Facesheet: 1. Request Information (1 of 2)

A. The **State of Maine** requests a waiver/amendment under the authority of section 1915(b) of the Act. The Medicaid agency will directly operate the waiver.

B. **Name of Waiver Program(s):** Please list each program name the waiver authorizes.

Short title (nickname)	Long title	Type of Program
Maine NET	Maine Non-Emergency Transportation Waiver	PAHP;

Waiver Application Title (*optional - this title will be used to locate this waiver in the finder*):
Maine Non-Emergency Transportation

C. **Type of Request.** This is an:

☑ **Initial request for a new waiver.**

☐ **Migration Waiver** - this is an existing approved waiver

Provide the information about the original waiver being migrated

Base Waiver Number:

Amendment Number (if applicable):

Effective Date: *(mm/dd/yy)*

Requested Approval Period: *(For waivers requesting three, four, or five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **1 year** ◉ **2 years** ○ **3 years** ○ **4 years** ○ **5 years**

Draft ID: ME.19.00.00
Waiver Number: ME.0001.R00.00

D. **Effective Dates:** This waiver is requested for a period of 2 years. (For beginning date for an initial or renewal request, please choose first day of a calendar quarter, if possible, or if not, the first day of a month. For an amendment, please identify the implementation date as the beginning date, and end of the waiver period as the end date)

Proposed Effective Date: *(mm/dd/yy)*
04/01/12

Proposed End Date: 03/31/14
Calculated as "Proposed Effective Date" (above) plus "Requested Approval Period" (above) minus one day.

Facesheet: 2. State Contact(s) (2 of 2)

E. **State Contact:** The state contact person for this waiver is below:

Name: Michelle Probert **Phone:** (207) 287-2641 **Ext:** **TTY** **If the State contact information is different for any of the authorized programs, please check the program name below and provide the contact information. The State contact information is different for the following programs:**

Fax: (207) 287-2675 **E-mail:** michelle.probert@maine.gs

☐ **Maine Non-Emergency Transportation Waiver**

Note: If no programs appear in this list, please define the programs authorized by this waiver on the first page of the

Section A: Program Description

Part I: Program Overview

Tribal consultation.

For initial and renewal waiver requests, please describe the efforts the State has made to ensure Federally recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal.
Tribes were invited to participate in all public forums. Additionally, there is a transportation advisory subcommittee of the MaineCare Advisory Committee (MAC). The tribes have membership in the MAC and have been invited to participate in the transportation subcommittee as well. Additionally, the Policy Director regularly attends quarterly tribal meetings. Maine has set up a web page dedicated to this NET initiative (http://www.maine.gov/dhhs/oms/nemt/nemt_index.html) which contains all public documents and responses from stakeholder interactions. Following is a list of specific activities related to tribal consultation . Documentation is available.

• 4/5 MAC Subcommittee on Transportation: A presentation was given outlining reason and plans for NET redesign. All tribes were invited. The presentation was posted on the NET website.
• 4/5 MAC: The full committee was provided a summary of the subcommittee presentation and discussion. All tribes were invited. The presentation was posted on the NET website.
• 4/25 Public NET forum: All tribes were invited. MaineCare staff outlined the reason and plans for NET redesign; facilitated discussion on potential RFP requirements. The presentation and notes were posted on the NET website.
• 5/3 MAC Staff provided transportation updates and discussion of the transportation initiative was on the agenda. All tribes were invited.
• 7/13 NET Tribal Consultation webinar: In order to compensate for the difficulty some tribal representatives had in attending public and MAC meetings in person in Augusta, OMS provided an overview of proposals for NET system redesign and outlined considerations regarding decision to implement regional or statewide brokerage system. A visual and audio link to the presentation was posted on line.
• 8/1 Public NET forum: All tribes were invited. The forum discussed the decision to pursue a regional brokerage system and laid out draft RFP requirements. The presentation, notes, and a Q&A were posted online.
• 8/2 MAC: Staff provided transportation updates and discussion of the transportation initiative was on the agenda. All tribes were invited.
• 8/4 OMS staff participated in a call with CMS and Passamaquoddy Indian Township tribe.
• 9/6 MAC: Staff provided transportation updates and discussion of the transportation initiative was on the agenda. All tribes were invited.
• 9/21 NET Tribal Consultation Meeting, Bangor.

The first concerns the tribes communicated to the Department were on the 8/4/2011 call the Passamaquoddy Indian township tribe requested with CMS and the State. The main purpose of the call was to work out some issues between Indian Township and the current Full Service Regional Transportation Provider (FSRTP) in its region. While not directly related to the Department's 1915(b) waiver application, the tribe was dissatisfied with communications and services from the FSRTP following the termination of its informal arrangement with the FSRTP to coordinate and reimburse volunteers. Over the course of the call, the state explained its proposal to change the current system to a regional, risk-based PAHP. The State explained that tribes may more easily become providers and potentially subcontract to coordinate and reimburse volunteers under the new system. Indian Township asked whether they could broker their own transportation services for their tribal members and the State agreed to work with CMS to clarify the options for the tribes to broker NET services. In addition to the concerns and questions expressed by Indian Township on the 8/4 call, the Houlton Band of Maliseet Indians also reached out to the Department via email asking how the tribe could either broker or provide its own NET services.

At the subsequent 9/21/2011 tribal consultation, per request of these tribes, the Department discussed the options available for the tribes to act as their own brokers, or act as the brokers for their regions as a whole. The Department also consulted with the tribes regarding the Department's ideas for provisions to include in the RFP and brokerage contracts for all brokers, in the case that the tribes were included under the proposed at-risk system. This proposal included:
• Requiring Brokers to subcontract with tribes that would like to be their own transportation providers and that meet provider qualifications.
• The state ensuring that negotiated rates between the Broker and the tribal provider are adequate and reasonable given other area rates and the cultural expertise offered by the tribal provider.
• Encouraging bidders to leverage efficient and effective tribal systems and resources for volunteer recruitment, coordination and, where appropriate, volunteer and family, friends and member reimbursement through sub contractual or other proposed arrangements.
• Requiring the Broker to have representation from federally recognized tribes on a regional advisory committee to review and discuss broker performance, coordination with local resources, and other community concerns.

The tribes indicated that they appreciated the information regarding the requirements they would need to meet in order to become an at-risk PAHP. They also indicated that they were satisfied with the Department's proposed RFP and contractual requirements and, with these requirements, did not feel it would be necessary to exempt the tribes from the at-risk PAHP system or reconfigure the proposed regions to create smaller, tribe-specific regions. The Department has adopted all of the above bulleted provisions in its RFP and contract drafts.

Maine will comply with section 5006(e) of the ARRA (Recovery Act) consultation requirements to solicit advice on an ongoing basis and prior to any future SPA, waiver or demonstration proposals to CMS concerning Medicaid or CHIP transportation services that are likely to have a direct effect on Indians, Indian health programs, or Urban Indian Organizations.

Program History required for renewal waivers only.

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (1 of 3)

1. **Waiver Authority.** The State's waiver program is authorized under section 1915(b) of the Act, which permits the Secretary to waive provisions of section 1902 for certain purposes. Specifically, the State is relying upon authority provided in the following subsection(s) of the section 1915(b) of the Act (if more than one program authorized by this waiver, please list applicable programs below each relevant authority):
   a. ☐ **1915(b)(1)** - The State requires enrollees to obtain medical care through a primary care case management (PCCM) system or specialty physician services arrangements. This includes mandatory capitated programs.
      -- *Specify Program Instance(s) applicable to this authority*
      ☐ **Maine NET**
   b. ☐ **1915(b)(2)** - A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among PCCMs or competing MCOs/PIHPs/PAHPs in order to provide enrollees with more information about the range of health care options open to them.
      -- *Specify Program Instance(s) applicable to this authority*
      ☐ **Maine NET**
   c. ☐ **1915(b)(3)** - The State will share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services. The savings must be expended for the benefit of the Medicaid beneficiary enrolled in the waiver. Note: this can only be requested in conjunction with section 1915(b)(1) or (b)(4) authority.
      -- *Specify Program Instance(s) applicable to this authority*
      ☐ **Maine NET**
   d. ☑ **1915(b)(4)** - The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services. The State assures it will comply with 42 CFR 431.55(f).
      -- *Specify Program Instance(s) applicable to this authority*
      ☑ **Maine NET**

      The 1915(b)(4) waiver applies to the following programs
      ☐ **MCO**
      ☐ **PIHP**
      ☑ **PAHP**
      ☐ **PCCM** (Note: please check this item if this waiver is for a PCCM program that limits who is eligible to be a primary care case manager. That is, a program that requires PCCMs to meet certain quality/utilization criteria beyond the minimum requirements required to be a fee-for-service Medicaid contracting provider.)
      ☐ **FFS** Selective Contracting program
      Please describe:

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (2 of 3)

2. **Sections Waived.** Relying upon the authority of the above section(s), the State requests a waiver of the following sections of 1902 of the Act (if this waiver authorizes multiple programs, please list program(s) separately under each applicable statute):
   a. **Section 1902(a)(1)** - Statewideness--This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State.
   -- *Specify Program Instance(s) applicable to this statute*
   Maine NET

   b. **Section 1902(a)(10)(B)** - Comparability of Services--This section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as case management and health education that will not be available to other Medicaid beneficiaries not enrolled in the waiver program.
   -- *Specify Program Instance(s) applicable to this statute*
   Maine NET

   c. **Section 1902(a)(23)** - Freedom of Choice--This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, beneficiaries enrolled in this program must receive certain services through an MCO, PIHP, PAHP, or PCCM.
   -- *Specify Program Instance(s) applicable to this statute*
   Maine NET

   d. **Section 1902(a)(4)** - To permit the State to mandate beneficiaries into a single PIHP or PAHP, and restrict disenrollment from them. (If state seeks waivers of additional managed care provisions, please list here). For non-emergency transportation only
   -- *Specify Program Instance(s) applicable to this statute*
   Maine NET

   e. **Other Statutes and Relevant Regulations Waived** - Please list any additional section(s) of the Act the State requests to waive, and include an explanation of the request.

   -- *Specify Program Instance(s) applicable to this statute*
   Maine NET

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:
Assistance with transportation is critical for many MaineCare members to access Medicaid covered services. The Maine Department of Health and Human Services assures necessary transportation of MaineCare members whose trips originate within our borders to Medicaid covered services.

Currently, Maine uses a brokerage system of Full-Service Regional Transportation Providers which correspond with the Maine Department of Transportation (MaineDOT)transit districts. These agencies: 1) Provide transportation using their own vehicles and employees, 2) Schedule other transportation when needed, and 3) Pay members, friends and family, volunteers, taxis, bus companies etc. when they provide transportation to members. Other transportation options include 13 year-round fixed route transit systems including urban bus systems, intercity services and ferry systems. There are also a number of agencies that provide wheelchair van services but are not full-service regional transportation providers. These providers often also provide emergency transport, which is not covered under this waiver.

By coordinating with MaineDOT-supported regional providers, MaineCare has been able to leverage the resources provided by MaineDOT – including support for the rolling stock, coordinated use of resources and technical support.

Maine is seeking to maximize efficiency of its system and meet all federal requirements while ensuring the stability of its transportation system in this largely rural state, which is necessary to ensure access to services. Under this waiver, Maine is proposing to implement regional risk-based PAHPs using the MaineDOT transit districts as the basis for an RFP solicitation. Entities responding to Maine's RFP may bid on one or more regions and will be required to support the full range of transportation options. Maine will be setting the actuarially sound price range for services on a regional basis, at least in the initial waiver period, and will select winning bidder(s) based on cost, access and quality, as well as ability to meet administrative and technical requirements.

Simultaneously, Maine will be implementing this same managed care NET system with its CHIP population.

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (1 of 3)

1. **Delivery Systems.** The State will be using the following systems to deliver services:

   a. **MCO:** Risk-comprehensive contracts are fully-capitated and require that the contractor be an MCO or HIO. Comprehensive means that the contractor is at risk for inpatient hospital services and any other mandatory State plan service in section 1905(a), or any three or more mandatory services in that section. References in this preprint to MCOs generally apply to these risk-comprehensive entities.

   b. **PIHP:** Prepaid Inpatient Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments or other payment arrangements that do not use State Plan payment rates; (2) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. Note: this includes MCOs paid on a non-risk basis.

      The PIHP is paid on a risk basis

      The PIHP is paid on a non-risk basis

   c. **PAHP:** Prepaid Ambulatory Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State Plan payment rates; (2) does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. This includes capitated PCCMs.

      The PAHP is paid on a risk basis

      The PAHP is paid on a non-risk basis

   d. **PCCM:** A system under which a primary care case manager contracts with the State to furnish case management services. Reimbursement is on a fee-for-service basis. Note: a capitated PCCM is a PAHP.

   e. **Fee-for-service (FFS) selective contracting:** State contracts with specified providers who are willing to meet certain reimbursement, quality, and utilization standards.

      the same as stipulated in the state plan

      different than stipulated in the state plan

      Please describe:

   f. **Other:** (Please provide a brief narrative description of the model.)

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (2 of 3)

2. **Procurement.** The State selected the contractor in the following manner. Please complete for each type of managed care entity utilized (e.g. procurement for MCO; procurement for PIHP, etc):

Procurement for MCO

Competitive procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)

Open cooperative procurement process (in which any qualifying contractor may participate)

Sole source procurement

Other (please describe)

Procurement for PIHP

Competitive procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)

Open cooperative procurement process (in which any qualifying contractor may participate)

Sole source procurement

Other (please describe)

Procurement for PAHP

Competitive procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)

Open cooperative procurement process (in which any qualifying contractor may participate)

Sole source procurement

Other (please describe)

Procurement for PCCM

Competitive procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)

Open cooperative procurement process (in which any qualifying contractor may participate)

Sole source procurement

Other (please describe)

Procurement for FFS

Competitive procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)

Open cooperative procurement process (in which any qualifying contractor may participate)

Sole source procurement

Other (please describe)

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part I: Program Overview

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs (1 of 3)

1. **Assurances.**
   - ☑ The State assures CMS that it complies with section 1932(a)(3) of the Act and 42 CFR 438.52, which require that a State that mandates Medicaid beneficiaries to enroll in an MCO, PIHP, PAHP, or PCCM must give those beneficiaries a choice of at least two entities.
   - ☐ The State seeks a waiver of section 1932(a)(3) of the Act, which requires States to offer a choice of more than one PIHP or PAHP per 42 CFR 438.52. Please describe how the State will ensure this lack of choice of PIHP or PAHP is not detrimental to beneficiaries' ability to access services.

