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

# Florida Medicaid
# Non-Emergency Medical Transportation Waiver (NEMT)

## Waiver Renewal

**Effective Dates: 7/1/2025 – 6/30/2027**
**Submission Date: March 31, 2025**

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

**Page Intentionally Left Blank**

# 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/renewal 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 Medical 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.

___Amendment request for existing waiver, which modifies Section/Part _____

___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

_X_ 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.

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

Section A is:

___replaced in full

_X_ carried over from previous waiver period. The State:

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

_X_ assures the same Program Description from the previous waiver period will be used, with exceptions noted in attached replacement pages. **(The entire section has been included with selection changes highlighted.)**

Section B is: ___replaced in full

_X_ carried over from previous waiver period. The State:

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

_X_ assures the same Monitoring Plan from the previous waiver period will be used, with exceptions noted in attached replacement pages. **(The entire section has been included with selection changes highlighted.)**

## EFFECTIVE DATES

This waiver/renewal/amendment is requested for a period of 2 years; effective 7/1/2025 and ending 6/30/2027. (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 Kimberly Quinn and can be reached by telephone at (850) 412-4277, or e-mail at Kimberly.Quinn@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 renewal request. See **Attachment I** for tribal letters, e-mailed on February 21, 2025. This notification provided the Tribal Organizations with an opportunity to obtain additional information on Florida's Non-Emergency Medical Transportation (NEMT) program or to provide comments regarding the renewal of the NEMT 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 provides NEMT services through two delivery systems: the fee-for-service (FFS) delivery system for recipients not enrolled in an MMA managed care plan and the managed care delivery system for those Medicaid recipients who are mandatory for enrollment in the managed care program or who are voluntary for participation in the managed care program and who have chosen to enroll in an MMA managed care plan. Recipients in the fee-for-service delivery system receive NEMT to and from State Plan covered services from one of the State's NEMT vendors. Recipients enrolled in an MMA managed care plan receive their plan-covered services from the MMA plan.

The State submitted a 1915(b)(4) NEMT 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 NEMT services to Florida Medicaid recipients who are in the FFS delivery system as explained above. 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

State submitted a renewal application to CMS on November 3, 2020 and CMS granted the renewal on January 05, 2021 for the period of April 1,2021 – March 31, 2023.

The State submitted a temporary extension request on March 10, 2023 and CMS approved the temporary extension request on March 15, 2023 for the period of April 1, 2023 through June 30, 2023. The State submitted a renewal application to CMS on March 30, 2023, and CMS granted the renewal on June 11, 2023, for the period July 1, 2023 – June 30, 2025.

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

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

The State assures CMS that it will comply with section 1932(c)(2) of the Act and 42 CFR 438 Subpart E, to arrange for an annual, independent, external quality review of the outcomes and timeliness of, and access to the services delivered under each MCO/PIHP contract. In accordance with the waiver requirements, an independent assessment was conducted for the first two waiver periods. The Agency has met this requirement and has complied with the number of assessments needed.

## 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)

(2) 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)

Florida law permits use of the Health Services Exemption when a formal competitive procurement is not practical and/or in the best interest of the Agency. The Agency maintains documentation of its written justification, which is approved by the Office of General Counsel.

## 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.

The State has two CNET vendors and has assigned specific regions to each vendor equally. Each vendor maintains their list of transportation providers for the regions they have been assigned. The vendors assign the most appropriate transportation provider suitable to the recipient's needs.

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 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.

## C. 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 A | PAHP | Modivcare |
| Region B | PAHP | Medical Transportation Management, Inc |
| Region C | PAHP | Medical Transportation Management, Inc |
| Region D | PAHP | Medical Transportation Management, Inc |
| Region E | PAHP | Medical Transportation Management, Inc |
| Region F | PAHP | Medical Transportation Management, Inc |
| Region G | PAHP | Modivcare |
| Region H | PAHP | Modivcare |
| Region I | PAHP | Modivcare |

## D. 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:

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

X Mandatory enrollment

____ Voluntary enrollment

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

- Recipients who have other credible health care coverage, excluding Medicare
- Children receiving services in a prescribed pediatric extended care

center.
- Recipients enrolled in the Developmental Disabilities Individual Budgeting (iBudget) Waiver, and those in pre-enrollment (waiting list) for iBudget, who are not enrolled in an MMA Plan

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

X Mandatory enrollment
____ Voluntary enrollment

Medicaid recipients who are excluded from enrollment in MMA:
- Women who are enrolled through the Breast and Cervical Cancer program
- Presumptively eligible pregnant women
- Recipients receiving services through the Medically Needy program.

