Greater Baltimore HIV Health Services Planning Council

Planning Council Meeting

5:30 p.m. – 8:30 p.m.

Questions to Presenters July 19, 2011

Maryland Medicaid Program

Presented by: Alice Middleton, Senior Staff Advisor, Office of the Deputy Secretary Health Care Financing, Department of Health and Mental Hygiene

1. On service delivery, you mentioned that MCOs must cover case management for HIV/AIDS enrollees. Is there a mechanism to ensure that all MCOs comply? I would not mention particular MCOs, but I heard of one MCO that does not cover HIV care.

Answer: MCOs are mandated to cover case management for HIV/AIDS enrollees according to DHMH regulations found in COMAR 10.09.67.22 (see 10.09.65.10 (C)).

COMAR 10.09.65.10 (C):

C. AIDS Case Management Services.

(1) An MCO shall ensure that an enrollee with HIV/AIDS receives case management services that:

(a) Link the enrollee with the full range of available benefits;

(b) Link the enrollee with any additional needed services including:

(i) Mental health services;

(ii) Substance abuse services;

(iii) Medical services;

(iv) Social services;

(v) Financial services;

(vi) Counseling services;

(vii) Educational services;

(viii) Housing services; and

(ix) Other required support services;

(c) Ensure timely and coordinated access to medically necessary levels of care that support continuity of care across the continuum of service providers;

(d) Are performed by licensed physicians, physician assistants, advanced practice nurses, registered nurses, social workers, or other individuals who are appropriately trained, experienced, and supervised by a licensed practitioner; and

(e) Include, but are not limited to:

(i) Initial and ongoing assessment of the enrollee's needs and personal support systems, including the MCO offering an enrollee one face-to-face meeting during the initial assessment and documenting the enrollee's acceptance or declination of the face to face meeting;

(ii) Development of a comprehensive, individualized service plan, using a multidisciplinary approach;

(iii) Coordination of the services required to implement the plan;

(iv) Periodic reevaluation and adaptation of the plan as necessary over the life of the enrollee;

(v) Development of an outreach system for the enrollee and family by which the case manager and primary care provider track services received, clinical outcomes, and the need for additional follow-up; and

(vi) Serving as an effective enrollee advocate to resolve differences between the enrollee and providers of care pertaining to the course or content of therapeutic interventions.

(2) An enrollee diagnosed with HIV/AIDS shall be offered case management services by the MCO at any time after diagnosis. An enrollee who has previously refused these services may request case management from the MCO at any time.

PLWH/As that are not receiving necessary case management services from their MCO should contact the MCO Enrollee Action Line to make a complaint. The number is 1-800-284-4510.

2. In reference to page 3 of the presentation, what is the definition of Rare and Expensive CM?

Answer: The Rare and Expensive Case Management program is a Medicaid program that provides a case managed fee for service alternative to HealthChoice Managed Care Organization (MCO) participation. Medicaid beneficiaries with specified rare and expensive conditions are eligible to participate. The qualifying conditions are set by regulation and can be found at COMAR 10.09.69.17.

Case management services are provided by either a registered nurse or a licensed clinical social worker who has the experience and knowledge to assist with coordinating the medically necessary services for the REM recipient. The main goal of the REM case manager is to help the recipient reach his/her highest level of functioning capability. This is done through service coordination, home visits and a variety of other case management services.

3. What does the TAP acronym mean?

Answer: TAP is not a Medicaid program and I did not mention it during my presentation, but it stands for the Transitional Assistance Program. If you need additional info, please contact IDEHA.

4. Is the REM program for adults or children only? Why?

Answer: Both adults and children are eligible for the Rare and Expensive Case Management (REM) program, depending on the condition. The program is designed to provide services to a diagnosis-defined HealthChoice eligible population. To be in REM, a beneficiary must have a certain medical condition that falls within a list of qualifying conditions determined through DHMH regulations. That regulation can be found in COMAR 10.09.69.17, which states that individuals with asymptomatic HIV and symptomatic HIV/AIDS are eligible for REM only from ages 0 to 20. The regulation also states that an infant with an inconclusive result for HIV is eligible for REM only from age 0 to 12 months.

5. How can I get more in depth information on Sec 1915(c) HCBS waiver and Sec 1915(i) state plan HCBS waiver?

Answer: To get more information about Maryland's Sec 1915(c) HCBS waiver programs, one should look at DHMH's website at www.dhmh.state.md.us/mma/waiverprograms. To learn more about Sec 1915(c) and Sec 1915(i) programs generally, one should visit the Centers for Medicare and Medicaid Services' web page for waivers at www.cms.gov/MedicaidStWaivProgDemoPGI.

