



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.

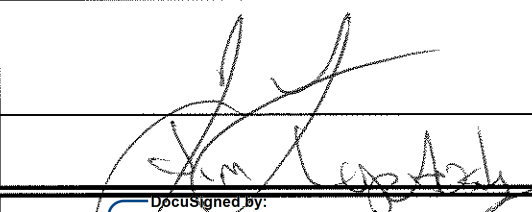
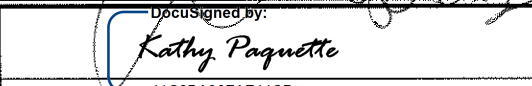
PART I: OVERVIEW				
Department Office/Division/Program:		DHSS/Office of MaineCare Services		
Department Contract Administrator or Grant Coordinator:		Chris Moiles/Matt Galletta		
(If applicable) Department Reference #:		OMS-22-601C		
Amount: (Contract/Amendment/Grant)		Current: \$172,000.00 Amend: \$25,000.00 Revised: \$197,000.00	Advantage CT / RQS #:	CT 10A 20210423000000002919
CONTRACT	Proposed Start Date:		Proposed End Date:	
AMENDMENT	Original Start Date:	7/1/2021	Effective Date:	5/1/2023
	Previous End Date:	12/31/2024	New End Date:	No change
GRANT	Project Start Date:		Grant Start Date:	
	Project End Date:		Grant End Date:	
Vendor/Provider/Grantee Name, City, State:		MaineGeneral Medical Ctr Augusta, ME		
Brief Description of Goods/Services/Grant:		MaineMom Care Delivery Partner		

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 checked="" type="checkbox"/>	G. Grant
<input checked="" type="checkbox"/>	B. Amendment	<input type="checkbox"/>	H. State Statute/Agency Directed
<input 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.	<p>The purpose of this Agreement is to establish a contract between the Department the Care Delivery Partner (CDP) to develop and implement the Maternal Opioid Misuse (MOM) model in Maine (called "MaineMOM") funded by the Centers for Medicare and Medicaid Innovation (CMMI) under Section 1115A of the Social Security Act (Maternal Opioid Misuse Model, <u>CFDA#93.687</u>).</p> <p>The Provider shall act as the CDP and support the design and implementation of the MaineMOM model which will improve the quality of care and services provided to pregnant and post-partum women with opioid use disorder (OUD) and their infants, resulting in improved maternal and infant outcomes.</p> <p>This amendment provides funding for Milestone Payments as specified by CMS under the MaineMOM grant. MaineMOM providers receive performance payments based on their collective success meeting the CMS data reporting milestone for Implementation Period 1, as part of the MOM model payment structure.</p>
2. Provide a brief justification for the selected vendor to supplement the response in Part II. Reference the RFP number, if applicable.	<p>This work is funded by a CMS grant, and the Provider is a sub-awardee in the grant application.</p>
3. Explain how the negotiated costs or rates are fair and reasonable; or how the funding was allocated to grantee.	<p>Milestone payments are based on an algorithm agreed upon with Care Delivery Partners; Milestone payments are awarded based on CMS established pay-for-reporting and pay-for-performance frameworks.</p>
4. Describe the plan for future competition for the goods or services.	<p>This work is supported by a Federal grant award and is not expected to continue beyond the grant period.</p>

PART IV: AMERICAN RESCUE PLAN ACT (ARPA) / MAINE JOBS & RECOVERY PLAN (MJRP)	
Does this request utilize ARPA/MJRP funds?	
<input type="checkbox"/> Yes – If Yes, please attach the approved Business Case(s).	
<input checked="" type="checkbox"/> 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):			Date:
Typed Name:			5-July-23
Signature of DAFS Procurement Official:			Date:
Typed Name:	Kathy Paquette	Date:	5/31/2023