Medicaid recipients who are voluntary for enrollment in Florida's MMA program, and have chosen not to enroll in an MMA plan:
- Recipients who have other credible health care coverage, excluding Medicare

**X** **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.

X Mandatory enrollment
____ Voluntary enrollment

Medicaid recipients who are voluntary for enrollment in Florida's MMA program, and have chosen not to enroll in an MMA plan:
- Recipients enrolled in the Developmental Disabilities Individual Budgeting (iBudget) Waiver, and those in pre-enrollment (waiting list) for iBudget, who are not enrolled in an MMA Plan
- Recipients residing in a group home facility licensed under Florida law governing group homes for developmentally disabled persons

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

X Mandatory enrollment
____ Voluntary enrollment

Medicaid recipients who are voluntary for enrollment in Florida's MMA program, and have chosen not to enroll in an MMA plan:
- Recipients enrolled in the Developmental Disabilities Individual Budgeting (iBudget) Waiver, and those in pre-enrollment (waiting list) for iBudget, who are not enrolled in an MMA Plan
- Recipients residing in a group home facility licensed under Florida law governing group homes for developmentally disabled persons

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

___ Mandatory enrollment
___ Voluntary enrollment

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

___ Mandatory enrollment
___ Voluntary enrollment

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

___ Mandatory enrollment
___ Voluntary enrollment

___ **Other –** Please Describe:

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:

_X_ **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.

_X_ **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).

ICF patients are an excluded population for NEMT; NF patients may be included.

_X_ **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.

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

Enrollees in Florida's Long-Term Care (LTC) Waiver receive services through MMA and are excluded from the NEMT Waiver. Enrollees in other HCBS Waivers are included based on their enrollment in an MMA Plan as noted previously.

___ **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.

**X** **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 reside in an institution, including:

- Statewide inpatient psychiatric program facilities
- 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

## E. 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 NEMT 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 PIHP, 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 NEMT program does not require recipients obtain prior authorization to access services. However, recipients are screened in order to provide the most appropriate and cost effective mode of transportation. When recipients or authorized representatives call the assigned region Vendor for transportation services, the screening process includes verifying ambulatory, wheelchair, or stretcher; traveling with oxygen; and traveling with an attendant.

## 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 NEMT plans.

**Table 1: 2025 Capacity Analysis**
**Medical Transportation Management, Inc.**

| County | Cab | Para Lift | Stretcher | Grand Total |
|---|---|---|---|---|
| Alachua | 13 | 16 | | 29 |
| Baker | 5 | 4 | | 9 |
| Bay | 5 | 2 | | 7 |
| Bradford | 3 | 4 | | 7 |
| Brevard | 14 | 15 | 1 | 30 |
| Broward | 32 | 63 | 5 | 100 |
| Calhoun | 1 | 1 | | 2 |
| Charlotte | 11 | 4 | | 15 |
| Citrus | 4 | 1 | | 5 |
| Clay | 10 | 5 | | 15 |
| Collier | 12 | 7 | 1 | 20 |
| Columbia | 7 | 3 | | 10 |
| DeSoto | 4 | 3 | | 7 |
| Dixie | 3 | 2 | | 5 |
| Duval | 23 | 10 | 2 | 35 |
| Escambia | 4 | 2 | | 6 |
| Flagler | 6 | 9 | | 15 |
| Franklin | 1 | 1 | | 2 |
| Gadsden | 7 | 2 | | 9 |
| Gilchrist | 4 | 3 | | 7 |
| Glades | 7 | 5 | | 12 |
| Gulf | 1 | 1 | | 1 |

| | | | | |
|---|---|---|---|---|
| Hamilton | 2 | 1 | | 3 |
| Hardee | 8 | 4 | | 12 |
| Hendry | 8 | 6 | | 14 |
| Hernando | 12 | 8 | | 20 |
| Highlands | 9 | 8 | | 17 |
| Hillsborough | 36 | 16 | 1 | 53 |
| Holmes | 1 | 1 | | 2 |
| Indian River | 4 | 5 | | 9 |
| Jackson | 1 | 1 | | 2 |
| Jefferson | 3 | 2 | | 5 |
| Lafayette | 4 | 2 | | 6 |
| Lake | 13 | 6 | 1 | 20 |
| Lee | 16 | 9 | 2 | 27 |
| Leon | 9 | 4 | | 13 |
| Levy | 3 | 2 | | 5 |
| Liberty | 1 | 1 | | 1 |
| Madison | 3 | 2 | | 5 |
| Manatee | 10 | 5 | | 15 |
| Marion | 16 | 3 | | 19 |
| Martin | 9 | 9 | 2 | 20 |
| Miami-Dade | 67 | 180 | 9 | 256 |
| Monroe | 6 | 3 | | 9 |
| Nassau | 5 | 3 | 2 | 10 |
| Okaloosa | 4 | 1 | | 5 |
| Okeechobee | 8 | 7 | | 15 |
| Orange | 43 | 26 | 6 | 75 |
| Osceola | 29 | 11 | 2 | 42 |
| Palm Beach | 26 | 57 | 1 | 84 |
| Pasco | 16 | 4 | 1 | 21 |
| Pinellas | 22 | 4 | | 26 |
| Polk | 29 | 7 | | 36 |
| Putnam | 9 | 6 | | 15 |
| Santa Rosa | 5 | 1 | | 6 |
| Sarasota | 13 | 4 | | 17 |
| Seminole | 12 | 10 | 2 | 24 |
| St. Johns | 7 | 12 | 2 | 21 |
| St. Lucie | 22 | 6 | | 28 |
| Sumter | 6 | 3 | | 9 |
| Suwannee | 3 | 2 | | 5 |
| Taylor | 1 | 2 | | 3 |
| Union | 4 | 3 | | 7 |

| | | | | |
|---|---|---|---|---|
| Volusia | 14 | 9 | 2 | 25 |
| Wakulla | 1 | 1 | | 1 |
| Walton | 3 | 1 | | 4 |
| Washington | 1 | 2 | | 3 |
| **Grand Total** | **701** | **620** | **42** | **1,363** |