To get the most up to date information on federal HCBS initiatives, please review the revised CMS letter to Medicaid directors originally dated on June 6, 2011. That letter is attached.

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

Center for Medicaid, CHIP and Survey & Certification

SMDL # 11-005

June 6, 2011

Re: Coverage and Service Design Opportunities for Individuals Living with HIV

Dear State Medicaid Director:

The purpose of this letter is to inform States of the opportunities available to provide Medicaid coverage to individuals living with HIV in support of President Obama's National HIV/AIDS Strategy (the Strategy).

This guidance informs States on how to apply for opportunities in the Medicaid program that allow for flexibility to improve care and care coordination and offer options to treat individuals living with HIV (including individuals living with AIDS, which refers to individuals living with an advanced stage of the HIV disease) in the community. Through the Medicaid program, there are numerous opportunities available for States. These coverage and service design opportunities may assist States in increasing access to care for individuals living with HIV, provide alternatives that could alleviate the current burden to AIDS Drug Assistance Programs (ADAP), and help States make progress towards implementing the expansion of Medicaid required in the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Affordable Care Act). States may choose or apply for one or more options to extend coverage to individuals living with HIV:

1. Community First Choice;
2. Health Home for Enrollees with Chronic Conditions;
3. Section 1915(c) Home and Community Based Services (HCBS) Waiver;
4. Section 1915(i) State plan option;
5. The Money Follows the Person (MFP) Rebalancing Demonstration; and
6. Section 1115 Demonstrations.

In addition, this letter provides guidance to States who wish to submit applications for section 1115 demonstrations to cover individuals living with HIV who are not otherwise eligible for Medicaid.

Background

The United States is experiencing a domestic HIV epidemic that demands a renewed commitment, increased public attention and leadership. More than 56,000 people become infected with HIV in the U.S. each year, and there are more than 1.1 million Americans with HIV. The epidemic has claimed the lives of nearly 600,000 Americans, and affects many

more, including families and friends of those with the disease.[1] Of those living with HIV, it is estimated that less than 17 percent have private health insurance and nearly 30 percent do not have any medical coverage. [2]

In response to this domestic epidemic, President Obama released the National HIV/AIDS Strategy, which aims to achieve three primary goals: 1) reduce HIV incidence; 2) increase access to care and optimize health outcomes; and 3) reduce HIV-related health disparities. In order to achieve the goal of increasing access to care and improving health outcomes for individuals living with HIV, the Strategy encourages Federal and private partners to take the following steps to improve service delivery for individuals living with HIV:

1. Establish a seamless system to immediately link individuals to continuous and coordinated quality care when they are diagnosed with HIV.

2. Take deliberate steps to increase the number and diversity of available providers of clinical care and related services for individuals living with HIV.

3. Support individuals living with HIV with co-occurring health conditions, and those who have challenges meeting their basic needs.

Please visit: http://www.whitehouse.gov/administration/eop/onap/nhas to learn more about the Strategy.

As part of the Strategy's Federal Implementation Plan, the Centers for Medicare & Medicaid Services (CMS) and the Health Resources and Services Administration (HRSA) are tasked with initiating a dialogue on ways to support Medicaid and Medicare providers in order to engage vulnerable populations in HIV care. To that end, CMS and HRSA strongly encourage Medicaid Directors to consult with and consider input from State Primary Care Association (PCA) Directors (http://www.bphc.hrsa.gov/technicalassistance/partner%20links/associations.html) and State AIDS Directors (http://www.nastad.org/about/res_state_Directory.aspx) to ensure that issues and concerns facing HRSA's Ryan White HIV/AIDS Programs and the federally-qualified health centers (FQHC) are addressed, since these providers are highly impacted by Medicaid policy. We are also asking States to consider how demonstration projects could be designed to improve access to HIV testing, care, and treatment for individuals living with HIV and individuals at risk for HIV infection. Please note that, in addition to the Web sites listed above, a list of PCA and State AIDS Director contacts can be obtained by emailing HIVandAIDS@cms.hhs.gov. States can reach out to these stakeholders as waiver considerations are being explored.

Medicaid is a major source of coverage for individuals living with HIV. Before the Affordable Care Act, most individuals living with HIV were ineligible for Medicaid unless they had very low incomes, or were deemed permanently disabled, due to an AIDS diagnosis. Starting in 2014, section 2001 of the Affordable Care Act expands coverage to individuals with income

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[1] Centers for Disease Control and Prevention. HIV/AIDS Surveillance Report. 2007; 19:7 Available at http://www.cdc.gov/hiv/surveillance/resources/reports/2007report/pdf/2007SurveillanceReport.pdf

[2] http://www.aids.gov/federal-resources/policies/health-care-reform/

under 133 percent of the Federal poverty level (FPL) and States have had the option to begin providing medical assistance to individuals eligible under this new expansion as of April 1, 2010.