     Because of Maine's relatively small population, its relative lack of public transit infrastructure, and the support from Maine DOT that can be leveraged by working in coordination with its structure, it is not efficient or cost effective to contract with more than one provider in each region. Members will not be adversely affected because they will still have the full range of transportation services provided in a more effective and efficient way.
2. **Details.** The State will provide enrollees with the following choices (please replicate for each program in waiver):

   Program: **" Maine Non-Emergency Transportation Waiver. "**

   - ☐ **Two or more MCOs**
   - ☐ **Two or more primary care providers within one PCCM system.**
   - ☐ **A PCCM or one or more MCOs**
   - ☐ **Two or more PIHPs.**
   - ☐ **Two or more PAHPs.**
   - ☐ **Other:**

     please describe

Section A: Program Description

Part I: Program Overview

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs (2 of 3)

3. **Rural Exception.**
   - ☐ The State seeks an exception for rural area residents under section 1932(a)(3)(B) of the Act and 42 CFR 438.52 (b), and assures CMS that it will meet the requirements in that regulation, including choice of physicians or case managers, and ability to go out of network in specified circumstances. The State will use the rural exception in the following areas ("rural area" must be defined as any area other than an "urban area" as defined in 42 CFR 412.62 (f)(1)(ii)):

4. **1915(b)(4) Selective Contracting.**

- **Beneficiaries will be limited to a single provider in their service area**
  Please define service area.

  The state of Maine is divided into eight geographic transit regions for the purpose of distributing federal transit funds administered by the Department of Transportation (MaineDOT). The regions were identified consistent with other regional designations such as the economic development districts, regional planning entities which commonly use designations such as population density, economic factors such as service centers and labor markets as well as county line designations.

  MaineDOT also uses the designated transit regions in response to the provision of 23 MRSA §4209 sub§1, which states in part: "The Department of Transportation shall divide the State into a number of geographic regions for regional distribution of state-administered transportation funds." Further, interagency agreements among the three state agencies (Departments of Transportation, Labor and Health and Human Services) mandate the continued efforts to coordinate public transportation.

  Beneficiaries will be assigned to the broker responsible for coordinating transportation for the transit region in which the member resides.

- **Beneficiaries will be given a choice of providers in their service area**

Section A: Program Description

Part I: Program Overview

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part I: Program Overview

D. Geographic Areas Served by the Waiver (1 of 2)

1. **General.** Please indicate the area of the State where the waiver program will be implemented. (If the waiver authorizes more than one program, please list applicable programs below item(s) the State checks.
   - ■ **Statewide** -- all counties, zip codes, or regions of the State
     -- Specify Program Instance(s) for Statewide
     Maine NET
   - ■ **Less than Statewide**
     -- Specify Program Instance(s) for Less than Statewide
     Maine NET
2. **Details.** Regardless of whether item 1 or 2 is checked above, please list in the chart below the areas (i.e., cities, counties, and/or regions) and the name and type of entity or program (MCO, PIHP, PAHP, HIO, PCCM or other entity) with which the State will contract.

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
Eight regions comprising the entire state (see attached map)	PAHP	To be determined for each region by RFP

Section A: Program Description

Part I: Program Overview

D. Geographic Areas Served by the Waiver (2 of 2)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (1 of 3)

Please note that the eligibility categories of Included Populations and Excluded Populations below may be modified as needed to fit the State's specific circumstances.

1. **Included Populations.** The following populations are included in the Waiver Program:

- **Section 1931 Children and Related Populations** are children including those eligible under Section 1931, poverty-level related groups and optional groups of older children.
  - **Mandatory enrollment**
  - **Voluntary enrollment**

- **Section 1931 Adults and Related Populations** are adults including those eligible under Section 1931, poverty-level pregnant women and optional group of caretaker relatives.
  - **Mandatory enrollment**
  - **Voluntary enrollment**

- **Blind/Disabled Adults and Related Populations** are beneficiaries, age 18 or older, who are eligible for Medicaid due to blindness or disability. Report Blind/Disabled Adults who are age 65 or older in this category, not in Aged.
  - **Mandatory enrollment**
  - **Voluntary enrollment**

- **Blind/Disabled Children and Related Populations** are beneficiaries, generally under age 18, who are eligible for Medicaid due to blindness or disability.
  - **Mandatory enrollment**
  - **Voluntary enrollment**

- **Aged and Related Populations** are those Medicaid beneficiaries who are age 65 or older and not members of the Blind/Disabled population or members of the Section 1931 Adult population.
  - **Mandatory enrollment**
  - **Voluntary enrollment**

- **Foster Care Children** are Medicaid beneficiaries who are receiving foster care or adoption assistance (Title IV-E), are in foster-care, or are otherwise in an out-of-home placement.
  - **Mandatory enrollment**
  - **Voluntary enrollment**

- **TITLE XXI SCHIP** is an optional group of targeted low-income children who are eligible to participate in Medicaid if the State decides to administer the State Children's Health Insurance Program (SCHIP) through the Medicaid program.
  - **Mandatory enrollment**

Voluntary enrollment

☑ **Other** (Please define):

Maine's HIV and Non-categorical waiver populations will be included in covered populations. Transportation to the limited service package for which they are eligible will be covered. Transportation to services provided under the following waivers will also be covered:
State Waiver # Draft ID Application title
ME ME.0127 ME.05 Consumer Directed Personal Assistance Services
ME ME.0159 ME.06 Home and Community Services for Adults with Intellectual Disabilities or Autistic Disorder
ME ME.0276 ME.01 Elderly and Adults with Disabilities Waiver
ME ME.0467 ME.13 Support Services for Adults with Intellectual Disabilities or Autistic Disorder
ME ME.0864 ME.10 Services for Children with Intellectual Disabilities and or Pervasive Developmental Disorders

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (2 of 3)

2. **Excluded Populations.** Within the groups identified above, there may be certain groups of individuals who are excluded from the Waiver Program. For example, the "Aged" population may be required to enroll into the program, but "Dual Eligibles" within that population may not be allowed to participate. In addition, "Section 1931 Children" may be able to enroll voluntarily in a managed care program, but "Foster Care Children" within that population may be excluded from that program. Please indicate if any of the following populations are excluded from participating in the Waiver Program:

☐ **Medicare Dual Eligible** --Individuals entitled to Medicare and eligible for some category of Medicaid benefits. (Section 1902(a)(10) and Section 1902(a)(10)(E))

☐ **Poverty Level Pregnant Women** -- Medicaid beneficiaries, who are eligible only while pregnant and for a short time after delivery. This population originally became eligible for Medicaid under the SOBRA legislation.

☐ **Other Insurance** --Medicaid beneficiaries who have other health insurance.

☐ **Reside in Nursing Facility or ICF/MR** --Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

☐ **Enrolled in Another Managed Care Program** --Medicaid beneficiaries who are enrolled in another Medicaid managed care program

☐ **Eligibility Less Than 3 Months** --Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program.

☐ **Participate in HCBS Waiver** --Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).

☐ **American Indian/Alaskan Native** --Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes.

☐ **Special Needs Children (State Defined)** --Medicaid beneficiaries who are special needs children as defined by the State. Please provide this definition.

☐ **SCHIP Title XXI Children** – Medicaid beneficiaries who receive services through the SCHIP program.

☑ **Retroactive Eligibility** – Medicaid beneficiaries for the period of retroactive eligibility.

☐ **Other** (Please define):

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part I: Program Overview

F. Services (1 of 5)

List all services to be offered under the Waiver in Appendices D2.S. and D2.A of Section D, Cost-Effectiveness.

1. **Assurances.**

☑ The State assures CMS that services under the Waiver Program will comply with the following federal requirements:

- Services will be available in the same amount, duration, and scope as they are under the State Plan per 42 CFR 438.210(a)(2).
- Access to emergency services will be assured per section 1932(b)(2) of the Act and 42 CFR 438.114.
- Access to family planning services will be assured per section 1905(a)(4) of the Act and 42 CFR 431.51(b)

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any. (See note below for limitations on requirements that may be waived).

☑ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of 42 CFR 438.210(a)(2), 438.114, and 431.51 (Coverage of Services, Emergency Services, and Family Planning) as applicable. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

☐ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply. The State assures CMS that services will be available in the same amount, duration, and scope as they are under the State Plan.

☑ The state assures CMS that it complies with Title I of the Medicare Modernization Act of 2003, in so far as these requirements are applicable to this waiver.

Note: Section 1915(b) of the Act authorizes the Secretary to waive most requirements of section 1902 of the Act for the purposes listed in sections 1915(b)(1)-(4) of the Act. However, within section 1915(b) there are prohibitions on waiving the following subsections of section 1902 of the Act for any type of waiver program:

- Section 1902(s) -- adjustments in payment for inpatient hospital services furnished to infants under age 1, and to children under age 6 who receive inpatient hospital services at a Disproportionate Share Hospital (DSH) facility.

- Sections 1902(a)(15) and 1902(bb) – prospective payment system for FQHC/RHC
- Section 1902(a)(10)(A) as it applies to 1905(a)(2)(C) – comparability of FQHC benefits among Medicaid beneficiaries
- Section 1902(a)(4)(C) -- freedom of choice of family planning providers
- Sections 1915(b)(1) and (4) also stipulate that section 1915(b) waivers may not waive freedom of choice of emergency services providers.

Section A: Program Description

Part I: Program Overview

F. Services (2 of 5)

2. **Emergency Services.** In accordance with sections 1915(b) and 1932(b) of the Act, and 42 CFR 431.55 and 438.114, enrollees in an MCO, PIHP, PAHP, or PCCM must have access to emergency services without prior authorization, even if the emergency services provider does not have a contract with the entity.

   ☐ The PAHP, PAHP, or FFS Selective Contracting program does not cover emergency services.

   Emergency Services Category General Comments (optional):
   Emergency transportation is not included; neither are emergency services.

3. **Family Planning Services.** In accordance with sections 1905(a)(4) and 1915(b) of the Act, and 42 CFR 431.51(b), prior authorization of, or requiring the use of network providers for family planning services is prohibited under the waiver program. Out-of-network family planning services are reimbursed in the following manner:

   ☐ The MCO/PIHP/PAHP will be required to reimburse out-of-network family planning services.

   ☐ The MCO/PIHP/PAHP will be required to pay for family planning services from network providers, and the State will pay for family planning services from out-of-network providers.

   ☐ The State will pay for all family planning services, whether provided by network or out-of-network providers.

   ☐ Other (please explain):

   ☑ Family planning services are not included under the waiver.

   Family Planning Services Category General Comments (optional):
   Transportation to family planning services is provided, but not the family planning services themselves.

Section A: Program Description

Part I: Program Overview

F. Services (3 of 5)

4. **FQHC Services.** In accordance with section 2088.6 of the State Medicaid Manual, access to Federally Qualified Health Center (FQHC) services will be assured in the following manner:

   ☐ The program is **voluntary**, and the enrollee can disenroll at any time if he or she desires access to FQHC services. The MCO/PIHP/PAHP/PCCM is not required to provide FQHC services to the enrollee during the enrollment period.

   ☐ The program is **mandatory** and the enrollee is guaranteed a choice of at least one MCO/PIHP/PAHP/PCCM which has at least one FQHC as a participating provider. If the enrollee elects not to select a MCO/PIHP/PAHP/PCCM that gives him or her access to FQHC services, no FQHC services will be required to be furnished to the enrollee while the enrollee is enrolled with the MCO/PIHP/PAHP/PCCM he or she selected. Since reasonable access to FQHC services will be available under the waiver program, FQHC services outside the

program will not be available. Please explain how the State will guarantee all enrollees will have a choice of at least one MCO/PIHP/PAHP/PCCM with a participating FQHC:

☑ The program is **mandatory** and the enrollee has the right to obtain FQHC services **outside** this waiver program through the regular Medicaid Program.

FQHC Services Category General Comments (optional):
Necessary transportation to FQHC services will be provided.
the state will ensure transportation to Indian health provider FQHC services and to EPSDT services for Indian children who are Medicaid beneficiaries through the following RFP and contract provisions:
• Requiring Brokers to subcontract with tribes that would like to be their own transportation providers and that meet provider qualifications.
• The state ensuring that negotiated rates between the Broker and the tribal provider are adequate and reasonable given other area rates and the cultural expertise offered by the tribal provider.
• Encouraging bidders to leverage efficient and effective tribal systems and resources for volunteer recruitment, coordination and, where appropriate, volunteer and family, friends and member reimbursement through sub contractual or other proposed arrangements.
• Requiring the Broker to have representation from federally recognized tribes on a regional advisory committee to review and discuss broker performance, coordination with local resources, and other community concerns.

In addition, the Broker must secure sufficient provider resources (numbers and types of vehicles, drivers, and attendants) under service agreements so that the failure of any provider to perform will not impede the ability of the Broker to provide NET services in accordance with the requirements of the contract. As part of the RFP, the Broker must provide letters of intent from transportation agencies with which they expect to negotiate service agreements, as well as a plan for maintaining and developing a volunteer network in order to ensure adequate capacity and access for all MaineCare members receiving NET services.

