NATIONAL ORGANIZATIONS RESPONDING TO AIDS

March 3, 1999

Nancy-Ann Min DeParle, Administrator
Health Care Financing Administration
200 Independence Avenue, SW
Room 314-G
Washington, DC 20201

Dear Ms. DeParle,

On behalf of the National Organizations Responding to AIDS (NORA), we are writing to urge that you approve Maine's request for a Medicaid 1115 waiver to grant life-extending therapies to low-income state residents infected with HIV. We also wish to reiterate our support for a nationwide Medicaid expansion for low-income persons with asymptomatic HIV. NORA is a coalition of over 175 health, labor, religious and professional advocacy groups that represent a broad consensus on HIV and AIDS-related issues policy, and funding levels.

The Maine waiver would provide coverage for life saving medications, office visits, laboratory tests, case management services and hospitalizations. It would give low-income persons with HIV access to highly active retroviral therapy (HAART) which is proven to be both a medically appropriate and cost effective treatment. For example, a cost-benefit analysis from a New England hospital, presented at the 12th World AIDS Conference in Geneva, found that during the period of introduction and availability of HAART, "the total number of patients increased, [but] overall costs remained level and cost per patient per year decreased." Further, Maine's expansion proposes treatment that is consistent with the HIV treatment guidelines issued by the Department of Health and Human Services (HHS) recommending the use of antiretroviral therapy early in the course of HIV infection, before the manifestation of symptoms. Since Medicaid eligibility requirements are incompatible with these clinical guidelines, the Maine waiver will take important steps to bring as many people as possible under the HHS guidelines.

We believe that both the health benefits and cost-effectiveness of early intervention, such as would be provided through the Maine waiver, are convincing arguments that support approval of the Maine waiver as being in the best interest of the government and its people. Therefore, we urge you to support this waiver to expand Medicaid to low-income people with HIV.

Sincerely,

Advocates For Youth

NORA
A coalition convened by AIDS Action Council
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Suite 700
Washington, DC 20009
202 986 1300
202 986 1345 fax

AIDS Action
AIDS Legal Referral Panel
AIDS Nutrition Services Alliance
AIDS Policy Center for Children, Youth and Families
American Foundation for AIDS Research
American Medical Student Association
American Public Health Association
American Public Hospital Association
American Social Health Association
Association of Nurses in AIDS Care
Center for Women Policy Studies
Committee for Children
Gay Men's Health Crisis
HIV Managed Care Network
Human Rights Campaign
Mothers' Voices
National Association of People with AIDS
National Association of People with AIDS
National Association of Protection and Advocacy Systems
National Association of Public Hospitals & Health Systems
National Catholic AIDS Network
National Health Care For the Homeless Council
Northern Counties Health Care, Inc.
Project Inform
The National Latina/o Lesbian, Gay, Bisexual & Transgender Organization
Title II Community AIDS National Network

Cc:
The Honorable Donna Shalala
Chris Jennings
John Podesta
Kevin Thurm
David Beier
Sandra L. Thurman

Internal Comments

1) Our budget neutrality principles dictate that we set a cap for Federal expenditures for the waiver program. It does not appear that the state's model would set an expenditure *limit* based on the state's likely Medicaid spending in absence of the waiver program.

2) We will require additional historical data from Maine to establish the state's spending history and trends for the HIV and AIDS population in Medicaid.

3) We are concerned that the state's ability to make this demonstration budget neutral is based on three unsubstantiated assumptions that overstate the cost of the non-waiver program and understate the expense of the waiver treatment:

a. Questionable assumptions about the precondition of the waiver expansion population upon entering the waiver program. We would expect that as the waiver matures, the proportion of newly diagnosed "asymptomatic" entrants will be higher than the state assumes. These individuals will receive Medicaid services under the waiver at a significant cost to the state, but would not have become ill enough in absence of the waiver to qualify for Medicaid so their costs cannot be included in the without-waiver baseline.

b. Understated assumptions about the access to therapy (pre-treatment) of the waiver expansion population upon entering the waiver program. It appears that the state assumes that none of its current asymptomatic non-Medicaid HIV population would have access to therapies that would slow the progression of the disease -- such as Ryan White of private insurance. This assumption would overstate the anticipated costs to Medicaid in absence of the waiver.

c. Optimistic assumptions about the ability of the waiver program to slow the rate of progression of the disease once the expansion population receives waiver treatment. Maine's cost model is *very sensitive* to its assumptions about the probability the treatment will slow the progression of HIV to a costlier state. We do not know at this time whether Maine's assumptions can be supported by scientific findings, or state experience.

From our initial review, it appears that the assumptions are overly optimistic in projecting the success of the specific treatments offered in the waiver program, versus its existing Medicaid program. For example, Maine assumes 100% beneficiary compliance with treatment program in the waiver -- which is not supported with the state's experience in its Medicaid program or HIV literature.

Specific Questions for the State

1) On page 8 of the application, the total cost of providing drugs and services to Medicaid eligibles with HIV do not appear to be based on actual per member per month spending in Maine of HIV+ and individuals with AIDS. These actual costs should be available for the Medicaid population, based on the state's explanation of its database on page 4.

Please provide the state's historical per member, per month costs (total spending/total clients identified as HIV+/AIDS) for the categories of ASXHIV, SXHIV, and AIDS. Please provide the data broken down for the costs of services and drugs for 1996 and 1997 and earlier years, if possible. If possible, please also provide this data for those who become eligible for Medicaid by meeting the SSI level of disability.

2) For the without-waiver probability of rates of disease progression, can Maine document its assumptions with historical data from its Medicaid experience? If not, how did the state determine the rates of disease progression in the without-waiver scenario?

3) Please provide a detailed explanation of the assumptions used to develop the probabilities for the slower rate of disease progression in the waiver program (ie Maine database, scientific literature).

4) Please elaborate on the assumptions made in creating the mythical cohort. In doing so, please respond to the following:

a. How did the state establish the probability of the various states of health of the individuals in the cohort?

b. The state assumes a certain percentage of the cohort will have access to Medicaid at various stages of the disease. How were these assumptions derived?

c. What assumptions were made about the cohort's access to private insurance, Ryan White, out of pocket, and state-only treatments that would slow the progression of the disease?

5) What are the state's assumptions about the state of health of the expansion

population when the population enters the waiver? Did the state consider the change in distribution of the health of the entrants as the waiver progresses? (As the demonstration progresses, we would expect that new entrants into the demonstration are more likely to be newly diagnosed asymptomatic patients than the cohort who enters the demonstration at the onset.)

6) What is the state's estimate of how many individuals are HIV + or living with AIDS in the state? What percentage is currently on Medicaid? Of those with the disease on Medicaid, please provide the percentage of those who are asymptomatic, symptomatic, and those with AIDS.

7) How many individuals does the state believe will access the demonstration?
8) Can the state produce a mythical cohort of comprised entirely of the expansion population that they expect will access the waiver program. In doing this, the state should provide its assumptions about the health of the expansion population, the progression of the disease, and the cost under the waiver and non-waiver scenarios through the five year waiver period.

HEALTH CARE FINANCING ADMINISTRATION
CENTER FOR MEDICAID AND STATE OPERATIONS
Disabled and Elderly Health Programs Group
7500 Security Boulevard, Mail Stop S2-14-26
Baltimore, Maryland 21244-1850

WAYNE SMITH
ACTING DEPUTY DIRECTOR
(410)786-6762
E-mail - wsmith@hcfa.gov

February 19, 1999

Kevin Concannon
Commissioner
State of Maine
Department of Human Services
11 State House Station
Augusta, Maine 04333-0011

Dear Mr. Concannon:

We are pleased to have received Maine's proposal for an HIV/AIDS demonstration project. You have requested waivers under the authority of section 1115 of the Social Security Act to expand Medicaid eligibility to individuals with HIV in order to provide them with a limited set of Medicaid services, with the intent of slowing the progression of the disease and improving individuals' quality of life. The proposal has been distributed throughout the Department of Health and Human Services for review. The purpose of this letter is to transmit to you questions for clarification resulting from that review (see enclosure). While the number and scope of our technical questions may seem extensive, questions of such breardth are not uncommon in the 1115 process, especially given the brevity of the State's submission. Moreover, due to the complexity of the issues before us, we beieve that a careful and through review is requiered.

We want to continue to work closely with you on this critical project. After you have had the opportunity to review the enclosure, I hope that we will be able to have a teleconference in order to discuss the questions. As I said, these are complicated issues, and I want to help make sure that there are no misunderstandings as to the meaning of the questions. Further, we would also like to offer you the opportunity to discuss verbally your answers prior to submission. In other 1115 projects, we have found it useful to talk through answers prior to their formal submission to HCFA. I scincerly hope that you will take advantage of this offer.

As we are committed to processing your demonstration waiver request in an expedited manner, we would appreciate a response to these questions by April 9, 1999. If you do not feel that you can complete your response by this date, please let us know your anticipated completion date. We would welcome the opportunity to meet with you to discuss your response once it has been completed and formally submitted.

Once we receive your response to our questions, the additional information provided may generate further questions, particularly in the area of budget neutrality. Although we recognize that this process can be cumbersome, we are committed to working with you to resolve our technical issues in a timely manner. We are currently working internally to develop viable options in setting a budget neutrality cap that we can refine and share with you once we have had a chance to review the additional information you provide in your response. This should be considered the first step in continuing negotiations; however, we will do our best to move forward quickly through the negotiation process.

If you or your staff have any questions, please feel free to contact the project officer, Laura Gange, on (410) 786-3395. We look forward to working with you on this demonstration and will await your response.

Sincerely,

Wayne Smith

Enclosure

cc
S. Richardson
R. Block
Maine Review Team

DRAFT
Maine Section 1115 HIV/AIDS Demonstration
Questions for Clarication

~~**I. Rationale for Waiver**~~

1. ~~In preparing this proposal, you explained that distinct advantages exist for HCFA to approve this demonstration in the State of Maine.~~ As part of all 1115 demonstrations, States are requiered to proved detailed data regarding the impact of the waiver. ~~Therefore,~~ Please describe in detail your data gathering capability and your ability to coordinate services, ~~and how a vitally important proposal such as this one would yield better results if approved in a State such as Maine.~~ [Moved to last section.]

2. Page 1 of the proposal states "most health insurers do not fully cover HIV/AIDS disease and its essential package of services, most notably antiretroviral drugs". Please provide us with any avaliable information that describes the insurance situation in Maine regarding this issue. ~~This broad statement is not sufficiently substantiated. Is there an empirical basis for the claim? What proportion of Maine health plans do not provide coverage for antiretroviral therapies, and how many individuals are affected by this shortfall? To what extent have you addressed this problem through health insurance market reform efforts, either by regulation or statute, for those plans that come under your jurisdiction?~~ [Moved to last section.]

