Section 1915(b) Waiver Proposal For
MCO, PIHP, PAHP, PCCM Programs and,
FFS Selective Contracting Programs

Florida Medicaid
Non-Emergency Transportation Waiver (NET)

Waiver Amendment

Submitted: January 10, 2022

US DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicaid and State Operations

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Table of Contents

Facesheet

Please fill in and submit this Facesheet with each waiver proposal, renewal, or amendment request.

The **State of Florida** requests a waiver amendment under the authority of section 1915(b) of the Social Security Act, herein referred to as 'the Act'. The Medicaid agency will directly operate the waiver.

The **name of the waiver program** is Non-Emergency Transportation. (Please list each program name if the waiver authorizes more than one program.).

TYPE OF REQUEST

___ Initial request for new waiver. All sections are filled.

_X_ Amendment request for existing waiver, which modifies Section/Part __D__

__X_ Replacement pages are attached for specific Section/Part being amended (note: the State may, at its discretion, submit two versions of the replacement pages: one with changes to the old language highlighted (to assist CMS review), and one version with changes made, i.e. not highlighted, to actually go into the permanent copy of the waiver).

___ Document is replaced in full, with changes highlighted

__ Renewal request

___ This is the first time the State is using this waiver format to renew an existing waiver. The full preprint (i.e. Sections A through D) is filled out.

__ The State has used this waiver format for its previous waiver period.

Section A is:

___ replaced in full

__ carried over from previous waiver period. The State:

___assures there are no changes in the Program Description from the previous waiver period.

__ assures the same Program Description from the previous waiver period will be used, with exceptions noted in attached replacement pages.

Section B is: ____replaced in full

__ carried over from previous waiver period. The State:

___ assures there are no changes in the Monitoring Plan from the previous waiver period.

__ assures the same Monitoring Plan from the previous waiver period will be used, with exceptions noted in attached replacement pages

EFFECTIVE DATES

This amendment is being requested for the entirety of the current waiver approval period, which began on April 1, 2021 and ends on March 31, 2023. (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)

STATE CONTACT

The State contact person for this waiver is Ann Dalton and can be reached by telephone at (850) 412-4257, or e-mail at Ann.Dalton@ahca.myflorida.com (Please list for each program)

Section A: Waiver 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.

The State notified the two Tribal Organizations in the State of Florida prior to submitting this waiver amendment request. See **Attachment I** for the tribal letters, which were delivered via email on December 6, 2021. This notification provided the Tribal Organizations with an opportunity to obtain additional information on Florida's Non-Emergency Transportation (NET) program or to provide comments regarding the renewal of the NET waiver proposal. No comments were received from either of the Tribal Organizations.

Program History, Description, and Services

For renewal waivers, please provide a brief history of the program(s) authorized under the waiver. Include implementation date and major milestones (phase-in timeframe; new populations added; major new features of existing program; new programs added).

The State submitted a 1915(b)(4) NET Waiver application to the Centers for Medicare & Medicaid Services (CMS) on June 30, 2014 and received approval on December 17, 2014 for the period January 1, 2015 – December 31, 2016. The purpose of this waiver is to allow the Agency for Health Care Administration (Agency) to contract with one or more vendors to provide NET services to Florida Medicaid recipients not enrolled in Florida's Statewide Medicaid Managed Care (SMMC) program. The State submitted a renewal application to CMS on September 30, 2016. A temporary extension was approved for the period of January 1, 2017 – January 31, 2017, and the State received approval from CMS on January 11, 2017 for the period February 1, 2017 – January 31, 2019. The State submitted a renewal application to CMS on November 16, 2018 and CMS granted the renewal on January 24, 2019 for the period of February 1, 2019 – January 31, 2021. The most recent waiver renewal application was submitted to CMS on November 3, 2020 and CMS granted the State approval on January 5, 2021 for the period beginning on April 1, 2021 and ending on March 31, 2023.

Currently, the Agency contracts with two vendors to provide statewide coordination and oversight of Florida Medicaid NET services. The two contracted NET vendors, referred to as CNET plans, are paid a capitated amount based on a per-member per-month (PMPM) reimbursement methodology for eligible recipients.

The CNET plans have the option to provide services directly or subcontract for services. The current CNET plans are responsible for centralized call intake, eligibility determination, authorization of trips, scheduling and dispatching trips, and monitoring transportation providers.

A. STATUTORY AUTHORITY

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. _X_ **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.

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.

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.

d. _X_ **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).

The 1915(b)(4) waiver applies to the following programs

___ MCO
___ PIHP
_X_ 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)

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.

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.

c. _X_ **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.

d. _X_ **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).

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.

B. Delivery Systems

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. _X_ **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.

_X_ 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:** A system under which the State contracts with specified providers who are willing to meet certain reimbursement, quality, and utilization standards. Reimbursement is:

___ the same as stipulated in the state plan
___ is different than stipulated in the state plan (please describe)

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

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):

__ **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

_X_ **Other** (please describe)

The CNET plans were procured under the authority of Section 287.057(3)(e)7, Florida Statutes (F.S.), which allows the Agency to selectively contract with qualified vendors providing health care related services without going through the competitive procurement process.

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs

1. Assurances.

_X_ 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.

_X_ The State seeks a waiver of section 1902(a)(4) 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.

2. Details.

The State will provide enrollees with the following choices (please replicate for each program in 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.
_X_ Other: (please describe)

The State is currently contracted with two vendors. Each CNET plan serves different regions of the State; see chart on the following page.

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

_X_ Beneficiaries will be limited to a single provider in their service area (please define service area).
___ Beneficiaries will be given a choice of providers in their service area.

D. Geographic Areas Served by the Waiver

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.

_X_ **Statewide** -- all counties, zip codes, or regions of the State
___ **Less than Statewide**

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)
Region 1	PAHP	LogistiCare Solutions, Inc.
Region 2	PAHP	LogistiCare Solutions, Inc.
Region 3	PAHP	Medical Transportation Management, Inc.
Region 4	PAHP	Medical Transportation Management, Inc
Region 5	PAHP	Medical Transportation Management, Inc
Region 6	PAHP	Medical Transportation Management, Inc
Region 7	PAHP	Medical Transportation Management, Inc
Region 8	PAHP	Medical Transportation Management, Inc
Region 9	PAHP	LogistiCare Solutions, Inc.
Region 10	PAHP	LogistiCare Solutions, Inc.
Region 11	PAHP	LogistiCare Solutions, Inc.

E. Populations Included in Waiver

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

_X_ **Other –** Please Describe:

Florida Medicaid recipients who are excluded from enrollment in Florida's Managed Medical Assistance (MMA) program:

- Women who are enrolled through the Breast and Cervical Cancer program
- Presumptively eligible pregnant woman
- Recipients receiving services through the Medically Needy program.

Florida Medicaid recipients who are voluntary for enrollment in Florida's MMA program, and have chosen not to enroll in a MMA plan:

- Recipients who have other credible health care coverage, excluding Medicare
- Recipients enrolled in the developmental disabilities home and community-based services waiver, pursuant to Chapter 393 Florida Statutes, and recipients on the waiting list for these waiver services
- Children receiving services in a prescribed pediatric extended care center
- Recipients residing in a group home facility licensed under Chapter 393, Florida Statutes.

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.

_X_ **Other** (Please define):

Florida Medicaid recipients who:

- Are mandatory for enrollment in Florida's MMA program and are enrolled in an MMA plan
- Are qualified Medicare Recipients, Special Low Income Medicare Recipients, Qualified Medicare Recipients Renal Dialysis

Florida Medicaid recipients who reside in an institution, including:

- Statewide inpatient psychiatric program facilities
- Intermediate care facility for individuals with intellectual disabilities
- State Hospitals
- Correctional institutions

Florida Medicaid recipients who reside in the following:

- Residential commitment programs/facilities operated through the Department of Juvenile Justice
- Residential group care operated by the Family Safety & Preservation Program of the Department of Children & Families (DCF)
- Children's residential treatment facilities purchased through the Substance Abuse & Mental Health (SAMH) District Offices of the DCF (also referred to as Purchased Residential Treatment Services)
- SAMH residential treatment facilities licensed as Level I and Level II facilities
- Residential Level I and Level II substance abuse treatment program

Florida Medicaid recipients eligible for emergency services only due to immigration status

Florida Medicaid recipients enrolled in the Family Planning Waiver

F. SERVICES

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)

_X_ 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).

This program does not provide emergency services or family planning services. This program provides NET services only.

_X_ 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.

_X_ 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.

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.

_X_ The PAHP, PAHP, or FFS Selective Contracting program does not cover 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):

_X_ Family planning services are not included under the waiver.

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.

_X_FQHC services are not included under the waiver.

5. EPSDT Requirements.

_X_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.

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.

7. Self-referrals.

_X_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:

The NET program does not require recipients obtain prior authorization to access services. However, recipients are screened in order to provide the most medically appropriate and cost effective mode of transportation.

PART II: ACCESS

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.

A. TIMELY ACCESS STANDARDS

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

_X_ 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.

_X_ 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.

B. CAPACITY STANDARDS

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

_X_ 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 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.

_X_ 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.

The following tables represent the vendor capacity for the CNET plans.

Table 1: 2020 Capacity Analysis Medical Transportation Management, Inc.			
County	**2020 Total Vehicles**	**2020 Wheelchair Vehicles**	**2020 Stretcher Vehicles**
Alachua	4	0	2
Baker	29	22	0
Bradford	0	0	0
Brevard	37	16	3
Charlotte	10	4	0
Citrus	5	1	1
Clay	23	6	0
Collier	16	9	1
Columbia	20	5	4
Desoto	0	0	0
Dixie	0	0	0
Duval	165	26	7
Flagler	18	0	0
Gilchrist	0	0	0
Glades	0	0	0
Hamilton	8	0	0
Hardee	0	0	0
Hendry	2	0	0
Hernando	19	18	0
Highlands	5	0	2
Hillsborough	251	57	5
Lafayette	0	0	0
Lake	6	1	2
Lee	41	24	0
Levy	0	0	0
Manatee	42	2	0
Marion	16	1	4
Nassau	0	0	0
Okaloosa	7	2	0
Orange	177	47	8
Pasco	72	21	0
Pinellas	129	95	6
Polk	71	22	1
Putnam	0	0	0
St. Johns	0	0	0
Sarasota	10	7	0
Seminole	52	21	1
Sumter	0	0	0
Suwannee	44	27	2
Union	0	0	0
Volusia	49	22	2

Table 2: 2020 Capacity Analysis LogistiCare Solutions, Inc.			
County	**2020 Total Vehicles**	**2020 Wheelchair Vehicles**	**2020 Stretcher Vehicles**
Bay	4	4	4
Broward	116	54	12
Calhoun	15	6	1
Escambia	70	42	9
Franklin	0	0	0
Gadsden	0	0	0
Gulf	1	1	0
Holmes	5	1	0
Indian River	0	0	0
Jackson	24	9	1
Jefferson	0	0	0
Leon	95	17	0
Liberty	1	1	0
Madison	0	0	0
Martin	4	3	0
Miami-Dade	1043	343	52
Monroe	6	0	0
Okaloosa	92	71	2
Okeechobee	0	0	0
Palm Beach	125	78	16
St Lucie	22	10	0
Santa Rosa	0	0	0
Taylor	0	0	0
Wakulla	5	1	1
Washington	1	0	0
Walton	1	0	0

C. Coordination and Continuity of Care Standards

1. Assurances For MCO, PIHP, or PAHP programs.

_X_ The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.208 Coordination and Continuity of Care, 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.

_X_ 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 438.208 Coordination and Continuity of Care. 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.

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

The following items are required.

a. _X_ 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.

The CNET plans must ensure NET services meet the medical needs of its recipients including use of multi-load vehicles, public transportation, wheelchair vehicles, stretcher vehicles, private volunteer transport, over-the-road bus services, or, where applicable, commercial air carrier transport and non-emergency ambulance transport.

The CNET plans must allow for one escort when, due to age or

disability, a recipient needs the accompaniment and support of another individual to be able to travel to receive necessary medical services.

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.

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.

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.

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.

3. 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.

The CNET plans must maintain contracts with a sufficient number of providers to ensure that NET services are provided promptly and are reasonably accessible. The CNET

plans are responsible for providing the most medically appropriate mode of transportation for the recipient's needs. If a CNET plan is unable to provide services to a recipient through its existing network of providers, the CNET plan must cover these services in an adequate and timely manner by using providers that are outside of the CNET plans' network.

The CNET plans must notify the Agency of any changes to the provider network that may impede recipients from accessing services in a timely manner. Significant changes in the network composition the Agency determines negatively impact recipient's access to services may be grounds for contract termination.

If recipients have difficulty with a transportation provider, he or she can report the provider to the CNET plans. Recipients are provided contact information for the CNET plans' call center in the recipient handbook. The recipient can also contact the Agency's central complaint hub.

The CNET plans are required to provide new recipients with a copy of the recipient handbook. The handbook must include, at a minimum, the following information:

- Vendor's toll-free trip scheduling telephone number,
- Time frames for requesting and receiving transportation services,
- Information on after hours, urgent care and emergency transportation requirements,
- Medicaid recipient's rights and responsibilities,
- Information regarding the availability of alternative communication formats,
- Complaints, grievances and appeals process, and
- Information regarding the vendor's "no-show" policy.

PART III: QUALITY

1. Assurances For PAHP program.

_X_ 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 a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above 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.

_X_ 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.

2. 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:

The CNET plans were procured under the authority of Section 287.057(3)(e)7, Florida Statutes (F.S.), which allows the Agency to selectively contract with qualified vendors providing health care related services without going through the competitive procurement process. The Agency assessed whether the potential contractors met all of the following criteria:

1. Experience in and or knowledge of the provision of providing NET to eligible recipients.
2. Adequate staffing requirements.
3. Adequate program coverage capacity for regions or statewide.
4. Able to determine recipient's eligibility for NET services and the type of service needed.
5. Able to maintain a sufficient network of transportation providers (either directly through its own network of transportation providers or through a provider contract relationship).
6. Ensure compliance with all applicable federal and state regulations, including the Americans with Disabilities Act requirements, vehicle and equipment safety standards, etc.
7. Compliance with encounter data submission requirements.
8. Utilization monitoring and reporting.
9. Procedures for providing transportation services outside of a region.
10. Able to develop and implement a timeline for a sufficient transportation network and system and to coordinate, deliver, monitor and track all NET services.
11. Able to describe their current network requirements, including vehicle descriptions, to best deliver the services.
12. Ability to process timely payment of claims.
13. Able to maintain and monitor a specialized complaint system.
14. Able to provide an estimate of cost to provide the NET to members based on a per-member, per-month basis.

The CNET plans must comply with the following performance standards:

1. At least ninety percent (90%) of recipients will arrive at their appointment at or before their scheduled appointment time.
2. The average speed of call answer shall not exceed forty-five (45) seconds.
3. The call blockage rate for direct calls to the vendor shall not exceed one percent (1%).
4. The average call abandonment rate for direct calls to the vendor shall not exceed five percent (5%).
5. At least ninety-five percent (95%) of service authorizations are processed within the timeframes specified in the contract.

PART IV: PROGRAM OPERATIONS

A. MARKETING

Marketing includes indirect MCO/PIHP/PAHP or PCCM administrator marketing (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general) and direct MCO/PIHP/PAHP or PCCM marketing (e.g., direct mail to Medicaid beneficiaries).

1. Assurances

_X_ 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 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(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.

This waiver is for a 1915(b)(4) Selective Contracting Program.

2. Details

a. Scope of Marketing

1._X_ 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.

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

1._X_ 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 into the languages listed below (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):

i.__ The languages comprise all prevalent languages in the service area. Please describe the methodology for determining prevalent languages.

ii.__ The languages comprise all languages in the service area spoken by approximately ___ percent or more of the population.

iii.__ Other (please explain):

B. Information to Potential Enrollees and Enrollees

1. Assurances.

_X_ 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.

_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)(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.

2. Details

a. Non-English Languages

_X_ Potential enrollee and enrollee materials will be translated into the **prevalent non-English languages** listed below (If the State does not require written materials to be translated, please explain):

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

1.__ The languages spoken by significant number of potential enrollees and enrollees. Please explain how the State defines "significant."

2. _X_ The languages spoken by approximately _5_ percent or more of the potential enrollee/ enrollee population.

3.__ Other (please explain):

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

The CNET plans must provide oral translation services to any recipient who speaks any non-English language regardless of whether the recipient speaks a language that meets the threshold of a prevalent non-English language.

The CNET plans must notify recipients of the availability of oral interpretation services and how to access them. The CNET plans must ensure oral interpretation services are available to recipients for all information provided, including notices of adverse action.

_X_ The State will have a **mechanism** in place to help enrollees and potential enrollees understand the managed care program. Please describe.

The CNET plans must notify recipients in writing of their rights and responsibilities; how to obtain routine transportation services; how to obtain transportation in an emergency or urgent care situation; how to file a complaint, grievance, appeal, or Medicaid fair hearing; and how to report suspected fraud and abuse.

b. Potential Enrollee Information
Information is distributed to potential enrollees by:

___ State

___ Contractor (please specify)

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

The State offers assistance to recipients on how to access NET services in their region. The CNET plans must mail or hand-deliver a recipient handbook to all eligible individuals.

c. Enrollee Information
The State has designated the following as responsible for providing required information to enrollees:

(i) ___ the State

(ii) ___State contractor (please specify): _

(ii) _X_ the MCO/PIHP/PAHP/PCCM/FFS selective contracting provider.

The CNET plans must mail or hand-deliver a recipient handbook to all eligible individuals.

C. Enrollment and Disenrollment

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 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. (Please check this item if the State has requested a waiver of the choice of plan requirements in section A.I.C)

_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.

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.** 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:

b. Administration of Enrollment Process.

_X_ 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.
The State automatically enrolls all eligible recipients into the CNET plan in his or her region.

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.):

___ This is an existing program that will be **expanded** during the renewal period. 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____days/month(s) to choose a plan.

ii. ___ Please describe the auto-assignment process and/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.

_X_ 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)

_X_ 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.

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.

_X_ 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. Please check items below that apply:

i.___ MCO/PIHP/PAHP and PCCM can request reassignment of an enrollee for the following reasons:

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.

D. ENROLLEE RIGHTS.

1. Assurances.

_X_ 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 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.

_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)(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.

_X_ 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.

E. GRIEVANCE SYSTEM

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.

_X_ The State assures CMS that it complies with Federal Regulations found at 42 CFR 431 Subpart E.

2. 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.

_X__ The State has a grievance procedure for its ___ PCCM and/or _X_ PAHP program characterized by the following (please check any of the following optional procedures that apply to the optional PCCM/PAHP grievance procedure):

_X__ The grievance procedures is operated by:
- ___ the State
- ___ the State's contractor. Please identify: _____
- ___ the PCCM
- _X__ the PAHP.

_X_ Please describe the types of requests for review that can be made in the PCCM and/or PAHP grievance system (e.g. grievance, appeals)

Any expression of dissatisfaction about any matter. Possible subjects for grievances include, but are not limited to, the quality and timeliness of services provided and aspects of interpersonal relationships such as unprofessional behavior or failure to respect a recipient's rights.

___ 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.

_X_ Specifies a time frame from the date of action for the enrollee to file a request for review, which is: 1 year (please specify for each type of request for review)

_X_ Has time frames for resolving requests for review. Specify the time period set: 30 days (please specify for each type of request for review)

_X_ Establishes and maintains an expedited review process for the following reasons: request of recipient. Specify the time frame set by the State for this process.

The vendor has 3 days to resolve an expedited review unless recipient's condition requires a specific timeframe.

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

_X_ 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):

F. PROGRAM INTEGRITY

1. Assurances.

_X_ 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; 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.

_X_ 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 B: Monitoring Plan

Per section 1915(b) of the Act and 42 CFR 431.55, states must assure that 1915(b) waiver programs do not substantially impair access to services of adequate quality where medically necessary. To assure this, states must actively monitor the major components of their waiver program described in Part I of the waiver preprint:

Program Impact	(Choice, Marketing, Enrollment/Disenrollment, Program Integrity, Information to Beneficiaries, Grievance Systems)
Access	(Timely Access, PCP/Specialist Capacity, Coordination and Continuity of Care)
Quality	(Coverage and Authorization, Provider Selection, Quality of Care)

For each of the programs authorized under this waiver, this Part identifies how the state will monitor the major areas within Program Impact, Access, and Quality. It acknowledges that a given monitoring activity may yield information about more than one component of the program. For instance, consumer surveys may provide data about timely access to services as well as measure ease of understanding of required enrollee information. As a result, this Part of the waiver preprint is arranged in two sections. The first is a chart that summarizes the activities used to monitor the major areas of the waiver. The second is a detailed description of each activity.

PAHP programs. The Medicaid Managed Care regulations in 42 CFR 438 require the state to establish certain access and quality standards for PAHP programs, including plan assurances on network adequacy. States are not required to have a written quality strategy for PAHP programs. However, states must still actively oversee and monitor PAHP programs (see 42 CFR 438.66 and 438.202(c)).

PART I: SUMMARY CHART OF MONITORING ACTIVITIES

Please use the chart on the next page to 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.

Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing	Enroll Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/ Continuity	Coverage/ Authorization	Provider Selection	Quality of Care
Accreditation for Non-duplication												
Accreditation for Participation												
Consumer Self-Report data												
Data Analysis (non-claims)						X						
Enrollee Hotlines					X	X	X	X				X
Focused Studies												
Geographic mapping												
Independent Assessment						X	X				X	X
Network Adequacy Assurance by Plan							X				X	
On-Site Review												
Performance Improvement Projects												
Performance Measures							X					
Periodic Comparison of # of Providers												
Profile Utilization by Provider Caseload												
Provider Self-Report Data												
Test 24/7 PCP Availability												
Utilization Review												
Other:	X	X	X	X	X	X	X		X	X		X

PART II: DETAILS OF MONITORING ACTIVITIES

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:

- Applicable programs (if this waiver authorizes more than one type of managed care program)
- 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)

___ NCQA
___ JCAHO
___ AAAHC
___ Other

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

___ NCQA
___ JCAHO
___ AAAHC
___ Other

c. ___ Consumer Self-Report data

___ CAHPS (please identify which one(s))
___ State-developed survey
___ Disenrollment survey
___ Consumer/beneficiary focus groups

d. _X_ Data Analysis (non-claims)

___ Denials of referral requests
___ Disenrollment requests by enrollee
___ From plan
___ From PCP within plan
_X_ Grievances and appeals data
___ PCP termination rates and reasons
___ Other (please describe)

The CNET plans must submit monthly summary reports, which cover all complaints, grievances and appeals data related to NET to the Agency for review. Grievances and appeals data is also reviewed, as applicable, during on-site reviews for each vendor. Daily calls, scheduled calls, and ad hoc calls take place with each vendor to ensure compliance and complaint resolution.

e. _X_ Enrollee Hotlines operated by State

The CNET plans must operate a toll-free help line equipped with caller identification, automatic call distribution equipment capable of handling the expected volume of calls, a telecommunication device for the deaf (TTY/TDD), and access to the interpreter services for non-English speaking recipients. The CNET plans may use an automated telephone triage system. The toll-free help line shall respond to all areas of recipient and provider inquiries.

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).

g. ___ Geographic mapping of provider network

h. ___ Independent Assessment of program impact, access, quality, and cost-effectiveness (**Required** for first two waiver periods)

In accordance with the waiver requirements, an independent assessment was conducted for the first two waiver periods. The results from the most recent independent assessment have been included as Attachment II. As this will be the third waiver period, the Agency does not intend to continue the contract for additional independent assessments.

i. ___ Measurement of any disparities by racial or ethnic groups

j. _X_ Network adequacy assurance submitted by plan [**Required** for MCO/PIHP/PAHP]

- The CNET plans are responsible for the administration and management of a transportation provider network.
- The Agency must be notified prior to the effective date of the non-renewal, suspension, termination, or withdrawal of a provider from the transportation provider network.
- The CNET plans must provide lists of subcontractors to the Agency by October 1 of every year.

k. ___ Ombudsman

l. ___ On-site review

m. ___ Performance Improvement projects [**Required** for MCO/PIHP]
___ Clinical
___ Non-clinical

n. _X_ Performance measures [**Required** for MCO/PIHP]
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

- At least ninety percent (90%) of recipients will arrive at their appointment at or before their scheduled appointment time.

- The average speed of call answer shall not exceed forty-five (45) seconds.
- The call blockage rate for direct calls to the CNET plan shall not exceed one percent (1%).
- The average call abandonment rate for direct calls to the CNET plan shall not exceed five percent (5%)
- At least ninety percent (90%) of service authorizations are processed within the timeframes specified in the contract.

o. ___ Periodic comparison of number and types of Medicaid providers before and after waiver

p. ___ Profile utilization by provider caseload (looking for outliers)

q. ___ Provider Self-report data
___ Survey of providers
___ Focus groups

r. ___ Test 24 hours/7 days a week PCP availability

s. ___ Utilization review (e.g. ER, non-authorized specialist requests)

t. _X_ Other: (please describe)

Marketing – The State does not permit marketing under the contract with the CNET plans. The CNET plans receive monthly eligibility information which outlines those recipients eligible to receive NET.

Enrollment/Disenrollment - Recipients are automatically assigned to a CNET plan based upon the region in which he or she resides. If a recipient is voluntary for enrollment in an MMA plan, the recipient may choose to enroll in an MMA plan upon which the recipient would be disenrolled from the NET waiver.

Coordination/Continuity - Recipients do not receive treatment from the CNET plans. The CNET plans must ensure NET services are provided to all assigned eligible recipients.

Coverage/Authorization - NET services are scheduled in advance and are not prior authorized.

Desk Reviews - The Agency performs annual desk reviews to ensure the CNET plans are compliant with contract requirements. Desk reviews include assessment of the following:

- Recipient Services
- Grievance and Appeals
- Provider Services
- Performance Standards
- Encounter Data

Section C: Monitoring Results

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.

_X_ This is a renewal request.

___ This is the first time the State is using this waiver format to renew an existing waiver. The State provides below the results of the monitoring activities conducted during the previous waiver period.

_X_ The State has used this format previously, and provides below the results of monitoring activities conducted during the previous waiver.

For each of the monitoring activities checked in Section B of the previous waiver request, the State should:

- **Confirm** it was conducted as described in Section B of the previous waiver preprint. If it was not done as described, please explain why.
- **Summarize the results** or findings of each activity. CMS may request detailed results as appropriate.
- **Identify problems** found, if any.
- **Describe plan/provider-level corrective action**, if any, that was taken. The State need not identify the provider/plan by name, but must provide the rest of the required information.
- **Describe system-level program changes**, if any, made as a result of monitoring findings.

Please replicate the template below for each activity identified in Section B.

1. Strategy: Data Analysis (Non-Claims)

Description: The CNET plans are required to submit monthly summary reports, which cover all complaints, grievances and appeals data related to NET to the Agency for review. Grievances and appeals data is also reviewed, as applicable, during on-site reviews for each vendor.
Confirmation it was conducted as described:

_X_ Yes
___ No. Please explain:

Summary of results: To monitor the progress and performance of the contractual services, as specified in the vendor's contract, the Agency reviews monthly deliverables as provided by the vendors. Both vendors have been 100% timely and complete in submitting monthly deliverables to the Agency in years 2018, 2019, and 2020.

The CNET plan's monthly deliverables address the following areas:

- Number of members utilizing transportation
- Trips set up with advance notice
- Trips with mileage in excess of 30 miles
- Service denials
- Trip utilization
- Trip mode (ambulatory, ambulance, and stretcher van)
- Call center timeliness
- Quality management
- Recipient complaints

Recipients have the option to submit their complaints directly to the CNET plan or to the Agency's Medicaid Complaint Operations Center. The Agency monitors all complaint sources, and the Agency addresses unresolved complaints on CNET plan operational calls until the complaint issues are resolved.
The Agency monitors all grievances and appeals relating to complaints that remain open and unresolved pursuant to the contractual guidelines. In 2018 and 2019, a review was conducted of both vendors and no additional follow-up was required.

