



STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene

*Larry Hogan, Governor - Boyd Rutherford, Lt. Governor - Van Mitchell, Secretary*

June 9, 2015

The Honorable Edward J. Kasemeyer  
Chair  
Senate Budget and Taxation Committee  
3 West Miller Senate Office Bldg.  
Annapolis, MD 21401-1991

The Honorable Maggie McIntosh  
Chair  
House Appropriations Committee  
121 House Office Bldg.  
Annapolis, MD 21401-1991

**RE: 2014 Joint Chairmen's Report (p. 72) – Report on Use of a Certain Procurement Provision**

Dear Chair Kasemeyer and Chair McIntosh:

The 2014 Joint Chairmen's Report (JCR) required the Department of Health and Mental Hygiene to submit a report to the budget committees detailing its use of Section 11-101(n)(2)(iii) of the State Finance and Procurement Article. Specifically, the JCR requests contract details, including number, purpose, and value of contracts awarded under this provision since fiscal year 2000. Please be advised that \$100,000 GF is being withheld pending approval of this report.

**Background**

Section 11-101(n)(2)(iii) exempts Medicaid provider agreements from the definition of "procurement contract" in the Procurement Article. Those agreements meet the terms of the exemption in that they are Medicaid contracts for which law sets user or recipient eligibility and price payable by the State. For example, the price term of the contract is not established through negotiation with Offerors but is fixed in rates established by the Department. As is evident from the discussion below, policy and operational necessities make Section 11-101(n)(2)(iii) essential.

The Department relies on this exemption for each agreement with health care providers participating in the Maryland Medicaid Program (Program). This includes hospitals, nursing homes, personal care providers, licensed health care professionals such as physicians, dentists, and all other providers of Medicaid covered services rendered by providers to Medicaid recipients. Provider Agreements are governed by federal and state law and contain the regulatory requirements to which providers must adhere in exchange for Medicaid reimbursement. Absent a waiver from the federal government, the Program is required to enter into agreements with all qualified providers who desire to participate.



## **Use of Section 11-101(n)(2)(iii)**

The number of provider agreements entered into under Section 11-101(n)(2)(iii) since fiscal year 2000 runs into the thousands with total reimbursements reaching into the billions of dollars. Therefore, the Department does not have the resources to provide the voluminous information requested in the JCR. However, the Department has entered into a few provider agreements for Medicaid programs for which the federal government has provided a waiver permitting the Program to contract selectively. Like the provider agreements referenced above, these agreements fall within the statutory exemption set forth in Procurement Article 11-101(n)(2)(iii). For these contracts the Department conducts a solicitation process similar to the process prescribed by the State Finance and Procurement Article for standard procurements. Information regarding three of these contracts is provided below.

### *Rare and Expensive Case Management Contract*

The purpose of this contract is to provide case management services to Medicaid recipients enrolled in the Rare and Expensive Case Management (REM) program. Five Offerors submitted proposals, which were evaluated according to the attached criteria (Attachment 1). The Evaluation Committee consisted of the Division Chief responsible for the REM Program, a Health Policy Analyst within the Medicaid Program's Office of Planning, and a Medicaid Program Adviser in the Office of the Deputy Secretary for Health Care Financing. This Contract was awarded to a single provider agency in fiscal year 2015 and is to extend for three years with 2 option years. The reasons for the selection were, among other things, the superiority of the Offeror's work plan and its excellent corporate and proposed staff experience. The award was based on the determination of the Evaluation Committee, with concurrence by the Department's Deputy Secretary for Health Care Financing. The Provider Agreement entered into as a result of the award was executed on behalf of the Program by the Director of the Medicaid Office of Health Services.

The budget for this contract year is \$9.5 million. Reimbursement is based on a rate established by the Department, so the ultimate contract value varies depending on the number of enrollees.

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

These contracts provide for comprehensive case management and support planning services for Medicaid long-term services and supports participants of the Medical Assistance Personal Care program, Community First Choice, Increased Community Services, as well as Community Options programs. This solicitation was conducted in two phases in order to obtain sufficient regional coverage for the programs' needs. Twenty Offerors, in all, submitted proposals, which were evaluated according to the attached RFPs (Attachments 2 and 3). The Evaluation Committees included the Division Chief responsible for the programs served, a Health Policy Analyst assigned to those programs, a Policy Specialist with expertise in policies related to balancing community and institutional services for Medicaid long term care recipients, another Policy Specialist in the Division of Long Term Care Services, and a Program

Administrator within that Division. This contract was ultimately awarded to six providers beginning on January 1, 2014, continuing until December 31, 2017. The reasons for the selections were among other things, the quality of their work plans and level of relevant experience. The awards were based on the determination of the Evaluation Committee. The Provider Agreements that resulted from the awards were executed by the Director of the Medicaid Program's Office of Health Services. The Program intends to conduct future solicitations as necessary to meet evolving program needs. The budgeted amount for this Fiscal Year is \$432,000. The providers are reimbursed fixed rates on a fee-for-service basis. To date, providers have billed approximately \$15 million under these contracts.

*Comprehensive Case Management Services for the Living at Home Waiver*

These contracts provided for comprehensive case management and support services for applicants and participants in the Medical Assistance Living at Home Waiver. Three offerors responded to the solicitation, which were evaluated according in accordance with the criteria set forth in the attached RFP (Attachment 4). The Evaluation Committee consisted of the Division Chief and Deputy Division Chief of the Program's Money Follows the Person Program, a Supervisor in the Program's Division of Nursing and Waiver Services, and a Health Policy Analyst in that Division. The contract was awarded to a single provider because of, among other things, its superior proposed work plan and excellent corporate and proposed staff experience. The awards were based on the determination of the Evaluation Committee. The Provider Agreement that resulted from the award was executed on behalf of the Program by the Director of the Medicaid Office of Health Services.

The contract ran from November 1, 2009 through December 31, 2013. The provider was reimbursed fixed rates on a fee-for-service basis. Over the course of the contract, providers billed approximately \$10 million.

If further information or contractual information is desired, please contact Allison Taylor, Director of Governmental Affairs, at (410) 767-6481.

Sincerely,



Van T. Mitchell  
Secretary

Enclosure

cc: Shannon McMahon  
Allison Taylor



# Attachment 1





## REQUEST FOR PROPOSALS

### **Rare and Expensive Case Management**

Issue Date: December 20, 2012

#### Amendments

[Sec. 3.2.10 \(2\) \(a\) \(iii\)](#): Clarified certification standards for social workers employed as case managers. (01/16/2013)

[Sec. 3.5.4 \(b\) – \(e\)](#): Eliminated references to items in section 3.6 for incongruity; added employee theft insurance requirements. (01/16/2013)

[Sec. 3.5.5](#): Eliminated “named” from insurance requirement. (01/16/2013)

[Attachment A](#): Revised contract term dates to July 1, 2013 – June 30, 2016. (01/16/2013)

[Appendix DD](#): Updated Notification of Unable to Locate or Non-Responsive REM Participant form. (01/16/2013)

#### **NOTICE**

Prospective Offerors that have received this document from the Department of Health and Mental Hygiene’s website, or who have received this document from a source other than the Contract Monitor, and who wish to assure receipt of any changes or additional materials related to this RFP, should immediately contact the Contract Monitor and provide their name and mailing address so that addenda to the RFP or other communications can be sent to them.

**Minority Business Enterprises Are Encouraged to Respond to this Solicitation**

**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE**

**KEY INFORMATION SUMMARY SHEET**

**Request for Proposals:** Rare and Expensive Case Management

**Issue Date:** December 20, 2012

**RFP Issuing Office:** Maryland Department of Health and Mental Hygiene  
Office of Health Services

**Contract Monitor:** Margaret Berman  
Maryland Department of Health and Mental Hygiene  
Office of Health Services  
201 W. Preston St., Room 210  
Baltimore, MD 21201  
Office: (410) 767-1620 Fax: (410) 333-5426  
margaret.berman@maryland.gov

**Proposals are to be sent to:** Elvira Smith  
Maryland Department of Health and Mental Hygiene  
Office of Health Services  
201 W. Preston St., Room 214D  
Baltimore, MD 21201  
Office: (410) 767-3637 Fax: (410) 333-5620  
elvira.smith@maryland.gov

**Pre-Proposal Conference:** Wednesday, January 16, 2013, 10:30 AM Local Time  
201 West Preston Street, Room L-4  
Baltimore, Maryland 21201

**Closing Date and Time:** Thursday, January 24, 2013, 2:00 PM Local Time



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## SECTION 1 - GENERAL INFORMATION

### 1.1 Summary Statement

- 1.1.1 The Maryland Department of Health and Mental Hygiene (DHMH), Office of Health Services, is issuing this Request for Proposals to provide case management services to individuals with rare and expensive conditions.

DHMH intends to contract for case management services for the Rare and Expensive Case Management (REM) program. The REM program is part of Maryland's HealthChoice program, a comprehensive Medicaid managed care program operated by DHMH under the authority of Maryland Medicaid Section 1115 Health Care Reform Demonstration (No. 11 –W-00099/3).

The REM program is available to HealthChoice-eligible Medicaid participants throughout the state. Enrollment into the REM program is dictated by a list of qualifying diagnoses found in COMAR 10.09.69 (also provided in Appendix A).

If a participant has one or more of the diagnoses specified in Appendix A and consents to participation, the participant will be disenrolled from the HealthChoice MCO and enrolled into the REM program.

Participants under 21 years of age comprise approximately 79% of the REM population. The total active REM population as of July 2012 is 4,075 participants (Appendix B). REM participants speak 20 different native languages other than English, the most prevalent being Spanish (Appendix X).

- 1.1.2 It is the State's intention to obtain services, as specified in this Request for Proposals, from a Contract between the successful Offeror and the State.
- 1.1.3 The Department intends to make one award to a single Offeror whose proposal is deemed the most advantageous to the State.
- 1.1.4 The Offeror must be able to provide all case management services directly, unless the Department grants approval to sub-contract services. For all services, either directly or through their sub-contractor(s), the Offeror must meet all of the requirements requested in this solicitation.
- 1.1.5 The State encourages the participation of minority business enterprises in this contract and Contractor efforts to maintain a significant percentage of employees in the State.

### 1.2 Abbreviations and Definitions

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

- a. **COMAR** – Code of Maryland Regulations, available at [www.dsd.state.md.us](http://www.dsd.state.md.us).
- b. **Contract** – The Contract awarded to the successful Offeror pursuant to this RFP. The Contract will be in the form of **Attachment A**.
- c. **Contract Monitor (CM)** – The State representative for this project who is primarily responsible for procurement and contract administration functions, including issuing written direction, invoice approval, monitoring this project to ensure compliance with the terms and conditions of the Contract, monitoring MBE compliance, and achieving on budget, on time, and within scope completion of the project.
- d. **Contractor** – The selected Offeror that is awarded a Contract by the State.
- e. **DHMH or The Department** – Maryland Department of Health and Mental Hygiene.
- f. **Local Time** – Time in the Eastern Time Zone as observed by the State of Maryland. Unless otherwise specified, all stated times shall be Local Time, even if not expressly designated as such.
- g. **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](http://www.dbm.maryland.gov) – keyword: State Holidays.
- h. **Notice to Proceed** – Letter from the Contract Monitor to the Contractor stating the date the Contractor can begin work subject to the conditions of the Contract.
- i. **Offeror** – An entity that submits a proposal in response to this RFP.
- j. **REM Participant** – A participant who:
  - i. consents to participating in REM,
  - ii. has completed all service coordination, and
  - iii. meets the diagnostic criteria set by the Department for the program.

Compensation begins for case management services with the month of enrollment.

- k. **REM Eligible Participant** – A participant who:
  - i. consents to participating in REM,
  - ii. meets the diagnostic criteria set by the Department for the program, and
  - iii. receives ongoing medical support services or supplies through a HealthChoice MCO.

