Application for

Section 1915(b) (4) Waiver
Fee-for-Service
Selective Contracting Program

v1.0

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Application for Section 1915(b) (4) Waiver
Fee-for-Service (FFS) Selective Contracting Program

Facesheet

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

The **name of the waiver program** is CFC Supports Planning, Nurse Monitoring, and Transition Service.
(List each program name if the waiver authorizes more than one program.).

Type of request. This is:
___ an initial request for new waiver. All sections are filled.
_X_ a request to amend an existing waiver, which modifies **Section A, Part I, B and C**
___ a renewal request

Section A is:
___ replaced in full
___ carried over with no changes
___ changes noted in **BOLD**.

Section B is:
___ replaced in full
___ changes noted in **BOLD**.

Effective Dates: This waiver/renewal/amendment is requested for a period of 5 years beginning ~~**02/01/2017**~~ **01/01/2019** and ending ~~**3/31/2019**~~**12/31/2023**

State Contact: The State contact person for this waiver is **Lorraine Nawara** and can be reached by telephone at (410) **767-1442**, or fax at (410) 333-5333, or e-mail at **lorraine.nawara@maryland.gov**.

Section A – Waiver Program Description

Part I: Program Overview

Tribal Consultation:
Describe the efforts the State has made to ensure that Federally-recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal.

In accordance with Section 1902(a)(73) of the Social Security Act, Maryland Medicaid seeks advice on a regular, ongoing basis from designees including Maryland's Urban Indian Organization. In November, 2010, the State appointed a designee of the Urban Indian Organization to the Maryland Medicaid Advisory Committee (MMAC). The MMAC meets monthly and receives updates on demonstration projects, pertinent policy issues, waivers, regulations and State Plan Amendments (SPAs) for all Medicaid Programs. These communications occur prior to the submission of waivers, amendments and other policy changes. Maryland also consults with the Urban Indian Organization on an as needed basis to develop SPAs and regulations which will have a direct impact on access to health care systems as well as the provision of care/services for Indian populations.

Program Description:
Provide a brief description of the proposed selective contracting program or, if this is a request to amend an existing selective contracting waiver, the history of and changes requested to the existing program. Please include the estimated number of enrollees served throughout the waiver.

The State was approved for the Community First Choice (CFC) State Plan option under 1915(k) in 2014 and offers all mandatory and optional services allowable under the program. This includes personal assistance services to provide assistance with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs), emergency back-up systems, supports planning, transition services, and items that substitute for human assistance. Under the 1915(b)(4) authority, the State intends to waive the freedom of choice of providers for three CFC services, supports planning, nurse monitoring and transition services. In the first two years of the program, approximately 7,900 individuals were enrolled in the CFC, and approximately 2,500 individuals have applied each year. The State has also implemented a new State Plan personal assistance program, Community Personal Assistance Services (CPAS), to mimic the services provided through CFC for those who have a lower level of care need. Supports planning is a covered service for all enrollees and applicants for both CFC and CPAS. All CFC and CPAS enrollees that receive personal assistance services are eligible to receive nurse monitoring services. It is estimated that 400 individuals will transition per year from an institution and enroll in CFC. Only CFC enrollees that transition from an institution or assisted living facility to a home and community based setting are eligible for transition services.

Waiver Services:
Please list all existing State Plan services the State will provide through this selective contracting waiver.
This 1915(b)(4) waiver covers three services, Supports Planning, Nurse Monitoring, and Transition Services.

A. Statutory Authority

1. **Waiver Authority.** The State is seeking authority under the following subsection of 1915(b):

   _X__ **1915(b) (4) - FFS Selective Contracting program**

2. **Sections Waived.** The State requests a waiver of these sections of 1902 of the Social Security Act:

   a.___ **Section 1902(a) (1) - Statewideness**
   b.___ **Section 1902(a) (10) (B) - Comparability of Services**
   c._X_ **Section 1902(a) (23) - Freedom of Choice**
   d.___ **Other Sections of 1902** – (please specify)

B. Delivery Systems

1. **Reimbursement.** Payment for the selective contracting program is:

   ___ the same as stipulated in the State Plan
   _X_ is different than stipulated in the State Plan (please describe)

   The rates for supports planning and nurse monitoring will be published in a fee schedule that is updated annually and referenced in regulation.

