; MCBM Section 14, Advanced Practice Registered Nurse
Early Intervention	MCBM Section 28, Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations
Development and Behavioral Clinical Services	MCBM Section 23, Developmental and Behavioral Clinic Services
Substance Abuse Treatment	MCBM Section 65, Behavioral Health Services
Audiologist; Certified Nurse Midwife; Certified Nurse Practitioner; Certified Registered Nurse Anesthetist; Occupational Therapist; Physician's Assistant; Physical Therapist; Registered Nurse First Assist	When provided by a qualified provider employed in a physician's practice (MCBM, Section 90, Physician Services); Section 31, Federally Qualified Health Center Services, Section 9, Indian Health Services and/or Section 45, Hospital Services

*All services in the table are found in Chapter II of MCBM unless otherwise specified.

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*
Adult Family Care	MCBM Section 2, Adult Family Care Services
Consumer Directed Attendant	MCBM Section 12, Consumer Directed Attendant Services
Home and Community-Based Waiver Services for the Elderly and Adults with Disabilities	MCBM Section 19, Home and Community-Based Waiver Services for the Elderly and for Adults with Disabilities
Home and Community-Based Waiver Services	MCBM Section 21, Home and Community-Based Waiver Services for Persons with Intellectual Disabilities or Autistic Disorder; Section 29, Support Services for Adults with Intellectual Disabilities or Autistic Disorder; Section 20 Home and Community Based Services for Adults with Other Related Conditions, Home and Community Benefits for the Physically Disabled; Section 32 Waiver Services for Children with Intellectual Disabilities or Pervasive Developmental Disorders
Private Non-Medical Institution	MCBM Section 97, Private Non-Medical Institution Services
Day Health	MCBM Section26, Day Health Services
Home Health	MCBM Section 40, Home Health Services
Hospice	MCBM Section 43, Hospice Services
Medical Supplies and Durable Medical Equipment	MCBM Section 60, Medical Supplies and Durable Medical Equipment
Nursing Facility	MCBM Section 67, Nursing Facility Services
Optician, Optometrist	MCBM Section 75, Vision Services (Ophthalmologist services are covered if the services are provided by a qualified practitioner billing under MCBM Section 90, Physician Services)
Physical Therapy	MCBM Section 85, Physical Therapy Services
Private Duty Nursing and Personal Care	MCBM Section 96, Private Duty Nursing and Personal Care Services

General Category of Service	Services*
Primary Care Case Management	MCBM Chapter VI, Section 1, Primary Care Case Management
Speech-Language Pathology	MCBM Section 109, Speech and Hearing Services, except when provided by a qualified provider billing under MCBM, Section 90, Physician Services, Section 31 Federally Qualified Health Center Services, Section 103 Rural Health Clinic Services or Section 45, Hospital Services
Speech and Hearing Services and Audiology	MCBM Section 109, Speech and Hearing Services
Chiropractic	MCBM Section 15, Chiropractic Services
Dental	MCBM Section 25, Dental Services
Hearing Aids and Services	MCBM Section 35, Hearing Aids and Services
ICF-ID	MCBM Section 50, ICF-ID Services
Occupational Therapy	MCBM Section 68, Occupational Therapy Services
Podiatric	MCBM Section 95, Podiatric Services
Rehabilitative Services	MCBM Section 102, Rehabilitative Services

*All services in the table are found in Chapter II of MCBM unless otherwise specified.

V. COST SHARING

19. **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[a]

Services	Demonstration "Enrollees"	Demonstration "Members"
Prescription Drugs[b]	$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

a. 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.

b. 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.

20. **Monthly Premiums**. "Enrollees" are responsible for payment of a monthly premium dependent on their income level. These premiums when added to other payments made by the "enrollee's" family to CHIP or Medicaid will not exceed five percent of an "enrollee's" gross annual family income. 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 11 7/2012 – 12/2013	$0	$31.04	$62.07
DY 12 1/2014 – 12/2014	$0	$32.59	$65.17

21. **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 60 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

22. **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.

23. **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

24. **General Financial Requirements.** The state must comply with all general financial requirements under Title XIX set forth in Section VIII.

25. **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.

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

27. **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. The state will notify CMS of proposed demonstration changes at the quarterly monitoring call, as well as in the written quarterly report, to determine if a formal amendment is necessary. Areas to be addressed during the call 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.

28. **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. As such, for DY 11 (7/1/12 – 12/31/13), the state must provide quarterly reports for the fourth federal fiscal quarter in 2013 and the first federal fiscal quarter in 2014. For DY 12 (1/1/14 – 12/31/14), the state must continue to provide quarterly reports starting with the second federal fiscal quarter in 2014. 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**

29. **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 (May 1st). As such, for DY 11, the state must submit the draft annual report by May 1, 2014. Within 60 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

30. **Quarterly Expenditure 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. As such, for DY 11 (7/1/12 – 12/31/13), the state must provide quarterly expenditure reports for the fourth federal fiscal quarter in 2013 and the first federal fiscal quarter in 2014. For DY 12 (1/1/14 – 12/31/14), the state must continue to provide quarterly expenditure reports starting with the second federal fiscal quarter in 2014. 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**.**

31. **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 "<u>members</u>" and "<u>enrollees</u>". ADAP is a separate federal program for which CMS does not provide federal match. Effective January 1, 2014, the state must report in the quarterly report, the amount of ADAP subsidies per "member" and "enrollee" on average for premiums and prescription drug cost as well as aggregate ADAP information.