The Department will refer REM eligible participants to the successful Offeror for service coordination and transition into the REM program. Compensation is not paid for REM eligible participants.

- l. **Request for Proposals (RFP)** – This Request for Proposals issued by the Maryland Department of Health and Mental Hygiene, Office of Health Services, dated December 20, 2012, including any addenda.
- m. **Significant Event** – An urgent or potential problem requiring immediate notification and/or assistance from the case manager or the Department. Refer to REM Reporting of Significant Events: Categories & Descriptions (Appendix T) for examples.
- n. **State** – The State of Maryland.

### **1.3 Contract Duration**

The Contract resulting from this RFP shall be for a period of three (3) years beginning on or about July 1, 2013 and ending June 30, 2016. There will be two (2) Contract renewal options for one (1) year each. The Contractor shall provide services upon receipt of a Notice to Proceed from the Contract Monitor.

### **1.4 Contract Monitor**

The Contract Monitor is:

Margaret Berman  
Maryland Department of Health and Mental Hygiene  
Office of Health Services  
201 W. Preston Street, Room 210  
Baltimore, MD 21201  
Phone Number: (410) 767-1620  
Fax Number: (410) 333-5426  
Email: [margaret.berman@maryland.gov](mailto:margaret.berman@maryland.gov)

### **1.5 Pre-Proposal Conference**

A Pre-Proposal Conference (Conference) will be held on Wednesday, January 16, 2013 beginning at 10:30 AM Local Time, at 201 West Preston Street, Room L-4, Baltimore, MD 21201. Attendance at the Conference is not mandatory, but all interested Offerors are encouraged to attend in order to facilitate better preparation of their proposals.

The Conference will be summarized. As promptly as is feasible, subsequent to the Conference, a summary of the Conference and all questions and answers known at that

time will be distributed to all prospective Offerors known to have received a copy of this RFP. This summary, as well as the questions and answers, will also be posted online.

In order to assure adequate seating and other accommodations at the Conference, please mail, e-mail, or fax the Pre-Proposal Conference Response Form to the attention of the Contract Monitor no later than 4:00 p.m. Local Time on Monday, January 14, 2013. The Pre-Proposal Conference Response Form is included as **Attachment D** to this RFP. In addition, if there is a need for sign language interpretation and/or other special accommodations due to a disability, please notify the Contract Monitor no later than Monday, January 14, 2013. The Department will make a reasonable effort to provide such special accommodation.

## **1.6 Questions**

Written questions from prospective Offerors will be accepted by the Contract Monitor prior to the Conference. If possible and appropriate, such questions will be answered at the Conference. (No substantive question will be answered prior to the Conference.) Questions may be submitted by e-mail to the Contract Monitor. Questions, both oral and written, will also be accepted from prospective Offerors attending the Conference. If possible and appropriate, these questions will be answered at the Conference.

Questions will also be accepted subsequent to the Conference and should be submitted to the Contract Monitor in a timely manner prior to the proposal due date. **Questions will be accepted until Monday, January 21, 2013.** Time permitting, answers to all substantive questions that have not previously been answered, and are not clearly specific only to the requestor, will be distributed to all vendors that are known to have received a copy of the RFP.

## **1.7 Proposals Due (Closing) - Date and Time**

Proposals, in the number and form set forth in section 4.2 "Proposals," must be received by the Contract Monitor at the address listed on the Key Information Summary Sheet no later than 2:00 PM Local Time on Thursday, January 24, 2013 to be considered.

Requests for extension of this date or time will not be granted. Offerors mailing proposals should allow sufficient mail delivery time to ensure timely receipt by the Contract Monitor. Proposals received by the Contract Monitor after the due date and time listed in this section will not be considered.

Proposals may be modified or withdrawn by written notice to the Contract Monitor before the time and date set forth in this section for receipt of proposals.

**Proposals may not be submitted by e-mail or facsimile.**

## **1.8 Duration of Offer**

Proposals submitted in response to this RFP are irrevocable for 120 days following the closing date of proposals. This period may be extended at the Contract Monitor's request only with the Offeror's written agreement.

## **1.9 Revisions to the RFP**

If it becomes necessary to revise this RFP before the due date for proposals, the Department shall endeavor to provide addenda to all prospective Offerors that were sent this RFP, or which are otherwise known by the Contract Monitor to have obtained this RFP. In addition, addenda to the RFP will be posted on the REM website, located at <http://mmcp.dhmd.maryland.gov/longtermcare/SitePages/Home.aspx>. It remains the responsibility of all prospective Offerors to check the website for any addenda issued prior to the submission of proposals. Addenda made after the due date for proposals will be sent only to those Offerors that submitted a timely proposal.

Acknowledgment of the receipt of all addenda to this RFP issued before the proposal due date must accompany the Offeror's proposal in the Transmittal Letter accompanying the Technical Proposal. Acknowledgement of the receipt of addenda to the RFP issued after the proposal due date shall be in the manner specified in the addendum notice. Failure to acknowledge receipt of an addendum does not relieve the Offeror from complying with the terms, additions, deletions, or corrections set forth in the addendum.

## **1.10 Cancellations; Discussions**

The State reserves the right to cancel this RFP, to accept or reject any and all proposals, in whole or in part, received in response to this RFP, to waive or permit the cure of minor irregularities, and to conduct discussions with all qualified or potentially qualified Offerors in any manner necessary to serve the best interests of the State. The State also reserves the right, in its sole discretion, to award a Contract based upon the written proposals received without discussions or negotiations.

## **1.11 Oral Presentation**

Offerors may be required to make oral presentations to State representatives. Offerors must confirm in writing any substantive oral clarification of, or change in, their proposals made in the course of discussions. Any written clarifications or changes then are incorporated into the Offeror's proposal and are binding if the Contract is awarded. The Contract Monitor will notify Offerors of the time and place of oral presentations.

## **1.12 Incurred Expenses**

The State will not be responsible for any costs incurred by an Offeror in preparing and submitting a proposal, in making an oral presentation, in providing a demonstration, or in performing any other activities related to this solicitation.

### **1.13 Economy of Preparation**

Proposals should be prepared simply and economically and provide a straightforward and concise description of the Offeror's proposals to meet the requirements of this RFP.

### **1.14 Protests/Disputes**

Any appeal related to this solicitation shall be subject to the provisions of COMAR 10.01.03, except that the Department shall hold a hearing, consider any exceptions and render a final decision within 30 days of the date an appeal is filed. Appeals must be filed with the Contract Monitor within seven (7) calendar days of the date of receipt by the Offeror of a letter of non-award or, if the Offeror requests a debriefing, within seven (7) calendar days of the debriefing. The Department may make an award of this contract notwithstanding an appeal. Appeal by an unsuccessful offeror of an award of this contract does not stay the start date of the contract as agreed to by the Department and the selected awardee.

### **1.15 Multiple or Alternate Proposals**

Multiple and/or alternate proposals will not be accepted

### **1.16 Public Information Act Notice**

An Offeror should give specific attention to the clear identification of those portions of its proposal that it considers confidential and/or proprietary commercial information or trade secrets, and provide justification why such materials, upon request, should not be disclosed by the State under the Public Information Act, Md. Code Ann., State Government Article, Title 10, Subtitle 6. (See section 4.4.3.2 "Claim of Confidentiality".) This confidential and/or proprietary information should be identified by page and section number and placed after Title Page and before the Table of Contents.

### **1.17 Offeror Responsibilities**

The selected Offeror shall be responsible for all services required by this RFP. All subcontractors must be identified and a complete description of their role relative to the proposal must be included in the Offeror's proposal. If an Offeror that seeks to perform or provide the services required by this RFP is a subsidiary of another entity, all information submitted by the Offeror, such as, but not limited to, references and financial reports shall pertain exclusively to the Offeror unless the parent organization will



guarantee the performance of the subsidiary. If applicable, the Offeror's proposal must contain an explicit statement that the parent organization will guarantee the performance of the subsidiary.

#### **1.18 Mandatory Contractual Terms**

By submitting an offer in response to this RFP, an Offeror, if selected for award, shall be deemed to have accepted the terms and conditions of this RFP and the Contract, attached herein as **Attachment A**. **Any exceptions to this RFP or the Contract must be raised prior to proposal submission. Changes to the solicitation or Contract made by the Offeror may result in rejection of the Offeror's proposal.**

#### **1.19 Bid/Proposal Affidavit**

A proposal submitted by an Offeror must be accompanied by a completed Bid/Proposal Affidavit. A copy of this Affidavit is included as **Attachment B** of this RFP.

#### **1.20 Contract Affidavit**

All Offerors are advised that if a Contract is awarded as a result of this solicitation, the successful Offeror will be required to complete a Contract Affidavit. A copy of this Affidavit is included as **Attachment C** of this RFP. This Affidavit must be provided within five (5) business days of notification of proposed Contract award; however, to expedite processing, it is suggested that this document be completed and submitted with the Technical Proposal.

#### **1.21 Arrearages**

By submitting a response to this solicitation, each Offeror represents that it is not in arrears in the payment of any obligations due and owing the State, including the payment of taxes and employee benefits, and that it shall not become in arrears during the term of the Contract if selected for Contract award.

#### **1.22 Verification of Registration and Tax Payment**

Before a corporation can do business in the State, it must be registered with the Department of Assessments and Taxation (SDAT). SDAT is located at State Office Building, Room 803, 301 West Preston Street, Baltimore, Maryland 21201. The SDAT website is <http://www.dat.state.md.us/sdatweb/datanote.html>.

It is strongly recommended that any potential Offeror complete registration prior to the due date for receipt of proposals. An Offeror's failure to complete registration SDAT

may disqualify an otherwise successful Offeror from final consideration and recommendation for Contract award.

### **1.23 Federal Funding Acknowledgement**

This Contract ( does) ( does not) contain federal funds. If contained, the source of these federal funds is Medical Care Programs – Provider Reimbursements, T380. The CFDA number is 93.778. The conditions that apply to all federal funds awarded by the Department are contained in Federal Funds **Attachment E**. Acceptance of this agreement indicates the Offeror’s intent to comply with all conditions, which are part of this agreement.

### **1.24 HIPAA - Business Associate Agreement**

Based on the determination by the Department that the functions to be performed in accordance with this solicitation constitute Business Associate functions as defined in HIPAA, the Offeror shall execute a Business Associate Agreement as required by HIPAA regulations at 45 C.F.R. §164.501 and set forth in **Attachment G**. This Agreement must be provided within five (5) business days of notification of proposed Contract award; however, to expedite processing, it is suggested that this document be completed and submitted with the bid. Should the Business Associate Agreement not be submitted upon expiration of the five (5) day period as required by this solicitation, the Contract Monitor, upon review of the Office of the Attorney General and approval of the Secretary, may withdraw the recommendation for award and make the award to the next qualified Offeror.

### **1.25 Conflict of Interest Affidavit and Disclosure**

All Offerors are advised that if a Contract is awarded as a result of this solicitation, the successful Contractor’s personnel and each of the participating subcontractor personnel shall be required to complete agreements such as **Attachment F** – Conflict of Interest Affidavit and Disclosure. For policies and procedures applying specifically to Conflict of Interests, the Contract is governed by COMAR 21.05.08.08. Offerors shall complete and sign the Conflict of Interest Affidavit and Disclosure and submit it with their proposals.

### **1.26 Electronic Procurements Authorized**

- A. Participation in the solicitation process for this contract shall constitute consent by the bidder/Offeror to conduct by electronic means all elements of the procurement of that Contract which are specifically authorized under the solicitation or the Contract.
- B. “Electronic means” refers to exchanges or communications using electronic, digital, magnetic, wireless, optical, electromagnetic, or other means of electronically conducting transactions. Electronic means includes facsimile, e-mail, internet-based communications, electronic funds transfer, specific electronic

bidding platforms (e.g., eMarylandMarketplace.com), and electronic data interchange.