In June 2020, as part of the of grievance appeals monitoring, the Agency identified a need for intervention with the vendor-issued Notice of Adverse Benefit Determinations (NABD) letters. The Agency identified the use of non-compliant NABD letters by both CNET plans. The Agency's findings were discussed on both weekly operational calls with the vendor. The Agency sent the vendors each a corrected template in July of 2020 for immediate implementation. The Agency is in the process of monitoring plan compliance with the corrected NABD template for the month of September 2020.
Problems identified: Yes
Corrective action (plan/provider level): Both CNET plans were required to immediately correct the NABD used for providing notice to recipients of denials, reduction, terminations, or suspensions of service. The Agency is in the process of monitoring plan compliance with issuing the corrected NABD letters.
Program change (system-wide level): None

2. Strategy: Enrollee Hotline

Description: The CNET plans must operate a toll-free help line equipped with caller identification, automatic call distribution equipment capable of handling the expected volume of calls, a telecommunication device for the deaf (TTY/TDD), and access to the interpreter services for non-English speaking recipients. The CNET plans may use an automated telephone triage system. The toll-free help line must respond to all areas of recipient and provider inquiries.
Confirmation it was conducted as described:
_X_ Yes
___ No. Please explain:
Summary of results: The CNET plans have maintained an enrollee hotline and have met all contract requirements related to the enrollee hotline.
Problems identified: None
Corrective action (plan/provider level): None
Program change (system-wide level): None

3. Strategy: Independent Assessment

Description: The Agency contracted with the University of South Florida to provide an independent assessment of the NET program.
Confirmation it was conducted as described:
_X_ Yes (See Attachment II)
___ No. Please explain:
Summary of results: The University of South Florida submitted the independent assessment for calendar year 2018 to the Agency on September 22, 2020. The CNET plans maintain medically appropriate modes of transportation that meet the needs of the recipients. There were issues with recipients arriving to their appointments on time with both vendors as reflected by the survey conducted by the independent assessment team. Regarding overall general satisfaction with the NET program and the two current CNET plans, 42% percent of recipients reported being satisfied and 8% percent reported being very satisfied.
Problems identified: Timeliness of arrival to appointments
Corrective action (plan/provider level): The CNET plans added credentialed backup providers to their networks based on this information. The Agency reviews each CNET plan's performance with the vendor on a monthly basis during one of the weekly operational calls to discuss vendor performance levels. In addition, both plans are in the process of adding new technology to facilitate communication and timely transport to appointments. Both plans have presented mobile applications that track drivers' locations, provide reminders via text and email, and allow for communication to the plan directly. This new strategy is an effort from both plans to alleviate issues with timeliness, improve recovery of missed trips, and improve the recipient experience.
Program change (system-wide level): None

4. Strategy: Network Adequacy

Description: The CNET plans are responsible for the administration and management of a transportation provider network. The Agency must be notified prior to the effective date of the non-renewal, suspension, termination, or withdrawal of a provider from the transportation provider network. The CNET plans must submit a Provider Termination and New Provider Notification Report by the fifteenth (15th) calendar day of the month following the reporting month.

Additionally, the CNET plans have numerous transportation modalities available for maintaining network adequacy. These include being able to use transportation network companies (ride sharing), starting in 2019. Others include private vehicles, taxis, public transportation, vans, ambulances, airlines, and non-profit agencies.

Confirmation it was conducted as described:

___ Yes
_X_ No. Please explain: The report has not been operationalized.

Summary of results:
Problems identified: Yes
Corrective action (plan/provider level): See strategy #3 above.
Program change (system-wide level): None

5. Strategy: On-site Review

Description: The Agency performs annual onsite contract monitoring reviews to ensure the CNET plans are compliant with the contract requirements.

Confirmation it was conducted as described:

___ Yes
_X_ No. Please explain: The Agency implemented remote monitoring to provide vendor oversight and ensure compliance as the on-site did not yield any additional information regarding performance

Summary of results:
The Agency completed remote monitoring in 2019. This remote monitoring evaluated the areas of complaints, claim submissions, encounter data accuracy, and provider network.

To date in 2020, the Agency has monitored vendors' compliance with Eligibility, Recipient Services, Grievance and Appeals, Provider Services, Performance Standards, Encounter Data, and Utilization Management.

Complaints are received directly by the Agency or the CNET plan. The Agency monitors all complaints that come through the Medicaid Complaint Operations Center as well as escalated complaints that come through to the Agency CNET Contract Manager for assistance with resolution. Opened complaints are also discussed on operational calls until they are closed. See also Strategy #1 above on Data Analysis (Non-Claims).

Problems identified: Yes
Corrective action (plan/provider level): See Corrective action listed for Strategy #6
Remediated: Yes
Program change (system-wide level): None

6. Strategy: Performance Measures

Description: Performance threshold(s), requirement(s), or expectation(s) that must be met to be evaluated at a particular level of performance.

These performance measures include:

- At least 90% of recipients will arrive at their appointment at or before their scheduled appointment time.
- The average speed of calls answered shall not exceed 45 seconds.

- The call blockage rate for direct calls to the CNET plan shall not exceed 1%.
- The average call abandonment rate for direct calls to the CNET plan shall not exceed 5%.
- At least 95% of service authorizations are processed within the timeframes specified in the contract.

Confirmation it was conducted as described:

_X_ Yes

___ No. Please explain:

Summary of results:

The Agency reviewed monthly CNET plan statistics. Findings are summarized as follows:

In 2018, and up through July 2019, the CNET plans' performance standards included:

- At least ninety percent (90%) of recipients will arrive at their appointment at or before their scheduled appointment time;
- The average speed of answer (ASA) shall not exceed forty-five (45) seconds;
- The call blockage rate for directed calls to the vendor shall not exceed one percent (1%);
- The average call abandonment rate for direct calls to the vendor shall not exceed five percent (5%); and
- At least ninety-five percent (95%) of service authorizations shall be processed within the timeframes specified in the contract.

Neither CNET plan met these standards during the contract period, however, during the period of time since the new contract was executed, they have met the standards.

New contracts went into effect in August 2019 and are effective through 2020. The new contracts contain the following performance standards:

- At least ninety percent (90%) of recipients will arrive at their appointment within fifteen (15) minutes of the scheduled appointment time;
- The average speed of calls answered by vendors shall be less than ten (10) seconds;
- The call blockage rate for direct calls to the CNET plans shall be less than one percent (1%);
- The average call abandonment rate for direct calls to the CNET plans shall not exceed five percent (5%); and
- More than ninety-five percent (95%) of service authorizations shall be processed by the vendors within the timeframes specified in the contract.

Both CNET plans have successfully met these standards during the period of time since the new contract was executed.

Quarterly Call-Center Metrics Statewide Average Average Speed of Answer (in seconds) under 45 Seconds		
	MTM	LogistiCare
7/2020 – 9/2020	4.95	0.35
4/2020 – 6/2020	7.36	0.08
1/2020 – 3/2020	17.61	0.07
10/2019 – 12/2019	23.26	7
7/2019 – 9/2019	18.14	15
4/2019 – 6/2019	8.67	12
1/2019 – 3/2019	112.14	23
10/2018 – 12/2018	9.65	0.15
7/2018 – 9/2018	20.76	0.40
4/2018 – 6/2018	69.19	0.33
1/2018 – 3/2018	12.67	0.14
10/2017 – 12/2017	15.67	0.28
7/2017 – 9/2017	1.10	0.27
4/2017 – 6/2017	8.22	0.28
1/2017 – 3/2017	8.38	1.01

Quarterly Call-Center Metrics Statewide Average 1% > Blocked Calls (in percent)		
	MTM	LogistiCare
7/2020 – 9/2020	0%	0%
4/2020 – 6/2020	0%	0%
1/2020 – 3/2020	0%	0%
10/2019 – 12/2019	0%	0%
7/2019 – 9/2019	0%	0%
4/2019 – 6/2019	0%	0%
1/2019 – 3/2019	0%	0%
10/2018 – 12/2018	0%	0%
7/2018 – 9/2018	0%	0%
4/2018 – 6/2018	0%	0%
1/2018 – 3/2018	0%	0%
10/2017 – 12/2017	0%	0%
7/2017 – 9/2017	0%	0%
4/2017 – 6/2017	0%	0%
1/2017 – 3/2017	0%	0%

Quarterly Call-Center Metrics Statewide Average 5% > Call Abandonment Rate (in percent)		
	MTM	LogistiCare
7/2020 – 9/2020	1.11%	0.08%
4/2020 – 6/2020	0.78%	0%
1/2020 – 3/2020	0.86%	0.01%
10/2019 – 12/2019	1.44%	0.02%
7/2019 – 9/2019	1.31%	0.03%
4/2019 – 6/2019	69.19%	0.33%
1/2019 – 3/2019	12.67%	0.14%
10/2018 – 12/2018	0.87%	0.07%
7/2018 – 9/2018	1.68%	0.24%
4/2018 – 6/2018	6.81%	0.37%
1/2018 – 3/2018	0.98%	0.05%
10/2017 – 12/2017	0.84%	0.13%
7/2017 – 9/2017	0.79%	0.18%
4/2017 – 6/2017	0.81%	0.16%
1/2017 – 3/2017	1.73%	0.47%

Problems identified: MTM fell short of the performance standards during the first quarter of 2019 for average speed of answer and the first and second quarters of 2019 for call abandonment rate. MTM experienced technology and staffing issues that led to higher call handling times during these periods.
Corrective action (plan/provider level): MTM hired more customer service representatives in both cases to remedy the issue. In the first part of 2019, a brief lag due to onboarding of staff contributed to the increase in call abandonment rates.
Remediated: Yes
Program change (system-wide level): None

Section D: Cost-Effectiveness

Please follow the Instructions for Cost-Effectiveness (in the separate Instructions document) when filling out this section. Cost-effectiveness is one of the three elements required of a 1915(b) waiver. States must demonstrate that their waiver cost projections are reasonable and consistent with statute, regulation and guidance. The State must project waiver expenditures for the upcoming two-year waiver period, called Prospective Year 1 (P1) and Prospective Year 2 (P2). The State must then spend under that projection for the duration of the waiver. In order for CMS to renew a 1915(b) waiver, a State must demonstrate that the waiver was less than the projection during the retrospective two-year period.

A complete application includes the State completing the seven Appendices and the Section D. State Completion Section of the Preprint:

Appendix D1.	Member Months
Appendix D2.S	Services in the Actual Waiver Cost
Appendix D2.A	Administration in the Actual Waiver Cost
Appendix D3.	Actual Waiver Cost
Appendix D4.	Adjustments in Projection
Appendix D5.	Waiver Cost Projection
Appendix D6.	RO Targets
Appendix D7.	Summary Sheet

States should complete the Appendices first and then describe the Appendices in the State Completion Section of the Preprint. Each State should modify the spreadsheets to reflect their own program structure. Technical assistance is available through each State's CMS Regional Office.

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 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 Medicaid Eligibility Group (MEG) in conjunction with the State's submitted CMS-64 forms.

b. Name of Medicaid Financial Officer making these assurances:
Peter Ring
Telephone Number: 850-412-4135
E-mail: peter.ring@ahca.myflorida.com

c. The State is choosing to report waiver expenditures based on
_X_ 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.

B. For Renewal Waivers only (not conversion)- Expedited or Comprehensive Test

To provide information on the waiver program to determine whether the waiver will be subject to the Expedited or Comprehensive cost effectiveness test. *Note: All waivers, even those eligible for the Expedited test, are subject to further review at the discretion of CMS and OMB.*

a.___ The State provides additional services under 1915(b)(3) authority.

b.___ The State makes enhanced payments to contractors or providers.

c.___ The State uses a sole-source procurement process to procure State Plan services under this waiver.

d.___ Enrollees in this waiver receive services under another 1915(b) waiver program that includes additional waiver services under 1915(b)(3) authority; enhanced payments to contractors or providers; or sole-source procurement processes to procure State Plan services. *Note: do not mark this box if this is a waiver for transportation services and dental pre-paid ambulatory health plans (PAHPs) that has overlapping populations with another waiver meeting one of these three criteria. For transportation and dental waivers alone, States do not need to consider an overlapping population with another waiver containing additional services, enhanced payments, or sole source procurement as a trigger for the comprehensive waiver test. However, if the transportation services or dental PAHP waiver meets the criteria in a, b, or c for additional services, enhanced payments, or sole source procurement then the State should mark the appropriate box and process the waiver using the Comprehensive Test.*

If you marked any of the above, you must complete the entire preprint and your renewal waiver is subject to the Comprehensive Test. If you did not mark any of the above, your renewal waiver (not conversion or initial waiver) is subject to the Expedited Test:

- Do not complete **Appendix D3**
- Attach the most recent waiver Schedule D, and the corresponding completed quarters of CMS-64.9 waiver and CMS-64.21U Waiver and CMS 64.10 Waiver forms, and
- Your waiver will not be reviewed by OMB *at the discretion of CMS and OMB*.

The following questions are to be completed in conjunction with the Worksheet Appendices. All narrative explanations should be included in the preprint. Where further clarification was needed, we have included additional information in the preprint.

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._X_ PAHP
d.___ Other (please explain):

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.___ First Year: $____ per member per month fee

2.___ Second Year: $____ per member per month fee

3.___ Third Year: $____ per member per month fee

4.___ Fourth Year: $____ 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.

E. Appendix D1 – Member Months

For Initial Waivers only: 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:

_____

d. ___ [Required] Explain any other variance in eligible member months from BY to P2:

_____

e.____ [Required] List the year(s) being used by the State as a base year:____. If multiple years are being used, please explain:_____

f.____ [Required] Specify whether the base year is a State fiscal year (SFY), Federal fiscal year (FFY), or other period _____.

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

_____

For Conversion or Renewal Waivers:

a. X [Required] Population in the base year and R1 and R2 data is the population under the waiver. YES

b.____ For a renewal waiver, because of the timing of the waiver renewal submittal, the State did not have a complete R2 to submit. Please ensure that the formulas correctly calculated the annualized trend rates. *Note: it is no longer acceptable to estimate enrollment or cost data for R2 of the previous waiver period.*

c. X [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:

Projected member months made for P1-P2 commenced from R2 (SFY19/20) population. We updated previous Projection Year 1 for MEG 1 (PPEC) and MEG 2 (Non-PPEC) to actuals, and new member months utilization is 2.76%. The updated member months Projection for Year 2 on both MEG's is now 3.26%.

d. X [Required] Explain any other variance in eligible member months from BY/R1 to P2:

MEG2 (Non-PPEC) population experienced even a greater growth rate than previous projection during waiver renewal due to the Families First Coronavirus Response Act.

e. X [Required] Specify whether the BY/R1/R2 is a State fiscal year (SFY), Federal fiscal year (FFY), or other period:

Other Period - Waiver Renewal Period

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.

For Conversion or Renewal Waivers:

a.___ [Required] Explain if different services are included in the Actual Waiver Cost from the previous period in **Appendix D3** than for the upcoming waiver period in **Appendix D5**. Explain the differences here and how the adjustments were made on **Appendix D5**:

There are no other services included from the previous period.

b.___ [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 service exclusions from the cost-effectiveness analysis.

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 Administration Expense	Savings projected in State Plan Services	Inflation projected	Amount projected to be spent in Prospective Period
(Service Example: Actuary, Independent Assessment, EQRO, Enrollment Broker- See attached documentation for justification of savings.)	*$54,264 savings or .03 PMPM*	*9.97% or $5,411*	*$59,675 or .03 PMPM P1* *$62,488 or .03 PMPM P2*
Total	*Appendix D5 should reflect this.*		*Appendix D5 should reflect this.*

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. X Other (please Explain):

The cost of the one administrative full-time employee (FTE) is proportioned by each MEG's expenditure amount.

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.

For an initial waiver, in the chart below, please document the amount of savings that will be accrued in the State Plan services. The amount of savings that will be spent on 1915(b)(3) services must be reflected on **Column T of Appendix D5** in the initial spreadsheet Appendices. Please include a justification of the amount of savings expected and the cost of the 1915(b)(3) services. Please state the aggregate budgeted amount projected to be spent on each additional service in the upcoming waiver period in the chart below. This amount should be reflected in the State's Waiver Cost Projection for P1 and P2 on **Column W in Appendix D5**.

Chart: Initial Waiver
State Specific 1915(b)(3) Service Expenses and Projections

1915(b)(3) Service	**Savings projected in State Plan Services**	**Inflation projected**	**Amount projected to be spent in Prospective Period**
(Service Example: 1915(b)(3) step-down nursing care services financed from savings from inpatient hospital care. See attached documentation for justification of savings.)	*$54,264 savings or .03 PMPM*	*9.97% or $5,411*	*$59,675 or .03 PMPM P1* *$62,488 or .03 PMPM P2*
Total	*(PMPM in Appendix D5 Column T x projected member months should correspond)*		(PMPM in Appendix D5 Column W x projected member months should correspond)

For a renewal or conversion waiver, in the chart below, please state the actual amount spent on each 1915(b)(3) service in the retrospective waiver period. This amount must be built into the State's Actual Waiver Cost for R1 and R2 (BY for Conversion) on **Column H in Appendix D3**. Please state the aggregate amount of 1915(b)(3) savings budgeted for each additional service in the upcoming waiver period in the chart below. This amount must be built into the State's Waiver Cost Projection for P1 and P2 on **Column W in Appendix D5**.

Chart: Renewal/Conversion Waiver
State Specific 1915(b)(3) Service Expenses and Projections

1915(b)(3) Service	**Amount Spent in Retrospective Period**	**Inflation projected**	**Amount projected to be spent in Prospective Period**
(Service Example: 1915(b)(3) step-down nursing care services financed from savings from inpatient hospital care. See attached documentation for justification of savings.)	*$1,751,500 or $.97 PMPM R1* *$1,959,150 or $1.04 PMPM R2 or BY in Conversion*	*8.6% or $169,245*	*$2,128,395 or 1.07 PMPM in P1* *$2,291,216 or 1.10 PMPM in P2*
Total	**(PMPM in Appendix D3 Column H x member months should correspond)**		**(PMPM in Appendix D5 Column W x projected member months should correspond)**

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.__X__ 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.__X__ 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 (please describe):

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.

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)**

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.

Current Initial Waiver Adjustments in the Pre-Print

I. Appendix D4 – Initial Waiver – Adjustments in the Projection OR Conversion Waiver For DOS within DOP

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: _____. Please document how that trend was calculated:

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_____ 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.

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.

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 schedule not accounted for in cost increases or pricing (+/-)

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.
For each change, 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 describe):
For each change, 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 describe):
For each change, 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):

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):

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).

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.

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):

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 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):

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**.

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.___ Other (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:

a. ___Potential Selection bias was measured in the following manner:

b. ___The base year costs were adjusted in the following manner:

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):

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
Administrative Adjustment	The Capitated Waiver Cost Projection includes an administrative cost adjustment. That adjustment is added into the combined Waiver Cost Projection adjustment. (This in effect adds an amount for administration to the Waiver Cost Projection for both the PCCM and Capitated program. You must now remove the impermissible costs from the PCCM With Waiver Calculations -- See the next column)	The PCCM Actual Waiver Cost must include an exact offsetting addition of the amount of the PMPM Waiver Cost Projection adjustment. (While this may seem counter-intuitive, adding the exact amount to the PCCM PMPM Actual Waiver Cost will subtract out of the equation: PMPM Waiver Cost Projection – PMPM Actual Waiver Cost = PMPM Cost-effectiveness).

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.___ This adjustment was made in the following manner:

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 (Please describe). This adjustment must be mathematically accounted for in **Appendix D5**.

J. Appendix D4 – Conversion or Renewal Waiver Cost Projection and Adjustments.

If this is an Initial waiver submission, skip this section: States may need to make certain adjustments to the Waiver Cost Projection in order to accurately reflect the waiver program. If the State has made an adjustment to its Waiver Cost Projection, the State should note the adjustment and its location in **Appendix D4**, and include information on the basis and method, and mathematically account for the adjustment in **Appendix D5**.

CMS should examine the Actual Waiver Costs to ensure that if the State did not implement a programmatic adjustment built into the previous Waiver Cost Projection, that the State did not expend funds associated with the adjustment that was not implemented.

If the State implements a one-time only provision in its managed care program (typically administrative costs), the State should not reflect the adjustment in a permanent manner. CMS should examine future Waiver Cost Projections to ensure one-time-only adjustments are not permanently incorporated into the projections.

a. **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The R1 and R2 (BY for conversion) data already include the actual Medicaid cost changes for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from R2 (BY for conversion) to the end of the waiver (P2). Trend adjustments may be service-specific and expressed as percentage factors. Some states calculate utilization and cost separately, while other states calculate a single trend rate. 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. X [Required, if the State's BY or R2 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: **(See below)**. Please document how that trend was calculated.

The State reimburses the CNET plans via a yearly capitated PMPM payment. The rates were prepared by an actuary consultant. The rates used for cost effectiveness cover the time period of July 2016 through June 2020. The State is using these rates for this waiver's Cost Effectiveness P1-P2 calculations.

In the table below, PPEC refers to recipients who receive prescribed pediatric extended care services.

COST EFFECTIVENESS P1-P2 PMPM CALCULATION											
	2016	2017		2018		2019		2020		2021	
MEGs	Dec 2015-Dec 2016	Jan-Dec 2017	Jul 2016-Jun 2017	Jan-Dec 2018	Jul 2017-Jun 2018	Jan-Dec 2019	Jul 2018 – Jun 2019	Jan – Jul 2020	Jul 2019 – Jun 2020	Aug 2020 - July 2021	July 2020 – Jun 2021
PPEC	$654.35	$552.62	$635.40	$628.94	$604.56	$660.61	$644.76	$718.61	$689.61	$900.13	$926.59
Non-PPEC	$2.11	$2.81	$2.29	$3.73	$3.04	$3.38	$3.56	$3.88	$3.63	$4.14	$4.02

2. _X_ [Required, to trend BY/R2 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 rate setting regulations) *(i.e., trending from present into the future)*.

   i. _X_ State historical cost increases. Please indicate the years on which the rates are based: base years: CY 2016, 2017, & 2018. 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.

   Please refer to the State's response in a.1. above.

   ii. _X_ National or regional factors that are predictive of this waiver's future costs. Please indicate the services and indicators used: Transportation services: see Milliman's letters for an explanation on factors. In addition, 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.

   Please refer to the State's response in a.1. above.

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 R2 and 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.

b. _X_ **State Plan Services Programmatic/Policy/Pricing Change Adjustment:** These adjustments should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. 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*. The R2 data was adjusted for changes that will occur after the R2 (BY for conversion) and during P1 and P2 that affect the overall Medicaid program.

Others:

- Additional State Plan Services (+)
- Reductions in State Plan Services (-)
- Legislative or Court Mandated Changes to the Program Structure or fee schedule not accounted for in Cost increase or pricing (+/-)
- Graduate Medical Education (GME) Changes - This adjustment accounts for **changes** in any GME payments in the program. 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments from the capitation rates. However, GME payments must be included in cost-effectiveness calculations.
- Copayment Changes - This adjustment accounts for changes from R2 to P1 in any copayments that are collected under the FFS program, but not collected in the MCO/PIHP/PAHP capitated program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program. If the State is changing the copayments in the FFS program then the State needs to estimate the impact of that adjustment.

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._X_ An adjustment was necessary and is listed and described below:

i.__ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods.

For each change, 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.__ The adjustment is a one-time only adjustment that should be deducted out of subsequent waiver renewal projections (i.e., start-up costs). Please explain:

iv.__ Changes brought about by legal action (please describe):
For each change, 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.__ Changes in legislation (please describe):

For each change, 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):

vi.__X__Other (please describe):

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.____X Other (please describe):

Please refer to the State's response in a.1. above.

c. **__X__ Administrative Cost Adjustment:** This adjustment accounts for **changes** in the managed care program. The administrative expense factor in the renewal is based on the administrative costs for the eligible population participating in the waiver for managed care. Examples of these costs include per claim claims processing costs, additional per record PRO review costs, and additional Surveillance and Utilization Review System (SURS) costs; as well as actuarial contracts, consulting, encounter data

processing, independent assessments, EQRO reviews, etc. *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 managed care program then the State needs to estimate the impact of that adjustment.

1.___ No adjustment was necessary and no change is anticipated.

2._X_ An administrative adjustment was made.

i.___ Administrative functions will change in the period between the beginning of P1 and the end of P2. Please describe:

ii._X_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.____State Historical State Administrative Inflation. The actual trend rate used is: _____. Please document how that trend was calculated:

D. _X_Other (please describe):

The State anticipates a general administrative FTE salary increase of 3% annually during P1-P2 for the single staff position assigned to this waiver's operation.

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.J.a**. above _____.

d. **1915(b)(3) Trend Adjustment:** The State must document the amount of 1915(b)(3) services in the R1/R2/BY **Section D.I.H.a** above. The R1/R2/BY already includes the actual trend for the 1915(b)(3) services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the R2/BY 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 or R2 is more than 3 months prior to the beginning of P1 to trend BY or R2 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 or R2 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 lower of State historical 1915(b)(3) trend or the State's trend for State Plan Services. Please document both trend rates and indicate which trend rate was used.

i. State historical 1915(b)(3) trend rates

1. Please indicate the years on which the rates are based: base years_____

2. Please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.):

ii. State Plan Service Trend

1. Please indicate the State Plan Service trend rate from **Section D.I.J.a**. above _____.

e. **Incentives (not in capitated payment) Trend Adjustment:** Trend is limited to the rate for State Plan services.

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

f. **Other Adjustments** including but not limited to federal government changes. (Please describe):

- 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.
- **Pharmacy Rebate Factor Adjustment (Conversion Waivers Only)*:** Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the 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**.

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.__ Other (please describe):

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

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 State reimburses the CNET plans via a yearly capitated PMPM payment. The rates were prepared by an actuary consultant. The rates used for cost effectiveness cover the time period of July 2016 through June 2020. The State is using these rates for this waiver's Cost Effectiveness P1-P2 calculations.

In the table below, PPEC refers to recipients who receive prescribed pediatric extended care services.

COST EFFECTIVENESS P1-P2 PMPM CALCULATION											
	2016	2017		2018		2019		2020		2021	
MEGs	Dec 2015-Dec 2016	Jan-Dec 2017	Jul 2016-Jun 2017	Jan-Dec 2018	Jul 2017-Jun 2018	Jan-Dec 2019	Jul 2018 – Jun 2019	Jan – Jul 2020	Jul 2019 – Jun 2020	Aug 2020 - July 2021	July 2020 – Jun 2021
PPEC	$654.35	$552.62	$635.40	$628.94	$604.56	$660.61	$644.76	$718.61	$689.61	$900.13	$926.59
Non-PPEC	$2.11	$2.81	$2.29	$3.73	$3.04	$3.38	$3.56	$3.88	$3.63	$4.14	$4.02

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.

Projected member months made for P1-P2 commenced from R2, State Fiscal Year (SFY)19/20 population. MEG 1 (PPEC) and MEG 2 (Non-PPEC) utilized a 5% population growth rate.

M. Appendix D7 – Summary

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

   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**:

      A 5% population growth rate calculated from both populations during SFY19/20 will yield an overall daily R1 to P2 weighted average PMPM case mix change of 0.01%, or 2.77% annually.

   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**:

      N/A

   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**:

      The State reimburses the CNET plans via a capitated PMPM payment (see Milliman's letter). Utilization used by Milliman in combination with adjustment cost in reflected in D.5 yields an annual rate of change for R1 to P2 of 36.75%.

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

PART II: APPENDICES D.1-7

Please see the Excel spreadsheets.

