CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00158/1

TITLE: MaineCare for Childless Adults Section 1115 Demonstration

AWARDEE: MaineCare Services (OMS)

I. PREFACE

The following are the Special Terms and Conditions (STCs) for Maine's Section 1115 Health Care Reform Demonstration (hereinafter "Demonstration"). The parties to this agreement are the Maine Department of 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 October 1, 2010, unless otherwise specified. All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below. This Demonstration renewal is approved through December 31, 2013.

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

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

II. PROGRAM DESCRIPTION AND OBJECTIVES

The Maine Childless Adults Demonstration provides a specified benefits package to childless adults and non-custodial parents who are at or below 100 percent of the federal poverty level (FPL). The Demonstration expands access to those without health insurance and who are otherwise ineligible for MaineCare. This Demonstration is funded by disproportionate share hospital (DSH) payments and is capped at $80.3 million total computable federal and state share. Enrollment is capped at 20,000 individuals.

The Childless Adults Demonstration will evaluate the outcomes of providing a targeted benefits package to a previously uninsured population on:

- reducing the uninsured rate;
- overall health care costs;

- improved health outcomes; and
- routine access to quality primary care.

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

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

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

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

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

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

6. **Changes Subject to the Amendment Process**. Changes related to eligibility, enrollment, benefits, cost sharing, sources of non-Federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as

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

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

    a) An explanation of the public process used by the State, consistent with the requirements of paragraph 12, 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) An up-to-date CHIP allotment neutrality worksheet, if necessary;

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

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

8. **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.

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

10. **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.

11. **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.

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

IV. ELIGIBILITY, BENEFITS, AND ENROLLMENT

The Maine Childless Adults Demonstration provides a specified benefits package to childless adults and non-custodial parents with family income at or below 100 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.

13. **Eligibility.**

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 Childless Adults Demonstration are as follows:

- Childless adult or non-custodial parent;
- U.S. Citizens;
- Financially eligible;
- Completed information form related to other insurance, i.e., third party liability (TPL); and
- Applicable cost-sharing.

Eligible individuals with access to employer sponsored insurance may be eligible to receive premium assistance and MaineCare may pay premiums/cost-sharing for this insurance according to current MaineCare rules.

Demonstration Eligibility Group	Federal Poverty Level (FPL) and/or Other qualifying Criteria	Eligible Benefit
"Childless Adults"	Childless adults or non-custodial parents at or below 100 percent of FPL	Comprehensive benefits package as defined in paragraph 15

14. **MaineCare Childless Adults Demonstration Benefits.** The targeted benefits package is designed to serve as many eligible individuals as possible with a comprehensive set of health care services, as described below.

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

General Category of Service	Specific Services Included
Hospital	MCBM Chapter II, Section 45, Hospital Services
Psychiatric Facility	MCBM Chapter II, Section 46, Psychiatric Facilities
Physician Services	MCBM Chapter II and III, Section 90 Physician
Medications	MCBM Chapter II, Section 80, Pharmacy Services
Ambulatory Surgical Center Services	MCBM Chapter II, Section IV, Ambulatory Surgical Center Services
Rural Health Care	MCBM Chapter II and III, Section 103, Rural Health Care Services
Federally Qualified Health Clinic Services	MCBM Chapter II and III, Section 31, FQHCs
Private Non-Medical Institutional Services, substance abuse facilities only.	MCBM Chapter II, Section 97 and Chapter III, Appendix B
Substance Abuse Treatment Services	MCBM Chapter II and III, Section 111, Substance Abuse Treatment Services
Family Planning	MCBM Chapter II and III, Section 30, Family Planning Agency Services
Advance Practice Registered Nursing	MCBM Chapter II, Section 14, Advance Practice Registered Nursing Services
Ambulatory Care Clinic Services	MCBM Chapter II and III, Section 3, Ambulatory Care Clinic Services

General Category of Service	Specific Services Included
Vision Services	MCBM Chapter II, Section 75, Vision Services (ophthalmologist and optometrist only)
Outpatient Psychiatric Care*	MCBM Chapter II, Section 46, Psychiatric Facility Services (outpatient)
Licensed Clinical Social Worker and Licensed Clinical Professional Counselor*	MCBM Chapter II and III, Section 58
Mental Health Services*	MCBM Chapter II and III, Section 65, Mental Health Services
Psychological Services*	MCBM Chapter II and III, Section 100
Dental	MCBM Chapter II and III, Section 25, Dental Services
Chiropractor	MCBM Chapter II and III, Section 15, Chiropractic Services
Transportation	MCMB Chapter II and III, Section 113, Transportation Services
Medical Supplies and Durable Medical Equipment, oxygen and insulin pumps/supplies only	MCBM Chapter II and III, Section 60,
Podiatric Services	MCBM Chapter II, Section 05, Podiatric Services
Ambulance Services	MCBM Chapter II and III, Section 5
Medical Imaging Services	MCBM Chapter II, Section 101
Laboratory Services	MCBM Chapter II, Section 55
Licensed Clinical Social Worker and Licensed Clinical Professional Counselor	MCBM Chapter II and III, Section 58

***** For all services received under Sections 46, 65, and 100 of the MCBM, MaineCare will cover only face to face visits with a licensed practitioner up to a total of 24 outpatient mental health visits in aggregate annually except for the following services that will not be counted against the 24 visit limit: (1) Section 46 outpatient methadone services being billed by hospitals as of the date the waiver is approved; and (2) Section 65 emergency, crisis, and medication management services.