   The reimbursement for administering transition funds will be ~~based on the costs of the former fiscal management services contract.~~ **established through a competitive procurement process for a fiscal management services vendor.**

2. **Procurement**. The State will select the contractor in the following manner:

   ___ **Competitive** procurement
   ___ **Open** cooperative procurement
   ___ **Sole source** procurement
   _X_ **Other** (please describe)

   Supports Planning:
   The State of Maryland will designate up to 19 area agencies on aging (AAAs) (the total number of AAAs in the state) ~~and 24 local health departments (the total number in the state)~~ as supports planning providers and will also use a competitive solicitation process

to identify additional providers. Since the rate will be set in regulation, the proposals will be evaluated on quality and experience.

Nurse Monitoring:
The State of Maryland will designate the 24 (County-Based) Local Health Departments as the sole provider of nurse monitoring. The rate will be set in regulation.

Transition Service:
The State of Maryland will ~~designate the supports planning providers as the providers of transition services. The rate will be set in regulation.~~**select a fiscal management services vendor to provide transition services through a competitive procurement process.**

C. Restriction of Freedom of Choice

1. **Provider Limitations**.

___ Beneficiaries will be limited to a single provider in their service area.
_X__ Beneficiaries will be given a choice of providers in their service area.
Supports Planning:
The State intends to have at least two providers per county.

Nurse Monitoring:
There will be one designated nurse monitoring agency per county.

Transition Service:
~~The State intends to have at least two providers per county.~~ **There will be one statewide provider of the transition service.**

(NOTE: Please indicate the area(s) of the State where the waiver program will be implemented)

2. **State Standards.**

Detail any difference between the state standards that will be applied under this waiver and those detailed in the State Plan coverage or reimbursement documents.

There will be no differences in the state standards that will be applied under the 1915(k) and those in the State Plan.

D. Populations Affected by Waiver

(May be modified as needed to fit the State's specific circumstances)

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

___ Section 1931 Children and Related Populations

x__ Section 1931 Adults and Related Populations
x__ Blind/Disabled Adults and Related Populations
x__ Blind/Disabled Children and Related Populations
x__ Aged and Related Populations
___ Foster Care Children
___ Title XXI CHIP Children

The CFC program does not have target criteria and will serve individuals of any age who meet the functional and financial eligibility requirements. All individuals who are determined eligible for Medical Assistance coverage under the State Plan, in a coverage group that pays for nursing facility care, will be financially eligible for CFC.

2. **Excluded Populations.** Indicate if any of the following populations are excluded from participating in the waiver:

___ Dual Eligibles
___ Poverty Level Pregnant Women
___ Individuals with other insurance
___ Individuals residing in a nursing facility or ICF/MR
___ Individuals enrolled in a managed care program
___ Individuals participating in a HCBS Waiver program
___ American Indians/Alaskan Natives
___ Special Needs Children (State Defined). Please provide this definition.
___ Individuals receiving retroactive eligibility
__X Other (Please define):

Individuals who do not meet the medical, technical, or financial criteria.

Part II: Access, Provider Capacity and Utilization Standards

A. Timely Access Standards

Describe the standard that the State will adopt (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State has adopted) defining timely Medicaid beneficiary access to the contracted services, *i.e.*, what constitutes timely access to the service?

1. How does the State measure (or propose to measure) the timeliness of Medicaid beneficiary access to the services covered under the selective contracting program?

Timely access will be defined for all three services (supports planning, nurse monitoring, and transition service) in the procurement documents and provider agreements. The State uses a web-based LTSS tracking system to monitor programs and it will use this system to monitor service provision of the covered services.

2. Describe the remedies the State has or will put in place in the event that Medicaid beneficiaries are unable to access the contracted service in a timely fashion.

The State will require a corrective action plan for a provider that fails to meet timely access standards. In the event the providers fail to meet timely access standards under the CAP, the State will take action based on procurement rules.