3. Page 1 of the proposal also describes a situation in which people with AIDS become eligible for Medicaid; their health status improves as a result of drug therapy; and then their Medicaid eligibility is terminated because their health has improved (and presumably they are no longer classified as disabled). Please provide any available data indicating that this is happening in Maine's Medicaid program. ~~This statement leaves the impression that the situation (as described) is widespread or occurs frequently, and yet we have little or no evidence to suggest that this is indeed the case. Does this scenario characterize what is going on in your Medicaid program, or does it simply highlight this possibility, which has been at least a theoretical concern among many providers and patient advocates?~~ [Moved to eligibility section.]

~~4. Title II of the Ryan White CARE Act provides formula grants to states for funding health care and support services for persons living with HIV disease. This includes funds for the AIDS Drug Assistance Program (ADAP). The Maine 1115 proposal would make a significant shift in the funding stream for antiretroviral therapies for HIV disease from the discretionary program under title II of the Ryan White CARE Act to the mandatory Medicaid program. Why is Maine proposing this shift? What options have been considered for increasing state effort through ADAP?~~

II. Requested Waivers

1. In item (a) on page 2, you have requested a waiver of section 1902(a)(10)(A) of the

Social Security Act (the Act) to permit individuals with income up to 300% of the Federal poverty level to access services under the demonstration. A waiver of this provision would not provide any affirmative authority to provide Medicaid coverage to otherwise ineligible individuals. This requested expansion of eligibility must be accomplished under the authority of section 1115(a)(2) of the Act, which permits the Secretary to regard as Federally-matchable those expenditures which "would not otherwise be included as [matchable] expenditures under . . . section 1903." Please revise your waiver request accordingly.

2. ~~In items (b) and (c) o~~On page 2, you have requested to waive certain provisions of title 16, specifically section 1613 and 1614 of the Act, concerning the State's disability regulations and resource limit regulations under the Supplemental Security Income program. There is no authority to waive these provisions. (Note--The references to title 16 in section 1115 do not refer to title 16, the SSI program; rather, they refer to the former title 16 state plan program, which now only applies to Guam, Puerto Rico and the U.S. Virgin Islands.) Again, if you wish to extend Medicaid benefits to otherwise ineligible individuals, you will have to use the section 1115(a)(2) authority. To get a fuller understanding of what you are planning to achieve in this demonstration and ensure that you have requested all of the necessary waivers, please explain why you believed you needed these waivers and what you hoped to accomplish.

3. In item (d) on page 2, you have requested a waiver of the amount, duration, and scope requirements in section 1902(a)(10)(B) of the Act ~~You state that you are requested this waiver~~ in order to offer a limited benefit package to waiver recipients~~, "thereby precluding the future use of the full range of Medicaid services"~~. Please provide further clarification for this statement. If an individual is enrolled in the demonstration later become eligible under the standard Medicaid program, will this person then have access to all Medicaid services? ~~Are you implying that individuals who enroll in the demonstration will be expected not to access the full range of Medicaid services if they later become eligible for Medicaid? Please clarify your intent.~~

4. In item (f) on page 2, you have requested a waiver of the residency regulations in section 1902(b) of the Act to impose an eighteen-month residency requirement for all demonstration eligibles. We are concerned that HCFA may not have the discreation to permit a durational residency requierment. Has the State considered any other eligibility requierements that would have a similar impact as this requierment in the event that the durational eliligibility requierment cannot be implemented? ~~Our Office of General Counsel has determined that this durational residency requirement is unconstitutional, as it would violate equal protection of the law and an individual's right to interstate travel. Please amend your proposal to remove this waiver request and all references to the eighteen-month residency requirement as a condition of eligibility.~~

III. Eligibility and Enrollment

1. As part of the evaluation process, we would like ~~need~~ to have a better understanding of the size and character population now being served by Medicaid; and more specificlly, the HIV/AIDS population being served by Maine's Medicaid program. ~~and the projected demonstration population. The proposal should provide descriptive information about the current (and projected) size and character of the target population (i.e., people living with HIV/AIDS) for this demonstration project, as well as the population of people with HIV/AIDS now being served by the your Medicaid program.~~ As part of your response; please provide ~~this additional information and include at least~~ the following:

- Estimated number of people living with AIDS in Maine (and the proportion of these individuals that currently rely on Medicaid);
- Estimated number of people living with HIV (symptomatic and asymtomatic);
- Demographic characteristics of the HIV/AIDS population (e.g., gender, race/ethnicity, age, exposure category/risk behavior);
- Information regarding ~~general characterization of~~ the socioeconomic status of people with HIV/AIDS who are not currently Medicaid eligible
- Information regarding the insurance profile of people with HIV/AIDS who are not currently Medicaid eligible; and
- Percentage of individulas who are Ryan White CARE Act recipients.

2. In order to help understand the demonstration better, we would like to learn more about poulation that will be enrolled in the waiver. Please provide the following information regarding the size and character of the target population. Please note that these questions relate to the characteristics of the population proior to enrollment. In your response, please respond to the following. ~~It is unclear from the current proposal whether you have assumed that individuals who would be eligible to participate in the demonstration are presently~~

- Insurance status prior to enrollment (e.g. uninsured or inadequately insured);
- For those who were insured, percentage in rolled in public (Veteran's Administration, Medicare) versus priviate insurance;
- Whether individuals currently have access to appropriate care; and ~~have gaps in coverage, or lack access to care altogether. Have you documented gaps in this current HIV services delivery system that have produced unmet needs?~~
- Percentage of the target population who are Ryan White CARE Act recipients.

4. What is the expected enrollment level of the demonstration?

5. How will enrollment fluctuate over time? Are new entrants allowed to enroll in the demonstration once the initial population has been selected and enrolled? Is it the State's intention to ~~Have you considered~~ enroll~~ing~~ a single, initial cohort and following this cohort through the demonstration?

3. It is not clear whether individuals who are currently eligible for Medicaid will be enrolled in the demonstration. Page 1 implies that participants will be disenrolled from the waiver if they become Medicaid eligible, yet page 8 refers to individuals "on Medicaid

under the waiver". Please clarify your intent and amend the proposal as necessary.

~~4. Why did you decide not to use a resource spenddown?~~

5. On page 4, under the first bullet in number 3, ~~it does not appear that you~~ the State assumes ~~presumption~~ that all persons who "...contract AIDS will become Medicaid eligible" ~~is correct~~. However, some persons may ~~have~~ receive income ~~benefits being paid to them in an amount~~ that would exceed Medicaid allowable income levels. ~~never permit them to meet the income test for Medicaid.~~ Given this possibility, please provide the basis for this assumption. ~~explain and revise as necessary.~~

~~6. It appears that the waiver application focuses on providing access to treatments for HIV-infected persons prior to an AIDS diagnosis and not eligible for Medicaid. Does the demonstration cover persons with AIDS who do not qualify for Medicaid due to income eligibility standards but who would qualify under the <%300 FPL cap?~~

7. One page one, the State describes one of the eligibility criteria as, "they [the enrollees] agree to comply fully with the course of treatment prescribed...". Full (100%) compliance with optimal drug therapy is also assumed in the cost model. However, it is well documented that even the most conscientious of HIV patients who are committed to their treatment regimen sometimes have difficulty with complete adherence. Will individuals who fail to "comply fully" with the treatment be disenrolled from the program? In not, please describe what is meant by this eligibility criteria. If indivudals will be disenrolled for failure to comply, please respond to the following. ~~Is this a realistic criterion for eligibility?~~

- How will compliance be defined?
- How do you plan to assess a patient's willingness and ability to adhere to the prescribed HIV treatment regimen as a condition of eligibility?
- How will certain ~~Is there any room for~~ extenuating circumstances (such as drug use, homelessness, etc.) be accounted for?
- Will enrollees who experience ~~HAART~~ treatment failure or substantial ~~significant~~ side-effects which cause them to discontinue ~~HAART~~ treatment be disenrolled?
- Once an individual is enrolled in the demonstration, how will providers then foster and measure patient adherence?
- Is there a potential for coercion or other negative consequences of this requirement?

~~8. What is the expected, estimated enrollment for this demonstration? Please break out the number of HIV-infected individuals expected to enroll, as well as how many of these individuals are existing Ryan White CARE Act recipients.~~ [Moved and combined with 2 or 10]

9. What steps are you planning to take to provide notice of the demonstration's availability to the HIV/AIDS population? ~~How will you recruit and enroll eligible persons into the demonstration program?~~ As part of your response, please provide a complete outreach plan.

~~10. Are new entrants allowed to enroll in the demonstration once the initial population has been selected and enrolled? Have you considered enrolling a single, initial cohort and following this cohort through the demonstration?~~ [Altered andmoved to Q3.]

11. Page 1 of the proposal also describes a situation in which people with AIDS become eligible for Medicaid; their health status improves as a result of drug therapy; and then their Medicaid eligibility is terminated because their health has improved (and presumably they are no longer classified as disabled).–Please provide any available data indicating that this is happening in Maine's Medicaid program.

IV. Premium Structure

1. For individuals on the waiver, it appears that there is a different premium structure for each stage of the illness. Since the amount of the premium may vary depending on the individual's condition, please identify the period of liability for the different premium charges. What would the amount of the premium be for each stage of the illness as you have defined it? What happens if an individual does not pay the premium? Did you consider other factors (e.g., family size) in calculating the premiums? ~~other than income (e.g., family size)?~~

2. It is our understanding that the premiums you propose will be monthly. If this understanding is correct, please amend Appendix B, Tables 9 and 10, to clarify this.

3. The text at the top of page 2 indicates that the premiums are adjusted by income and disease status. Although the titles of the columns in Table 9, i.e., "Blended Premium" also infer this, the table does not appear to reflect an adjustment in premium based on disease status. Neither does the list of premiums on page 6. On page 8, the last paragraph of the text states, "the premium is reduced as the stage of the illness worsens." This would seem to be the inverse of what should be happening if income remains constant. Please clarify.

4. In Table 10, we noted that the amounts in the three columns labeled "blended premium Asx, blended premium symptomatic HIV, and blended premium AIDS" do not add up to the amount in the "premium" column. Please explain the methodology you used to arrive at the amount in the "premium" column.

V. Benefit Package

1. You are proposing to offer a benefit package consisting of (a) highly active antiretroviral therapy (HAART); (b) other medications covered by Medicaid; (c) office visits; (d) laboratory services; (e) case management services; and (f) hospitalizations. Please provide further detail describing what is included in each of these service categories. In your description, please specifically address the following:

- What is included under office visits? For example, is a visit with a nurse covered for purposes of patient education and ~~drug~~ treatment adherence interventions? Is a

mental health provider covered? Is the office visit restricted to an ambulatory setting or does it include hospital-based outpatient program (e.g., Maine Medical Center's AIDS consultation services)?

- ~~Why does this demonstration include other drugs covered by Medicaid and office visits, but not home health and other services that may be needed?~~ Are office visits and drugs only available for HIV/AIDS-related health concerns? If so, then how will it be determined whether or not an illness or condition is related to the person's HIV status and therefore if it is a covered condition?

- How do you propose to ensure that individuals enrolled in the demonstration receive needed services if those services are not included in the demonstration's benefit package?