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

    a) **Tracking Expenditures.** 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). As such, expenditures for health care coverage for the demonstration must be reported by DY according to dates of service, which will be summarized on the CMS-64 C report. 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) **Use of Waiver Forms**. 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:

    - **"<u>Members</u>"** 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

    - **"<u>Enrollees</u>"** 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) **Title XIX Expenditures Subject to the Budget Neutrality Cap.** 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) **Cost Sharing Contributions.** 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.** 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) **Claiming Period.** 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.

g) **Mandated Increase in Physician Payment Rates in 2013 and 2014.** Section 1202 of the Health Care and Education Reconciliation Act of 2010 (Pub. Law 110-152) requires state Medicaid programs to pay physicians for primary care services at rates that are no less than what Medicare pays, for services furnished in 2013 and 2014. The federal government provides a federal medical assistance percentage of 100 percent for the claimed amount by which the minimum payment exceeds the rates paid for those services as of July 1, 2009. The state must exclude from the budget neutrality test for this demonstration the portion of the mandated increase for which the federal government pays 100 percent. These amounts must be reported on the base forms CMS-64.9, 64.21, or 64.21U (or their "P" counterparts), and not on any waiver form.

33. **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:

- **“<u>Members</u>”** 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

- **“<u>Enrollees</u>”** 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 subparagraph (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.

34. **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.

35. **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.

36. **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.

37. **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.

38. **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

39. **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 40 of this section.

40. **Budget Neutrality Expenditure Cap.** The aggregate financial cap is determined by applying the President's 2014 budget trend rate to obtain annual budget limits for demonstration year 12 (1/1/2014 – 12/31/2014). In the state's modeling for the renewal period, annual budget limits are based on disease-stage-specific PMPMs. The budget neutrality cap will be for the total computable cost of **$**154,141,747for 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 demonstration approval period, the budget neutrality test will be based on the time period through the termination date.

43. **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	Annual Limit Definition	Cumulative Limit Definition	Allowed Margin
DY 01 (2003)	$8,706,056	$9,402,540	8%
DY 02 (2004)	$10,243,192	$19,517,725	3%
DY 03 (2005)	$11,758,699	$31,015,026	1%
DY 04 (2006)	$13,229,739	$44,157,724	.5%
DY 05 (2007)	$ 14,633,870	$58,571,556	0%
DY 06 (2008)	$ 8,811,261	$68,056,645	1%
DY 07 (2009)	$11,582,977	$79,360,623	.5%
DY 08 (2010)	$14,289,233	$93,255,027	0%
DY09 (2011)	$11,181,494	$105,480,886	1%
DY10 (2012)	$14,472,654	$119,503,721	.5%
DY11 (2013)*	$ 22,237,601	$141,146,776	0%
DY12 (2014)	$12,994,971	$154,141,747	0%

*** DY 11 costs reflected for the time period of 7/1/2012 through 12/31/2013**

44. **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

45. **Submission of Draft Evaluation Design.** The state must submit to CMS for approval a draft evaluation design for an overall evaluation of the demonstration no later than 120 days after approval of the demonstration. At a minimum, the draft design must include a discussion of the goals and objectives set forth in Section II of these STCs, as well as the specific hypotheses that are being tested. The draft design must discuss the outcome measures that will be used in evaluating the impact of the demonstration during the period of approval. It shall 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 must 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.

46. **Interim Evaluation Reports.** In the event the state requests to extend the demonstration beyond the current approval period under the authority of §1115(a), (e), or (f) of the Act, the state must submit an interim evaluation report as part of the state's request for each

subsequent renewal.

47. **Final Evaluation Design and Implementation.** CMS shall provide comments on the draft designs within 60 days of receipt, and the state shall submit a final design for the overall evaluation of the demonstration within 60 days of receipt of CMS comments. The state must implement the evaluation design and submit its progress in each of the quarterly and annual progress reports. The state must submit to CMS a draft of the evaluation report within 120 days after expiration of the demonstration. CMS must provide comments within 60 days after receipt of the report. The state must submit the final evaluation report within 60 days after receipt of CMS comments. The final report must include the following:

    a) An executive summary;

    b) A description of the demonstration, including programmatic goals, interventions implemented, and resulting impact of these interventions;

    c) A summary of the evaluation design employed, including hypotheses, study design, measures, data sources, and analyses;

    d) A description of the population included in the evaluation (by age, gender, race/ethnicity, etc.);

    e) Final evaluation findings, including a discussion of the findings (interpretation and policy context); and

    f) Successes, challenges, and lessons learned.

    The state must submit a final evaluation report for the demonstration through DY 11 by February 28, 2014 as indicated in the previously approved STCs.