B. Provider Capacity Standards

Describe how the State will ensure (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State has ensured) that its selective contracting program provides a sufficient supply of contracted providers to meet Medicaid beneficiaries' needs.

1. Provide a detailed capacity analysis of the number of providers (e.g., by type, or number of beds for facility-based programs), or vehicles (by type, per contractor for non-emergency transportation programs), needed per location or region to assure sufficient capacity under the selective contracting program.

The State will require any Area Agency on Aging ~~or Local Health Department~~ that chooses to provide supports planning to provide the number of people they are able to serve. Based on these numbers, the State will solicit supports planning proposals and will award based on sufficient capacity to serve all enrollees and applicants to CFC.

The Local Health Departments previously provided nurse case monitoring services to the legacy MAPC population, most of this population will be eligible for CFC. A large portion of their previous duties are now covered as supports planning by other providers. Staff time was redistributed and is now spent on nurse monitoring of personal assistance services.

The ~~Supports Planning Agencies~~ **fiscal management services vendor** will **be contractually required to** provide transition services to all enrollees that are eligible.

2. Describe how the State will evaluate and ensure on an ongoing basis that providers are appropriately distributed throughout the geographic regions covered by the selective contracting program so that Medicaid beneficiaries have sufficient and timely access throughout the regions affected by the program.

In order to allow flexibility, the State will enroll supports planning providers in two year provider agreements. The State will review on a biannual basis the distribution of enrollees and applicants to CFC and will revise the number of supports planning providers accordingly. The State will monitor provider capacity monthly and may solicit additional supports planning providers more frequently if needed.

The duration and frequency of the nurse monitoring service will be listed on each participant's plan of service. The State will review information in the LTSS tracking system to evaluate timely services on an on-going basis.

The ~~supports planning agencies~~**fiscal management services vendor** will be **the sole statewide provider and will be** required to have capacity to serve all enrollees that are eligible for the transition service in a timely manner. The State will review information in the LTSS tracking system to evaluate timely services on an on-going basis.

C. Utilization Standards

Describe the State's utilization standards specific to the selective contracting program.

1. How will the State (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State) regularly monitor(s) the selective contracting program to determine appropriate Medicaid beneficiary utilization, as defined by the utilization standard described above?

Supports Planning:

Enrollees will have an identified amount of supports planning units on their approved CFC Plan of Service which is maintained in the LTSS tracking system. The number of supports planning units is determined and requested by the applicant/enrollee and must be approved by the State. Supports planning is not a required service and therefore there is no minimum number of units an enrollee must receive.
The maximum units for supports planning is 28 units per day (7 hours of service).
The State will review utilization reports for enrollees that have supports planning listed as an approved service on their CFC Plan of Service.

Nurse Monitoring:

Enrollees will have an identified amount of nurse monitoring units on their approved CFC Plan of Service which is maintained in the LTSS tracking system. The number of nurse monitoring units is determined and requested by the applicant/enrollee and must be approved by the State. Enrollees receive a minimum of one contact and one visit annually. The maximum units for nurse monitoring is 28 units per day (7 hours of service).

The State will review utilization reports for enrollees that have nurse monitoring listed as an approved service on their CFC Plan of Service.

Transition Service:

Eligible enrollees will have transition-related needs identified on their approved CFC Plan of Service which is maintained in the LTSS tracking system. The items requested under transition service are determined and requested by the applicant/enrollee and must be approved by the State. The transition service is not a

required service and therefore there is no minimum number of units an enrollee must receive.

The limit for transition services is up to a maximum of $3,000 per transition.

The State will review quarterly utilization reports for enrollees that have transition service listed as an approved service on their CFC Plan of Service.

2. Describe the remedies the State has or will put in place in the event that Medicaid beneficiary utilization falls below the utilization standards described above.

   As previously stated, these are optional services and therefore utilization standards are not required, utilization will be monitored in the following manners:

Supports Planning:

Plans of service must be updated to correctly display the number of supports planning units an enrollee has selected. If it is determined that the provider is failing to provide adequate services as approved on the plan of service, the enrollee will be given the option to change providers. MMIS will not allow billing for more than the maximum units per day.