- ~~Are outpatient hospital services covered? Current literature indicates that as inpatient hospital costs decrease for persons with HIV disease that outpatient costs increase.~~

- What laboratory tests are included in the benefit package? Will the tests only include those for monitoring the progression of HIV or will it also include other diagnostic tests for related conditions, such as sexually transmitted diseases or cancer?

- ~~What is the definition of~~ Please describe what services constitute "case management services?" On page 4, the listed services include "case management/social services:~~?~~ does this include outreach, transportation and services to promote treatment adherence ~~adherence treatment services~~?

- Is prevention counseling covered under any of the services categories? People with HIV need to be counseled about practicing safe sex and not sharing needles in order to protect others and to protect themselves from other diseases which could be difficult to treat and could complicate the management of their HIV infection. Some sexually transmitted diseases, such as cytomegalovirus and herpes simplex virus ~~CMV and HSV~~, act as opportunistic infections. Others STDS make it more likely that they will transmit HIV to others. Finally, persons with HIV should avoid acquiring other HIV strains which could be drug resistant and complicate their medical management. ~~Prevention counseling is generally regarded as an intervention to protect the public; however, it is equally important as an intervention to protect the HIV-infected person. Compromising the management of HIV infection can increase the overall costs of treating HIV infection.~~

~~2. HAART is still a relatively new mode of therapy, and clinicians continue to identify complications from treatment that require a range of ancillary medical services. Mental~~

~~health and substance abuse services are essential for addressing some of the most common issues that interfere with patient compliance to a HAART regimen. While you propose to require that beneficiaries fully comply with their plans of care, how will you ensure that they also have access to critical services that may be necessary to support compliance?~~

~~32.~~ ~~Service limitations on the benefits package appears incongruous with the emerging needs of the newly diagnosed AIDS cases, especially the lack of coverage for mental health and substance abuse services.~~ The proposed benefit package appears not to cover mental health and substance abuse services. Given that such services can be important for improving patient adherence to a HAART regimen, if such services are needed by waiver recipients, ~~H~~how do you propose to provide access to these services to waiver recipients? ~~Do you intend to create linkages with existing service delivery programs? For example, are such service linkages established with the newly Ryan White funded Title III EIS program in the Portland Public Health Division? Are linkages available with the local community mental health centers? What would be the cost implications of including these services as part of the limited Medicaid coverage package?~~

~~43.~~ In the event that some waiver recipients have private insurance coverage, please explain ~~H~~how might the waiver benefit package wrap around someone's private insurance? ~~The proposal does not address how you intend to deal with individuals with partial service coverage other than including a line item in the actuarial parameters. Have you considered potential crowd out?~~

VI. Service Delivery System/Provider Network

1. ~~The proposal provides no information about~~ Please describe the current HIV/AIDS services delivery system in the State and the patients it serves. What is the general configuration of Ryan White-supported providers (e.g., types of providers, services offered) as well as the AIDS Drug Assistance Program, and the characteristics of the clients they serve? Where do low-income people with HIV/AIDS who do not qualify for Medicaid currently receive their care? ~~Since it is likely that many of these individuals will constitute the waiver population, it is important to understand where and how they may receive care.~~

2. Please describe the provider network that typically serves people with HIV/AIDS who are covered by Medicaid. Will the existing Medicaid provider network, however configured, be adequate to serve the expanded patient population?

3. On page 1, the proposal refers to an "assigned waiver program provider." Would this be a primary care provider? What is the anticipated array of participating providers (e.g., their qualifications, training requirements, expertise, types of services offered)? How will the State assure that participating providers have experience in treating HIV disease and managing the complex treatment regimen required?

4. Please describe the criteria for identifying and assigning HIV-experienced providers to

beneficiaries.

5. How will participating providers be reimbursed? How will you identify and contract with providers of other services (e.g., specialists, laboratory, hospitals)?

~~6. What mechanisms will be available to enrollees who disagree with the clinical regiment recommended by a program providers~~?

~~7. What happens if a person is already receiving care from a Ryan White provider?~~

~~8. How does the State propose to address situations in which a beneficiary's current primary care physician is not part of the demonstration's provider pool?~~

6. How will the waiver program providers coordinate with existing Ryan White providers? Will Ryan White providers be included among the pool of waiver program providers? If a person is currently receiving care from a Ryan White provider, how will continuity of care be assured when this person enrolls in the waiver?

~~9. How does the State propose to ensure geographic accessibility?~~

~~10~~7. Are there any reasons to be concerned with the potential disruption in care for persons on the waiver program who eventually qualify for full Medicaid coverage? ~~For example, are HIV infected persons subjected to mandatory enrollment in a Medicaid managed care program as part of the regular Medicaid program and not in the expansion program? Does the state have a mandatory managed care policy for HIV under Medicaid? If so, how are Ryan White providers integrated in such a program?~~ [Note to reviewers: the HCFA Regional Office should know the answer to questions about the State's Medicaid managed care program]

8. What is the proposed structure of the provider network that will be participating in the demonstration? Will the network be fee-for-service or manage care? If the network will be managed care, to what extent enrollment be mandatory and to what extent will demonstration enrollees have a choice of healths plans?

VII. Cost Model/Budget Neutrality

1. On page 8 of the application, the total cost of providing drugs and services to people with HIV who are Medicaid eligibles ~~with HIV~~ do not appear to be based on actual per member per month spending in Maine for people with HIV and AIDS ~~of HIV+ and individuals with AIDS~~. ~~These~~ We would expect these actual costs data should be available for the Medicaid population, based on the state's explanation of its database on page four. Please provide historical per member, per month costs (total spending/total clients identified as HIV+/AIDS) for the categories of asymptomatic HIV, symptomatic HIV, and AIDS. Please provide data for both 1996 and 1997 that separately shows the costs for services and drugs. ~~the data~~

~~broken down for the costs of services and drugs for 1996 and 1997~~. If possible, please also provide this data by eligibility category such that ~~for~~ those who become eligible for Medicaid by meeting the SSI level of disability are clearly distinguished.

2. For the "without-waiver" probability of rates of disease progression, can you explain ~~document~~ your assumptions with historical data from your Medicaid experience? If not, how did you determine the rates of disease progression in the "without-waiver" scenario?

3. You refer to using data from current literature and the clinical experience of Maine physicians in developing your assumptions for the transitional probability model. Please provide further information on these data sources (e.g., current literature citations, reports of Maine clinical experience) and any other data sources that were used in developing your assumptions. Please provide a detailed explanation of the assumptions used to develop the probabilities for the slower rate of progression in the waiver program.

4. Please elaborate on the assumptions made in creating the hypothetical cohort. In doing so, please respond to the following questions:

a. How did you establish the probability of the various states of health of the individuals in the cohort?

b. You have assumed that a certain percentage of the cohort will have access to Medicaid at various stages of the disease. How were these assumptions derived?

c. What assumptions were made about the cohort's access to private insurance, the Ryan White program, ~~out of pocket~~, and state-funded ~~only~~ treatments that might ~~would~~ slow the progression of the disease?

5. How did you arrive at your assumptions regarding the costs of care for asymptomatic HIV and symptomatic HIV individuals? ~~The costs that you are showing for asymptomatic HIV and symptomatic HIV appear to be roughly 50% higher than what we are seeing from other sources. Could you explain why your costs are higher?~~

, model shows only a $100 cost difference for non-drug treatment between .c HIV category and the AIDS category. Why is there so little difference in oetween these two groups?

7. .re no It appears as if the model assumes that no new individuals with AIDS beyond those who would be on Medicaid anyway would ~~assumed to~~ enroll in the demonstration? If this is accurate, what is the basis for this assumption?

~~8. Please explain your assumption that a higher percentage of individuals with symptomatic~~

~~HIV will be eligible for Medicaid than those with asymptomatic HIV.~~

~~98. Please explain why~~ Your cost model appears to assumes that no one currently enrolled in Medicaid~~, including those who would otherwise be on Medicaid,~~ is receiving HAART. ~~without the waiver~~? If this is accurate, what is the basis for this assumption?

~~109.~~ ~~What evidence exists~~ How did you arrive at the assumption that persons living with AIDS will constitute 20% of the waiver population?

~~11. What are your assumptions about the state of health of the expansion population when the population enters the demonstration? Did you consider the change in distribution of the health of the entrants as the demonstration progresses, if new entrants are allowed to participate? (As the demonstration progresses, we would expect that new entrants into the demonstration are more likely to be newly diagnosed asymptomatic patients than the cohort who enters the demonstration at the onset.)~~ [Same as question 4 of this section]

~~12. What is your estimate of how many individuals are HIV+ or living with AIDS in Maine? What percentage is currently on Medicaid? Of those with the disease on Medicaid, please provide the percentage of those who are asymptomatic, symptomatic, and those with AIDS.~~ [Already asked on page 4 under eligibility and enrollment section]

~~13. Can you produce a hypothetical cohort comprised entirely of the expansion population that you expect will access the demonstration program? In doing this, please provide your assumptions about the health of the expansion population, the progression of the disease, and the cost under the waiver and non-waiver scenarios through the five year waiver period.~~

~~14~~10. It appears from your waiver submission that you have begun counting waiver costs in the second semi-annual period. Just as a baby's first year begins at age 0 (and not age 1), the waiver costs for the first period start at point 0 and not point 1. By calculating the cost at point 1 instead of point 0, the model is, in effect, using the 2nd through 11th semi-annual periods instead of the first 10 semi-annual periods, 1-10. Please check your calculations and provide any necessary corrections. ~~recalculate the model correctly.~~

~~15~~11. How are the costs for dual eligibles entitled to both Medicare and Medicaid being handled in the cost model?

~~16. Since the cost model assumes "100% compliance with optimal drug therapy", please explain how optimal drug therapy was defined. Why does the model not reflect the likelihood that some enrollees will not be able to remain on HAART? What adjustment will be made for new therapies and new sets of combination therapies?~~ [already asked in Q.7 on page 5]

~~17~~12. Page 10 contains an error in the "non-waiver cost" column. The total of the three

numbers add up to $10,239,588, not $10,207,907 as reported. Please verify the correctness of these figures, and revise as necessary.

~~18~~13. Please provide a narrative explaining Table 4 on page 8.

~~19~~14. Please define "residential care" and "miscellaneous" categories of service in Table 1 on page 3. Where do these services fit in Appendix C, pages C-1 and C-2?

VIII. Miscellaneous

1. Public involvement is a critical part of any 1115 demonstration project. In your cover letter, you indicated that members of the community (e.g., providers, advocates, consumers) were involved in the development of this demonstration proposal. Please describe the groups that have been participating and what their involvement has been. Are they supportive of the proposal?

~~2. Will a proposal such as this one be adaptable to the rapidly shifting pace of medical technology?~~

~~32. We are unaware of any discussions between~~ the How will the Portland Public Health Division (new Title III recipient) and the State Medicaid agency coordinate their activities under the demonstration project? Have any such discussions occurred, or are any anticipated? ~~How will these two programs work together?~~

~~4~~3. Assuring that enrollees are receiving quality care will obviously be of utmost importance, especially given the focus on HAART therapy. The proposal at this point does not address the development of quality assurance. What clinical standards will be used to assess quality (e.g., PHS guidelines for the use of antiretroviral therapies)? How will these standards be disseminated to providers? Will training be available?

