Maryland
DEPARTMENT OF HEALTH

*Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D., M.P.H., Secretary*

**MARYLAND DEPARTMENT OF HEALTH**

**1915(b)(4) for Community First Choice — RENEWAL APPLICATION**

**Request for Public Comment**

The Maryland Department of Health (MDH) will submit a 1915(b)(4) FFS Selective Contracting Waiver application for its Community First Choice (CFC) program to the Centers for Medicare and Medicaid Services (CMS). The 1915(b)(4) allows the MDH to limit the providers of case management, nurse monitoring, and transition services for the CFC program. Case management providers are limited to local Area Agencies on Aging (AAA) and agencies selected through competitive procurement. Nurse monitoring providers are limited to Local Health Departments and transition services are limited to a single statewide contractor selected through a competitive procurement.

A copy of the 1915(b)(4) waiver application for the CFC program will be available here on April 25, 2024. Public comments can be emailed to mdh.cfc@maryland.gov or mailed to the MDH, Office of Long Term Services and Supports, ATTN: 1915(b)(4) for CFC Waiver Public Comment, 201 W. Preston Street, Room 135, Baltimore, MD 21201. Public comments can be submitted from April 25, 2024, through May 24, 2024.

CONTACT: Fiona Fennel Pryce 410-767-1483

# Application for

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

April, 2024

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 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 Services.
(List each program name if the waiver authorizes more than one program.).

**Type of request**. This is:
_**X** an initial request for new waiver. All sections are filled.
___ a request to amend an existing waiver, which modifies Section/Part ____
___ 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 is requested for a period of 5 years beginning **07/01/2024** and ending **06/30/2029**.

**State Contact:** The State contact person for this waiver is **Jamie Smith** and can be reached by telephone at **(410) 767-1442**, or fax at (___) _____, or e-mail at **jamie.smith1@maryland.gov**. (List for each program)

# 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 offer**s** 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), **personal** emergency **response** 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 service**s**. **As of April 2024, there were approximately 10,100 individuals enrolled in CFC.** The State has also implemented a State Plan personal assistance program, Community Personal Assistance Services (CPAS), to mimic the services provided through CFC for those who **meet** a lower level of care. **As of January 2024, there were approximately 500 individuals enrolled in CPAS.** Supports planning is a covered service for all enrollees and applicants for both CFC and CPAS. All CFC and CPAS enrollees who receive personal assistance services are eligible to receive nurse monitoring services. It is estimated that **99** individuals will transition **from an institution,** per year**,** and enroll in CFC. Only CFC enrollees who transition from an institution or assisted living facility to a **private residence** 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:

   _**X**_ the same as stipulated in the State Plan
   ___ is different than stipulated in the State Plan (please describe)

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 has designated the 19 Area Agencies on Aging (AAAs) as supports planning agencies and will also use a competitive solicitation process to identify additional providers. The proposals will be evaluated on quality and experience since rates are established by regulation.**

   Nurse Monitoring:
   **The State of Maryland has designated the 24 Local Health Departments (23 counties and Baltimore City) as the sole provider of nurse monitoring.** The rate **is** set in regulation.

Transition Service**s**:
The State of Maryland **is currently administering transition funds. It will use a competitive procurement to select a statewide contractor to administer transition funds. Bids will be evaluated on quality, experience, and financial proposal.**

## C. Restriction of Freedom of Choice

1. **Provider Limitations**.

_ **X**__ 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.

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

**The CFC and CPAS programs operate statewide.**

Supports Planning:
The State **has designated** at least two providers per **local jurisdiction (city/county)**.

Nurse Monitoring:
There **is** one designated nurse monitoring agency per **local jurisdiction (city/county)**.

Transition Service**s**:
The State **will award a statewide contract to one provider to provide transition services**. **While the competitive procurement is in process, the State is administering transition funds.**

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:

_**X**__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
_**X**__Foster Care Children

___ Title XXI CHIP Children

**Foster care children are included unless they are in State-funded foster care.**

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
_**X**__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 are not fully eligible for Medical Assistance under the State Plan are excluded from participation in the CFC program. Additionally, i**ndividuals who do not meet the medical **or** technical criteria **are excluded from participation**.