C. The following transactions are authorized to be conducted by electronic means on the terms described:

1. The Contract Monitor may conduct the procurement using e-mail or facsimile to issue:

- (a) the solicitation;
- (b) any amendments;
- (c) pre-proposal conference documents;
- (d) questions and responses;
- (e) communications regarding the solicitation or proposal to any Offeror or potential Offeror including requests for clarification, explanation, or removal of elements of an Offeror's proposal deemed not acceptable;
- (f) notices of award selection or non-selection; and
- (g) the Contract Monitor's decision on any bid protest related to this solicitation.

2. An Offeror or potential Offeror may use e-mail to:

- (a) ask questions regarding the solicitation;
- (b) reply to any material received from the Contract Monitor by electronic means that includes a Contract Monitor's request or direction to reply by e-mail or facsimile, but only on the terms specifically approved and directed by the Contract Monitor;
- (c) request a debriefing; or
- (d) submit a "No Bid Response" to the solicitation.

3. The Contract Monitor and the Contractor may conduct day-to-day Contract administration, except as outlined in section E of this subsection utilizing e-mail, facsimile, or other electronic means if authorized by the Contract Monitor.

D. The following transactions related to this procurement and any Contract awarded pursuant to it are *not authorized* to be conducted by electronic means:

- 1. submission of initial bids or proposals;
- 2. filing of protests and other appeals related to this Contract;
- 3. submission of documents determined by the Department to require original signatures (e.g., Contract execution, Contract modifications, etc); or
- 4. any transaction, submission, or communication where the Contract Monitor has specifically directed that a response from the Contractor or Offeror be provided in writing or hard copy.

- E. Any facsimile or electronic mail transmission is only authorized to the facsimile numbers or e-mail addresses for the identified person as provided in the solicitation, the Contract, or in the direction from the Contract Monitor.

<b>1.27 Substitution of Personnel</b>
---------------------------------------

- A. Continuous Performance of Key Personnel

Unless substitution is approved per paragraphs B-D of this section, key personnel shall be the same personnel proposed in the Contractor's Technical Proposal, which will be incorporated into the Contract by reference. Such identified key personnel shall perform continuously for the duration of the Contract, or such lesser duration as specified in the Technical Proposal. Key personnel may not be removed by the Contractor from working under this Contract, as described in the RFP or the Contractor's Technical Proposal, without the prior written approval of the Contract Monitor.

- B. Definitions

For the purposes of this section, the following definitions apply:

**Extraordinary Personal Circumstance** – means any circumstance in an individual's personal life that reasonably requires immediate and continuous attention for more than fifteen (15) days and that precludes the individual from performing his/her job duties under this Contract. Examples of such circumstances may include, but are not limited to: a sudden leave of absence to care for a family member who is injured, sick, or incapacitated; the death of a family member, including the need to attend to the estate or other affairs of the deceased or his/her dependents; substantial damage to, or destruction of, the individual's home that causes a major disruption in the individual's normal living circumstances; criminal or civil proceedings against the individual or a family member; jury duty; and military service call-up.

**Incapacitating** – means any health circumstance that substantially impairs the ability of an individual to perform the job duties described for that individual's position in the RFP or the Contractor's Technical Proposal.

**Sudden** – means when the Contractor has less than thirty (30) days prior notice of a circumstance beyond its control that will require the replacement of any key personnel working under the Contract.

- C. Key Personnel General Substitution Provisions

The following provisions apply to all of the circumstances of staff substitution described in paragraph D of this section.

1. The Contractor shall demonstrate to the Contract Monitor's satisfaction that the proposed substitute key personnel have qualifications at least equal to those of the key personnel for whom the replacement is requested.
2. The Contractor shall provide the Contract Monitor with a substitution request that shall include:
  - A detailed explanation of the reason(s) for the substitution request;
  - The resume of the proposed substitute personnel, signed by the substituting individual and his/her formal supervisor;
  - The official resume of the current personnel for comparison purposes; and
  - Any evidence of any required credentials.
3. The Contract Monitor may request additional information concerning the proposed substitution. In addition, the Contract Monitor and/or other appropriate State personnel involved with the Contract may interview the proposed substitute personnel prior to deciding whether to approve the substitution request.
4. The Contract Monitor will notify the Contractor in writing of: (i) the acceptance or denial, or (ii) contingent or temporary approval for a specified time limit, of the requested substitution. The Contract Monitor will not withhold approval of a requested key personnel replacement unreasonably.

D. Replacement Circumstances

1. Voluntary Key Personnel Replacement

To replace any key personnel voluntarily, the Contractor shall submit a substitution request as described in paragraph C of this section to the Contract Monitor at least fifteen (15) days prior to the intended date of change. Except in a circumstance described in paragraph D.2 of this clause, a substitution may not occur unless and until the Contract Monitor approves the substitution in writing.

2. Key Personnel Replacement Due to Vacancy

The Contractor shall replace key personnel whenever a vacancy occurs due to the Sudden termination, resignation, leave of absence due to an Extraordinary Personal Circumstance, Incapacitating injury, illness or physical condition, or death of such personnel. (A termination or resignation with thirty (30) days or more advance notice shall be treated as a Voluntary Key Personnel Replacement as per section D.1 of this section.).

Under any of the circumstances set forth in this paragraph D.2, the Contractor shall identify a suitable replacement and provide the same information or items required under paragraph C of this section within fifteen (15) days of

the actual vacancy occurrence or from when the Contractor first knew or should have known that the vacancy would be occurring, whichever is earlier.

3. Key Personnel Replacement Due to an Indeterminate Absence

If any key personnel has been absent from his/her job for a period of ten (10) days due to injury, illness, or other physical condition, leave of absence under a family medical leave, or an Extraordinary Personal Circumstance and it is not known or reasonably anticipated that the individual will be returning to work within the next twenty (20) days to fully resume all job duties, before the 25th day of continuous absence, the Contractor shall identify a suitable replacement and provide the same information or items to the Contract Monitor as required under paragraph C of this section.

However, if this person is available to return to work and fully perform all job duties before a replacement has been authorized by the Contract Monitor, at the option and sole discretion of the Contract Monitor, the original personnel may continue to work under the Contract, or the replacement personnel will be authorized to replace the original personnel, notwithstanding the original personnel's ability to return.

4. Directed Personnel Replacement

- a. The Contract Monitor may direct the Contractor to replace any personnel who are perceived as being unqualified, non-productive, unable to perform the job duties fully due to full or partial Incapacity or Extraordinary Personal Circumstance, disruptive, or known, or reasonably believed, to have committed a major infraction(s) of law, agency, or Contract requirements. Normally, a directed personnel replacement will occur only after prior notification of problems with requested remediation, as described in paragraph 4.b. If after such remediation the Contract Monitor determines that the personnel performance has not improved to the level necessary to continue under the Contract, if possible at least fifteen (15) days notification of a directed replacement will be provided. However, if the Contract Monitor deems it necessary and in the State's best interests to remove the personnel with less than fifteen (15) days' notice, the Contract Monitor can direct the removal in a timeframe of less than fifteen (15) days, including immediate removal.

In circumstances of directed removal, the Contractor, in accordance with paragraph C of this section, shall provide a suitable replacement for approval within fifteen (15) days of the notification of the need for removal, or the actual removal, whichever occurs first.

- b. If deemed appropriate in the discretion of the Contract Monitor, the Contract Monitor shall give written notice of any personnel performance issues to the Contractor, describing the problem and delineating the remediation requirement(s). The Contractor shall provide a written Remediation Plan within ten (10) days of the date of the notice and shall implement the Remediation Plan immediately upon written acceptance by the Contract Monitor. If the Contract Monitor rejects the Remediation Plan, the Contractor shall revise and resubmit the plan to the Contract Monitor within five (5) days, or in the timeframe set forth by the Contract Monitor in writing.

Should performance issues persist despite the approved Remediation Plan, the Contract Monitor will give written notice of the continuing performance issues and either request a new Remediation Plan within a specified time limit or direct the substitution of personnel whose performance is at issue with a qualified substitute, including requiring the immediate removal of the key personnel at issue.

Replacement or substitution of personnel under this section shall be in addition to, and not in lieu of, the State's remedies under the Contract or which otherwise may be available at law.

#### **1.28 Non-Disclosure Agreement**

All Offerors are advised that this solicitation and any resultant Contract(s) are subject to the terms of the Non-Disclosure Agreement (NDA) contained in this solicitation as **Attachment H**. This Agreement must be provided within five (5) business days of notification of proposed Contract award; however, to expedite processing, it is suggested that this document be completed and submitted with the Technical Proposal.

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## **SECTION 2 – OFFEROR MINIMUM QUALIFICATIONS**

The Offeror must provide proof with its proposal that the following minimum qualifications have been met.

The Offeror must have at least five (5) years experience providing health care case management services.

Neither the Offeror nor the parents, affiliates, or subsidiaries of the Offeror may provide any other direct health care services than case management under Maryland Medical Assistance program.

The Offeror must commit in writing to being available beyond the termination of this contract for the accountability of any services performed as part of the contract including, but not limited to, providing documents and witnesses.

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## SECTION 3 – SCOPE OF WORK

### 3.1 Purpose

- 3.1.1. The REM program arranges and oversees the cost-effective provision of case management services for a diagnosis-defined HealthChoice eligible population. This is accomplished through a competitively procured statewide contract with a case management service provider who is capable of meeting REM program standards and requirements. The REM program's guiding principle is to provide individualized case management services that take into consideration the client's special health care and psychosocial needs. The goals of REM case management are to facilitate access to quality health care, to promote coordination of services in the most cost-effective manner, and to optimize the REM participant's functional ability.

### 3.2 Scope of Work - Requirements

#### 3.2.1 Case Assignment

**Standard:** The Contractor shall provide case management services for all REM participants. The effective date of enrollment in REM for a REM participant and a REM eligible participant is the REM begin date on the REM Enrollment and Disenrollment form.

**The Contractor shall:**

1. Assign a case manager to new REM participants and provide the Department with the name of the case manager within one (1) business day.
2. Provide REM case management services to a REM participant or REM eligible participant only after receiving a REM referral form from the Department.
3. Provide interpreter services for case management contact or assign a case manager with appropriate language proficiency if the REM participant or REM eligible participant is limited in their English proficiency, and include a note in the case file about language interpretation services for future activities. (A breakdown of languages spoken by REM participants to date is in Appendix X.)
4. Complete a REM Service Coordination Form (Appendix C-3) within fourteen (14) days of the Contractor's receipt of the referral for a REM eligible participant and a list of ongoing services and medical supplies from the MCO.
  - a. Verify through the Medicaid Management Information System (MMIS) if the current services and supply providers are a Medical Assistance (MA) fee-for-service provider. If the current provider is not a fee-for-service provider, provide a list of fee-for-service providers to

the REM eligible participant to use in the selection of another provider.

- b. Contact the REM eligible participant to verify that they have adequate medical supplies on hand to allow sufficient time for the transition of the participant's services over to a fee for service provider.

### 3.2.2 **REM Participant Assessment and Development of Case Management Plan**

**Standard:** A REM participant's overall medical and psychosocial health status shall be comprehensively assessed by the Contractor's assigned case manager using the required Assessment Form (Appendix C-1).