| Table 2: 2025 Capacity Analysis<br>Modivcare Solutions, LLC | | | | |
|---|---|---|---|---|
| **TP County** | **Ambulatory Vehicles** | **Wheelchair Vehicles** | **Stretcher Vehicles** | **Total Vehicles** |
| ALACHUA* | 12 | 13 | | 25 |
| BAKER* | 12 | 16 | | 28 |
| BAY* | 12 | 9 | 1 | 22 |
| BREVARD* | 7 | 7 | 2 | 16 |
| BROWARD* | 282 | 58 | 21 | 361 |
| CALHOUN* | 8 | 10 | 2 | 20 |
| CITRUS* | | 2 | 2 | 4 |
| CLAY* | 11 | 11 | 2 | 24 |
| COLLIER* | 3 | | | 3 |
| COLUMBIA* | 11 | 9 | 10 | 30 |
| DESOTO* | 3 | 2 | | 5 |
| DUVAL* | 36 | 20 | 8 | 64 |
| ESCAMBIA | 5 | 21 | | 26 |
| FLAGLER* | 7 | 5 | 1 | 13 |
| GADSDEN* | 3 | 1 | | 4 |
| GULF* | 6 | 9 | | 15 |
| HAMILTON* | 11 | | | 11 |
| HIGHLANDS* | 13 | 3 | 1 | 17 |
| HILLSBOROUGH* | 52 | 19 | 7 | 78 |
| HOLMES* | 3 | | | 3 |
| JACKSON* | 18 | 11 | 6 | 35 |
| LAKE* | 2 | 2 | | 4 |
| LEE* | 15 | 25 | | 40 |
| LEON* | 13 | 6 | 2 | 21 |
| LIBERTY* | 10 | 8 | 1 | 19 |
| MADISON* | 1 | | | 1 |
| MARION* | 3 | 1 | | 4 |
| MIAMI-DADE* | 319 | 273 | 20 | 612 |
| MONROE* | 4 | | 7 | 11 |
| NASSAU* | 7 | 2 | | 9 |
| OKALOOSA | 10 | 38 | 1 | 49 |
| ORANGE* | 77 | 41 | 11 | 129 |
| OSCEOLA* | 14 | 16 | | 30 |
| PALM BEACH | 21 | 22 | 6 | 49 |
| PASCO* | 11 | 10 | | 21 |
| PINELLAS* | 6 | 9 | | 15 |
| POLK* | 6 | 10 | 3 | 19 |
| PUTNAM* | 6 | 4 | | 10 |
| SANTA ROSA | 17 | 10 | 1 | 28 |
| SEMINOLE* | 5 | 1 | 3 | 9 |
| ST. LUCIE | 2 | 36 | 7 | 45 |
| ST. JOHNS | 3 | 10 | 4 | 17 |
| SUMTER* | | 3 | | 3 |
| SUWANNEE* | 7 | 23 | | 30 |
| VOLUSIA* | 9 | 14 | 1 | 24 |
| WAKULLA | 11 | 1 | | 12 |
| WALTON* | 11 | 10 | 3 | 24 |
| WASHINGTON | 1 | | | 1 |
| **Grand Total** | **1,106** | **801** | **133** | **2,040** |

*Counties included outside of the NEMT service area are counties where a member is being picked up from a residence within the service area but traveling to a treating facility outside the service area.

## 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 NEMT plans must ensure NEMT 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 NEMT 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.

Both NEMT vendors provide monthly reporting to the Agency on utilization of eligible recipients. The State has frequent conversations with the vendors regarding utilization and capacity to ensure recipients get to their medical appointments. Both vendors submit annually a network development plan where they provide their strategy to keep their provider networks with sufficient providers. Both vendors actively review their current networks to ensure accurate coverage and capacity. The State reviews complaints and has follow-up with the vendors to address any gaps that appear to be caused by lack of providers. When necessary, both vendors have worked together to supply transportation to recipients outside of their regions until the assigned Vendor has a provider in place. The State monitors timely access monthly via a detailed report that provides transparency to Leg A, Leg B, unscheduled trips, late trips, missed trips, and total trips. For the NEMT review, missed trips from the vendor are discussed and documented. If the vendor does not meet the timeliness metric in NEMT, the vendor is placed on corrective action.

The NEMT plans must maintain contracts with a sufficient number of providers to ensure that NEMT services are provided promptly and are reasonably accessible. The plans are responsible for providing the most medically appropriate mode of transportation for the recipient's needs. If a plan is unable to provide services to a recipient through its existing network of providers, the NEMT plan must cover these services in an adequate and timely manner by using providers that are outside of the NEMT plans' network.

The NEMT 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 NEMT plans. Recipients are provided contact information for the NEMT plans' call center in the recipient handbook. The recipient can also contact the Agency's central complaint hub.

The NEMT 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:

Florida law permits use of the Health Services Exemption when a formal competitive procurement is not practical and/or in the best interest of the Agency. The Agency maintains documentation of its written justification, which is approved by the Office of General Counsel.The NEMT Waiver does not utilize State-Directed Payments (SDP).