## 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 **is defined** for all three services (supports planning, nurse monitoring, and transition service**s**) in the procurement documents and provider agreements. The State uses a **data management system** to monitor programs and provision of 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 **requires** a corrective action plan (CAP) for **any** provider that fails to meet timely access standards. In the event **a** provider fail**s** to meet timely access standards under the CAP, the State will take action based on **the terms of the** procurement **documents, provider agreements, and as authorized by state regulations**.

## 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** AAA**s** that choose to provide supports planning to **report** the number of people they are able to serve. **The minimum case ratio is one (1) supports planner to 20 applicants/participants and the maximum case ratio is one (1) supports planner to 55 applicants/participants.** Based on **the maximum service capacity for the AAAs**, the State will **solicit, review, and approve supports planning proposals until there is sufficient provider capacity to serve all CFC enrollees and applicants.**

The Local Health Departments (LHDs) **provide nurse monitoring to participants receiving personal assistance services and each LHD ensures their provider capacity is sufficient to provide nurse monitoring services to all CFC enrollees at the minimum frequency required.**

The **selected statewide contractor** will provide transition services for all eligible CFC enrollees. **Until the statewide contractor is selected, the State is administering transition funds.**

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.

**The** State **enters into one-year provider agreements with** supports planning **agencies**. **The provider agreement includes three (3) option years that the State may exercise at its discretion.** The State **reviews** the distribution of **CFC** enrollees and applicants **on an annual basis** and will revise the number of supports planning **agencies** accordingly. The State **monitors** provider capacity monthly and may solicit additional supports planning providers more frequently if needed.

**The State's provider agreement with the LHDs regarding the nurse monitoring service includes annual performance measures that allow the State to evaluate the degree to which each LHD has met its obligations under the agreement, including those relating to timeliness and provider capacity. The State will utilize its data management system, and other data sources as necessary, to perform its evaluation. The minimum benchmark for each performance measure is 86 percent, in**

**alignment with the minimum benchmark established by CMS for performance measures associated with the State's 1915(c) authorities. If an LHD falls below 86 percent on any one (1) measure, the State requires the LHD to submit for review and approval, a Quality Improvement Plan (QIP).**

The **selected statewide contractor** will be required to have the capacity to serve all enrollees that are eligible for transition service**s** in a timely manner. The State will **conduct an ongoing** review **of** information in i**ts data management system** to evaluate **the delivery of** timely services. **The State is currently providing transition services. As such, it is leveraging its data management system to evaluate its delivery of timely services.**

## 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:

**Supports Planning is required on the applicant's or participant's plan of service. Unless an applicant/participant waives supports planning to the minimum standard of once annually, the supports planning provider must contact the participant at least once a month to ensure that their needs are being met with the services and supports outlined in the plan of service and complete the monthly contact form. Unless otherwise specified by the State, the supports planning provider must meet with the participant in-person at least once every 90 days in the community where the participant receives services to monitor the implementation of the plan of service and identify any unmet needs.**

**The Department evaluates the utilization of services during annual Supports Planning Agency audits, weekly billing audits, and ongoing review of other reports in the State's data management system to ensure the provision of services meets Department standards for utilization.**

Nurse Monitoring:

**Participants receiving personal assistance services must also receive nurse monitoring at the minimum frequency of twice annually, with at least one of the two contacts occurring in person**. **Outside of the minimum requirement, the frequency of nurse monitoring visits is determined by the nurse monitor in collaboration with the participant and/or their authorized representative, if applicable. The frequency of visits is based on a participant's needs, centered on**

**participant choice and considers factors including, but not limited to: the availability of informal supports, environmental accessibility, current or previous allegations of abuse, neglect and/or exploitation, or other concerns regarding the health and welfare of the participant.** The **provider may not submit activities for reimbursement totaling more than seven-eights (⅞) of the hours worked by the nurse monitor, per day, per participant (e.g., if the nurse monitor works a total of 10 hours, activities totaling no more than 8.5 hours may be submitted to the State for payment).**

The State review**s** utilization reports **monthly** for **participants who are eligible to receive** nurse monitoring **to ensure that nurse monitoring services are delivered at the minimum frequency required**.

