

Application for

Section 1915(b) (4) Waiver

Fee-for-Service

Selective Contracting Program

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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 **Home and Community-Based Options (formerly known as Waiver for Older Adults)**.

(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.

a request to amend an existing waiver, which modifies Section/Part A.

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 amendment is requested for the period of **7/1/2016** to **6/30/2021**.

State Contact: The State contact person for this waiver is Christin Whitaker and can be reached by telephone at (410) 767-4449, or fax at (410) 333-5362 or e-mail at christin.whitaker@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 waiver requested is limited to the case management services in the existing 1915(c) waiver, Home and Community-Based Options.

This waiver provides services, including case management to adults ages 18 and over who meet nursing facility level of care. Under the 1915(b)(4) authority, the State currently waives the freedom of choice of providers for case management services offered under the 1915(c) authority. The Area Agencies on Aging (AAAs) will continue to be designated providers, and competitive solicitation will **continue to** identify one or more providers per region to offer a limited choice of providers to the participants within each region.

Waiver Services:

Please list all existing State Plan services the State will provide through this selective contracting waiver.

Waiver case management services.

A. Statutory Authority

1. **Waiver Authority.** The State seeks 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)

Reimbursement rates for waiver case management services in the 1915(c) Home and Community Based Options Waiver will be published in a fee schedule that is updated annually and referenced in regulation. The effective date of the existing fee schedule is 7/1/2015.

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

___ **Competitive** procurement

___ **Open** cooperative procurement

___ **Sole source** procurement

X **Other** (please describe)

The State of Maryland will designate up to 19 area agencies on aging (AAAs) (the total number of AAAs in the state) as case management 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 solely on quality and experience.

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.

The State intends to have at least two providers per county.

(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.

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

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
- Other (Please define): The population covered for this waiver is limited to applicants and enrollees of the 1915(c) Home and Community-Based Options Waiver.

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 for case management will be defined 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 the following 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 requires any AAA that chooses to provide supports planning to establish a maximum number of people they are able to serve. Based on these numbers, the State will solicit case management providers and will award based on sufficient capacity to serve all enrollees and applicants.

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 enrolls case management providers in yearly agreements. The State will review on an annual basis the distribution of enrollees and applicants and will revise the number of providers accordingly. The State monitors provider capacity monthly and may solicit additional providers more frequently if needed.

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?

The State maintains a case management module through the LTSS tracking system that monitors the number of case management units approved on the plan of service and billed by each provider. Reports from this system will be used to by the State to monitor service utilization.

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.

Participants have case management units identified on their person-centered and Department-approved Plan of Service which is maintained in the LTSS tracking system. The number of case management units utilized is monitored via reports in the LTSS tracking system. The State monitors the total number of applicants and participants to be served against the capacity of current agencies, taking into account predetermined caseload ratios and enrollment trends. If and when the maximum capacity of current providers is expected to be reached within the next 6 months, the State will solicit additional providers. The State will also allow existing providers who have no pending CAPs to expand their capacity to meet additional need.

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.

Quality requirements and remediation activities will be defined in the competitive solicitation process for case management.

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 Services 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.dhmh.maryland.gov/docs/RE-POLICY-FINAL-VERSION-OHS.pdf>

Providers are required to meet certain case management standards and are monitored with regards to their performance in the matters of participant safeguards in the quality improvement-health and welfare section of the 1915(c) application. Performance measures are outlined in the provider solicitation and agreement monitored on a quarterly basis by the State.

The State or designee conducts at least an annual review of each case management agency. N: Total number of case management oversight reviews completed annually. D: Total number of approved case management agencies.

Unlicensed providers of case management will be sent a letter of minimum qualifications they must meet. PM – Number of unlicensed case management providers who meet minimum qualifications for providing services annually. N: Number of unlicensed case management providers that meet waiver requirements. D: Number of unlicensed providers who billed for the year.

- ii. Take(s) corrective action if there is a failure to comply.
The State will require a corrective action plan for a provider that fails to meet quality standards. In the event the providers fail to meet standards under the CAP, the State will take action to terminate the designation as a case management provider and transition all participants to other providers identified through the competitive solicitation process.
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. 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.

The State estimates that applicants and participants will receive **3 hours per month** of case management which equals **\$192.46 per month at the rate of \$16.04 per 15 minute unit. The pre-waiver PMPM cost has been projected to be \$230.28, based on historical PMPM costs, which were paid at a flat administrative amount per participant then**

adjusted for the standard 2.5% annual rate increase. These projections reflect reduced utilization of waiver case management services as many waiver participants receive the service through the Community First Choice state plan program. The state share is made up of combined local and state funds.

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

Year 1 from: **7/1/2016 to 6/30/2017**

Trend rate from current expenditures (or historical figures): N/A %

Projected pre-waiver cost	<u>\$ 11,081,013</u>
Projected Waiver cost	<u>\$ 9,261,133</u>
Difference:	<u>\$ 1,819,880</u>

Year 2 from: **7/1/2017 to 6/30/2018**

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

Projected pre-waiver cost	<u>\$ 12,618,297</u>
Projected Waiver cost	<u>\$ 10,636,568</u>
Difference:	<u>\$ 1,981,729</u>

Year 3 (if applicable) from: **7/1/2018 to 6/30/2019**

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

Projected pre-waiver cost	<u>\$ 14,368,965</u>
Projected Waiver cost	<u>\$ 12,216,278</u>
Difference:	<u>\$ 2,152,687</u>

Year 4 (if applicable) from: **7/1/2019 to 6/30/2020**

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

Projected pre-waiver cost	<u>\$ 16,362,521</u>
Projected Waiver cost	<u>\$ 14,030,602</u>
Difference:	<u>\$ 2,331,919</u>

Year 5 (if applicable) from: **7/1/2020 to 6/30/2021**

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

Projected pre-waiver cost	<u>\$ 19,420,100</u>
Projected Waiver cost	<u>\$ 16,795,395</u>
Difference:	<u>\$ 2,624,705</u>