~~5~~4. Does the State intend to complete a civil rights assurance affirming that it will comply with all applicable Federal civil rights laws (such as Title VI of the Civil Rights Act of 1964; Section 504 of the Rehabilitation Act of 1973; the Americans with Disabilities Act of 1990, etc.) in the conduct of its program?

~~6~~5. On page 6, what is meant by "pharmaceutical participation"?. Do you intend to obtain discounts from pharmaceutical companies for the drugs covered by the demonstration program? If so, will this discount be applied across the board or only to those enrolled in the demonstration? ~~Are agreements already in place with pharmaceutical companies to provide discounts? Will these be in addition to the drug rebate program?~~

~~7~~6. ~~The~~ Please explain how the third party liability statistics shown on page 6 were derived?. ~~Please explain how these were derived.~~

~~8. Have you considered what would happen if the waiver does not demonstrate budget neutrality and is halted after five years? What provisions would be made to assume the costs of maintaining these persons on drugs? Would the Ryan White program be expected to reassume financial responsibility for these individuals?~~

9. As part of all 1115 demonstrations, States are requiered to proved detailed data regarding the impact of the waiver. Please describe in detail your data gathering capability and your ability to coordinate services.

10. Page 1 of the proposal states "most health insurers do not fully cover HIV/AIDS disease and its essential package of services, most notably antiretroviral drugs". Please provide us with any avaliable information that describes the insurance situation in Maine regarding this issue.

HEALTH CARE FINANCING ADMINISTRATION
CENTER FOR MEDICAID AND STATE OPERATIONS
Disabled and Elderly Health Programs Group
Division of Integrated Health Systems
7500 Security Boulevard, Mail Stop S2-14-26
Baltimore, Maryland 21244-1850

WAYNE SMITH
DIRECTOR
(410)786-6762
E-mail - wsmith@hcfa.gov

DATE: November 12, 1998

FROM: Wayne Smith, Director Wayne Smith /pc

SUBJECT: Maine's 1115 HIV/AIDS Demonstration Waiver Request--ACTION

TO: See Below

The State of Maine has submitted to the Health Care Financing Administration (HCFA) a request for Section 1115 demonstration waivers to implement a health care demonstration model for persons with HIV/AIDS. The Project Officer for the demonstration is Laura Gange who can be reached at (410) 786-3395. Your comments and questions should be identified and sent to the attention of the Project Officer by Friday, December 4, 1998. After we receive the comments, we will arrange for an informative conference call meeting before HCFA's responses are forwarded to the State. Because of this, we would especially appreciate your timely response to this request. Information should be mailed to the following address:

HCFA/CMSO/DEHPG/DIHS
Attention: Laura Gange
S2-14-26
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Peter
Cynthia } mtg next week
Rob

Comments can also be sent electronically via facsimile to (410) 786-9004 via internal HCFA e-mail to lgange, or through the Internet to lgange@HCFA.GOV.

Thank for your expedient review of the attached material.

Attachment

DC no decision

① do we allow a lighter benefit pkg to → savings?
NOT traditionally.
have we made a deal? NO.

② breast cancer vs. AIDS?

③ drug costs — VP's office benefit detail

Addressees:
Sally Richardson, CMSO
Rachel Block, CMSO
David Cade, FCHP
Jerome Jackson, FCHP/BCP
Joe Dunne, FCHP/EEO
Lloyd Bishop, IGTA
Tom Lenz, PCP
Trish MacTaggart, QPM
Kathy King, OA
Robert Jaye, OGC
Donald Johnson, OL
John Klemm, OSP/AHCA
Ann Verano, Press Office
John Eisenberg, AHCPR
Richard Tarplin, ASL
John Callahan, ASMB
Gary Claxton, ASPE
Bob Williams, ASPE
Earl Fox, HRSA
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STATE OF MAINE
DEPARTMENT OF HUMAN SERVICES
11 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0011

NOV 9 REC'D

ANGUS S. KING, JR.
GOVERNOR

KEVIN W. CONCANNON
COMMISSIONER

October 30, 1998

Wayne Smith, Ph.D., Director
Division of Integrated Health Systems
Disabled & Elderly Health Programs Group
Mail Stop S2-11-07
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Dr. Smith:

The Maine Department of Human Services is pleased to submit our proposal for an HIV/AIDS demonstration project. This project will show the feasibility of managing HIV/AIDS disease in an integrated cost contained method by limiting benefits to a circumscribed essential package of services which will delay, prevent or even reverse the progress of this deadly disease. The project will require waivers under Title XIX, Section 1115 of the Social Security Act, as described in the application.

This HIV/AIDS waiver proposal is the product of over eighteen months or research, analysis, and planning and it incorporates ideas from consumers, providers, advocates and the Maine Department of Human Services. The design reflects conditions unique to Maine, and recognizes the critical needs of the individuals to be assisted. The Maine Health Research Institute at the University of Maine, Farmington has developed a model which shows this to be cost effective to the Medicaid Program and beneficial to the population to be served. The proposal indicates that cost neutrality will be achieved in the first five years of the project, and that even greater savings of resources and lives would be realized in the second five years. Further, we believe this waiver would affect substantial cost savings to many other federal programs, such as, but not limited to SSI.

We appreciate the Health Care Financing Administration's assistance, guidance and other support of Maine's efforts in developing this demonstration project. My staff stands ready to work with HCFA's staff, both regionally and at the Central Office, in clarifying, completing, and implementing this project.

Sincerely:

Kevin W Concannon

Kevin W. Concannon
Commissioner

cc: Francis Finnegan, Director , Bureau of Medical Services

STATE OF MAINE

HIV/AIDS DEMONSTRATION PROJECT

October 1998

STATE OF MAINE 1115 WAIVER APPLICATION
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A. Overview of Waiver

1. **Introduction**. The 1115 demonstration project for Maine, described in this application, is designed to overcome the current obstacles in the Medicaid Program that provides barriers to Maine residents in accessing drug therapies that are proven to prevent the progression of HIV disease and AIDS disease

2. **The Need for the Maine HIV/AIDS Waiver**. The drug therapies are very costly and most health insurers do not fully cover HIV/AIDS disease and its essential package of services, most notably antiretroviral drugs. Without financial assistance, people who require these drugs can not obtain the drug therapy treatment necessary for the control of this progressive disease. There is no debate that HIV/AIDS disease is progressive to the point of death in a relatively short time, usually less than ten years without treatment. Under current regulations an adult individual would not be eligible for Medicaid until they were found to be disabled under the Social Security Administration guidelines. This process leads to people becoming Medicaid eligible for short periods of time after their HIV disease deteriorates into AIDS disease, and after then after the prescribed treatments and medications improve their health their Medicaid eligibility is terminated. After a brief time, the client re-enters the Medicaid eligibility pool at a higher cost due to the discontinuation of the optimal drug therapy while ineligible for Medicaid. Most chronic illnesses when not treated in the optimal way would not result in an assurance of death, however, the critical problem when dealing with HIV disease is that when left untreated HIV disease progresses to AIDS disease and then to death. The only uncertainty is the time factor involved in completing the cycle.

3. **Eligibles Included in the Waiver**. All persons who have been diagnosed with HIV disease will be eligible for participation in the demonstration project when: (a) their gross family income is less than or equal to 300% of the federal poverty guidelines (FPL); (b) they have resided in Maine for at least 18 months; and (c) they agree to comply fully with the course of treatment prescribed by their assigned waiver program provider, including but not limited to viral load tests and Highly Active Antiretroviral Therapy (HAART). If a waiver participant becomes eligible for Medicaid, they would be disenrolled from the waiver program and continue treatment utilizing the medical benefits of the Medicaid Program.

4. **Circumscribed HIV/AIDS Waiver Benefits Package**. The waiver program will provide a circumscribed essential package of services that includes: (a) highly active anti-retroviral therapy (HAART); (b) other medications covered by Medicaid; (c) office visits; (d) laboratory tests for monitoring; (e) case management services; and (f) hospitalizations. This benefits package is designed to delay, prevent or even reverse the progress of this deadly disease, and be cost neutral or cost beneficial within five years.

STATE OF MAINE 1115 WAIVER APPLICATION
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5. **Premiums for Participation in HIV/AIDS Waiver**. The monthly premiums are on a sliding scale according to income and further adjusted as an individual progresses to a more advanced level of illness. The premiums are also adjusted each year for inflation so that proportionately the premium cost share remains constant with the increase of the costs of drugs due to inflation. The blended premium structure is shown in Appendix B, Tables 9 and 10.

6. **Regulatory Waivers Requested**. Maine has determined that the following six separate regulatory areas require waivers to implement this demonstration program:

   (a) income eligibility regulations in Section 1902 (a)(10)(A), to permit individuals with income up to 300% of the Federal poverty level to access services;

   (b) disability regulations located in Section 1614 of the Social Security Act, to permit those with HIV disease to access combination therapies so they will not progress to AIDS disease;

   (c) state's resource limit regulations in Section 1613 and 1614 of the Social Security Act, to permit those with HIV/AIDS disease to access combination therapies regardless of resources and will not cause individuals to delay initiation of treatment due to fear of exhausting their resources;

   (d) amount, duration, and scope regulations located at Section 1902 (a)(10)(B) of the Social Security Act so that waiver recipients can access the smaller package of waiver services, thereby precluding the future use of the full range of Medicaid services;

   (e) freedom of choice regulations located in Section 1902(a)(23) of the Social Security Act, to restrict choice by limiting the provider pool to those providers that the Department deems acceptable for delivery of the waiver services;

   (f) residency regulations located in Section 1902 (b) of the Social Security Act, to impede residents of other states from moving to Maine to access services not available in their home state. Individuals who have not resided in the State for eighteen months will be prohibited from gaining eligibility to the waiver program. Maine expects to file an amendment to the waiver, that eliminates this restriction, after other states implement similar programs. This waiver allows the State the flexibility of moving individuals in the waiver program to Medicaid when eligible. Otherwise, the waiver would have to be limited to a fixed number of eligible individuals to preclude the migration of individuals from other states. This scenario makes movement between Medicaid and the waiver program administratively burdensome and less stable, which would create resistance from persons with HIV/AIDS disease in accessing the critical services necessary for treatment of their disease.

B. Method of Design

A cost model has been developed that incorporates the disease states in estimating the cost of care for individuals in each state and the time individuals will spend in each state. The model utilizes two sets of parameters, one for those under the waiver program and the other for a similar group under the non-waiver program. The results show that the waiver program will be cost neutral within five years.

C. Cost Model

1. **Clinical Classification**. Patients were identified as HIV positive based on either a clinical diagnosis provided as part of a Medicaid claim or a pattern of use of anti-retroviral therapy over a period of at least several months. Cases of short-term use of antiretroviral agents were excluded because of the possibility of post-exposure drug prophylaxis.

   Once identified as HIV positive, patients were stratified as having asymptomatic HIV infection (ASxHIV), symptomatic HIV infection (SxHIV), or AIDS based on diagnoses provided on claims and the pattern of clinical use of services and medications. In particular, ongoing treatment for apparent opportunistic infections was considered a marker for AIDS.