48. **Cooperation with CMS Evaluators.** Should CMS conduct an independent evaluation of any component of the demonstration; the state shall cooperate fully with CMS or the independent evaluator selected by CMS. The state shall submit the required data to CMS or the contractor as requested.

XI. SCHEDULE OF STATE DELIVERABLES FOR THE DEMONSTRATION EXTENSION PERIOD

Date – Specific	Deliverable	STC Reference
11/30/2013	Submit Quarterly Operational Report, CMS-64 Report, and Member Months Report for DY 11 (7/1/12 – 12/31/13)	Section VII, paragraph 28 Section VIII, paragraph 30 Section VIII, paragraph 33

2/28/2014	Submit Last Quarterly Operational Report, CMS-64 Report, and Member Months Report for DY 11 (7/1/12 – 12/31/13)	Section VII, paragraph 28 Section VIII, paragraph 30 Section VIII, paragraph 33
2/28/2014	Submit Final Evaluation Report through DY11	Section X, paragraph 47
5/31/2014	Submit First Quarterly Operational Report, CMS-64 Report, and Member Months Report for DY 12 (1/1/14 – 12/31/14)	Section VII, paragraph 28 Section VIII, paragraph 30 Section VIII, paragraph 33

	Deliverable	**STC Reference**
Annual	By May 1st Draft Annual Report	Section VII, paragraph 29
Each Quarter		
	Quarterly Operational Reports	Section VII, paragraph 28
	CMS-64 Reports	Section VIII, paragraph 30
	Disease-Stage Specific Eligible Member Months	Section VIII, paragraph 33

ATTACHMENT A
Quarterly Report Content and Format

Under Section VII, paragraph 28, 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: 12 (01/01/2014 – 12/31/2014)
Federal Fiscal Quarter: 02/2014 (01/01/2014 - 03/31/2014)

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 provide the following information. If there was no activity under a particular facet of the tables below, the state should indicate that by "0."

1. Report on enrollment numbers using the following table:
Note: Enrollment counts should be person counts, not member months

Demonstration Populations (as hard coded in the CMS-64)	Column A: Current number of persons enrolled at start of quarter	Column B: Number of persons enrolled during quarter	Column C: Number of persons disenrolled during the quarter for non-payment of premiums	Column D: Number of persons disenrolled during the quarter for other reasons	Column E: Number of persons enrolled at the end of the quarter (E)=(A)+(B)-(C) – (D)

"Enrollees" at or below 100% FPL: Demonstration "Enrollees"			N/A		
"Enrollees" above 100% FPL: Demonstration "Enrollees"					
"Members": HIV Positive and MaineCare eligible			N/A		

2. Report on ADAP expenditures as discussed in paragraph 31 using the following table:

Demonstration Populations	**Average ADAP Expenditures for Prescription Drugs**	**Total ADAP Expenditures for Prescription Drugs**	**Average ADAP Expenditures for Premiums**	**Total ADAP Expenditures for Premiums**
"Enrollees" at or below 100% FPL: Demonstration "Enrollees"			N/A	N/A
"Enrollees" above 100% FPL: Demonstration "Enrollees"				
"Members": HIV Positive and MaineCare eligible			N/A	N/A

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

CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER AUTHORITY

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

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

AWARDEE: **MaineCare Services (OMS)**

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived in this list, shall apply to MaineCare Members, as described for the demonstration project, beginning December 9, 2013, through December 31, 2014.

The following waivers shall enable Maine to implement the section 1115 demonstration for individuals with human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS).

1. **Amount, Duration, and Scope of Services** **Section 1902(a)(10)(B)**

   To enable Maine to offer additional benefits to MaineCare Members than are being otherwise offered under the Medicaid state plan.

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

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

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

AWARDEE: **MaineCare Services (OMS)**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by Maine for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period of this demonstration extension, be regarded as expenditures under the state's title XIX plan.

The following expenditure authority shall enable Maine to implement the Maine section 1115 demonstration for individuals with human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS). Except as identified below as not applicable to the demonstration expenditures, all Medicaid requirements will apply.

1. **Demonstration Population 2 ("Enrollees")** Expenditures for medical assistance for individuals who do not meet the eligibility requirements of MaineCare, but who are HIV-positive and are at or below 250 percent of the federal poverty level.

2. **Disease Management Services:** Expenditures for case management services that coordinate care and services related to HIV/AIDS that are not otherwise available under the state plan.

Requirements Not Applicable to the Demonstration Expenditures:

1. Section 1902(a)(10) of the Act -- Benefit Package Requirements:

To the extent necessary to enable the state to provide only a targeted benefit to demonstration population 2, which may not include all required benefits available to state plan populations.

2. Section 1902(a)(14) of the Act -- Premiums and Cost Sharing:

To the extent necessary to permit the State to impose premiums or cost sharing upon Demonstration Population 2 that exceeds the limitations set forth in sections 1916 or 1916A of the Act.

3. Section 1902(a)(43) of the Act -- Early and Periodic Screening Diagnosis and Treatment (EPSDT) Services

To the extent necessary to permit the state to limit the provision of EPSDT services for demonstration population 2 to examinations and other services included in the targeted benefit package.