Transition Service**s**:

**The State monitors the utilization of transition services for** eligible **participants who request and receive approval for transition services on their plans of service**. **As** transition service**s are** not required, there is no minimum number of units an enrollee must receive.

The **maximum allowable** for transition services is $3,000 per **participant, per** transition. **The maximum allowable for Money Follows the Person (MFP) flexible funds is $700 per participant, per transition.**

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.

**Utilization** will be monitored in the following manners:

Supports Planning:

**The State evaluates the utilization of services during annual Supports Planning Agency audits, as well as through weekly billing audits, and ongoing review of reports in the State's data management system to ensure the provision of services meets Department standards for utilization.**

**During the annual audit process, if the Supports Planning Agency falls below 86 percent in its composite score, a closing letter is issued indicating the areas of deficiencies. The agency is required to submit a quality improvement plan (QIP), which must include a work plan to remediate the deficiency and the timeframe for implementation of the work plan. The QIP remains in place until such time as the Supports Planning Agency has demonstrated proficient performance as outlined in the provider agreement and as determined by the Department.**

Nurse Monitoring:

**The State's provider agreement with the LHDs regarding the nurse monitoring service includes annual performance measures that allow the State to evaluate the degree to which each LHD has met its obligations under the agreement,**

**including those relating to delivering the service at the minimum required frequency. If an LHD falls below 86 percent on any one (1) measure, the State requires the LHD to submit for review and approval, a QIP. The State's provider agreement delineates the maximum allowable units of nurse monitoring and the LHDs are evaluated on adherence to this policy as part of the annual performance measures.**

**If a participant who is required to receive nurse monitoring refuses to accept the service in line with the minimum required frequency, the participant may be disenrolled from the CFC program if the participant continues to refuse participation in required activities even after the State has exhausted all available interventions.**

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Transition Service**s**:

Should **the statewide contractor** fail to provide the approved transition services **and/or flexible funds**, **the State will require a QIP, which includes a work plan to remediate the deficiency and the timeframe for implementation of the work plan. The QIP will remain in place until such time as the contractor demonstrates proficient performance as outlined in the provider agreement and as determined by the Department.**

## 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 for supports planning, **the nurse monitoring agreement for nurse monitoring,** and **the competitive procurement for** transition **services and MFP flexible funds**.

**The State will require a QIP from a provider who has failed to meet its obligations in the provider agreement. Should the provider continue to be non-compliant with the provisions in the provider agreement after the work plan implementation timeframe, the State will require a CAP and assess any penalties as defined and permitted in the provider agreements.**

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 State's data management 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 **CAP** for a provider that fails to meet contractual/provider agreement requirements and **assess any penalties as defined and permitted in the contract/provider agreement.**

## 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 **improves** quality and oversight by limiting the number of **service** providers **which allows the** Department **to** closely monitor the provision of services. Monthly oversight of performance **for selected providers, using reports generated through** the **State's data management** system, **allows the Department to monitor outcomes of interest, including utilization** and other quality indicators, **with greater ease**.

# Part IV: Program Operations

## A. Beneficiary Information

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

**A** packet of information **is** sent to applicants **and includes a list of** the available **Supports Planning** 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 **MFP** Options Counselors. The **AAA** and additional providers identified through the competitive solicitation are also responsible for providing required information to **applicants and participants**.