The NEMT plans report monthly on their compliance with the contractual performance standards. Monthly reports are reviewed by the Agency contract monitor for compliance. If the Agency identifies a trend in vendor non-compliance, the Agency may implement corrective action plans, liquidated damages, and or sanctions as permitted by the contract.

The Agency assessed whether the potential contractors met all of the following criteria:

1. Experience in and or knowledge of the provision of providing NEMT to eligible recipients.
2. Adequate staffing requirements.
3. Adequate program coverage capacity for regions or statewide.
4. Able to determine recipient's eligibility for NEMT 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 NEMT 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 NEMT to members based on a per-member, per-month basis.

The NEMT 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 NEMT 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. If a recipient calls the vendor and does not speak English, translation services are available if needed or requested for any language. This information is provided to the recipients in the recipient handbook.

The NEMT plans must notify recipients of the availability of oral interpretation services and how to access them. The NEMT 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 NEMT 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. The Agency website provides information on NEMT services, contact information for both vendors, and information on how to file complaints with the Medicaid program. The Agency NEMT contract manager works with the Medicaid Complaint Operations Center/Medicaid Helpline to address complaints and identify complaints that require recipient education. The State also works with both vendors to ensure that they provide education to the recipient regarding NEMT services. Both vendors have dedicated staff to address the

needs of special population recipients who have extensive medical needs and require additional support. These recipients communicate frequently with the NEMT plan, the Agency NEMT contract manager, and the Medicaid Complaint Operations Center/Medicaid Helpline. The Agency has operational calls with the vendors at least monthly to ensure recipient transportation needs are being met. The vendors also have recipient education materials on their website such as the recipient handbook.

**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 NEMT services in their region. The NEMT 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 NEMT 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 NEMT 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)

- The vendor shall resolve complaints by close of business on the business day following receipt.
- If a complaint is not resolved within one (1) business day following receipt, the vendor shall enter the complaint as a grievance.
- A grievance may be filed orally or in writing within one (1) year of the occurrence.

_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)

- An appeal may be filed orally or in writing within thirty (30) days of the recipient's receipt of the notice of action and, except when expedited resolution is required.
- The Vendor shall review grievances and provide written notice of results to the recipient no later than thirty (30) days from the original date the Vendor received the grievance, whether it was received orally or in writing.

_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 | | | 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 | | | | | | | | | | | X | X |
| Other: | N/A | N/A | N/A | 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 NEMT plans must submit monthly summary reports, which cover all complaints, grievances and appeals data related to NEMT to the Agency for review. Grievances and appeals data is also reviewed, as applicable, for each vendor. Daily calls, scheduled calls, and ad hoc calls take place with each vendor to ensure compliance and complaint resolution.

Recipients can file complaints directly with the vendor or with the Medicaid Complaint Operations Center/Medicaid Helpline. Reports filed with the vendor are reviewed

monthly with the deliverables submissions. Reports filed with the State are forwarded by the Medicaid Complaint Operations Center/Medicaid Helpline to the Agency contract manager who reviews them, reaches out to the recipient to ensure a clear understanding of the issue, and then sends them to the vendor complaint department for investigation and resolution. The resolved complaint is sent back to the Agency contract manager who reviews to ensure all areas of the complaint have been addressed. Resolved complaints are then forwarded to the Agency Medicaid Complaint Operations Center/Medicaid Helpline. Complaints are also discussed on operational or ad hoc calls if needed to address concerns. Complaints received directly by the vendor are reviewed when submitted and the Agency provides feedback if needed as to the vendor's complaint resolution. The Agency has designated staff who receive transportation related complaints. Grievances and Appeals are reviewed to ensure that any complaints not resolved timely are accurately reflected on the report.

e. _X_ Enrollee Hotlines operated by State

Anyone can submit a complaint to the Medicaid Complaint Operations Center/Medicaid Helpline. When a recipient files a complaint, they receive a tracking number. A recipient can use this tracking number to check the status of their complaint online. If a recipient needs help submitting a complaint , they can call the Medicaid Helpline. Staff are available to assist Monday through Friday 8:00am to 5:00pm.

The NEMT 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 NEMT plans may use an automated telephone triage system. The toll-free help line shall respond to all areas of recipient and provider inquiries. The Agency monitors the vendor's recipient hotline and has metrics reviewed monthly to ensure compliance. When any of the associated performance standards below have not been met, the Agency has addressed with the vendor. These standards are reported to the Agency monthly.

- The average speed of answer (ASA) shall not exceed forty-five (45) seconds
- The call blockage rate for direct 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%).

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.

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

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

- The NEMT 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 NEMT plans must provide an updated Network Adequacy Plan to the Agency by September 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
Timeliness Metrics (regular medical trips, missed trips and urgent care trips)
Customer Call Center (enrollee hot-line) Metrics detailed in (e) above
Utilization

- At least ninety percent (90%) of recipients will arrive at their appointment at or before their scheduled appointment time.
- At least ninety percent (90%) of the total scheduled Leg B trip requests were fulfilled within thirty (30) minutes of the scheduled time for pick-up.
- At least eighty-five percent (85%) of unscheduled trips are fulfilled within three (3) hours of the request.
- No more than two-tenths percent (0.2%) of transportation requests will result in a missed trip.
- The average speed of call answer shall not exceed forty-five (45) seconds.
- The call blockage rate for direct calls to the NEMT plan shall not exceed one percent (1%).
- The average call abandonment rate for direct calls to the NEMT 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)

**Program Integrity (Fraud and Abuse) -** Both NEMT plans report to the State on Fraud and Abuse. Both plans complete pre- and post-verifications of trip to ensure the trips are for medical purposes. The plans also conduct regular audits and trending to identify areas of potential concerns. The vendor staff receive continuos training in this area. The vendors report any fraud and suspicion of fraud to the Agency.