**The Contractor shall:**

1. Make a telephone contact with the REM participant or REM eligible participant by the next business day of the Contractor's assignment.
2. Obtain from the REM participant, or from the REM participant's parents or legal guardian, a signed Consent to Release Information Form (Appendix P).
3. Gather and review all relevant information needed to determine the REM participant or REM eligible participant's condition and needs, upon assignment. This information may include medical records and consultation with service providers and MCO Special Needs Coordinators (if applicable), as well as psychosocial and environmental assessments. This also includes reviewing the information about the services being provided by the MCO from the Current MCO Services Form (Appendix AA).
4. Conduct a face-to-face meeting with the REM participant or REM eligible participant and their parent or guardian (if applicable), and complete an initial onsite assessment of the REM participant or REM eligible participant's condition and needs within ten (10) calendar days of the Contractor's receipt from the Department of the REM participant or REM eligible participant's referral. The parent, guardian, or legally competent REM participant or REM eligible participant must sign and date the REM Participant Visit Form (Appendix Q).
5. Assist the family with completing the Emergency Information Form for Children with Special Needs (Appendix C-2).
6. Complete the following reports within thirty (30) calendar days of the receipt of referral:
  - a. Assessment Report (Appendix C-1)
    - Develop the Assessment Report based upon the initial onsite visit; the information gathered during document review; and consultations with the REM participant, the REM participant's family member(s) and/or guardian(s) (as appropriate), the primary care provider, and other

- providers involved in the participant's care.
    - Review and revise every twelve (12) months according to the date of enrollment for each REM participant.
  - b. Interdisciplinary Plan of Care (Appendix E)
    - Develop the Interdisciplinary Plan of Care (Appendix E), in consultation with the REM participant, the REM participant's family member(s) and/or guardian(s) (as appropriate), the primary care provider, and other providers involved in the participant's care.
  - c. Case Management Plan (Appendix F)
    - Develop a Case Management Plan (Appendix F) in which the case manager identifies current and potential complications and problems, interventions that the case manager plans to initiate, and mutually agreed upon goals for the REM participant.
- 7. Use the Level of Care Guidelines (Appendix G) to assign a level of care to the REM participant or REM eligible participant.
- 8. Ensure the Assessment Report, Interdisciplinary Plan of Care, Case Management Plan, and Level of Care assignment receive supervisory approval within 10 days of completion.
- 9. Within 30 days of the receipt of referral, provide the DSS caseworker with a copy of the REM participant or REM eligible participant's signed Consent to Release Information Form (Appendix P) allowing the Contractor to be identified as an Authorized Representative.
- 10. Based on information from the Current MCO Services Form (Appendix AA), assist the REM participant to select appropriate providers who participate in the Medicaid fee-for-service program.

### 3.2.3 Implementation and Monitoring of the Case Management Plan

**Standard:** The case manager shall ensure the achievement of case management goals for the client as described in the Case Management Plan by implementing and monitoring stated interventions towards successful completion.

**The Contractor shall:**

1. Contact the REM participant and primary care provider at the minimum communication frequency specified for the accompanying level of care in the REM Case Manager Minimum Reporting and Contact Requirements (Appendix H), and more frequently when necessitated by the participant's condition.
2. Ensure all case managers are able to have face-to-face consultations with their assigned REM participants within 24 hours notice.
3. Maintain a record of contacts for each REM participant utilizing the Contact Record format (Appendix J).
4. Notify the Department if unable to maintain the minimum contact guidelines

- with the REM participant as described in the REM Case Manager Minimum Reporting and Contact Requirements (Appendix H).
5. Report to the Department any significant event relating to a REM participant as soon as the Contractor becomes aware of the problem using the Real Time Significant Events Reporting Form (Appendix R).
  6. Notify the Department of any issue concerning interagency cooperation or coordination within the Department that adversely affects a REM participant.
  7. Submit to the Department a REM Participant Roster (Appendix M) for each calendar month, by the fifteenth (15<sup>th</sup>) of the following month. The Participant Roster must include the correct payment code abbreviation as described in Appendix N-1.
  8. Submit to the Department a Case Management Activity Summary (Appendix N), by the fifteenth (15<sup>th</sup>) of the following month. The Case Management Activity Summary must include the correct level of care abbreviation as described in Attachment N-1.
  9. Review and revise the Assessment Report (Appendix C-1), the Interdisciplinary Plan of Care (Appendix E), and Case Management Plan (Appendix F), according to the REM Case Manager Minimum Reporting and Contact Requirements (Appendix H).
  10. Educate REM participants, their parent(s), and guardian(s) (as appropriate) on proper utilization of medical services and supplies, using pattern of utilization information from quarterly paid claims reports.
  11. Revise the Interdisciplinary Plan of Care when the acuity of the participant's medical condition changes, when a significant event occurs, or when a level of care changes.
  12. Communicate changes in the Interdisciplinary Plan of Care to the REM participant, family, the primary care provider, and other providers who would be affected by the change in the plan of care.

#### 3.2.4 Coordination of REM Participant Services

**Standard:** The case manager shall assist the REM participant to obtain, arrange, and coordinate medically necessary services, equipment, and supplies to ensure continuity of care and achievement of case management goals for the participant. Requests for services may require contact with the providers and DHMH.

**The Contractor shall:**

1. Based on the participant or caregiver's level of ability, assist the REM participant in gaining access to medically necessary services and verify that the recommended levels of services were received.
2. Submit to the Department, upon request, a current Interdisciplinary Plan of Care and Case Management Plan, or other additional information to support a determination of medical necessity with respect to services, equipment, and supplies requested for a REM participant.
3. Serve as a liaison between the somatic care providers and the Maryland public

- mental health systems provider, if the REM participant has received a referral or services from both.
4. Refer REM participants back to the Department and stop providing REM case management services if unable to meet minimum contact and reporting requirements for 60 days (Appendix DD).
  5. Serve as a liaison between other case managers and service coordinators when the REM participant is participating in additional waiver programs.
  6. Facilitate receipt of services in accordance with the current Maryland Schedule of Preventive Health Care (Appendix D) to EPSDT-eligible REM participants.
    - a. Assist participants and family (if applicable) with scheduling appointments for EPSDT services.
    - b. Arrange transportation for REM participant to and from the provider's location (if applicable).
  7. Upon notification from the Department or its designee about a hospital admission of a REM participant, contact and assist the REM participant's inpatient case manager with discharge planning by assessing discharge needs, assisting with identifying community service providers, and arranging transportation (if needed).
  8. Submit to the Department, upon request, a Private Duty Nursing Assessment (Appendix W), if the REM participant is requesting new or additional private duty nursing or shift home health aide services, and once every twelve (12) months for a REM participant receiving ongoing private duty nursing services.
  9. Assist the REM participant in coordination of school health-related services with the local educational agency responsible for implementing a REM participant's Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP), if applicable.
  10. Assist the REM participant in coordination of services through other state agencies including the Developmental Disability Administration of the Department.
  11. Encourage the REM participant to complete their Medicaid re-determination paperwork timely and to contact their DSS worker for assistance if necessary, in order to ensure uninterrupted eligibility.

### 3.2.5 REM Participant Case Transition and Closure

**Standard:** The case manager shall assist the REM participant in selecting an MCO, renewing eligibility as needed, and continuing to coordinate services when the participant is determined to be non-eligible for REM but eligible for HealthChoice.

**The Contractor shall:**

1. Case Transition
  - a. Assist the REM participant in determining which MCO best suits their

- health care needs when a REM participant is no longer eligible for the REM program but is eligible for HealthChoice.
- b. If the REM participant has chosen an MCO, complete the Current FFS Services Form (Appendix Z) and send it to the appropriate MCO Special Needs Coordinator.
  - c. Continue all required activities for Interdisciplinary Plan of Care implementation and monitoring, until Contractor receives confirmation of the effective date of termination from the REM program.
2. Case Closure
- a. Complete and submit a Request for Case Closure Form (Appendix L-1) for REM participants transitioning from or exiting the program, including REM participants who have been continuously hospitalized in a long-term care facility for longer than 30 days.
  - b. Complete the REM Closure Report (Appendix L-2) summarizing case management activities within fourteen (14) calendar days of the approval of the Request for Case Closure (Appendix L-1).

### 3.2.6 Case Management Administration

**Standard:** The Contractor shall have the organizational expertise, structure, and capacity to administer case management services to REM participants properly and efficiently.

**The Contractor shall:**

1. Maintain a Maryland office with a daily business schedule of 8 AM – 5 PM, except for weekends and holidays. For a holiday schedule, refer to the State Holiday schedule located at <http://www.dbm.maryland.gov/employees/Pages/StateHolidays2012.aspx>.
2. Have the ability to serve approximately 4000 - 5500 cases at any one time. However, there is no minimum case assignment guaranteed to the Contractor on a monthly or aggregate basis.
3. Assign a Provider Relations Representative to handle inquiries from providers and serve as a liaison between providers and case managers when case managers are unavailable.
  - a. The Provider Relations Representative will be responsible for returning provider calls and emails on the same or the next business day, as appropriate.
  - b. The Provider Relations Representative will be responsible for relaying pertinent information affecting REM participants from providers to the appropriate case managers, and vice versa.
  - c. All calls received should be documented in the case file for the REM participant.
  - d. The Provider Relations Representative will prepare monthly reports for the Contract Monitor, accounting for the nature and volume of contacts received, in a format determined by the Contractor.

- e. The Contractor will submit a monthly Provider Relations Activity Report (Appendix I) for the Department describing the nature of their contacts and feedback from providers.
  - f. Additional staff may be required for this position, depending on call volume.
4. Train case management staff in procedures and policies necessary to fulfill contract requirements, as well as share all ongoing policy, procedure, and program changes.
  5. Designate a Contract Manager who will serve as the main point of contact between the Contractor and the Department, and will be held responsible for fulfilling all the obligations provided in the Contract.
  6. Participate in Department-sponsored Contractor meetings and training as directed by the Department. Meetings will begin on a weekly basis and adjust in frequency commensurate with the Contractor's performance.
  7. Provide a monthly report totaling the number of REM participants by case manager and case supervisor, using the REM Case Manager, Case Load, and Supervisor Monthly Reporting Format (Appendix U).
  8. Ensure compliance with the Health Information Portability and Accessibility Act (HIPAA) by limiting access to REM participants' Medicaid information 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.
  9. Maintain adequate records that fully describe the nature and extent of all services provided to REM participants, including but not limited to case management reports, medical records, charts, laboratory test results, and medication records, for a minimum of six (6) years.
  10. Provide certified copies of medical records and originals of business records upon request to the Department and/or its designee, the Medicaid Fraud Control Unit, any other authorized state, or Federal agency, as otherwise required by State and Federal law or regulation, and/or pursuant to subpoena or court order.
  11. Provide a functioning voice mail system and return all calls and messages received by the next business day.
  12. Ensure all case managers are able to have face-to-face consultations with their assigned REM participants within 24 hours notice.
  13. Produce all reports and letters in formats approved by the Department.
  14. Forward all referrals for potential REM participants to the Department.
  15. Notify providers in writing about inappropriate utilization of services using formats approved by the Department.

### 3.2.7 **Quality Improvement and Performance Measures**

**Standard:** The Contractor shall develop, implement, evaluate, and report case management quality improvement and performance activities that are designed to

achieve REM participants' case management goals. These activities shall include development of a Quality Improvement Program (Appendix O) and monitoring of health outcomes for the REM population.

**The Contractor shall:**

1. Quality Improvement
  - a. Under the direction of a Quality Improvement Manager, establish a system of review and approval for all case management Assessment Forms, Interdisciplinary Plans of Care, Case Management Plans and pertinent supporting documentation (i.e. contact records, level of care designations, significant event reports, etc.)
  - b. Train supervisors to conduct reviews and issue approvals for assessments and plans of care. The case management supervisors must review each report of a case manager concerning a REM participant's activity level change or a significant event to determine and certify that the report is complete and timely.
  - c. Perform monthly internal audits of case managers' adherence to contracted case management standards and requirements (Appendix H) to include at a minimum timely completion of required tasks.
    - i. Report to the Department the quantitative results of its monthly internal audits summarizing whether case managers failed to complete contact and reporting requirements, using the template provided by DHMH (Unmet Quality Improvement Indicator Report Form, Appendix V).
    - ii. Plan and conduct at least two (2) formal training sessions for case managers per contract year on areas of weakness as identified in the reviews and audits of case management performance.
  - d. Adhere to national clinical practice guidelines and nationally recognized case management standards.
  - e. Conduct one-on-one training and/or coordinate case review sessions for selected REM participant cases that pose significant challenges to case managers on an as-needed basis.
  - f. Participate in Department-sponsored case management training and continuing education seminars.
  - g. Investigate and report to the Department, using the forms specified by DHMH, quality of care incidents subject to the Quality Improvement Program Requirements (Appendix O).
  - h. Submit a monthly complaint log to the Department in the format provided in Appendix Y by the 15<sup>th</sup> of the following month.
  - i. Submit a monthly significant events report to the Department in the format provided in Appendix S by the 15<sup>th</sup> of the following month.
  - j. Submit a monthly Provider Relations Activity Report (Appendix I) to the Department, in a format to be provided by the Department, by the 15<sup>th</sup> of the following month.