5. **EPSDT Requirements.**

☑ The managed care programs(s) will comply with the relevant requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements including informing, reporting, etc.), and 1905(r) (definition) of the Act related to Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

EPSDT Requirements Category General Comments (optional):
Necessary transportation to EPSDT services will be provided.

Section A: Program Description

Part I: Program Overview

F. Services (4 of 5)

6. **1915(b)(3) Services.**

☐ This waiver includes 1915(b)(3) expenditures. The services must be for medical or health-related care, or other services as described in 42 CFR Part 440, and are subject to CMS approval. Please describe below what these expenditures are for each waiver program that offers them. Include a description of the populations eligible, provider type, geographic availability, and reimbursement method.

1915(b)(3) Services Requirements Category General Comments:

7. **Self-referrals.**

☐ The State requires MCOs/PIHPs/PAHPs/PCCMs to allow enrollees to self-refer (i.e. access without prior authorization) under the following circumstances or to the following subset of services in the MCO/PIHP/PAHP/PCCM contract:

Self-referrals Requirements Category General Comments:

Not Applicable. NET services will be accessed by calling the regional broker who will screen members to determine MaineCare eligibility and to ensure the request meets the criteria for NET.

8. **Other.**

Other (Please describe)

Section A: Program Description

Part I: Program Overview

F. Services (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part II: Access

A. Timely Access Standards (1 of 7)

Each State must ensure that all services covered under the State plan are available and accessible to enrollees of the 1915(b) Waiver Program. Section 1915(b) of the Act prohibits restrictions on beneficiaries' access to emergency services and family planning services.

1. **Assurances for MCO, PIHP, or PAHP programs**

The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services; in so far as these requirements are applicable.

The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II.B. Capacity Standards.

Section A: Program Description

Part II: Access

A. Timely Access Standards (2 of 7)

2. **Details for PCCM program.** The State must assure that Waiver Program enrollees have reasonable access to services. Please note below the activities the State uses to assure timely access to services.

   a. **Availability Standards.** The State's PCCM Program includes established maximum distance and/or travel time requirements, given beneficiary's normal means of transportation, for waiver enrollees' access to the following providers. For each provider type checked, please describe the standard.

   1. PCPs

      Please describe:

   2. Specialists

      Please describe:

   3. Ancillary providers

      Please describe:

   4. Dental

      Please describe:

   5. Hospitals

      Please describe:

   6. Mental Health

      Please describe:

   7. Pharmacies

      Please describe:

   8. Substance Abuse Treatment Providers

      Please describe:

   9. Other providers

      Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (3 of 7)

2. **Details for PCCM program.** (Continued)

b. **Appointment Scheduling**means the time before an enrollee can acquire an appointment with his or her provider for both urgent and routine visits. The State's PCCM Program includes established standards for appointment scheduling for waiver enrollee's access to the following providers.

1. PCPs

Please describe:

2. Specialists

Please describe:

3. Ancillary providers

Please describe:

4. Dental

Please describe:

5. Mental Health

Please describe:

6. Substance Abuse Treatment Providers

Please describe:

7. Urgent care

Please describe:

8. Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (4 of 7)

2. Details for PCCM program. (Continued)

c. **In-Office Waiting Times**: The State's PCCM Program includes established standards for in-office waiting times. For each provider type checked, please describe the standard.

1. PCPs

Please describe:

2. Specialists

Please describe:

3. Ancillary providers

Please describe:

4. Dental

Please describe:

5. Mental Health

Please describe:

6. Substance Abuse Treatment Providers

Please describe:

7. Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (5 of 7)

2. **Details for PCCM program.** (Continued)

   d. **Other Access Standards**

Section A: Program Description

Part II: Access

A. Timely Access Standards (6 of 7)

3. **Details for 1915(b)(4)FFS selective contracting programs:** Please describe how the State assures timely access to the services covered under the selective contracting program.

Section A: Program Description

Part II: Access

A. Timely Access Standards (7 of 7)

Additional Information. Please enter any additional information not included in previous pages:
The NET managed care system will ensure timely access to services by requiring 24/7 access and requiring performance standards to be met as part of contract compliance, including trip length and timeliness.

Section A: Program Description

Part II: Access

B. Capacity Standards (1 of 6)

1. **Assurances for MCO, PIHP, or PAHP programs**

   ☑ The State assures CMS that it complies with section 1932(b)(5) of the Act and 42 CFR 438.207 Assurances of adequate capacity and services, in so far as these requirements are applicable.

   ☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

   Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

   ☐ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(b)(5) and 42 CFR 438.207 Assurances of adequate capacity and services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II, C. Coordination and Continuity of Care Standards.

Section A: Program Description

Part II: Access

B. Capacity Standards (2 of 6)

2. **Details for PCCM program.** The State must assure that Waiver Program enrollees have reasonable access to services. Please note below which of the strategies the State uses assure adequate provider capacity in the PCCM program.
   a. The State has set **enrollment limits** for each PCCM primary care provider.

      Please describe the enrollment limits and how each is determined:

   b. The State ensures that there are adequate number of PCCM PCPs with **open panels.**

      Please describe the State's standard:

   c. The State ensures that there is an **adequate number** of PCCM PCPs under the waiver assure access to all services covered under the Waiver.

      Please describe the State's standard for adequate PCP capacity:

Section A: Program Description

Part II: Access

B. Capacity Standards (3 of 6)

2. **Details for PCCM program.** (Continued)
   d. The State compares **numbers of providers** before and during the Waiver.

Provider Type	# Before Waiver	# in Current Waiver	# Expected in Renewal

   Please note any limitations to the data in the chart above:

   e. The State ensures adequate **geographic distribution** of PCCMs.

      Please describe the State's standard:

Section A: Program Description

Part II: Access

B. Capacity Standards (4 of 6)

2. **Details for PCCM program.** (Continued)

f. PCP:Enrollee Ratio. The State establishes standards for PCP to enrollee ratios.

Area/(City/County/Region)	PCCM-to-Enrollee Ratio	

Please note any changes that will occur due to the use of physician extenders.:

g. Other capacity standards.

Please describe:

Section A: Program Description

Part II: Access

B. Capacity Standards (5 of 6)

3. **Details for 1915(b)(4)FFS selective contracting programs:** Please describe how the State assures provider capacity has not been negatively impacted by the selective contracting program. Also, please provide a detailed capacity analysis of the number of beds (by type, per facility) – for facility programs, or vehicles (by type, per contractor) – for non-emergency transportation programs, needed per location to assure sufficient capacity under the waiver program. This analysis should consider increased enrollment and/or utilization expected under the waiver.

Section A: Program Description

Part II: Access

B. Capacity Standards (6 of 6)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (1 of 5)

1. **Assurances for MCO, PIHP, or PAHP programs**

The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services; in so far as these requirements are applicable.

The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

These providers will have no contact with treatment plans, but will coordinate transportation services.

The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services. If

this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (2 of 5)

2. Details on MCO/PIHP/PAHP enrollees with special health care needs.

The following items are required.

a. The plan is a PIHP/PAHP, and the State has determined that based on the plan's scope of services, and how the State has organized the delivery system, that the **PIHP/PAHP need not meet the requirements** for additional services for enrollees with special health care needs in 42 CFR 438.208.

Please provide justification for this determination:

b. **Identification.** The State has a mechanism to identify persons with special health care needs to MCOs, PIHPs, and PAHPs, as those persons are defined by the State.

Please describe:

NET services are provided and specifically designed to accommodate and transport people with special health needs and disabilities, including wheelchairs. The transportation brokers will be required to understand special health care needs and disabilities. At the time of accessing services the regional transportation broker will have a conversation with the individual member or representative to understand the member's needs and meet those needs in the most cost-effective way possible.

c. **Assessment.** Each MCO/PIHP/PAHP will implement mechanisms, using appropriate health care professionals, to assess each enrollee identified by the State to identify any ongoing special conditions that require a course of treatment or regular care monitoring. Please describe:

Please describe the enrollment limits and how each is determined:

The NET contractor will obtain medical information from clinical personnel if necessary to assure the most appropriate transportation is used to meet these member's special needs. In most instances if special transportation is required it is apparent, particularly in the cases of wheelchairs and stretchers.

d. **Treatment Plans.** For enrollees with special health care needs who need a course of treatment or regular care monitoring, the State requires the MCO/PIHP/PAHP to produce a treatment plan.If so, the treatment plan meets the following requirements:

1. Developed by enrollees' primary care provider with enrollee participation, and in consultation with any specialists' care for the enrollee.
2. Approved by the MCO/PIHP/PAHP in a timely manner (if approval required by plan).
3. In accord with any applicable State quality assurance and utilization review standards.

Please describe:

e. **Direct access to specialists.** If treatment plan or regular care monitoring is in place, the MCO/PIHP/PAHP has a mechanism in place to allow enrollees to directly access specialists as appropriate for enrollee's condition and identified needs.

Please describe:

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (3 of 5)

3. **Details for PCCM program.** The State must assure that Waiver Program enrollees have reasonable access to services. Please note below which of the strategies the State uses assure adequate provider capacity in the PCCM program.
   - a. Each enrollee selects or is assigned to a **primary care provider** appropriate to the enrollee's needs.
   - b. Each enrollee selects or is assigned to a designated **designated health care practitioner** who is primarily responsible for coordinating the enrollee's overall health care.
   - c. Each enrollee is receives **health education/promotion** information.

     Please explain:
   - d. Each provider maintains, for Medicaid enrollees, **health records** that meet the requirements established by the State, taking into account professional standards.
   - e. There is appropriate and confidential **exchange of information** among providers.
   - f. Enrollees receive information about specific health conditions that require **follow-up** and, if appropriate, are given training in self-care.
   - g. Primary care case managers **address barriers** that hinder enrollee compliance with prescribed treatments or regimens, including the use of traditional and/or complementary medicine.
   - h. **Additional case management** is provided.

     Please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case manager's files.
   - i. **Referrals.**

     Please explain in detail the process for a patient referral. In the description, please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case managers' files.

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (4 of 5)

4. **Details for 1915(b)(4) only programs:** If applicable, please describe how the State assures that continuity and coordination of care are not negatively impacted by the selective contracting program.
   NET services play a vital role in the provision of appropriate, coordinated, cost effective, quality healthcare for MaineCare members. Without reliable access to regular preventive services and urgent care, members are more likely to go without care or to turn to hospital Emergency Departments (ED), resulting in delayed, fractured and expensive care. The Broker is required to establish and convene a regional advisory committee that meets quarterly to
   • Review and discuss Broker performance, including any corrective action plans,
   • Identify and discuss plans to resolve any recurrent issues with NEMT service or coordination in tribal areas, specific communities, and/or the region as a whole.

• Identify opportunities and make linkages with existing programs and services for the NEMT member population to minimize duplicate efforts and fragmentation of services,
• Determine appropriate strategies to ensure safe transportation for members with behavioral challenges and other issues that could affect the safety and comfort of drivers and other passengers.

The Regional Advisory Committee shall include, at a minimum:

• MaineCare members receiving NEMT services (2)
• Representative from each federally recognized tribe in the region, if any (1 per tribe)
• Representative from each Patient Centered Medical Home Community Care Team(s) serving members in the region, if any (1 per PCMH CCT)
• Representative from MaineCare PCCM or Health Home provider (1)
• Representative from area hospital (1 per hospital)
• Home and Community Based Service provider (1)
• MaineDOT-designated regional transportation provider for the region (1)
• Representative from each fixed route transit system in the region, if any (1 for each fixed route transit system)
• Volunteer driver (1)
• Other transportation providers (2)

The Broker must provide the Department with meeting dates and times, agendas, minutes and action items from all Regional Advisory Committee meetings. In addition, the State may attend any scheduled meeting with or without advance notice. The Regional Advisory Committee Meetings will act as a vehicle to resolve community issues raised internally or externally to the group, and to ensure that NET services are coordinated with the Medicaid healthcare system as a whole, rather than treated as isolated services.

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part III: Quality

1. **Assurances for MCO or PIHP programs**

The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242 in so far as these regulations are applicable.
The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.
Section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202 requires that each State Medicaid agency that contracts with MCOs and PIHPs submit to CMS a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs.

The State assures CMS that this **quality strategy** was initially submitted to the CMS Regional Office on:

(mm/dd/yy)

The State assures CMS that it complies with section 1932(c)(2) of the Act and 42 CFR 438 Subpart E, to arrange for an annual, independent, **external quality review** of the outcomes and timeliness of, and access to the services delivered under each MCO/ PIHP contract. Note: EQR for PIHPs is required beginning March 2004.

Please provide the information below (modify chart as necessary):

Program Type	Name of Organization	Activities Conducted		
		EQR study	Mandatory Activities	Optional Activities
MCO				
PIHP				

Section A: Program Description

Part III: Quality

2. Assurances For PAHP program

The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236, in so far as these regulations are applicable.

The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

The CMS Regional Office has reviewed and approved the PAHP contracts for compliance with the provisions of section 1932(c) (1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section A: Program Description

Part III: Quality

3. Details for PCCM program. The State must assure that Waiver Program enrollees have access to medically necessary services of adequate quality. Please note below the strategies the State uses to assure quality of care in the PCCM program.

a. The State has developed a set of overall quality **improvement guidelines** for its PCCM program.