NET Waiver Attachments	
Attachment I	Tribal Letters
Attachment II	September 2020 Independent Assessment of the Florida Medicaid NET Program
Attachment III	NET Waiver Excel Workbooks *(included as a separate document)*

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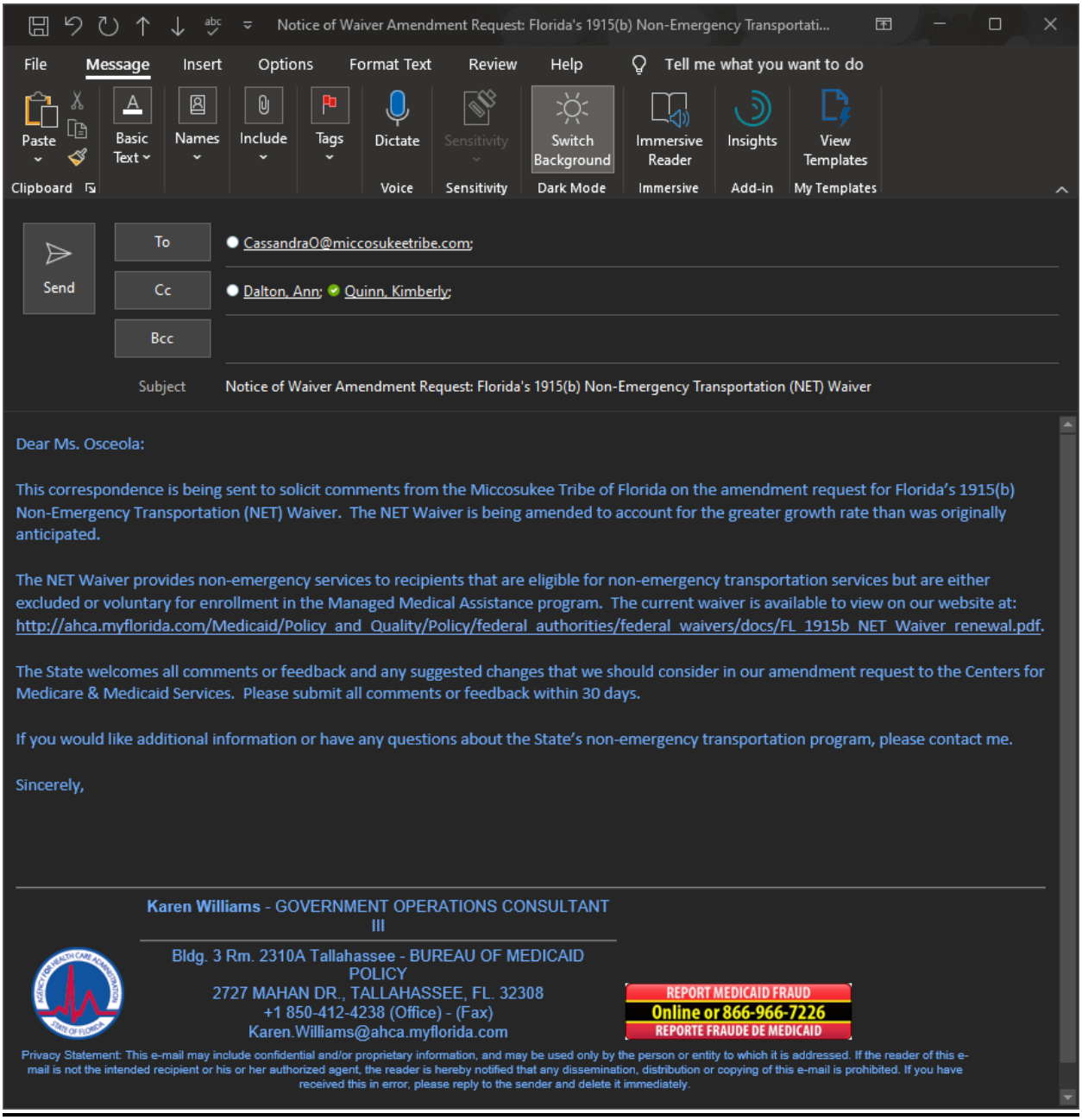
Attachment I: Tribal Letters

The Tribal Notice to the Miccosukee Tribe of Indians of Florida was delivered via email on December 6, 2021 to Cassandra Osceola, the Health Director for the tribe.



Notice of Waiver Amendment Request: Florida's 1915(b) Non-Emergency Transportati...

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Clipboard Voice Sensitivity Dark Mode Immersive Add-in My Templates

Send

To CassandraO@miccosukeetribe.com;

Cc Dalton, Ann; Quinn, Kimberly;

Bcc

Subject Notice of Waiver Amendment Request: Florida's 1915(b) Non-Emergency Transportation (NET) Waiver

Dear Ms. Osceola:

This correspondence is being sent to solicit comments from the Miccosukee Tribe of Florida on the amendment request for Florida's 1915(b) Non-Emergency Transportation (NET) Waiver. The NET Waiver is being amended to account for the greater growth rate than was originally anticipated.

The NET Waiver provides non-emergency services to recipients that are eligible for non-emergency transportation services but are either excluded or voluntary for enrollment in the Managed Medical Assistance program. The current waiver is available to view on our website at: http://ahca.myflorida.com/Medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/FL_1915b_NET_Waiver_renewal.pdf.

The State welcomes all comments or feedback and any suggested changes that we should consider in our amendment request to the Centers for Medicare & Medicaid Services. Please submit all comments or feedback within 30 days.

If you would like additional information or have any questions about the State's non-emergency transportation program, please contact me.

Sincerely,

Karen Williams - GOVERNMENT OPERATIONS CONSULTANT III

Bldg. 3 Rm. 2310A Tallahassee - BUREAU OF MEDICAID POLICY
2727 MAHAN DR., TALLAHASSEE, FL. 32308
+1 850-412-4238 (Office) - (Fax)
Karen.Williams@ahca.myflorida.com

REPORT MEDICAID FRAUD
Online or 866-966-7226
REPORTE FRAUDE DE MEDICAID

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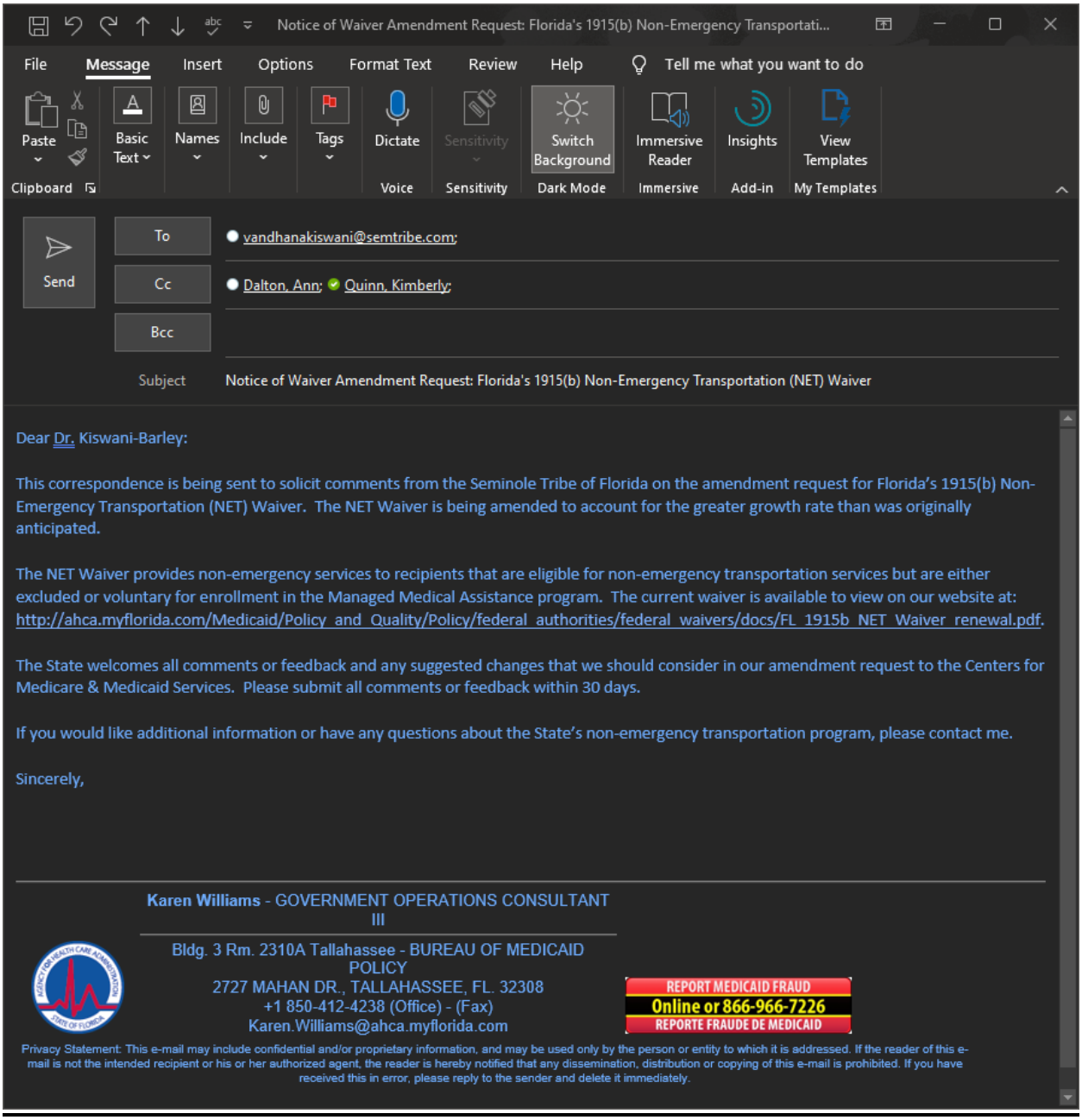
The Tribal Notice to the Seminole Tribe of Florida was delivered via email on December 6, 2021 to Dr. Vandhana Kiswani-Barley, a staff physician and the Interim Executive Director of Health and Human Services for the tribe.



Notice of Waiver Amendment Request: Florida's 1915(b) Non-Emergency Transportati...

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Clipboard Voice Sensitivity Dark Mode Immersive Add-in My Templates

Send

To vandhanakiswani@semtribe.com;

Cc Dalton, Ann; Quinn, Kimberly;

Bcc

Subject Notice of Waiver Amendment Request: Florida's 1915(b) Non-Emergency Transportation (NET) Waiver

Dear Dr. Kiswani-Barley:

This correspondence is being sent to solicit comments from the Seminole Tribe of Florida on the amendment request for Florida's 1915(b) Non-Emergency Transportation (NET) Waiver. The NET Waiver is being amended to account for the greater growth rate than was originally anticipated.

The NET Waiver provides non-emergency services to recipients that are eligible for non-emergency transportation services but are either excluded or voluntary for enrollment in the Managed Medical Assistance program. The current waiver is available to view on our website at: http://ahca.myflorida.com/Medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/FL_1915b_NET_Waiver_renewal.pdf.

The State welcomes all comments or feedback and any suggested changes that we should consider in our amendment request to the Centers for Medicare & Medicaid Services. Please submit all comments or feedback within 30 days.

If you would like additional information or have any questions about the State's non-emergency transportation program, please contact me.

Sincerely,

Karen Williams - GOVERNMENT OPERATIONS CONSULTANT III

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REPORT MEDICAID FRAUD
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REPORTE FRAUDE DE MEDICAID

Independent Assessment of the Florida Medicaid NET Program

Final Report on Access to Services, Quality of Services, and Cost Effectiveness of Services (2018)

Deliverable #27

Lodi Rohrer
John Robst
David Lamb
Flandra Ismajli

Louis de la Parte Florida Mental Health Institute
University of South Florida

September 22, 2020

Submitted to the Florida Agency for Health Care Administration
Contract MED187

Table of Contents

List of Tables

List of Figures

Appendices

Executive Summary

This report was prepared by the University of South Florida to summarize the results of an independent assessment of access to services, quality of services, and cost effectiveness of services for Medicaid recipients enrolled in the Non-Emergency Transportation (NET) program in 2018. The NET program provides transportation services for recipients to their Medicaid-compensable services if they have no other means of transportation or require assistance during transport to a Medicaid-covered service. Currently, two vendors (LogistiCare and MTM) provide transportation services to Medicaid recipients under a fee-for-service delivery system. Nine research questions were addressed for this report using a quantitative design:

1. Based on the current performance measures, how have NET vendors improved access since last year? What strategies have the NET vendors implemented to improve deficient areas related to access? (Access)
2. (a) Have the number of unique riders per 1,000 Medicaid recipients using transportation gone up or down? (b) Have the number of rides per recipient per month gone up or down? (c) How has the type of transportation changed (e.g., mode of transportation)? (Access)
3. What changes in timeliness of arriving to services, scheduling services, and receiving transportation services have occurred since implementation of the waiver? What are the wait times associated with recipients being picked up from their scheduled appointments? (Access)
4. What are the residential clusters of high NET utilization? Have these geographic utilization patterns changed over time or remained stable? What are the demographic characteristics (age, gender, Prescribed Pediatric Extended Care (PPEC) versus non-PPEC) of these high utilization neighborhoods (using census and Medicaid data)? (Access)
5. How has the rate of consumer complaints reported to the vendors changed since implementation? What are the most commonly reported complaints? How are the NET vendors addressing the most commonly reported complaints? (Quality)
6. How do the complaints submitted by the NET vendors to the Agency align with consumer complaints made directly to the Agency? (Quality)
7. Are consumers satisfied with the NET services they receive? (Quality)
8. How have encounter costs gone up or down per rider per month and why? How has the change in distribution by region and rate group affected this amount? (Cost Effectiveness)
9. How has the encounter cost by transportation type per rider per month gone up or down? (Cost Effectiveness)

The evaluation team utilized a variety of data to conduct analyses, including Medicaid data (e.g., eligibility, encounter, and capitation files), vendor monthly performance reports, U.S. Census data, consumer complaint data, and electronic survey data. The majority of the analyses were descriptive in nature, and regression analyses were used to examine trends in costs.

Overall, results of the evaluation suggest that the vendors' performance standards were lower in 2018 as compared to 2017. However, it appears that access to NET services is satisfactory, with the vendors providing more rides per user in 2018 than 2017 and increasing the use of high capacity vehicles in order to transport more than one member at a time. As expected, the highest rates of eligibility and utilization in 2018 were in urban areas, with two additional

counties (Palm Beach and Hillsborough) included in this classification as compared to 2017. Additionally, individuals in urban areas are less likely to have access to a personal vehicle and more likely to rely on public transportation, which may explain the high rates of utilization.

The rate of consumer complaints was consistently less than 1% for both vendors in 2018 which suggests that the majority of consumers are satisfied with NET services. The analysis of information from the Agency's Complaint Operations Center indicated that most complaints were associated with eligibility, appointment setting, and "no-shows".

As compared to 2017, fewer recipients received services in 8 out of 12 months in 2018, despite the fact that fee-for-service enrollment steadily increased. Additionally, results suggest overall per rider costs increased between 2017 and 2018. Although per rider costs were stable for MTM, LogistiCare had higher per rider costs, particularly in Region 11, and among mini-bus and wheelchair van services.

The evaluation team offers the following recommendations:

- Vendor performance reports should include the number of standing orders, advance reservations, and will-call rides. It is unclear whether these requests are included in the calculation of the number of reservation calls in the vendor monthly performance reports. Information about the types of reservation calls will allow for improved scheduling and monitoring of rides needed in advance or with short notice.
- Vendors should address the concern raised by consumers regarding transportation provider lateness and no-shows. Provider lateness has been an ongoing issue that can be caused by many factors, including heavy traffic; however, late arrivals to medical appointments could result in missed or canceled visits and should be avoided.
- Vendors should consistently report both Agency complaints as well as complaints reported to the vendor in monthly reports sent to the Agency, as required by the Agency. A comprehensive accounting of all complaints is important so that they are not undercounted.
- Vendors should document why costs per rider are changing. This information could provide insight into whether different vehicle types or additional subcontractors are needed to provide transportation services.

Introduction

The Code of Federal Regulations (42 CFR 431.53) requires all states to ensure that eligible, qualified Medicaid recipients receive non-emergency transportation (NET) so they can get to and from Medicaid-compensable appointments and services (Centers for Medicare & Medicaid Services, 2014). The Agency for Health Care Administration ("Agency"), which administers the Medicaid program in Florida, is required to provide NET for Medicaid recipients to access medical care if they (1) have no other means of transportation, (2) require assistance during transport to a Florida Medicaid covered service, and (3) the mode of transport is medically appropriate for the recipient's mental or physical condition as determined by a licensed health care professional (Agency for Health Care Administration, 2016).

With the statewide implementation of the Statewide Medicaid Managed Care (SMMC) program in 2014, Medicaid's Managed Medical Assistance (MMA) plans became responsible for providing NET as a covered service to plan enrollees. In addition, NET is provided to Medicaid recipients who are receiving fee-for-service benefits because they are excluded from enrollment in an MMA plan or their enrollment is voluntary. NET services for this population are provided by two CNET plans under the authority of a Section 1915(b) waiver. Each vendor subcontracts with multiple transportation providers in order to provide NET services.

One requirement of the Section 1915(b) waiver is an independent assessment of NET services provided to individuals who are not eligible or not enrolled in a managed care plan. The Agency contracted with the University of South Florida to conduct the assessment for both the initial and renewal periods. The assessment evaluates three elements of the NET program: access to services, quality of services, and cost effectiveness of services. In the remaining sections, the data sources, analytic approach, and results are described for each question. The report concludes with a summary of findings and recommendations.

Method

Access to Services: Data and Analysis

The primary data sources for this report included (1) NET vendor monthly reports submitted to the Agency, (2) capitation and encounter data from the Florida Medicaid Managed Information System [1] (FMMIS) for 2018, and (3) data from the U.S. Census Bureau. The evaluators conducted a descriptive analysis of data contained in the monthly reports. Details about the analysis of FMMIS data are described under Question 2 in Results—Access to Services.

Quality of Services: Data and Analysis

The primary data sources for this report include the NET vendor monthly reports submitted to the Agency and complaints submitted to the Agency's Complaint Operations Center. The monthly reports from both vendors are restricted to complaints from fee-for-service (FFS) recipients. However, the vendors do not submit complaints to the Agency from the same sources. In their monthly reports, MTM submits FFS complaints made directly to them, their subcontracted providers, and to the Agency. LogistiCare only submits complaints received from

[1] The data did not include services provided to medically needy recipients. While the Agency provided data on the number of members in each month, the evaluators lack data on the number of riders and rides.

their subcontracted providers. However, the Agency's complaint data does include FFS complaints made directly to the Complaint Operations Center. The Agency is aware of this reporting issue and is working with LogistiCare to include all required data going forward. The evaluation team conducted a descriptive analysis of data from both sources.

Cost Effectiveness: Data and Analysis

The data sources for this report included capitation and encounter data from FMMIS for 2016–2018. For the analysis, encounters were only included if the submitting provider was MTM or LogistiCare. Encounters submitted by MMA plans for transportation services provided by MTM or LogistiCare through subcontracts with MMA plans were excluded. There were 231,634 encounters in FMMIS for CY 2016 submitted by LogistiCare (102,385) and MTM (129,249) for transportation services. There were 209,922 encounters in FMMIS for CY 2017 submitted by LogistiCare (102,224) and MTM (107,698) for transportation services. There were 220,138 encounters in FMMIS for CY 2018 submitted by LogistiCare (120,205) and MTM (99,933).

Two different comparisons were made throughout the analysis. First, a month-by-month comparison was made between 2017 and 2018. Thus, costs for January 2017 were compared with January 2018, February 2017 with February 2018, etc. Month-by-month comparisons between 2016 and 2017 were made in the 2017 evaluation report and thus, were not repeated here in the 2018 report. To summarize, month-by-month comparisons between 2016 and 2017 showed higher per rider costs in 11 of the 12 months for the overall program, 11 of the 12 for LogistiCare, and 8 of the 12 months for MTM.

Second, a simple regression was estimated that examined whether monthly costs increased, decreased, or remained statistically constant between 2016 and 2018. Such regressions examined the overall trend in costs.

Results

Access to Services

Five research questions were addressed for this report on access to services. In the following sections, each question is listed with results presented.

1. Based on the current performance measures, how have NET vendors improved access since last year? What strategies have the NET vendors implemented to improve deficient areas related to access?

Performance measures are used by the Agency to monitor NET vendor operations. These measures and the corresponding performance of each vendor in 2018 as well as strategies for improvement are described in Table 1. The information presented in this table is summarized from complaints submitted to the Agency's Complaint Operations Center.

In 2018, the NET vendors experienced some declines in performance as compared to 2017. As shown in Table 1, both vendors had increases in late arrivals and no-shows. MTM experienced an increase in the average speed of call answer and abandoned calls.

Table 1. *Performance measures related to access*

Performance Measure	Data Source		
	Vendor Monthly Reports		Complaint Resolutions
	LogistiCare Performance	MTM Performance	Strategies for Improvement
90% of recipients will arrive at their appointment at or before their scheduled appointment time.	The monthly performance reports specify the number of instances in which the transportation provider arrived more than 15 minutes after scheduled pickup. In 2018, this occurred 52 times, and was most common in Region 11.	The monthly reports do not indicate the number of instances in which the transportation provider arrived late. Information about timeliness is available from the consumer satisfaction survey administered to riders by the evaluation team. Results indicate that 69.2% of respondents arrived at their appointments most of the time or always, but these findings are based on a small sample size (*n* = 13).	When delays occur, LogistiCare places the rider on a monitor list to prevent problems from recurring. If necessary, future trips will be set with a different transportation provider. In the event of delays, MTM also excludes providers with multiple infractions. In addition, they (1) advise providers to create an internal schedule to ensure all trips are on time, (2) remind providers that significant delays should be reported to the vendor and the member immediately, and (3) remind providers about acceptable wait times.
The average speed of call answer shall not exceed 45 seconds.	The performance reports indicate that calls were answered, on average within 26 seconds in 2018. Average duration to answer calls ranged from 14.66 seconds in Quarter 1 to 40.33 seconds in Quarter 3.	The performance reports indicate that calls were answered, on average, within 28.07 seconds in 2018. Average duration to answer calls ranged from 9.65 seconds in Quarter 4 to 69.19 seconds in Quarter 2.	In 2018, performance exceeded standards in all quarters for both NET vendors, except Quarter 2 for MTM, in which the average speed to answer calls was longer than the allotted time. No strategies for improvement are offered at this time because calls were answered quickly in subsequent quarters.
The call blockage rate for direct calls to the vendor shall not exceed 1%.	In 2018, LogistiCare reported that no calls were blocked (i.e., caller receives a busy signal).	In 2018, the monthly performance reports for MTM indicate that the percentage of blocked (abandoned) calls was 2.61%.	The percentage of blocked calls exceeds the performance standard of 1% for MTM. The vendor should investigate the reasons for the high blockage rate.
The average call abandonment rate for direct calls to the vendor shall not exceed 5%.	For LogistiCare, the average rate of abandoned calls in 2018 was 1.30% and ranged from 0.20% in December 2018 to 2.30% in May.	For MTM, the average rate of abandoned calls in 2018 was 2.59% and ranged from 0.87% in Quarter 4 to 6.81% in Quarter 2.	Both vendors averaged a lower call abandonment rate than allowed, but MTM exceeded that abandonment rate in Quarter 2. No strategies for improvement are offered at this time because the call abandonment rate improved significantly in subsequent quarters.

Performance Measure	Data Source		
	Vendor Monthly Reports		Complaint Resolutions
	LogistiCare Performance	MTM Performance	Strategies for Improvement
At least 95% of service authorizations are processed within the timeframes specified in the contract.	This information is not available in the 2018 performance report.	This information is not available in the 2018 performance report.	Not applicable

As compared to 2017, LogistiCare experienced a decline in performance with ensuring that recipients arrive at their appointments on time. For example, the monthly performance reports for LogistiCare indicate that the number of instances in which the transportation provider arrived late for pickup was 26 in 2017 and 52 in 2018. However, LogistiCare experienced improvement in the average speed of call answer, whereas MTM did not. The average rate of abandoned calls was higher for MTM in 2018 as compared to 2017. Thus, the evaluation team cannot conclude that the vendors have improved access based on most of the established performance measures.

2. (a) Have the number of unique riders per 1,000 Medicaid recipients using transportation gone up or down? (b) Have the number of rides per recipient per month gone up or down? (c) How has the type of transportation changed (e.g., mode of transportation)?

For the analysis, encounters were only included if the submitting provider was MTM or LogistiCare.

There were 225,707 encounters in FMMIS for CY 2016, 209,922 in CY 2017, and 220,138 in CY 2018 submitted by LogistiCare and MTM for transportation services.

In general, questions are answered using two different approaches. First, utilization is examined per 1,000 Capitated Non-Emergency Transportation (CNET) enrollees, including users and non-users. This analysis captures aspects of service penetration (i.e., what proportion of eligible recipients use transportation services) and the intensity of services (i.e., how many services do users of transportation services receive)? Second, utilization is examined per user of transportation of services. This analysis focuses on the intensity of services received by users of services.

a. Have the number of unique riders per 1,000 Medicaid recipients using transportation gone up or down?

Table 2 contains the average monthly numbers of CNET enrollees, riders, and riders per 1,000 CNET enrollees. The number of enrollees, riders, and riders per 1,000 enrollees was computed for each month of 2016-2018 with the table containing the average monthly numbers of each year. Appendix 1 contains the monthly data. Average monthly enrollment was 151,015, 100,519, and 96,425, in 2016, 2017, and 2018, respectively. The average number of riders per month was 1,639, 1,400, and 1,381 in 2016, 2017, and 2018, respectively. The number of riders in a month per 1,000 CNET enrollees was 10.9, 13.9, and 14.3 in 2016, 2017, and 2018, respectively.

Table 2. *Average number of monthly CNET enrollees – 2016-2018*

	CNET enrollees	Riders	Riders per 1,000 CNET enrollees
2016	151,015	1,639	10.9
2017	100,519	1,400	13.9
2018	96,425	1,381	14.3

Figures 1, 2, and 3 contain trend lines for the number of CNET enrollees[2], the number of riders, and the number of riders per 1,000 CNET enrollees. Appendix 1 contains the data upon which the graphs were created.

There was a considerable decline in CNET enrollment in the first six months of 2016, with a smaller decline in early 2017. Since early 2017, CNET enrollment has been stable. The number of riders also declined in the first six months of 2016. With the exception of September 2017, when Hurricane Irma struck Florida, the number of riders has also been fairly stable. Similarly, the number of riders per 1,000 CNET enrollees stabilized in early 2017 and with the exception of September 2017, has been fairly stable.

To more formally test whether a time trend exists, a simple regression was estimated. The dependent variable is the number of riders per 1,000 enrollees and the single independent variable denotes time (the month/year). The *p* value for the time coefficient informs whether a time trend exists. If the *p* value for the time coefficient is less than .05, there is a statistically significant time trend. Otherwise, there is no statistically significant time trend. Given the large changes in enrollment and number of riders in 2016, the regressions were limited to data from 2017 and 2018 to focus on more recent trends. The results from the regression indicated a statistically significant downward trend in the number of CNET enrollees ($p = .0002$) with an average loss of 318 enrollees (approximately .3%) per month. Trends in the number of riders and riders per 1,000 CNET enrollees did not achieve statistical significance.

[2] The number of CNET enrollees include individuals with a CNET capitation payment and individuals that received transportation services due to medical need.