**Quality of Care -** Both NEMT plans have Quality of Care departments. Both vendors ensure the quality control of vehicle compliance through a model of transportation managers and vendor account managers. This team also does on site inspections and town hall formats for provider quality. Quality of Care complaints are reviewed and addressed with the vendor to ensure issues are addressed. Both vendors have outreach

departments for recipients with special needs.
**Marketing** – The State does not permit marketing under the contract with the NEMT plans. The NEMT plans receive monthly eligibility information which outlines those recipients eligible to receive NEMT.
**Enrollment/Disenrollment** - Recipients are automatically assigned to a NEMT 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 NEMT waiver.
**Coordination/Continuity** - Recipients do not receive treatment from the NEMT plans. The NEMT plans must ensure NEMT services are provided to all assigned eligible recipients.
**Coverage/Authorization** - NEMT services are scheduled in advance and are not prior authorized.
**Desk Reviews** - The Agency performs monthly desk reviews to ensure the NEMT 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 NEMT plans are required to submit monthly summary reports, which cover all complaints, grievances and appeals data related to NEMT 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 submitted monthly deliverables to the agency 100% timely and complete in 2018, 2019, 2020, 2021, 2022, 2023, and 2024. To date, the vendor has continued submitting timely deliverables for 2025.

   The NEMT 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 NEMT plan or to the Agency's Medicaid Complaint Operations Center. The Agency monitors all complaint sources, and the Agency addresses unresolved complaints on NEMT 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 October of 2020, the Agency advised the NEMT plans that they would be responsible for providing a grievances and appeals report to the Agency monthly. The Agency provided the reporting template with instructions to the vendors and spent considerable time reviewing reporting categories and expectations. The Agency met with the grievance and appeals coordinators for both plans. The report was implemented during the first quarter of 2021. The Agency has continued monitoring grievances and appeals during 2022, 2023 and 2024. The

Agency has continued these efforts in 2025. The Agency receives the grievances and appeals reports monthly and reviews for adherence with CMS federal guidelines and Agency standards. The Agency continues to monitor all complaints aggressively and plays a major role in ensuring that complaints reported to the State follow strict guidelines for resolution. The Agency also monitors complaints received by both transportation vendors to ensure compliance and expedient resolution.

Problems identified: No
**Corrective action (plan/provider level):** Program change (system-wide level): None

2. Strategy: Enrollee Hotline

**Description**: The NEMT 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 NEMT 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 NEMT 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: Network Adequacy

**Description**: The NEMT 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 NEMT plans must submit a Provider Termination and New Provider Notification Report by the fifteenth ($15^{th}$) calendar day of the month following the reporting month.

Additionally, the NEMT 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. Yearly, both NEMT plans provide an updated Network Development Plan to the Agency for review. This year, both NEMT plans completed a walk-through presentation to explain how they determine network adequacy for each of their assigned regions. The Agency has reviewed the Network Adequacy Plan yearly for 2021, 2022, 2023 and 2024. The next Network Adequacy Plan is due September 1, 2025.
**Confirmation it was conducted as described:**
**___X__** Yes
_____. Please explain:
**Summary of results:** The Agency has met this requirement and has complied with the number of assessments needed. This strategy is non-applicable
**Problems identified:**
**Corrective action (plan/provider level):** None.
**Program change (system-wide level):** None

4. Strategy: On-site Review

**Description**: The Agency performs annual onsite contract monitoring reviews to ensure the NEMT 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 beginning in 2021. The Agency plans to continue remote monitoring efforts in 2025. This remote monitoring evaluated complaints, claim submissions, encounter data accuracy, and provider network.

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

Complaints are received directly by the Agency or the NEMT 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 NEMT 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 #5
**Remediated:** Yes
**Program change (system-wide level):** None

5. 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 ninety percent (90%) of recipients will arrive within 15 minutes of the Scheduled Leg A appointment time.
- At least 90% of recipients will arrive at their appointment at or before their scheduled appointment time.
- At least ninety percent (90%) of the total scheduled Leg B trip requests were fulfilled within thirty (30) minutes of the scheduled time for pick-up.
- At least eighty-five percent (85%) of unscheduled trips are fulfilled within three (3) hours of the request.
- No more than two-tenths percent (0.2%) of transportation requests will result in a missed trip.
- The average speed of calls answered shall not exceed 45 seconds.
- The call blockage rate for direct calls to the NEMT plan shall not exceed 1%.
- The average call abandonment rate for direct calls to the NEMT 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:**

New contracts went into effect in August 2019 and are effective through July 31, 2025. The contracts contain the following performance standards:

- At least ninety percent (90%) of recipients will arrive within 15 minutes of the Scheduled Leg A appointment time.
- At least ninety percent (90%) of recipients will arrive at their appointment at or before their scheduled appointment time.
- At least ninety percent (90%) of the total scheduled Leg B trip requests were fulfilled within thirty (30) minutes of the scheduled time for pick-up.
- At least eighty-five percent (85%) of unscheduled trips are fulfilled within three (3) hours of the request.
- No more than two-tenths percent (0.2%) of transportation requests will result in a missed trip.
- The average speed of calls answered by vendors shall not exceed forty-five (45) seconds;
- The call blockage rate for direct calls to the NEMT plans shall be less than one percent (1%);
- The average call abandonment rate for direct calls to the NEMT 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.

