

State of Maryland
Department of Health and Mental Hygiene
Office of Health Services
Long-Term Care and Community Support Services

Provider Solicitation

Request for Responses

Comprehensive Case Management and Supports
Planning Services for Medicaid Long-Term Services and
Supports

March 1, 2014 - December 31, 2015

Option #1: January 1, 2016 to December 31, 2016

Option #2: January 1, 2017 to December 31, 2017

Solicitation Summary

Description of Services

The Office of Health Services within the Department of Health and Mental Hygiene (“the Department”) is soliciting responses from qualified providers to provide supports planning and case management services to participants of the Medical Assistance Personal Care (MAPC) program, Community First Choice (CFC), Increased Community Services (ICS), and the Community Options (CO) waiver beginning March 1, 2014. Supports planning services include assisting applicants and participants with accessing Medicaid and non-Medicaid funded home and community-based services and supports. Case management services include assisting applicants and participants with waiver eligibility maintenance and determination. The Department has applied for waivers under § 1915(b)(4) of the Social Security Act in order to engage in selective contracting for the services described in this proposal.

The current rate for these services is \$14.64 per 15 minute unit, which equates to \$58.56 per hour.

Regions

There are four regions designated in this solicitation. Up to three providers will be selected per region; providers may submit a single proposal for multiple regions. Proposals will be evaluated for each region independently. The four regions are as follows.

1. Baltimore City
2. Baltimore County
3. Montgomery County
4. Prince George’s County

Provider Agreement Term

March 1, 2014 through December 31, 2015

Option #1: January 1, 2016 to December 31, 2016

Option #2: January 1, 2017 to December 31, 2017

Solicitation Point of Contact

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Deadline for receipt of provider proposals: January 13, 2014 at 2:00pm EST.

Pre-Proposal Conference

To be held at The Department of Health and Mental Hygiene 201 W. Preston Street, Baltimore, Maryland 21201 Room L-3 on December 18, 2013 at 10 am (EST).

Section 1. General Information

1.1 Relevant Acronyms, Terms, and Definitions

For purposes of this RFP, the following abbreviations or terms have the meanings indicated below:

- A. Aging and Disability Resource Center (ADRC) - The Aging and Disability Resource Center Program (ADRC) is a collaborative effort of the Administration on Aging and the Centers for Medicare & Medicaid Services. ADRCs serve as single points of entry into the long-term supports and services system for older adults and people with disabilities.
- B. Area Agency on Aging (AAA) –Area Agencies on Aging address the concerns of older Americans at the local level by identifying community and social service needs and assuring that social and nutritional supports are made available to older people in communities where they live.
- C. Centers for Medicare and Medicaid Services (CMS) - Federal agency which administers Medicare, Medicaid, and the Children's Health Insurance Program, including the Money Follows the Person demonstration grants.
- D. COMAR – Code of Maryland Regulations available on-line at www.dsd.state.md.us
- E. Community First Choice (CFC) – A program created by Section 2401 of the Patient Protection and Affordable Care Act that allows states the option to offer certain community-based services as a state plan benefit to individuals who meet an institutional level of care.
- F. Community Options Waiver (CO) – The new merged waiver program that combines the Living at Home and Waiver for Older Adults. This waiver will become effective January 6, 2014 and serve adults aged 18 years and older. It will provide assisted living, senior center plus, family training, behavioral consultation, and case management services.
- G. DHMH or the Department – Maryland Department of Health and Mental Hygiene, the State Medicaid Agency.
- H. Division of Eligibility Waiver Services (DEWS) –DEWS is responsible for determining waiver financial eligibility.
- I. Home and Community-based Services (HCBS) – HCBS are an array of supports provided to individuals living in the community to assist in activities of daily living.
- J. Increased Community Services (ICS) – A program included in the Department's 1115 waiver that allows individuals residing in institutions with incomes above 300 percent of Supplemental Security Income (SSI) to move into the community while also permitting them to keep income up to 300 percent of SSI. ICS is currently capped at 30 individuals and eligibility is limited to individuals who: reside in a nursing facility for at least 90 consecutive days; and are receiving Medicaid benefits for nursing facility services.
- K. The Living at Home (LAH) waiver – The LAH waiver program serves individuals between the ages of 18 and 64 who meet a nursing facility level of care and provides attendant care, case management, assistive technology, home-delivered meals, environmental accessibility adaptations, and nurse monitoring as part of its service package.
- L. Local Health Department (LHD) – LHDs administer and enforce State, county and municipal health laws, regulations, and programs in Maryland's twenty-three counties and Baltimore City and are overseen by the Public Health Services of the Department of Health and Mental Hygiene.
- M. Local Time – Time in the Eastern Time Zone as observed by the State of Maryland.

- N. Maryland Access Point (MAP) – Maryland’s Aging and Disability Resource Centers are called MAP sites, Maryland’s single-point of entry to community-based services.
- O. Maryland Department of Aging (MDoA) – Maryland’s State Unit on Aging designated to manage, design and advocate for benefits, programs and services for the elderly and their families; administers the Older Americans Act and the Aging and Disability Resource Center initiative in partnership with the local Area Agencies on Aging.
- P. Maryland Department of Disabilities (MDOD) – Authorized by Senate Bill 188 in 2004, the Maryland Department of Disabilities is charged with unifying and improving the delivery of services to people with disabilities by working collaboratively with all state government agencies; and develops and facilitates the implementation of the State Disabilities Plan, calling for collaborative partnerships with state agencies to improve services for people with disabilities.
- Q. Medicaid /Medical Assistance - A program, funded by the federal and state governments, which pays for medical care for low-income individuals or families, as well as elderly or disabled individuals. To receive Medicaid, an individual must meet certain financial requirements and also must go through an application process.
- R. Medicaid State Plan - A written plan between a State and the Federal Government that outlines Medicaid eligibility standards, provider requirements, payment methods, and health benefit packages. A Medicaid State Plan is submitted by each State and approved by the Centers for Medicare and Medicaid Services.
- S. Medical Assistance Personal Care (MAPC) Program - Provides assistance with activities of daily living to Medicaid recipients who have a chronic illness, medical condition or disability. Services are provided in the eligible individual's home or community residence by self-employed or agency employed providers, who are approved and monitored by a nurse case monitor from a local health department.
- T. Money Follows the Individual - The State’s Money Follows the Individual policy allows individuals, who reside in institutions and whose services are being funded by Medicaid, to apply for the waiver program regardless of budgetary caps.
- U. Money Follows the Person (MFP) –Demonstration authorized by the Deficit Reduction Act of 2005 and extended through the Patient Protection and Affordable Care Act of 2010 offered through the Centers for Medicare and Medicaid Services as an opportunity for states to rebalance long-term care systems.
- V. Normal State Business Hours - Normal State business hours are 8:00 a.m. – 5:00 p.m. Monday through Friday except State Holidays, which can be found at: www.dbm.maryland.gov - keyword State Holidays.
- W. Waiver for Older Adults (WOA) - Statewide program for adults 50 and older who meet nursing facility level of care, but wish to receive their long term services and supports in their own home or assisted living, rather than a nursing facility. Services include: personal care, respite care, assisted living services, senior center plus, family/consumer training, personal emergency response systems, dietitian/nutritionist services, assistive devices, behavior consultation services, home delivered meals, case management, medical day care, and transition services.

1.2 Background

Philosophy

Medicaid's HCBS programs are based on a philosophy of self-direction, where program participants are empowered to make choices that work best for them regardless of the nature or extent of their disability. Self-directed Medicaid services means that participants, or their representatives if applicable, have decision-making authority over certain services and take direct responsibility to manage their services with the assistance of a system of available supports. The self-directed service delivery model is an alternative to traditionally delivered and managed services, such as an agency delivery model. Self-direction of services allows participants to have the responsibility for managing all aspects of service delivery in a person-centered planning process.

Self-direction promotes personal choice and control over the delivery of waiver and state plan services, including who provides the services and how services are provided. For example, participants are afforded the decision-making authority to recruit, hire, train and supervise the individuals who furnish their services.

A supports planning provider assists participants and applicants in understanding their self-direction options, maximizing the participant's choice and control, creating a person-centered plan of service (POS), goal setting, and coordinating services based on their individual needs and choices.