Please describe:

Section A: Program Description

Part III: Quality

3. **Details for PCCM program.** (Continued)
   b. **State Intervention:** If a problem is identified regarding the quality of services received, the State will intervene as indicated below.
      1. Provide education and informal mailings to beneficiaries and PCCMs
      2. Initiate telephone and/or mail inquiries and follow-up
      3. Request PCCM's response to identified problems
      4. Refer to program staff for further investigation
      5. Send warning letters to PCCMs
      6. Refer to State's medical staff for investigation
      7. Institute corrective action plans and follow-up
      8. Change an enrollee's PCCM
      9. Institute a restriction on the types of enrollees
      10. Further limit the number of assignments
      11. Ban new assignments
      12. Transfer some or all assignments to different PCCMs
      13. Suspend or terminate PCCM agreement
      14. Suspend or terminate as Medicaid providers
      15. Other

      Please explain:

Section A: Program Description

Part III: Quality

3. **Details for PCCM program.** (Continued)
   c. **Selection and Retention of Providers**: This section provides the State the opportunity to describe any requirements, policies or procedures it has in place to allow for the review and documentation of qualifications and other relevant information pertaining to a provider who seeks a contract with the State or PCCM administrator as a PCCM. This section is required if the State has applied for a 1915(b)(4) waiver that will be applicable to the PCCM program.
   Please check any processes or procedures listed below that the State uses in the process of selecting and retaining PCCMs. The State (please check all that apply):
      1. Has a documented process for selection and retention of PCCMs (please submit a copy of that documentation).
      2. Has an initial credentialing process for PCCMs that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.
      3. Has a recredentialing process for PCCMs that is accomplished within the time frame set by the State and through a process that updates information obtained through the following (check all that apply):
         A. Initial credentialing
         B. Performance measures, including those obtained through the following (check all that apply):
            - The utilization management system.
            - The complaint and appeals system.
            - Enrollee surveys.
            - Other.

            Please describe:

4. Uses formal selection and retention criteria that do not discriminate against particular providers such as those who serve high risk populations or specialize in conditions that require costly treatment.
5. Has an initial and recredentialing process for PCCMs other than individual practitioners (e.g., rural health clinics, federally qualified health centers) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).
6. Notifies licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of PCCMs take place because of quality deficiencies.
7. Other

Please explain:

Section A: Program Description

Part III: Quality

3. **Details for PCCM program.** (Continued)

   d. Other quality standards (please describe):

Section A: Program Description

Part III: Quality

4. **Details for 1915(b)(4) only programs:** Please describe how the State assures quality in the services that are covered by the selective contracting program. Please describe the provider selection process, including the criteria used to select the providers under the waiver. These include quality and performance standards that the providers must meet. Please also describe how each criteria is weighted:
   Brokers will be selected using 3 main criteria

   I. Organizational Qualifications and Experience: The bidder must demonstrate adequate organizational structure, fiscal solvency, and well qualified key personnel. They shall additionally document their experience with similar projects, including references from persons or entities for whom the bidder provided such service.
   II. Specifications of Work to be Performed: The bidder will provide a detailed plan outlining how it intends to perform the responsibilities detailed in the scope of work. This will include the ability to establish and maintain an adequate network of vehicles, agency and volunteer drivers, to operate a customer contact center, and to provide the reporting required by the state.
   III. Cost Proposal: The PMPM cost submitted by the bidder will be compared to other proposals. The lowest bid that complies with the actuarially sound rates determined by the department will receive the top score. Higher priced bids will receive points based on the ratio of their costs to the lowest cost bid.

   The Department has extensive Driver and Vehicle standards which have been sent to CMS under a separate attachment.

   Complaint & Grievance Requirements:

   Complaints:

   The Broker shall submit to the Department a log and summary report of member complaints received the previous calendar month. The log should separate the complaints by their nature (timeliness, courtesy, etc), as well as contain a cumulative total. The Broker should address any observable trends, detailing actions taken or anticipated to resolve the root causes of the trends.

The log should contain a detailed report describing each complaint, containing the following information:

- Member Name;
- Complainant;
- Date of Complaint;
- Date of Transportation
- Complaint Details;
- Who the complaint is against;
- Complaint Resolution;
- Resolution Date

The Broker must meet the monthly performance benchmark that the member complaint rate shall not exceed one complaint per 100 eligible members. If the Broker fails to meet this benchmark, there shall be a one percent (1%) reduction of the Broker's total payment for the subsequent calendar month.

Grievance:

The Broker shall have a Grievance and Appeal System in place that includes a Grievance process, an Appeal of Adverse Action process, and access to the DHHS Fair Hearing system. In order to ensure a "one-step" appeals process from the member's perspective, if a member goes through the Broker's internal appeals process and wants to contest the decision, the Broker shall assist the member to request a fair hearing from the State. At this time, the Broker shall prepare and submit an appeal summary to the Office of Administrative Hearings, the OMS Contract Monitor, and the member involved in the appeal in accordance with required time frames.

The Department will review all policies and procedures regarding the Broker's proposed Grievance and Appeal System prior to implementation and upon revision. The Broker's Grievance and Appeal System must ensure that appropriate decisions are made as promptly as possible. The process shall include provisions for expediting decisions within five (5) working days. Brokers shall include as part of the RFP their proposed Grievance and Appeal System.

The Broker shall comply with all state and federal laws, regulations, and OMS policies regarding the content and timeframes for a state fair hearing and appeal summaries. The Broker shall attend and defend the Broker's decisions at all Department appeal hearings, whether in person or by telephone, as deemed necessary by the Department Office of Administrative Hearings. Broker travel and telephone expenses in relation to appeal activities shall be borne by the Broker.

The Department shall maintain final decision making authority regarding the disposition of any member grievance or appeal. The Broker agrees to accept such decisions as binding and may not appeal them.

The Broker will provide OMS with monthly reports indicating the number of appeal requests received, any resolution reached, requests that went to a state fair hearing, detailed analysis and disposition.

Section A: Program Description

Part IV: Program Operations

A. Marketing (1 of 4)

1. **Assurances**

The State assures CMS that it complies with section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities; in so far as these regulations are applicable.
The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

Section A: Program Description

Part IV: Program Operations

A. Marketing (2 of 4)

2. Details

a. Scope of Marketing

1.

The State does not permit direct or indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers.

2. The State permits indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general).

Please list types of indirect marketing permitted:

3. The State permits direct marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., direct mail to Medicaid beneficiaries).

Please list types of direct marketing permitted:

Section A: Program Description

Part IV: Program Operations

A. Marketing (3 of 4)

2. Details (Continued)

b. Description. Please describe the State's procedures regarding direct and indirect marketing by answering the following questions, if applicable.

1.

The State prohibits or limits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers from offering gifts or other incentives to potential enrollees.

Please explain any limitation or prohibition and how the State monitors this:

2. The State permits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers to pay their marketing representatives based on the number of new Medicaid enrollees he/she recruited into the plan.

Please explain how the State monitors marketing to ensure it is not coercive or fraudulent:

3. The State requires MCO/PIHP/PAHP/PCCM/selective contracting FFS providers to translate marketing materials.

Please list languages materials will be translated into. (If the State does not translate or require the translation of marketing materials, please explain):

The State has chosen these languages because (check any that apply):

a. The languages comprise all prevalent languages in the service area.

Please describe the methodology for determining prevalent languages:

b. The languages comprise all languages in the service area spoken by approximately _____ percent or more of the population.

c. Other

Please explain:

Section A: Program Description

Part IV: Program Operations

A. Marketing (4 of 4)

Additional Information. Please enter any additional information not included in previous pages:
Marketing requirements are not applicable. Any marketing material would not be pertinent to enrollment. All MaineCare members will be automatically enrolled with the single broker in their region. Any information provided would be related to informing members of the availability of transportation services.

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (1 of 5)

1. Assurances

The State assures CMS that it complies with Federal Regulations found at section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements; in so far as these regulations are applicable.

The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (2 of 5)

2. Details

a. Non-English Languages

1.

Potential enrollee and enrollee materials will be translated into the prevalent non-English languages.

Please list languages materials will be translated into. (If the State does not require written materials to be translated, please explain):

There is no marketing because members are automatically enrolled with a single broker. Informational mailings must include a Census Language Identification Flashcard (provided separately) offering translation services. If the Broker doesn't have a translator available, it will use a telephone language line. Initial mailings to new members include a welcome packet including info on transportation.

If the State does not translate or require the translation of marketing materials, please explain:

The State defines prevalent non-English languages as: (check any that apply):

a. The languages spoken by significant number of potential enrollees and enrollees.

Please explain how the State defines "significant.":

Welcome packets are in Arabic, Cantonese, Chinese, French, Khmer, Mandarin, Russian, Serb, Somali, Spanish and Vietnamese. Languages were determined by use of the MaineCare language lines and consultation with the Portland Public Schools, the area in which the vast majority of non-English speaking Mainers live.

b. The languages spoken by approximately percent or more of the potential enrollee/enrollee population.

c. Other

Please explain:

2. Please describe how oral translation services are available to all potential enrollees and enrollees, regardless of language spoken.

If the Broker does not have a translator available to assist, the Broker will use a telephone-based language line.

3. ☑ The State will have a mechanism in place to help enrollees and potential enrollees understand the managed care program.

Please describe:

If the Broker does not have a translator available to assist, the Broker will use a telephone-based language line.

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (3 of 5)

2. **Details** (Continued)

b. **Potential Enrollee Information**

Information is distributed to potential enrollees by:

☐ State
☐ Contractor

Please specify:

☑ There are no potential enrollees in this program. (Check this if State automatically enrolls beneficiaries into a single PIHP or PAHP.)

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (4 of 5)

2. **Details** (Continued)

c. **Enrollee Information**

The State has designated the following as responsible for providing required information to enrollees:

☑ the State
☑ State contractor

Please specify:

The State, through a separate contract, is responsible for sending out information to new enrollees. Any other information the Brokers send out must be approved by the State.

☑ The MCO/PIHP/PAHP/PCCM/FFS selective contracting provider.

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (1 of 6)

1. **Assurances**

- [x] The State assures CMS that it complies with section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment; in so far as these regulations are applicable.
- [ ] The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs. (Please check this item if the State has requested a waiver of the choice of plan requirements in section A.I.C.)

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

- [x] The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.
- [ ] This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (2 of 6)

2. **Details**

Please describe the State's enrollment process for MCOs/PIHPs/PAHP/PCCMs and FFS selective contracting provider by checking the applicable items below.

a. Outreach

- [x] The State conducts outreach to inform potential enrollees, providers, and other interested parties of the managed care program.

Please describe the outreach process, and specify any special efforts made to reach and provide information to special populations included in the waiver program:

All members are automatically enrolled on a mandatory basis so no outreach is necessary.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (3 of 6)

2. **Details** (Continued)

b. Administration of Enrollment Process

☑ State staff conducts the enrollment process.

☐ The State contracts with an independent contractor(s) (i.e., enrollment broker) to conduct the enrollment process and related activities.

☐ The State assures CMS the enrollment broker contract meets the independence and freedom from conflict of interest requirements in section 1903(b) of the Act and 42 CFR 438.810.

Broker name:

Please list the functions that the contractor will perform:

☐ choice counseling

☐ enrollment

☐ other

Please describe:

☐ State allows MCO/PIHP/PAHP or PCCM to enroll beneficiaries.

Please describe the process:

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (4 of 6)

2. Details (Continued)

c. Enrollment . The State has indicated which populations are mandatorily enrolled and which may enroll on a voluntary basis in Section A.I.E.

☐ This is a **new** program.

Please describe the **implementation schedule** (e.g. implemented statewide all at once; phased in by area; phased in by population, etc.):

All populations will be enrolled at once at the beginning of the waiver period.

☐ This is an **existing program** that will be expanded during the renewal period.

Please describe: Please describe the **implementation schedule** (e.g. new population implemented statewide all at once; phased in by area; phased in by population, etc.):

If a potential enrollee **does not select** an MCO/PIHP/PAHP or PCCM within the given time frame, the potential enrollee will be **auto-assigned** or default assigned to a plan.

i. ☐ Potential enrollees will have **day(s)** / **month(s)** to choose a plan.

ii. ☐ There is an auto-assignment process or algorithm.

In the description please indicate the factors considered and whether or not the auto-assignment process assigns persons with special health care needs to an

MCO/PIHP/PAHP/PCCM who is their current provider or who is capable of serving their particular needs:

☑ The State automatically enrolls beneficiaries.

- ☐ on a mandatory basis into a single MCO, PIHP, or PAHP in a rural area (please also check item A.I.C.3).
- ☑ on a mandatory basis into a single PIHP or PAHP for which it has requested a waiver of the requirement of choice of plans (please also check item A.I.C.1).
- ☐ on a voluntary basis into a single MCO, PIHP, or PAHP. The State must first offer the beneficiary a choice. If the beneficiary does not choose, the State may enroll the beneficiary as long as the beneficiary can opt out at any time without cause.

Please specify geographic areas where this occurs:

☐ The State provides **guaranteed eligibility** of _____ months (maximum of 6 months permitted) for MCO/PCCM enrollees under the State plan.

☐ The State allows otherwise mandated beneficiaries to request **exemption** from enrollment in an MCO/PIHP/PAHP/PCCM.

Please describe the circumstances under which a beneficiary would be eligible for exemption from enrollment. In addition, please describe the exemption process:

☑ The State **automatically re-enrolls** a beneficiary with the same PCCM or MCO/PIHP/PAHP if there is a loss of Medicaid eligibility of 2 months or less.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (5 of 6)

2. Details (Continued)

d. Disenrollment

☐ The State allows enrollees to **disenroll** from/transfer between MCOs/PIHPs/PAHPs and PCCMs. Regardless of whether plan or State makes the determination, determination must be made no later than the first day of the second month following the month in which the enrollee or plan files the request. If determination is not made within this time frame, the request is deemed approved.

- **i.** ☐ Enrollee submits request to State.
- **ii.** ☐ Enrollee submits request to MCO/PIHP/PAHP/PCCM. The entity may approve the request, or refer it to the State. The entity may not disapprove the request.
- **iii.** ☐ Enrollee must seek redress through MCO/PIHP/PAHP/PCCM grievance procedure before determination will be made on disenrollment request.

☐ The State **does not permit disenrollment** from a single PIHP/PAHP (authority under 1902 (a)(4) authority must be requested), or from an MCO, PIHP, or PAHP in a rural area.

☐ The State has a **lock-in** period (i.e. requires continuous enrollment with MCO/PIHP/PAHP/PCCM) of _____ months (up to 12 months permitted). If so, the State assures it meets the requirements of 42 CFR 438.56(c).