- k. Submit to the Department, no later than November 1 of each contract year, the Contractor's written Quality Improvement Plan for the subsequent contract year. The Department must approve the plan prior to implementation. Quality Improvement Plan requirements are outlined in Appendix O.
  - l. Participate in the development, implementation, data collection, and evaluation of Department-initiated Quality Outcome Studies, special Quality Improvement Reviews, REM participant satisfaction studies, or any other quality initiative required by the Department.
  - m. Prepare and submit Corrective Action Plans when requested by the Department that describe the activities that will be adopted to correct the Contractor's poor performance or non-performance.
  - n. Review participant specific cost data at a minimum of once every three months.
    - i. Educate REM participants and their parent(s) or guardian(s) about proper service utilization, as needed.
    - ii. Coordinate services for REM participants to decrease, at a minimum, duplicative diagnostic testing, repetitive hospital admissions, emergency room visits, unnecessary medical equipment and supplies, and urgent care visits.
2. Performance Measures
- a. The Department will evaluate the outcomes of case management and the Contractor's service delivery, using at a minimum:
    - i. Current Maryland Schedule of Preventive Health Care included in Appendix D, REM participant referrals to school programs, state agencies, or other private agencies;
    - ii. REM participant hospital admissions or long term care admissions; and
    - iii. REM participant use of emergency or urgent care services.
  - b. Case managers should monitor that REM participants receive the medical services including but not limited to the following, as appropriate to their ages and health needs:
    - i. Child immunizations
    - ii. Adolescent immunizations
    - iii. Lead screenings for children
    - iv. Adult access to preventative care
    - v. Flu immunizations
    - vi. Well child visits for children ages 0-15 months
    - vii. Well child visits for children ages 3-4 years
    - viii. Well child visits for children ages 5-6 years
    - ix. Adolescent well care visits
    - x. Ambulatory care services for SSI participants (all ages)
  - c. Current REM participant care measures are included in Appendix BB.

### 3.2.8 Contractor Evaluation

**Standard:** The Department shall conduct contract compliance reviews assessing the Contractor's performance, including but not limited to the assignment of the appropriate level of care, and the minimum contract requirements. If the Department determines that a Contractor, any agent or employee of the Contractor, or any person with an ownership interest in the Contractor or related party of the Contractor has failed to comply with all contract requirements, the Department may initiate one or more actions against the Contractor, including but not limited to:

- a. Corrective action plan;
- b. Monetary penalties;
- c. Termination of the contractual relationship.

### 3.2.9 **Information Technology**

The Contractor shall:

1. Use computer hardware and software compatible with hardware and software used and designated by the Department (including, but not limited to, internet access for case managers).
2. Manage all case management records electronically, with the capability of incorporating scanned documents and information into the record.
3. Have the capability of electronically transmitting any forms, records, data, or reports to the Department.
4. Develop a secure, electronic case management record system containing all files and information on all REM and REM-eligible participants with web portal access for the Department staff.
  - a. The portal must have the capability to exchange files securely between the Department and the Contractor.
  - b. The portal must have the capability to permit the Department staff to securely access, view, and print REM participant case management files.
  - c. The portal must have the capability to maintain an audit trail of all modifications to records and documents, the person responsible, and the date and time of the change.
  - d. The portal must store reports in a downloadable format.
  - e. The portal must have the capability to print all records, rosters, logs, reports and information relating to individual cases, supervision, and quality improvement tracking.
5. Generate downloadable electronic files for all REM data, including REM Assessment Reports, IPOCs, CMPs, activity notes, and participant rosters.
6. Implement prudent information system operational procedures including, but not limited to, current virus protection, daily data back-up, off-site storage of backup, and data recovery procedures.
7. Develop and implement an effective disaster recovery plan for restoring software, master files and hardware if management information systems

- are disabled, with the plan including the timeframe to restore all function.
8. Update the computer resources promptly to maintain compatibility with the Department.

### 3.2.10 Staffing

1. Key Staff
  - a. Contract Manager
    - i. The Contract Manager must have at least five (5) years of clinical experience.
    - ii. The Contract Manager must have at least five (5) years (concurrent or consecutive) of case management and supervisory experience.
  - b. Quality Improvement Manager
    - i. The Quality Improvement Manager must have at least five (5) years of previous health care experience in program improvement, case management, or utilization review, with specific experience in developing and implementing performance programs.
    - ii. The Quality Improvement Manager must have familiarity with designing and implementing quality improvement or disease management programs for severely disabled and medically compromised populations is preferred.
2. Other Personnel
  - a. Case Managers
    - i. All case managers must have at least two (2) years experience in providing healthcare case management services.
    - ii. All case managers must be either licensed registered nurses or licensed social workers.
    - iii. All licensed social workers must have nationally recognized certifications in case management. In lieu of the nationally recognized certification in case management, the Department will accept licensed certified social workers – clinical (LCSW-C). Examples of nationally recognized certifications include Certified Case Manager (CCM), Certified Advanced Social Work Case Manager (C-ASWCM), and Certified Social Work Case Manager (C-SWCM).
  - b. Case Manager Supervisors
    - i. Case manager supervisors must have at least five (5) years experience in providing healthcare case management services to adults and/or children.
    - ii. Case manager supervisors must have at least two (2) years of supervisory experience in a nursing or case management setting.
  - c. Provider Relations Representatives

Provider Relations Representatives must have at least two (2) years experience in provider relations.

### 3.2.11 Transition

#### 1. Contract Commencement Transition Requirements

A 60-day transition period shall begin on the day this contract is effective. During the transition, the new Contractor shall work cooperatively with the Department to ensure an efficient and timely commencement of contract responsibilities.

The transition phase is the time leading up to the point when the REM contractor will be expected to actually deliver case management services to participants on behalf of the State. It is expected that this phase will last approximately two (2) months, beginning on May 1, 2013. During this phase, the REM Contractor shall complete its case management staffing development and participant transition plans; develop and distribute education materials to eligible participants and providers; and establish its participant and provider call-in numbers. Also during this phase, the REM contractor must establish connectivity with the Department for file exchange using a secure web portal, gain access to eMedicaid for provider enrollment on Department's MMIS, and enroll as EDI submitter to submit claims in the HIPAA compliant 837P and 5010 formats. During this transition phase, there will be no payment made to the REM contractor. Payments will begin when REM case management service delivery under this contract begins on July 1, 2013.

- A. Within 10 business days of the award of this contract, the new Contractor shall submit to the Department a Transition Plan and Schedule of Activities to facilitate the assumption of responsibilities, information, computer databases, software and documentation, materials, etc. The Transition Plan shall include, at a minimum:
  - i. The Contractor's proposed approach to the transition;
  - ii. The Contractor's tasks, subtasks, and schedule for all transition activities; and
  - iii. An updated organizational chart and list of the Contractor's staff (titles, phone, fax, email) responsible for transition activities.
- B. The Department must approve the Transition Plan before it can be implemented.
- C. The new Contractor shall work closely and cooperatively with the Department to acquire appropriate software, hardware, records,

equipment, and other requirements deemed necessary by the Department.

- D. If the Department determines the Contractor is ready to commence work prior to the end of the transition period, the Department may give the Contractor approval to begin performing the duties and tasks outlined in the Scope of Work.

## 2. Contract Conclusion Transition Requirements

In the event that a new Contractor is selected, the Contractor shall work cooperatively with the Department and the successor Contractor at the end of this Contract to ensure an efficient and timely transition of contract responsibilities with minimal disruption of services.

- A. The Contractor shall prepare and submit an Exit Transition Plan and Schedule of Activities to facilitate the transfer of responsibilities, information, software and documentation, materials, etc., to a successor Contractor and/or the Department. The Exit Transition Plan shall be submitted by the Contractor within 30 days of the date of notification of termination by the Department. The Exit Transition Plan shall include, at a minimum:
  - i. Proposed approach to transition operations to another vendor;
  - ii. Identification and release of State owned documents;
  - iii. Timely turnover of all records and other necessary data to another review entity or appropriate custodian;
  - iv. Electronic records or files to be turned over to another entity, in an acceptable format to the Department (the cost of converting to the appropriate format will be the responsibility of the Contractor);
  - v. Designation of a knowledgeable person who will be available daily to assist the Department during the transition process and for one month following the transition date; and
  - vi. Proposed timeline for the transfer process.
- B. The Department must approve the Exit Transition Plan before it can be implemented.
- C. The Department and the successor Contractor will define all data files related to the Contract for transfer during this transition period and

deadlines for submission. The Department will have the final authority for determining the information required.

- D. The Contractor shall work closely and cooperatively with the Department and the successor Contractor to transfer appropriate software, records, and other items deemed necessary by the Department, and to ensure uninterrupted services to providers and the Department during the transition period. This includes concluding all unresolved audits initiated prior to the conclusion of the contract, attending any hearings resulting from the Contractor's assessments during the course of the contract, and defending the State's position at hearings pending final payment.
- E. At its sole discretion, the Department may elect to hold the final contract payment until all elements of the Exit Transition Plan are completed to the Department's satisfaction.

### 3.2.12 Deliverables

1. Work Plan – The final work plan must be submitted 15 days after the contract is awarded.
  - a. The work plan submitted by the Offeror should include an outline of the overall project management plan describing how they propose to assist the Department in the smooth transition of participants from their present case manager under the existing contracts to new case managers
  - b. Offerors must state how they intend to provide case management services for the entire state under the contract, and include documentation of its ability to serve all geographic areas.
  - c. Offerors must state their plan to complete re-assessments on all REM participants transferred to the Offeror at the beginning of the contract period.
2. Reports and Deadlines
  - a. Reports from the Department to Contractor
    - i. Hospital admissions data
    - ii. Nursing home admissions data
    - iii. Participant specific paid claim data
    - iv. Eligibility reports
    - v. Current levels of care for REM participants (for re-assessments at the beginning of the contract period only)
  - b. Reports from Contractor to the Department
    - i. Monthly Reports:
      1. A report listing each case management supervisor and the case managers assigned to the supervisor including a summary of the total number of case managers, the total number of REM participants, and the total number

- of each level of care assigned to each supervisor and case manager (Appendix U).
2. A REM Participant Roster for each calendar month (Appendix M), provided by the fifteenth (15<sup>th</sup>) of the following month. The Participant Roster must include the correct payment code abbreviation as described in Appendix N-1.
  3. A Case Management Activity Summary for each REM participant for each calendar month (Appendix N), provided by the fifteenth (15<sup>th</sup>) of the following month. The Activity Summary must include the correct level of care abbreviation as described in Appendix N-1.
  4. A completed Private Duty Nursing Assessment Form (Appendix W) for new private duty nursing and shift home health aide service requests for REM participants and every twelve (12) months for each REM participant who receives ongoing private duty nursing or shift home health aide services.
  5. An Unmet Quality Improvement Indicator Report (Appendix V), identifying the REM participants with un-met contact or reporting requirements.
  6. Monthly complaint log in the format provided in Appendix Y by the 15<sup>th</sup> of the following month.
  7. Monthly significant event report in the format provided by Appendix S, by the 15<sup>th</sup> of the following month.
  8. Monthly Provider Relations Activity Report (Appendix I) by the 15<sup>th</sup> of the following month.
- ii. Ad Hoc Reports and Ongoing Reports:
1. Results of quality of care incident investigations, subject to the reporting requirements of Appendix O, Section C (2) (a).
  2. Assessment Reports, an Interdisciplinary Plans of Care, and Case Management Plans for selected REM participants, upon request. Minimum reporting requirements are detailed in Appendix H.
  3. A Real-Time Significant Event Report (Appendix R) to the Department, as soon as the Contractor becomes aware of any occurrence, issue, adverse action, or adverse event relating to a REM participant
  4. Reviews of quarterly paid claims reports and notifications for patterns of overutilization and underutilization for REM participants inconsistent with the needs of the participant's medical condition.
  5. Corrective action plans in response to on-site case management record reviews or other problematic issues that may arise during this Contract.