Under the law, for the first time since the Medicaid program was established, States can receive Federal Medicaid payments under their State Medicaid plans to provide coverage for the lowest income adults in their States, without regard to disability, parental status, or most other categorical limitations. For more information regarding this option for coverage of individuals under Medicaid, please visit http://www.cms.gov/smdl/downloads/SMD10005.PDF. The Affordable Care Act also includes a variety of options for States to offer services to help those who need long-term services and supports at home and in the community.

Summaries of Medicaid service design and coverage opportunities that are available are outlined below.

1. Community First Choice

Section 2401 of the Affordable Care Act creates a new State Plan option to provide home and community-based attendant services and supports (Community First Choice Option) through section 1915(k)of the Social Security Act (the Act). This provision will be effective October 1, 2011. Community First Choice utilizes a person-centered plan, and allows for the provision of services to be self-directed under either an agency-provider model or a traditional self-directed model with a service budget. States can make available home and community-based attendant services and supports to assist in accomplishing activities of daily living, instrumental activities of daily living, and health-related tasks through hands-on assistance, supervision, or cueing. Community First Choice also allows for transition costs (such as security deposits for an apartment or utilities) and the purchase of bedding, basic kitchen supplies, and other necessities required for transition from an institution. In addition, Community First Choice allows for the provision of services that increase independence or substitute for human assistance to the extent that expenditures would have been made for the human assistance, such as non-medical transportation services. This option also allows for the purchase of back-up systems or mechanisms (such as the use of beepers or other electronic devices) to ensure continuity of services and supports. States that elect to provide the Community First Choice option will receive an increase of 6 percent in their Federal Medical Assistance Percentage (FMAP) for the provision of these services. For more information about Community First Choice, CMS has released a proposed rule. Please visit http://www.gpo.gov/fdsys/pkg/FR-2011-02-25/pdf/2011-3946.pdf for more information.

2. Health Home for Enrollees with Chronic Conditions

Section 2703 of the Affordable Care Act (Health Home for Enrollees with Chronic Conditions) offers a new Medicaid State Plan option to provide coordinated care to individuals with chronic conditions, which may include individuals living with HIV. As mentioned in the State Medicaid Director letter on health homes, issued on November 16, 2010, section 1945(h)(2) of the Act authorizes the Secretary to expand the list of chronic conditions reflected in this provision and the Secretary will consider HIV/AIDS for incorporation into health home models. Since individuals with HIV may also be experiencing mental health and/or substance use issues, this provision offers important coordinated care opportunities for supporting physical and behavioral

health, as well as linkages to long-term supports, which are fundamental elements of a successful health home.

However, a State cannot offer a health home to an individual solely on the basis of having an HIV diagnosis. Per statutory requirement, the individual must have two or more chronic conditions (as defined by the State and approved by CMS), or have one chronic condition and be at risk of another. If you have any questions about health homes, please refer to the State Medicaid Director letter at http://www.cms.gov/smdl/downloads/SMD10024.pdf. You may also send any questions about health homes to the CMS health homes mailbox at healthhomes@cms.hhs.gov.

3. HIV Initiatives under Section 1915(c) HCBS Waivers

Under section 1915(c) of the Act, States may design HCBS waiver programs. The section 1915(c) HCBS waiver program is the predominant Medicaid program for providing long-term services and supports in the community (non-institutional settings) as an alternative to an institutional setting, such as a hospital or nursing home.

The section 1915(c) HCBS waiver program is used by a number of States to serve individuals with HIV in the community. States may use additional targeting criteria to specifically design a waiver to serve individuals with HIV or they may define a broader target group into which individuals with HIV would be included. Thirteen States currently operate stand alone section 1915(c) waivers for individuals with HIV. Many others successfully serve individuals with HIV in their more broadly targeted waivers, which often offer a rich service package that can address diverse service needs.

States offer a wide range of services under the section 1915(c) waivers, including those targeted solely for individuals with HIV. Examples of services that States currently offer in section 1915(c) HIV waivers include: Case Management, Attendant Care, Home Health, Specialized Medical Equipment and Supplies, Nutritional Consultation, Respite, Environmental Modifications and Supplies, Private Duty Nursing, Personal Care, Home Maker Services, Personal Assistance, and Home Delivered Meals. To learn more about HCBS waivers or to submit an application on-line please visit https://www.hcbswaivers.net/CMS/faces/portal.jsp.