2. **Cost of Care**. The costs of care were developed using a traditional actuarial model for monthly costs of care. This model uses a grid stratifying care into various categories with a utilization assumption and a unit cost assumption for each category. Care was categorized into drugs and medical services. Drug costs were categorized as retroviral drugs, anti-infective drugs, and other drugs. Table 1 lists the 12 categories of service that were used in the model.

Routine Office Visits
Office Visits for Complications and side effects
Laboratory HIV Monitoring
Laboratory Other
Hospitalizations
Case Management/Social Work
Residential Care
Allied Health
Home Health
Miscellaneous
Nursing Home
Psychological/Substance Abuse

Table 1 Categories of Service

The Maine Medicaid databases were used to:

- Identify HIV infected patients,
- Develop an HIV patient Medicaid client file including Medicaid coverage dates during 1996 and 1997
- Identify all medical services and prescriptions provided to those clients during four semi-annual periods from January 1, 1996 through December 31, 1997.
- Categorize drug and medical service claims using the above grid, and develop an average unit cost and monthly utilization for each category.

To develop the expected costs of the proposed Waiver program, unit costs were generally derived directly from the Medicaid database. Monthly utilization by Medicaid clients was reviewed and adjusted to allow for "best practice" medical care under a Waiver program. For example, actual utilization of anti-retroviral drugs among the HIV-infected Maine Medicaid clients is far from the ideal of all clients taking HAART therapy. Therefore, the utilization assumption for anti-retroviral drugs was adjusted to allow for 100% compliance with optimal drug therapy. Likewise, the cost and utilization assumptions for HIV viral monitoring were adjusted to allow for frequent monitoring of viral loads. In order to model a "non-Waiver program" alternative, both cost and utilization data was taken directly from averages developed from the Medicaid databases.

3. **Parameters For The Waiver and Non-waiver Programs**. Both the waiver and the non-waiver programs begin with an initial mythical cohort of 100 individuals. The original cohort are assumed to enter either program at various stages of the illness. After close consultation with the primary care providers for people with HIV/AIDS disease in Maine, it was determined from their actual clinical cases the assumptions for the model initially is that 45% are ASxHIV, 35% are SxHIV and 20% have AIDS. In each program, based on separate transitional probabilities, some of the original cohort will transition to having SxHIV, or AIDS, and a few will die. The transitional probabilities are based on a Markov transitional probability model. The resulting transitional probabilities for the waiver and non-waiver programs are shown in Tables 2 and 3 respectively.

- For the individuals in both programs, the model assumes, based on the same clinical studies cited above, that 10% of those who are ASxHIV and 50% of those who are SxHIV are Medicaid eligible. All individuals who contract AIDS will become Medicaid eligible.

- The services for the waiver option include the following categories: drugs/medications, office visits, laboratory, case management/social services and hospitalizations. For cost purpose, these were combined into three cost categories: (1) anti-retroviral drugs; (2) non anti-retroviral drugs; and (3) service

- The no waiver option lists all services currently covered by Medicaid: Drugs/Medications, Office Visits, Laboratory, Hospitalizations, Case Management/Social Service, Residential Care, Allied Health, Home Health, Miscellaneous, Nursing Home, and Psychological/Substance.

4. **Markov Transitional Probability Model**. The medical literature has focused on the Markov fundamental matrix model to estimate the average number of cycles an individual spends in a non-absorbing state before transitioning into the next state. In this model, the absorbing (final) state is death. Transitional probabilities are assigned to each state to establish the Markov model for the waiver (Table 2) and the non-waiver (Table 3). This model does not include reversions, because the probability of remaining in a current state is so high that the small probability of reversion would not significantly affect the results. The transitional probabilities that we use in our model are based on current literature and the clinical experience of physicians in Maine treating patients with the HIV disease.

		Waiver		
	Asx HIV	Sx HIV	AIDS	Death
Asx HIV	0.98	0.015	0.005	0
Sx HIV	0	0.98	0.015	0.005
AIDS	0	0	0.98	0.02
Death	0	0	0	1

Table 2. Markov Model for the Waiver.

	No Waiver		
Asx HIV	Sx HIV	AIDS	Death
0.85	0.11	0.04	0
0	0.91	0.08	0.01
0	0	0.98	0.02
0	0	0	1

Table 3. Markov Model for the Non-Waiver

Some of the literature has stratified the HIV disease into four states based upon $CD4^+$ cell count of: >500, 201-500, 51-200, ≤50 cells/mm^3 . Other sources used three states which we also used in our model. We have classified HIV into three states: Asymptomatic HIV (Asx HIV); Symptomatic HIV (Sx HIV); and AIDS. We have generally collapsed 51-200 and ≤50 cells/mm^3 into the AIDS category; 201-500 into Sx HIV; and >500 into Asx HIV. Our actual assignment of individuals was based upon a review of their medical status from the Medicaid claims data base.

5. **Additional Parameters**.

a. Probability Of HIV Patient Being On Medicaid

• Probability of Asx HIV patient being on Medicaid	10%
• Probability of Sx HIV patient being on Medicaid	50%
• Probability of AIDS patient being on Medicaid	100%

b. Inflation Rates

• Inflation rate of cost of Anti Retroviral Drugs (i_{ar})	3%
• Inflation rate of cost of Other Drugs (i_{mar})	3%
• Inflation rate of cost of Medical Services (i_{ser})	6%

c. Pharmaceutical Participation – in what?

• Aids drug	18%
• Other drugs	18%
• Additional Anti-Retroviral Participation	13%

d. Third Party Liability (TPL)

• Medicaid Population TPL_{NW}	1%
• Non-Medicaid Waiver Population TPL_{W}	8.5%

e. Monthly Premiums

• People with incomes 250 – 300% of FPL	$80
• People with incomes 200 - 250% of FPL	$40
• People with incomes 150 – 200% of FPL	$20
• People with incomes < 150% of FPL	0

Monthly premiums are adjusted to take into consideration the fact that as an individual's condition worsens, his or her ability to pay decreases. For those on the waiver, there is a different premium structure for each stage of the illness. Individuals who are on Medicaid do not pay a premium. The blended premium structure is shown in Tables 9 and 10 of Appendix B (Page B-4)

A detailed list of notations is given in Appendix A.

D. Data Sources

1. **Drug Claims**. Population drug claims data set for 1996 and 1997, where n=31390, were chosen based on the following variables: client, prescription date, drug description, and paid amount. This variable reflects 90% of charges.

2. **Service Claims**. The Service claims data set for 1996 and 1997, where n=25138, were chosen based on the following variables: client, service start date, category of service, paid amount and TCN.

3. **Category of Service**: There was a category of services (COS) mapping (Appendix C) whereby 65 Medicaid COS costs were calculated separately and then subsequently collapsed into broader categories classified as: Office Visits, Laboratory, Hospitalizations, Case Management/Social Service, Residential Care, Allied Health, Home Health, Miscellaneous, Nursing Home and Psychological/Substance. These individual cost categories were calculated and collapsed into one category called Services.

4. **Drug Codes**. The drug code types were classified into 5 categories: Anti-retrovirals, Anti- infectives, Psychological, Pain medications and Miscellaneous where n=247. The costs for the first category formed the Anti-retroviral category cost, and the costs for the last four formed the non anti-retroviral category cost.

All the data sets that include the drug claims data set, service claims data set, COS mapping data set, and drug code type data sets were collapsed into the Total costs by patient file.

E. Cost Calculations Method

In order to compare the cost of the waiver program to the non-waiver program, the costs are calculated separately for an original cohort of 100 who begin on the waiver program and for a separate group of 100 who are on the non-waiver program.

1. General Cost Components For Each Of The Levels Of The Illness.

a. Number of Individuals

- The number of individuals (N_{it}) from the original cohort who are at a particular time period and at a particular stage of the illness (based upon the Markov model).

b. Probabilities

- The probability that an individual on the waiver will remain on the waiver (P_W) and the probability that a person on the waiver will go onto the non-waiver Medicaid program (P_{NW})

c. Costs

- For those remaining on the waiver, the separate six-month costs include: the anti-retroviral drugs (CAR_W); non anti-retroviral drugs ($CNAR_W$); and services ($CSER_W$), each adjusted for inflation. These costs include all shared participation by the pharmaceutical companies, and the third party liability (TPL_W) for those on the Waiver program.

- For those moving from the waiver to the Non-Waiver (Medicaid) program, the separate six-month costs include: the anti-retroviral drugs (CAR_{NW}); non anti-retroviral drugs ($CNAR_{NW}$); and services ($CSER_{NW}$), each adjusted for inflation. These costs include all shared participation by the pharmaceutical companies, and the third party liability (TPL_{NW}) for those transitioning to the Non-Waiver program.

	WAIVER NON-MEDICAID			WAIVER MEDICAID		
	ASxHIV	SxHIV		ASxHIV	SxHIV	AIDS
CAR_W	$ 596	$ 698		$ 645	$ 756	$ 784
$CNAR_W$	$ 81	$ 123		$ 87	$ 133	$ 421
$CSER_W$	$ 242	$ 340		$ 499	$ 1,275	$ 1,360
	NON-WAIVER MEDICAID					
	ASxHIV	SxHIV	AIDS			
CAR_{NW}	$ 766	$ 898	$ 932			
$CNAR_{NW}$	$ 87	$ 133	$ 421			
$CSER_{NW}$	$ 499	$ 1,275	$ 1,360			

Table 4. Costs for Waiver and Non-Waiver Programs.

The cost difference between those on Medicaid under the waiver and those on Medicaid not on the waiver occurs because of the cost savings for anti-retroviral drugs under the waiver.

F. Premiums and Monthly Costs

1. **Pro-rated Premium (PRM_W).** The pro-rated premium is paid by the individual on the waiver program. The premium is reduced as the stage of the illness worsens. Cost figures are based on actual Medicaid data for the years 1996 and 1997. Costs are calculated on six-month time periods. The five-year span of the calculations includes 10 time periods.

2. **Monthly Costs Per Category (CPM).**

a. Cost of Drugs Per Month

The cost per month is the cost per unit times the number of units per month. (CPU*UPM)

b. Cost Per Unit (CPU)

The cost per unit is the actual Medicaid cost of the unit. In the case of both anti-retroviral and non anti-retroviral drugs, the unit is usually a prescription. The cost per unit of medication is the cost of the unit before participation by the pharmaceutical companies.

c. Units Per Month (UMP)

In the case of both anti-retroviral and non anti-retroviral drugs, the unit is usually a prescription, and the number of units per month is determined by first finding the average drug dosage for the number of days prescribed by utilizing all of the Medicaid individuals involved and then converting this to a monthly figure.

d. Cost of Services Per Month

An average monthly cost by drug category was calculated as follows: Total of 6 month costs divided by the number of days of service = average daily cost (ADC). ADC*365/12=Average Monthly Cost per client for therapy by various classifications.