Figure 1. *CNET enrollees by month – 2016-2018*

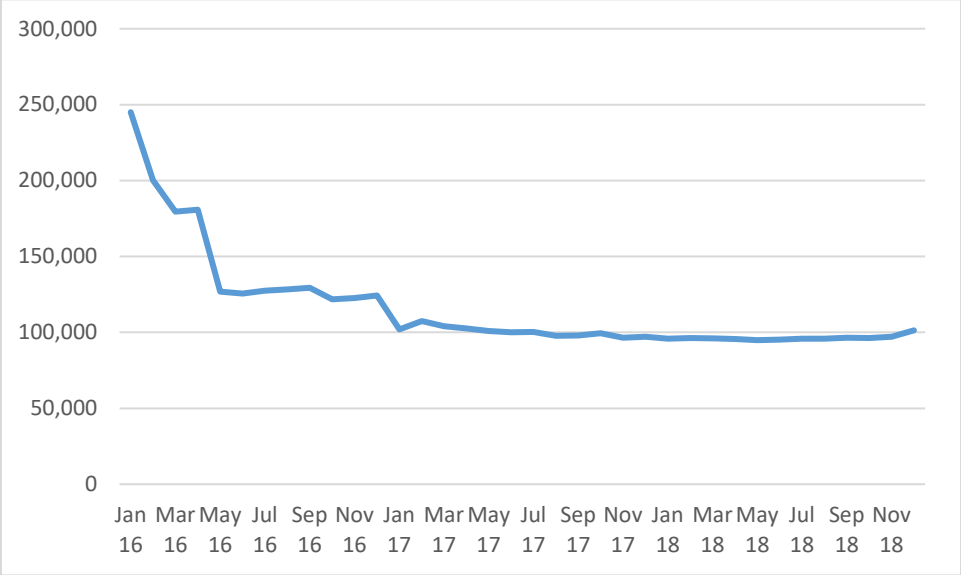


Figure 2. *Number of riders by month – 2016-2018*

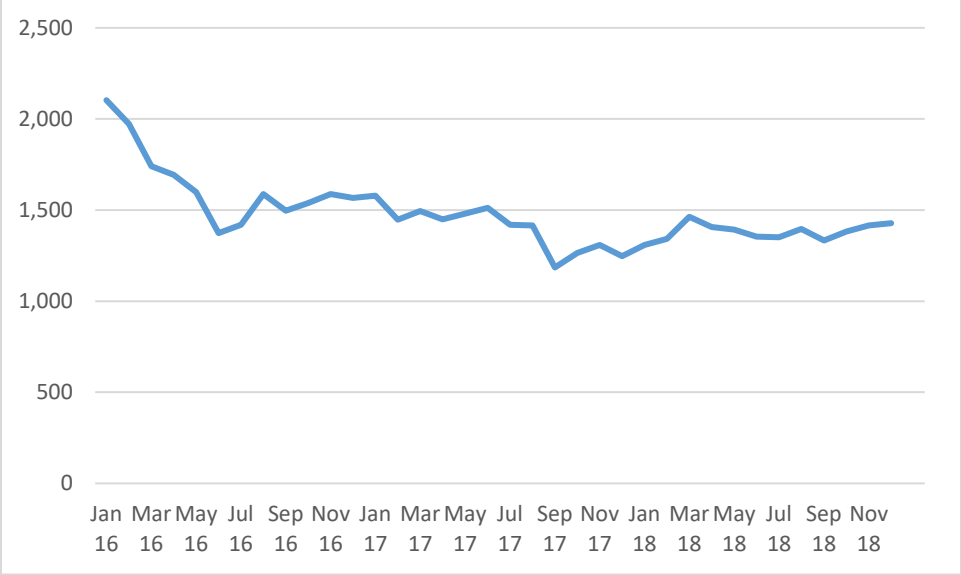
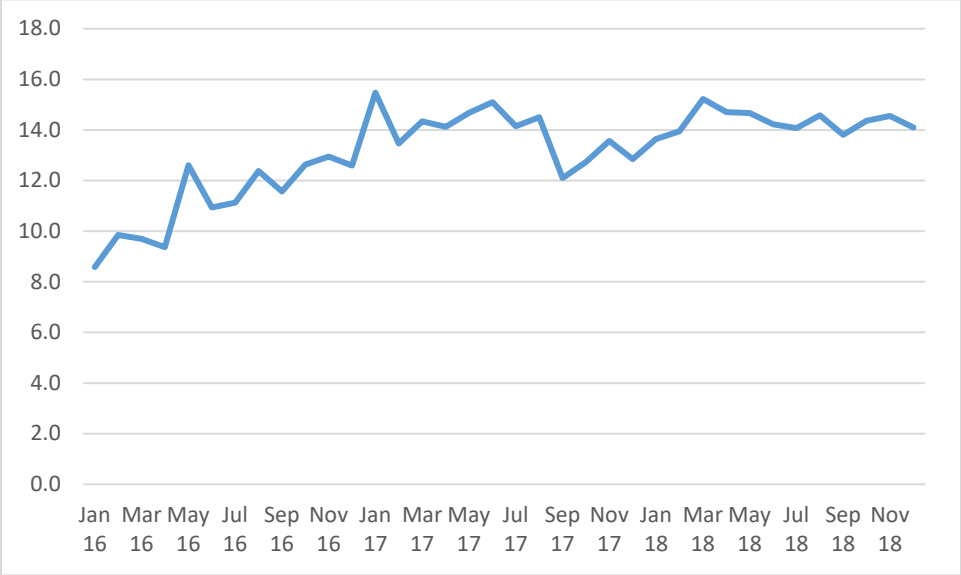


Figure 3. *Riders per 1,000 CNET enrollees by month – 2016-2018*



b. Have the number of rides per recipient per month gone up or down?

Table 3 contains the average monthly number of rides, rides per 1,000 CNET enrollees, and rides per user of CNET services. Monthly data are provided in Appendix 2. The average number of rides per month was 18,809, 17,494, and 18,345, in 2016, 2017, and 2018, respectively. The average number of rides per 1,000 CNET enrollees was 130.1, 173.9, and 190.3 in 2016, 2017, and 2018, respectively. Finally, the average number of rides per user of CNET services was 11.6, 12.5, and 13.3 in 2016, 2017, and 2018, respectively.

Table 3. *Average number of monthly rides by type of transportation service – 2016-2018*

	Rides	Rides per 1,000 CNET enrollees	Rides per user of CNET services
2016	18,809	130.1	11.6
2017	17,494	173.9	12.5
2018	18,345	190.3	13.3

Figures 4, 5 and 6 contain graphs illustrating the trend in the number of rides, rides per 1,000 CNET enrollees, and rides per user of CNET services. Appendix 2 contains the data upon which the graphs were created. Consistent with the number of riders reported in Figure 1, the number of rides also declined in the first six months of 2016. Since mid-2016, with the exception of September 2017 when Hurricane Irma struck Florida, the number of rides has been fairly stable. The number of rides per 1,000 CNET enrollees has trended upwards over time. Finally the average monthly number of rides per user of services has also shown an increasing trend over the three years.

A regression that examined the trend in the number of rides per user also indicated a positive trend over 2017 and 2018 (p = .0264). The upward trend in the number of rides per 1,000 CNET enrollees did not achieve statistical significance.

Figure 4. *Number of rides by month – 2016-2018*

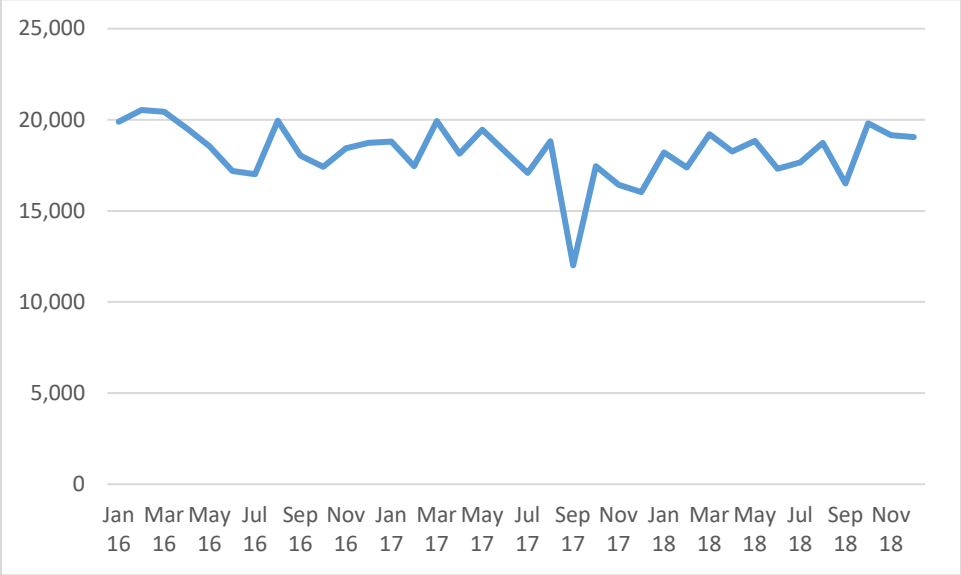


Figure 5. *Rides per 1,000 CNET enrollees by month – 2016-2018*

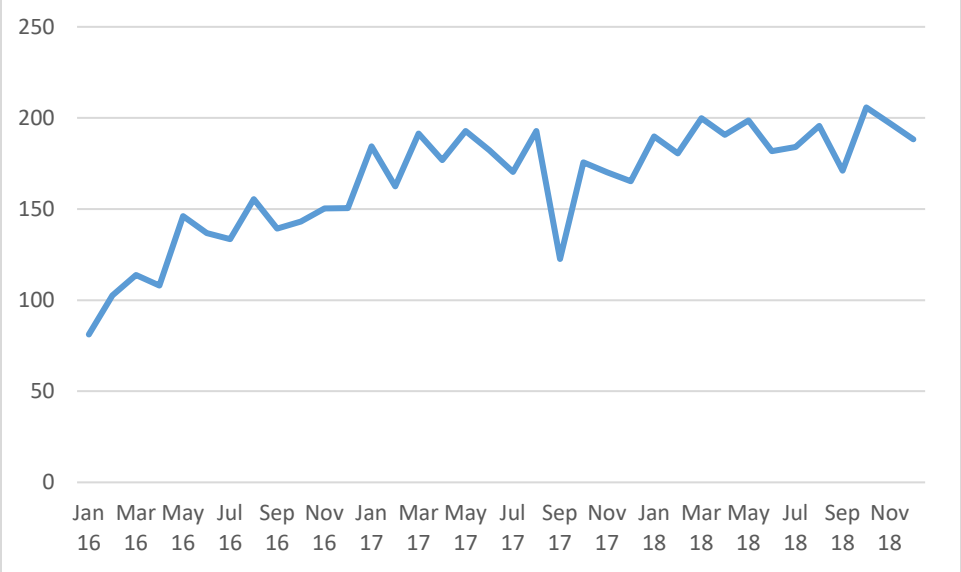
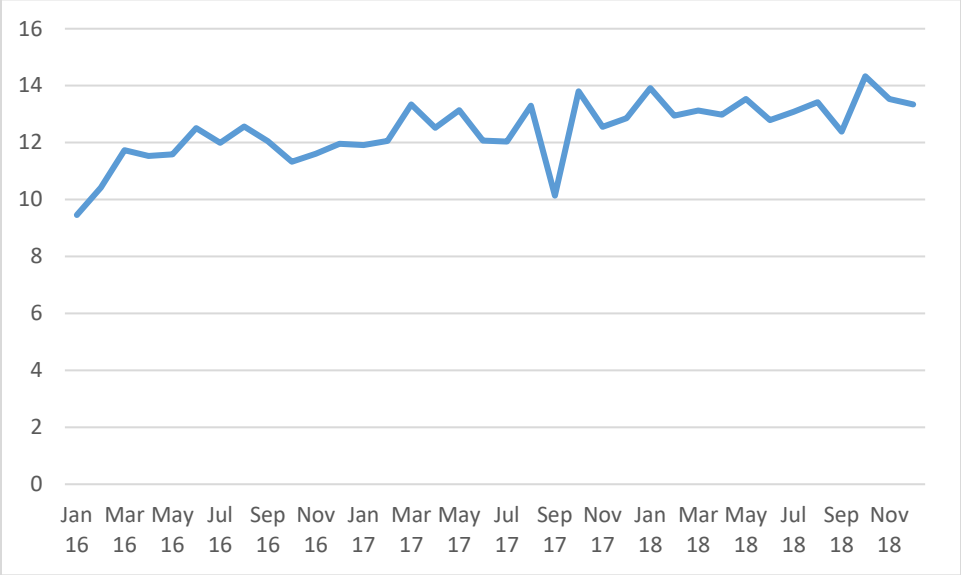


Figure 6. *Rides per user of transportation services by month – 2016-2018*



c. *How has the type of transport changed (e.g., mode of transportation)?*

The number of riders by type of transportation service is reported in Table 4. Taxi, mini-bus, and wheelchair van are the most common forms of transportation service. The average monthly number of riders that used taxi services was 522 in 2016, 392 in 2017, and 387 in 2018. The use of taxi services was stable between 2017 and 2018. The decline between 2016 and 2017 in the number of taxi riders mirrored the overall decline in CNET enrollment. A similar decline between 2016 and 2017 was seen for mini-bus ridership. Wheelchair van use did not see such a decline and was fairly stable over the three years.

It is important to note that MTM and LogistiCare are required to use the most appropriate type of transportation given the enrollees needs. Thus, changing patterns would suggest that the needs for users of transportation services have changed over time. It is beyond the scope of this evaluation to test whether the needs of riders have changed over time or whether patterns reflect changes in provider criteria.

Table 4. *Average number of monthly riders by type of transportation service – 2016-2018*

	Mileage Reimbursement Rides	Taxi	Mini-bus	Wheelchair van	Other
2016	59	522	651	409	53
2017	63	392	515	430	38
2018	78	387	519	426	37

Table 5 contains the average number of monthly riders per 1,000 CNET enrollees by type of transportation. The average number of taxi riders, mini-bus riders, and wheelchair van riders has increased over time. The average number of monthly taxi riders has increased from 3.5 (per 1,000 CNET enrollees) in 2016, to 3.9 in 2017 and 4.0 in 2018. Similarly, the number of mini-bus riders has increased from 4.4 in 2016, to 5.1 in 2017, and 5.4 in 2018. Wheelchair van riders have also increased; from 2.9 in 2016, to 4.3 in 2017, and 4.4 in 2018.

Table 5. *Average number of monthly riders per 1,000 CNET enrollees by type of transportation service – 2016-2018*

	Mileage reimbursement rides	Taxi	Mini-bus	Wheelchair van	Other
2016	0.415	3.501	4.409	2.862	0.355
2017	0.627	3.896	5.116	4.279	0.381
2018	0.806	4.008	5.375	4.423	0.381

Figure 7 contains the trend lines for the number of riders per 1,000 CNET enrollees from 2016 through 2018. Regressions examining data from 2017 and 2018 found an increasing trend in mileage reimbursement rides ($p < .0001$).

Figure 7. *Riders per 1,000 CNET enrollees*

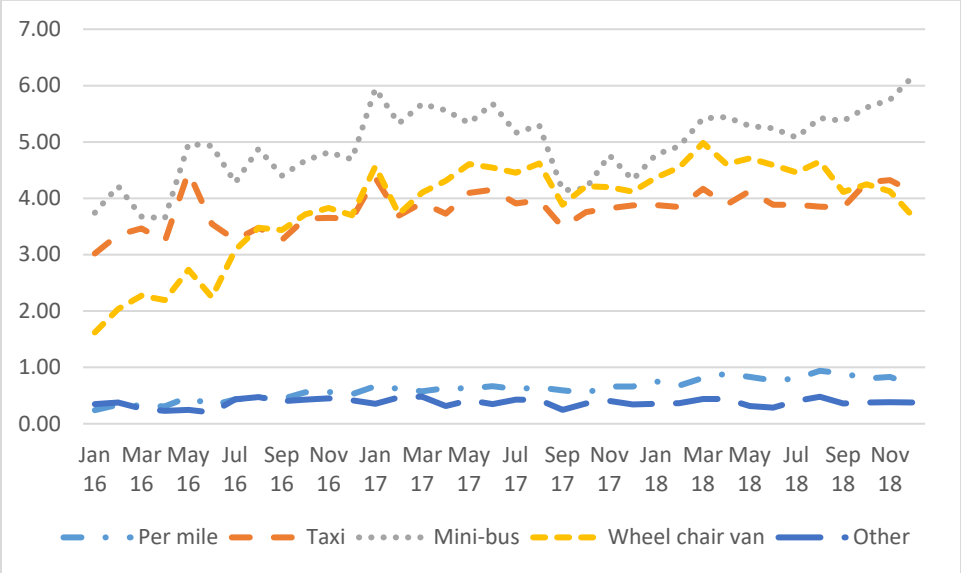


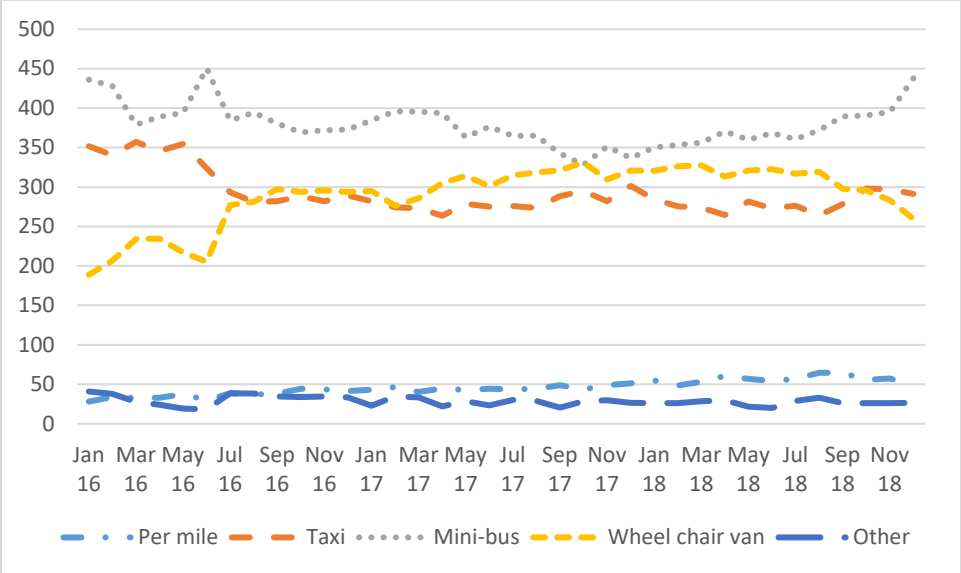
Table 6 contains the average number of monthly riders per 1,000 users of CNET services by type of transportation. The average number of taxi riders, mini-bus riders, and wheelchair van riders has varied over time. The average number of monthly taxi riders decreased from 2016 to 2017 from 316 (per 1,000 users of CNET services) in 2016 to 280 in 2017 and remained stable in 2018 at 280 riders per 1,000 users of CNET services. The number of wheelchair van riders increased from 252 in 2016 to 308 in 2017 but remained stable between 2017 and 2018.

Table 6. *Average number of monthly riders per 1,000 users of CNET services by type of transportation service – 2016-2018*

	Mileage reimbursement rides	Taxi	Mini-bus	Wheelchair van	Other
2016	36.5	315.7	395.9	252.1	31.8
2017	45.2	280.3	366.5	307.8	27.4
2018	56.3	279.9	375.3	308.7	26.6

Figure 8 contains the trend lines for the number of riders per 1,000 users of CNET services. Regressions examining data from 2017 and 2018 found an increasing trend in mileage reimbursement rides ($p < .0001$).

Figure 8. *Riders per 1,000 users of CNET services*



The number of rides by type of transportation service is reported in Table 7. Taxi, mini-bus, and wheelchair van are the most common forms of transportation service. The average monthly number of taxi rides was 7,643 in 2016, 6,449 in 2017, and 6,044 in 2018. Wheelchair van use increased over the three years, from 4,564 in 2016, to 4,794 in 2017, and 5,169 in 2018.

Table 7. *Number of rides by type of transportation services – 2016-2018*

	Mileage reimbursement rides	Taxi	Mini-bus	Wheelchair van	Other
2016	632	7,643	5,684	4,564	285
2017	683	6,449	5,382	4,794	185
2018	756	6,044	6,228	5,169	147

Table 8 contains the average number of monthly rides per 1,000 CNET enrollees by type of transportation. Similar to the number of riders, the average number of taxi rides, mini-bus

rides, and wheelchair van rides has varied over time. The average number of monthly taxi rides increased from 2016 to 2017 from 52.3 (per 1,000 CNET enrollees) in 2016 to 64.1 in 2017 and remained stable in 2018 at 62.7 riders per 1,000 CNET enrollees. The number of mini-bus rides increased from 39.5 in 2016 to 53.5 in 2017 and 64.5 in 2018. Similarly, the number of wheelchair van riders increased from 31.9 in 2016 to 47.7 in 2017 and 53.6 in 2018.

Table 8. *Number of rides per 1,000 CNET enrollees by type of transportation services – 2016-2018*

	Mileage reimbursement rides	Taxi	Mini-bus	Wheelchair van	Other
2016	4.39	52.28	39.52	31.94	1.94
2017	6.80	64.13	53.47	47.70	1.82
2018	7.85	62.73	64.52	53.64	1.52

Figure 9 contains the trend lines for the number of rides per 1,000 CNET enrollees. Regressions indicated a negative trend for taxi rides between 2017 and 2018 (p = .0049) and a positive trend in the number of mini-bus rides per 1,000 CNET enrollees (p = .0188).

Figure 9. *Rides per 1,000 CNET enrollees*

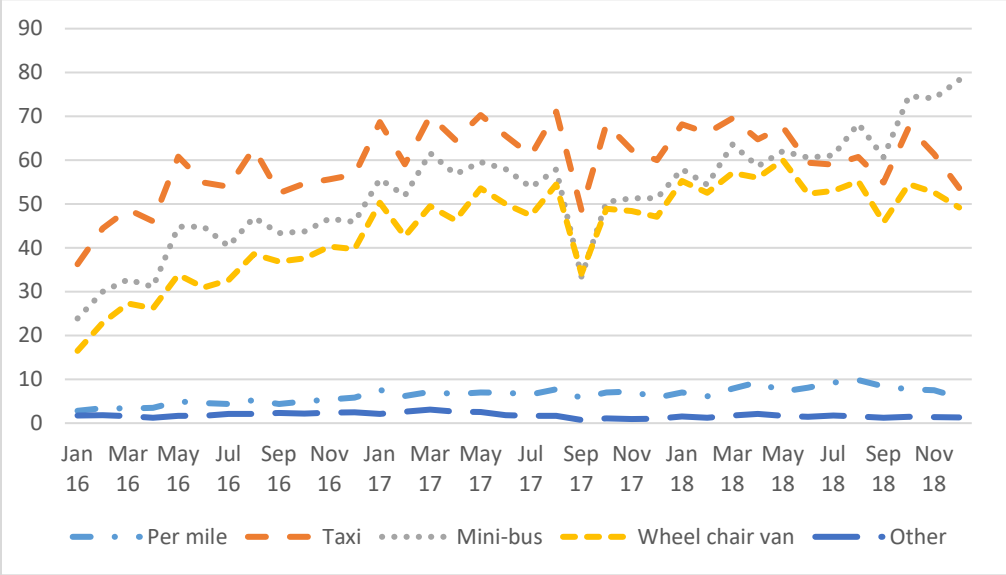


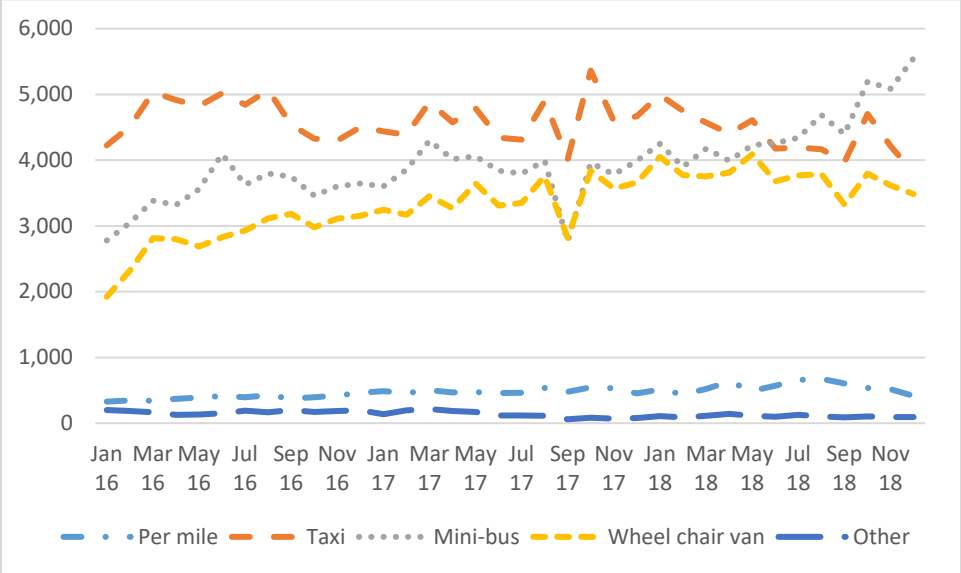
Table 9 contains the average number of monthly rides per 1,000 users of CNET services by type of transportation. Similar to the number of riders, the average number of taxi rides, mini-bus rides, and wheelchair van rides has varied over time. The average number of monthly taxi rides decreased from 2016 to 2017 from 4,676 (per 1,000 users of CNET services) in 2016 to 4,606 in 2017 and 4,380 in 2018. The number of mini-bus rides increased from 3,505 in 2016 to 3,830 in 2017 and 4,505 in 2018. Similarly, the number of wheelchair van rides increased from 2,820 in 2016 to 3,424 in 2017 and 3,744 in 2018.

Table 9. *Number of rides per 1,000 users of CNET services by type of transportation services – 2016-2018*

	Mileage reimbursement rides	Taxi	Mini-bus	Wheelchair van	Other
2016	389	4,676	3,505	2,820	173
2017	488	4,606	3,830	3,424	129
2018	548	4,380	4,505	3,744	106

Figure 10 contains the trend lines for the number of rides per 1,000 users of CNET services. Regression models examining trends over 2017 and 2018 indicate a positive trend in mini-bus ($p < .0001$) and wheelchair van rides ($p = .0233$) per 1,000 users of transportation services. The number of taxi rides per 1,000 users of services decreased between 2017and 2018 ($p = .0494$).

Figure 10. *Rides per 1,000 users of CNET services*



In summary, the evaluators examined the trend of ridership and rides during 2017 and 2018. There was a significant increase in service use per 1,000 CNET enrollees and also an increase in the number of rides per 1,000 users of CNET services.

In an analysis of transportation types, the number of riders per CNET enrollee and per user of CNET services trended upward in 2017 and 2018 for mileage reimbursement. Other transportation types did not have a statistically significant change. The number of rides trended upward for mini-buses and decreased for taxis. Wheelchair van use trended upward but achieved statistical significance only for rides per CNET user of services. Thus, overall, the number of people that used specific transportation types did not change much in 2017 and 2018. However, there were some changes in the number of rides for specific transportation services with a greater use of mini-buses and a lower use of taxis.

3. What changes in timeliness of arriving to services, scheduling services, and receiving transportation services have occurred since implementation of the waiver? What are the

wait times associated with recipients being picked up from their scheduled appointments?

Tables 10 and 11 summarize information from the vendors' monthly performance reports about scheduling, receiving, and delivering NET services. Specifically, scheduling services is described by Indicator 3, receiving services is described by Indicators 1, 4, and 5, and delivering services is described by Indicators 6-11.