NEMT plans did not successfully meet these standards during the 2022, 2023, and 2024 contract years. While the vendor met the quarterly metric, there were specific months where they were below the performance metric for timeliness in certain regions of the state.

| Quarterly Call-Center Metrics: Statewide Average Speed of Answer under 45 Seconds (in seconds) | | |
|---|---|---|
| | MTM | Modivcare |
| 10/2022 – 12/2022 | 6.62 | 0.07 |
| 01/2023 – 03/2023 | 7.98 | 0.11 |
| 04/2023 – 06/2023 | 7.68 | 0.12 |
| 07/2023 – 09/2023 | 8.95 | 0.37 |
| 10/2023 – 12/2023 | 14.41 | 0.36 |
| 01/2024 – 03/2024 | 5.73 | 0.11 |
| 04/2024 – 06/2024 | 12.26 | 0.13 |
| 07/2024 – 09/2024 | 20.95 | 0.33 |
| 10/2024 – 12/2024 | 23.02 | 0.12 |

| Quarterly Call-Center Metrics: Statewide Average 1% > Blocked Calls (in percent) | | |
|---|---|---|
| | MTM | Modivcare |
| 10/2022 – 12/2022 | 0% | 0% |
| 01/2023 – 03/2023 | 0% | 0% |
| 04/2023 – 06/2023 | 0% | 0% |
| 07/2023 – 09/2023 | 0% | 0% |
| 10/2023 – 12/2023 | 0% | 0% |
| 01/2024 – 03/2024 | 0% | 0% |
| 04/2024 – 06/2024 | 0% | 0% |
| 07/2024 – 09/2024 | 0% | 0% |
| 10/2024 – 12/2024 | 0% | 0% |

| Quarterly Timeliness Goal: 90% of recipients will arrive at their appointment within fifteen (15) minutes of the scheduled Leg A appointment time | | |
|---|---|---|
| | MTM | Modivcare |
| 10/2022 – 12/2022 | 97.43% | 93.7% |
| 01/2023 – 03/2023 | 96.9% | 91.3% |
| 04/2023 – 06/2023 | 96.43% | 95.4% |
| 07/2023 – 09/2023 | 95.66% | 95.9% |
| 10/2023 – 12/2023 | 96.16% | 94.6% |
| 01/2024 – 03/2024 | 94.13% | 91.3% |
| 04/2024 – 06/2024 | 94.36% | 95.2% |
| 07/2024 – 09/2024 | 93.1% | 84.1% |
| 10/2024 – 12/2024 | 96.1% | 89.6% |

| Quarterly Timeliness Goal: 90% of recipients will arrive at or before their scheduled appointment time | | |
|---|---|---|
| | MTM | Modivcare |
| 10/2023 – 12/2023 | 94.65% | 94.32% |
| 01/2023 – 03/2024 | 94.8% | 93.03% |
| 04/2024 – 06/2024 | 94.73% | 94.56% |
| 07/2024 – 09/2024 | 94.36% | 86.5% |
| 10/2024 – 12/2024 | 96.9% | 90.9% |

| Quarterly Timeliness Goal: 90% of total scheduled Leg B trip requests were fulfilled within thirty (30) minutes of the scheduled time for pick-up. | | |
|---|---|---|
| | MTM | Modivcare |
| 10/2023 – 12/2023 | 97.87% | 95.65% |
| 01/2024 – 03/2024 | 98.23% | 94.16% |
| 04/2024 – 06/2024 | 98.9% | 94.86% |
| 07/2024 – 09/2024 | 99% | 91.9% |
| 10/2024 – 12/2024 | 99.3% | 96% |

| Quarterly Timeliness Goal: 85% of unscheduled trips are fulfilled within three (3) hours of the request. | | |
|---|---|---|
| | MTM | Modivcare |
| 10/2023 – 12/2023 | 99.6% | 100% |
| 01/2024 – 03/2024 | 99.3% | 88.9% |
| 04/2024 – 06/2024 | 99.6% | 100% |
| 07/2024 – 09/2024 | 98.1% | 100% |
| 10/2024 – 12/2024 | 99.5% | 99.7% |

| Quarterly Timeliness Goal: No more than two-tenths percent (0.2%) of transportation requests will result in a missed trip. | | |
|---|---|---|
| | MTM | Modivcare |
| 10/2023 – 12/2023 | 0.18% | 0.05% |
| 01/2024 – 03/2024 | 0.17% | 0.025% |
| 04/2024 – 06/2024 | 0.16% | 0.00% |
| 07/2024 – 09/2024 | 0.11% | 0.00% |
| 10/2024 – 12/2024 | 0.05% | 0.00% |

| Quarterly Call-Center Metrics: Statewide Average Call Abandonment Rate < 5% (in percent) | | |
|---|---|---|
| | MTM | Modivcare |
| 10/2022 – 12/2022 | 0.00% | 0.00% |
| 01/2023 – 03/2023 | 0.32% | 0.00% |
| 04/2023 – 06/2023 | 0.37% | 0.00% |
| 07/2023 – 09/2023 | 0.44% | 0.18% |
| 10/2023 – 12/2023 | 1.11% | 0.01% |
| 01/2024 – 03/2024 | 0.30% | 0.00% |
| 04/2024 – 06/2024 | 1.03% | 0.01% |
| 07/2024 – 09/2024 | 1.82% | 0.22% |
| 10/2024 – 12/2024 | 2.20% | 0.12% |