15. **Expenditure Cap**. The expenditure cap is set at $80.3 million total computable per year as per the Maine State legislature. Should the State exceed $80.3 million annually in redirected DSH, the State will be subject to return FFP in excess of the annual cap.

16. **Enrollment Cap**. The enrollment cap is set at 20,000. The State employs a rolling enrollment methodology outlined below:

Major Action Steps	Procedural Actions	Responsible Party	Due Date	Completion Date
Monitor size and cost of childless adult group to keep population under 20,000	Monthly query WELFRE for childless adult population size.	OIAS/OIT*	1st of each month	Ongoing
	Monthly query MECMS for childless adult expenditures.	OMS	1st of each month	Ongoing
	Query ACES to determine monthly closure rate	OIAS/OIT	1st of each month	Ongoing
Add applicants from waiting list up to 20,000 cap	Determine number to get to 20,000.	OIAS	15th of month	Ongoing
	Determine date up to which wait list added	OIAS	15th of month	Ongoing
	Mass data fix to add identified wait list.	OIT	25th of month	Ongoing
	Letters/MaineCare cards to those added.	OIT	25th of month	Ongoing

* OIAS: Office of Integrated Access and Support
OIT: Office of Information Technology
OMS: Office of MaineCare Services

V. COST SHARING

Allowable premiums and cost-sharing are charged to "childless adults" as defined below:

Population	Premiums	Deductibles	Co-Payments
"Childless Adults" at or below 100% FPL	None	Same as Medicaid (see MaineCare State Plan), nominal	Same as Medicaid, nominal Type: Rx — Amt: $3 Type: Services — Amt: $1-$3

VI. DELIVERY SYSTEMS

17. **Service Delivery.** Services for the demonstration are provided using the same mechanism as MaineCare members (Medicaid-eligible individuals), including services that require prior authorization and are ordered and prescribed by a physician.

Participants will be permitted to choose among MaineCare participating providers (agencies).

Individuals with other insurance may be participants of this demonstration. The Office of MaineCare Services may pay premiums/cost-sharing for this insurance according to current Medicaid (MaineCare) State Plan rules.

18. **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

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

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

21. **Quarterly Calls.** CMS will 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.

22. **Quarterly Operational Reports:** The State must submit progress reports in the format specified in Attachment A no later than 60 days following the end of each quarter. The intent of these reports is to present the State's analysis and the status of the various operational areas. These quarterly reports must include, but are not limited to:

    a) An updated budget neutrality monitoring spreadsheet;

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

a. Systems and Reporting Issues;
b. Approval and contracting with new health plans;
c. Benefits;
d. Enrollment;
e. Grievances;
f. Quality of care;
g. Access;
h. Health plan financial performance that is relevant to the Demonstration, including progress towards corrective action related to expenditure reporting;
i. Pertinent legislative activity; and
j. Other operational issues.

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

d) Evaluation activities and interim findings.

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**
Quarterly report for the quarter ending September 30 is due **November 30**

VIII. Transition Activities under the Patient Protection Affordable Care Act (ACA)

23. **Transition Plan.** The state is required to prepare, and incrementally revise a Transition Plan consistent with the provisions of the ACA 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 ACA without interruption in coverage to the maximum extent possible. The State must submit a draft to CMS by July 1, 2012, with progress updates included in each quarterly report. The State will revise the Transition Plan as needed.

24. **Annual Report.** The State must submit a draft annual report documenting accomplishments project status, 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. 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.

IX. 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 section 1115 authority. This project is approved for expenditures applicable to services rendered

during the Demonstration period. CMS shall provide FFP for allowable Demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in section X**,** Monitoring Budget Neutrality.

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

    a) In order to track expenditures under this Demonstration, Maine must report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 and Section 2115 of the State Medicaid Manual (SMM). All Demonstration expenditures claimed under the authority of title XIX of the Act must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the Demonstration project number assigned by CMS (including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made). For monitoring purposes, cost settlements must be recorded on Line 10.b, in lieu of Lines 9 or 10.C. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10.C, as instructed in the SMM.

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

        - **"Childless adults"** who do not meet the eligibility requirements of MaineCare, but who are childless adults or non-custodial parents and are at or below 100 percent of the FPL.