Detailed Cost Calculations for the model are shown in Appendix B

G. Analytical Results

1. **The waiver program is cost beneficial to the Medicaid program**

Total 5-year costs under the waiver program and under the non-waiver program show that the total cost under the waiver program is $10,157,131 while the total costs with the non-waiver program are $10,207,907. The cost difference is $50,776 less for the waiver program than for the non-waiver program.

The five-year total cost for each stage of the illness is calculated by finding the cumulative cost over the five years. The cumulative costs for each stage are then added to find the total five-year cost.

TOTAL 5-YEAR COSTS	Waiver	Non-Waiver
ASxHIV	2,465,076	181,454
SxHIV	3,881,138	2,742,307
AIDS	3,810,917	7,315,827
TOTAL	10,157,131	10,207,907
Difference	(50,776)	Cost Beneficial

Table 5. Five-Year Cost Waiver Program and Non-Waiver Medicaid Program

The total 5-year costs utilizing six-month intervals are also illustrated in Figure 1. The waiver program is cost beneficial prior to interval 10.

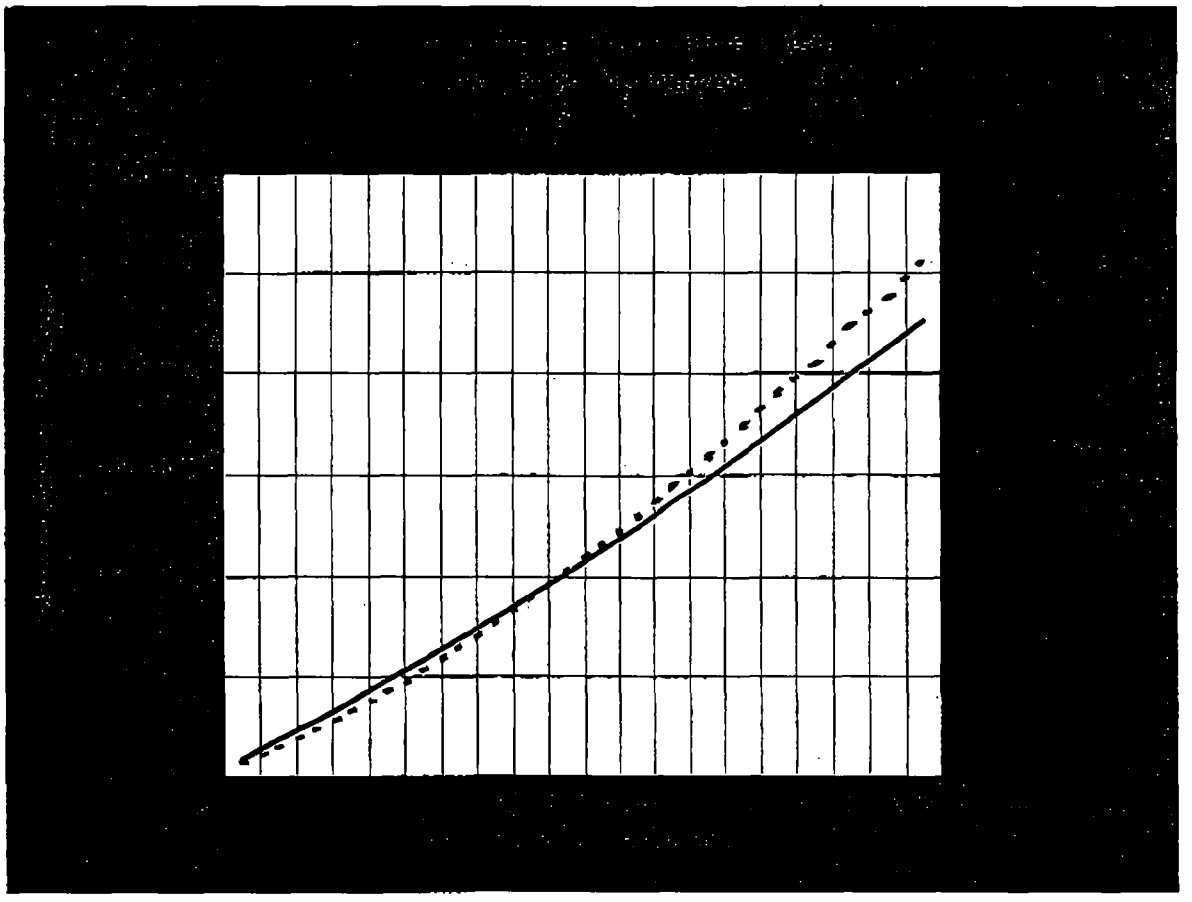

Figure 1. The Total Five-Year Costs.

2. **Lower Mortality Rate**. The number of individuals who are alive and who do not have AIDS is dramatically greater with the waiver program. At the end of 5 years, under the waiver, of the original 40 who were ASxHIV, 37 still remained ASxHIV, while for the non-waiver cohort of 40 who were ASxHIV, only 9 still remained ASxHIV as can be seen in Table 6. Under the waiver, 34 would be SxHIV compared to 30 under the non-waiver. In addition, under the waiver, 23 would be living with AIDS, compared with 51 who would be living with AIDS under the non-waiver. Furthermore, under the waiver program, 6 individuals would have died from AIDS, while under the non-waiver option, 11 would have died.

TOTAL 5-YEAR	Waiver	Non-Waiver
ASxHIV	37	9
SxHIV	34	30
AIDS	23	51
DEATHS	6	11

Table 6. Five Year Results: Waiver vs. Non- Waiver

The ten-year figures are even more dramatic. As can be seen in Table 7, of the original cohort of 100 individuals under the waiver, 30 are still Asx HIV, while only 2 individuals remain ASxHIV under the non-waiver program. For those on the waiver, 33 have Sx HIV; while on the non-waiver there are 15. In addition, with the waiver, 25 have AIDS compared to 59 under the non-waiver. And, at the end of 10 years, under the waiver, 12 have died, compared to 24 individuals who have died under the non-waiver.

TOTAL 10-YEAR	Waiver	Non-Waiver
ASxHIV	30	2
SxHIV	33	15
AIDS	25	59
DEATHS	12	24

Table 7. Ten Year Results: Waiver vs. Non-Waiver

The comparisons of the ten-year death rates for the waiver and non-waiver programs are clearly illustrated in Figure 2.

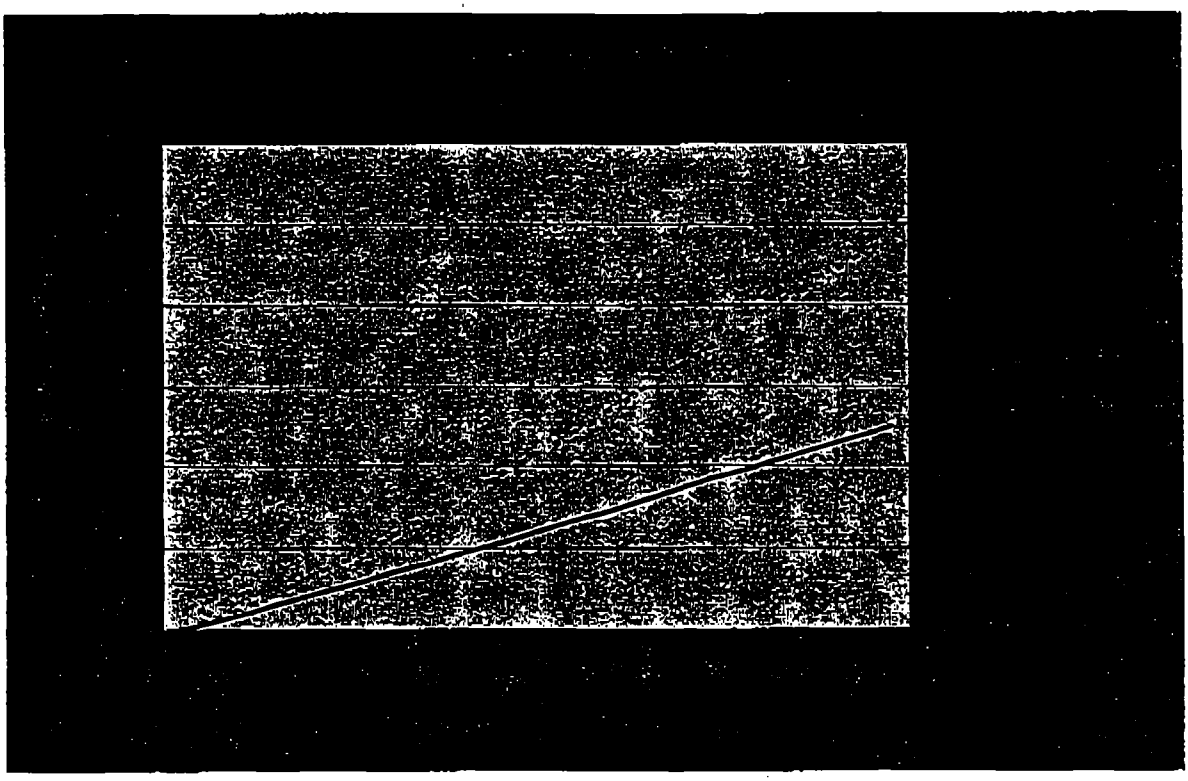

Figure 2. Ten Year Results: Waiver vs. Non-Waiver

References

1. Beck JR, Pauker SG. The Markov Process in Medical Prognosis. *Medical Decision Making* 1983;3(4):419-58.
2. Moore, Richard D. and Chaisson, Richard E. Cost to Medicaid of Advancing Immunosuppression in an Urban HIV-Infected Patient Population in Maryland. *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology* 1997;14:223-231 © Lippincott-Raven Publishers, Philadelphia

STATE OF MAINE 1115 WAIVER APPLICATION
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APPENDIX A LIST OF ANNOTATIONS

Notations

Costs

CPM	Cost per month
CPU	Cost per unit
CAR_W	Cost of anti-retroviral drugs for those on the waiver
$CNAR_W$	Cost of non anti-retroviral drugs for those on the waiver
$CSER_W$	Cost of services for those on the waiver
CAR_{NW}	Cost of anti-retroviral drugs for those on the non-waiver program
$CNAR_{NW}$	Cost of non anti-retroviral drugs for those on the non-waiver program
$CSER_{NW}$	Cost of services for those on the non-waiver program

Inflation Percentages

i_{ar}	Percent of inflation for anti-retroviral drugs
i_{nar}	Percent of inflation for non anti-retroviral drugs
i_{ser}	Percent of inflation for services

Probabilities

P_{W-s}	Probability of being on the waiver program for a stage of the illness
P_{NW-s}	Probability of being on the non-waiver Medicaid program for a stage of the illness
P_{W-ASx}	Probability of being on the waiver and having asymptomatic HIV
P_{W-Sx}	Probability of being on the waiver and having symptomatic HIV
P_{W-AIDS}	Probability of being on the waiver and having AIDS
P_{NW-Asx}	Probability of being on the non-waiver and having asymptomatic HIV
P_{NW-Sx}	Probability of being on the non-waiver and having symptomatic HIV
$P_{NW-AIDS}$	Probability of being on the non-waiver and having AIDS

Other

ASxHIV	Asymptomatic HIV
SxHIV	Symptomatic HIV
UPM	Units per month
N_{ts}	Number at a given time period and stage
TPL_W	Third party liability for those on the waiver
TPL_{NW}	Third party liability for those on the non-waiver program
PRM_W	Premiums for those on the waiver program
COS	Category of service

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APPENDIX B COST CALCULATIONS

Detailed calculations of determining costs for both the waiver and non-waiver programs is given in this appendix.