**Problems identified:** Modivcare did not meet overall timeliness standards during the first and second quarters of 2022 and the first two quarters of 2023 for overall timeliness including Prescribed Pediatric Extended Care (PPEC). They had previously been on a corrective action plan and came into compliance. The Agency placed them on a Quality Improvement Plan in May of 2023. Modivcare complied with the Quality Improvement Plan. However, Modivcare did not meet overall timeliness during the first quarter of 2024 for the 85% metric of unscheduled trips being fulfilled within 3 hours of the request for February 2024. Their score of 66.7% brought down their quarterly results to 88.9%. Modivcare did not meet timeliness for the 90% metric of recipient trips being fulfilled within 15 minutes of the scheduled Leg A appointment time and the 90% metric of recipients arriving to their appointment at or before their scheduled appointment time. Both metrics were not met for August, September and October, the last two quarters of 2024. The vendor was placed on a corrective action plan in December of 2024. Modivcare is presently in compliance with the timeliness metric. The corrective action plan is in place until July 31, 2025. Modivcare stated that some providers recently transitioned digital platforms and that their drivers were in the process of re-training to ensure digital execution actions were being completed accurately. Most of the trips that arrived past their scheduled appointment time were associated with PPEC Services. Modivcare experienced issues with how most PPECs set the “appointment time” as the time the transportation escort is to go out to pick up the member – not the time the member is scheduled to arrive at the PPEC facility. These trips are set as recurring - at the same time, for each day. PPECs operate on a “reservation”-basis meaning recipients do not have defined times by when they must arrive, unlike medical, behavioral, or dental appointments. This causes the timeliness reporting point to reflect the timeliness of the recipient's arrival inaccurately. Recipients may have a variety of variables affecting times, such as medical appointments or school, and PPEC facilities do not update the schedules to reflect the daily fluctuations or new appointment times due to technology challenges, staffing, and other required needs. Also, Modivcare reported that they use claims data to compile their timeliness report. Modivcare reported that recipients are still arriving at PPEC facilities to receive full PPEC services. The Agency has not received any complaints regarding PPEC recipients arriving late.
**Corrective action (plan/provider level):** As part of the corrective action plan, Modivcare was required to do extensive outreach to the PPEC facilities and report to the Agency on their efforts weekly. Both NEMT Plans are presently in compliance with timeliness.
Remediated: Yes

**Program change (system-wide level):**

## *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:
Brian Meyer
Telephone Number: 850-412-4115
E-mail: Brian.Meyer@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 (CY2024) population. Since R1 (CY2023) and R2 (CY2024) cover the end of the Federal Public Health Emergency (PHE) and unwinding periods, trends in member months are not representative of post-PHE normal. The state is projecting 2% growth in member month utilization for P1 and P2.

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

Variance in eligible member months during the R1 and R2 periods are due to the PHE unwinding, as well as indirect service impacts as a result of several natural disasters that have impacted the state in the last year.

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

Calendar year, which aligns with the capitation rate year.

### 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*<br><br>*$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*<br><br>*$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**

| C1915(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*<br><br>*$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*<br><br>*$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 rate setting 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 NEMT vendors via monthly Per Member Per Month (PMPM) capitation payments set by the Agency's contracted actuarial vendor, Milliman Inc.. The actual costs used to determine cost effectiveness cover the time period of January 2023 through December 2024. The State is utilizing these costs 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 | | | |
|---|---|---|---|
| MEGS | CY2023 | CY2024 | CY2025 |
| PPEC | $ 1,214.49 | $ 1,298.59 | $ 1,464.90 |
| non-PPEC | $ 2.38 | $ 3.63 | $ 3.95 |

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: Calendar Year 2023 (1/1/2023-12/31/2023) and Calendar Year 2024 (1/1/2024 – 12/31/2024).

      The NEMT program's rate year runs on a calendar year cycle.

      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: 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):

MEG1 (PPEC) and MEG2 (non-PPEC) PMPM capitation rates have seen significant changes - increases and decreases - from CY2023 to CY2024 and again from CY2024 to CY2025 as a result of PHE unwinding. The most significant change for the non-PPEC MEG occurred during the CY2023 to CY2024 period, while the most significant change for the PPEC MEG occurred during the CY2024 to CY2025 period. The average annual rate of increase from CY2023 to CY2025 for the non-PPEC MEG is approximately 30.67%, while the average annual rate of increase from CY2023 to CY2025 for the PPEC MEG is approximately 9.87%. Given the persistence of higher inflation, the State is using these inflation rates for both P1 and P2.