4. HIV Initiatives under Section 1915(i) State Plan Home and Community-Based Services

Section 1915(i) of the Act (HCBS as a State Plan option) offers an unprecedented opportunity to serve individuals with HIV. Section 1915(i) was modified through section 2402 of the Affordable Care Act with changes that became effective October 1, 2010. CMS released a State Medicaid Director letter (http://www.cms.gov/smdl/downloads/SMD10015.pdf) on August 6, 2010, discussing the changes to section 1915(i) of the Act, including expanded eligibility criteria, the ability for States to target the benefit to certain populations, and an expanded array of services. HCBS can be an essential component of an individual's health care continuum, and can work to support and bolster clinical interventions. Five States currently have approved section 1915(i) HCBS in their State plans.

This option provides more flexibility than the section 1915(c) HCBS waivers because it includes less restrictive cost neutrality and institutional level of care requirements, allowing States to provide HCBS to prevent or delay the need for institutional care. The services that the States may offer now under the section 1915(i) benefit are the same as those available under section 1915(c) of the Act, and can include personal care, nutritional counseling, anticipatory grief and bereavement counseling, nursing and other specialized supports that can be effectively tailored to meet the needs of an individual with HIV.

5. The Money Follows the Person Rebalancing Demonstration Program

The Money Follows the Person (MFP) Rebalancing Demonstration Program was authorized by Congress in section 6071 of the Deficit Reduction Act of 2005, and was designed to provide assistance to States to balance their long-term care systems and to help Medicaid beneficiaries transition from institutions to the community. Congress initially authorized up to $1.75 billion in Federal funds through fiscal year (FY) 2011 to:

1. Increase the use of HCBS, and reduce the use of institutionally-based services;

2. Eliminate barriers and mechanisms in State law, State Medicaid plans, or State budgets that prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive long-term care in the settings of their choice;

3. Strengthen the ability of Medicaid programs to ensure continued provision of HCBS to those individuals who choose to transition from institutions; and

4. Ensure that procedures are in place to provide quality assurance and continuous quality improvement of HCBS.

Section 2403 of the Affordable Care Act extended the MFP Demonstration Program for an additional 5 years through 2016, and appropriates an additional $450 million for each fiscal year 2012 through 2016, totaling an additional $2.25 billion in Federal funds. Funds awarded in 2016 are available to States for expenditures until fiscal year 2020. The extension of the MFP Demonstration Program offers States substantial resources and additional program flexibilities to remove barriers and improve an individual's access to community supports and independent living arrangements.

MFP grantees may amend their Operational Protocols at any time during the demonstration to include individuals living with HIV as a target population for transition from qualified institutions to community-based settings. For an individual's first 365 days in the community, MFP grantees may also include additional demonstration and supplemental services that can address the special needs of an individual with HIV. For more information on the MFP Rebalancing Demonstration, please visit: http://www.cms.gov/DeficitReductionAct/20_MFP.asp

6. Section 1115 Demonstrations

Section 1115 of the Act allows the Secretary of Health and Human Services (the Secretary) to waive certain provisions of title XIX of the Act for experimental, pilot, or demonstration projects

(demonstrations). When the Secretary finds that the demonstration project is likely to assist in promoting the objectives of Medicaid, section 1115 also provides for Federal Financial Participation (FFP) for demonstration costs which would not otherwise be considered as expenditures under the Medicaid State plan.

An HIV section 1115 demonstration will allow States the flexibility to expand access to individuals with HIV and allow such individuals to become eligible for services through a demonstration, without having to be permanently disabled due to an AIDS diagnosis. In addition, providing these services will help promote health and better health outcomes among individuals with HIV, helping them to lead healthier and longer lives. The demonstration may be designed to provide more effective, early treatment of HIV by making available a limited or comprehensive package of services, which may include anti-retroviral therapies or case management to ensure treatment adherence. Early treatment and case management services provided to individuals with HIV create efficiencies in the Medicaid program enabling the extension of coverage to individuals who would otherwise be without health insurance.

Features of Existing Section 1115 HIV Demonstrations

CMS has previously approved two section 1115 HIV demonstrations for the District of Columbia and Maine. The District of Columbia's HIV demonstration provided full Medicaid benefits to uninsured District residents who are HIV positive, and whose incomes are at or below 100 percent of the FPL. The goal of the demonstration was to provide more effective, early treatment of HIV utilizing discount drug pricing. Through the Department of Defense drug pricing, only available to the District, and a limited pharmacy network, the District was able to provide anti-retroviral prescription drugs to demonstration enrollees at a significantly lower price. One of the key features of the District's Demonstration was that intake for the program was conducted by the HIV/AIDS Administration case managers, allowing individuals with HIV to be linked to all HIV programs available to them in the District.