Note: The numbers used in the examples are rounded to the nearest whole value while, for purpose of calculation, the numbers in the spread sheet are not rounded. As a result, the calculated results in the examples do not exactly match the calculated results from the spread sheet. The results from the spread sheet were used as the final result in the examples.

Steps with Examples for calculating costs under the waiver program for individuals at a particular time period and stage of the illness.

Step 1 In calculating the waiver cost, the first step is to calculate the number of individuals from the original cohort who are at a particular stage of the illness based upon the transitional probability model (Table 2).

The number of individuals in the current six-month time period at a particular stage of the illness (N_t) is calculated using the number of individuals from the previous time period in each of the illness multiplied by the transitional probability that they will move to the current level of the illness.

Example: We want to calculate the number of individuals at the Symptomatic HIV (SxHIV) stage of illness for the last six months of year five. This is time period 10. We look to the previous time period (period 9). As can be seen in Table 8, at time period 9, there are 38 individuals who are A-symptomatic HIV (ASxHIV) and 34 who are Symptomatic HIV (SxHIV).

		Waiver		
		Total Patients		
Period	Asx HIV	Sx HIV	AIDS	Dead
	Waiver			Waiver
0	45	35	20	-
1	44	35	20	1
2	43	35	21	1
3	42	35	21	2
4	42	35	21	2
5	41	35	22	3
6	40	35	22	4
7	39	35	22	4
8	38	34	22	5
9	38	34	23	5
10	37	34	23	6

Table 8. Probability Distribution of Waiver Cohort.

Based on the Markov model, the probability that a person will transition from ASxHIV to SxHIV is 1.5% (.015). The probability that a person who is SxHIV will remain SxHIV is 98% (.98).

The number of people who are SxHIV at the 10th period is:
$38 * .015 + 34 * .98 = 34$

Step 2 The second step is to determine the probability that individuals on the waiver will remain on the waiver (P_W) and the probability that individuals on the waiver will go onto the non-waiver Medicaid program (P_{NW}) for each level of the illness ($P_{W\text{-}ASx}$, $P_{W\text{-}Sx}$, $P_{W\text{-}AIDS}$, and $P_{NW\text{-}ASx}$, $P_{NW\text{-}Sx}$, $P_{NW\text{-}AIDS}$) These probabilities multiplied by the monthly cost of the level of illness, Steps 3 and 4, determine the basic monthly costs of the waiver program.

Example: For each time period, the model assumes that of the original cohort on the waiver, 10% of those who are ASxHIV, 50% who are SxHIV and all of those who contract AIDS will transition to the non-waiver Medicaid program. Based on these percentages, the resulting probabilities are: ($P_{W\text{-}ASx} = .90$, $P_{W\text{-}Sx} = .50$, $P_{W\text{-}AIDS} = 0$, $P_{NW\text{-}ASx} = .10$, $P_{NW\text{-}Sx} = .50$, and $P_{NW\text{-}AIDS} = 1.0$)

Step 3 The third step is to calculate the monthly waiver costs for each of the cost categories adjusted for inflation. [Anti-retroviral drugs (CAR_W), Non Anti-retroviral drugs ($CNAR_W$), and Services ($CSER_W$)]. For those on the waiver, these costs are determined by taking the average billed costs for each cost category and for each stage of the illness and then adjusting them for shared participation by the pharmaceutical companies and for third party liability coverage (TPL_W). These adjusted costs are the cost per month (CPM) for each category multiplied by 6.

Example: The cost in each category is found by multiplying the units per month (UPM) times the cost per unit (CPU), times the percent of cost after pharmaceutical participation, times the percent of cost after third party liability coverage. The formula is:

UPM * CPU * (% after pharmaceutical participation) * (% after TPL)

For example, for someone who is on the waiver with SxHIV, the actual figures used in the model for CAR_W are: $3.75 * 295 * 69\% * 91.5\% = 698$. The costs for the other categories are determined in a similar manner, by first finding the separate costs for each component of the category and adding these separate costs. The resulting monthly costs are:

Waiver: $CAR_W = \$698$ $CNAR_W = \$123$ $CSER_W = \$340$

Non-Waiver: $CAR_{NW} = \$898$ $CNAR_{NW} = \$133$ $CSER_{NW} = \$1275$

Step 4 Step 4 combines steps 1- 3 to determine the basic monthly cost of the waiver program for a particular period and stage of the illness. Step 1 is the number of individuals at a particular period and stage of illness (N_{ts}). Step 2 is the proportion of these individuals who will incur the separate costs associated with the formulas in Steps 3 and 4.

$$6* N_{ts} * P_{W\text{-}s} * [CAR_W * (1+ i_{ar}/2)^t + CNAR_W * (1+ i_{nar}/2)^t + CSER_W * (1+i_{ser}/2)^t + 6 * N_{NW\text{-}s} [CAR_{NW} * (1+i_{ar}/2)^t + CNAR_{NW} * (1+i_{nar}/2)^t + CSER_{NW} * (1+i_{ser}/2)^t]$$

Example: The example continues with determining the six-month cost for the time period (t = 10) for all individuals who began on the waiver program, are currently SxHIV, and who remain on the waiver program.

For each of the cost categories, the inflation rate is determined from historical Medicaid data and professional judgment. The inflation rates used are: Anti-retroviral drugs, 3%; non anti-retroviral drugs, 3%; and services, 6% compounded semi-annually.

$$6 * 34 * .50 *[698 * (1+.03/2)^{10} + 123 * (1+.03/2)^{10} + 340 * (1+.06/2)^{10} + 6* 34 * [.50 * 898 * (1+.03/2)^{10} + 133 * (1+.03/2)^{10} + 1275 * (1+.06/2)^{10}] = \$426,473$$

Step 5 The fifth step is to determine the amount of the blended premium which will be paid by the individuals on the waiver. The blended monthly premium is pro-rated based upon the level of income above the poverty level and the stage of illness that the individual is in . This blended monthly premium is adjusted for inflation by compounding at 5% annually. The model assumes an equal distribution of waiver individuals among the four income levels with 25% at each level.

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Income as a Percent of Poverty	Percent Premium	Premium	Percent of Waiver Population ASx HIV	Blended Premium HIV Asx	Percent of Waiver Populatio n Sx HIV	Blended Premium Sx HIV	Percent of Waiver Populatio n AIDS	Blended Premium AIDS
<150%	0%	$ -	0.25	$ -	38%	$ -	50%	$ -
150-200%	25%	$ 20.00	0.25	$ 5.00	25%	$ 5.00	25%	$ 5.00
200-250%	50%	$ 40.00	0.25	$ 10.00	20%	$ 8.00	15%	$ 6.00
250-300%	100%	$ 80.00	0.25	$ 20.00	17%	$ 13.60	10%	$ 8.00
Total Blended Premium				$ 35.00		$ 26.60		$ 19.00

Table 9. The number of individuals at each level, the premium paid by individuals at each income level and the blended premium for the first year

Period	Premium	Blended Premium Asx	Blended Premium Sx HIV	Blended Premium AIDS
0	80	$ 35.00	$ 26.60	$ 19.00
1	82	$ 35.88	$ 27.27	$ 19.48
2	84	$ 36.77	$ 27.95	$ 19.96
3	86	$ 37.69	$ 28.65	$ 20.46
4	88	$ 38.63	$ 29.36	$ 20.97
5	91	$ 39.60	$ 30.10	$ 21.50
6	93	$ 40.59	$ 30.85	$ 22.03
7	95	$ 41.60	$ 31.62	$ 22.59
8	97	$ 42.64	$ 32.41	$ 23.15
9	100	$ 43.71	$ 33.22	$ 23.73
10	102	$ 44.80	$ 34.05	$ 24.32

Table 10. Total Blended Monthly Premium Adjusted for Inflation

The savings for a particular period and stage of illness depends upon the number of individuals who are on the waiver program at that point and the blended monthly premium (PRM_W). The total number of individuals who are at this time period and stage is denoted by (N_{ts}) and was calculated in Step 1 and is shown in Table 8. The proportion of this group who remain on the waiver program for this time period and stage is determined by the transitional probability and is denoted in general by ($P_{W-(ts)}$). The formula for calculating the savings due to the premium is: $6*N_{ts} * P_{W-(ts)} * PRM_W$

Have we counted collected premiums as savings?

Example: The total of the premiums that contribute to reducing the cost for individuals who are on the waiver program with SxHIV at the 10th time period is:

$6 * 34 * .5 * \$33.22 = \$3388$

Step 6 The final step is to put together the entire computation for one six-month time period and for one stage of the illness under the waiver. This step reduces the amount in Step 4 by the blended premium (PRM_W) which is paid by the individuals on the waiver program (Step 5)

$$6* N_{ts} * P_{W\text{-}s}* [CAR_W * (1+ i_{ar}/2)^t + CNAR_W * (1+ i_{nar}/2)^t + CSER_W * (1+i_{ser}/2)^t + 6 * N_{NW\text{-}s} [CAR_{NW} * (1+i_{ar}/2)^t + CNAR_{NW} * (1+i_{nar}/2)^t + CSER_{NW} * (1+i_{ser}/2)^t] - 6*N_{ts} * P_{W\text{-}(ts)} * PRM_W$$

Example: The six-month cost for the 13 individuals from the original waiver cohort who are SxHIV and who remain on the waiver program is:

$\$426,473 - \$3388 = \$423,085$

This figure is calculated using the formulas in Steps 5 and 6.

$$6 * 34 * .50 *[689 * (1+.03/2)^{10} + 123 * (1+.03/2)^{10} + 340 * (1+.06/2)^{10} + 6* 34 * [.50 * 756 * (1+.03/2)^{10} + 133 * (1+.03/2)^{10} + 1275 * (1+.06/2)^{10}] - 6 * 34 * .5 * 33.22 = \$423,085$$

Cost Calculations for Those on the Non-Waiver (Medicaid) Program

In order to compare the costs of the waiver program to the non-waiver program, it was necessary to develop costs for the non-waiver program in a similar manner to those for the waiver program.

The model for the non-waiver Medicaid program begins with a cohort of 100 individuals, all of whom are ASxHIV and who will transition to the various stages of the illness based upon the Markov transitional probabilities.

The steps are similar for finding the costs for the non-waiver (Medicaid) program to those for finding the costs under the waiver. The exceptions are that: (a) all the individuals are on the non-waiver program all the time and (b) there is no premium for anyone on the non-waiver program.

The steps for determining the cost under the non-waiver Medicaid program are:

Step 1 The first step is to calculate the number of individuals from the original non-waiver cohort who are at a particular stage of the illness based on the Markov

transitional model. This is done in the same way as in step 1 of the waiver program.

