



## PROCUREMENT JUSTIFICATION FORM (PJF)

This form must accompany all contract requests and sole source requisitions (RQS) over \$5,000 submitted to the Division of Procurement Services.

*INSTRUCTIONS: Please provide the requested information in the white spaces below. All responses (except signatures) must be typed; no hand-written forms will be accepted. See the guidance document posted with this form on the Division of Procurement Services intranet site (Forms page) for additional instructions.*

PART I: OVERVIEW			
Department Office/Division/Program:	DHHS/Office of MaineCare Services		
Department Contract Administrator or Grant Coordinator:	Stacy Martin Shawn Belanger		
(If applicable) Department Reference #:	OMS-22-1000		
Amount: (Contract/Amendment/Grant)	\$ 30,000.00	Advantage CT / RQS #:	CT 10A 2022031000000002047
<b>CONTRACT</b>	Proposed Start Date:	4/1/2022	Proposed End Date: 6/30/2023
<b>AMENDMENT</b>	Original Start Date:		Effective Date:
	Previous End Date:		New End Date:
<b>GRANT</b>	Project Start Date:		Grant Start Date:
	Project End Date:		Grant End Date:
Vendor/Provider/Grantee Name, City, State:		Marianne Ringel dba Ringel Health Policy Consulting Brooklyn, NY	
Brief Description of Goods/Services/Grant:		Waiver Consulting Services	

PART II: JUSTIFICATION FOR VENDOR SELECTION			
Check the box below for the justification(s) that applies to this request. (Check all that apply.)			
<input type="checkbox"/>	A. Competitive Process	<input type="checkbox"/>	G. Grant
<input type="checkbox"/>	B. Amendment	<input type="checkbox"/>	H. State Statute/Agency Directed
<input checked="" type="checkbox"/>	C. Single Source/Unique Vendor	<input type="checkbox"/>	I. Federal Agency Directed
<input type="checkbox"/>	D. Proprietary/Copyright/Patents	<input type="checkbox"/>	J. Willing and Qualified
<input type="checkbox"/>	E. Emergency	<input type="checkbox"/>	K. Client Choice
<input type="checkbox"/>	F. University Cooperative Project	<input type="checkbox"/>	L. Other Authorization

Please respond to ALL of the questions in the following sections.

**PART III: SUPPLEMENTAL INFORMATION**

1. Provide a more detailed description and explain the need for the goods, services or grant to supplement the response in Part I.

The Department technical assistance with the renewal of its 1915(b) Managed Care Waiver governing Non-Emergency Transportation (NET). CMS requires a waiver as a condition of providing financial participation.

The Provider will provide consulting services to the Department to support the development, posting, and submission to CMS of the non-financial portion of the Department's 1915(b) Managed Care Waiver renewal governing NET.

2. Provide a brief justification for the selected vendor to supplement the response in Part II. Reference the RFP number, if applicable.

The Provider has 20 years of Medicaid experience, a substantial portion of which includes her service as the Department's MaineCare Policy Director. She helped develop the initial 1915(b) NEMT waiver submission.

3. Explain how the negotiated costs or rates are fair and reasonable; or how the funding was allocated to grantee.

Rates are consistent with other Medicaid consultants contracted with the Department

4. Describe the plan for future competition for the goods or services.

The Department does not plan to continue these services beyond the term of this contract.

**PART IV: AMERICAN RESCUE PLAN ACT (ARPA) / MAINE JOBS & RECOVERY PLAN (MJRP)**

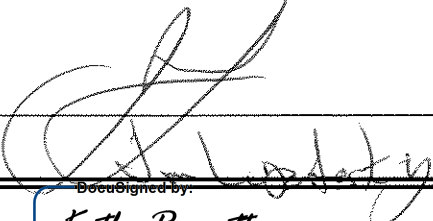

Does this request utilize ARPA/MJRP funds?

Yes – If Yes, please attach the approved Business Case(s).

No – If No, proceed to Part V.

**PART V: APPROVALS**

The signatures below indicate approval of this procurement request.

Signature of requesting Department's Commissioner (or designee):			
Typed Name:		Date:	23 Nov 22
Signature of DAFS Procurement Official:			
Typed Name:	Kathy Paquette	Date:	6/13/2022