**During the person-centered planning process, Supports Planners share information about the LHD in the applicant's/participant's geographic region responsible for the**

**provision of nurse monitoring. Additionally, applicants/participants expressing interest in transition services are informed of the statewide vendor during this planning process.**

## 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 **services are** detailed individually.

Supports **P**lanning:
This (b)(4) is based on approved rates and standards set forth in previous (b)(4) waiver applications **approved by** CMS. The State collaborated with The Hilltop Institute to **calculate** an average per member per month **(PMPM)** utilization of **12.12785** units (15 minute increments) **at a rate of $20.9129 per unit** which translates to a **PMPM** cost of **$253.63 for FY 2023** based on **actual FY 2019 through FY 2023 claims data**.

**To estimate the PMPM cost trend factor for supports planning, Hilltop applied regression analyses to yield an annualized trend factor of 8.89 percent based on actual FY 2019 to FY 2023 claims data. To estimate the utilization trend factor for supports planning, Hilltop used a 5-year average of the percentage change in utilization from FY 2019 to FY 2023 to yield a trend factor of 3.62 percent. Estimated PMPM cost trend factors incorporate both utilization and rate increase from past years.**

Prior to providing case management as a service, the administrative **PMPM** 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 8.89 percent per year and utilization will increase by 3.62 percent**.**

**The same trend rates for waiver and pre-waiver costs were applied to years 1 through 5. Actual expenditures reported on the CMS-64 are aggregated for all program services whereas this selecting contracting program is specific to three services (e.g.; Supports Planning, Nurse Monitoring, and Transition Services). Using actual Supports Planning claims data for FY 2019 to FY 2023 to determine the trend rates provides a more accurate baseline and estimated future expenditures.**

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

Year 1 from: **07/01/2024** to **06/30/2025**

Trend rate from current expenditures (or historical figures): **8.89** %

Projected pre-waiver cost **$103,935,783**
Projected Waiver cost **$50,076,785**
Difference: **$53,858,998**

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Year 2 from: **07/01/2025** to **06/30/2026**

Trend rate from current expenditures (or historical figures): **8.89** %

Projected pre-waiver cost **$117,264,733**
Projected Waiver cost **$56,498,740**
Difference: **$60,765,993**

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Year 3 (if applicable) from: **07/01/2026** to **06/30/2027**
(*For renewals, use trend rate from previous year and claims data from the CMS-64*)
Projected pre-waiver cost **$132,303,291**
Projected Waiver cost **$63,744,394**
Difference: **$68,558,897**

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Year 4 (if applicable) from: **07/01/2027** to **06/30/2028**
(*For renewals, use trend rate from previous year and claims data from the CMS-64*)

Projected pre-waiver cost **$149,270,848**
Projected Waiver cost **$71,919,448**
Difference: **$77,351,400**

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Year 5 (if applicable) from: **07/01/2028** to **06/30/2029**
(*For renewals, use trend rate from previous year and claims data from the CMS-64*)

Projected pre-waiver cost **$168,413,827**
Projected Waiver cost **$81,142,633**
Difference: **$87,271,194**

Nurse Monitoring:
**Previously,** participants across the Living at Home Waiver, Waiver for Older Adults, and Medical Assistance Personal Care Program all **received** some **level** of nurse monitoring with differing rates and service descriptions. **CFC consolidated** and standardized nurse monitoring across the programs, **which eliminated** duplication of service and **created one single rate system**. Figures have been adjusted to trend forward calendar **year 2023** actuals.

**The State collaborated with the Hilltop Institute to calculate trends based on actual claims data from FY 2019 through FY 2023. The pre-waiver costs were carried over from the previously approved application and trended forward using actual rate increases through**

**FY 2023 to calculate the base year pre-waiver PMPM cost. The base year rate was multiplied by 8 units per month as PMPM cost.**

**To estimate the PMPM cost trend factor for nurse monitoring services, and account for utilization impact of the Public Health Emergency (PHE) in FY 2020 and FY 2021, Hilltop used a 5-year average of the percentage change of PMPM costs from FY 2019 to FY 2023 as the trend factor—7.05 percent. Additionally, to estimate the utilization trend factor for nurse monitoring, and account for utilization impact of the PHE, Hilltop used the average percentage change in utilization from FY 2019 to FY 2020 and from FY 2022 to FY 2023 to yield a trend factor of 3.36 percent. Estimated PMPM cost trend factors incorporate both utilization and rate increase from past years.**