Nurse Monitoring:

Plans of service must be updated to correctly display the number of nurse monitoring units an enrollee has selected. If it is determined that the provider is failing to provide adequate services as approved on the plan of service, a corrective action plan will be required. MMIS will not allow billing for more than the maximum units per day.

Transition Service:

Should a ~~Supports Planning Agency~~**fiscal management services vendor** fail to provide the approved transition services, as documented on plans of service, a corrective action plan will be required. MMIS will not allow billing for more than the maximum dollar amount per transition.

Part III: Quality

A. Quality Standards and Contract Monitoring

1. Describe the State's quality measurement standards specific to the selective contracting program.

   a. Describe how the State will (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State):

i. Regularly monitor(s) the contracted providers to determine compliance with the State's quality standards for the selective contracting program.
ii. Take(s) corrective action if there is a failure to comply.

Quality requirements and remediation activities will be defined in the competitive solicitation processes for both supports planning and transition services.

The State has one reportable events policy that is used to follow-up on significant incidents and complaints for the Home and Community-Based Options waiver as well as State Plan Community First choice and Community Personal Assistance programs. All providers are required to comply with the reportable events policy. Once a complaint is received by the State, staff will review the findings and supporting documentation, follow-up with appropriate entities/parties, and if necessary, determine and implement appropriate action involving the participant, provider, etc., such as recommending a Corrective Action Plan (CAP). The policy in its entirety may be found at; https://mmcp.health.maryland.gov/waiverprograms/Documents/RE/Reportable%20Event%20Policy%20updated%201.1.2017.pdf~~https://mmcp.dhmh.maryland.gov/docs/RE-POLICY-FINAL-VERSION-OHS.pdf~~

2. Describe the State's contract monitoring process specific to the selective contracting program.

a. Describe how the State will (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State):

i. Regularly monitor(s) the contracted providers to determine compliance with the contractual requirements of the selective contracting program.

ii. Take(s) corrective action if there is a failure to comply.

The web-based LTSS system contains data related to service provision, including dates of services, activities performed, and billing. The contract/agreement monitor will review utilization reports to monitor timeliness and compliance.

The State will require a corrective action plan for a provider that fails to meet contractual/provider agreement requirements. In the event the providers fail to meet contractual requirements under the CAP, the State will take action based on procurement rules.

B. Coordination and Continuity of Care Standards

Describe how the State assures that coordination and continuity of care is not negatively impacted by the selective contracting program.

The selective contracting program will improve quality and oversight by limiting the number of providers of the service such that the Department may more closely monitor the provision of services. Monthly oversight of performance via reports in the LTSS tracking system of the number of units of service budgeted on plans of service, utilized by participants, time frames for enrollment, and other quality indicators becomes more manageable with fewer providers.

Part IV: Program Operations

A. Beneficiary Information

Describe how beneficiaries will get information about the selective contracting program.

Upon application, a packet of information will be sent to applicants regarding the available providers in their geographic region. Each provider may submit a brochure for the informational packet. Applicants from nursing facilities will receive this information through the Money Follows the Person Options Counselors. ~~Participants will be mailed this information at least 30 days prior to the choice of provider becoming available on January 1, 2014.~~ The AAAs and additional providers identified through the competitive solicitation are also responsible for providing required information to enrollees.

B. Individuals with Special Needs.

___ The State has special processes in place for persons with special needs (Please provide detail).

Section B – Waiver Cost-Effectiveness & Efficiency

Efficient and economic provision of covered care and services:

1. Provide a description of the State's efficient and economic provision of covered care and services.

Information related to the three services of supports planning, nurse monitoring, and transition funds will be detailed individually.