Waiver for Older Adults

Under the authority of the Centers for Medicare and Medicaid Services (CMS), The Department of Health and Mental Hygiene, Office of Health Services (OHS), Waiver for Older Adults (WOA) provides home and community-based services to adults with long term support needs as an alternative to residing in a nursing facility. WOA serves individuals who are medically, technically and financially eligible for Medicaid waiver services who have been transitioned or diverted from a nursing facility under the Code of Maryland Regulations (COMAR) 10.09.54 located at <http://www.dsd.state.md.us/comar/>. Eligible individuals are age 50 or over, require a nursing facility level of care, choose to receive services in the community versus a nursing facility, and have a cost neutral plan of services that supports the individual safely in the community.

Living at Home Waiver

Under the authority of the Centers for Medicare and Medicaid Services (CMS), The Department of Health and Mental Hygiene (the Department), Office of Health Services (OHS), Living at Home Waiver Division (LAHWD) provides home and community-based services (HCBS) to adults with physical disabilities as an alternative to residing in a nursing facility. LAHWD serves individuals who are medically, technically and financially eligible for Medicaid waiver services and who have been transitioned or diverted from a nursing facility under the Code of Maryland Regulations (COMAR) 10.09.55 available at <http://www.dsd.state.md.us/comar/>. Individuals enroll between the ages of 18 and 64, require a nursing facility level of care, choose to receive services in the community versus a nursing facility, and have a cost neutral plan of services that supports the individual in the community.

Community Options Waiver

Effective January 6, 2014, the Waiver for Older Adults and the Living at Home Waiver will be merged in to one waiver program. Community Options will serve individuals who are medically, technically and financially eligible for Medicaid waiver services who have been transitioned or diverted from a nursing facility under the Code of Maryland Regulations (COMAR) 10.09.54. Eligible individuals must be age 18 or over, require a nursing facility level of care, choose to receive services in the community versus a

nursing facility, and have a cost neutral plan of services that supports the individual safely in the community. This waiver will offer assisted living, senior center plus, family training, behavioral consultation, and case management services.

Increased Community Services

DHMH has been operating the Increased Community Services (ICS) Program since 2009. The ICS program allows individuals residing in institutions with incomes above 300 percent of Supplemental Security Income (SSI) to move into the community while also permitting them to keep income up to 300 percent of SSI. The ICS program is an expansion population and is currently capped at 30 individuals. Eligibility criteria are currently being updated for consistency with the federal rules under the Money Follows the Person Demonstration. Specifically, eligibility will be available to an individual who: resides (and has resided for a period of not less than 90 consecutive days) in a nursing facility. Any days that an individual resides in an institution on the basis of having been admitted solely for purposes of receiving short-term rehabilitative services for a period for which payment for such services is limited under title XVIII shall not be taken into account for purposes of determining the 90-day nursing home stay requirement; and is receiving Medicaid benefits for nursing facility services furnished by such nursing facility. The ICS program currently offers all of the services available under the Living at Home and Waiver for Older Adults programs and will mirror the Community Options once effective.

Medical Assistance Personal Care Program

The Medicaid Personal Care Program (MAPC) is offered under the Medicaid State Plan authority and provides personal care services, including assistance with activities of daily living, to Medicaid recipients who have a chronic illness, medical condition or disability. Services are provided in the individual's home or community residence by self-employed or agency employed providers. MAPC is governed by COMAR 10.09.20 which can be found at <http://www.dsd.state.md.us/comar/>. MAPC differs from the waiver programs described above in that it does not offer additional services beyond personal care, does not require that a recipient meet nursing facility level of care to participate, does not have age limitations on the service, and does not have a cost neutrality limitation.

Community First Choice

Section 2401 of the Patient Protection and Affordable Care Act (PPACA), created a program called Community First Choice (CFC), which provides states the option to offer certain community-based services as a state plan benefit to individuals who meet an institutional level of care. Maryland currently plans to pursue this option and consolidate personal care services across three existing programs; the State Plan Medical Assistance Personal Care program, Living at Home Waiver, and Waiver for Older Adults under one State Plan program that offers both self-direction and agency model services. It is anticipated that the CFC program will be available to participants on January 6, 2014.

The Department proposes to offer all required and optional services allowed under CFC. Specifically, CFC would offer:

- Personal Assistance;
- Personal Emergency Response Systems (PERS);
- Voluntary training for participants;
- Transition Services; and
- Services that increase independence or substitute for human assistance.

Services offered under CFC would no longer be covered as waiver services because they will be covered as a State Plan service for waiver and non-waiver participants. It is anticipated that all waiver

participants and approximately 70% of the current participants in the MAPC program will become eligible for and begin being served through CFC in 2014.

Waiver Budget Limitations

The Waiver programs have a certain number of slots available to serve individuals in the community and reached their caps in 2003. At that time, a waiver registry was created to collect information on individuals interested in applying for waiver services. As funding becomes available due to attrition or special funding designations, individuals from the registry are invited to apply for services. It is anticipated that approximately 600 individuals will apply from the registry each year for the duration of this agreement. The State's Money Follows the Individual policy allows individuals, who reside in nursing facilities and whose services are being funded by Medicaid, to apply for the waiver program regardless of caps. Approximately 850 nursing facility residents apply for waiver services each year, and approximately one-third (30%) of the applicants successfully transition and become waiver participants within the year. Please see Appendix 1 for a detailed breakdown of the number of applicants and participants per program and region.

Increased Community Services is limited to 30 participants, but has not yet reached its enrollment limit.

Community First Choice and the MAPC program do not have caps or registries.

Money Follows the Person

Maryland's Money Follows the Person (MFP) demonstration is a grant designed to rebalance long-term care support systems to increase home and community-based services as an alternative to institutional care. Maryland's MFP program focuses on streamlining and supporting transitions from institutions to the community by increasing outreach and education to institutional residents and decreasing barriers to transition. Efforts under MFP include peer outreach, flexible transition funds, and housing assistance. These rebalancing initiatives are detailed in Maryland's Money Follows the Person Operational Protocol, a document developed in cooperation with stakeholders and required by CMS. The Operational Protocol is available online at <http://mmcp.dhmh.maryland.gov/longtermcare/SitePages/Home.aspx> or by request via email to LTCReform@maryland.gov.

To be eligible for the MFP demonstration, individuals must have resided in an institution for at least 90 continuous days, have Medicaid paying for their institutional stay at least one day prior to their transition, and move to a qualified residence in the community. Qualified residences exclude assisted living facilities licensed to serve more than 4 individuals. Many waiver and CFC applicants will also be eligible to participate in the MFP demonstration.

Information Technology

The Department maintains a web-based tracking system for many long-term supports and services. This system tracks all MAPC, CFC, and waiver activities and is called the LTSSMaryland tracking system. Supports planning providers will be required to use this system to document activities, complete forms and reportable events, and enter other data used for reporting. The In-Home Supports Assurance System (ISAS) is a call-in system that will be used by personal assistance providers to confirm their presence in the participant's home. Providers must call-in to the system to create an electronic time sheet used for billing. The call can be initiated from the participant's land line phone or any cell phone. The landline phone number will be associated with the participant to verify that the provider is in the participant's home. A One-Time Password (OTP) device will be assigned to participants without a land line phone. This keychain-sized device has an electronic password that changes every minute. The

provider must enter the password from this device when calling in to the ISAS and providing services to verify the presence of the participant. Supports planners will be responsible for training and providing information to participants on the use of the ISAS, assigning and delivering OTP devices to participants, and reviewing monthly ISAS claims with the participant to verify accurate billing and ensure service delivery.

Freedom of Choice of Providers

Applicants and Participants of the MAPC, CFC, and waiver programs will have free choice of eligible supports planning providers. The Department anticipates that up to three providers will be available per region as identified through this solicitation. The Department has decided to limit the available providers through this application process and its § 1915(b)(4) waiver applications in order to ensure that providers meet enhanced quality standards and are subject to additional oversight by the Department. The local Area Agencies on Aging are designated case management providers and will be eligible supports planning providers as well. Eligible providers of MAPC and CFC supports planning services will be limited to providers who are also enrolled to provide waiver case management services.

Upon application for services, the Department will provide a packet of materials that includes brochures from each eligible provider to all applicants. All existing participants in MAPC will have freedom of choice of providers among those selected through this solicitation as of January 6, 2014. Participants in the waiver programs will receive the informational packet prior to implementation of the CFC program and will gain freedom of choice of providers on January 6, 2014. The applicant may choose a provider by contacting the Department, the local health department, or the chosen provider directly. This choice will be noted in the LTSSMaryland tracking system and the chosen provider shall secure a signature from the applicant confirming the choice within 14 calendar days.