**The same trend rates for waiver and pre-waiver costs were applied to years 1 through 5. Actual expenditures reported on the CMS-64 are aggregated for all program services whereas this selecting contracting program is specific to three services (e.g.; Supports Planning, Nurse Monitoring, and Transition Services). Using actual Nurse Monitoring claims data for FY 2019 to FY 2023 to determine the trend rates provides a more accurate baseline and estimated costs for future expenditures.**

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

Year 1 from: **07/01/2024** to **06/30/2025**

Trend rate from current expenditures (or historical figures): **7.05** %

Projected pre-waiver cost $**11,612,688**
Projected Waiver cost $**9,715,125**
Difference: $**1,897,563**

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Year 2 from: **07/01/2025** to **06/30/2026**

Trend rate from current expenditures (or historical figures): **7.05** %

Projected pre-waiver cost **$13,069,678**
Projected Waiver cost **$10,749,549**
Difference: **$2,320,129**

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Year 3 (if applicable) from: **07/01/2026** to **06/30/2027**
(*For renewals, use trend rate from previous year and claims data from the CMS-64*)
Projected pre-waiver cost **$14,709,444**
Projected Waiver cost **$11,894,092**
Difference: **$2,815,352**

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Year 4 (if applicable) from: **07/01/2027** to **06/30/2028**
(*For renewals, use trend rate from previous year and claims data from the CMS-64*)

Projected pre-waiver cost **$16,554,983**
Projected Waiver cost **$13,160,533**
Difference: **$3,394,450**

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Year 5 (if applicable) from: **07/01/2028** to **06/30/2029**
(*For renewals, use trend rate from previous year and claims data from the CMS-64*)

Projected pre-waiver cost **$18,632,173**
Projected Waiver cost **$14,561,896**
Difference: **$4,070,277**

Transition Service:
Currently, **the State is administering transition funds while it conducts a competitive procurement to solicit a single statewide vendor to administer transition funds.** Limiting the providers of transition services to **one single statewide contractor** 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 administrative costs.

**The projected costs do not include costs related to transition fund administration since the State is performing this function while it solicits a single statewide contractor. The pre-waiver costs were carried over from the previously approved application and trended forward using a trend factor of 2 percent. For the Waiver cost, the State calculated a 5-year average using actual claims data from FY 2019 through FY 2023 to establish a base year and then applied a trend factor of 2 percent for years 1 through 5.**

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

Year 1 from: **07/01/2024** to **06/30/2025**

Trend rate from current expenditures (or historical figures): **2**%

Projected pre-waiver cost **$328,040**
Projected Waiver cost **$126,534**
Difference: **$201,506**

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Year 2 from: **07/01/2025** to **06/30/2026**

Trend rate from current expenditures (or historical figures): **2**%

Projected pre-waiver cost **$334,601**
Projected Waiver cost **$129,065**
Difference: **$205,536**

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Year 3 (if applicable) from: **07/01/2026** to **06/30/2027**
(*For renewals, use trend rate from previous year and claims data from the CMS-64*)
Projected pre-waiver cost **$341,293**

Projected Waiver cost **$131,646**_____
Difference: **$209,647**_____

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Year 4 (if applicable) from: **07/01/2027** to **06/30/2028**
(*For renewals, use trend rate from previous year and claims data from the CMS-64*)

Projected pre-waiver cost **$348,119**_____
Projected Waiver cost **$134,279**_____
Difference: **$213,840**_____

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Year 5 (if applicable) from: **07/01/2028** to **06/30/2029**
(*For renewals, use trend rate from previous year and claims data from the CMS-64*)

Projected pre-waiver cost **$355,081**_____
Projected Waiver cost **$136,965**_____
Difference: **$218,116**_____