Table 10. *Monthly performance data submitted by LogistiCare, 2017-2018*

No	Indicator	1st Quarter Jan – Mar		2nd Quarter Apr – Jun		3rd Quarter Jul – Sep		4th Quarter Oct – Dec	
		2017	2018	2017	2018	2017	2018	2017	2018
1	Number of unique members utilizing transportation	3,388	2,963	3,404	2,977	2,932	2,962	2,666	3,579
2	Number of eligible members (all Medicaid)	157,855	67,848	131,348	40,147	128,241	40,320	127,993	39,429
3	Number of reservations calls received	22,938	73,587	20,139	71,046	16,430	67,380	14,771	66,162
4	Number of completed trips	72,362	76,004	70,528	72,475	68,045	71,491	69,537	85,655
5	Average utilization rate	45.8%	33.3%	53.7%	43.8%	53.1%	41.5%	54.3%	73.0%
6	Trips provided by sedan	49,586	47,229	47,484	45,736	43,678	45,458	41,965	58,020
7	Trips provided by wheelchair vehicle	21,073	25,357	21,449	25,584	23,292	24,876	24,622	25,949
8	Trips provided by stretcher vehicle	94	311	90	359	432	556	277	687
9	Trips provided by ambulance	479	477	503	457	430	323	461	623
10	Trips provided by mileage reimbursement	75	47	77	132	46	110	46	200
11	Trips provided by public transit	238	166	106	207	164	168	164	176

Table 11. *Monthly performance data submitted by MTM, 2017-2018*

No	Indicator	1st Quarter Jan – Mar		2nd Quarter Apr – Jun		3rd Quarter Jul – Sep		4th Quarter Oct – Dec	
		2017	2018	2017	2018	2017	2018	2017	2018
1	Number of unique members utilizing transportation	2,097	2,094	2,076	2094	1,912	2094	1,928	2094
2	Number of eligible members (all Medicaid)	178,453	171,305	172,319	171,305	168,070	171,305	171,018	171,305
3	Number of reservations calls received	11,253	9,072	9,595	10,154	9,068	10,798	8,711	10,210
4	Number of completed trips	36,973	37,235	36,891	37,235	33,076	37,235	34,918	37,235
5	Average utilization rate	20.7%	20.1%	21.4%	20.1%	19.7%	20.1%	20.4%	20.1%
6	Trips provided by sedan	26,292	27,501	26,583	27,501	24,065	27,501	26,152	27,501
7	Trips provided by wheelchair vehicle	7,921	7,836	7,570	7,836	6,389	7,836	6,335	7,836
8	Trips provided by stretcher vehicle	148	83	212	83	187	83	127	83
9	Trips provided by ambulance	137	312	170	312	126	312	143	312
10	Trips provided by mileage reimbursement	2,153	1,999	2,050	1,999	1,964	1,999	1,949	1,999
11	Trips provided by public transit	322	348	306	348	345	348	212	348

The number of eligible members declined substantially for LogistiCare between 2017 and 2018, but the vendor experienced a sharp increase in the number of reservations calls and a modest increase in the number of completed trips. By contrast, these totals for MTM were relatively stable across both years. The average utilization rate was consistent over time for both vendors; i.e., around 50% for LogistiCare and 20% for MTM, although these rates are not directly comparable because the vendors use different methods to calculate eligible members (i.e., MTM obtains member counts from their accounting office, whereas LogistiCare uses monthly and daily enrollment files).

From 2017 to 2018, LogistiCare had an increase in the number of trips provided by wheelchair and stretcher vehicles. By contrast, MTM had fewer trips provided by stretcher vehicles but more trips provided by ambulance.

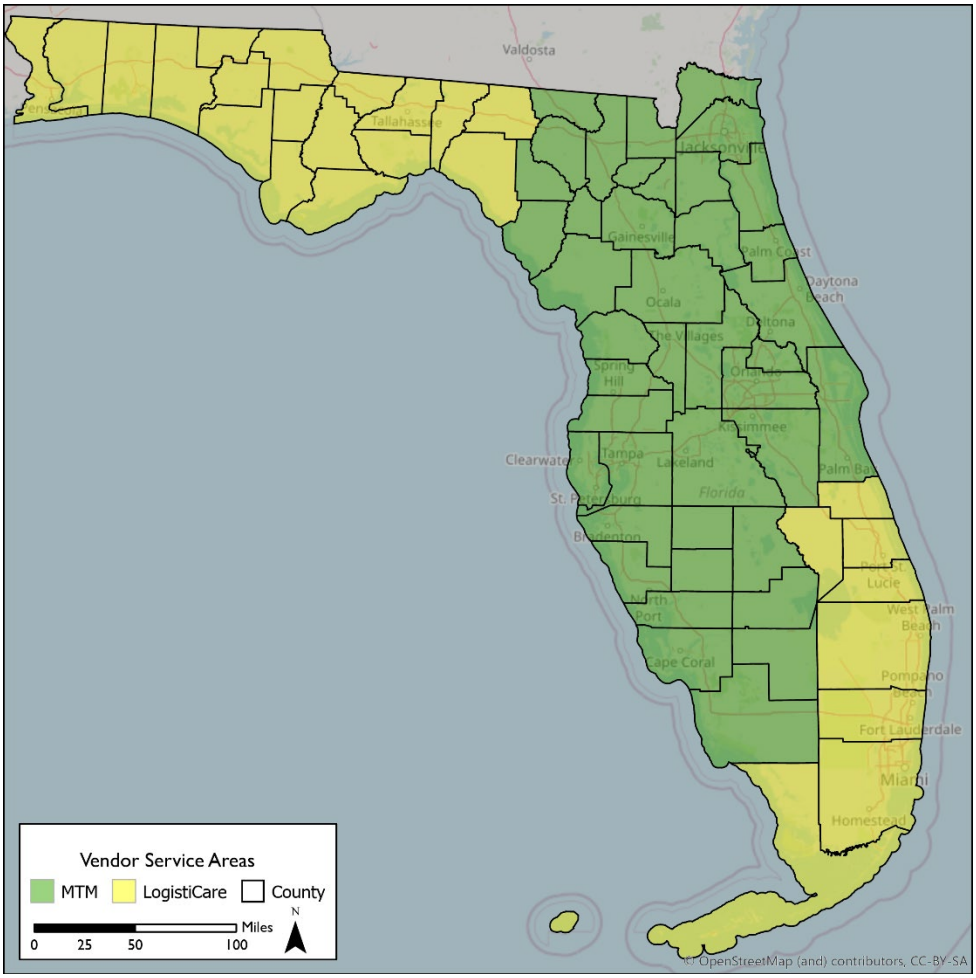
Transportation providers are advised that members should not be dropped off more than 30 minutes prior to a scheduled appointment and should not remain in the vehicle from more than 45 minutes over the travel time. A review of complaints submitted to the Agency's Complaint Operations Center indicates that delays do occur due to a variety of reasons, including traffic, incorrect addresses, emergencies, and unforeseen delays caused by transporting other members. If drivers are late and the rider submits a complaint, MTM's Quality and Compliance department advises the provider to create an internal schedule so that all trips are on time and

reminds the provider that significant delays must be reported to MTM and the member immediately so that the trip can be rerouted. In the event of late pickups or arrivals that are reported as complaints, LogistiCare places the member on a monitor list to ensure that future trips are on time.

4. What are the residential clusters of high NET utilization? Have these geographic utilization patterns changed over time or remained stable? What are the demographic characteristics (age, gender, Prescribed Pediatric Extended Care (PPEC) versus non-PPEC) of these high utilization neighborhoods (using census and Medicaid data)?

Figure 11 presents the vendor service areas for MTM and LogistiCare in Florida. LogistiCare encompasses 26 counties, and MTM encompasses 41. This approximately equates to 8 million persons within LogistiCare's service area, and 12 million in MTM's (according to the 2017 American Community Survey).

Figure 11. *Vendor service areas*

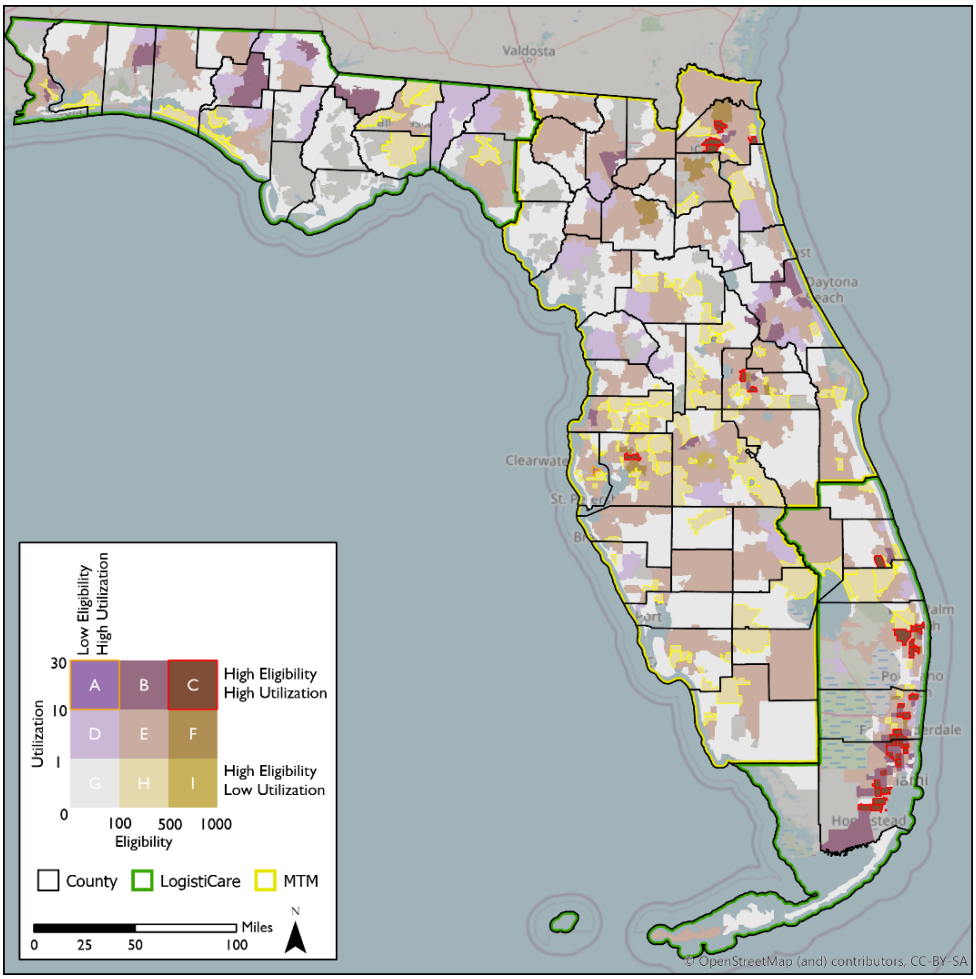


In order to understand the location of eligible NET users, residential addresses of fee-for-service recipients in FMMIS were aggregated by their 5-digit zip code after removing addresses not in the state of Florida. Since zip code numbers are not directly associated with U.S. Census boundaries, these values needed to be matched with the closest U.S. Census boundaries called Zip Code Tabulation Areas (ZCTA). These ZCTAs are created by the U.S. Census Bureau to match the postal zip codes and treat them as areas. By matching the postal zip codes to the

U.S. Census ZCTAs, the aggregated FMMIS information could be associated with the U.S. Census demographic and economic information. This type of data is collected through the annual American Community Survey (ACS). Because the ACS is a random sample, 5-year averages from 2012 to 2017 were used to give a more complete sample. (The 2018 ACS data were not available at the time of the analysis.) The ACS provides demographic information on the total population of residents within a ZCTA. This provided a picture of the characteristics of a typical resident of a ZCTA in order to better understand eligible users.

One challenge with understanding the users is the relatively low number per zip code, despite eligibility. To understand the relationship and identify areas with high use and eligibility, a bivariate categorization was created. Using three ranges for each variable, the evaluators created nine groups labeled as A through I. These groups are presented in Figure 12, and their associated ZCTA. The grid in the lower left corner of the figure color codes each group. The bottom row of this grid shows groups that had no utilization across different ranges of eligibility (0 to 100, 101 to 500, and 501 to 1,000 individuals). The middle row shows utilization ranging from 2 to 10, and the top row shows utilization from 11 to 30. Group C represents high eligibility and high utilization zip codes. LogistiCare contains 33 of the Group C zip codes within its service area.

Figure 12. *Utilization and eligibility by Zip Code Tabulation Area*



Each group is summarized in Table 12. Only one ZCTA fell into Group A (low eligibility/high utilization), located in Pinellas County, MTM service area. For Group B, 58 of the ZCTAs were

located in Miami-Dade and Volusia counties. Group C (high eligibility/high utilization) had 41 ZCTAs within Miami-Dade, Broward, Palm Beach, and Duval (Jacksonville). The group with the most ZCTAs and total overall population was Group E, the middle group. There was one ZCTAs that fell in Group I (high eligibility/no utilization) in Polk County.

Table 12. *Summary of groups derived from the Zip Code Tabulation Areas*

Group	Utilization Range	Eligibility Range	Total Active	Total Eligible	Total ZCTA	Total Population in ZCTA*
A	11 to 30	0 to 100	11	80	1	7,666
B	11 to 30	101 to 500	936	19,594	58	1,980,074
C	11 to 30	501 to 1,000	1,041	28,875	41	2,211,978
D	2 to 10	0 to 100	165	3831	60	691,274
E	2 to 10	101 to 500	1,510	79,338	326	9,191,854
F	2 to 10	501 to 1,000	93	7509	13	612,484
G	<=1	0 to 100	83	12,605	330	2,832,734
H	<=1	101 to 500	73	17,758	106	2,495,544
I	<=1	501 to 1,000	0	502	1	38,733
Note. ZCTA = Zip Code Tabulation Area. *Derived from 2017 ACS 5-year average.						

Figures 13, 14, and 15 present detailed views of south, central, and northern Florida. Group C-related ZCTA are highlighted with a red boundary. These zip codes tend to be in more densely populated urban areas. Many zip codes in Group F fall adjacent to ZCTAs in Group C in these urban areas. It is not entirely clear why there would be low use in these areas versus the higher utilization areas, despite being relatively similar in location. One potential answer is shown in Figure 16. This figure provides context for commuting patterns of households in the different ZCTAs. The left panel shows the percent of public transit use by workers 16 years and older who use public transportation. The right panel shows percent of workers that live in a household with no vehicle. These have been grouped together based on the categories presented in Table 12. Group C has the highest proportion of commuters using public transit of all the other groups, and also for households that do not have a vehicle. Group B is second in both categories. This suggests that residents in these ZCTAs are more likely to use public transit and not have access to a personal vehicle. The difference between Group B and C is just a cutoff point in Eligibility Range, so they are possibly very similar in their demographics.

Figure 13. *Detail of Zip Code Tabulation Areas in South Florida*

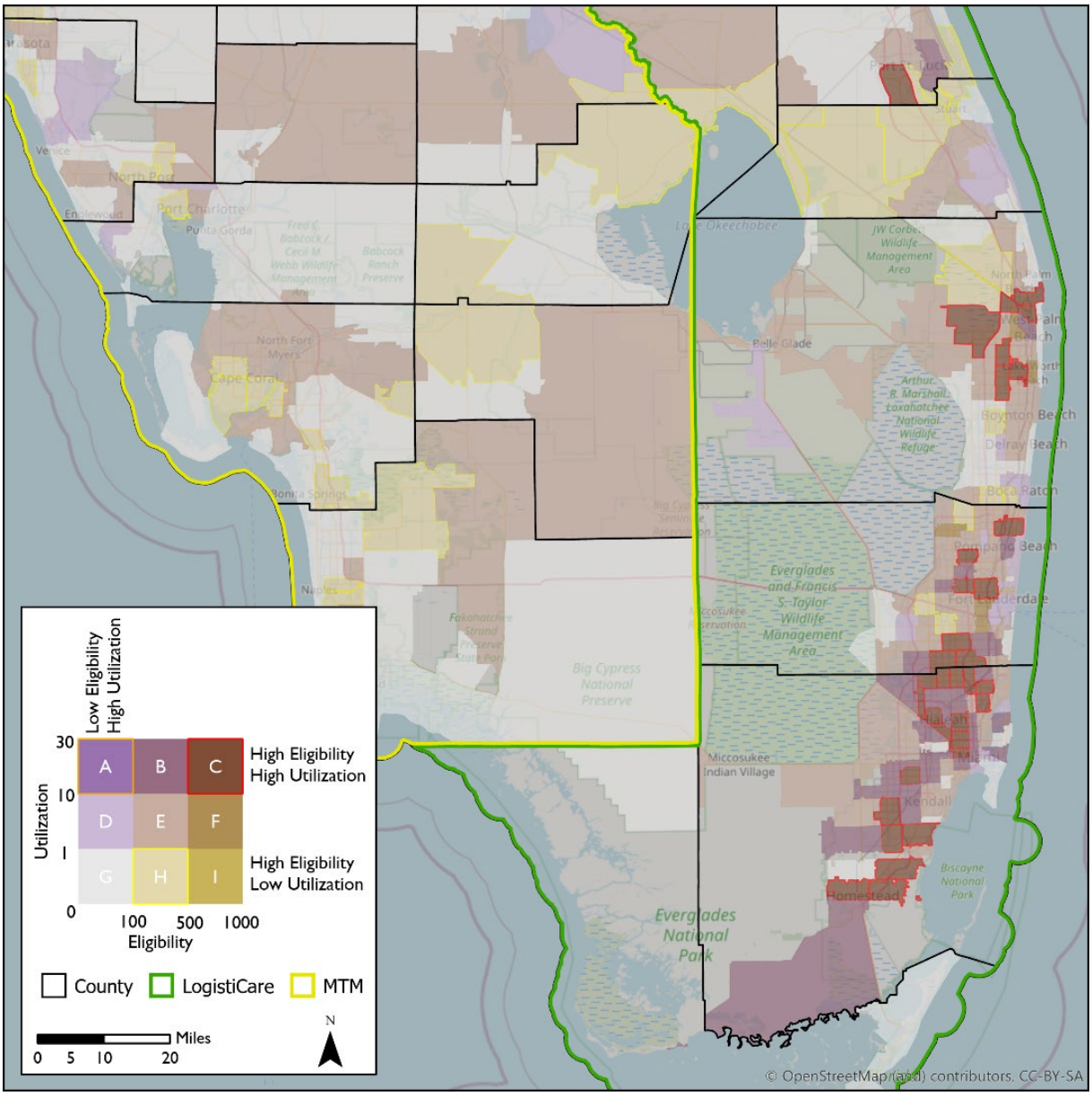


Figure 14. *Detail of Zip Code Tabulation Areas in Central Florida*

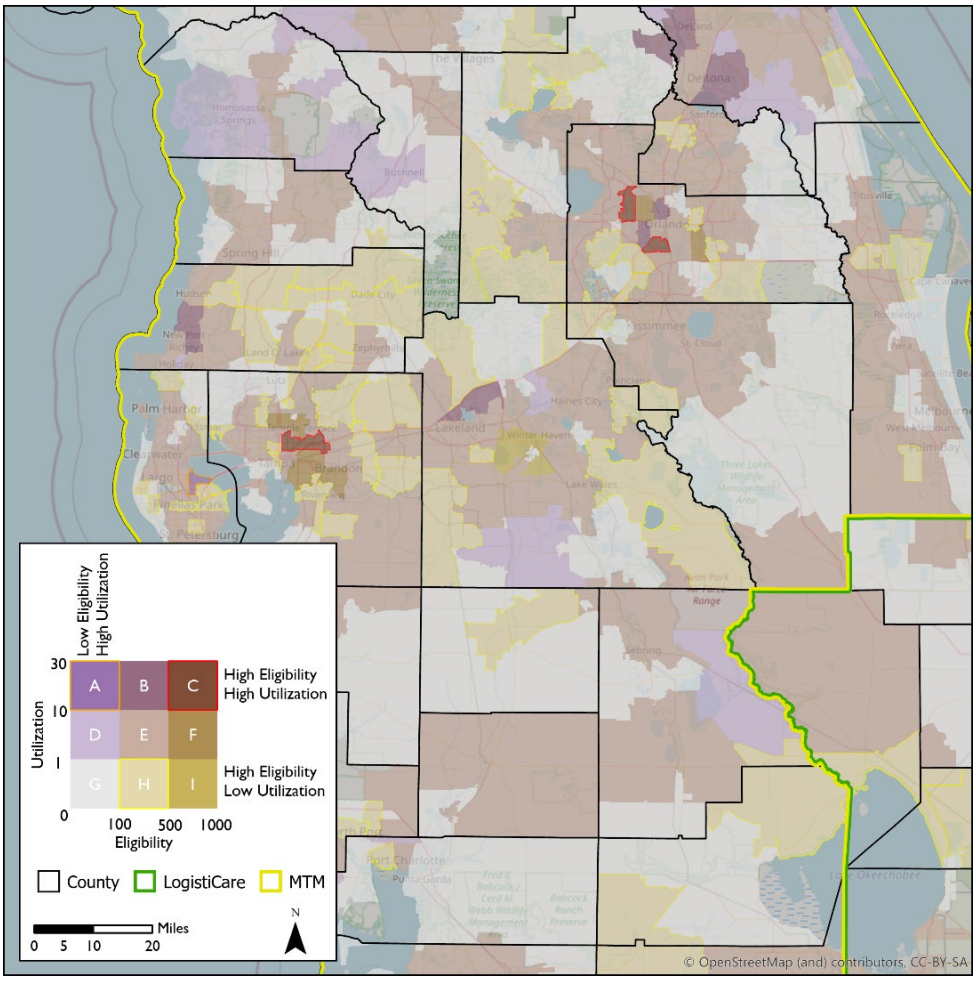


Figure 15. *Detail of Zip Code Tabulation Areas in North Florida*

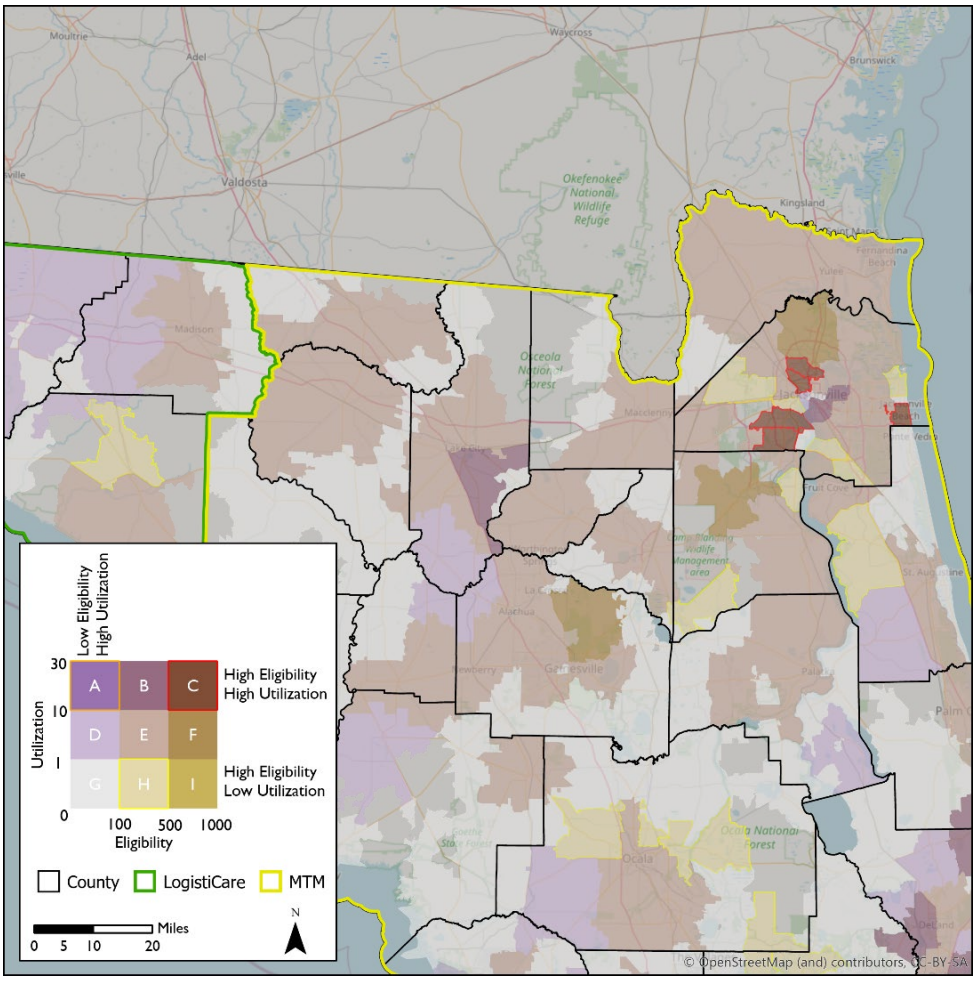
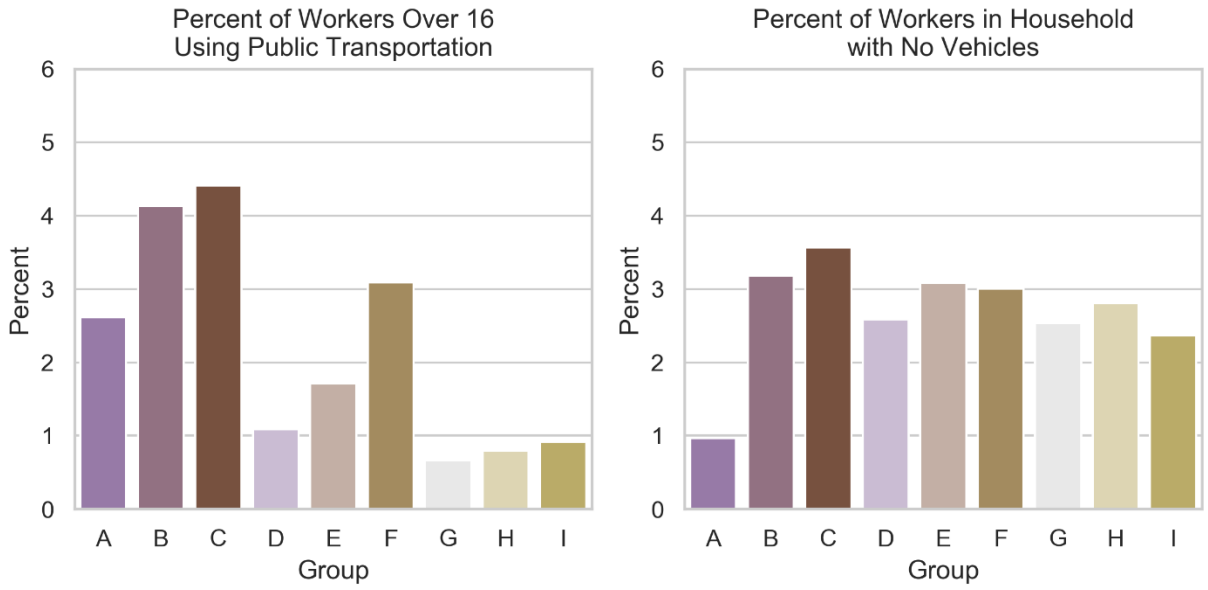


Figure 16. *Selected commuting variables from the ACS for Zip Code Tabulation Areas*



QUALITY OF SERVICES

Three research questions were addressed for this report on quality of services. In the following sections, each question is listed with results presented.

1. How has the rate of consumer complaints reported to the vendors changed since implementation? What are the most commonly reported complaints? How are the NET vendors addressing the most commonly reported complaints?

For this report, the rate of consumer complaints is calculated as the number of complaints divided by the number of reservation calls received. (This denominator was selected to ensure consistency with previous evaluation reports, but the total number of requested trips also is commonly used.) The counts are obtained from the vendor monthly summary reports which are submitted to the Agency.

As shown in Table 13, the rate of consumer complaints for LogistiCare was stable in 2018. The actual number of substantiated complaints was very low, and the rate was consistently less than 1%. Figure 17 compares the rate of consumer complaints for LogistiCare between 2015 and 2018. Results indicate that the 2018 rates were consistently lower than in previous years, and the second and fourth quarters of 2018 had the lowest rate of complaints for any quarter since 2015. Overall, results suggest that the majority of consumers are satisfied with LogistiCare's NET services.

Table 13. *LogistiCare Consumer Complaints (CY 2018)*

No	Indicator	1st Quarter Jan – Mar	2nd Quarter Apr – Jun	3rd Quarter Jul – Sep	4th Quarter Oct – Dec
1	Number of substantiated complaints	26	17	19	19
2	Number of reservations calls received	73,587	71,046	67,380	66,162
3	Complaint percentage	0.04%	0.03%	0.04%	0.03%

Note. Information obtained from the NET Vendor Performance Reports.