Please describe the good cause reasons for which an enrollee may request disenrollment during the lock-in period (in addition to required good cause reasons of poor quality of care, lack of access to covered services, and lack of access to providers experienced in dealing with enrollee's health care needs):

The State does not have a **lock-in**, and enrollees in MCOs/PIHPs/PAHPs and PCCMs are allowed to terminate or change their enrollment without cause at any time. The disenrollment/transfer is effective no later than the first day of the second month following the request.

The State permits **MCOs/PIHPs/PAHPs and PCCMs to request disenrollment** of enrollees.

i. MCO/PIHP/PAHP and PCCM can request reassignment of an enrollee.

Please describe the reasons for which enrollees can request reassignment

ii. The State reviews and approves all MCO/PIHP/PAHP/PCCM-initiated requests for enrollee transfers or disenrollments.

iii. If the reassignment is approved, the State notifies the enrollee in a direct and timely manner of the desire of the MCO/PIHP/PAHP/PCCM to remove the enrollee from its membership or from the PCCM's caseload.

iv. The enrollee remains an enrollee of the MCO/PIHP/PAHP/PCCM until another MCO/PIHP/PAHP/PCCM is chosen or assigned.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (6 of 6)

Additional Information. Please enter any additional information not included in previous pages:
No disenrollment is permitted.

Section A: Program Description

Part IV: Program Operations

D. Enrollee Rights (1 of 2)

1. **Assurances**

The State assures CMS that it complies with section 1932(a)(5)(B)(ii) of the Act and 42 CFR 438 Subpart C Enrollee Rights and Protections.

The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5)(B)(ii) of the Act and 42 CFR Subpart C Enrollee Rights and Protections. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

☑ The State assures CMS it will satisfy all HIPAA Privacy standards as contained in the HIPAA rules found at 45 CFR Parts 160 and 164.

Section A: Program Description

Part IV: Program Operations

D. Enrollee Rights (2 of 2)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part IV: Program Operations

E. Grievance System (1 of 5)

1. **Assurances for All Programs** States, MCOs, PIHPs, PAHPs, and States in PCCM and FFS selective contracting programs are required to provide Medicaid enrollees with access to the State fair hearing process as required under 42 CFR 431 Subpart E, including:

    a. informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,
    b. ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if State takes action without the advance notice and as required in accordance with State Policy consistent with fair hearings. The State must also inform enrollees of the procedures by which benefits can be continued for reinstated, and
    c. other requirements for fair hearings found in 42 CFR 431, Subpart E.

    ☑ The State assures CMS that it complies with section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment; in so far as these regulations are applicable.

Section A: Program Description

Part IV: Program Operations

E. Grievance System (2 of 5)

2. **Assurances For MCO or PIHP programs.** MCOs/PIHPs are required to have an internal grievance system that allows an enrollee or a provider on behalf of an enrollee to challenge the denial of coverage of, or payment for services as required by section 1932(b)(4) of the Act and 42 CFR 438 Subpart H.

    The State assures CMS that it complies with section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System, in so far as these regulations are applicable.

    Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

    ☐ The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section A: Program Description

Part IV: Program Operations

E. Grievance System (3 of 5)

3. **Details for MCO or PIHP programs**

   a. **Direct Access to Fair Hearing**

   ☐ The State **requires** enrollees to **exhaust** the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.
   ☐ The State **does not require** enrollees to **exhaust** the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.

   b. **Timeframes**

   ☐ The State's timeframe within which an enrollee, or provider on behalf of an enrollee, must file an **appeal** is _____ days (between 20 and 90).
   ☐ The State's timeframe within which an enrollee must file a **grievance** is _____ days.

   c. **Special Needs**

   ☐ The State has special processes in place for persons with special needs.

   Please describe:

   _____

Section A: Program Description

Part IV: Program Operations

E. Grievance System (4 of 5)

4. **Optional grievance systems for PCCM and PAHP programs.** States, at their option, may operate a PCCM and/or PAHP grievance procedure (distinct from the fair hearing process) administered by the State agency or the PCCM and/or PAHP that provides for prompt resolution of issues. These grievance procedures are strictly voluntary and may not interfere with a PCCM, or PAHP enrollee's freedom to make a request for a fair hearing or a PCCM or PAHP enrollee's direct access to a fair hearing in instances involving terminations, reductions, and suspensions of already authorized Medicaid covered services.

   ☑ The State has a grievance procedure for its ☐ PCCM and/or ☑ PAHP program characterized by the following (please check any of the following optional procedures that apply to the optional PCCM/PAHP grievance procedure):
   The grievance procedures are operated by:
   ☐ the State
   ☐ the State's contractor.

   Please identify: _____
   ☐ the PCCM
   ☑ the PAHP
   ☑ Requests for review can be made in the PCCM and/or PAHP grievance system (e.g. grievance, appeals):

   Please describe:

Members can appeal actions to DHHS under fed & Maine regs. Broker must have processes for grievances & appeals of adverse actions. In order to ensure a "1-step" appeals process for the member, the Broker shall assist members dissatisfied with the Broker's decision to request a fair hearing. DHHS must approve all broker processes. DHHS' decision is final. Broker must submit monthly reports.

☐ Has a committee or staff who review and resolve requests for review.

Please describe if the State has any specific committee or staff composition or if this is a fiscal agent, enrollment broker, or PCCM administrator function:

☑ Specifies a time frame from the date of action for the enrollee to file a request for review.

Please specify the time frame for each type of request for review:

Members must file a grievance within less than sixty (60) calendar days of the date of written notification to the member of the action the member wishes to appeal to be eligible for an administrative hearing. [Request for hearing must be received by DHHS in 60 days]

☑ Has time frames for resolving requests for review.

Specify the time period set for each type of request for review:

The Broker must complete its internal grievance procedure within 30 days of receipt of the grievance or appeal.

☐ Establishes and maintains an expedited review process.

Please explain the reasons for the process and specify the time frame set by the State for this process:

☐ Permits enrollees to appear before State PCCM/PAHP personnel responsible for resolving the request for review.

☐ Notifies the enrollee in writing of the decision and any further opportunities for additional review, as well as the procedures available to challenge the decision.

☐ Other.

Please explain:

Section A: Program Description

Part IV: Program Operations

E. Grievance System (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:
Complaint & Grievance Requirements:

Complaints:

The Broker shall submit to the Department a log and summary report of member complaints received the previous calendar month. The log should separate the complaints by their nature (timeliness, courtesy, etc), as well as contain a cumulative total. The Broker should address any observable trends, detailing actions taken or anticipated to resolve the root causes of the trends.

The log should contain a detailed report describing each complaint, containing the following information:

- Member Name;
- Complainant;
- Date of Complaint;

- Date of Transportation
- Complaint Details;
- Who the complaint is against;
- Complaint Resolution;
- Resolution Date

The Broker must meet the monthly performance benchmark that the member complaint rate shall not exceed one complaint per 100 eligible members. If the Broker fails to meet this benchmark, there shall be a one percent (1%) reduction of the Broker's total payment for the subsequent calendar month.

Grievance:

The Broker shall have a Grievance and Appeal System in place that includes a Grievance process, an Appeal of Adverse Action process, and access to the DHHS Fair Hearing system. In order to ensure a "one-step" appeals process from the member's perspective, if a member goes through the Broker's internal appeals process and wants to contest the decision, the Broker shall assist the member to request a fair hearing from the State. At this time, the Broker shall prepare and submit an appeal summary to the Office of Administrative Hearings, the OMS Contract Monitor, and the member involved in the appeal in accordance with required time frames.

The Department will review all policies and procedures regarding the Broker's proposed Grievance and Appeal System prior to implementation and upon revision. The Broker's Grievance and Appeal System must ensure that appropriate decisions are made as promptly as possible. The process shall include provisions for expediting decisions within five (5) working days. Brokers shall include as part of the RFP their proposed Grievance and Appeal System.

The Broker shall comply with all state and federal laws, regulations, and OMS policies regarding the content and timeframes for a state fair hearing and appeal summaries. The Broker shall attend and defend the Broker's decisions at all Department appeal hearings, whether in person or by telephone, as deemed necessary by the Department Office of Administrative Hearings. Broker travel and telephone expenses in relation to appeal activities shall be borne by the Broker.

The Department shall maintain final decision making authority regarding the disposition of any member grievance or appeal. The Broker agrees to accept such decisions as binding and may not appeal them.

The Broker will provide OMS with monthly reports indicating the number of appeal requests received, any resolution reached, requests that went to a state fair hearing, detailed analysis and disposition.

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (1 of 3)

1. Assurances

The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.610 Prohibited Affiliations with Individuals Barred by Federal Agencies. The State assures that it prohibits an MCO, PCCM, PIHP, or PAHP from knowingly having a relationship listed below with:

1. An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or
2. An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above.

The prohibited relationships are:

1. A director, officer, or partner of the MCO, PCCM, PIHP, or PAHP;
2. A person with beneficial ownership of five percent or more of the MCO's, PCCM's, PIHP's, or PAHP's equity;
3. A person with an employment, consulting or other arrangement with the MCO, PCCM, PIHP, or PAHP for the provision of items and services that are significant and material to the MCO's, PCCM's, PIHP's, or PAHP's obligations under its contract with the State.

The State assures that it complies with section 1902(p)(2) and 42 CFR 431.55, which require section 1915(b) waiver programs to exclude entities that:

1. Could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual;
2. Has a substantial contractual relationship (direct or indirect) with an individual convicted of certain crimes described in section 1128(b)(8)(B) of the Act;
3. Employs or contracts directly or indirectly with an individual or entity that is
   a. precluded from furnishing health care, utilization review, medical social services, or administrative services pursuant to section 1128 or 1128A of the Act, or
   b. could be exclude under 1128(b)(8) as being controlled by a sanctioned individual.

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (2 of 3)

2. Assurances For MCO or PIHP programs

The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.608 Program Integrity Requirements, in so far as these regulations are applicable.
State payments to an MCO or PIHP are based on data submitted by the MCO or PIHP. If so, the State assures CMS that it is in compliance with 42 CFR 438.604 Data that must be Certified, and 42 CFR 438.606 Source, Content, Timing of Certification.
The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(d)(1) of the Act and 42 CFR 438.604 Data that must be Certified; 438.606 Source, Content , Timing of Certification; and 438.608 Program Integrity Requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (1 of 3)

The charts in this section summarize the activities used to monitor major areas of the waiver program. The purpose is to provide a "big picture" of the monitoring activities, and that the State has at least one activity in place to monitor each of the areas of the waiver that must be monitored.

Please note:

- **MCO, PIHP, and PAHP** programs:
  - There must be at least one checkmark in each column.
- **PCCM and FFS selective contracting** programs:

- There must be at least one checkmark in each column under "Evaluation of Program Impact."
- There must be at least one check mark in one of the three columns under "Evaluation of Access."
- There must be at least one check mark in one of the three columns under "Evaluation of Quality."

Summary of Monitoring Activities: Evaluation of Program Impact

Evaluation of Program Impact						
Monitoring Activity	**Choice**	**Marketing**	**Enroll Disenroll**	**Program Integrity**	**Information to Beneficiaries**	**Grievance**
Accreditation for Non-duplication	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Accreditation for Participation	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Consumer Self-Report data	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Data Analysis (non-claims)	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Enrollee Hotlines	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Focused Studies	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Geographic mapping	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Independent Assessment	MCO PIHP PAHP	MCO PIHP PAHP	MCO PIHP PAHP	MCO PIHP PAHP	MCO PIHP PAHP	MCO PIHP PAHP

Evaluation of Program Impact						
Monitoring Activity	**Choice**	**Marketing**	**Enroll Disenroll**	**Program Integrity**	**Information to Beneficiaries**	**Grievance**
	PCCM FFS	PCCM FFS	PCCM FFS	PCCM FFS	PCCM FFS	PCCM FFS
Measure any Disparities by Racial or Ethnic Groups	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Network Adequacy Assurance by Plan	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Ombudsman	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
On-Site Review	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Performance Improvement Projects	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Performance Measures	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Periodic Comparison of # of Providers	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Profile Utilization by Provider Caseload	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS

Evaluation of Program Impact						
Monitoring Activity	Choice	Marketing	Enroll Disenroll	Program Integrity	Information to Beneficiaries	Grievance
Provider Self-Report Data	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Test 24/7 PCP Availability	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Utilization Review	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Other	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (2 of 3)

The charts in this section summarize the activities used to monitor major areas of the waiver program. The purpose is to provide a "big picture" of the monitoring activities, and that the State has at least one activity in place to monitor each of the areas of the waiver that must be monitored.

Please note:

- **MCO, PIHP, and PAHP** programs:
  - There must be at least one checkmark in each column.
- **PCCM and FFS selective contracting** programs:
  - There must be at least one checkmark in each column under "Evaluation of Program Impact."
  - There must be at least one check mark in one of the three columns under "Evaluation of Access."
  - There must be at least one check mark in one of the three columns under "Evaluation of Quality."

Summary of Monitoring Activities: Evaluation of Access

Evaluation of Access			
Monitoring Activity	Timely Access	PCP / Specialist Capacity	Coordination / Continuity
Accreditation for Non-duplication	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS

Evaluation of Access			
Monitoring Activity	**Timely Access**	**PCP / Specialist Capacity**	**Coordination / Continuity**
Accreditation for Participation	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Consumer Self-Report data	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Data Analysis (non-claims)	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Enrollee Hotlines	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Focused Studies	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Geographic mapping	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Independent Assessment	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Measure any Disparities by Racial or Ethnic Groups	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Network Adequacy Assurance by Plan	MCO PIHP PAHP	MCO PIHP PAHP	MCO PIHP PAHP

Evaluation of Access			
Monitoring Activity	**Timely Access**	**PCP / Specialist Capacity**	**Coordination / Continuity**
	PCCM FFS	PCCM FFS	PCCM FFS
Ombudsman	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
On-Site Review	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Performance Improvement Projects	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Performance Measures	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Periodic Comparison of # of Providers	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Profile Utilization by Provider Caseload	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Provider Self-Report Data	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Test 24/7 PCP Availability	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Utilization Review	MCO	MCO	MCO

Evaluation of Access			
Monitoring Activity	Timely Access	PCP / Specialist Capacity	Coordination / Continuity
	PIHP PAHP PCCM FFS	PIHP PAHP PCCM FFS	PIHP PAHP PCCM FFS
Other	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (3 of 3)

The charts in this section summarize the activities used to monitor major areas of the waiver program. The purpose is to provide a "big picture" of the monitoring activities, and that the State has at least one activity in place to monitor each of the areas of the waiver that must be monitored.