Supports planning:
Although not a renewal, this (b)(4) is based on approved rates and standards set forth in previous (b)(4) waiver applications that CMS approved. The State projects an average per member per month utilization of ~~13.5~~**11.22** units (15 minute increments) which translates to a per member per month cost of $~~203.65~~**173.57** based on **calendar year 2017~~5~~ actuals**. Prior to providing case management as a service, the administrative per member per month cost that was a result of a competitive solicitation process was $378 per person in 2004. This rate is used for the pre-

waiver cost calculations. It is estimated that rates will increase by 2.5% per year and utilization will increase by 7%**.**

2. Project the waiver expenditures for the upcoming waiver period.

Year 1 from: **01/01/2019 to 12/31/2019**
Trend rate from current expenditures (or historical figures): 2.5 %

Projected pre-waiver cost **$57,461,986**
Projected Waiver cost **$25,436,674**
Difference: **$32,025312**

Year 2 from: **01/01/2020 to 12/31/2020**
Trend rate from current expenditures (or historical figures): 2.5 %

Projected pre-waiver cost **$63,021,433**
Projected Waiver cost **$27,897,672**
Difference: **$39,027,234**

Year 3 (if applicable) from: **01/01/2021 to 12/31/2021**
Trend rate from current expenditures (or historical figures): 2.5 %

Projected pre-waiver cost **$69,118,757**
Projected Waiver cost **$30,596,772**
Difference: **$42,803,119**

Year 4 (if applicable) from: **01/01/2022 to 12/31/2022**
Trend rate from current expenditures (or historical figures): 2.5 %

Projected pre-waiver cost **$ 75,805,996**
Projected Waiver cost **$ 33,557,010**
Difference: **$ 46,944,321**

Year 5 (if applicable) from: **01/01/2023 to 12/31/2023**
Trend rate from current expenditures (or historical figures): 2.5 %

Projected pre-waiver cost **$83,140,227**
Projected Waiver cost **$36,803,651**
Difference: **$51,486,184**

Nurse Monitoring:

~~Currently~~ **Previously,** participants across the Living at Home Waiver, Waiver for Older Adults, and Medical Assistance Personal Care Program all ~~have~~ **had** some variation of nurse monitoring with differing rates and service descriptions. Community First Choice ~~will~~ **consolidated** and **standardized** nurse monitoring across the programs, therefore removing duplication of service

and varying levels of reimbursement. Figures have been adjusted to trend forward calendar **2017**~~5~~ actuals. ~~The changes reflect lower than projected enrollment and utilization.~~

3. Project the waiver expenditures for the upcoming waiver period.

Year 1 from: **01/01/2019 to 12/31/2019**

Trend rate from current expenditures (or historical figures): 2.5 %

Projected pre-waiver cost **$18,369,797**
Projected Waiver cost **$6,937,107**
Difference: **$11,432,690**

Year 2 from: **01/01/2020 to 12/31/2020**

Trend rate from current expenditures (or historical figures): 2.5 %

Projected pre-waiver cost **$20,147,075**
Projected Waiver cost **$7,608,272**
Difference: **$12,538,803**

Year 3 (if applicable) from: **01/01/2021 to 12/31/2021**
Trend rate from current expenditures (or historical figures): 2.5 %

Projected pre-waiver cost **$22,096,304**
Projected Waiver cost **$8,344,372**
Difference: **$13,751,932**

Year 4 (if applicable) from: **01/01/2022 to 12/31/2022**
Trend rate from current expenditures (or historical figures): 2.5 %

Projected pre-waiver cost **$24,234,122**
Projected Waiver cost **$9,151,690**
Difference: **$15,082,431**

Year 5 (if applicable) from: **01/01/2023 to 12/31/2023**
Trend rate from current expenditures (or historical figures): 2.5 %

Projected pre-waiver cost **$26,578,773**
Projected Waiver cost **$10,037,116**
Difference: **$16,541,657**

Transition Service:

The supporting planning agencies do not have the capacity to provide transition funds services moving forward. As of 2017 there is only one supports planning agency providing transition funds services to the state. The state is in the process of procuring a fiscal management services vendor who willould be responsible for providing transition funds services. Due to the unknown vendor and associated costs, the financial projections for this service will be updated once a vendor is chosen.

~~**Currently the case management entities provide transition services. Limiting the providers of transition services to the supports planning agencies lowers the cost of the service because a single agency is responsible for administering and coordinating the service and there is less financial risk to the provider. This reduced risk lowers the administrative costs. It is estimated that projected users will increase by 2% per year and per person utilization will also increase by 2%.**~~