The Maine HIV Demonstration applies rigorous care protocols, along with case management, to disabled Medicaid recipients under 100 percent of the FPL with the goal of delaying the onset of full-blown AIDS, and using those savings to expand coverage to uninsured low-income individuals living with HIV who are at or below 250 percent of the FPL. The expanded coverage provides a comprehensive benefit package, including anti-retroviral therapies to individuals not otherwise eligible for Medicaid, but who are HIV positive.

Budget Neutrality for Section 1115 Demonstrations

In addition to serving the purposes of the Medicaid program and improving care for low-income individuals, demonstrations must be budget-neutral. This means that the proposed demonstration cannot cost the Federal government more than it would absent the demonstration. In order to meet budget neutrality, CMS and the State establish a budget ceiling based on five years of historic State specific expenditure data for each individual population the State is going to cover under the demonstration. This initial amount is then trended forward based on a negotiated trend rate for the approved demonstration period. Administrative costs are not included in the budget neutrality limit, but the State must separately track and report additional administrative costs that are directly attributable to the demonstration. When developing the budget neutrality models, the initial set of data that States should try to obtain are the historic enrollment and budgetary

data by eligibility category, then project future enrollment and per member per month costs of coverage for populations that would be covered in the waiver. CMS has available data on HIV spending by State that States may use to facilitate the construction of budget neutrality. These data can be obtained by contacting Mr. Richard Jensen (contact information included near end of letter).

CMS will work with States to develop a streamlined and flexible approach to budget neutrality for these waivers. We encourage States interested in applying for an 1115 demonstration to contact CMS to identify the most appropriate and efficient budget neutrality methodology for each State.

Submission Process for Section 1115 Demonstrations

To assist States in applying for section 1115 demonstrations to cover individuals with HIV, CMS has developed a draft application template for consideration. Please review the instructions at the beginning and throughout the template for the portions that require the State to input information. CMS hopes that this information is helpful to States for successful submission of a section 1115 demonstration.

CMS must review and approve the request before it will be considered complete, even when a State uses the draft template. For the purpose of initiating the Federal review process, States must provide the information listed below:

- A demonstration program description, and goals and objectives that will be implemented under the demonstration project.
- The description of the proposed health care delivery system, eligibility requirements, benefit coverage, and cost sharing (for example, premiums, copayments, and deductibles) required of individuals that will be impacted by the demonstration.
- An estimate of the expected increase or decrease in annual aggregate expenditures by population group impacted by the demonstration. If available, include historic data for these populations.
- An estimate of historic coverage and enrollment data (as appropriate), and estimated projections expected over the term of the demonstration, for each category of beneficiary whose health care coverage is impacted by the demonstration. For example, States may choose to have a certain benefit set for enrollees at or below a certain FPL and a different benefit package for those above that certain FPL.
- Other demonstration program features that require the State to deviate from the provisions of the Medicaid and CHIP programs.
- The types of waivers and expenditure authorities that the State believes to be necessary to authorize the demonstration.
- The research hypothesis or hypotheses that are related to the demonstration's proposed changes, goals, and objectives, a plan for testing the hypotheses in the context of an evaluation, and, if a quantitative evaluation design is feasible, the identification of appropriate evaluation indicators.
- CMS recommends that States seek consultation with the State Substance Abuse Authority, State Mental Health Authority, and other State Agencies that fund or oversee HIV treatment during the development of their HIV demonstration proposal.

Additionally, States must 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 of 2009. 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.

Lastly, section 1115 demonstration applications may be submitted electronically to HIVandAIDS@cms.hhs.gov or by mail to:

Mr. Richard Jensen
Centers for Medicare & Medicaid Services
Children and Adults Health Programs Group
Mail Stop: S2-1-16
7500 Security Boulevard
Baltimore, MD 21244

We hope this information will be helpful. CMS is available to provide technical assistance to States regarding special Medicaid programs for HIV. Questions regarding this guidance may be directed to Ms. Barbara Edwards, Director, Disabled and Elderly Health Program Group, or Ms. Vikki Wachino, Director, Children and Adults Health Program Group at (410) 786-5647. We look forward to our continuing our work together.