Applicants and participants may choose to change their provider as needed, but not more than every 45 calendar days. Once an applicant or participant chooses a new provider, the current provider will have 14 calendar days to complete their work with the participant. The new provider will receive 14 calendar days' notice and become responsible for the provision of services on day 15. An applicant or participant may only request a change of providers after 45 calendar days with their current provider to ensure adequate transition time and continuity of services.

Applicants and participants who do not choose a case management provider within 14 days of receipt of the provider information packet will be auto assigned to a provider via the LTSSMaryland tracking system to assure equal distribution of auto assignments among eligible providers. The applicant or participant will be able to change the auto-assigned provider at any time. However, once a provider is chosen by the participant, the 45 day limitation prior to changing providers will apply.

1.3 Description of Case Management and Supports Planning Services

Providers identified through this solicitation shall provide supports planning to applicants and participants of the waiver programs, ICS, MAPC, and CFC. In addition, the providers shall provide waiver case management services to CO waiver participants to assist them in the annual redetermination process. Providers shall coordinate community services and supports from various programs and payment sources to aid applicants and participants in developing a comprehensive plan for community living. Providers shall support applicants in locating and accessing housing options, identifying housing barriers such as past credit, eviction, and criminal histories, and in resolving the identified barriers. The providers shall assist individuals referred by the Department in developing comprehensive plans of service that include both State and local community resources, coordinating the transition from an institution to the community, and maintaining community supports throughout the individual's participation in services.

Person-Centered Planning

Person-Centered Planning (PCP) is essential to assure that the participant's personal strengths, goals, risks, and preferences are incorporated into service planning and reflected on the plan of service. Providers of case management and supports planning service must engage every applicant and participant in a person-centered planning process designed to encourage self-direction and offer the participant choice and control over the process and resulting plan. Examples of person-centered planning strategies include Essential Lifestyle Planning, Planning Alternative Tomorrows with Hope (PATH), and Life Maps.

Application Assistance for Community Applicants

Individuals residing in the community who are eligible for Medical Assistance may apply for CFC and MAPC services at any time. Individuals who reside in the community may only apply for the waiver as funding becomes available and they are selected from the waiver registry to receive an invitation to apply.

For applicants to MAPC or CFC, the application process begins with contact to the Department and completion of a medical assessment by the Local Health Department (LHD). The Department will provide a packet of materials that includes brochures from each eligible supports planning provider to all MAPC and CFC applicants at the time of referral to the LHD. For individuals who are invited to apply for a waiver from the registry, the Department will provide this packet of information about supports planning providers when the invitation to apply is sent. The applicant may choose a provider by contacting the Department, the LHD, or the chosen provider directly. This choice will be noted in the LTSSMaryland tracking system and the chosen provider shall secure a signature from the applicant confirming the choice. A provider will be auto-assigned 21 calendar days after the informational materials are sent to the applicant if a provider is not selected.

When an applicant is initially assigned to a provider, the provider will be alerted via the LTSSMaryland tracking system and shall arrange a meeting with the applicant within 14 calendar days. At the initial meeting, the provider shall provide detailed information about the programs. MAPC and CFC do not require additional financial eligibility determinations and there is no additional application packet needed. Waiver applicants will receive assistance from the provider in completing the waiver application. Assistance to complete the waiver application includes gathering supporting documentation including obtaining copies of financial and identifying documents from family members, guardians, and other supporters of the referred individual. A waiver application is not considered

complete until all supporting documentation is submitted with the application to the Division of Eligibility Waiver Services (DEWS), the entity that determines financial eligibility. The provider shall complete and submit the waiver application with the referred individual within 5 business days of the initial meeting. The submission of the waiver application in the LTSSMaryland system will alert the LHD to perform the medical assessment.

Application Assistance for Nursing Facility Residents

Nursing facility residents will be assisted in accessing services and completing applications by Options Counselors funded through the Money Follows the Person Demonstration. Options Counselors will inform residents of their service options, including supports planning provider options.

For nursing facility residents with community Medical Assistance benefits, the Options Counselors will make referrals to the LHD for a medical assessment.

For individuals with long-term care Medical Assistance benefits, Options Counselors will complete and submit waiver applications to DEWS and through the LTSSMaryland tracking system, which will trigger a referral to the LHD for a medical assessment.

For individuals with no Medical Assistance benefit, the Options Counselors will complete and submit the community Medicaid application and make a referral to the LHD for a medical assessment.

The submission of the application and the referral to the LHD for a medical assessment will start the 21 calendar day time frame for auto-selection of a supports planning provider.

Coordination of Medical Eligibility Determination

All program applicants will be assessed for medical eligibility by the local health departments. All referrals to the LHD for the assessment will be made via the LTSSMaryland tracking system. For MAPC and CFC community applicants, the Department will complete a referral for the medical eligibility determination. For community waiver applicants referred from the registry, the completion of the waiver application by the supports planning provider in the LTSSMaryland system will create the referral. For nursing facility residents, the MFP Options Counselors will complete the referral to the LHD in the LTSSMaryland system.

The LHD will complete a comprehensive medical assessment to determine if the individual meets the medical necessity criteria for any of the programs (MAPC, CFC, or a waiver). The interRAI-HC Maryland assessment instrument is used to determine medical eligibility and identify service and supports needed in the community. The LHD is obligated to perform the interRAI-HC assessment in the LTSSMaryland system within 15 calendar days. The supports planning provider shall be responsible for following up with the LHD to ensure that the assessment is completed.

Developing a Transition Plan for Nursing Facility Applicants

Once the LHD assessment is received, the provider shall review it and meet with the applicant to develop an initial plan of service (POS). The POS shall include all services and other supports that address the applicant's medical, social, educational, employment/vocational, psychological, and other needs. Each plan shall include specific strengths, goals and action steps, risks, home and community-based services including non-Medicaid services, identified services providers, etc. The provider shall seek various resources to support the applicant. These include, but are not limited to: donated items, vocational programs, and community and faith-based services as needed. The provider shall assess the individual's transition needs such as the need for household items, accessible housing, furniture, etc. Transition needs shall be included in the POS as CFC transition services, a flexible benefit designed to

provide for these needs. If the applicant does not have a community residence identified, the provider shall share information about available housing supports including subsidized housing and homeownership programs including but not limited to the Housing Choice Voucher program, Section 811 Project Rental Assistance, public housing, low-income housing opportunities, and rental assistance. The provider shall assist the applicant in identifying and overcoming potential housing barriers such as accessibility, affordability, and credit problems, evictions, and criminal convictions.

The provider shall submit the initial POS to the Department for approval within 20 calendar days of receipt of the LHD evaluation. Plans of Service for a waiver program must be cost neutral, meaning the services provided in the community cannot exceed the cost of institutional services. The “cost” is determined annually by the Department based on a formula. If the plan of service is denied due to exceeding the cost neutrality standard, the applicant may choose to eliminate or decrease the amount or type of service(s) outlined in the plan in order to meet or equal the cost neutrality requirement. The revised POS shall then be resubmitted to the Department for reevaluation.

Transitioning Nursing Facility Applicants to the Community

Once the POS is approved and the applicant has secured community housing, the provider shall work with the applicant to identify a transition date, coordinate access to the identified services and supports in the POS including identifying providers of Medicaid services and coordinating payment through the fiscal intermediary to secure needed transition goods and services, and facilitate a smooth transition to the community. The provider shall coordinate the day of transition including assuring that support providers are scheduled and that essential goods, such as a hospital bed or power wheelchair, are delivered and available to the applicant. CFC transition funds and MFP flex funds can be administered via the fiscal intermediary up to 60 calendar days post transition.

Continuing Application for Nursing Facility Residents

Waiver applicants who do not transition within six months after signing the waiver application must submit a new application. Waiver technical eligibility must be reassessed with each application. For waiver applicants who need to reapply, the provider shall meet with the applicant at least one month prior to the six month expiration date to inquire regarding their interest in reapplying. If the applicant is interested in reapplying, the provider shall assist them with completing a new waiver application and consent form and forward the information to DEWS as noted above. The submission of the waiver application on the LTSSMaryland system will also alert the LHD to verify the most recent interRAI-HC assessment or complete a new one if there have been significant changes to the individual’s health. The provider shall update the POS as needed. If the individual is not interested in reapplying, the provider shall complete a new freedom of choice consent form indicating the person’s choice to remain in the nursing facility and forward the consent form to DEWS.