### **3.3 Security Requirements**

#### 3.3.1 Employee Identification

- (a) Each person who is an employee or agent of the Contractor or subcontractor shall display his or her company ID badge at all times while on State premises. Upon request of State personnel, each such employee or agent shall provide additional photo identification.
- (b) At all times at any facility, the Contractor's personnel shall cooperate with State site requirements that include but are not limited to being prepared to be escorted at all times, providing information for badging, and wearing the badge in a visual location at all times.

#### 3.3.2 Information Technology

- (a) Contractors shall comply with and adhere to the State IT Security Policy and Standards. These policies may be revised from time to time and the Contractor shall comply with all such revisions. Updated and revised versions of the State IT Policy and Standards are available online at: [www.doit.maryland.gov](http://www.doit.maryland.gov) – keyword: Security Policy.
- (b) The Contractor shall not connect any of its own equipment to a State LAN/WAN without prior written approval by the State. The Contractor shall complete any necessary paperwork as directed and coordinated with the Contract Monitor to obtain approval by the State to connect Contractor-owned equipment to a State LAN/WAN.

#### 3.3.3 Criminal Background Check

The Contractor shall obtain from each prospective employee a signed statement permitting a criminal background check. The Contractor shall secure at its own expense a Maryland State Police and/or FBI background check and shall provide the Contract Monitor with completed checks on all new employees prior to assignment. The Contractor may not assign an employee with criminal record unless prior written approval is obtained from the Department.

### **3.4 Claim Submission**

3.4.1 Contractor shall have a process for resolving billing errors.

3.4.2 The contractor shall submit claims in accordance with the following schedule:

- 1.) The contractor shall bill the Department no later than 12 months from the date of service. One unit of service is considered one month. The Offeror shall submit a claim after the completion of the service, which, at the



earliest can be the first day of the following month. The Offeror shall submit claims electronically directly to the MMIS and must have the capability to submit claims in the HIPAA compliant 837P and 5010 formats. The minimum contact and reporting requirements corresponding with the submitted procedure code must be met for all submitted claims (Appendix H).

- 2.) The Department will reimburse the Offeror on a case rate, per participant per month basis, according to the Case Rate Schedule in Appendix K. The billing procedure codes are listed in Appendix N-1.
- 3.) Offerors shall obtain a Maryland Medicaid Provider number and maintain an active provider status within MMIS.
- 4.) Offerors shall meet and maintain the requirements as specified in COMAR 10.09.36.

3.4.3 Funds for any contract(s) resulting from this RFP are dependent upon appropriations from the Maryland General Assembly.

3.4.4 The Department reserves the right to reduce or withhold contract payment (see terms set forth in this Section above) in the event the contractor does not provide the Department with all required deliverables within the time frame specified in the contract or in the event that the contractor otherwise materially breaches the terms and conditions of the contract until such time as the contractor brings itself into full compliance with the contract.

### **3.5 Insurance Requirements**

3.5.1 The Contractor shall maintain Commercial General Liability Insurance with limits sufficient to cover losses resulting from, or arising out of, Contractor action or inaction in the performance of the Contract by the Contractor, its agents, servants, employees, or subcontractors, but no less than a Combined Single Limit for Bodily Injury, Property Damage and Personal and Advertising Injury Liability of \$1,000,000 per occurrence and \$3,000,000 aggregate.

3.5.2 The Contractor shall maintain Errors and Omissions/Professional Liability insurance with minimum limits of \$3,000,000 per occurrence.

3.5.3 The Contractor shall maintain Automobile and/or Commercial Truck Insurance as appropriate with Liability, Collision, and PIP limits no less than those required by the State where the vehicle(s) is registered but in no case less than those required by the State of Maryland.

3.5.4 Upon execution of a Contract with the State, Contractor shall provide the Contract Monitor with current certificates of insurance, and shall update such certificates from time to time, as directed by the Contract Monitor. Such copy of the Contractor's current certificate of insurance shall contain at minimum the following:

- a. Workers' Compensation – The Contractor shall maintain such insurance as necessary and/or as required under Worker's Compensation Acts, the Longshore and Harbor Workers' Compensation Act, and the Federal Employers' Liability Act.
  - b. Commercial General Liability.
  - c. Errors and Omissions/Professional Liability.
  - d. Automobile and/or Commercial Truck Insurance as required.
  - e. Employee Theft Insurance, with a minimum limit of \$1,000,000 per occurrence.
- 3.5.5 The State shall be named as an additional insured on the policies with the exception of Worker's Compensation Insurance and Professional Liability Insurance. Certificates of insurance evidencing coverage shall be provided prior to the commencement of any activities in the Contract. All insurance policies shall be endorsed to include a clause that requires that the insurance carrier provide the Contract Monitor, by certified mail, not less than sixty (60) days advance notice of any non-renewal, cancellation, or expiration. In the event the Contract Monitor receives a notice of non-renewal, the Contractor shall provide the Contract Monitor with an insurance policy from another carrier at least thirty (30) days prior to the expiration of the insurance policy then in effect. All insurance policies shall be with a company licensed by the State to do business and to provide such policies.
- 3.5.6 The Contractor shall require that any subcontractors obtain and maintain similar levels of insurance and shall provide the Contract Monitor with the same documentation as is required of the Contractor.

<b>3.6 Problem Escalation Procedure</b>
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3.6.1 The Contractor must provide and maintain a Problem Escalation Procedure (PEP) for both routine and emergency situations. The PEP must state how the Contractor will address problem situations as they occur during the performance of the Contract, especially problems that are not resolved to the satisfaction of the State within appropriate timeframes.

The Contractor shall provide contact information to the Contract Monitor, as well as to other State personnel, as directed should the Contract Monitor not be available.

3.6.2 The Contractor must provide the PEP no later than ten (10) days after notice of Contract award or after the date of the Notice to Proceed, whichever is earlier.

The PEP, including any revisions thereto, must also be provided within ten (10) days after the start of each contract year (and within ten (10) days after any change in circumstance that changes the PEP). The PEP shall detail how problems with work under the Contract will be escalated in order to resolve any issues in a timely manner. The PEP shall include:

- The process for establishing the existence of a problem;
- The maximum duration that a problem may remain unresolved at each level in the Contractor's organization before automatically escalating the problem to a higher level for resolution;
- Circumstances in which the escalation will occur in less than the normal timeframe;
- The nature of feedback on resolution progress, including the frequency of feedback, to be provided to the State;
- Identification of, and contact information for, progressively higher levels of personnel in the Contractor's organization who would become involved in resolving a problem;
- Contact information for persons responsible for resolving issues after normal business hours (e.g., evenings, weekends, holidays, etc.) and on an emergency basis; and
- A process for updating and notifying the Contract Monitor of any changes to the PEP.

Nothing in this section shall be construed to limit any rights of the Contract Monitor or the State that may be allowed by the Contract or applicable law.

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## **SECTION 4 – PROPOSAL FORMAT**

### **4.1 Single Submission**

Offerors shall submit a TECHNICAL PROPOSAL only; no FINANCIAL PROPOSAL is required.

### **4.2 Proposals**

4.2.1 The Technical Proposal shall contain an unbound original, so identified, and five (5) copies. The sealed original Volume shall be submitted under one (1) label bearing:

- The RFP title and number,
- Name and address of the Offeror,
- The volume number (I), and
- Closing date and time for receipt of proposals

to the attention of Elvira Smith, Room 214D, prior to the date and time for receipt of proposals (see section 1.7 “Proposals Due (Closing) - Date and Time”).

4.2.2 An electronic version (CD) of the Technical Proposal in Microsoft Word format must be enclosed with the original Technical Proposal. CDs must be labeled on the outside with the RFP title and number, name of the Offeror, and volume number. CDs must be packaged with the original copy of the Technical Proposal.

4.2.3 A second electronic version of the Technical Proposal in searchable pdf format shall be submitted on CD for Public Information Act (PIA) requests. This copy shall be redacted so that confidential and/or proprietary information has been removed (see section 1.19 “Public Information Act Notice”).

4.2.4 All pages of the proposal volume shall be consecutively numbered from beginning (Page 1) to end (Page “x”). Numbering within individual sections is acceptable.

4.2.5 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.

### **4.3 Delivery**

Offerors may either mail or hand-deliver proposals.

- 4.3.1 For U.S. Postal Service deliveries, any proposal that has been received at the appropriate mailroom, or typical place of mail receipt, for the respective procuring unit by the time and date listed in the RFP will be deemed timely. If an Offeror chooses to use the U.S. Postal Service for delivery, the Department recommends that it use Express Mail, Priority Mail, or Certified Mail only as these are the only forms for which both the date and time of receipt can be verified by the Department. An Offeror using first class mail will not be able to prove a timely delivery at the mailroom and it could take several days for an item sent by first class mail to make its way by normal internal mail to the procuring unit.
- 4.3.2 Hand-delivery includes delivery by commercial carrier acting as agent for the Offeror. 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.
- 4.3.3 After receipt, a Register of Proposals will be prepared that identifies each Offeror. The register of proposals will be open to inspection only after the Contract Monitor makes a determination recommending the award of the Contract.

#### **4.4 Technical Proposal**

##### 4.4.1 Format of Technical Proposal

Inside a sealed package described in section 4.2 “Proposals,” the unbound original, five (5) copies, and the electronic version shall be provided. The RFP sections are numbered for ease of reference. Section 4.4.3 sets forth the order of information to be provided in the Technical Proposal, e.g., section 1 “Title and Table of Contents,” section 2 “Claim of Confidentiality,” section 3 “Transmittal Letter,” section 4 “Executive Summary,” etc. In addition to the instructions below, the Offeror’s Technical Proposal should be organized and numbered in the same manner as this RFP. This proposal organization will allow State officials and the Evaluation Committee to “map” Offeror responses directly to RFP requirements by section number and will aid in the evaluation process.

##### 4.4.2 Additional Required Technical Submissions

The following documents shall be included in the Technical Proposal; each in its own section.

- a. Minimum Qualifications Documentation (See section 2 “Offeror Minimum Qualifications.”)
- b. Completed Bid/Proposal Affidavit (**Attachment B**)
- c. Completed Federal Funds Attachment (**Attachment E**)
- d. Signed Conflict of Interest Affidavit and Disclosure (**Attachment F**)

Please note that the following documents are not required to be submitted with the Technical Proposal:

- a. signed Contract (**Attachment A**),
- b. a completed Contract Affidavit (**Attachment C**),
- c. a signed Business Associate Agreement (**Attachment G**),
- d. a signed Non-Disclosure Agreement (Award) (**Attachment H**), and
- e. a signed Provider Agreement for Participation in Maryland Medical Assistance Program (**Attachment CC**)

These documents will be completed and submitted by the successful Offeror within five (5) business days from notification by the Contract Monitor that the Offeror has been determined to be the awardee.

4.4.3 The Technical Proposal shall include the following documents and information in the order specified as follows:

4.4.3.1 Title Page and Table of Contents

The Technical Proposal should begin with a title page bearing the name and address of the Offeror and the name and number of this RFP. A table of contents shall follow the title page for the Technical Proposal organized by section, subsection, and page number.