Sincerely,

/s/

Cindy Mann
Director

Enclosure

cc:

CMS Regional Administrators

CMS Associate Regional Administrators
Division of Medicaid and Children's Health

Matt Salo
President
National Association of Medicaid Directors

Alan R. Weil, J.D., M.P.P.
Executive Director
National Academy for State Health Policy

Director of Health Legislation
National Governors Association

Rick Fenton
Acting Director
Health Services Division
American Public Human Services Association

Christine Evans, M.P.H.
Director, Government Relations
Association of State and Territorial Health Officials

Debra Miller
Director for Health Policy
Council of State Governments

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Julie M. Scofield
Executive Director
National Alliance of State & Territorial AIDS Directors

Section 1115 Demonstration
HIV and AIDS
APPLICATION TEMPLATE

Instructions: Throughout the template you will see <instructions>; please complete with information that is unique to the State's HIV (including individuals living with AIDS, which refers to individuals living at an advanced stage of the HIV disease) demonstration request.

Demonstration applications may be submitted by electronically to HIVandAIDS@cms.hhs.gov or by mail to:

Mr. Richard Jensen
Centers for Medicare & Medicaid Services
Children and Adults Health Programs Group
Mail Stop: S2-1-16
7500 Security Boulevard
Baltimore, MD 21244

The <insert State name>, <insert Medicaid State Agency name>, proposes this demonstration under the authority of section 1115(a) of the Social Security Act (the Act). This demonstration is for the purpose of addressing the domestic HIV epidemic that demands renewed commitment to increasing access to care and improving health outcomes for individuals living with HIV.

State Name:
State Medicaid Director Name:
Telephone Number:
E-mail Address:
Other Key Contacts:

The State information above identifies contact information for CMS to use in discussing demonstration applications, as necessary.

I. GENERAL DESCRIPTION OF PROGRAM

<Please add and/or change the description of the State's program>

The HIV section 1115(a) Demonstration expands access to certain individuals with HIV without health insurance who are not otherwise eligible for Medicaid, the Children's Health Insurance Program (CHIP), or Medicare. The Demonstration allows such individuals to become eligible for a targeted benefits package without having to spend down income or resources, and allows individuals with HIV 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 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 <insert number> eligibility group(s):

Eligibility Group Name	Description	FPL
<insert eligibility group name> Example: Group A	<insert eligibility group description> Example: Adults between the ages of 21 and 64.	<insert FPL level for eligibility for Group A> Example: Above 100% but below 133%
<insert eligibility group name> Example: Group B	<insert eligibility group description> Example: Premium assistance	<insert FPL level for Group B> Example: Above 133% but below 250%

State's goal(s) in implementing the Demonstration is:

<insert goal(s)>

II. ELIGIBILITY AND BENEFITS

1. **Eligibility.** <delete those that do not apply or insert additional requirements that will apply to the Demonstration>

□ 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 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 Demonstration are as follows: <insert eligibility criteria>

Examples (not limited to list below):

- Positive HIV status;
- Completed information form related to other insurance, i.e., third party liability (TPL);
- Payment of premiums (if applicable);
- Have income above ### percent and at or below ### percent of the FPL; <insert FPL range>;
- Be ages ## through ##; <insert age range>;
- Be ineligible under other categories of Medicaid;
- Be ineligible for Medicare;
- Not reside in mental health, or penal institutions;
- Other (please describe).

Demonstration Eligibility Groups	Federal Poverty Level (FPL) and/or Other Qualifying Criteria	Eligible Benefit
<insert information>	<insert information>	<insert information>

2. Eligibility Exclusions (if applicable). The following persons are excluded from the HIV Demonstration.

<insert exclusionary criteria>

<Insert methodology for determining income>

3. **State's** HIV Demonstration Benefits. The following categories of services are covered in the participant benefit package: <insert all benefit categories and descriptions to be included in the demonstration>

General Category of Service	Specific Services Include
Example: Inpatient	**Example:** Including medical/surgical, substance abuse, detoxification and psychiatric.

The following categories of services not included in the participant benefit package. <enter all excluded benefit categories>

General Category of Service	Services Do Not Include
Example: Consumer Directed Attendant	**Example:** Consumer Directed Services

III. COST SHARING

4. **Co-payments.** <insert co-payment requirements, if applicable, or delete if there will be no co-payments>

□ Demonstration participants pay a co-payment for physician services and pharmaceuticals (see table below):

Demonstration Co-Pays

Services	Co-payment
Example: Prescription Drugs	**Example:** $3.00, capped at $30 per month per member

No co-payment may be imposed on "demonstration eligibles" with respect to the following services and populations:

- 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 his/her income for costs of care, with the exception of a minimal amount 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 State's Medicaid 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.

□ This Demonstration will be coordinated with the AIDS Drug Assistance Program (ADAP) that is funded through the Ryan White HIV/AIDS Program statute (codified in Part B of title XXVI of the Public Health Service Act), and will pay primary to the ADAP for covered benefits. ADAP assistance may be available as a wrap-around benefit, for Demonstration participant liability for premiums and co-payments. Individuals may participant in both benefit programs.