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 NEMT vendors via monthly PMPM capitation payments set by the Agency's contracted actuarial vendor, Milliman Inc. The actual costs used to determine cost effectiveness cover the time period of January 2023 through December 2024. The State is utilizing these costs 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 | | | |
|---|---|---|---|
| MEGS | CY2023 | CY2024 | CY2025 |
| PPEC | $ 1,214.49 | $ 1,298.59 | $ 1,464.90 |
| non-PPEC | $ 2.38 | $ 3.63 | $ 3.95 |

### 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 calculated for P1-P2 commenced from R2 (CY2024) population. Overall program utilization is expected to grow at approximately 2%.

### 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**:

   Projected member months calculated for P1-P2 commenced from R2 (CY2024) population. Overall program utilization is expected to grow at approximately 2%. Caseload changes are the result of PHE unwinding and natural disasters across the state.

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 NEMT vendors via a capitated PMPM payment (see Milliman's letter). Utilization provided by Milliman in combination with adjustment to costs reflected in D.5 yields an annual rate of change for R1 to P2 of 20.17%.

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.**


| NEMT Waiver Attachments | |
|---|---|
| **Attachment I** | Tribal Letters |
| **Attachment II** | NEMT Waiver Excel Workbooks<br>*(Included as a separate document)* |

**Page Intentionally Left Blank**

# *Attachment I: Tribal Letters*

Notice to the Miccosukee Tribe of Florida was delivered via email on February 21, 2025, to Cassandra Osceola, Health Director for the tribe, and additional staff members by her request.

Comment period for the Florida Medicaid 1915(b) Non-Emergency Transportation (NET) Waiver renewal

PJ

Pate, Joseph

To CassandraO@miccosukeetribe.com; SorabB@miccosukeetribe.com; CarminaS@miccosukeetribe.com

Reply | Reply All | Forward

Fri 2/21/2025 3:03 PM

Phish Alert

+ Get more add-ins

Dear Ms. Osceola, Ms. Boga, and Ms. Santiago:

This correspondence is being sent to solicit comments from the Miccosukee Tribe of Florida on the upcoming renewal request for Florida's 1915(b) Non-Emergency Transportation (NET) Waiver. The NET Waiver provides non-emergency services to recipients who 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: FL 1915(b) Managed Care Waiver | Florida Agency for Health Care Administration. The State welcomes all comments or feedback and any suggested changes that we should consider in our renewal request to the Centers for Medicare & Medicaid Services (CMS). Please submit all comments or feedback within 30 days.

To make comments or to request additional information, please contact J. Frank Pate by phone at (850) 412-4140 or email at joseph.pate@ahca.myflorida.com. If we do not hear from you within 30 days of receiving this notice, we assume you have no comments.

Thank you,

**J. Frank Pate**
GOVERNMENT OPERATIONS CONSULTANT III

Bldg 3, Rm 2309 - BUREAU OF MEDICAID POLICY
2727 MAHAN DR, TALLAHASSEE FL 32308
850-412-4140 (Office)
Joseph.Pate@ahca.myflorida.com

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

Privacy Statement: This e-mail may include confidential and/or proprietary information, and may be used only by the person or entity to which it is addressed. If the reader of this e-mail is not the intended recipient or his or her authorized agent, the reader is hereby notified that any dissemination, distribution or copying of this e-mail is prohibited. If you have received this in error, please reply to the sender and delete it immediately.

Notice to the Seminole Tribe of Florida was delivered via email on February 21, 2025, to Dr. Vandhana Kiswani-Barley, Executive Director of Health and Human Services for the tribe.

Comment period for the Florida Medicaid 1915(b) Non-Emergency Transportation (NET) Waiver renewal

PJ

Pate, Joseph
To Vandhanakiswani@semtribe.com

Reply | Reply All | Forward

Fri 2/21/2025 3:09 PM

Phish Alert

+ Get more add-ins

Dear Dr. Kiswani-Barley:

This correspondence is being sent to solicit comments from the Seminole Tribe of Florida on the upcoming renewal request for Florida's 1915(b) Non-Emergency Transportation (NET) Waiver. The NET Waiver provides non-emergency services to recipients who 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: FL 1915(b) Managed Care Waiver | Florida Agency for Health Care Administration. The State welcomes all comments or feedback and any suggested changes that we should consider in our renewal request to the Centers for Medicare & Medicaid Services (CMS). Please submit all comments or feedback within 30 days.

To make comments or to request additional information, please contact J. Frank Pate by phone at (850) 412-4140 or email at joseph.pate@ahca.myflorida.com. If we do not hear from you within 30 days of receiving this notice, we assume you have no comments.

Thank you,

**J. Frank Pate**
GOVERNMENT OPERATIONS CONSULTANT III

Bldg 3, Rm 2309 - BUREAU OF MEDICAID POLICY
2727 MAHAN DR, TALLAHASSEE FL 32308
850-412-4140 (Office)
Joseph.Pate@ahca.myflorida.com

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

Privacy Statement: This e-mail may include confidential and/or proprietary information, and may be used only by the person or entity to which it is addressed. If the reader of this e-mail is not the intended recipient or his or her authorized agent, the reader is hereby notified that any dissemination, distribution or copying of this e-mail is prohibited. If you have received this in error, please reply to the sender and delete it immediately.

## *Attachment II: Excel Workbooks*

Submitted as separate documents.