4.4.3.2 Claim of Confidentiality

Information which is claimed to be confidential is to be noted by reference and included after the title page and before the table of contents, and if applicable in the Offeror's Financial Proposal. An explanation for each claim of confidentiality shall be included (see subsection 1.19 "Public Information Act Notice").

4.4.3.3 Transmittal Letter

A transmittal letter shall accompany the Technical Proposal. The purpose of this letter is to transmit the Technical Proposal and acknowledge the receipt of any addenda. The transmittal letter should be brief and signed by an individual who is authorized to commit the Offeror to the services and requirements as stated in this RFP.

4.4.3.4 Executive Summary

The Offeror shall condense and highlight the contents of the Technical Proposal in a section titled "Executive Summary." The Offeror shall clearly demonstrate an understanding of the objectives and goals of the Department, as well as an understanding of the Scope of Work. This

section should also include an analysis of the effort and resources which will be needed to realize the Department's objectives.

The summary shall also identify any exceptions the Offeror has taken to the requirements of this RFP, the Contract (**Attachment A**), or any other attachments (see section 1.21 "Standard Contract"). Exceptions to terms and conditions may result in having the proposal deemed unacceptable or classified as not reasonably susceptible of being selected for award. If no exceptions to terms and conditions are made, the summary shall so state.

#### 4.4.3.5 Proposed Work Plan

- a. The Offeror shall give a definitive description of the proposed plan to meet the requirements of the RFP, i.e., a Work Plan. It shall include the specific methodology and techniques to be used by the Offeror in providing the required services as outlined in RFP section 3 "Scope of Work," and specifically section 3.2 "Scope of Work – Requirements." The description shall include an outline of the overall management concepts employed by the Offeror and a project management plan, including project control mechanisms and overall timelines. Project deadlines considered contract deliverables must be recognized in the Work Plan.
- b. The Offeror shall identify the location(s) in which it proposes to provide the services.
- c. The Offeror must explain, as per the requirements in section 3.7 "Problem Escalation Procedure," how problems associated with the work to be performed under the Contract will be escalated in order to resolve any issues in a timely manner.

#### 4.4.3.6 Corporate Qualifications and Capabilities

The Offeror shall include information on past corporate experience with similar projects and/or services. The Offeror shall describe how its organization can meet the requirements of this RFP and shall include the following information:

- a. An overview of the Offeror's experience and capabilities providing similar services. This description shall include:
  - i. The number of years the Offeror has provided the similar services; and
  - ii. The number of clients and geographic locations that the Offeror currently serves.

- b. The names and titles of key management personnel who will be directly involved with supervising the services to be performed under this Contract.
- c. At least three (3) references from customers who are capable of documenting the Offeror's ability to provide the services specified in this RFP. Each reference shall be from a client for whom the Offeror provided services within the past five (5) years and shall include the following information:
  - i. Name of client organization;
  - ii. Name, title, telephone number, and e-mail address, if available, of point of contact for client organization; and
  - iii. Value, type, duration, and services provided.

**The Department reserves the right to request additional references or use references not provided by an Offeror.**

- d. Offerors must include in its proposal a commonly accepted method to prove its fiscal integrity. Some acceptable methods include but are not limited to one or more of the following:
  - i. Dunn and Bradstreet Rating;
  - ii. Standard and Poor's Rating;
  - iii. Recently audited (or best available) financial statements;
  - iv. Lines of credit;
  - v. Evidence of a successful financial track record; and
  - vi. Evidence of adequate working capital.

The Offeror shall also describe how it is configured managerially, financially, and individually to afford the assurance that it can execute a contract successfully.

- e. The Offeror's process for resolving billing errors.
- f. Corporate organizational chart that identifies the complete structure of the company including any parent company, headquarters, regional offices, and subsidiaries of the Offeror.
- g. Complete list of all subcontractors. This list shall include a full description of the duties each subcontractor will perform and why/how each subcontractor was deemed the most qualified for this project.
- h. Legal Action Summary. This summary shall include:



- i. A statement as to whether there are any outstanding legal actions or potential claims against the Offeror and a brief description of any action;
- ii. A brief description of any settled or closed legal actions or claims against the Offeror over the past five (5) years;
- iii. A description of any judgments against the Offeror within the past five (5) years, including the case name, number court, and what the final ruling or determination was from the court; and
- iv. In instances where litigation is ongoing and the Offeror has been directed not to disclose information by the court, provide the name of the judge and location of the court.

i. Past State Experience

The Offeror shall provide a list of all contracts with any entity of the State of Maryland for which it is currently performing services or for which services have been completed within the last five (5) years. For each identified contract, the Offeror is to provide:

- i. The State contracting entity;
- ii. A brief description of the services/goods provided;
- iii. The dollar value of the contract;
- iv. The term of the contract;
- v. The State employee contact person (name, title, telephone number, and, if possible, e-mail address); and
- vi. Whether the contract was terminated before the end of the term specified in the original contract, including whether any available renewal option was not exercised.

Information obtained regarding the Offeror's level of performance on State contracts will be used by the Contract Monitor to determine responsibility of the Offeror and considered as part of the experience and past performance evaluation criteria of the RFP.

#### 4.4.3.7 Experience and Qualifications of Proposed Staff

The Offeror shall describe in detail how the proposed staff's experience and qualifications relate to their specific responsibilities, as detailed in the Work Plan. The Offeror shall include individual resumes for the key personnel who are to be assigned to the project if the Offeror is awarded the contract. Each resume should include the amount of experience the individual has had relative to the scope of work set forth in this solicitation. Letters of intended commitment to work on the project, including from subcontractors, should be included in this section.

The Offeror is required to provide an Organizational Chart outlining personnel and their related duties. The Offeror shall include job titles and the percentage of

time each individual will spend on his/her assigned tasks. Offerors using job titles other than those commonly used by industry standards must provide a crosswalk document.

The Offeror will provide documentation demonstrating their competence to provide a sample case management plan for each of the following examples of a potential REM participant:

- a 30-40 year old with quadriplegic infantile cerebral palsy (ICD 9 code 343.2),
- a 15-20 year old with human immunodeficiency virus (HIV) disease (ICD 9 code 042), and
- a 10-15 year old with congenital factor VIII disorder (ICD 9 code 286.0).

#### 4.4.3.8 Economic Benefit Factors

The Offeror shall describe the benefits that will accrue to the State economy as a direct or indirect result of the Offeror's performance of the Contract resulting from this RFP. The Offeror shall not include any detail of the Financial Proposal with this technical information. The Offeror will take into consideration the following elements:

- a. The estimated percentage of Contract dollars to be recycled into Maryland's economy in support of the Contract, through the use of Maryland subcontractors, suppliers, and joint venture partners. The Offeror should be as specific as possible and provide a percentage breakdown of expenditures in this category.
- b. The estimated number and types of jobs for Maryland residents resulting from this Contract. The Offeror should indicate job classifications, number of employees in each classification, and the aggregate Maryland payroll percentages to which the Contractor has committed at both prime and, if applicable, subcontract levels.
- c. Tax revenues to be generated for Maryland and its political subdivisions as a result of this Contract. The Offeror should indicate the appropriate tax category (e.g., sales tax, inventory taxes, and estimated personal income taxes for new employees). The Offeror should provide a forecast of the total tax revenues resulting from the Contract.
- d. The estimated percentage of subcontract dollars committed to Maryland small businesses and MBEs.

#### 4.4.3.9 Offeror Technical Response to RFP Requirements

If the State is seeking Offeror agreement to a requirement(s), the Offeror shall state agreement or disagreement. The Offeror shall address each major section in its Technical Proposal and describe how its proposed services will meet the requirement(s). Any paragraph in the Technical Proposal that responds to a work

requirement 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 deemed unacceptable or the Offeror classified as not reasonably susceptible of being selected for award.

4.4.3.10 Certificate of Insurance

The Offeror shall provide a copy of the Offeror's current certificate(s) of insurance with the prescribed limits set forth in section 3.6 "Insurance Requirement." The successful Offeror must provide a certificate of insurance naming the State as an additional insured, if required, within five (5) business days from notification by the Contract Monitor that the Offeror has been determined to be the apparent awardee.

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## **SECTION 5– EVALUATION CRITERIA AND SELECTION PROCEDURE**

### **5.1 Evaluation Criteria**

Evaluation of proposals will be based on the criteria set forth below. The Contract(s) resulting from this RFP will be awarded to the Offeror(s) that submits the proposal most advantageous to the State considering the technical factors set forth herein.

### **5.2 Technical Criteria**

The criteria to be applied to each Technical Proposal are listed in descending order of importance.

#### 5.2.1 Proposed Work Plan (See RFP § 4.4.3.5)

- a. To what extent does the work plan demonstrate the ability of the Offeror to meet the requirements and timeframes of the RFP successfully, including a timeline showing all critical steps and responsible staff for each requirement?
- b. Is the work plan reasonable to achieve the Department’s goals, objectives, and requirements?
- c. Is the staffing plan appropriate and most likely to lead the fulfillment of the Department’s goals, objectives, and requirements?

#### 5.2.2. Executive Summary (See RFP § 4.4.3.4)

To what extent has the Offeror demonstrated an understanding of the requirements of the RFP?

#### 5.2.3. Experience and Qualifications of the Proposed Staff (See RFP § 4.4.3.7)

- a. To what extent has the Offeror documented that key staff members assigned to the REM program are licensed nurses and licensed and certified social workers?
- b. In the Contractor’s Staffing Organization Chart, are the appropriate personnel identified with their job titles, their percentage of work time that will be devoted exclusively to this contract and their respective areas of responsibility?
- c. To what extent do the resumes document that staff members assigned to this Contract are experienced case managers, including any areas of specialized training or certification education?

#### 5.2.4. Corporate Qualifications (See RFP § 4.4.3.6)

- a. To what extent has the Offeror documented and demonstrated sufficient physical, technological, personnel, and financial resources to fulfill the requirements of the RFP?
- b. To what extent has the Offeror documented and demonstrated the successful performance of similar projects including references from past clients?
- c. Does the Offeror's legal history (e.g., legal action summary) indicate it is a trustworthy partner?
- d. Is the organizational structure of the Offeror well suited to the provision of services under this RFP?

5.2.5. Economic Benefit to State of Maryland (See RFP § 4.4.3.8)

- a. Is the percentage of contract dollars to be recycled into Maryland's economy adequate, above average, or exceptional?
- b. How many and what types of jobs for Maryland residents will be created? What collateral job creation or retention may result from an award to this Offeror?
- c. Is the estimated percentage of dollars committed to small or minority businesses substantial or inconsequential?
- d. How much tax revenue is anticipated for the State and local subdivisions, etc.?

<b>5.3 Selection Procedures</b>
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5.3.1 Selection Process Sequence

Proposals are usually evaluated by a committee, which then makes a recommendation for award to the Contract Monitor. However, the Contract Monitor may evaluate proposals without a committee and recommend an Offeror for award. In either case, the Contract Monitor, with the concurrence of the issuing agency head or designee, will make the final determination and recommendation for contract award.

5.3.1.1 Technical proposals are evaluated for technical merit and ranked. During this review, oral presentations and discussions may be held. The purpose of such discussions will be to assure a full understanding of the State's requirements and the Offeror's ability to perform the services, as well as to facilitate arrival at a Contract that is most advantageous to the State. For scheduling purposes, Offerors should be prepared to make an oral presentation and to participate in discussions within two (2) weeks of the delivery of proposals to the State. Qualified Offerors will be contacted by the State as soon as discussions are scheduled.

5.3.1.2 Offerors must confirm in writing any substantive oral clarifications of, or changes in, their proposals made in the course of discussions. Any such written clarifications or changes then become part of the Offeror's proposal. Proposals are given a final review and ranked.