Please note:

- **MCO, PIHP, and PAHP** programs:
  - There must be at least one checkmark in each column.
- **PCCM and FFS selective contracting** programs:
  - There must be at least one checkmark in each column under "Evaluation of Program Impact."
  - There must be at least one check mark in one of the three columns under "Evaluation of Access."
  - There must be at least one check mark in one of the three columns under "Evaluation of Quality."

Summary of Monitoring Activities: Evaluation of Quality

Evaluation of Quality			
Monitoring Activity	Coverage / Authorization	Provider Selection	Qualitiy of Care
Accreditation for Non-duplication	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Accreditation for Participation	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Consumer Self-Report data	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Data Analysis (non-claims)	MCO PIHP	MCO PIHP	MCO PIHP

Evaluation of Quality			
Monitoring Activity	**Coverage / Authorization**	**Provider Selection**	**Qualitiy of Care**
	☑ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS	☑ PAHP ☐ PCCM ☐ FFS
Enrollee Hotlines	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☑ PAHP ☐ PCCM ☐ FFS
Focused Studies	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Geographic mapping	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Independent Assessment	☐ MCO ☐ PIHP ☑ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☑ PAHP ☐ PCCM ☐ FFS
Measure any Disparities by Racial or Ethnic Groups	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Network Adequacy Assurance by Plan	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Ombudsman	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
On-Site Review	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☑ PAHP ☐ PCCM ☐ FFS

Evaluation of Quality			
Monitoring Activity	**Coverage / Authorization**	**Provider Selection**	**Qualitiy of Care**
Performance Improvement Projects	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Performance Measures	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Periodic Comparison of # of Providers	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Profile Utilization by Provider Caseload	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Provider Self-Report Data	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Test 24/7 PCP Availability	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Utilization Review	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Other	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS

Section B: Monitoring Plan

Part II: Details of Monitoring Activities

Details of Monitoring Activities by Authorized Programs

For each program authorized by this waiver, please provide the details of its monitoring activities by editing each program listed below.

Programs Authorized by this Waiver:

Program	Type of Program
Maine NET	PAHP;

Note: If no programs appear in this list, please define the programs authorized by this waiver on the

Section B: Monitoring Plan

Part II: Details of Monitoring Activities

Program Instance: Maine Non-Emergency Transportation Waiver

Please check each of the monitoring activities below used by the State. A number of common activities are listed below, but the State may identify any others it uses. If federal regulations require a given activity, this is indicated just after the name of the activity. If the State does not use a required activity, it must explain why.
For each activity, the state must provide the following information:

- Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor)
- Detailed description of activity
- Frequency of use
- How it yields information about the area(s) being monitored

a. ☐ **Accreditation for Non-duplication** (i.e. if the contractor is accredited by an organization to meet certain access, structure/operation, and/or quality improvement standards, and the state determines that the organization's standards are at least as stringent as the state-specific standards required in 42 CFR 438 Subpart D, the state deems the contractor to be in compliance with the state-specific standards)

Activity Details:

- **NCQA**
- **JCAHO**
- **AAAHC**
- **Other**

Please describe:

b. ☐ **Accreditation for Participation** (i.e. as prerequisite to be Medicaid plan)

Activity Details:

- **NCQA**
- **JCAHO**
- **AAAHC**
- **Other**

Please describe:

c. ☑ **Consumer Self-Report data**

Activity Details:

A consumer survey will be conducted by a third party (University of Southern Maine, Muskie School) at the beginning and end of the waiver period. It will include questions related to 1)receipt of information, 2) timely access to transportation services, 3)provider capacity (e.g are appropriate vehicles such as wheelchair vans available) and 4) quality of service

- [ ] **CAHPS**

Please identify which one(s):

- [x] **State-developed survey**
- [ ] **Disenrollment survey**
- [ ] **Consumer/beneficiary focus group**

d. [x] **Data Analysis (non-claims)**

Activity Details:
The Broker will be responsible for doing high level analysis and the State or its contractor will do further analysis. the Broker must submit a monthly report relating to grievances and appeals. To support Program Integrity the broker will provide a monthly report on the required verification of 10% of trips. The broker will also submit monthly reports on timely access based on self report data, on coverage authorization, and a log of complaints.

- [ ] **Denials of referral requests**
- [ ] **Disenrollment requests by enrollee**
  - [ ] **From plan**
  - [ ] **From PCP within plan**
- [x] **Grievances and appeals data**
- [ ] **Other**

Please describe:

e. [x] **Enrollee Hotlines**

Activity Details:
The Broker maintains a hotline. Review will include issues ranging from measurement of the effectiveness of the call center such as response time, dropped calls, etc., to issues reported to the callcenter such as complaints, reports of any stranded members, etc. Monthly reports will provide data on timely access to services and quality of care.

f. [ ] **Focused Studies** (detailed investigations of certain aspects of clinical or non-clinical services at a point in time, to answer defined questions. Focused studies differ from performance improvement projects in that they do not require demonstrable and sustained improvement in significant aspects of clinical care and non-clinical service)

Activity Details:

g. [ ] **Geographic mapping**

Activity Details:

h. [x] **Independent Assessment** (Required for first two waiver periods)

Activity Details:
The State is planning to contract with the University of Southern Maine, Muskie School to implement the required assessment. As noted above a member survey will be part of their review. They will also assist with data analysis, particularly related to encounter data.

i. [ ] **Measure any Disparities by Racial or Ethnic Groups**

Activity Details:

j. ☑ **Network Adequacy Assurance by Plan** [Required for MCO/PIHP/PAHP]

Activity Details:
Broker must demonstrate sufficient number of vehicles and drivers. Bidders will be required to submit letters of intent from potential providers as part of the bids they submit to the Department.

k. ☐ **Ombudsman**

Activity Details:

l. ☑ **On-Site Review**

Activity Details:
Broker will need to monitor its providers related to vehicle safety.

m. ☐ **Performance Improvement Projects** [Required for MCO/PIHP]

Activity Details:

- ☐ **Clinical**
- ☐ **Non-clinical**

n. ☑ **Performance Measures** [Required for MCO/PIHP]

Activity Details:
The state will include performance measures related to timely access to appropriate transportation in the Broker contracts and enforce adherence to these measure through contract monitoring. There will also be financial incentives built into the contract.

- ☐ **Process**
- ☐ **Health status/ outcomes**
- ☐ **Access/ availability of care**
- ☐ **Use of services/ utilization**
- ☐ **Health plan stability/ financial/ cost of care**
- ☐ **Health plan/ provider characteristics**
- ☐ **Beneficiary characteristics**

o. ☑ **Periodic Comparison of # of Providers**

Activity Details:
Brokers must report the number and type of vehicles and professional and volunteer drivers in its network at least annually.

p. ☐ **Profile Utilization by Provider Caseload** (looking for outliers)

Activity Details:

q. ☐ **Provider Self-Report Data**

Activity Details:

- ☐ **Survey of providers**
- ☐ **Focus groups**

r. ☐ **Test 24/7 PCP Availability**

Activity Details:

s. ☐ **Utilization Review** (e.g. ER, non-authorized specialist requests)

Activity Details:

t. ☐ **Other**

Activity Details:

In summary,the Department's Office of MaineCare Services will have a position dedicated to monitoring and oversight of the Brokers. Areas, method, and frequency of oversight are indicated in the table below:

Area of Oversight	Method	Frequency
Incidents	Broker Report	Real time with monthly summary
Encounter Data	CMS 1500 Claim Forms	Monthly
Trip Timeliness	Broker Reports	Weekly with monthly summary
	State access to daily trip logs	State can conduct ad hoc audits of daily trip logs for confirmation
Call Center Measures	Broker Reports	Get reports daily with monthly state audit of phone calls &
(Abandonment Rate,	State Access to Broker Records	access to records from broker's call system
answer calls in 3 rings,	State audit of phone Calls	
service level)	Site Visits	
Agcy Vehicle Inspections	Broker reports	Reports received monthly.Site visits to be conducted no less
	Site visits	than annually, more frequently if needed
Payments to Provider	Broker reports	Monthly, State can conduct ad hoc audits of daily trip logs
	State access to Broker records	to confirm report validity.
Customer Satisfaction /	Broker reports	Monthly, State can conduct ad hoc audits of daily trip logs
Complaints	State access to Broker records	to confirm report validity.

Section C: Monitoring Results

Initial Waiver Request

Section 1915(b) of the Act and 42 CFR 431.55 require that the State must document and maintain data regarding the effect of the waiver on the accessibility and quality of services as well as the anticipated impact of the project on the State's Medicaid program. In Section B of this waiver preprint, the State describes how it will assure these requirements are met. For an initial waiver request, the State provides assurance in this Section C that it will report on the results of its monitoring plan when it submits its waiver renewal request. For a renewal request, the State provides evidence that waiver requirements were met for the most recent waiver period. Please use Section D to provide evidence of cost-effectiveness.

CMS uses a multi-pronged effort to monitor waiver programs, including rate and contract review, site visits, reviews of External Quality Review reports on MCOs/PIHPs, and reviews of Independent Assessments. CMS will use the results of these activities and reports along with this Section to evaluate whether the Program Impact, Access, and Quality requirements of the waiver were met.

This is an Initial waiver request.

☑ **The State assures that it will conduct the monitoring activities described in Section B, and will provide the results in Section C of its waiver renewal request.**

Section D: Cost-Effectiveness

Medical Eligibility Groups

Title	
All Medicaid Members (Including Waivers)	

	First Period		Second Period	
	Start Date	End Date	Start Date	End Date
Actual Enrollment for the Time Period**	07/01/2008	06/30/2009	07/01/2009	06/30/2010
Enrollment Projections for the Time Period*	04/01/2012	03/31/2013	04/01/2013	03/31/2014
**Include actual data and dates used in conversion - no estimates *Projections start on Quarter and include data for requested waiver period				

Section D: Cost-Effectiveness

Services Included in the Waiver

Document the services included in the waiver cost-effectiveness analysis:

Service Name	State Plan Service	1915(b)(3) Service	Included in Actual Waiver Cost	
Non-Emergency Transportation			☑	

Section D: Cost-Effectiveness

Part I: State Completion Section

A. Assurances

a. **[Required] Through the submission of this waiver, the State assures CMS:**

- The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.
- The State assures CMS that the actual waiver costs will be less than or equal to or the State's waiver cost projection.
- Capitated rates will be set following the requirements of 42 CFR 438.6(c) and will be submitted to the CMS Regional Office for approval.
- Capitated 1915(b)(3) services will be set in an actuarially sound manner based only on approved 1915(b)(3) services and their administration subject to CMS RO prior approval.
- The State will monitor, on a regular basis, the cost-effectiveness of the waiver (for example, the State may compare the PMPM Actual Waiver Cost from the CMS 64 to the approved Waiver Cost Projections). If changes are needed, the State will submit a prospective amendment modifying the Waiver Cost Projections.
- The State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the State's submitted CMS-64 forms.

Signature: Stephanie Nadeau

State Medicaid Director or Designee

Submission Date: Mar 7, 2012

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

b. **Name of Medicaid Financial Officer making these assurances:**

Luke Lazure

c. **Telephone Number:**

(207) 287-5499

d. **E-mail:**

luke.lazure@maine.gov

e. **The State is choosing to report waiver expenditures based on**

(●) **date of payment.**

( ) **date of service within date of payment. The State understands the additional reporting requirements in the CMS-64 and has used the cost effectiveness spreadsheets designed specifically for reporting by date of service within day of payment. The State will submit an initial test upon the first renewal and then an initial and final test (for the preceding 4 years) upon the second renewal and thereafter.**

Section D: Cost-Effectiveness

Part I: State Completion Section

B. Expedited or Comprehensive Test

This section is only applicable to Renewals

Section D: Cost-Effectiveness

Part I: State Completion Section

C. Capitated portion of the waiver only: Type of Capitated Contract

The response to this question should be the same as in A.I.b.

a. ( ) **MCO**
b. ( ) **PIHP**
c. (✓) **PAHP**
d. ( ) **PCCM**
e. ( ) **Other**

Please describe:

The Non-Emergency Transportation Services will be provided by Regional Brokers that will be paid a PMPM to provide the service to all medicaid eligible members, including those on waiver programs.

Section D: Cost-Effectiveness

Part I: State Completion Section

D. PCCM portion of the waiver only: Reimbursement of PCCM Providers

Under this waiver, providers are reimbursed on a fee-for-service basis. PCCMs are reimbursed for patient management in the following manner (please check and describe):

a. ( ) **Management fees are expected to be paid under this waiver.**

The management fees were calculated as follows.

1. **Year 1: $** _____ **per member per month fee.**
2. **Year 2: $** _____ **per member per month fee.**

3. Year 3: $ _____ per member per month fee.
4. Year 4: $ _____ per member per month fee.

b. **Enhanced fee for primary care services.**

Please explain which services will be affected by enhanced fees and how the amount of the enhancement was determined.

c. **Bonus payments from savings generated under the program are paid to case managers who control beneficiary utilization.** Under **D.I.H.d.** , please describe the criteria the State will use for awarding the incentive payments, the method for calculating incentives/bonuses, and the monitoring the State will have in place to ensure that total payments to the providers do not exceed the Waiver Cost Projections (Appendix D5). Bonus payments and incentives for reducing utilization are limited to savings of State Plan service costs under the waiver. Please also describe how the State will ensure that utilization is not adversely affected due to incentives inherent in the bonus payments. The costs associated with any bonus arrangements must be accounted for in Appendix D3. Actual Waiver Cost.

d. **Other reimbursement method/amount.**

$

Please explain the State's rationale for determining this method or amount.