Example: Based on the Markov model (Table 3), the probability that a person will transition from ASxHIV to SxHIV is 11% (.11) and the probability that a person who is SxHIV will remain SxHIV is 91% (.91).

		No Waiver		
		Total Patients		
Period	Asx HIV	Sx HIV	AIDS	Dead
Year	No Waiver			No Waiver
0	45	35	20	-
1	38	37	24	1
2	33	38	28	2
3	28	38	32	3
4	23	38	35	4
5	20	37	39	5
6	17	36	42	6
7	14	34	44	7
8	12	33	47	8
9	10	31	49	9
10	9	30	51	11

Table 11. The number of individuals who are ASxHIV and SxHIV under the non-waiver program.

The number of people who are SxHIV at the 10th period is:

$10 * .11 + 31 * .91 = 30$

Note: The second step from the waiver program is not applicable to the non-waiver program because the second step determines the probability that a person on the waiver remains on the waiver.

Step 3: In calculating the non-waiver cost, the third step is to calculate the monthly costs for each of the cost categories adjusted for inflation in a manner similar to that done for step 3 of the waiver. [Anti-retroviral drugs (CAR_{NW}), Non Anti-retroviral drugs ($CNAR_{NW}$), and Services ($CSER_{NW}$)]. For those on the

non-waiver, these costs are determined by taking the average billed cost for each cost category and for each stage of the illness and then adjusting them for the current shared participation by the pharmaceutical companies and for third party liability coverage (TPL_{NW}). These adjusted costs are the cost per month CPM for each category multiplied by 6.

Example: The non-waiver costs for each category are:

$CAR_{NW} = \$898$ $CNAR_{NW} = \$133$ $CSER_{NW} = \$1275$

Step 4 Step 4 combines steps 1- 3 to determine the basic monthly cost of the waiver program for a particular period and stage of the illness under the waiver program. Step 1 is the number of individuals at a particular period and stage of illness (N_{ts}), Step 2 is the proportion of these individuals who will incur the separate costs associated with the formulas in Steps 3 and 4.

$$6^* N_{ts} * P_{NW\text{-}s} * [CAR_{NW} * (1+ i_{ar}/2)^t + CNAR_{NW} * (1+ i_{nar}/2)^t + CSER_{NW} * (1+i_{ser}/2)^t$$

Example: The example continues with determining the six-month cost for the time period t = 10 for all individuals who began on the non-waiver program, are currently SxHIV, and who remain on the non-waiver program.

The inflation rate is determined from historical Medicaid data and professional judgement for each of the cost categories. The inflation rates used are: Anti-retroviral drugs 3%, non anti-retroviral drugs 3%, and services 6% compounded semi-annually.

$$6 * 30 * .50 *[898 * (1+.03/2)^{10} + 133 * (1+.03/2)^{10} + 1275 * (1+.06/2)^{10}] = \$257,630$$

Under the non-waiver Medicaid program, there is no premium, thus, the formula in step 4 of the non waiver program reflects the six-month cost for a particular time period and a particular stage of the illness. In the example, it is the cost for the last six months of year five (time period 10) for individuals who are SxHIV.

Note: Under the waiver, step 5 is used to determine the premium to be paid and step 6 takes the value from step 4 and subtracts the premium. There is no premium under the non-waiver program.

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APPENDIX C MEDICAID CATEGORIES OF SERVICE

The Medicaid categories of service (COS) were initially mapped into a set of twelve categories. The mapping is shown below in Table 12.

COS	Description	COS2
7	Podiatry	AlliedHealth
9	Dental	AlliedHealth
17	Prosthetics	AlliedHealth
27	Speech & Hearing	AlliedHealth
31	Physical Therapy	AlliedHealth
32	Chiropractic	AlliedHealth
33	Occupational Therapy	AlliedHealth
37	Optometry	AlliedHealth
42	Optical Services	AlliedHealth
45	Hearing Aid Dealers	AlliedHealth
46	Audiology	AlliedHealth
47	Speech Pathology	AlliedHealth
53	Nurse/Midwife	AlliedHealth
65	Non-traditional PHP	AlliedHealth
10	Drugs	Drugs
11	Home Hlth	HomeHlth
55	Attendant Services	HomeHlth
58	Private Duty Nursing	HomeHlth
59	Personal Care Services	HomeHlth
61	Rehabilitative Svcs	HomeHlth
1	General Inpt	Hosp
18	Ambulatory Surgery Center	Hosp
41	Medicare Crossover-A	Hosp
14	Lab & Xray	Lab
15	Transportation	Misc
16	Supplies & DME	Misc
29	Ambulance	Misc
51	Unclassified	Misc
52	HMO Waiver	Misc
3	Nursing Facility	NH
23	Swing Bed	NH
34	ICF/MR Svcs	NH
35	Day Habilitation	NH
36	Day Health	NH
4	General Outpt	Office
6	Physician	Office
8	PHP	Office
25	Family Planning	Office
30	Ambul Care Clinic	Office
43	Cert Rural Health Clinic	Office

44	VD Screening	Office
50	Medical Crossover-B	Office
54	Child Health	Office
60	Nurse Practitioner	Office
63	Early Intervention	Office
2	Psych Facility	Psych/Sub
19	Clozaril Monitoring	Psych/Sub
26	BMR Waiver	Psych/Sub
28	Mental Health	Psych/Sub
38	Psychology Svcs	Psych/Sub
48	Substance Abuse	Psych/Sub
62	Home-Based Mental Health	Psych/Sub
64	Develop/Behav Clinical Services	Psych/Sub
22	Phys Disabled Waiver	Residency
39	Private Nonmedical Inst	Residency
40	ICF/MR (Boarding)	Residency
49	Boarding Home	Residency
56	Waivered Boarding Home	Residency
5	Soc Svc	SocSvc
12	Community Support Svc	SocSvc
13	Social Worker Svc	SocSvc
24	Case Mgt	SocSvc
57	BME Waiver	

Table 12. Medicaid Categories of Service (COS) Mapping

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MAINE HIV/AIDS 1115 DEMONSTRATION PROPOSAL
Budget Neutrality Response Presentation Talking Points for Mike Hash
Nov. 5, 1999

Introduction

- I want to apologize for how long this process has taken, but the complex nature of your innovative demonstration project and the new issues that it raised required lengthy analysis and discussion within the Administration.

- We have appreciated your willingness to work so closely with us on this program and thank you for all of your dedication to the project. As you know, we are committed to working with you on this project so that we can reach resolution in the near future, and look forward to working toward common goals.

- Today, I am calling you to discuss our response to your submission. We would like to suggest modifications to your proposal in the hopes that we can reach a position that meets the needs of the State of Maine and one that meets our legal and policy requirements. As we will discuss, we believe this project is budget neutral under certain assumptions, some of which are noted below.

Enrollment Ceiling

- You have made it clear how important it is for you to limit enrollment in this demonstration project, and we believe that in the context of HIV demonstrations that an enrollment ceiling would be appropriate.

- Therefore, we would propose to work with you prior to the implementation of the program to set an appropriate number for the enrollment ceiling. In addition, so as to provide you with additional flexibility, our proposal would allow you to adjust the enrollment ceiling higher or lower during the course of the demonstration.

- Under no circumstances may the State limit enrollment for HIV positive individuals who are eligible to enroll in the traditional (non-waiver) Medicaid program. The enrollment ceiling may apply to demonstration enrollees only.

- However, if the state believes it is necessary to adjust the enrollment ceiling downward during the course of the demonstration, we feel that it would not be appropriate to terminate eligibility for those who have already enrolled in the project. Therefore, we want a mechanism in place that keeps current participants on the program; in other words, they will be held harmless if the State changes the eligibility levels. The new lower enrollment ceiling would only affect new enrollees who are otherwise not eligible for Medicaid. [Background: It is important to note that regardless of what happens to the budget neutrality cap, those who are eligible for Medicaid must be enrolled]

Expenditure Limit

- You proposed a 5-year aggregate expenditure limit of $30 million on expenditures for the demonstration population and for those who begin on the demonstration and then convert to the Medicaid program during the course of the waiver. You did not include under the budget cap those individuals who are currently on Medicaid.

- However, we request the following modification: the population under the budget neutrality cap should include both those HIV+ individuals who begin on the demonstration project and those HIV+ individuals who are currently enrolled in the Medicaid program [Background: HIV+ individuals include those with AIDS also].

- We recognize that our budget neutrality population is larger than the one offered by Maine. We believe that this approach is necessary to limit the financial exposure of the Federal government in the most appropriate way possible.

- At the same time, however, our budget neutrality analysis will help offset this by providing you with a higher budget neutrality ceiling than Maine originally requested.

- Based on this Administration's best estimates, we are prepared to offer a budget neutrality ceiling of $53 million for the 5-year demonstration. This figure includes what it would cost to cover current Medicaid eligibles and those HIV+ individuals progressing to Medicaid in the absence of the demonstration. [Background: The $53 million number is OMB's preferred number since it was derived through a more traditional budget neutrality calculation. The Department has agreement on $52.2 million, which is the product of OACT's more sophisticated model].

- Related to the budget neutrality issue is that of data collection. With regard to costs incurred by Maine under he demonstration, I want to stress that data collection will be an important part of our terms and conditions, and we are hoping that information form Maine will help to inform our decision process on any future waivers of this type.

Drug Discount

- You have indicated that you anticipate savings due to a drug discount of 14% from pharmaceutical companies. It is our current understanding that the drug discount has not yet been finalized with the drug companies.

- As I said before, this Administration's calculations indicate that the program is budget neutral; however, calculations assume certain critical items -such as the fact that the drug discount will be in place. HCFA will need to have this discount finalized with the drug companies before the waiver can be implemented. We are prepared to approve the demonstration before the discount is final, but in order for the State to proceed with implementation, HCFA would require documentation of a final agreement.

Limited Benefit Package

- You proposed a limited benefit package that covers all drugs, physician visits and hospitalizations, but you did not include other benefits that are in your Medicaid benefits package.

- While we can accept a limited benefits package as being necessary for achieving budget neutrality, we believe that mental health and substance abuse services are critically important for the HIV positive population in order for them to maintain compliance with the complex combination drug therapies. We also believe that those in the target population truly need such services.

- Therefore, we would like you to include mental health and substance abuse services in the benefits package. The Administration's budget neutrality estimates show that the demonstration will be budget neutral with these services included.

Next Steps

- We will be sending you draft terms and conditions that provide the details of our response.
- My staff will arrange a conference call with you to go over these terms and conditions and to clarify any detailed questions that you may have.
- Just so there is no misunderstanding, please let me be clear. This call is only to provide you with our response. I'm not saying that the waiver is approved or that it will be approved. This step is part of our on-going discussion.
- Assuming that there are no other issues that arise, and if our proposal proves satisfactory to you, then we will be in a position to work with you to move toward approval of your demonstration project.
- Thank you again for all of your dedication to this population and this project. You have truly been leaders among the States with this ground-breaking program.