Ongoing Supports Planning

Once an individual transitions to the community and/or is enrolled in MAPC, ICS, CFC, or a waiver program, the provider shall contact each participant at least once a month to ensure that his or her needs are being met with the services and supports outlined in the POS and complete the monthly supports planning contact form. The provider shall meet with the participant in-person at least once every 90 days to monitor the implementation of the POS and identify any unmet needs. If there is a needed or requested change in the POS, the provider shall follow Departmental guidelines to submit a POS modification for approval and assist the participant in changing his or her services. Ongoing supports planning also includes quality monitoring and compliance with the Department’s Reportable

Events Policy, which can be found at https://mmcp.dhmf.maryland.gov/docs/Appendix_C-1_Reportable_Events.pdf. Quality monitoring includes reviewing documentation of nurse monitoring visits to identify any significant changes in the participant's support needs and reviewing ISAS reports to ensure services are being provided in a manner consistent with the POS.

Continuing Participant Eligibility

The provider shall verify the participant's Medicaid eligibility each month via the LTSSMaryland tracking system and its reporting functions. All participants must verify their continued technical and medical eligibility annually. Waiver participants must also redetermine financial eligibility on an annual basis. The supports planning provider shall be responsible for ensuring that there is no lapse in eligibility and that each redetermination process is completed each year. The provider shall monitor the redetermination time frames and initiate actions for each redetermination process.

For medical and technical redeterminations, the provider shall request via the LTSSMaryland tracking system, the medical assessment and confirmation of continued medical eligibility from the local health department 10 months after the last medical assessment (60 calendar days prior to the annual anniversary of the last assessment). Upon receipt of the medical assessment and recommended plan from the LHD, the provider shall review the recommendations and revise the plan of service with the participant, and submit the revised POS to the Department at least 30 calendar days prior to the expiration of eligibility.

For financial redeterminations required for waiver and ICS participants, the provider shall monitor annual redetermination dates, meet with the waiver or ICS participant to complete financial redetermination paperwork and, facilitate the gathering of required documentation for the redeterminations.

For financial redeterminations initiated by the local Department of Social Services for MAPC and CFC participants, the provider shall meet with the participant to complete financial redetermination paperwork and facilitate the gathering of required documentation for the redeterminations, as needed and requested by the participant.

Section 2 - Provider Qualifications

2.1 Minimum Qualifications

The following qualifications are required of all provider applicants. Providers should include in their response to this solicitation a concise description detailing how these requirements are met by the organization or agency.

- 2.1.1. At least two years of successful experience providing community based case management services and/or supports planning for individuals with complex medical needs and/or older adults.
- 2.1.2. At least two years of experience working with Medical Assistance programs including Managed Care Organizations.
- 2.1.3. At least two years of experience with and understanding of Medicare and private insurance programs as they relate to Medicaid.

2.2 Highly Desirable Qualifications

The following qualifications are highly desirable. Providers should describe how they meet these qualifications in their response to this solicitation.

- 2.2.1. Demonstrated knowledge of resources available for older adults and/or adults with disabilities, co-morbid conditions, and individuals experiencing poverty. These may include private, public, non-profit, local, regional, and national entities. Where applicable, provide examples of established linkages and affiliations with these resources.
- 2.2.2. Prior experience transitioning older adults and/or individuals with disabilities out of institutions to independent housing in the community.
- 2.2.3. Demonstrated understanding of and experience with consumer direction and person-centered planning.
- 2.2.4. Demonstrated ability to provide services in a time efficient and cost-effective manner.
- 2.2.5. Capability of communicating and providing written materials in alternative formats, if requested. Formats include large print, electronic copies, Braille, translators, and interpreters. Provide relevant agency materials or samples in proposals.
- 2.2.6. Capability of communicating in other languages; provide relevant agency materials or samples in proposals.
- 2.2.7. Demonstrated ability to be culturally sensitive in all business practices and effectively relate to the cultural/ethnic diversity of participants. Provide relevant agency materials or activities in proposals.
- 2.2.8. Demonstrated communication and/or coordination with other programs and groups serving older adults and/or individuals with disabilities in community based services.
- 2.2.9. Demonstrated experience with other programs and groups serving individuals with behavioral health disabilities such as mental illness, brain injury, dementia, substance abuse, and other cognitive disabilities, in community based services.

Section 3. Provider Agreement

By submitting a proposal for this solicitation, in addition to the requirements of this proposal, the provider agrees to comply with all of the provisions of the provider agreement, all of the relevant policies of Community First Choice, Medical Assistance Personal Care, and waiver programs and all applicable provisions of Maryland regulations, specifically COMAR 10.09.20, 36, 55, 81, and 84.

The Department may terminate this agreement at any time by notifying the provider in writing. The provider may terminate the agreement with no less than 6 months (180 calendar days) written notice to the Department and submission of a transition plan that clearly describes assistance to be provided to participants regarding the selection of new provider, transition of files and other data, and the reason for termination.

3.1 Specifications

The provider shall complete the following tasks and bill the Department the 15-minute units for allowable services as described below.

3.2 Administration, Record Keeping, Management, and Staffing

The provider agrees to:

- 3.2.1. Enroll as a Medicaid provider;
- 3.2.2. Provide an accessible environment, in compliance with the Americans with Disabilities Act (ADA) Part 36. Nondiscrimination on the Basis of Disability by Public Accommodations and in Commercial Facilities, Subpart C. Specific Requirements, Sections 36.301-36.310;
- 3.2.3. Provide at least one program manager and adequate supervisors/lead workers to support the day-to-day supports planning activities;
- 3.2.4. Hire supports planners who meet the following minimum qualifications: Bachelor's degree in a human services field, including psychology, social work, sociology, nursing, counseling, sociology, or a related field with work pertaining to older adults or adults with chronic conditions and disabilities. Exceptions to this, including the use of interns completing Bachelor's and Master's degree programs through colleges and universities, may be approved at the Department's discretion;
- 3.2.5. Hire and train a sufficient number of professional supports planning staff to maintain a staff such that the minimum case ratio is 1 case manager to 20 participants/applicants and the maximum case ratio is 1 case manager to 45 applicants/participants for all direct services and responsibilities;
- 3.2.6. Provide an alternate case manager, who is familiar with an individual's needs, to act on behalf of the original case manager if the original case manager is unavailable. DHMH must be notified within 24 hours if a qualified alternate case manager is not available;
- 3.2.7. Conduct criminal background investigations of supports planning or other direct program staff to ensure that they do not have a history of behavior that is potentially harmful to program participants or offenses relating to abuse, neglect, and/or exploitation of vulnerable populations;
- 3.2.8. Have access to a licensed, registered nurse to review plans of service for health and safety concerns, review provider and nurse monitor's case notes, to advise case managers on issues as they arise, and to conduct visits as health concerns arise. The nurse shall have experience in psychiatric nursing, developmental disability and addictions issues;

- 3.2.9. Have access to a licensed clinical staff person (LGSW, LCSW, LCSW-C, LGPC, LCPC) with experience assessing and delivering services to individuals experiencing mental illness, acquired brain injury, substance abuse, and/or developmental disability
- 3.2.10. Submit staffing standards and qualifications for all staff roles to the Department for approval to ensure adequate knowledge and training;
- 3.2.11. Submit a training plan that includes a process for evaluating the competence of staff and efficacy of the training, such as testing or evaluation methods that ensure staff are competent to conduct person-centered planning, train participants on self-direction, and perform all other functions described in this solicitation.
- 3.2.12. Develop a supports planning training manual, within 30 days of award, to be approved by the Department and to include applicable Code of Maryland Regulations (COMAR), Program fact sheets, consumer direction philosophy, self-direction tools and training materials, program policies including Reportable Events and Fair Hearing and Appeal Rights, participant letters and forms, provider applications, provider services forms, tracking system instructions, and other documents as requested by the Department;
- 3.2.13. Provide training to ensure all supports planning staff become highly knowledgeable about Maryland Medicaid, including its programs, services, medical and financial eligibility criteria, complaint and fair hearing processes, and administrative processes and community resources such as: housing options, home health providers, disability-specific resources and issues, aging resources and issues, assistive technology, medical equipment and supplies, and other local area resources;
- 3.2.14. Provide staff training on laws regarding guardianship and other forms of legal representation such as power of attorney and surrogate decision makers;
- 3.2.15. Conduct the following minimum training before case managers render services to participants:
 - A. Crisis intervention,
 - B. Health Insurance Portability and Accountability Act (HIPAA),
 - C. Identifying and reporting abuse/neglect/exploitation,
 - D. Person-centered planning and self-direction principles, philosophy, and tools,
 - E. Overview of community based service delivery, consumer direction/empowerment, harm reduction philosophy, and person centered planning,
 - F. Medicaid, Managed Care Organizations and waivers,
 - G. Medicaid Program Policies and Procedures, including reportable events, and the web-based tracking system,
 - H. Overview of population characteristics including acquired brain injury, mental illness, substance abuse, developmental disabilities, and
 - I. Other training as recommended by the Department.
- 3.2.16. Provide supports planning staff with on-going guidance and training related to Medicaid and waiver policies and procedures and in areas reflecting program and population changes;
- 3.2.17. Provide training materials to the Department for review prior to use with supports planning staff;
- 3.2.18. Establish and maintain a toll-free phone number. A representative of the contractor shall be available between the hours of 9 a.m. to 5 p.m. Monday through Friday excluding State of Maryland holidays;
- 3.2.19. Establish an emergency procedure to make a case manager or trained professional available to respond to calls 24 hours per day; 7 days per week. Access to voice mail is not sufficient to satisfy this requirement. A pager system or answering service that ensures access to a