Figure 17. *LogistiCare Rate of Consumer Complaints (CYs 2015-2018)*

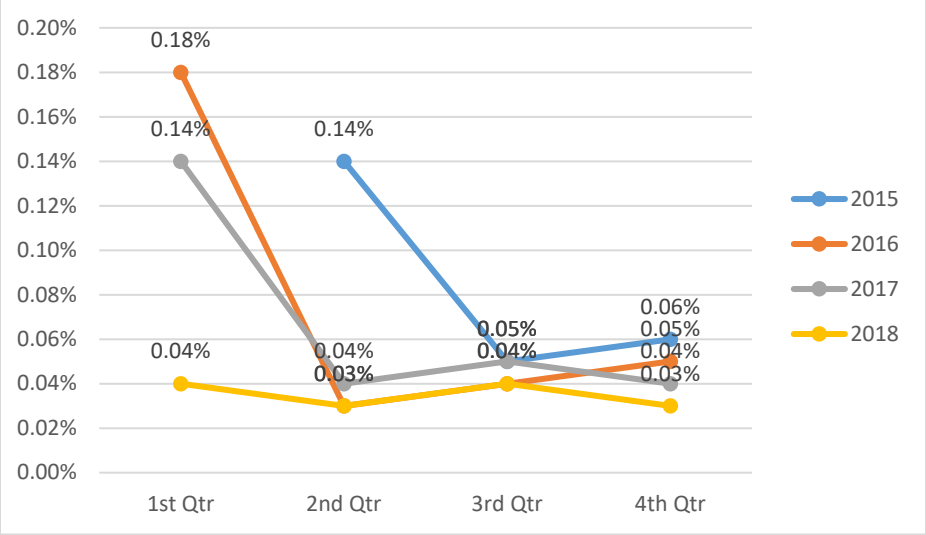


Table 14 shows that the rate of consumer complaints for MTM decreased steadily from the first to the fourth quarter of 2018 with a noticeable decline from the third to the fourth quarter. Figure

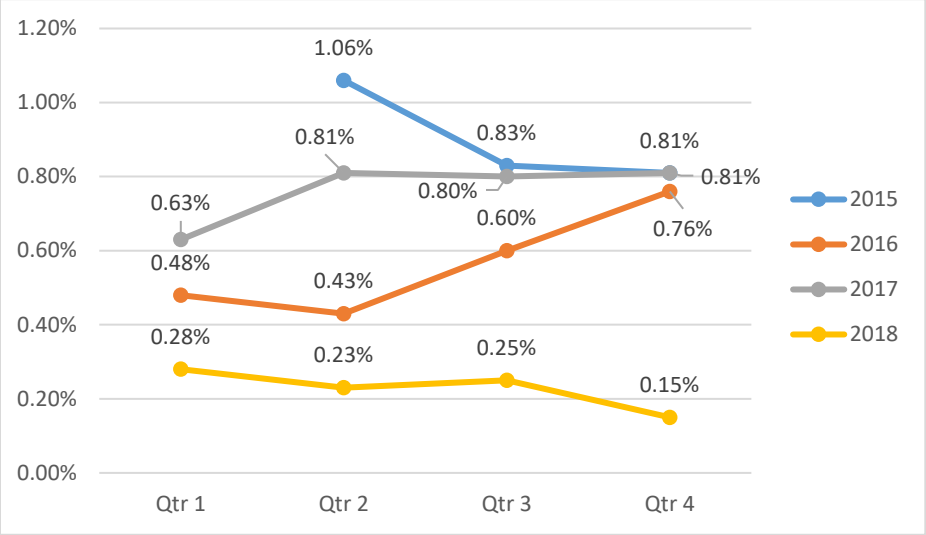
18 compares the rate of consumer complaints for MTM between 2015 and 2017. Results indicate that the rate of complaints was lower in all quarters of 2018 as compared to previous years, suggesting that consumers are satisfied with services.

Table 14. *MTM Consumer Complaints (CY 2018)*

No	Indicator	1st Quarter Jan – Mar	2nd Quarter Apr – Jun	3rd Quarter Jul – Sep	4th Quarter Oct – Dec
1	Number of complaints	67	96	104	78
2	Number of reservations calls received	45,935	48,014	62,429	61,579
3	Complaint percentage	0.28%	0.23%	0.25%	0.15%

Note. Information obtained from the NET Vendor Performance Reports.

Figure 18. *MTM Rate of Consumer Complaints (CYs 2015-2018)*



As noted below, the most commonly reported complaints include late pick-ups or returns as well as driver no-shows. (This information is obtained from complaints made directly to the Agency's Complaint Operations Center for LogistiCare and the monthly summary reports for MTM.) In order to prevent problems from recurring, MTM forwards complaints received by their Quality Management Department for "immediate attention and response" (MTM, 2018). Complaints are typically documented, investigated, and resolved within three business days. Similarly, LogistiCare investigates complaints received by their Quality Assurance Department, and "excess complaints may result in a decrease in work assigned to that company or removal of that company from the transportation network" (LogistiCare, 2014).

2. How do the complaints submitted by the NET vendors to the Agency align with consumer complaints made directly to the Agency?

In order to answer this question, the evaluation team requested CY 2018 complaint reports for both vendors from the Agency's Complaint Operations Center. The information is summarized in Tables 3 and 4. LogistiCare and MTM use different categories, so in order to make the data more comparable, the evaluation team coded the complaints using MTM's codes, which are more detailed than LogistiCare's. However, some of the complaints were challenging to assign

and could belong in multiple categories. This was true for both vendors. Categories and definitions for each type of complaint are provided in Appendix C.

Between January 1, 2018, and December 31, 2018, the Agency received a total of 702 complaints: 200 for LogistiCare and 502 for MTM. For LogistiCare, this represents an increase of nearly 200% in the number of complaints since 2017 in which 69 complaints were logged. By contrast, the rate of complaints for MTM increased by approximately 30% from 2017 to 2018. As shown in Tables 15 and 16, the most common complaints for both vendors were late pickups or no show pickups.

As in previous years, it is difficult to compare information about complaints in the NET vendor monthly reports with complaints submitted to the Complaint Operations Center because the populations are slightly different. The monthly reports should include fee-for-service complaints from two sources: (1) complaints that are received by the Agency and (2) complaints that are received by the vendor directly or via their subcontracted transportation providers. LogistiCare's monthly reports only contain complaints they received from their providers, whereas MTM's monthly reports contain complaints from all sources. The Agency is aware of this discrepancy and is working with LogistiCare to resolve the issue. In the meantime, any comparisons of complaint types and rates across vendors should be made cautiously and with these differences in mind.

Table 15. LogistiCare Consumer Complaints Reported to the Agency's Complaint Operations Center

	2017		2018	
Problem	**N**	**%**	**N**	**%**
Driver – Behavior	7	8.0	11	5.5
Driver – Service/Delivery	5	5.7	4	2.0
Internal Complaint – Client Protocols	7	8.0	0	0.0
Internal Complaint – Customer Service	1	1.1	2	1.0
Internal Complaint – LogistiCare Processes	0	0.0	3	1.5
Internal Complaint – Trip Accuracy	3	3.4	0	0.0
Provider – Early Pick Up	1	1.1	5	2.5
Provider – Early Return	2	2.3	1	0.5
Provider – Late Pick Up	22	25.3	52	26.0
Provider – Late Return	3	3.4	28	14.0
Provider – Multi Timeliness	3	3.4	8	4.0
Provider – No Show Pick Up	1	1.1	28	14.0
Provider – No Show Return	20	23.0	17	8.5
Provider – Service/Behavior	3	3.4	11	5.5
Provider – Travel Time	4	4.6	5	2.5
Vehicle – Appearance/Odor	0	0.0	1	0.5
Vehicle – Quality/Safety	5	5.7	10	5.0
Other	7	8.0	14	7.0
Total	**87**	**100.0**	**200**	**100.0**

Table 16. *MTM Consumer Complaints Reported to the Agency's Complaint Operations Center*

Problem	2017		2018		% change
	N	%	N	%	
Driver – Behavior	18	4.7	19	3.8	+5.6
Driver – Service/Delivery	5	1.3	15	3.0	+200.0
Internal Complaint – Client Protocols	38	9.9	68	13.5	+78.9
Internal Complaint – Customer Service	19	4.9	33	6.6	+73.7
Internal Complaint – MTM Processes	30	7.8	49	9.8	+63.3
Internal Complaint – Trip Accuracy	24	6.2	31	6.2	+29.2
Provider – Early Pick Up	11	2.9	11	2.2	0.0
Provider – Early Return	2	0.5	1	0.2	-50.0
Provider – Late Pick Up	55	14.3	42	8.4	-23.6
Provider – Late Return	40	10.4	41	8.2	+2.5
Provider – Multi Timeliness	7	1.8	17	3.4	+142.9
Provider – No Show Pick Up	71	18.4	102	20.3	+43.7
Provider – No Show Return	11	2.9	25	5.0	+127.3
Provider – Service/Behavior	46	11.9	33	6.6	-28.3
Provider – Travel Time	4	1.0	7	1.4	+75.0
Vehicle – Appearance/Odor	1	0.3	1	0.2	0.0
Vehicle – Quality/Safety	3	0.8	7	1.4	+133.3
Total	**385**	**100.0**	**502**	**100.2**	30.4

Note. Percentages may not total 100% due to rounding.

In addition to the complaints that are submitted by the NET vendors to the Agency, the Agency also receives complaints from consumers directly. The evaluation team reviewed 738 complaints made by NET recipients in 2018 from 51 counties in Florida. These complaints were submitted to the evaluators in a narrative format. After an initial review, the evaluation team developed a codebook for the complaint types and resolution types. The evaluation team adjusted these codes as needed and finalized 13 codes for complaints:

1. **Eligibility issues**: issues related to service enrollment or activation
2. **Untimely arrival**: provider arrived earlier or later than expected time
3. **No arrival**: provider did not arrive, or, provider arrived but did not wait for recipient and left, or, provider picked up recipient but was not able to find appropriate location and returned the recipient home
4. **Missed appointment**: recipient missed their appointment as a result of delays
5. **Provider/Agency error**: technical or scheduling issues caused by agencies (such as Medicare or Medicaid offices, MTM or LogistiCare, or MTM/LogistiCare providers) that interfered with a recipient's ability to enroll in services, receive services, schedule appointments, file complaints, request authorizations, or be picked up/dropped off as scheduled
6. **Mistreatment by driver**: instances of rudeness or verbal, physical, or sexual harassment

7. **Phone service**: recipient has difficulty contacting agencies or providers for assistance (not related to technical problems on behalf of the agencies and providers), or is unsatisfied with assistance (such as being placed on hold for an extended period of time)
8. **Billing, payment, and reimbursement**: issues related to billing, payment, and reimbursement (including clarification of policies) on behalf of agencies, providers, and recipients
9. **Three-day notice**: recipient needs to schedule an appointment within the typical 72-hour window (and/or is having trouble doing so)
10. **Inadequate accommodations**: recipient needs specific physical conditions for transportation that provider cannot provide or is having trouble providing (such as riding up in front seat, wheelchair accessibility, seat belts, etc.)
11. **Address**: recipient needs address (and sometimes other contact information) updated; address (and sometimes other contact information) discrepancies has caused issues with accessing assistance
12. **Provider preference**: recipient explicitly asks for a new provider, to remove a provider from their transportation options, or to change listing of provider to "last resort"
13. **Authorization/Verification**: agency, provider, or recipient need clarification on plan policies (such as transporting children unaccompanied by an adult age 21+) or need to complete a specific form

The evaluation team also created 12 codes for the actions taken by representatives to solve a recipient's complaints:

1. **Eligibility updated**: recipient was given information related to their ability to receive care (such as if they have met their monthly requirements), recipient had their eligibility updated after calling in, or recipient received authorization needed to proceed with scheduling
2. **No contact**: issue was left unresolved due to lack of contact with recipient after repeated attempts
3. **Appointment setting**: representative helped recipient schedule a new appointment, schedule an appointment within the typical 72-hour window, or helped switch to another provider for a trip
4. **Plan overview**: recipient was given information about the benefits, limitations, regulations, and proceedings (such as payment or complaint proceedings) related to their plan (this code was often used for complaints in which a recipient was told why a service was not provided)
5. **Complaint resubmission**: a recipient was given a task and asked to call back if there were any problems, or a recipient was told they must file their complaint with another agency or provider
6. **Monitoring**: the provider or recipient was placed on a monitoring list (or was otherwise tracked to examine the completion of future appointments) to ensure improvement in service
7. **Address confirmation**: addresses, and sometimes other contact information, was updated for a recipient
8. **Provider education**: a provider was given knowledge about procedures and errors made to ensure service improvement, or a provider was given a task to help connect recipients to care

9. **Allegation investigation**: a recipient's complaint, payment, and travel histories were further examined (in cooperation with a provider) to find causes for errors and make a plan for service improvement
10. **Provider/mode of transport switch**: a recipient's provider preference was updated, a recipient's trip was rescheduled with a different provider, or a recipient changed how they would reach their appointment (such as by opting out of scheduling a trip and instead finding their own transportation to be later reimbursed)
11. **Payment procedure**: responses to billing, payment, and reimbursement issues, including clarification on policies and where to direct questions
12. **Disregard**: not an issue related to non-emergency transportation, or issue was dropped by recipient before further action was taken by agency or provider

Many of the 738 complaints made to the Agency were given multiple codes to reflect that, in many cases, recipients made multiple complaints simultaneously. Table 17 specifies the unique number of calls that were assigned issue numbers (first column) as well as the total number of complaints reflected in those issue numbers (second column).

Table 17. *Total Number of NET Unique Issue Numbers and Consumer Complaints to the Agency by County*

County	Total Unique Issue Numbers by County	Total Complaints Coded among All Unique Issue Numbers by County
Alachua	24	31
Baker	7	10
Bay	10	18
Brevard	38	51
Broward	20	22
Charlotte	15	17
Citrus	5	8
Clay	22	25
Collier	13	13
Columbia	11	13
Dade	33	44
Desoto	4	4
Dixie	1	1
Duval	61	71
Escambia	3	3
Gilchrist	1	1
Gulf	1	1
Hardee	2	2
Hernando	21	28
Highlands	20	21
Hillsborough	62	75
Indian River	4	5
Jackson	1	1

County	Total Unique Issue Numbers by County	Total Complaints Coded among All Unique Issue Numbers by County
Lake	4	10
Lee	12	13
Leon	3	7
Levy	1	2
Manatee	19	26
Marion	21	25
Martin	4	4
Monroe	1	1
Nassau	1	1
Okaloosa	3	5
Okeechobee	2	3
Orange	46	55
Osceola	19	21
Palm Beach	9	13
Pasco	63	80
Pinellas	22	29
Polk	34	39
Putnam	13	18
Sarasota	2	2
Seminole	17	21
St. Johns	6	10
St. Lucie	6	6
Sumter	2	4
Taylor	1	2
Volusia	35	42
Wakulla	1	2
Walton	6	6
Washington	6	10
Total	**738**	922

Table 18 shows a breakdown of how many types of issues were reported (taking into account that original complaints could include multiple problems). The most commonly cited problems were those related to eligibility, appointment setting within the typical 72-hour window, and driver no-shows, which made up more than three-quarters of all problems reported. Many complaints included multiple issues. For example, a consumer could request assistance with two issues within one phone call, such as updating their eligibility and obtaining authorization for scheduling a trip several hundred miles away.

To address eligibility concerns, representatives educated consumers about whether they were eligible to receive NET services. Representatives explained how certain services (such as trips to locations several hundred miles away or out of state) could be requested. They explained that some services were not covered (such as those requested for trips unrelated to medical need).

One of the most frequent problems consumers called about was that their eligibility needed to be updated for the month. Representatives updated their eligibility and often reminded consumers of the requirements to maintain eligibility for services, such as meeting monthly Share of Cost (SOC). Sometimes consumers were transferred to outside personnel for more information related to eligibility. Eligibility issues were usually resolved fairly quickly. Here is an example of the steps a representative took to address eligibility concerns. The consumer called in the morning because she was not able to set up an appointment. In the notes, the representative sent an “email to MTM to confirm the recipient's eligibility for transportation and need for ride to appointment next week and to pick up [consumer].” Less than six hours later, the representative completed “phone call to the recipient to inform her that her eligibility is updated with MTM and she can call to schedule her transportation.”

Many consumers needed help requesting transportation within the 72-hour window. Representatives responded in multiple ways. In many cases, representatives responded by updating a consumer’s eligibility for services (or informing them of why they were not eligible for services that month). Then the representative requested help with scheduling directly from MTM or LogistiCare. Although trips were usually scheduled within the window, representatives explained to consumers that they may need to find an alternative mode of transport just in case. Some consumers independently found their own transportation or asked about using mileage reimbursement. Here is an example note of how a representative dealt with issues related to appointment setting: “Email to MTM to request they put in the recipient's file to schedule her transportation for [date] when the recipient calls to schedule her transportation. She was delayed from meeting the 3-day time frame due to MTM not showing her eligibility.”

The third most common complaint consumers made was that their drivers failed to arrive. This included times when a driver arrived too early, did not notify the consumer of their early arrival, and left before the consumer was ready. Follow-up on these incidents was more intensive than follow-up on many other types of problems consumers reported. Representatives investigated the issue by gathering details from both the consumer and the transportation agency about what happened during the trip. They then offered to help reschedule a trip, switch modes of transportation, and in rare cases, switch agencies that typically provided their transportation. Consumers were often encouraged to contact LogistiCare or MTM so they could create a record of issues. Consumers were also placed on an “internal monitoring list.” Their future trips would be monitored so that the issue of no-shows could be tracked and prevented. Agencies updated their systems to include accurate contact information and educated their drivers about proper protocol. These issues were often resolved within two to four weeks. Here is a brief example of how one representative dealt with a failed arrival: “Email from [agency worker] at LogistiCare. She says that the member's trips on [date], [date], [date], and [date] were canceled… She says they will continue to monitor his trips through 11/10 to ensure timely service. They will confirm that the assigned provider has the correct information and reach out to the member to ensure they were picked up appropriately and timely. They will escalate any issues that are reported.”

Table 18. *Total Number of NET Consumer Complaints to the Agency by County and Type of Issue*

County	Eligibility	Untimely arrival	No arrival	Missed appointment	Error	Mistreat	Phone	Bill/Pay	Notice	Accommodate	Address	Preference	Authorize
Alachua	17	1	5	0	0	0	3	2	1	1	0	0	1
Baker	5	0	2	0	0	0	0	0	1	0	1	0	1

County	Eligibility	Untimely arrival	No arrival	Missed appointment	Error	Mistreat	Phone	Bill/Pay	Notice	Accommodate	Address	Preference	Authorize
Bay	4	2	3	1	1	2	0	0	2	1	0	1	1
Brevard	21	4	6	1	1	1	1	1	2	0	0	5	8
Broward	19	1	0	0	0	0	0	0	1	0	1	0	0
Charlotte	13	0	1	0	0	0	0	0	2	0	1	0	0
Citrus	4	1	1	0	0	0	0	0	1	1	0	0	0
Clay	20	0	0	0	2	0	0	0	2	0	1	0	0
Collier	12	0	0	0	1	0	0	0	0	0	0	0	0
Columbia	11	0	0	0	0	0	0	0	2	0	0	0	0
Dade	26	2	2	3	0	0	0	1	6	2	0	2	0
Desoto	3	1	0	0	0	0	0	0	0	0	0	0	0
Dixie	1	0	0	0	0	0	0	0	0	0	0	0	0
Duval	55	4	3	1	2	0	0	2	4	0	0	0	0
Escambia	1	0	1	0	0	0	0	0	0	0	0	0	1
Gilchrist	1	0	0	0	0	0	0	0	0	0	0	0	0
Gulf	1	0	0	0	0	0	0	0	0	0	0	0	0
Hardee	0	0	0	0	0	0	0	2	0	0	0	0	0
Hernando	18	0	2	1	1	0	0	0	4	0	2	0	0
Highlands	10	0	0	0	0	0	0	9	2	0	0	0	0
Hillsborough	51	3	5	0	0	1	2	5	5	1	0	1	1
Indian River	4	0	0	0	0	0	0	0	1	0	0	0	0
Jackson	0	0	0	0	0	0	0	0	0	0	0	0	1
Lake	1	1	1	2	1	1	0	0	0	0	2	1	0
Lee	10	0	0	0	0	0	2	0	0	0	0	0	1
Leon	2	1	0	1	0	0	0	3	0	0	0	0	0
Levy	0	0	1	0	0	0	1	0	0	0	0	0	0
Manatee	13	2	5	2	2	0	0	1	0	1	0	0	0
Marion	16	0	2	1	2	0	1	1	1	1	0	0	0
Martin	4	0	0	0	0	0	0	0	0	0	0	0	0
Monroe	0	0	0	0	0	0	0	1	0	0	0	0	0
Nassau	1	0	0	0	0	0	0	0	0	0	0	0	0
Okaloosa	3	0	0	1	1	0	0	0	0	0	0	0	0
Okeechobee	1	1	1	0	0	0	0	0	0	0	0	0	0
Orange	43	1	1	2	0	0	0	2	2	0	2	0	2
Osceola	18	0	0	0	0	0	0	0	2	1	0	0	0
Palm Beach	6	1	0	0	1	0	1	1	2	1	0	0	0
Pasco	56	2	6	2	1	2	1	0	6	2	2	0	0
Pinellas	18	1	4	1	1	0	0	1	3	0	0	0	0

County	Eligibility	Untimely arrival	No arrival	Missed appointment	Error	Mistreat	Phone	Bill/Pay	Notice	Accommodate	Address	Preference	Authorize
Polk	20	0	0	0	0	0	0	13	5	1	0	0	0
Putnam	10	1	1	2	1	0	0	0	1	1	0		1
Sarasota	2	0	0	0	0	0	0	0	0	0	0	0	0
Seminole	15	1	1	0	0	0	0	1	3	0	0	0	0
St. Johns	4	2	1	0	1	0	0	1	0	0	0	1	0
St. Lucie	6	0	0	0	0	0	0	0	0	0	0	0	0
Sumter	0	0	0	0	0	0	0	1	1	1	0	0	1
Taylor	1	0	0	0	0	0	0	0	1	0	0	0	0
Volusia	27	0	3	1	1	0	1	0	3	3	1	2	0
Wakulla	1	0	0	0	0	0	0	0	1	0	0	0	0
Walton	6	0	0	0	0	0	0	0	0	0	0	0	0
Washington	4	1	2	1	1	0	0	0	1	0	0	0	0
Total	**585**	**34**	**60**	**23**	**21**	**7**	**13**	**48**	**68**	**18**	**13**	**13**	**19**

3. Are consumers satisfied with the NET services they receive?

In order to answer this question, the evaluation team developed and distributed an electronic survey to a random sample of 1,351 Medicaid recipients who utilized NET services in CY 2018 (see Appendix 5). Names and telephone numbers were obtained directly from MTM (*N* = 4,044 unique individuals) and LogistiCare (*N* = 3,535 unique individuals), and these lists were randomized using Microsoft Excel in order to select the recipients. These individuals were contacted via text message that contained a link to the electronic survey in Qualtrics. The survey contained 17 items and included Likert-type scales[3], yes/no questions, and open-ended responses. For Likert-type items, responses were given on 5-point scales; for example, Item #4 was scored as 1 = *very difficult* and 5 = *very easy*, and Item #7 was scored as 1 = *never* and 5 = *always*. The survey was also available in Spanish (see Appendix 6). Questionnaire data were analyzed using the Statistical Package for the Social Sciences (SPSS) 25.

The evaluation team has received a total of 57 survey responses. Of those, 26 respondents fully completed the survey and indicated that they had used NET services in the past 12 months. Four of the respondents used the Spanish language version. Due to the low response rate, readers should exercise caution when making conclusions about the NET program in general.

[3] A Likert scale is a measurement tool that is used to gauge attitudes, values, and opinions. Respondents complete a questionnaire in which they indicate the extent to which they agree or disagree with a series of statements.

Table 19. *Demographics of the Consumer Questionnaire Respondents*

	N (26)	%
Vendor		
LogistiCare	13	50.0
MTM	13	50.0
Gender		
Male	8	30.8
Female	15	57.7
Missing	3	11.5
Age Group		
Under 18	0	0.0
18-24	1	3.8
25-39	1	3.8
40-60	8	30.8
61 or older	14	53.8
Missing	2	7.7
Trips per Month		
< 1	1	3.8
1-5	12	46.2
6-10	2	7.7
11-15	7	26.9
16-20	0	0.0
> 20	0	0.0
Missing	4	15.4

Figures 19-24 summarize the results of consumer questionnaire items pertaining to quality and satisfaction with NET services. As shown in Figure 19, 50% of the respondents indicated that it is very easy or easy to schedule a ride. This represents a decrease from results obtained in 2016 for the same item (64%). In addition, most respondents indicated that it would be difficult or very difficult to get to their appointments without the service (77%). One respondent stated: “I do want it to continue. It is very helpful and valuable.”

Figure 19. *How easy is it for you to schedule rides?*

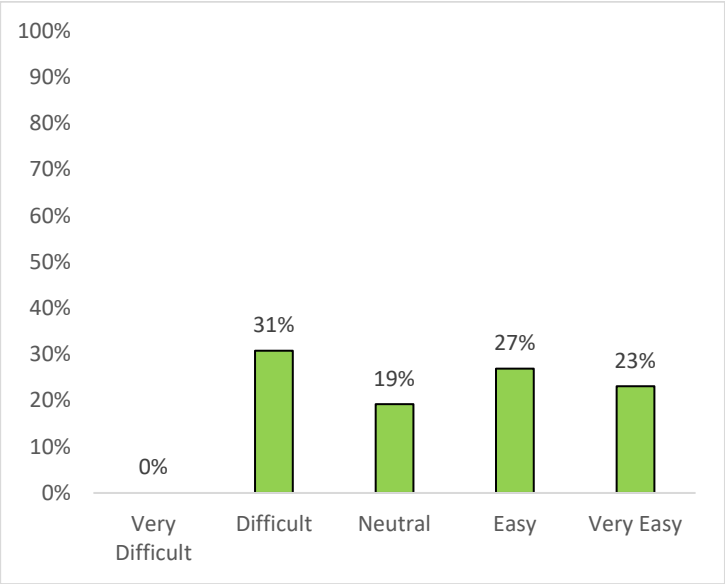


Figure 20. *How easy would it be for you (or your family member) to get to your appointments if non-emergency transportation were not available?*

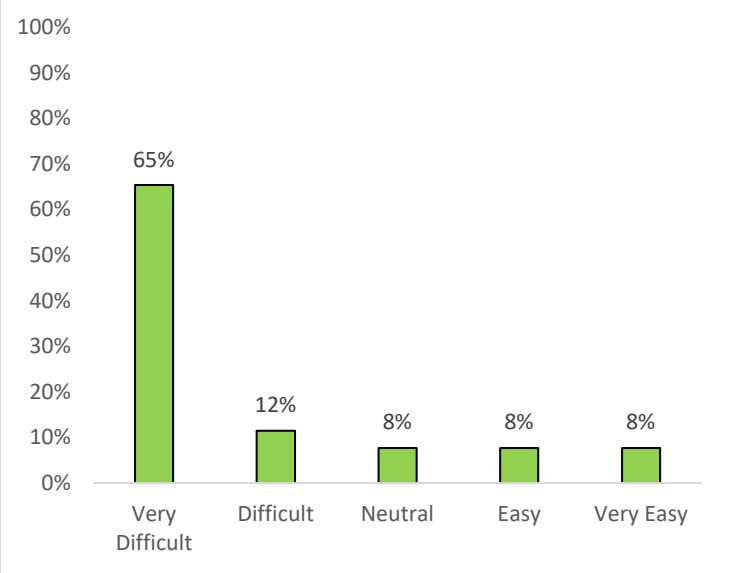


Figure 21 indicates that the majority of respondents are usually or always picked up on time from home (69%). This finding represents a slight increase from the results obtained last year for the same item (64%). Additionally, as shown in Figure 22, a majority reported that they usually or always arrive at their appointments on time (73%). When respondents were asked to indicate how long they usually wait to be picked up after their appointments, most individuals (69%) reported waits of one hour or less.