5. Monthly Premiums. <please delete if not applicable, otherwise please insert premium information based on FPL level>

□ Enrollees are responsible for payment of a monthly premium dependent on their income level.

Income Level	Monthly Premium
<if applicable, create a row for each FPL range that has a monthly premium>	<insert premium amount>

□ Not applicable

6. Cost Sharing Protections. In the event demonstration eligibles 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 demonstration eligibles may make the payment without termination from the program. During the grace period, the State will notify the demonstration eligible that failure to make the required payment may cause termination from the program. 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 eligible 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.

IV. SERVICE DELIVERY MODEL

7. Service Delivery.

<insert service delivery model description>

V. BUDGET NEUTRALITY

<please contact CMS to discuss your budget neutrality optionsl>

<[3]end of application>

[3] According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-NEW**. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Attachment to Demonstration Application Template

STANDARD TERMS AND CONDITIONS (STCs)

(When developing your program, please note these terms and conditions which may apply to the Demonstration. These terms and conditions are current as of March 2011. Depending upon the Demonstration design, additional STCs may apply.)

I. 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, 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 State plan amendments under 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 6, 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. **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 9, 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 are 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.

9. Enrollment Limitation During Demonstration Phase-Out. If the State elects to suspend, terminate, or not renew this Demonstration as described in paragraph 8, during the last 6 months of the Demonstration, the State may choose to not enroll individuals

into the Demonstration who would not be eligible for Medicaid under the current Medicaid State plan. Enrollment may be suspended if CMS notifies the State in writing that the Demonstration will not be renewed.

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 of the Act. 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 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 (the Recovery Act) of 2009, when any program changes to the Demonstration, including (but not limited to) those referenced in paragraph 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.

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

II. ELIGIBILITY, BENEFITS, AND ENROLLMENT

<unique to State's approved program design>

III. COST SHARING

<unique to State's approved program design>

IV. DELIVERY SYSTEMS

16. **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).

V. GENERAL REPORTING REQUIREMENTS

17. **General Financial Requirements.** The State must comply with all general financial requirements under title XIX of the Act set forth in Section VI.

18. **<Delete if not applicable> 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.

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

20. **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.

21. **Quarterly Reports:** The State must submit progress reports in the format to be provided at a later date 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) An update on 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 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 <insert month and day > is <insert month and day>
- Quarterly report for the quarter ending <insert month and day > is <insert month and day>
- Quarterly report for the quarter ending <insert month and day > is <insert month and day>
- Quarterly report for the quarter ending <insert month and day > is <insert month and day>

22. **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 <Insert month and day>. 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.

23. **<Delete if not applicable> AIDS Drug Assistance Program (ADAP).** By <insert date> the State will submit for CMS approval a proposed methodology to provide aggregate ADAP information on premium or co-payments provided to Demonstration participants. 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 <insert date>, and will continue to report this information on each quarterly report with a summary provided on the annual report.

24. **Transition Plan.** On or before July 1, 2012, the State is required to prepare, and incrementally revise, a transition plan consistent with the provisions of the Affordable Care Act for individuals enrolled in the Demonstration, including how the State plans to coordinate the transition of these individuals to a coverage option available under the Affordable Care Act, without interruption in coverage to the maximum extent possible. The plan must contain the required elements and milestones described in paragraphs 24a-e outlined below. In addition, the Plan will include a schedule of implementation activities that the State will use to operationalize the Transition Plan.

    a) Seamless Transitions. Consistent with the provisions of the Affordable Care Act, the Transition Plan will include details on how the State plans to obtain and review any additional information needed from each individual to determine eligibility under all eligibility groups, and to coordinate the transition of individuals enrolled in the Demonstration (by FPL or newly applying for Medicaid) to a coverage option available under the Affordable Care Act, without interruption in coverage to the maximum extent possible. Specifically, the State must:

        i. Determine eligibility under all January 1, 2014, eligibility groups for which the State is required or has opted to provide medical assistance, including the group described in section1902(a)(10)(A)(i)(VIII) of the Act for individuals under age 65 and regardless of disability status, with income at or below 133 percent of the FPL.

        ii. Identify Demonstration populations not eligible for coverage under the Affordable Care Act, and explain what coverage options and benefits these individuals will have effective January 1, 2014.

        iii. Implement a process for considering, reviewing, and making preliminarily determinations under all January 1, 2014, eligibility groups for new applicants for Medicaid eligibility.

        iv. Conduct an analysis that identifies populations in the Demonstration that may not be eligible, for or affected by, the Affordable Care Act, and the authorities the State identifies that may be necessary to continue coverage for these individuals.

        v. Develop a modified adjusted gross income (MAGI) calculation for program eligibility.