- trained case manager or staff person outside of business hours and during emergencies is required.
- 3.2.20. Return all routine, non-emergency calls within one business day from the time the message is recorded;
 - 3.2.21. Accommodate reasonable date, time, and location preferences for the individuals served under this agreement and requests for accessible communications. Similar accommodations should be made for others involved including family members, friends, guardians, legal representatives, and others as identified by the individual. This may include evenings, holidays, and weekends;
 - 3.2.22. Establish and maintain a clear and accessible communication path for participants, providers, fiscal intermediaries, and the Department to answer questions, resolve problems, and provide information;
 - 3.2.23. Operate, at a minimum, a 28.8 speed fax machine 24 hours each day;
 - 3.2.24. Provide access to computers with an internet connection and e-mail addresses for all supports planning staff;
 - 3.2.25. Ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA) and ensure access to participant's Medicaid information is limited during transportation and/or to the area of the office with a functional need for the information.
 - A. Take measures to prudently safeguard and protect unauthorized disclosure of the Medicaid information in its possession.
 - B. Maintain confidentiality of all participants' records and transactions in accordance with Federal and State laws and regulations;
 - 3.2.26. Develop and implement an effective disaster recovery plan for restoring software, master files and hardware if management information systems are disabled which includes the timeframe anticipated to restore all function;
 - 3.2.27. Have the ability to transmit data to the Department utilizing at minimum Microsoft Office 97;
 - 3.2.28. Attend scheduled meeting and/or training convened by the Department and ensure that the appropriate staff attend each meeting;
 - A. Training is typically less than one training session per month but may increase in frequency during programmatic changes and updates to the LTSSMaryland tracking system.
 - 3.2.29. Share all policy, procedures, regulations and program changes with the appropriate staff;
 - 3.2.30. Become a partner with the local Maryland Access Point sites that serve as a single point of entry for individuals seeking long-term community supports;
 - 3.2.31. Complete all required documentation in the LTSSMaryland tracking system or other format as requested by the Department including but not limited to:
 - A. Logging billable case management/supports planning activities in 15 minute units, with enough descriptive text to justify the billing;
 - B. Document all contacts with the applicants and participants with the date, type of contact, length of time, substance of meeting, contact outcome, and a clear narration;
 - C. Completing monthly participant contact forms;
 - D. Completing and submitting Plans of Service and modification requests;
 - E. Registering participants for one-time password devices for use with ISAS, as needed;
 - F. Maintaining current addresses, phone numbers, and other contact information for applicants, participants, and their representatives; and
 - G. Maintaining current staff directories by adding new staff and deleting former staff within 5 business days;

- 3.2.32. If importing required data from another supports planning database,
 - A. Bear all costs for establishing and maintaining daily data exchanges with the LTSSMaryland tracking system; and
 - Assure all requested data is complete and submitted timely;
- 3.2.33. Establish and maintain individual participant files in a locked location and in accordance with COMAR requirements;
- 3.2.34. Ensure case files are available for immediate review by the State or Federal Auditors;
- 3.2.35. Retain copies of program files for six years from contract ending date;
- 3.2.36. Cooperate with Federal and State inspections, reviews, audits, and appeal hearings; and
- 3.2.37. Develop, reproduce, and supply sufficient Department-approved agency outreach brochures for applicants and participants.

3.3 Self-Direction

Participants who utilize CFC services will have the option to self-direct their services, including waiving all but the annual supports planning and semi-annual nurse monitoring visits. It also includes setting rates for certain services and managing personal assistance services. The LTSSMaryland tracking system will host a client portal through which participants may log-on and view their client records. Participants who choose to self-direct will be able to change their supports planning agency, request revisions to the plan of service, and view the claims generated by ISAS. This functionality will be available in the LTSSMaryland tracking system beginning in April of 2014.

The Provider shall:

- 3.3.1. Accept training from the Department, the Maryland Department of Disabilities (MDOD) or other Departmental designee on self-direction and person-centered planning.
- 3.3.2. Inform applicants and participants about the opportunities of self-direction including the availability of training and support from MDOD.
- 3.3.3. Ask the participant to determine the level of self-direction that they would like to assume and document the participant choice in the LTSSMaryland tracking system.
- 3.3.4. Refer the participant, upon request, to the MDOD for voluntary training in self-direction via the LTSSMaryland tracking system.
- 3.3.5. Assist the participant in learning skills necessary to increase their level of self-direction as requested by the participant. Assistance may include training on the LTSSMaryland tracking system, person-centered planning, goal setting, and plan of service development.
- 3.3.6. Generate a request for a participant log-on via the LTSSMaryland tracking system to set-up access for participants upon their request.
- 3.3.7. Provide participants with training on the client portal and use of the LTSSMaryland system.
- 3.3.8. Assist participants in navigating the system, generating reports, and using data to manage their services and providers.

3.4 Services to Applicants

- 3.4.1. Receive referrals via the LTSSMaryland web-based tracking system.
- 3.4.2. Receive and accept self-referrals from applicants and participants;
- 3.4.3. Document the referral and provider selection in the LTSSMaryland tracking system.
- 3.4.4. For community waiver applicants applying from the registry,
 - A. Provide assistance with completing waiver applications within 14 calendar days of Departmental referral or selection of supports planning provider indicated by an alert in the LTSSMaryland tracking system;

- B. Confirm or verify the basic waiver technical eligibility requirements including age and residency;
 - C. Assist the individual in obtaining supporting documentation as required for applications such as copies of birth certificates and bank statements;
 - D. Secure signatures of the individual, the legal representative or guardian, and others as needed to complete applications;
 - E. Submit the signed waiver application and consent for waiver services to the Division of Eligibility Waiver Services within 5 business days of the initial meeting with the applicant;
 - F. Retain paper copies of all completed applications and waiver consent forms for reference;
 - G. Document application completion and related activities in the LTSSMaryland tracking system. This documentation generates a referral to the Local Health Department (LHD) for a medical eligibility determination.
- 3.4.5. Monitor the LTSSMaryland tracking system for completion of the medical assessment by the LHD;
- 3.4.6. If the medical assessment and recommended plan of care are not received by the 15th day after the LHD referral date, contact the local health department regarding the status of the assessment to attempts to resolve any barriers to its completion and document the contact in the Activities module of the LTSSMaryland tracking system;
- 3.4.7. If the medical assessment and recommended plan of care are not received by the 20th calendar day after the LHD referral date, contact the Department via email to report issues and reasons for the delay as discussed with the LHD;
- 3.4.8. Upon receipt of the medical assessment and recommended plan of care from the LHD via the LTSSMaryland system, review the documents to identify applicant needs;
- 3.4.9. Conduct a “face-to-face” meeting with the applicant after receipt of the LHD assessment to:
- A. Engage in a person-centered planning process with the applicant;
 - B. Educate the applicant about self-directed options and the availability of training to increase skills in self-directing services;
 - C. Identify the applicant’s strengths, goals, and preferences;
 - D. Review the medical assessment with the applicant;
 - E. If applicable, assess the individual’s transition needs such as the need for household items, accessible housing, furniture, etc.;
 - F. Identify various resources to support the applicant in the community to include, but not be limited to: Medicaid services, family support, non-Medicaid funded community resources, donated items, vocational programs, and faith-based services; and
 - G. Complete the initial Plan of Service (POS).
- 3.4.10. Discuss housing and living arrangements with the applicant to determine if there are unmet housing needs;
- 3.4.11. Provide information about available housing supports including subsidized housing and homeownership programs including but not limited to the Housing Choice Voucher program, public housing, low-income housing opportunities, senior housing, and rental assistance programs;
- 3.4.12. Provide housing assistance to meet housing needs including the following:
- A. Assist the applicant in identifying and overcoming potential housing barriers such as accessibility, affordability, and credit, evictions, and convictions;
 - B. Refer the applicant to programs and/or services to overcome credit and conviction barriers to accessing housing;
 - C. Assist the applicant in completing applications for preferred housing options;