Figure 21. *How often are you (or your family member) picked up on time from home?*

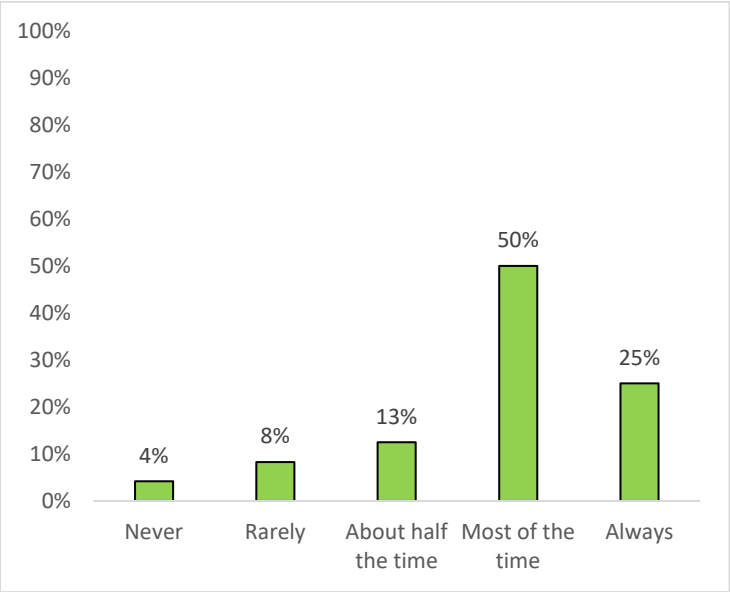
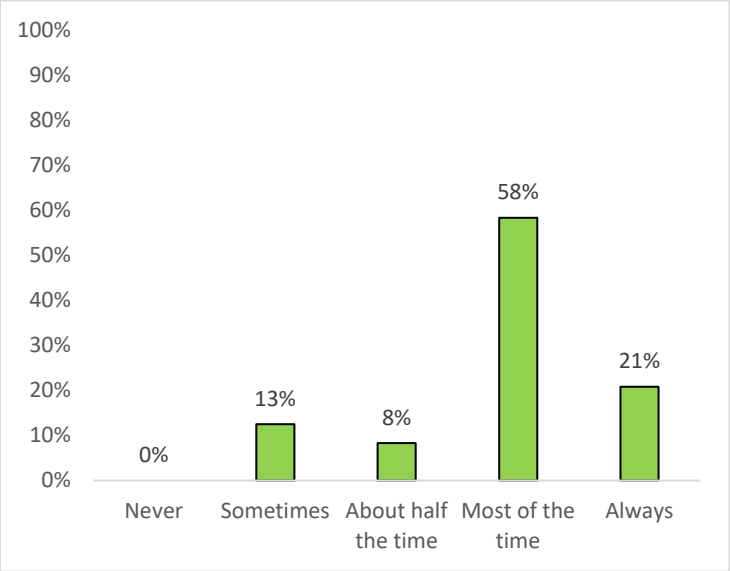
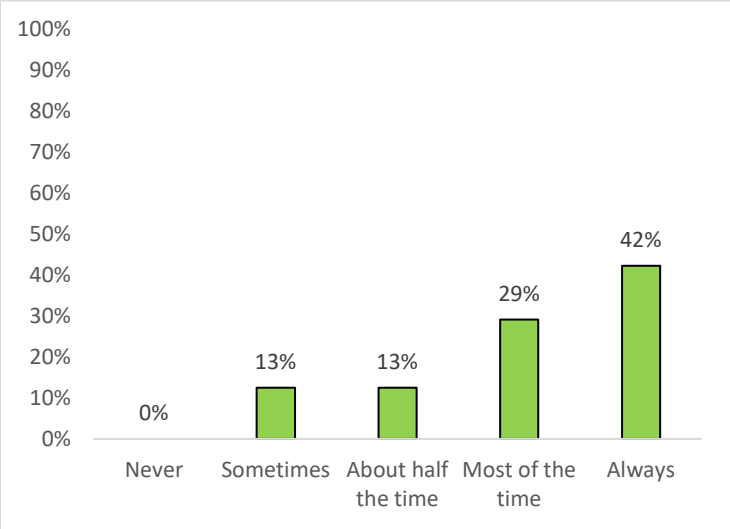


Figure 22. *How often do you (or your family member) get to your appointments on time?*



With regard to safety and comfort, 73% of respondents indicated that drivers usually operate the vehicles in a safe manner. However, a few individuals reported occasional problems with painful seating arrangements. One respondent stated: “Without being ungrateful, most of the time the vehicle is a small one like an old model of Toyota Corolla and they put 4 people in the back. Sometimes also the AC doesn’t work and in others the seat belts are not working.” As shown in Figure 23, 69% of respondents stated that the drivers usually or always treat them with courtesy and respect, which is a slight decrease from last year (73%).

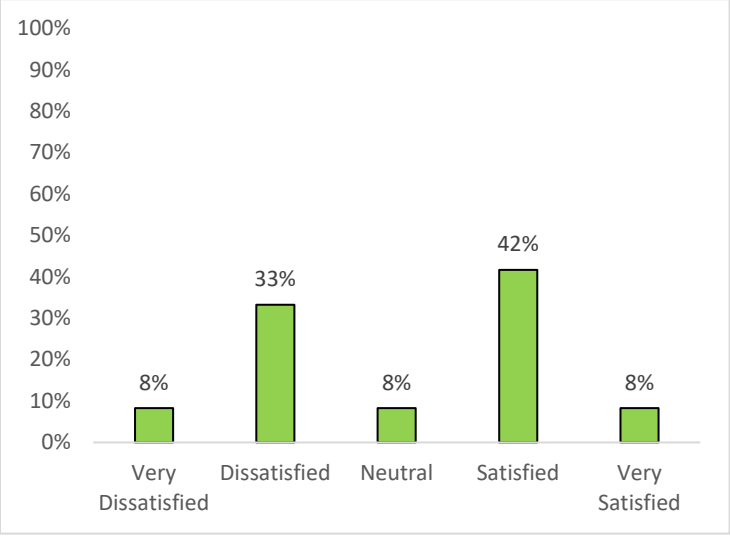
Figure 23. *How often do the drivers treat you (or your family member) with courtesy and respect?*



The survey included several new questions this year specifically related to complaints. Of the 26 respondents, 12 (46%) had filed a complaint regarding NET services within the past 12 months. Approximately the same number of respondents indicated that they reported their complaint(s) to the NET vendor (*N* = 7) as opposed to the Agency (*N* = 8). Of these individuals, 10 (67%) were not satisfied with the way their complaint(s) were handled.

In general, however, about half of the respondents were satisfied with NET services as shown in Figure 24. Several respondents indicated that they were very pleased with their transportation providers. One person noted, “I appreciate their punctuality. I hope they will keep it up.” Others, however, cited specific areas of concern, such as long waits, language barriers, and late arrivals.

Figure 24. *How do you feel about the quality of non-emergency transportation services in general?*



COST EFFECTIVENESS

Two research questions were addressed for this report on cost effectiveness of services. In the following sections, each question is listed with results presented.

1. ***How have encounter costs gone up or down per rider per month and why? How has the change in distribution by region and rate group affected this amount?***

For each month, the number of Medicaid recipients using CNET services, the total number of CNET trips, and the average number of one-way trips per recipient are reported in Table 20.

The number of Medicaid recipients who received CNET services each month was fairly stable during CY 2018. The highest number of people were served in March with 1,463 receiving transportation services, while January had the fewest number of riders at 1,308. The number of transportation services ranged from 16,513 trips in September to 19,803 trips in October.

Month-by-month comparisons between 2017 and 2018 showed fewer recipients receiving services in 8 of the 12 months. While the first eight months of 2018 had fewer recipients receiving services, the last four months of the year had more recipients receiving services.[4] The number of trips per recipient was higher in 11 of the 12 months in 2018. Thus, while fewer recipients were receiving transportation services, the number of trips per recipient served increased.

Regression results found a decreased number of recipients receiving NET services in 2017 ($p < .0001$) and 2018 ($p < .0001$) compared to 2016, with no significant difference between 2017 and 2018 ($p = .791$).[5] Similarly, regressions examining the number of trips found a decline in the number of trips in 2017 ($p = .085$) and 2018 ($p = .003$) compared to 2016, with no significant difference between 2017 and 2018 ($p = .1239$). Finally, the number of trips per rider has been trending upward with 2017 being greater than 2016 ($p = .0011$) and 2018 being greater than 2017 ($p = .031$).

Table 20. *Transportation Services Provided to CNET Enrollees – 2016-2018*

	2016			2017			2018		
	Recipients served	**One-way trips**	**Trips per recipient**	**Recipients served**	**One-way trips**	**Trips per recipient**	**Recipients served**	**One-way trips**	**Trips per recipient**
January	2,397	20,949	8.7	1,579	18,811	11.9	1,308	18,203	13.9
February	2,239	21,622	9.7	1,447	17,457	12.1	1,342	17,378	12.9
March	1,970	21,470	10.9	1,494	19,939	13.3	1,463	19,212	13.1
April	1,907	20,529	10.8	1,449	18,139	12.5	1,407	18,261	13.0
May	1,790	19,460	10.9	1,481	19,464	13.1	1,392	18,844	13.5
June	1,539	18,013	11.7	1,512	18,255	12.1	1,354	17,311	12.8
July	1,419	17,009	12.0	1,420	17,095	12.0	1,350	17,661	13.1

[4] One possibility is that the differences in the number of recipients receiving NET services reflected trends in Medicaid enrollment. However, Medicaid fee-for-service enrollment has steadily increased between January 2017 and December 2018.

[5] The regression examined whether the number of recipients exhibited an increase or decrease between years. A significant coefficient ($p < .05$) indicates the number of recipients changed between the years. An insignificant coefficient ($p > .05$) indicates that costs did not exhibit a statistically significant change.

	2016			2017			2018		
	Recipients served	One-way trips	Trips per recipient	Recipients served	One-way trips	Trips per recipient	Recipients served	One-way trips	Trips per recipient
August	1,587	19,947	12.6	1,416	18,831	13.3	1,397	18,743	13.4
September	1,497	18,034	12.0	1,185	12,014	10.1	1,333	16,513	12.4
October	1,538	17,426	11.3	1,265	17,453	13.8	1,382	19,803	14.3
November	1,588	18,440	11.6	1,309	16,429	12.6	1,415	19,152	13.5
December	1,566	18,735	12.0	1,247	16,035	12.9	1,428	19,057	13.3

Table 21 contains per rider per month costs for the CNET program overall and for each CNET plan from 2016 through 2018. Month-by month service use is reported, in part, to highlight the impact of potentially contributing factors, such as weather events (e.g., hurricanes) in Florida. In 2018, costs per rider were lowest in September at $445. LogistiCare had their lowest costs in September at $509 per rider while MTM had their lowest costs in June at $331 per rider. September 2018 is when Hurricane Michael struck the panhandle of Florida, which is part of the LogistiCare service region. For the CNET program overall, per rider costs were highest in October at $521. Costs per rider were highest for LogistiCare in August ($618) and for MTM in October ($391).

Month-by-month comparisons between 2017 and 2018 showed higher per rider costs in all 12 months of 2018 for the overall program, 11 of the 12 for LogistiCare, and 6 of the 12 months for MTM. There was an increasing trend in per rider costs for the CNET program between CY 2016-2018. A simple regression examining whether costs were increasing or decreasing during the years found statistically significant increases in per rider costs between 2016 and 2017 ($p < .0001$) and 2017 and 2018 ($p < .0001$) for the overall program ($p < .0001$). Per rider costs increased between 2016 and 2017 ($p < .0001$) and 2017 and 2018 ($p < .0001$) for LogistiCare, while per rider costs increased between 2016 and 2017 ($p = .031$) for MTM.[6]

Table 21. *Per Rider Per Month Costs – 2016-2018*

	Total		LogistiCare		MTM	
	People served	Per rider cost	People served	Per rider cost	People served	Per rider cost
2016						
January	2,397	271.59	1,337	269.72	1,060	273.95
February	2,239	301.94	1,238	304.94	1,001	298.23
March	1,970	344.16	1,009	372.35	961	314.57
April	1,907	338.75	989	361.79	918	313.92
May	1,790	345.78	942	378.02	848	309.96
June	1,539	374.83	901	387.46	638	356.99
July	1,419	375.57	796	385.88	623	362.40
August	1,587	401.39	901	407.08	686	393.92
September	1,497	400.94	838	423.28	659	372.54

[6] The regression examined whether costs exhibited an increase or decrease between years. A significant coefficient ($p < .05$) indicates that costs changed between the years. An insignificant coefficient ($p > .05$) indicates that costs did not exhibit a statistically significant change.

	Total		LogistiCare		MTM	
	People served	**Per rider cost**	**People served**	**Per rider cost**	**People served**	**Per rider cost**
October	1,538	382.90	841	409.79	697	350.45
November	1,588	385.57	885	426.32	703	334.27
December	1,566	396.10	887	429.19	679	352.87
2017						
January	1,579	397.11	895	431.14	684	352.58
February	1,447	406.61	846	439.48	601	360.33
March	1,494	450.56	879	489.64	615	394.69
April	1,449	427.28	848	458.23	601	383.60
May	1,481	452.13	844	505.64	637	381.22
June	1,512	422.60	880	474.96	632	349.68
July	1,420	424.65	830	474.28	590	354.84
August	1,416	463.39	821	512.51	595	395.61
September	1,185	346.71	663	378.06	522	306.89
October	1,265	463.67	676	532.22	589	385.00
November	1,309	436.59	734	500.42	575	355.12
December	1,247	461.13	690	560.40	557	338.16
2018						
January	1,308	495.76	743	586.80	565	376.03
February	1,342	452.33	766	511.76	576	373.29
March	1,463	462.13	843	539.85	620	356.46
April	1,407	450.50	815	528.16	592	343.58
May	1,392	482.32	804	575.15	588	355.39
June	1,354	471.87	792	571.77	562	331.00
July	1,350	495.59	799	603.31	551	339.38
August	1,397	511.65	819	618.64	578	360.05
September	1,333	445.50	810	509.68	523	346.10
October	1,382	521.68	837	606.64	545	391.21
November	1,415	490.99	866	560.30	549	381.65
December	1,428	479.84	911	547.25	517	361.04

Per rider costs were examined at the regional level to determine whether there was variation across the state of Florida. Figure 25 examines per rider costs for LogistiCare. Regressions examining whether costs increased or decreased between the years 2016 and 2017 found a statistically significant decrease in per rider costs in Region 2 ($p = .0022$) and statistically significant increased costs in Regions 1 ($p = .0005$), 9 ($p = .0003$), 10 ($p = .0236$), and 11 ($p < .0001$). Between 2017 and 2018, per rider costs continued to increase in Region 11 ($p < .0001$). Region 11 is the largest region served by LogistiCare. Thus, the increase in Region 11 was a major contributing factor leading overall per rider costs for LogistiCare (see Table 2) to increase between 2017 and 2018. Remaining regions did not experience a statistically significant change in per rider costs between 2017 and 2018. While not creating an overall statistically significant

change, Region 2 had a rapid increase in NET use in late 2018 after Hurricane Michael struck the panhandle of Florida.

Figure 25. *Per Rider Per Month Costs by Region for LogistiCare*

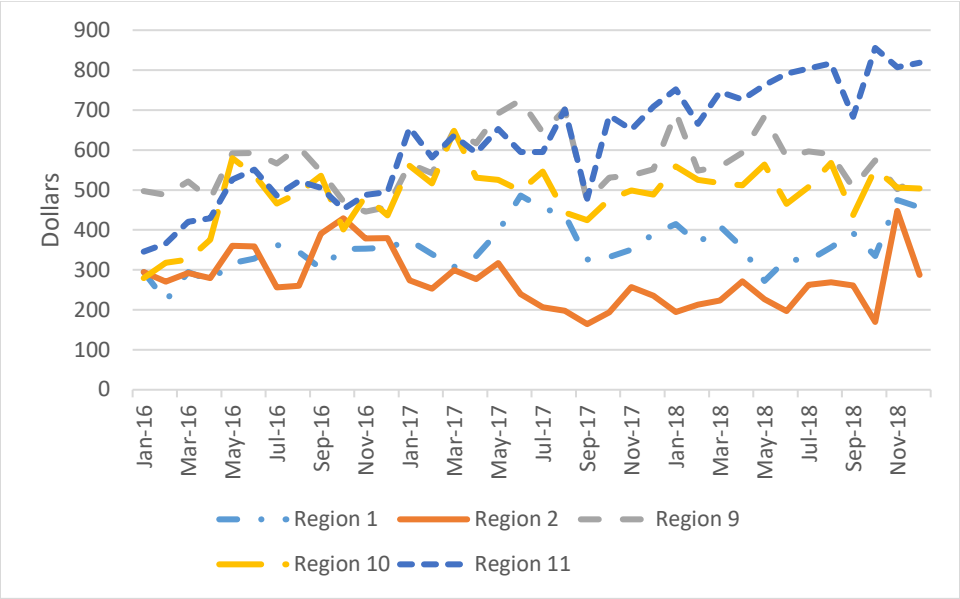
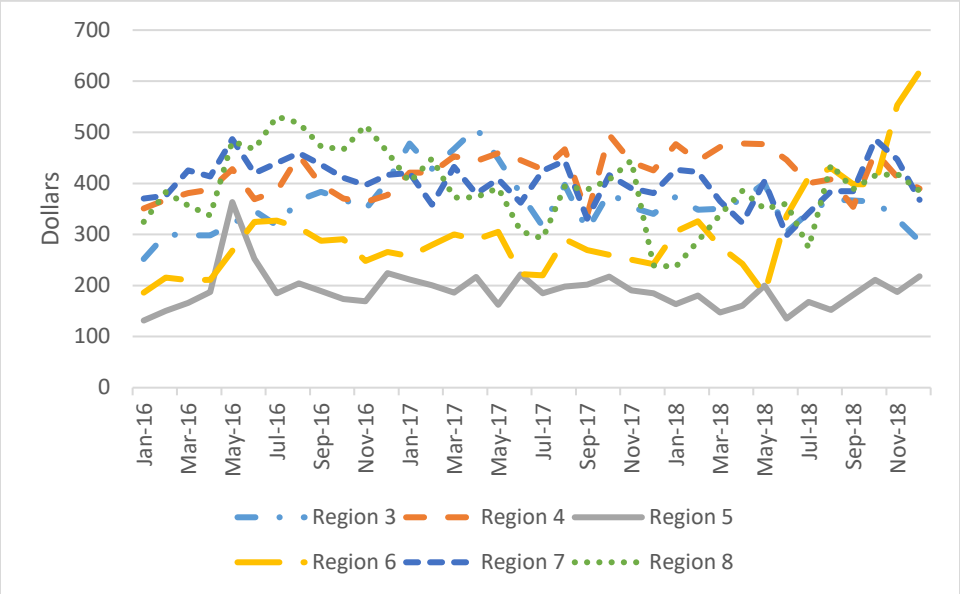


Figure 26 contains the per rider costs in each region served by MTM. Between 2016 and 2017, per rider costs increased in Regions 3 (p = .0065) and 4 (p = .0009) and decreased in Region 8 (p = .0111). Between 2017 and 2018, there was a statistically significant increase in per rider costs in Region 6 (p = .0033) and a decrease in per rider costs in Region 3 (p = .0335). Also, noteworthy, there was a substantive drop in CNET enrollment in Region 5 in 2016. The decline was primarily among low users, leading to an increase in average costs, particularly in May 2016. However, it is unclear whether the decline in enrollment explains the change in costs. The change in costs was a transitory, but enrollment did not rebound to previous levels.

Figure 26. *Per Rider Per Month Costs by region for MTM*



Figures 27 and 28 contain per rider costs when differentiating between PPEC and non-PPEC enrollees.[7] In 2018, monthly per rider costs for non-PPEC enrollees ranged from $299 (March) to $377 (August) for LogistiCare and from $287 (June) to $330 (November) for MTM. Monthly per rider costs for PPEC enrollees ranged from $805 (February) to $1,023 (October) for LogistiCare and from $519 (July) to $691 (October) for MTM.

Month-by-month comparisons between 2017 and 2018 for LogistiCare showed higher per rider costs in 2018 in 8 of the 12 months for non-PPEC enrollees and all 12 months for PPEC enrollees. MTM had higher per rider costs in 2018 in 7 of the 12 months for non-PPEC enrollees and only 3 of the 12 months for PPEC enrollees. Both LogistiCare and MTM had declines in utilization in September 2017. While difficult to assess causal effects using administrative data, Hurricane Irma caused widespread disruptions in Florida in September 2017. LogistiCare also saw declines in September 2018, but the only major storm activity was Tropical Storm Gordon which crossed South Florida. However, the storm was not sufficiently strong to cause major NET service interruptions. Further work should explore whether service fluctuations continue in September 2019 and 2020, and if so, whether there are additional reasons for service fluctuations in September.

Regressions examined whether costs increased or decreased between years. Per rider costs increased between 2016 and 2017 for LogistiCare non-PPEC recipients ($p = .0014$) and for MTM non-PPEC ($p < .0001$) and PPEC riders ($p = .0002$). Between 2017 and 2018, per rider costs increased for LogistiCare (non-PPEC, $p = .0013$ and PPEC, $p < .0001$) and decreased for MTM PPEC recipients ($p < .0001$).

[7] Prescribed Pediatric Extended Care (PPEC) centers allow Medicaid-eligible children with medically complex conditions to receive continual medical care in a non-residential setting. Different capitation rates are used for members receiving services through PPEC. A table providing monthly per rider costs is provided in the appendix (Table 3). Additional information on regional trends in costs for PPEC and non-PPEC enrollees will be added to the final report due July 15, 2020.

Figure 27. *Per Rider Per Month Costs by PPEC Status for LogistiCare*

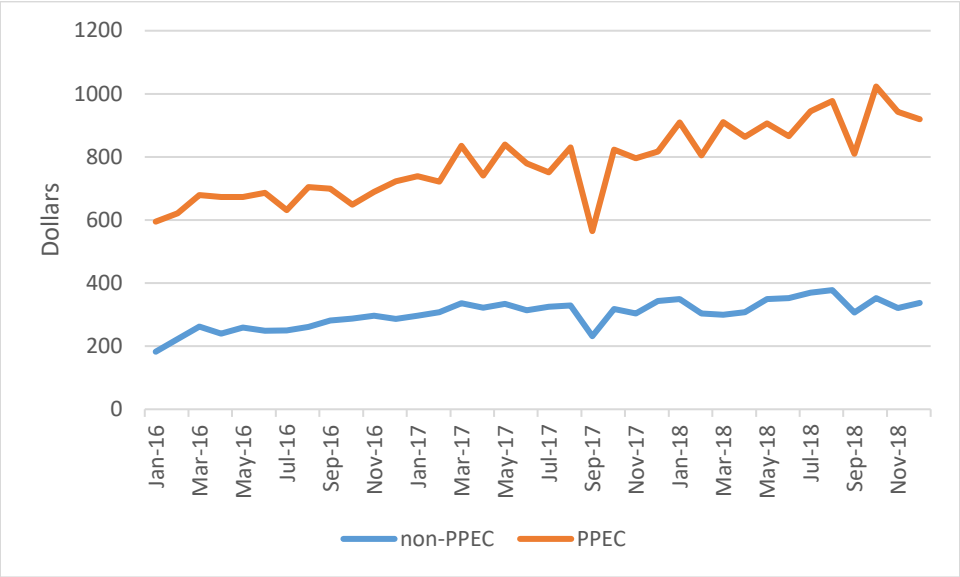
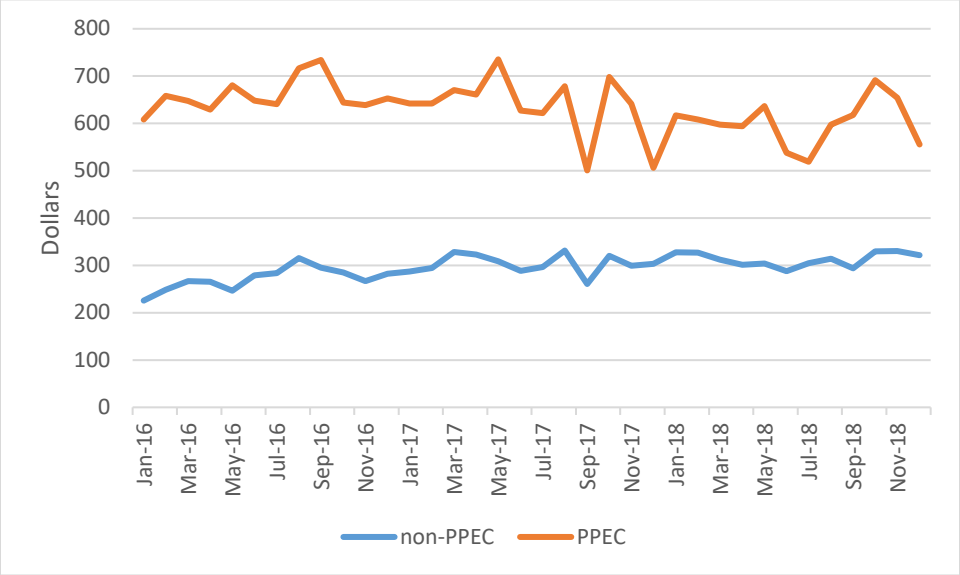


Figure 28. *Per Rider Per Month Costs by PPEC Status for MTM*



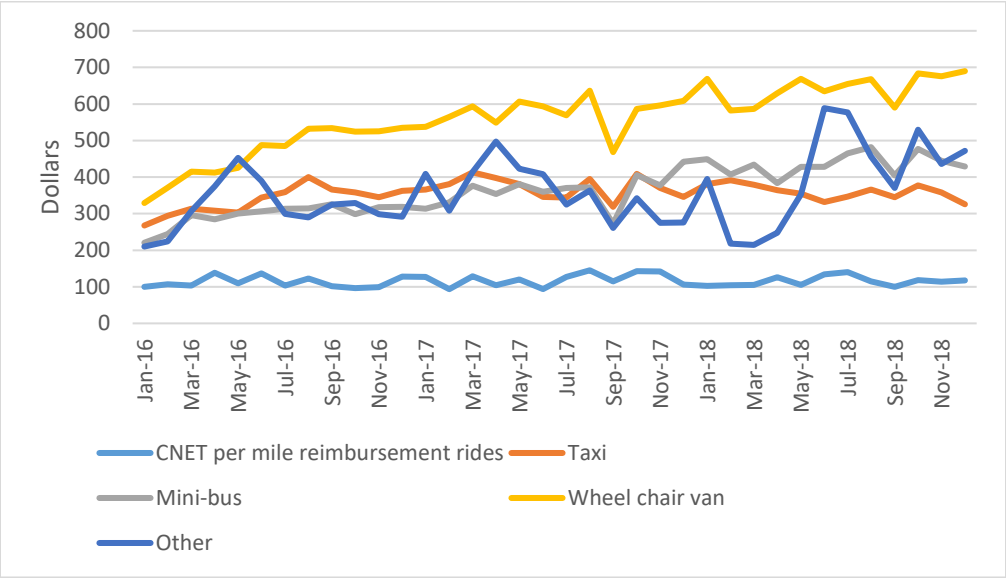
2. How has the encounter cost by transportation type per rider per month gone up or down?

Per rider costs by type of transportation are provided in Figure 29. A table containing per rider costs by type of transportation is also provided in the Appendix 9. The type of transportation was determined based on the encounter procedure code. There are four primary types of transportation used: (a) per mile reimbursement, (b) taxi, (c) mini-bus, and (d) wheelchair van. There are also several transportation types used infrequently: (a) bus, (b) air transportation, and (c) CNET ambulance. These were combined into an “other” category to provide sufficient sample size for reporting. As shown in Figure 29, costs for the other category rose notably in early 2018. The increase reflected an increase over the first few months of 2018 in CNET ambulance use and costs.

Month-by-month comparisons between CY 2017 and 2018 indicate increasing per rider costs for mini-bus and wheelchair van services but decreasing per rider costs for CNET reimbursement and taxi services. Per rider costs were higher in 5 of the 12 months for CNET per mile reimbursements, 4 months for taxi services, 11 months for mini-bus services, and 11 months for wheelchair van services.