b) Access to Care and Provider Payments and System Development or Remediation. As necessary to meet the State's priorities, the State should ensure adequate provider supply for the State plan and Demonstration populations affected by the Demonstration on December 31, 2013. Additionally, the Transition Plan for the Demonstration is expected to expedite the State's readiness for compliance with the requirements of the Affordable Care Act and other Federal legislation.

c) **Pilot Programs.** Progress towards developing and testing, when feasible, pilot programs that support Affordable Care Act-defined "medical homes," "accountable care organizations," and / or "person-centered health homes" to allow for more efficient and effective management of the highest risk individuals.

d) **Progress Updates.** After submitting the initial Transition Plan for CMS approval, the State must include progress updates in each quarterly and annual report. The Transition Plan shall be revised as needed.

e) **Implementation.**

i. By July 1, 2013, the State must begin to implement a simplified, streamlined process for transitioning eligible participants in the Demonstration to Medicaid, the Exchange, or other coverage options in 2014. In transitioning these individuals from coverage under the waiver to coverage under the State plan, the State will not require these individuals to submit a new application.

ii. On or before December 31, 2013, the State must provide notice to the individual of the eligibility determination, using a process that minimizes demands on the participants.

VI. GENERAL FINANCIAL REQUIREMENTS

25. **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 the authority of section 1115 of the Act. 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 those expenditures do not exceed the pre-defined limits on the costs incurred as specified in section VII**.**

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

a) To track expenditures under this Demonstration, the State 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 Demonstration Year (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:

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 36 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 report 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.

27. **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:

<Insert description(s)>

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 25, the actual number of eligible member months for the Demonstration Populations defined in paragraph 27. 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.

28. **Standard Medicaid Funding Process.** The standard Medicaid funding process shall be used during the demonstration. The State 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.

29. **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 VII:

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 Demonstration.

30. **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 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.

31. **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.

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

VII. MONITORING BUDGET NEUTRALITY

33. **Limit on Federal Title XIX funding.** The State shall be subject to a limit on the amount of Federal title XIX funding that the State may receive on selected Medicaid expenditures during the period of approval of the Demonstration. The limit is determined by using a per capita cost method, and budget neutrality expenditure caps are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire Demonstration. The data supplied by the State to CMS to set the annual caps is subject to review and audit, and, if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the State's compliance with these annual limits will be done using the Schedule C report from the CMS-64.

34. **Risk**. The State shall be at risk for the per capita cost for Demonstration eligibles under this budget neutrality agreement, but not for the number of Demonstration eligibles. Because CMS provides FFP for all Demonstration eligibles, the State shall not be at risk for changing economic conditions that impact enrollment levels. However, by placing the State at risk for the per capita costs for current eligibles, CMS ensures that the Federal Demonstration expenditures do not exceed the level of expenditures had there been no Demonstration.

35. **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.

36. **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 (2011)	<insert amount>	<insert percentage>
DY 02 (2012)	<insert amount>	<insert percentage>
DY 03 (2013)	<insert amount>	<insert percentage>

37. **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.

VIII. EVALUATION OF THE DEMONSTRATION

38. **State Must Evaluate the Demonstration.** As outlined in the subparagraph below, 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 <insert date>. The evaluation must outline and address evaluation questions for the following:

    The HIV Demonstration. At a minimum, the draft design must:

    - Include a discussion of the goals, objectives, and evaluation questions specific to the entire Demonstration.
    - 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.
    - Discuss the data sources and sampling methodology for assessing these outcomes.
    - Include a detailed analysis plan that describes how the effects of the Demonstration shall be isolated from other initiatives occurring in the State.
    - Identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation.
    - The evaluation report that encompasses the outcomes since the beginning of the demonstration must be submitted to CMS by <insert date>.

39. **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 38, 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.

40. **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.

IX. SCHEDULE OF STATE DELIVERABLES FOR THE DEMONSTRATION EXTENSION PERIOD

Date - Specific	Deliverable	STC Reference
	Submit Draft Evaluation Plan, including Evaluation Designs for the State HIV demonstration	Section VIII, paragraph 38
	Submit Draft Evaluation Report, including preliminary analysis and recommendations related to the State HIV demonstration	Section VIII, paragraph 38
	Submit Final Evaluation Report	Section VIII, paragraph 39

	Deliverable	STC Reference
Annual	By <insert date> Draft Annual Report	Section VII, paragraph 22
Each Quarter		
	Quarterly Operational Reports	Section VII, paragraph 21
	CMS-64 Reports	Section VIII, paragraph 26
	Disease-Stage Specific Eligible Member Months	Section VIII, paragraph 27