- D. Facilitate communication with housing managers to ensure applications are received and to monitor placement on waiting lists.
- 3.4.13. Assist applicants in applying for Section 811 Project-based Rental Assistance (PRA).
- A. Receive training from the Maryland Department of Disabilities and/or other Department designee regarding the Section 811 PRA program.
 - B. Train all case managers on the Section 811 PRA Users Guide.
 - C. Inform applicants and participants of the availability of 811 PRA funding and the location of units.
 - D. Enter information about outreach conducted related to the 811 PRA housing opportunities into a web-based tracking system.
 - E. Enter applicants/participants on the 811 PRA waiting list via a web-based tracking system as needed.
- 3.4.14. Note all needed services on the POS (i.e. waiver, Medicaid State Plan, other services regardless of funding source), emergency back-up plan for services vital to health and safety, service start date, duration, frequency, units, and costs in plan;
- 3.4.15. Calculate the costs for all Medicaid-funded services (i.e. skilled nursing, medical assistance personal care, occupational therapy, physical therapy, speech therapy, disposable medical supplies, and durable medical equipment);
- 3.4.16. For waiver applicants, determine if POS is cost neutral using the current cost neutrality figures provided by the Department;
- A. If the individual's POS exceeds cost neutrality, assist the individual to examine options to reduce the cost of the plan of service, including eliminating or reducing services;
 - B. If the individual chooses to change the POS, assist the individual in modifying the plan to their satisfaction;
- 3.4.17. Obtain the individual's signature and any additional signatures needed on the POS such as those of the guardian, legal representative, etc.
- 3.4.18. Submit the POS to the Department within 20 calendar days of receipt of the LHD assessment;
- 3.4.19. Coordinate service start dates by making verbal and written referrals to enrolled Medicaid providers and forwarding any necessary information for their review;
- 3.4.20. Complete and submit Fiscal Intermediary Referral Form, if applicable;
- 3.4.21. Ensure POS approval prior to delivering or accessing Medicaid services;
- 3.4.22. For waiver applicants, ensure waiver eligibility is confirmed by DEWS via the Advisory Opinion Letter prior to the transition;
- 3.4.23. For nursing facility applicants, coordinate the transition to the community, including but not limited to the following tasks:
- A. Coordinate the final discharge transition meeting with the applicant and others as applicable and identified by the individual, such as the guardian, authorized representative, and nursing facility staff;
 - B. Coordinate with institutional staff the continuation of services such as occupational, speech, and physical therapy and durable medical equipment and disposable medical supplies;
 - C. Coordinate with the fiscal intermediary to procure approved goods and services such as security deposits, utility hook-ups, household items, furniture, etc. using CFC transition funds;
 - D. Maintain and upload to the LTSSMaryland tracking system copies of receipts and other documents related to the expenditure of transition funds.

- E. Ensure that all vital household items including furnishings, toiletries, medical equipment and supplies, food, and medication are available on the day of transition;
- F. Ensure service providers are available and ready to begin services on the discharge date,
- G. Perform coordination of the transition and be present on the day of the move to assure success of the transition and participant satisfaction with living conditions in the community residence.
- H. Submit the discharge form 257 and the AC-12 to the Department within 5 business days of discharge;

3.5 Money Follows the Person

For all applicants transitioning out of an institution, the provider shall:

- 3.5.1. Confirm and document MFP eligibility by verifying that the applicant:
 - A. Is eligible for long-term care Medicaid immediately prior to transitioning,
 - B. Resided in a qualified institutional setting (or settings) for a period of 90 days prior to transitioning,
 - C. Transitions to a qualified residence in the community,
 - D. Freely chooses to sign the MFP consent form;
- 3.5.2. Document MFP eligibility verification on the MFP questionnaire in the LTSSMaryland tracking system;
- 3.5.3. Secure the applicant's signature on the MFP consent form and submit the paper form with original signature to the Department within 2 business days of completion;
- 3.5.4. Ensure MFP eligibility criteria will be met prior to transition and that the MFP questionnaire is accurate and submitted via the LTSSMaryland tracking system.
- 3.5.5. Assist the fiscal intermediary in the procurement of goods and services such as non-medical transportation or an initial supply of groceries using MFP flexible funds,
- 3.5.6. Maintain and upload to the LTSSMaryland tracking system any receipts or documentation related to the expenditure of MFP flexible funds.
- 3.5.7. Update the MFP questionnaire upon transition to assure the correct MFP eligibility status is reflected in the LTSSMaryland tracking system at the time of transition.

3.6 Services to Participants

The provider agrees to:

- 3.6.1. Receive and accept referrals from the Department and participants via the LTSSMaryland tracking system;
- 3.6.2. Establish contact and perform an initial home visit with referred participants within 14 calendar days of referral;
- 3.6.3. Monitor participant Medicaid and program eligibility via LTSSMaryland tracking system;
 - A. Notify the participant and appropriate partner agencies and providers upon discovery of a lapse in eligibility.
 - B. Assist the participant in taking steps to re-establish eligibility within 72 hours of knowledge of the eligibility lapse.
- 3.6.4. Provide program orientation for participants and their representatives, including an explanation of the responsibilities of the participant, the case manager/supports planning provider, and the Department.
 - A. Train participants on the In-home Supports Assurance System and related program policies.

- B. Inform participants about self-direction options, including the ability to waive all but minimum requirements for nurse monitoring, case management, and supports planning services.
- C. Inform participants of the provider's person-centered planning methodology.
- 3.6.5. Assist participants in registering with local emergency services providers such as the local Fire Department;
- 3.6.6. Assist each participant with the development of an Emergency Back-Up Plan that is documented in the Plan of Service.
- 3.6.7. Issue One-Time Password (OTP) devices to participants who do not have a land line phone or who may begin services at a location other than their primary residence.
 - A. Use the LTSS Maryland tracking system to assign OTPs to participants.
- 3.6.8. Verify the presence of the OTP device during participant contacts and in-home visits.
 - A. Report lost or stolen OTPs to the Department within 24 hours of knowledge.
 - B. Issue a new OTP to the participant within 72 hours of notification of the loss of an OTP.
- 3.6.9. Make direct contact with participants as needed and as follows:
 - A. Contact participants no less frequently than once per month by phone or e-mail;
 - i. If a participant cannot be contacted within 30 days, send a certified letter to the participant to establish contact and/or conduct a drop in visit where feasible.
 - ii. If a participant has not been contacted within 60 days, conduct a home visit.
 - B. Meet with participants in person at the participant's home where they receive services at least every 90 days;
 - C. Document all contacts and attempts to contact in the LTSSMaryland tracking system.
- 3.6.10. Complete monthly contact forms in the LTSSMaryland tracking system to verify contact or attempts to contact each participant each month.
 - A. For waiver participants who receive only CFC services and have waived the monthly case management contact, complete the monthly waiver eligibility verification via the monthly case management contact form.
- 3.6.11. When critical issues of health and safety are identified, notify the Department by phone within 24 hours of knowledge;
- 3.6.12. Monitor participants' service utilization to ensure services authorized in the POS are received, acceptable, and adequate.
- 3.6.13. Identify any need to reassess services through monitoring visits and participant contact and refer the participant for a new medical assessment when the participant experiences a significant change in health, medical conditions, or disability;
- 3.6.14. If there is a needed or requested change to the POS, follow Departmental guidelines to submit a POS modification to modify services and notify affected providers;
- 3.6.15. Assist the individual in accessing new services or providers as approved on a POS modification;
- 3.6.16. Review documentation of nurse monitoring visits logged into the LTSSMaryland tracking system;
 - A. Monitor the completion of nurse monitoring visits and assure visits are conducted at the frequency indicated in the POS.
 - B. Contact the LHD to inquire about missed nurse monitoring visits and to offer assistance in contacting or scheduling with the participant.
 - C. Discuss any issues identified in the nurse monitoring visits with the participant during contacts.
- 3.6.17. Provide assistance in accessing and maintaining non-Medicaid services by making referrals, providing information, or providing other assistance as requested by the individual;

- 3.6.18. Meet with all program participants annually to facilitate the medical and technical validation of continued eligibility.
 - A. Make a referral for a new medical assessment by the LHD at least 60 days before the individual's waiver eligibility expires;
 - B. Review the new medical assessment and recommended plan of care with the participant.
 - C. Conduct a person-centered planning process to update the participant's POS.
 - D. Submit the updated POS to the Department at least 30 days before the individual's eligibility expires;
- 3.6.19. Meet with waiver participants at least annually to facilitate continued financial eligibility by completing the following:
 - A. Assist the individual with completing a new waiver application;
 - B. Forward the new application information to the Division of Eligibility Waiver Services (DEWS) 60 days before the individual's waiver eligibility expires;
- 3.6.20. Ensure approval of the annual POS and verification of continuing eligibility is completed.
- 3.6.21. If a participant in a waiver program indicated that they will no longer accept services, complete a new waiver freedom of choice form indicating the individual's choice to decline services and document the expressed reason for declining services;
- 3.6.22. Be responsible for the cost for any and all services initiated by the provider without prior approval from the Department or for failing to cease services after being notified that a participant is no longer eligible for services;
- 3.6.23. Notify the participant, their representatives, and providers of any loss of eligibility determined by the annual process or discovered during routine eligibility monitoring.
 - A. Assist the individual with identifying and accessing alternate community resources, and
 - B. Provide information about the appeals process.