    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 26 and who are receiving the services subject to the budget neutrality cap, provided by DSH funds). 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 from "Childless Adults" that are collected by the State from "Childless Adults" under the Demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet line 9.D, columns A and B. Additionally, the total amounts that are attributable to the Demonstration must be separately reported on the CMS-64Narr by Demonstration year.

    e) Administrative costs will not be included in the budget neutrality limit, but the State must separately track and report additional administrative costs that are directly

attributable to the Demonstration. All administrative costs will be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver.

f) All claims for expenditures subject to the budget neutrality cap (including any costsettlements) 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 cap:

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 Population described below:

- **"Childless Adults"** who do not meet the eligibility requirements of MaineCare, but who are childless adults or non-custodial parents and are at or below 100 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 operational report required under paragraph 22, the actual number of eligible member months for the Demonstration Population defined in paragraph 27 (b). The State must submit a statement accompanying the quarterly operational 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. 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.

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 X:

    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 Childless Adults 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 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.

31. **State Certification of Public Expenditures.** Nothing in these STCs concerning certification of public expenditures relieves the State of its responsibility to comply with Federal laws and regulations, and to ensure that claims for Federal funding are consistent with all applicable requirements. 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.

X. Monitoring Budget Neutrality for the MaineCare Childless Adults Demonstration

33. **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 Childless Adults Demonstration. For the purposes of this demonstration, Maine has imposed a cap of $80.3 million total computable per year in the use of available DSH funds. Maine is capping enrollment at 20,000.

34. **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.

35. **How the Limit will be Applied.** The limit calculated above will apply to actual expenditures for the Demonstration on an annual basis, as reported by the State under section VIII. If at the end of any demonstration year, including the approval period ending demonstration year 5, the budget neutrality provision has been exceeded, the excess Federal funds will be returned to CMS. There will be no new limit placed on the FFP that the State can claim for expenditures for recipients and program categories not listed. If the demonstration is terminated prior to the 3-year period, the budget neutrality test will be based on the time period through the termination date.

    The population under this budget neutrality agreement is childless adults and non-custodial parents up to or equal to 100 percent of the FPL:

    a) For each year of the budget neutrality agreement an annual limit is calculated for the "Childless Adults"

    b) The "Childless Adults" estimate will be based on available DSH funds.

    c) Budget neutrality limit for "Childless Adults" will be assessed on an annual basis and is limited to an amount that, when added to total DSH payments under the plan, does not exceed the allowable aggregate DSH allotment for the State under the Federal statute (calculated with the Federal and State shares) for *each* of the years of the demonstration. The State must continue to comply with the hospital specific limits as provided in OBRA 1993 for DSH payments under the plan; for purposes of these hospital specific limits, individuals eligible only under the demonstration shall be considered "eligible for medical assistance under the State plan."

    d) For the purpose of monitoring budget neutrality, within 60 days of the end of each quarter and within 90

    e) days of the end of each waiver year, the State will provide a report to CMS, in the format provided by CMS, identifying the State's actual enrollment and corresponding actual expenditures for "Childless Adults".

36. **Enforcement of Budget Neutrality.** CMS will enforce budget neutrality on an annual basis. If Maine exceeds the budget neutrality limit of $80.3 million total computable on any given demonstration year, Maine must submit a corrective action plan to CMS for approval and will be subject to the return of FFP for expenditures over the annual cap.

XI. EVALUATION OF THE DEMONSTRATION

37. **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 CMS's approval of the Demonstration extension. 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.

38. **Final Evaluation Design and Implementation.** CMS must provide comments on the draft evaluation design within 60 days of receipt, and the State shall submit a final design within 60 days after 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.

39. **Cooperation with Federal Evaluators.** Should CMS undertake 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.

XI. SCHEDULE OF STATE DELIVERABLES FOR THE DEMONSTRATION EXTENSION PERIOD

	Deliverable	STC Reference
Annually (by February 1st)	Draft Annual Report	Section VIII, paragraph 24
Quarterly	Quarterly Operational Reports	Section VII, paragraph 22
	CMS-64 Reports	Section VIII, paragraph 25
7/1/2012	Initial Transition Plan	Section VIII, paragraph 23

ATTACHMENT A
QUARTERLY REPORT CONTENT AND FORMAT

Under Section VII, paragraph 23, 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.

NARRATIVE REPORT FORMAT:

Title Line One – MaineCare for Childless Adults Demonstration

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:
Example:
Demonstration Year: 6 (10/1/2010 – 9/30/2011)
Federal Fiscal Quarter: 1/2008 (10/1/10 - 12/31/10)

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

Enrollment Information

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

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

Demonstration Populations (as hard coded in the CMS 64)	**Current "childless adults"** (to date)	**Disenrolled in Current Quarter**
"Childless adults": Demonstration "Childless adults"		

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.

Consumer Issues
A summary of the types of complaints or problems consumers possibly 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