Section D: Cost-Effectiveness

Part I: State Completion Section

E. Member Months

Please mark all that apply.

a. ☑ Population in the base year data
   1. ☑ Base year data is from the same population as to be included in the waiver.
   2. ☐ Base year data is from a comparable population to the individuals to be included in the waiver. (Include a statement from an actuary or other explanation, which supports the conclusion that the populations are comparable.)

b. For an initial waiver, if the State estimates that not all eligible individuals will be enrolled in managed care (i.e., a percentage of individuals will not be enrolled because of changes in eligibility status and the length of the enrollment process) please note the adjustment here.

c. ☑ [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:
There was a trend created based on the two years of member eligibility. The Base Years of expenditures (SFY 2009 and SFY 2010) were used in this analysis.

d. ☑ [Required] Explain any other variance in eligible member months from BY to P2:
There is no other variance

e. ☑ [Required] List the year(s) being used by the State as a base year:
07/01/08 - 06/30/09 and 07/01/09 - 06/30/1(
If multiple years are being used, please explain:
The member month trend used the same data that was used to create the actuarially sound PMPM numbers.

f. ☑ [Required] Specify whether the base year is a State fiscal year (SFY), Federal fiscal year (FFY), or other period:
SFY 2009 and SFY 2010

g. ☑ [Required] Explain if any base year data is not derived directly from the State's MMIS fee-for-service claims data:
All claims data is from the State's MMIS System.

Appendix D1 – Member Months

Section D: Cost-Effectiveness

Part I: State Completion Section

F. Appendix D2.S - Services in Actual Waiver Cost

For Initial Waivers:

a. **[Required] Explain the exclusion of any services from the cost-effectiveness analysis.**
For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account.

There are no Non Emergency Transportation Services being excluded.

Appendix D2.S: Services in Waiver Cost

State Plan Services	MCO Capitated Reimbursement	FFS Reimbursement impacted by MCO	PCCM FFS Reimbursement	PIHP Capitated Reimbursement	FFS Reimbursement impacted by PIHP	PAHP Capitated Reimbursement	FFS Reimbursement impacted by PAHP
Non-Emergency Transportation							

Section D: Cost-Effectiveness

Part I: State Completion Section

G. Appendix D2.A - Administration in Actual Waiver Cost

[Required] The State allocated administrative costs between the Fee-for-service and managed care program depending upon the program structure. *Note: initial programs will enter only FFS costs in the BY. Renewal and Conversion waivers will enter all waiver and FFS administrative costs in the R1 and R2 or BY.*
For Initial Waivers:

a. **For an initial waiver, please document the amount of savings that will be accrued in the State Plan services. Savings under the waiver must be great enough to pay for the waiver administration costs in addition to those costs in FFS. Please state the aggregate budgeted amount projected to be spent on each additional service in the upcoming waiver period in the chart below. Appendix D5 should reflect any savings to be accrued as well as any additional administration expected. The savings should at least offset the administration.**

Additional Administrative Expense	Savings projected in State Plan Services	Inflation projected	Amount projected to be spent in Prospective Period
Non-Emergency Transportation	PY 1: 58,822,674 PY 2: 69,185,781	Trend rate of 13.84%	PY 1: 58,822,674 PY 2: 69,185,781
Total:			

The allocation method for either initial or renewal waivers is explained below:

a. **The State allocates the administrative costs to the managed care program based upon the number of waiver enrollees as a percentage of total Medicaid enrollees** *Note: this is appropriate for MCO/PCCM programs.*
b. **The State allocates administrative costs based upon the program cost as a percentage of the total Medicaid budget. It would not be appropriate to allocate the administrative cost of a mental health program based upon the percentage of enrollees enrolled.** *Note: this is appropriate for statewide PIHP/PAHP programs.*
c. **Other**

Please explain:

The administration entails 1 full FTE along with a quarter of a management level FTE. There is also the cost that will be incurred due to the Cooperative Agreement contract the state will need to enter due to the waiver-required

independent assessment. These are costs that were incurred under the FFS, but are now going to be transferred to the waiver.

Appendix D2.A: Administration in Actual Waiver Cost

Section D: Cost-Effectiveness

Part I: State Completion Section

H. Appendix D3 - Actual Waiver Cost

a. The State is requesting a 1915(b)(3) waiver in **Section A.I.A.1.c** and will be providing non-state plan medical services. The State will be spending a portion of its waiver savings for additional services under the waiver.

b. **The State is including voluntary populations in the waiver.**
Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:

c. **Capitated portion of the waiver only -- Reinsurance or Stop/Loss Coverage:** Please note how the State will be providing or requiring reinsurance or stop/loss coverage as required under the regulation. States may require MCOs/PIHPs/PAHPs to purchase reinsurance. Similarly, States may provide stop-loss coverage to MCOs/PIHPs/PAHPs when MCOs/PIHPs/PAHPs exceed certain payment thresholds for individual enrollees. Stop loss provisions usually set limits on maximum days of coverage or number of services for which the MCO/PIHP/PAHP will be responsible. If the State plans to provide stop/loss coverage, a description is required. The State must document the probability of incurring costs in excess of the stop/loss level and the frequency of such occurrence based on FFS experience. The expenses per capita (also known as the stoploss premium amount) should be deducted from the capitation year projected costs. In the initial application, the effect should be neutral. In the renewal report, the actual reinsurance cost and claims cost should be reported in Actual Waiver Cost.
Basis and Method:

1. **The State does not provide stop/loss protection for MCOs/PIHPs/PAHPs, but requires MCOs/PIHPs/PAHPs to purchase reinsurance coverage privately. No adjustment was necessary.**
2. **The State provides stop/loss protection**
   Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:

d. **Incentive/bonus/enhanced Payments for both Capitated and fee-for-service Programs:**

1. **[For the capitated portion of the waiver] the total payments under a capitated contract include any incentives the State provides in addition to capitated payments under the waiver program.** The costs associated with any bonus arrangements must be accounted for in the capitated costs (Column D of Appendix D3 Actual Waiver Cost). Regular State Plan service capitated adjustments would apply.

   Document
   i. **Document the criteria for awarding the incentive payments.**
   ii. **Document the method for calculating incentives/bonuses, and**
   iii. **Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs do not exceed the Waiver Cost Projection.**

2. **For the fee-for-service portion of the waiver, all fee-for-service must be accounted for in the fee-for-service incentive costs (Column G of Appendix D3 Actual Waiver Cost).**). For PCCM providers, the amount listed should match information provided in D.I.D Reimbursement of Providers. Any adjustments applied would need to meet the special criteria for fee-for-service incentives if the State elects to provide incentive payments in addition to management fees under the waiver program (See D.I.I.e and D.I.J.e)

Document:

i. **Document the criteria for awarding the incentive payments.**
ii. **Document the method for calculating incentives/bonuses, and**
iii. **Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs/PCCMs do not exceed the Waiver Cost Projection.**

Appendix D3 – Actual Waiver Cost

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (1 of 8)

Initial Waiver Cost Projection & Adjustments (If this is a Conversion or Renewal waiver for DOP, skip to J. Conversion or Renewal Waiver Cost Projection and Adjustments): States may need to make certain adjustments to the Base Year in order to accurately reflect the waiver program in P1 and P2. If the State has made an adjustment to its Base Year, the State should note the adjustment and its location in Appendix D4, and include information on the basis and method used in this section of the preprint. Where noted, certain adjustments should be mathematically accounted for in Appendix D5.

The following adjustments are appropriate for initial waivers. Any adjustments that are required are indicated as such.

a. **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The BY data already includes the actual Medicaid cost changes to date for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from BY to the end of the waiver (P2). Trend adjustments may be service-specific. The adjustments may be expressed as percentage factors. Some states calculate utilization and cost increases separately, while other states calculate a single trend rate encompassing both utilization and cost increases. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**

1. ☐ [Required, if the State's BY is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period (i.e., trending from 1999 to present)
   The actual trend rate used is: 13.84
   Please document how that trend was calculated:
   For the projection of waiver costs, we analyzed monthly fee-for-service claims data on a date of incurral basis, using historical data with dates of service between July 1, 2006 through June 30, 2010, and payment runout through November 30, 2010. In the development of the proposed utilization trends, we first analyzed the historical monthly NEMT paid. After reviewing the data, regression analysis was performed on a monthly basis. A linear regression was performed on the historical data on a monthly rides per NEMT member basis to determine the annual trend for NEMT services. We analyzed the annual utilization trend on a 24, 36 and 48 months basis and determined the 36-month regression represents the average trend level for the historical period studied.
2. ☐ [Required, to trend BY to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated ratesetting regulations) (i.e., trending from present into the future)
   i. ☑ State historical cost increases.
      Please indicate the years on which the rates are based: base years
      07/01/08 - 06/30/09 and 07/01/09 - 06

In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.
For the projection of waiver costs, we analyzed monthly fee-for-service claims data on a date of incurral basis, using historical data with dates of service between July 1, 2006 through June 30, 2010, and payment runout through November 30, 2010. In the development of the proposed utilization trends, we first analyzed the historical monthly NEMT paid. After reviewing the data, regression analysis was performed on a monthly basis. A linear regression was performed on the historical data on a monthly rides per NEMT member basis to determine the annual trend for NEMT services. We analyzed the annual utilization trend on a 24, 36 and 48 months basis and determined the 36-month regression represents the average trend level for the historical period studied. The calculation is as follows: To trend the base year (FY2009 and FY 2010) waiver costs to P1, 39 months of trend was applied, resulting in a total BY to P1 waiver cost trend of 52.39 percent (1.1384^(39/12)-1). To trend the P1 waiver costs to P2, 12 months of trend was applied, resulting in a total P1 to P2 waiver cost trend of 13.83 percent (1.1384^(12/12)-1).

ii. ☐ National or regional factors that are predictive of this waiver's future costs.

Please indicate the services and indicators used.

Please indicate how this factor was determined to be predictive of this waiver's future costs. Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

3. The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service -specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between the BY and the beginning of the P1 and between years P1 and P2.

i. Please indicate the years on which the utilization rate was based (if calculated separately only).

ii. Please document how the utilization did not duplicate separate cost increase trends.

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (2 of 8)

b. **State Plan Services Programmatic/Policy/Pricing Change Adjustment:** This adjustment should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. Adjustments to the BY data are typically for changes that occur after the BY (or after the collection of the BY data) and/or during P1 and P2 that affect the overall Medicaid program. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA.*

Others:

- **Additional State Plan Services (+)**
- **Reductions in State Plan Services (-)**
- **Legislative or Court Mandated Changes to the Program Structure or fee**

1. ☐ The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.
2. ☑ An adjustment was necessary. The adjustment(s) is(are) listed and described below:
   - i. ☐ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods.
     Please list the changes.

     For the list of changes above, please report the following:
     - **A.** The size of the adjustment was based upon a newly approved State Plan Amendment (SPA).
       PMPM size of adjustment
     - **B.** ☐ The size of the adjustment was based on pending SPA.
       Approximate PMPM size of adjustment
     - **C.** Determine adjustment based on currently approved SPA.
       PMPM size of adjustment
     - **D.** ☐ Determine adjustment for Medicare Part D dual eligibles.
     - **E.** Other:
       Please describe
   - ii. ☐ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.
   - iii. ☐ Changes brought about by legal action:
     Please list the changes.

     For the list of changes above, please report the following:
     - **A.** ☐ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA).
       PMPM size of adjustment
     - **B.** ☐ The size of the adjustment was based on pending SPA.
       Approximate PMPM size of adjustment
     - **C.** Determine adjustment based on currently approved SPA.
       PMPM size of adjustment
     - **D.** ☐ Other
       Please describe
   - iv. ☑ Changes in legislation.

Please list the changes.
There was a rate adjustment for a SFY11 policy change that included a rate standardization action and termination of certain procedure codes
Adjustments were based on 1) rate reduction on particular procedure codes; and 2) Maine study of overall cost impact. This had an overall impact of 20.5% in Year 1 only.

For the list of changes above, please report the following:

A. The size of the adjustment was based upon a newly approved State Plan Amendment (SPA).
PMPM size of adjustment

B. The size of the adjustment was based on pending SPA.
Approximate PMPM size of adjustment

C. Determine adjustment based on currently approved SPA
PMPM size of adjustment

D. Other
Please describe

v. Other
Please describe:
ADMIN costs were not included in the expenditures used to trend out the PMPM for PY1 and PY2. The administration costs thus needed to be added to the PMPM separately. These are costs that were incurred under the FFS, but are now going to be transferred to the waiver.

A. The size of the adjustment was based upon a newly approved State Plan Amendment (SPA).
PMPM size of adjustment

B. The size of the adjustment was based on pending SPA.
Approximate PMPM size of adjustment

C. Determine adjustment based on currently approved SPA.
PMPM size of adjustment

D. Other
Please describe
These administrative costs are estimated to total: $195,147.00 a year or .05 PMPM.

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (3 of 8)

c. **Administrative Cost Adjustment*:** The administrative expense factor in the initial waiver is based on the administrative costs for the eligible population participating in the waiver for fee-for-service. Examples of these costs include per claim claims processing costs, per record PRO review costs, and Surveillance and Utilization Review System (SURS) costs. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the fee-for-service program then the State needs to estimate the impact of that adjustment.