3.7 In-Home Supports Assurance System (ISAS)

- 3.7.1. Accept training from the Department and/or its designee on the ISAS system.
- 3.7.2. Inform applicants and participants of the ISAS to be used by providers to verify service provision.
- 3.7.3. Issue One-Time Password (OTP) devices to participants who do not have a land line phone or who may begin services at a location other than their primary residence.
- 3.7.4. Use the LTSS Maryland tracking system to assign OTPs to participants.
- 3.7.5. Verify the presence of the OTP device during supports planning contacts and in-home visits.
- 3.7.6. Report lost or stolen OTPs to the Department within 24 hours of knowledge.
- 3.7.7. Issue a new OTP to the participant within 72 hours of notification of the loss of an OTP.
- 3.7.8. Provide information to providers and participants upon request regarding the provider enrollment and voice verification systems related to ISAS.
- 3.7.9. Provide participant training on the use of the ISAS web-based interface as a means to review and approve requests for billing submitted via ISAS by their providers.
- 3.7.10. Cooperate with the Department to resolve billing exceptions generated by ISAS, including but not limited to verifying the current providers, remediating errors on the plan of service, locating and contacting a participant to verify service provision, and identifying any gaps in service.
- 3.7.11. Generate participant-specific ISAS reports from the LTSS Maryland tracking system to review with the participant at monthly and annual contacts to assure service delivery and appropriate billing.

3.8 Reportable Events

- 3.8.1. Implement the Department approved Reportable Events policy and procedure for reporting critical incidents, complaints, service interruption, and grievances;
- 3.8.2. Utilize the LTSSMaryland tracking system to submit, track, and monitor reportable events.
- 3.8.3. Report to the Department within 24 hours any complaints, incidents, etc. to include reports on any interruption of services to a waiver participant due to refusal of services, lack of provider, lack of required documentation, or any other reason per the program policy;
- 3.8.4. Maintain a registry identifying complaints of applicants and participants;
- 3.8.5. Develop corrective action plans that resolve complaints described in reportable events and provide corrective action plans to the Department within required time frames;
- 3.8.6. Implement corrective action plans within five business days of the report and record actions in the registry of reportable events;
- 3.8.7. Notify the Department by fax within 24 hours of knowledge if the complaint cannot be resolved;
- 3.8.8. Report all suspected abuse, neglect, and exploitation immediately upon knowledge to Adult Protective Services at 1-800-917-7383;

3.9 Quality

- 3.9.1. Develop a client satisfaction survey for participants to evaluate supports planning services within 90 days of signing the provider agreement;
 - A. The survey and all policies related to implementation shall be approved by the Department prior to implementation;
 - B. Implement the survey within six months of contract award;
 - C. Complete the survey with ten percent (10%) of participants at least annually;
- 3.9.2. Develop a "Supports Planning Satisfaction Survey Report" that includes a summary and analysis of the participants' satisfaction with services based on the contractor's annual satisfaction survey;
- 3.9.3. Develop and implement a Quality Assurance Plan, to be approved by the Department to monitor and ensure:
 - A. All responsibilities contained in this provider solicitation are accomplished.
 - B. The provider has clearly defined goals and standards for each responsibility outlined in this solicitation.
- 3.9.4. Review and amend the Quality Assurance Plan at least bi-annually to evaluate effectiveness in meeting supports planning responsibilities;
- 3.9.5. Complete a "Quality Assurance Report" documenting quality services related to the goals and standards set forth in their Quality Assurance Plan within 30 calendar days after the review date;
- 3.9.6. Ensure compliance with all statutes, regulations, program policy and procedures, codes, ordinances, licensure or certification requirements that pertain to the waivers, MAPC, and CFC programs;
- 3.9.7. Report to the Department potential misuse of program services, suspected program abuse, and other information deemed as critical by the Department in writing within two business days;
- 3.9.8. Ensure compliance with all performance measures noted in the Department's waiver applications to the Centers for Medicare and Medicaid Services.

3.10 Transition Plan

3.10.1. Describe the transition plan to ensure the continuity of services for all applicants and participants at the end of the term of this provider agreement. The transition plan shall include:

- A. Time line for notification to the Department, participants and their representatives, and other providers;
- B. Secure transmission of paper files to new providers identified by the participant;
- C. Ensuring adequate staffing during the transition;
- D. Creating a plan to ensure the timeliness of data entry into the LTSSMaryland tracking system.

3.11 Billing

The provider agrees to:

- 3.11.1. Bill the Department for administrative transitional case management/supports planning services provided to applicants on a monthly basis, no later than the 10th of each month, according to Departmental guidelines.
- 3.11.2. Bill the Department for comprehensive transitional case management/supports planning activities provided to applicants up to 180 days prior to their transition on or after the date of discharge and the applicant's enrollment in services according to Departmental guidelines.
- 3.11.3. Bill the Department for ongoing case management/supports planning services provided to participants on a monthly basis, no later than the 10th of each month, according to Departmental guidelines.
- 3.11.4. Utilize the LTSSMaryland tracking system to track all billable activities.
- 3.11.5. Utilize electronic billing functionality in the LTSSMaryland tracking system beginning March 1, 2014.
- 3.11.6. If importing required data from another supports planning database,
 - A. Bear all costs for establishing and maintaining daily data exchanges with the LTSSMaryland tracking system; and
 - B. Assure all requested data is complete and submitted timely.

3.12 Required Documentation

The provider shall submit to the Department:

- 3.12.1. A Final Work Plan within 30 days of the initiation of the provider agreement, to meet all provider agreement requirements including:
 - A. Working with family, guardians, legal representatives, and other involved persons as needed and as requested by the applicant;
 - B. Establishing a person-centered planning process for POS development;
 - C. Incorporating consumer-direction into policies, procedures, training, and activities;
 - D. Creating Staffing standards for all staff roles;
 - E. Creating staff training materials and training schedule;
 - F. Creating participant orientation materials;
 - G. Creating a client satisfaction survey;
 - H. Creating a Disaster Recovery Plan;
 - I. Creating a plan to ensure the timeliness of data entry into the LTSSMaryland tracking system;

- 3.12.2. Submit a monthly Reportable Events Analysis to the Department by the 15th of the month following the service month. This report should identify the applicant/participant's name, complaint, and corrective action plan (if applicable).
- 3.12.3. Submit Participant Satisfaction Survey Report to the Department by June 15th of every year for the previous year;
- 3.12.4. Submit a Quality Assurance Report twice annually, within 30 days of the completion of the Quality Assurance Plan biannual review.

Section 4 - Provider Selection Process

4.1 The Agreement between Provider and DHMH shall consist of:

- A. This solicitation;
- B. Offeror's proposal, including any subsequent revisions and written responses to DHMH questions;
- C. The Provider Agreement and Acknowledgement of Provider Agreement and Responsibilities form; and
- D. Applicable regulations, including payment rates established by regulation.

A committee will conduct the evaluation of proposals in response to this solicitation. During the evaluation process, the committee may request technical assistance from any source. The evaluation criteria set forth below are arranged in descending order of importance. (1 is more important than 2 and 2 is more important than 3, etc.).