Regressions examined whether costs increased or decreased between years. Per rider costs for taxi services increased between 2016 and 2017 ($p = .008$). Per rider costs for wheelchair services increased between 2016 and 2017 ($p < .0001$), and 2017 and 2018 ($p < .0001$). Per rider costs for mini-bus services also increased between 2016 and 2017 ($p < .0001$), and 2017 and 2018 ($p < .0001$). The evaluation team recommends that NET vendors document why costs per rider are increasing as well as market changes specific to certain regions or transportation types.

Figure 29. *Per Rider Per Month Costs by Transportation Type*



Summary and Conclusions

Access to Services

Non-emergency transportation services are an important benefit for Medicaid recipients who are unable to afford the cost of public or private transportation. Results of the service utilization assessment indicated that the rate of eligible recipients utilizing NET services did not change significantly between 2017 and 2018. During this same period, however, the number of rides per user of transportation services increased. A downward trend in the number of taxi rides was evident as well as an increasing trend in the number of mini-bus and wheelchair van rides.

A review of the NET vendor performance reports based on all Medicaid recipients revealed a sharp decrease in the number of eligible NET recipients enrolled in LogistiCare but a substantial increase in the number of reservation calls. The performance data reported by MTM was more stable across years. One possibility for the discrepancy between the numbers of eligible members and calls is that existing users are relying on NET vendors for more frequent trips.

As expected, the highest rates of eligibility and utilization in 2018 were in urban areas, with two additional counties (Palm Beach and Hillsborough) included in this classification as compared to 2017. Additionally, individuals in these areas are less likely to have access to a personal vehicle and more likely to rely on public transportation, which may explain the high rates of utilization.

Quality of Services

In 2018, the rate of consumer complaints was consistently less than 1% for both MTM and LogistiCare. As compared to previous years, the rate of complaints for both vendors was lower in every quarter of 2018. Results suggest that the vast majority of Medicaid recipients are satisfied with their transportation services. The analysis of information from the Agency's Complaint Operations Center revealed that most complaints were associated with eligibility, appointment setting, and driver no-shows.

Cost Effectiveness

Overall, per rider costs were higher in CY 2018 than CY 2017. Per rider costs increased for LogistiCare but were stable for MTM. The higher per rider costs for LogistiCare were primarily limited to Region 11 and mini-bus and wheelchair van services.

Recommendations

The evaluation team offers the following recommendations:

- Vendor performance reports should include the number of standing orders, advance reservations, and will-call rides. It is unclear whether these requests are included in the calculation of the number of reservation calls in the vendor monthly performance reports. Information about the types of reservation calls will allow for improved scheduling and monitoring of rides needed in advance or with short notice.
- Vendors should address the concern raised by consumers regarding transportation provider lateness and no-shows. Provider lateness has been an ongoing issue that can be caused by many factors, including heavy traffic; however, late arrivals to medical appointments could result in missed or canceled visits and should be avoided.

- Vendors should consistently report both Agency complaints as well as complaints reported to the vendor in monthly reports sent to the Agency, as required by the Agency. A comprehensive accounting of all complaints is important so that they are not undercounted.
- Vendors should document why costs per rider are changing. This information could provide insight into whether different vehicle types or additional subcontractors are needed to provide transportation services.

References

Agency for Health Care Administration [AHCA]. (2016). *Florida Medicaid non-emergency transportation services coverage policy.* Tallahassee, FL: Author.

Centers for Medicare & Medicaid Services. (2014). *Medicaid Non-Emergency Medical Transportation Booklet for Providers*. Retrieved from http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/nemt-booklet.pdf

LogistiCare. (2014). *Provider operational procedures manual*. Atlanta, GA: Author.

Medical Transportation Management [MTM]. (2018). MTM transportation provider handbook. Stuart, FL: Author.

Appendix 1. *CNET enrollees, unique riders, and riders per 1,000 CNET enrollees*

	CNET enrollees	Riders	Riders per 1000 enrollees
Jan 16	245027	2103	8.6
Feb 16	200290	1972	9.8
Mar 16	179615	1741	9.7
Apr 16	180773	1693	9.4
May 16	126891	1599	12.6
Jun 16	125616	1374	10.9
Jul 16	127486	1419	11.1
Aug 16	128267	1587	12.4
Sep 16	129409	1497	11.6
Oct 16	121709	1538	12.6
Nov 16	122689	1588	12.9
Dec 16	124410	1566	12.6
Jan 17	102048	1579	15.5
Feb 17	107503	1447	13.5
Mar 17	104157	1494	14.3
Apr 17	102553	1449	14.1
May 17	100897	1481	14.7
Jun 17	100177	1512	15.1
Jul 17	100333	1420	14.2
Aug 17	97665	1416	14.5
Sep 17	97986	1185	12.1
Oct 17	99355	1265	12.7
Nov 17	96500	1309	13.6
Dec 17	97063	1247	12.8
Jan 18	95866	1308	13.6
Feb 18	96258	1342	13.9
Mar 18	96130	1463	15.2
Apr 18	95721	1407	14.7
May 18	94893	1392	14.7
Jun 18	95196	1354	14.2
Jul 18	95935	1350	14.1
Aug 18	95831	1397	14.6
Sep 18	96555	1333	13.8
Oct 18	96234	1382	14.4
Nov 18	97215	1415	14.6
Dec 18	101264	1428	14.1

Appendix 2. *The number of rides, rides per CNET enrollee, and rides per unique rider*

	Rides	Rides per 1,000 CNET enrollees	Rides per user
Jan 16	19888	81.2	9.5
Feb 16	20538	102.5	10.4
Mar 16	20437	113.8	11.7
Apr 16	19527	108.0	11.5
May 16	18536	146.1	11.6
Jun 16	17190	136.8	12.5
Jul 16	17009	133.4	12.0
Aug 16	19947	155.5	12.6
Sep 16	18034	139.4	12.0
Oct 16	17426	143.2	11.3
Nov 16	18440	150.3	11.6
Dec 16	18735	150.6	12.0
Jan 17	18811	184.3	11.9
Feb 17	17457	162.4	12.1
Mar 17	19939	191.4	13.3
Apr 17	18139	176.9	12.5
May 17	19464	192.9	13.1
Jun 17	18255	182.2	12.1
Jul 17	17095	170.4	12.0
Aug 17	18831	192.8	13.3
Sep 17	12014	122.6	10.1
Oct 17	17453	175.7	13.8
Nov 17	16429	170.2	12.6
Dec 17	16035	165.2	12.9
Jan 18	18203	189.9	13.9
Feb 18	17378	180.5	12.9
Mar 18	19212	199.9	13.1
Apr 18	18261	190.8	13.0
May 18	18844	198.6	13.5
Jun 18	17311	181.8	12.8
Jul 18	17661	184.1	13.1
Aug 18	18743	195.6	13.4
Sep 18	16513	171.0	12.4
Oct 18	19803	205.8	14.3
Nov 18	19152	197.0	13.5
Dec 18	19057	188.2	13.3

Appendix 3. *The number of riders by transportation type – 2016-2018*

	Mileage reimbursement rides	Taxi	Mini-bus	Wheelchair van	Other
Jan 16	59	740	917	397	86
Feb 16	67	671	844	407	75
Mar 16	57	622	660	408	48
Apr 16	56	585	659	397	41
May 16	60	567	630	347	31
Jun 16	41	445	619	282	25
Jul 16	55	416	545	393	55
Aug 16	59	446	626	446	61
Sep 16	57	422	570	445	52
Oct 16	68	443	568	452	52
Nov 16	69	448	591	470	55
Dec 16	65	453	584	460	52
Jan 17	68	445	607	466	36
Feb 17	67	397	573	400	50
Mar 17	60	408	591	427	50
Apr 17	65	382	570	442	32
May 17	63	413	538	465	42
Jun 17	67	416	569	455	35
Jul 17	62	392	518	447	43
Aug 17	63	387	517	451	41
Sep 17	58	342	406	381	24
Oct 17	55	373	415	419	36
Nov 17	64	369	460	405	39
Dec 17	64	376	420	400	33
Jan 18	72	372	458	419	34
Feb 18	65	370	474	438	35
Mar 18	78	401	521	479	42
Apr 18	85	372	521	441	42
May 18	79	392	501	447	30
Jun 18	73	370	499	437	27
Jul 18	77	373	487	428	39
Aug 18	90	369	520	446	46
Sep 18	86	371	519	397	35
Oct 18	77	412	540	409	36
Nov 18	81	420	559	401	37
Dec 18	69	416	625	371	38

Appendix 4. *The number of rides by transportation type – 2016-2018*

	Mileage reimbursement rides	Taxi	Mini-bus	Wheelchair van	Other
Jan 16	690	8885	5850	4042	421
Feb 16	681	8897	6007	4583	370
Mar 16	597	8759	5888	4901	292
Apr 16	627	8326	5618	4738	218
May 16	627	7713	5689	4295	212
Jun 16	572	6896	5626	3885	211
Jul 16	560	6875	5145	4161	268
Aug 16	672	8042	6024	4942	267
Sep 16	564	6794	5613	4765	298
Oct 16	607	6656	5323	4579	261
Nov 16	663	6825	5718	4941	293
Dec 16	723	7053	5710	4940	309
Jan 17	773	7006	5685	5129	218
Feb 17	664	6347	5578	4585	283
Mar 17	747	7296	6418	5156	322
Apr 17	679	6628	5822	4742	268
May 17	703	7092	6011	5403	255
Jun 17	695	6565	5808	5006	181
Jul 17	657	6126	5395	4753	164
Aug 17	756	6941	5655	5319	160
Sep 17	566	4761	3275	3341	71
Oct 17	693	6784	5011	4859	106
Nov 17	698	6017	4953	4669	92
Dec 17	567	5824	4977	4567	100
Jan 18	669	6534	5557	5300	143
Feb 18	592	6373	5233	5062	118
Mar 18	760	6686	6113	5488	165
Apr 18	893	6196	5613	5360	199
May 18	687	6417	5886	5695	159
Jun 18	769	5657	5769	4981	135
Jul 18	891	5656	5860	5085	169
Aug 18	942	5819	6547	5288	147
Sep 18	808	5298	5859	4429	119
Oct 18	744	6495	7177	5248	139
Nov 18	732	5968	7199	5119	134
Dec 18	589	5432	7927	4978	131

Appendix 5: *Consumer Questionnaire (English)*

This survey will ask you about your experiences with Medicaid non-emergency transportation services. These services help you get to and from your medical appointments. The University of South Florida is evaluating these services on behalf of the Agency for Health Care Administration. The information you provide will help us learn about what is being done well and what could use some improvement. The survey takes only about 10 minutes, and any information you provide will be kept confidential. Your responses or non-responses will not affect your Medicaid coverage. You don't have to answer any question you don't want to, and you can end the survey at any time.
If you have any questions or concerns about this survey, please call the survey administrators at the University of South Florida. They are Lodi Rohrer (813-974-0517) and Flandra Ismajli (813-974-6135).
Thank you! Your participation is greatly appreciated.

Q1 In the past 12 months, have you scheduled a ride for non-emergency transportation?

- ○ Yes (1)
- ○ No (2)

Skip To: End of Survey If In the past 12 months, have you scheduled a ride for non-emergency transportation? = No

Skip To: Q2 If In the past 12 months, have you scheduled a ride for non-emergency transportation? = Yes

Q2 Do you schedule non-emergency transportation for yourself or a family member (such as your child)? If you answer with "Both myself and a family member", please respond to the remaining questions about rides specifically for yourself.

- ○ Myself (1)
- ○ Family member (2)
- ○ Both myself and a family member (4)

Q3 How many times per month do you (or your family member) use non-emergency transportation?

_____

Q4 How easy is it for you to schedule rides?

- ○ Very Difficult (1)
- ○ Difficult (2)
- ○ Neither easy nor difficult (3)
- ○ Easy (4)
- ○ Very Easy (5)

Q5 How easy would it be for you (or your family member) to get to appointments if non-emergency transportation were not available?

- ○ Very Difficult (1)
- ○ Difficult (2)
- ○ Neither easy nor difficult (3)
- ○ Easy (4)
- ○ Very Easy (5)

Q6a In the past 12 months, have you filed a complaint regarding non-emergency transportation services?

- ○ Yes (1)
- ○ No (2)

Skip To: Q6b If In the past 12 months, have you filed a complaint regarding non-emergency transportation services? = Yes

Skip To: Q7 If In the past 12 months, have you filed a complaint regarding non-emergency transportation services? = No

Q6b How many complaints have you filed in the past 12 months?

_____

Q6c Did you file the complaint with the NET vendor directly?

- Yes (1)
- No (2)

Q6d Did you file the complaint with the Agency (Medicaid) complaint hub?

- Yes (1)
- No (2)

Q6e Were you satisfied with the way your complaint was handled?

- Yes (1)
- No (2)

Q6f Please explain:

_____

Q7 How often are you (or your family member) picked up on time from home?

- Never (1)
- Sometimes (2)
- About half the time (3)
- Most of the time (4)
- Always (5)

Q8 How often do you (or your family member) get to your appointments on time?

- ○ Never (1)
- ○ Sometimes (2)
- ○ About half the time (3)
- ○ Most of the time (4)
- ○ Always (5)

Q9 How long do you (or your family member) usually wait to be picked up after your appointments?

_____

Q10 Do the drivers usually operate the vehicles in a safe manner?

- ○ Yes (1)
- ○ No (2)

Q11a Do the type and size of vehicles provided for your travel meet your (or your family member's) needs?

- ○ Yes (1)
- ○ No (2)

Q11b If no, please explain:

_____

Q12a Are you (or your family member) usually comfortable in the vehicle during transport?

- ○ Yes (1)
- ○ No (2)

Q12b If no, please explain:

_____

Q13 How often do the drivers treat you (or your family member) with courtesy and respect?

- Never (1)
- Sometimes (2)
- About half the time (3)
- Most of the time (4)
- Always (5)

Q14 How do you feel about the quality of non-emergency transportation services in general?

- Very Dissatisfied (1)
- Dissatisfied (2)
- Neither Satisfied nor Dissatisfied (3)
- Satisfied (4)
- Very Satisfied (5)

Q15 What is your gender?

- Male (1)
- Female (2)

Q16 What is your age group?

- 18-24 (1)
- 25-39 (2)
- 40-60 (3)
- 61 or older (4)

Q17 Do you have any additional comments about non-emergency transportation services?

_____

_____

Appendix 6: *Consumer Questionnaire (Spanish)*

Esta encuesta le preguntará sobre sus experiencias con los servicios de transporte que no son de emergencia de Medicaid. Estos servicios le ayudan a llegar y salir de sus citas médicas. Si acepta participar, la información que proporcione nos ayudará a conocer qué se está haciendo bien y qué podría mejorar. La encuesta toma solo unos 10 minutos y cualquier información que proporcione será confidencial. Sus respuestas o no respuestas no afectarán su cobertura de Medicaid. No tiene que responder ninguna pregunta que no desee, y puede finalizar la encuesta en cualquier momento.

Si tiene alguna pregunta o inquietud acerca de esta encuesta, llame a las personas que están a cargo de esta encuesta. Ellas son Lodi Rohrer (813-974-0517) y Flandra Ismajli (813-974-6135).

¡Gracias! Su participación es altamente apreciada.

Q1 En los últimos 12 meses, ¿ha programado un transporte que no era de emergencia?

- ○ Si (2)
- ○ No (3)

Skip To: Q2 If En los últimos 12 meses, ¿ha programado un transporte que no era de emergencia? = Si

Skip To: End of Survey If En los últimos 12 meses, ¿ha programado un transporte que no era de emergencia? = No

Q2 ¿Usted programa el transporte que no sea de emergencia para usted o un miembro de su familia (como su hijo)? Si responde con “Tanto yo como un miembro de mi familia”, responda a las preguntas restantes sobre los viajes específicamente para usted.

- ○ Yo mismo (1)
- ○ Un miembro de mi familia (2)
- ○ Tanto yo como un miembro de mi familia (4)

Q3 ¿Cuántas veces al mes usa usted (o el miembro de su familia) transporte que no es de emergencia?

_____

Q4 ¿Qué tan fácil es para que programes viajes?

- ○ Muy difícil (1)
- ○ Difícil (2)
- ○ Ni fácil ni difícil (3)
- ○ Fácil (4)
- ○ Muy fácil (5)

Q5 ¿Qué tan fácil estuviera para usted o los miembros de su familia para llegar a las citas si el transporte que no sea de emergencia no estuviera disponible?

- ○ Muy difícil (1)
- ○ Difícil (2)
- ○ Ni fácil ni difícil (3)
- ○ Fácil (4)
- ○ Muy fácil (5)

Q6a En los últimos 12 meses, ¿ha presentado una queja sobre los servicios de transporte que no son de emergencia?

- ○ Si (1)
- ○ No (2)

Skip To: Q6b If En los últimos 12 meses, ¿ha presentado una queja sobre los servicios de transporte que no son de... = Si

Skip To: Q7 If En los últimos 12 meses, ¿ha presentado una queja sobre los servicios de transporte que no son de... = No

Q6b ¿Cuántas quejas ha presentado en los ultimos 12 meses?

_____

Q6c ¿Presentó la queja directamente con el proveedor de NET?

- Si (1)
- No (2)

Q6d ¿Presentó la queja al centro de quejas de la Agencia (Medicaid)?

- Si (1)
- No (2)

Q6e ¿Estaba satisfecho con la manera en que se tramitó su queja?

- Si (1)
- No (2)

Q6f Por favor explique:

_____

Q7 ¿Con qué frecuencia lo recogen (o al miembro de su familia) de su casa a tiempo?

- Nunca (1)
- A veces (2)
- Como la mitad del tiempo (3)
- La mayoría de las veces (4)
- Siempre (5)

Q8 ¿Con qué frecuencia llega usted (o al miembro de su familia) a sus citas a tiempo?

- Nunca (1)
- A veces (2)
- Como la mitad del tiempo (3)
- La mayoría de las veces (4)
- Siempre (5)

Q9 ¿Cómo cuánto tiempo espera usted (o su familia) para ser recogido después de sus citas?

_____

Q10 ¿Los conductores operan los vehículos de una manera segura?

- Si (1)
- No (2)

Q11a ¿El tipo y el tamaño de los vehículos provistos para viajar satisfacen sus necesidades (o las de su familiar)?

- Si (1)
- No (2)

Q11b Si puso no, por favor explique:

_____

Q12a ¿Típicamente está cómodo usted (o al miembro de su familia) en el vehículo durante el transporte?

- Si (1)
- No (2)

Q12b Si puso no, por favor explique:

_____

Q13 ¿Con qué frecuencia los conductores lo tratan a usted (o al miembro de su familia) con cortesía y respeto?

- Nunca (1)
- A veces (2)
- Como la mitad del tiempo (8)
- La mayoría de las veces (4)
- Siempre (5)

Q14 ¿En general qué le parece la calidad de los servicios de transporte que no son de emergencia?

- Muy insatisfecho (1)
- Insatisfecho (2)
- Ni satisfecho ni insatisfecho (3)
- Satisfecho (4)
- Muy satisfecho (5)

Q15 ¿Cuál es su género?

- Masculino (1)
- Femenino (2)

Q16 ¿Cual es su grupo de edad?

- 18-24 (1)
- 25-39 (2)
- 40-60 (3)
- 61 o mayor (4)

Q17 ¿Tiene comentarios adicionales sobre los servicios de transporte que no sean de emergencia?

_____

_____

_____

_____

Appendix 7: *Complaint Definitions*

Complaint Type	Definition
Driver Behavior	• Driver is rude • Driver does not open the door to assist passenger
Driver Service/Delivery	• Driver speeding • Driver drives in an alleged erratic manner
Internal Complaint – Client Protocols	• Member requests not to ride with a certain provider
Internal Complaint – Customer Service	• Hold time • Rude Customer Care Representative
Internal Complaint – MTM Process	• Trip is turned back and cannot be reset • Member does not receive a call in regard to a change in transportation
Internal Complaint – Trip Accuracy	• Trip set with the wrong appointment date/time • Wrong mode of transportation is associated with trip (i.e., member requests paralift, but trip is set with cab/sedan service)
Provider – Early Pick Up	• Driver arrives early for the scheduled pick up and delivers the member to the appointment too early
Provider – Early Return	• Driver arrives too early for the prescheduled return ride; member was not finished with the appointment yet
Provider – Late Pick Up	• Driver arrives late resulting in the member being late for the appointment
Provider – Late Return	• Driver arrives late for the return ride (more than 30 minutes later than the prescheduled return ride time or more than an hour after the will call return ride was activated)
Provider – Multi Timeliness	• A combination of untimeliness (e.g., late pick up and late return)
Provider – Travel Time	• Member is kept onboard the vehicle for longer than the allotted amount of time (a member can be onboard the vehicle for 45 minutes plus direct drive time)
Provider – No Show Pick Up	• Driver does not arrive for the scheduled pick up
Provider – No Show Return	• Driver does not arrive for the return ride
Provider – Service/Behavior	• Dispatch/office staff is rude • Wrong type of vehicle is sent to accommodate a member
Vehicle Appearance/Odor	• Vehicle was reported to be dirty or have an odor
Vehicle Quality/Safety	• Seatbelt allegedly not functioning correctly • Window allegedly does not roll down

Appendix 8: *Per Rider Per Month Costs for PPEC and Non-PPEC Riders*

Month	LogistiCare				MTM			
	non-PPEC		PPEC		non-PPEC		PPEC	
	People served	Per rider cost	People served	Per rider cost	People served	Per rider cost	People served	Per rider cost
2016								
January	1,054	182.47	283	594.65	926	225.58	134	608.23
February	983	222.84	255	621.42	879	248.25	122	658.31
March	743	262.55	266	679.05	840	266.65	121	647.22
April	710	239.70	279	672.49	795	265.16	123	629.09
May	671	259.09	271	672.51	724	246.52	124	680.33
June	616	249.26	285	686.18	503	278.84	135	648.17
July	512	249.63	284	631.51	486	283.95	137	640.71
August	604	260.95	297	704.24	552	315.66	134	716.30
September	554	281.62	284	699.60	543	295.34	116	733.89
October	557	287.88	284	648.87	570	285.00	127	644.19
November	593	296.81	292	689.34	575	266.48	128	638.82
December	597	286.80	290	722.33	550	282.55	129	652.65
2017								
January	622	296.13	273	738.74	558	287.25	126	641.94
February	577	307.83	269	721.88	487	294.35	114	642.17
March	608	335.72	271	834.97	496	328.59	119	670.22
April	573	322.44	275	741.17	493	322.77	108	661.26
May	558	334.40	286	839.75	529	308.91	108	735.41
June	575	313.52	305	779.33	518	288.66	114	626.95
July	539	324.98	291	750.81	484	296.32	106	622.03
August	520	328.55	301	830.33	485	331.38	110	678.81
September	372	232.05	291	564.71	421	260.39	101	500.72
October	389	317.80	287	822.85	488	320.13	101	698.39
November	441	304.01	293	796.03	481	299.16	94	641.47
December	374	343.47	316	817.15	462	303.57	95	506.36
2018								
January	428	349.25	315	909.57	471	327.86	94	617.35
February	448	303.43	318	805.26	481	326.94	95	608.02
March	511	299.16	332	910.31	524	312.26	96	597.70
April	492	307.71	323	863.95	506	300.95	86	594.36
May	478	349.44	326	906.10	497	303.94	91	636.37
June	453	352.04	339	865.39	465	287.97	97	537.84
July	475	370.13	324	945.16	462	304.72	89	519.31
August	490	377.74	329	977.44	484	313.94	94	597.45

Month	LogistiCare				MTM			
	non-PPEC		PPEC		non-PPEC		PPEC	
	People served	Per rider cost	People served	Per rider cost	People served	Per rider cost	People served	Per rider cost
September	483	306.71	327	809.47	439	294.07	94	618.05
October	520	352.73	317	1023.15	452	329.58	93	691.72
November	533	321.23	333	942.97	462	330.33	87	654.18
December	582	336.67	329	919.78	430	321.69	87	555.50

Appendix 9: *Per Rider Per Month Costs by Transportation Type*

Month	Total		CNET per mile reimbursement rides		Taxi		Mini-bus		Wheelchair van		Other	
	People served	Per rider cost	People served	Per rider cost	People served	Per rider cost	People served	Per rider cost	People served	Per rider cost	People served	Per rider cost
2016												
January	2,397	271.59	59	100.16	740	267.61	917	220.54	657	329.16	136	210.07
February	2,239	301.94	68	106.94	671	293.97	844	244.01	642	371.41	121	224.21
March	1,970	344.16	57	103.34	622	313.3	661	295.84	612	414.53	91	307.68
April	1,907	338.75	56	138.11	585	307.82	661	284.14	586	412.11	77	374.93
May	1,790	345.78	60	109.92	567	303.03	631	300.73	516	425.45	69	452.67
June	1,539	374.83	41	136.39	445	344.25	623	306.42	415	487.4	64	389.23
July	1,419	375.57	55	103.71	416	358.74	545	313.76	393	484.81	55	299.4
August	1,587	401.39	59	122.87	446	399.75	626	314.02	446	531.83	61	290.1
September	1,497	400.94	57	101.93	422	365.66	570	325.37	445	534.2	52	325.22
October	1,538	382.9	68	96.32	443	358.37	568	298.17	452	524.54	52	329.46
November	1,588	385.57	69	98.92	448	344.55	591	317.7	470	525.33	55	298.94
December	1,566	396.1	65	127.89	453	362.77	584	319.07	460	535.15	52	291.15
2017												
January	1,579	397.11	68	127.15	445	366.33	607	313.35	466	537.48	36	408.51
February	1,447	406.61	67	93.58	397	380.6	573	331.04	400	564.7	50	308.44
March	1,494	450.56	60	129.11	408	412.89	591	376.78	427	593.82	50	413.81
April	1,449	427.28	65	104.18	382	397.67	570	354.05	442	549.15	32	497.13
May	1,481	452.13	63	119.75	413	380.87	538	381.11	465	606.41	42	422.39
June	1,512	422.6	67	93.65	416	345.76	569	359.68	455	593.27	35	407.61
July	1,420	424.65	62	126.79	392	343.95	518	370.65	447	569.06	43	324.47
August	1,416	463.39	63	145.13	387	394.59	517	372.24	451	636.33	41	363.02
September	1,185	346.71	58	114.77	342	318.47	406	272.63	381	468.04	24	261.19
October	1,265	463.67	55	142.37	373	408.51	415	405.31	419	586.66	36	342.41
November	1,309	436.59	64	141.61	369	370.16	460	377.58	405	596.1	39	275.26
December	1,247	461.13	64	106.34	376	345.69	420	442.02	400	608.76	33	275.54
2018												
January	1,308	495.76	72	102.7	372	380.84	458	449.02	419	669	34	394.71
February	1,342	452.33	65	103.9	370	391.14	474	407.22	438	581.99	35	217.86
March	1,463	462.13	78	104.94	401	379.12	521	434.13	479	586.02	42	214.29
April	1,407	450.5	85	126.49	372	363.8	521	383.26	441	629.62	42	248.07
May	1,392	482.32	79	105	392	354.42	501	428.26	447	668.84	30	352.61
June	1,354	471.87	73	133.7	390	331.6	499	427.72	437	634.2	27	588.57

Month	Total		CNET per mile reimbursement rides		Taxi		Mini-bus		Wheelchair van		Other	
	People served	Per rider cost	People served	Per rider cost	People served	Per rider cost	People served	Per rider cost	People served	Per rider cost	People served	Per rider cost
July	1,350	495.59	77	140.4	393	346.81	487	464.71	428	654.35	39	576.81
August	1,397	511.65	90	115.11	369	366.21	520	481.94	446	667.5	46	455.95
September	1,333	445.5	86	99.8	371	345.22	519	404.84	397	589.73	35	370.05
October	1,382	521.68	77	118.54	412	377.36	540	476.94	409	683.97	36	529.94
November	1,415	490.99	81	113.85	420	357.66	559	444.27	401	675.37	37	436.25
December	1,428	479.84	69	117.23	416	325.31	625	428.74	371	689.77	38	471.61

Attachment III: Excel Workbooks

Submitted as separate documents.