1. ☑ No adjustment was necessary and no change is anticipated.
2. ☐ An administrative adjustment was made.
   - i. ☐ FFS administrative functions will change in the period between the beginning of P1 and the end of P2.
     Please describe
     - A. Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).
     - B. Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP)
       Please describe
     - C. ☐ Other
       Please describe
   - ii. ☐ FFS cost increases were accounted for.
     - A. Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).
     - B. Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).
     - C. Other
       Please describe
   - iii. ☐ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate.
     Please document both trend rates and indicate which trend rate was used.
     - A. Actual State Administration costs trended forward at the State historical administration trend rate.

       Please indicate the years on which the rates are based: base years

       In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase.
     - B. Actual State Administration costs trended forward at the State Plan Service Trend rate.
       Please indicate the State Plan Service trend rate from Section D.I.I.a. above

* For Combination Capitated and PCCM Waivers: If the capitated rates are adjusted by the amount of administration payments, then the PCCM Actual Waiver Cost must be calculated less the administration amount. For additional information, please see Special Note at end of this section.

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (4 of 8)

d. **1915(b)(3) Adjustment:** The State must document the amount of State Plan Savings that will be used to provide additional 1915(b)(3) services in ***Section D.I.H.a*** above. The Base Year already includes the actual trend for the State Plan services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the Base Year and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.

1. ☐ [Required, if the State's BY is more than 3 months prior to the beginning of P1 to trend BY to P1] The State is using the actual State historical trend to project past data to the current time period (i.e., trending from 1999 to present).
The actual documented trend is: _____
Please provide documentation.

2. ☐ [Required, when the State's BY is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future (i.e., trending from present into the future), the State must use the State's trend for State Plan Services.

   i. **State Plan Service trend**

      A. Please indicate the State Plan Service trend rate from Section D.I.I.a. above

e. **Incentives (not in capitated payment) Trend Adjustment:** If the State marked **Section D.I.H.d** , then this adjustment reports trend for that factor. Trend is limited to the rate for State Plan services.

1. List the State Plan trend rate by MEG from Section D.I.I.a _____
2. List the Incentive trend rate by MEG if different from Section D.I.I.a
3. Explain any differences: _____

f. **Graduate Medical Education (GME) Adjustment:** 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments for managed care participant utilization in the capitation rates. However, GME payments on behalf of managed care waiver participants must be included in cost-effectiveness calculations.

1. ☐ We assure CMS that GME payments are included from base year data.
2. ☐ We assure CMS that GME payments are included from the base year data using an adjustment.
Please describe adjustment.
3. ☐ Other
Please describe _____

If GME rates or the GME payment method has changed since the Base Year data was completed, the Base Year data should be adjusted to reflect this change and the State needs to estimate the impact of that adjustment and account for it in **Appendix D5.**

1. GME adjustment was made.
   i. GME rates or payment method changed in the period between the end of the BY and the beginning of P1.
   Please describe

   ii. GME rates or payment method is projected to change in the period between the beginning of P1 and the end of P2.
   Please describe
2. No adjustment was necessary and no change is anticipated.

Method:

1. Determine GME adjustment based upon a newly approved State Plan Amendment (SPA).
2. Determine GME adjustment based on a pending SPA.
3. Determine GME adjustment based on currently approved GME SPA.
4. Other
   Please describe

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (5 of 8)

g. ***Payments / Recoupments not Processed through MMIS Adjustment:*** Any payments or recoupments for covered Medicaid State Plan services included in the waiver but processed outside of the MMIS system should be included in the Waiver Cost Projection. Any adjustments that would appear on the CMS-64.9 Waiver form should be reported and adjusted here. Any adjustments that would appear on the CMS summary form (line 9) would not be put into the waiver cost-effectiveness (e.g., TPL, probate, fraud and abuse). Any payments or recoupments made should be accounted for in ***Appendix D5.***

1. Payments outside of the MMIS were made.
   Those payments include (please describe):
2. Recoupments outside of the MMIS were made.
   Those recoupments include (please describe):
3. The State had no recoupments/payments outside of the MMIS.

h. ***Copayments Adjustment:*** This adjustment accounts for any copayments that are collected under the FFS program but will not be collected in the waiver program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program.

Basis and Method:

1. Claims data used for Waiver Cost Projection development already included copayments and no adjustment was necessary.
2. State added estimated amounts of copayments for these services in FFS that were not in the capitated program. Please account for this adjustment in Appendix D5.
3. The State has not to made an adjustment because the same copayments are collected in managed care and FFS.
4. Other
   Please describe

If the State's FFS copayment structure has changed in the period between the end of the BY and the beginning of P1, the State needs to estimate the impact of this change adjustment.

1. No adjustment was necessary and no change is anticipated.
2. The copayment structure changed in the period between the end of the BY and the beginning of P1. Please account for this adjustment in Appendix D5.

Method:

1. Determine copayment adjustment based upon a newly approved State Plan Amendment (SPA).
2. Determine copayment adjustment based on pending SPA.
3. Determine copayment adjustment based on currently approved copayment SPA.
4. Other
   Please describe

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (6 of 8)

i. **Third Party Liability (TPL) Adjustment:** This adjustment should be used only if the State is converting from fee-for-service to capitated managed care, and will delegate the collection and retention of TPL payments for post-pay recoveries to the MCO/PIHP/PAHP. If the MCO/PIHP/PAHP will collect and keep TPL, then the Base Year costs should be reduced by the amount to be collected.

Basis and method:

1. No adjustment was necessary
2. Base Year costs were cut with post-pay recoveries already deducted from the database.
3. State collects TPL on behalf of MCO/PIHP/PAHP enrollees
4. The State made this adjustment:*
   i. Post-pay recoveries were estimated and the base year costs were reduced by the amount of TPL to be collected by MCOs/PIHPs/PAHPs. Please account for this adjustment in Appendix D5.
   ii. Other
   Please describe

j. **Pharmacy Rebate Factor Adjustment:** Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the fee-for-service or capitated base. If the base year

costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.

***Basis and Method*:**

1. Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population which includes accounting for Part D dual eligibles. Please account for this adjustment in Appendix D5.
   Please describe
2. The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS or Part D for the dual eligibles.
3. Ohter
   Please describe

k. **Disproportionate Share Hospital (DSH) Adjustment:** Section 4721 of the BBA specifies that DSH payments must be made solely to hospitals and not to MCOs/PIHPs/PAHPs. Section 4721(c) permits an exemption to the direct DSH payment for a limited number of States. If this exemption applies to the State, please identify and describe under "Other" including the supporting documentation. Unless the exemption in Section 4721(c) applies or the State has a FFS-only waiver (e.g., selective contracting waiver for hospital services where DSH is specifically included), DSH payments are not to be included in cost-effectiveness calculations.

1. We assure CMS that DSH payments are excluded from base year data.
2. We assure CMS that DSH payments are excluded from the base year data using an adjustment.
3. Other
   Please describe

l. **Population Biased Selection Adjustment** (Required for programs with Voluntary Enrollment): Cost-effectiveness calculations for waiver programs with voluntary populations must include an analysis of the population that can be expected to enroll in the waiver. If the State finds that the population most likely to enroll in the waiver differs significantly from the population that will voluntarily remain in FFS, the Base Year costs must be adjusted to reflect this.

1. This adjustment is not necessary as there are no voluntary populations in the waiver program.
2. This adjustment was made:
   i. Potential Selection bias was measured.
      Please describe
   ii. The base year costs were adjusted.
      Please describe

m. **FQHC and RHC Cost-Settlement Adjustment:** Base Year costs should not include cost-settlement or supplemental payments made to FQHCs/RHCs. The Base Year costs should reflect fee-for-service payments for services provided at these sites, which will be built into the capitated rates.

1. We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the Base Year costs.
   Payments for services provided at FQHCs/RHCs are reflected in the following manner:
2. We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the base year data using an adjustment.
3. We assure CMS that Medicare Part D coverage has been accounted for in the FQHC/RHC adjustment.
4. Other
   Please describe

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (7 of 8)

Special Note Section:

Waiver Cost Projection Reporting: Special note for new capitated programs:

The State is implementing the first year of a new capitated program (converting from fee-for-service reimbursement). The first year that the State implements a capitated program, the State will be making capitated payments for future services while it is reimbursing FFS claims from retrospective periods. This will cause State expenditures in the initial period to be much higher than usual. In order to adjust for this double payment, the State should not use the first quarter of costs (immediately following implementation) from the CMS-64 to calculate future Waiver Cost Projections, unless the State can distinguish and exclude dates of services prior to the implementation of the capitated program.

a. The State has excluded the first quarter of costs of the CMS-64 from the cost-effectiveness calculations and is basing the cost-effectiveness projections on the remaining quarters of data.
b. The State has included the first quarter of costs in the CMS-64 and excluded claims for dates of services prior to the implementation of the capitated program.

Special Note for initial combined waivers (Capitated and PCCM) only:

Adjustments Unique to the Combined Capitated and PCCM Cost-effectiveness Calculations -- Some adjustments to the Waiver Cost Projection are applicable only to the capitated program. When these adjustments are taken, there will need to be an offsetting adjustment to the PCCM Base year Costs in order to make the PCCM costs comparable to the Waiver Cost Projection. **In other words, because we are creating a single combined Waiver Cost Projection applicable to the PCCM and capitated waiver portions of the waiver, offsetting adjustments (positive and/or negative) need to be made to the PCCM Actual Waiver Cost for certain capitated-only adjustments.** When an offsetting adjustment is made, please note and include an explanation and your calculations. The most common offsetting adjustment is noted in the chart below and indicated with an asterisk (*) in the preprint.

Adjustment	Capitated Program	PCCM Program	

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (8 of 8)

n. ***Incomplete Data Adjustment (DOS within DOP only)*** – The State must adjust base period data to account for incomplete data. When fee-for-service data is summarized by date of service (DOS), data for a particular period of time is usually incomplete until a year or more after the end of the period. In order to use recent DOS data, the State must calculate an estimate of the services ultimate value after all claims have been reported . Such incomplete data adjustments are referred to in different ways, including "lag factors," "incurred but not reported (IBNR) factors," or incurring factors. If date of payment (DOP) data is used, completion factors are not needed, but projections are complicated by the fact that payments are related to services performed in various former periods.

Documentation of assumptions and estimates is required for this adjustment.:

1. Using the special DOS spreadsheets, the State is estimating DOS within DOP.
   Incomplete data adjustments are reflected in the following manner on Appendix D5 for services to be complete and on Appendix D7 to create a 12-month DOS within DOP projection:
2. The State is using Date of Payment only for cost-effectiveness – no adjustment is necessary.
3. Other
   Please describe

o. ***PCCM Case Management Fees (Initial PCCM waivers only)*** – The State must add the case management fees that will be claimed by the State under new PCCM waivers. There should be sufficient savings under the waiver to offset these fees. The new PCCM case management fees will be accounted for with an adjustment on ***Appendix D5.***

1. This adjustment is not necessary as this is not an initial PCCM waiver in the waiver program.
2. Other
   Please describe

p. ***Other adjustments:*** Federal law, regulation, or policy change: If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.

- Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
  - Excess payments addressed through transition periods should not be included in the 1915(b) cost effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
  - For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap around. The recipient of the supplemental payment does not matter for the purposes of this analysis.

1. No adjustment was made.
2. This adjustment was made. This adjustment must be mathematically accounted for in Appendix D5.
   Please describe

Section D: Cost-Effectiveness

Part I: State Completion Section

J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (1 of 5)

This section is only applicable to Renewals

Section D: Cost-Effectiveness

Part I: State Completion Section

J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (2 of 5)

This section is only applicable to Renewals

Section D: Cost-Effectiveness

Part I: State Completion Section

J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (3 of 5)

This section is only applicable to Renewals

Section D: Cost-Effectiveness

Part I: State Completion Section

J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (4 of 5)

This section is only applicable to Renewals

Section D: Cost-Effectiveness

Part I: State Completion Section

J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (5 of 5)

This section is only applicable to Renewals

Section D: Cost-Effectiveness

Part I: State Completion Section

K. Appendix D5 – Waiver Cost Projection

The State should complete these appendices and include explanations of all adjustments in Section D.I.I and D.I.J above.

The Appendices have been completed and all adjustments have been explained.
Appendix D5 – Waiver Cost Projection

Section D: Cost-Effectiveness

Part I: State Completion Section

L. Appendix D6 – RO Targets

The State should complete these appendices and include explanations of all trends in enrollment in Section D.I.E. above.

The Appendices have been completed and all trends have been explained.
Appendix D6 – RO Targets

Section D: Cost-Effectiveness

Part I: State Completion Section

M. Appendix D7 - Summary

a. Please explain any variance in the overall percentage change in spending from BY/R1 to P2.

The increase in spending Between BY1 and PY 2 is based on the PMPM trending, a Rate change and an Administration adjustment which were explained in the trend sections of this waiver.

1. Please explain caseload changes contributing to the overall annualized rate of change in Appendix D7 Column I. This response should be consistent with or the same as the answer given by the State in Section D.I.E.c & d:

   Caseload changes did not impact the overall annualized rate of change in Appendix D7 Column I.
2. Please explain unit cost changes contributing to the overall annualized rate of change in Appendix D7 Column I. This response should be consistent with or the same as the answer given by the State in the State's explanation of cost increase given in Section D.I.I and D.I.J:

   A unit cost trend of 1.5% was used to account for inflation. This is less than the CMS market basket trend, which is around 3%.
3. Please explain utilization changes contributing to the overall annualized rate of change in Appendix D7 Column I. This response should be consistent with or the same as the answer given by the State in the State's explanation of utilization given in Section D.I.I and D.I.J:

   In the development of the projected NEMT paid, we analyzed the historical monthly utilization for FY 2009 and FY 2010. The utilization is defined as the number of one way rides per 1,000 eligible members. A linear regression was performed on the historical data on a monthly utilization per 1,000 basis to determine the annual trend for the NEMT services.

b. Please note any other principal factors contributing to the overall annualized rate of change in Appendix D7 Column I.

Appendix D7 - Summary