1. Quality of Proposed Work Plan
 - a. How well the offeror proposes to perform each duty described in the Provider Agreement
2. Corporate Qualifications and Experience
 - a. The organization documents that it meets each of the Minimum Qualifications
 - b. The extent to which the organization meets the Highly Desirable Qualifications
3. Experience and Qualifications of Proposed Staff
 - a. Experience and qualifications of proposed staff
 - b. Quality of the proposed training plan

For each region, the committee will evaluate each technical proposal offered for that region on the criteria set forth above. As part of this evaluation, the Committee may hold discussions with potentially qualified providers. Providers may be asked to participate in face-to-face discussions with the committee or other State representatives concerning their technical proposals. Discussions may also be conducted via teleconference or may take the form of questions to be answered by the providers and conducted by mail, e-mail, or facsimile transmission at the discretion of the Department. Following the completion of the technical evaluation of all providers that submitted complete proposals in each region, including any discussions, the committee will rank each qualified provider's proposal.

In each region, one or more providers with the highest ranked proposals will be selected to provide the services detailed in the Provider Agreement of this solicitation.

4.2 Pre-Submission Processes

4.2.1 Pre-Proposal Conference

While attendance at the pre-proposal conference is not mandatory, the information presented may be informative. All interested offerors are encouraged to attend in order to be better able to prepare an acceptable proposal. In order for the Department to prepare for this conference, prospective attendees are requested to telephone Carolyn Williams (410) 767-1739 **no later than 3 pm on December 13, 2013** to provide notice of the anticipated number of individuals who will attend, as well as to provide an acknowledgement of receipt of the solicitation. Any individual interested in attending the pre-proposal conference who is in need of an accommodation due to his/her disability should contact the Issuing

Office a minimum of five working days prior to the conference to request the necessary accommodation.

4.2.2 Questions and Inquiries

Questions may be submitted in writing to the Solicitation Point of Contact in advance of the pre-proposal conference. As practical and appropriate, the answers to these pre-submitted questions will be provided at the pre-proposal conference. Additionally, questions, both oral and written, will be accepted from the prospective offerors attending the pre-proposal conference and will be answered at this conference or in a subsequent transmittal. Subsequent to the pre-proposal conference, the Issuing Office will accept written questions until there is insufficient time for a response to impact on a proposal submission. Questions that have not been previously answered and that are deemed to be substantive in nature will be answered only in writing, with both the question(s) and answer(s) being distributed to all persons known by the Issuing Office to have obtained the solicitation.

4.2.3 Revisions to the Solicitation

If it becomes necessary to revise any part of this solicitation, addenda will be provided to all persons who are known by the Contract Monitor to have received the solicitation. Acknowledgement of the receipt of all amendments, addenda, and changes issued shall be required from all persons receiving the solicitation. Failure to acknowledge receipt of addenda will not excuse any failure to comply with the contents of the addenda.

4.2.4 Incurred Expenses

The State of Maryland is not responsible for any expenses incurred by the offeror in preparing and submitting a proposal in response to this solicitation.

4.2.5 Delivery/Handling of Proposals

Offerors may either mail or hand-deliver proposals. Hand-delivery includes delivery by commercial carrier. For any type of direct (non-mail) delivery, offerors are advised to secure a dated, signed, and time-stamped (or otherwise indicated) receipt of delivery. Proposals and modifications will be shown only to State employees, members of the Evaluation Committee, or other persons, deemed by the Department to have a legitimate interest in them.

4.2.6 Proposal Submission Guidelines

All proposals in response to this solicitation should be addressed to:

Lorraine Nawara
Community Integration Programs
201 W. Preston Street, Room 135
Baltimore, MD 21201

Deadline for receipt of proposals: January 13, 2014 at 2PM EST.

Incomplete proposals and proposals received after the deadline will not be evaluated and will be returned to the submitter.

Offerors may submit proposals for multiple regions; but may not submit multiple proposals for evaluation per region. Only a single proposal from a given offeror will be evaluated in each region.

4.2.7 Components of a Complete Proposal

Offerors should use the most cost effective and efficient means of preparing their proposal. The Department will not, under any circumstance, reimburse or pay for work done to prepare submission of a proposal.

4.2.7.1. A complete proposal packet contains:

- A. Two (2) original copies of the proposal with signatures, marked “Original” on each cover page;
- B. Four (4) copies, marked “Copy” on each cover page;
- C. If the proposal contains confidential or proprietary information, include one (1) copy with this information removed, marked “PIA Copy” to be used for Public Information Act requests; this copy must also include a statement by the offeror regarding the rationale for the removal – a blanket statement by an offeror that its entire proposal is confidential or proprietary is unacceptable.

4.2.7.2. Each proposal must contain:

- A. A cover page that includes:
 - iii. Name of the offering organization;
 - iv. Address of the offering organization;
 - v. Contact information for correspondence related to the proposal;
 - vi. Title of the solicitation, “Comprehensive Case Management and Supports Planning Services for Medicaid Long-Term Services and Supports”;
 - vii. Region or regions for which the proposal is offered, list the names of the individual regions or “Statewide” for a proposal to provide services in all regions.
Note: An offeror may be selected to provide services in any of the regions for which the proposal is offered, and will not necessarily be selected in all regions covered by the proposal.
 - viii. The maximum number of applicants and participants that the offeror agrees to serve, per region.
 - ix. The date of submission.
- B. A Proposed Work Plan that affirmatively addresses how the offeror proposes to perform each duty described in the Provider Agreement. The statement “Agreed” or “Will comply” is not a sufficient response and offerors will be rated on their description of how they meet each requirement. The Offeror shall address each requirement in its proposal and describe how its proposed services will meet or exceed the requirement(s). Any paragraph in the proposal that responds to a Provider Agreement Specification shall include an explanation of how the work will be done. Any exception to a requirement, term, or condition may result in having the proposal classified as not reasonably susceptible of being selected for award or the Offeror deemed not responsible.
- C. In proposals covering multiple regions, clearly identify any aspect of the Proposed Work Plan that does not pertain to all regions covered by the proposal.
- D. A concise description of Corporate Qualifications and Experience that:
 - i. Specifically explains how the organization meets each of the Minimum Qualifications;
 - ii. Explains the extent to which the organization meets the Highly Desirable Qualifications;
 - iii. Identifies programs for which the organization has provided case management or supports planning services including:
 - iv. The scope of services provided;

- v. The types of individuals served; and
 - vi. Internal program monitoring activities.
- E. A section describing the Experience and Qualifications of Proposed Staff, including:
- i. A list of proposed staff and their proposed roles;
 - ii. The relevant experience and qualifications of each proposed staff member
Note: A short summary of each staff person's most relevant experience and qualifications is preferred over attaching resumes.
- F. At least three (3) professional reference letters that include:
- i. Name of reference
 - ii. Organization of reference
 - iii. Phone number and email address of reference
 - iv. A signed letter of reference that includes the nature and extent of the relationship with the offeror.
- G. A complete and signed Acknowledgement of Provider Agreement and Responsibilities form (see below).

4.2.7.3 Acknowledgement of Provider Agreement and Responsibilities

Replace all underlined and bracketed sections with the requested information.

Provider Organization

[Name of Offeror's Organization]

[Address of Organization]

[Address of Organization]

Tax ID Number: [Insert Tax ID Number]

Offeror's Contact Information

[Name of Representative]

[Title of Representative]

[Mailing Address]

[Mailing Address]

[Telephone Number(s)]

[Email Address]

4.2.8 Electronic Funds Transfer

By submitting a response to this solicitation, the offeror agrees to accept payments by electronic funds transfer unless the State Comptroller's Office grants an exemption. The selected offeror shall register using form COT/GAD X-10 Vendor Electronic Funds (EFT) Registration Request Form. Any request for exemption must be submitted to the State Comptroller's Office for approval at the address specified on the COT/GAD X-10 form and must include the business identification information as stated on the form and include the reason for the exemption.

4.2.9 Acknowledgement of Provider Agreement

By submitting a response to this solicitation, the offeror agrees to perform all duties and comply with all requirements identified in the Provider Agreement included in this solicitation. If the offeror fails to meet all requirements, the Department may withhold payment or terminate the contract at its discretion.

Signature

As an authorized representative of [Name of Offeror’s Organization], by my signature below, I affirm that if the attached proposal is selected by the Department, [Name of Offeror’s Organization] will perform all duties and comply with all requirements and regulations described and referenced in the solicitation “Comprehensive Case Management and Supports Planning Services for Medicaid Long-Term Services and Supports”.

(Signature)

Date

Attachment 1 - Projected participants

Region	Participants	Applicants	Total	Already Assigned to a provider
Baltimore City	3,179	198	3,377	1,157
Baltimore County	1,731	212	1,943	1,005
Montgomery	1,892	154	2,046	660
Prince George's	904	88	992	603
Total	7,706	652	8,358	3,425