### 5.3.2 Award Determination

Upon completion of all discussions and negotiations, reference checks, and site visits (if any), the Contract Monitor will recommend award of the Contract to the responsible Offeror(s) that submitted the proposal(s) determined to be the most advantageous to the State considering technical evaluation factors as set forth in this RFP.

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## **SECTION 6 – ATTACHMENTS**

### **ATTACHMENT A – Contract**

This is the Contract used by the Department. It is provided with the RFP for informational purposes and is not required to be signed at proposal submission time. Upon notification of recommendation for award, a completed contract will be sent to the selected Offeror for signature. The Offeror must return three (3) executed copies of the Contract within five (5) working days after receipt. Upon award, a fully executed copy will be sent to the Contractor.

### **ATTACHMENT B – Bid/Proposal Affidavit**

This document must be completed and submitted with the Offeror's technical proposal.

### **ATTACHMENT C – Contract Affidavit**

This document is not required at the time of proposal submission, but may be submitted to expedite processing. If not received with the proposal, it must be submitted by the selected Offeror to the Contract Monitor with the Contract (see Attachment A).

### **ATTACHMENT D – Pre-Proposal Conference Response Form**

It is requested that this form be completed and submitted as described in the RFP by those potential Offerors that plan to attend the Pre-Proposal Conference.

### **ATTACHMENT E – Federal Funds Attachment**

Certifications and documents must be completed and submitted with the Technical Proposal.

### **ATTACHMENT F – Conflict of Interest Affidavit and Disclosure**

This document must be completed and submitted with the Technical Proposal.

### **ATTACHMENT G – Business Associate Agreement**

This document is not required at the time of proposal submission, but may be submitted to expedite processing. If not received with the proposal, it must be submitted by the selected Offeror to the Contract Monitor with the Contract (see Attachment A).

### **ATTACHMENT H – Non-Disclosure Agreement (Award)**

This document is not required at the time of proposal submission, but may be submitted to expedite processing. If not received with the proposal, it must be submitted by the selected Offeror to the Contract Monitor with the Contract (see Attachment A).

## ATTACHMENT A – CONTRACT

### Rare and Expensive Case Management

THIS CONTRACT (the “Contract”) is made this \_\_\_\_ day of \_\_\_\_, \_\_\_\_ by and between \_\_\_\_ (the “Contractor”) and the STATE OF MARYLAND, acting through the DEPARTMENT OF HEALTH AND MENTAL HYGIENE, OFFICE OF HEALTH SERVICES (the “Department”).

In consideration of the promises and the covenants herein contained, the parties agree as follows:

#### **1. Definitions**

In this Contract, the following words have the meanings indicated:

- 1.1 “COMAR” means Code of Maryland Regulations.
- 1.2 “Contract Monitor” means the individual identified in the RFP as the Contract Monitor.
- 1.3 “Contractor” means \_\_\_\_ whose principal business address is \_\_\_\_ and whose principal office in Maryland is \_\_\_\_.
- 1.4 “Department” means the Maryland Department of Health and Mental Hygiene and any of its Agencies, Offices, Administrations, Facilities, or Commissions.
- 1.5 “RFP” means the Request for Proposals titled Rare and Expensive Case Management, and any addenda thereto issued in writing by the State.
- 1.6 “State” means the State of Maryland.
- 1.7 “Technical Proposal” means the Contractor’s Technical Proposal, dated\_\_\_\_\_.

#### **2. Scope of Contract**

- 2.1 The Contractor shall provide all deliverables as defined in the RFP Section 3 “Scope of Work.” These services shall be provided in accordance with the terms and conditions of this Contract and the following Exhibits, which are attached hereto and incorporated herein by reference. If there is any conflict between this Contract and the Exhibits, the terms of the Contract shall govern. If there is any conflict among the Exhibits, the following order of precedence shall determine the prevailing provision:

Exhibit A – The RFP

Exhibit B – The Technical Proposal



Exhibit C - State Contract Affidavit, executed by the Contractor and dated \_\_\_\_.

- 2.2 The Contract Monitor may, at any time, by written order, make changes in the work within the general scope of the Contract or the RFP. No other order, statement, or conduct of the Contract Monitor or any other person shall be treated as a change or entitle the Contractor to an equitable adjustment under this section. Except as otherwise provided in this Contract, if any change under this section causes an increase or decrease in the Contractor's cost of, or the time required for, the performance of any part of the work, whether or not changed by the order, an equitable adjustment in the Contract price shall be made and the Contract modified in writing accordingly. The Contractor must assert in writing its right to an adjustment under this section within thirty (30) days of receipt of written change order and shall include a written statement setting forth the nature and cost of such claim. No claim by the Contractor shall be allowed if asserted after final payment under this Contract. Failure to agree to an adjustment under this section shall be a dispute under the Disputes clause. Nothing in this section shall excuse the Contractor from proceeding with the Contract as changed.
- 2.3 Modifications to this Contract may be made provided (a) the modifications are made in writing and (b) all parties sign the modifications.

### **3. Period of Performance.**

- 3.1 The Contract resulting from this RFP shall be for a period of three (3) years beginning on July 1, 2013 and ending on June 30, 2016. The Contractor shall provide services upon receipt of official notification of award and at the rates established by the regulations. The current rates are the Initial Assessment rate of \$388.55, Level of Care One rate of \$286.90, Level of Care Two rate of \$171.00, and Level of Care Three rate of \$90.25. The Department reserves the right to amend the rates through regulation during the course of this contract.
- 3.2 Further, this contract may be extended for two (2) periods of one year each at the sole discretion of the Department and at the rates established by the regulations.

### **4. Consideration and Payment**

- 4.1 In consideration of the satisfactory performance of the work set forth in this Contract, the Department shall pay the Contractor in accordance with the terms of this Contract and at the rates specified by regulation.
- 4.2 Payments to the Contractor shall be made no later than thirty (30) days after the Department's receipt of claim submission for services provided by the Contractor, acceptance by the Department of services provided by the Contractor, and pursuant to the conditions outlined in Section 4 of this Contract. Claims shall be submitted to the Contract Monitor via MMISII using the Contractor's MD MA provider number. Electronic funds transfer shall be used by the State to pay

Contractor pursuant to this Contract and any other State payments due Contractor unless the State Comptroller's Office grants Contractor an exemption.

- 4.3 In addition to any other available remedies, if, in the opinion of the Contract Monitor, the Contractor fails to perform in a satisfactory and timely manner, the Contract Monitor may refuse or limit approval of any invoice for payment, and may cause payments to the Contractor to be reduced or withheld until such time as the Contractor meets performance standards as established by the Contract Monitor.

## **5. Rights to Records**

The Contractor agrees that all documents and materials including, but not limited to, software, reports, drawings, studies, specifications, estimates, tests, maps, photographs, designs, graphics, mechanical, artwork, computations and data prepared by the Contractor for purposes of this Contract shall be the sole property of the State and shall be available to the State at any time. The State shall have the right to use the same without restriction and without compensation to the Contractor other than that specifically provided by this Contract.

## **6. Exclusive Use**

The State shall have the exclusive right to use, duplicate, and disclose any data, information, documents, records, or results, in whole or in part, in any manner for any purpose whatsoever, that may be created or generated by the Contractor in connection with this Contract. If any material, including software, is capable of being copyrighted, the State shall be the copyright owner and Contractor may copyright material connected with this project only with the express written approval of the State.

## **7. Patents, Copyrights, and Intellectual Property**

- 7.1 If the Contractor furnishes any design, device, material, process, or other item, which is covered by a patent, trademark or service mark, or copyright or which is proprietary to or a trade secret of, another, the Contractor shall obtain the necessary permission or license to permit the State to use such item or items.
- 7.2 The Contractor will defend or settle, at its own expense, any claim or suit against the State alleging that any such item furnished by the Contractor infringes any patent, trademark, service mark, copyright, or trade secret. If a third party claims that a product infringes that party's patent, trademark, service mark, trade secret, or copyright, the Contractor will defend the State against that claim at Contractor's expense and will pay all damages, costs and attorneys' fees that a court finally awards, provided the State: (a) promptly notifies the Contractor in writing of the claim; and (b) allows Contractor to control and cooperates with Contractor in, the defense and any related settlement negotiations. The obligations of this paragraph are in addition to those stated in Section 7.3 below.

- 7.3 If any products furnished by the Contractor become, or in the Contractor's opinion are likely to become, the subject of a claim of infringement, the Contractor will, at its option and expense: (a) procure for the State the right to continue using the applicable item; (b) replace the product with a non-infringing product substantially complying with the item's specifications; or (c) modify the item so that it becomes non-infringing and performs in a substantially similar manner to the original item.

## **8. Public Information**

- 8.1 Subject to the Maryland Public Information Act and any other applicable laws, all confidential or proprietary information and documentation relating to either party (including, without limitation, any information or data stored within the Contractor's computer systems) shall be held in absolute confidence by the other party. Each party shall, however, be permitted to disclose relevant confidential information to its officers, agents, and employees to the extent that such disclosure is necessary for the performance of their duties under this Contract, provided that the data may be collected, used, disclosed, stored, and disseminated only as provided by and consistent with the law. The provisions of this section shall not apply to information that: (a) is lawfully in the public domain; (b) has been independently developed by the other party without violation of this Contract; (c) was already in the possession of such party; (d) was supplied to such party by a third party lawfully in possession thereof and legally permitted to further disclose the information; or (e) which such party is required to disclose by law.
- 8.2 Offerors should give specific attention to the identification of those portions of their proposals that they deem to be confidential, proprietary information or trade secrets and provide any justification why such materials, upon request, should not be disclosed by the State under the Public Information Act, Md. Code Ann., State Government Article, Title 10, Subtitle 6.

## **9. Loss of Data**

In the event of loss of any State data or records where such loss is due to the intentional act or omission or negligence of the Contractor or any of its subcontractors or agents, the Contractor shall be responsible for recreating such lost data in the manner and on the schedule set by the Contract Monitor. The Contractor shall ensure that all data is backed up and recoverable by the Contractor. Contractor shall use its best efforts to assure that at no time shall any actions undertaken by the Contractor under this Contract (or any failures to act when Contractor has a duty to act) damage or create any vulnerabilities in data bases, systems, platforms, and/or applications with which the Contractor is working hereunder.

## **10. Indemnification**

- 10.1 The Contractor shall hold harmless and indemnify the State from and against any and all losses, damages, claims, suits, actions, liabilities and/or expenses, including, without limitation, attorneys' fees and disbursements of any character that arise from, are in connection with or are attributable to the performance or nonperformance of the Contractor or its subcontractors under this Contract.
- 10.2 The State has no obligation to provide legal counsel or defense to the Contractor or its subcontractors in the event that a suit, claim, or action of any character is brought by any person not party to this Contract against the Contractor or its subcontractors as a result of or relating to the Contractor's obligations under this Contract.
- 10.3 The State has no obligation for the payment of any judgments or the settlement of any claims against the Contractor or its subcontractors as a result of or relating to the Contractor's obligations under this Contract.
- 10.4 The Contractor shall immediately notify the Contract Monitor of any claim or suit made or filed against the Contractor or its subcontractors regarding any matter resulting from, or relating to, the Contractor's obligations under the Contract, and will cooperate, assist, and consult with the State in the defense or investigation of any claim, suit, or action made or filed against the State as a result of, or relating to, the Contractor's performance under this Contract.

## **11. Non-Hiring of Employees**

No official or employee of the State, as defined under Md. Code Ann., State Government Article, § 15-102, whose duties as such official or employee include matters relating to or affecting the subject matter of this Contract, shall, during the pendency and term of this Contract and while serving as an official or employee of the State, become or be an employee of the Contractor or any entity that is a subcontractor on this Contract.

## **12. Maryland Law**

- 12.1 This Contract shall be construed, interpreted, and enforced according to the laws of the State of Maryland.
- 12.2 Any and all references to the Maryland Code Annotated contained in this Contract shall be construed to refer to such Code sections as are from time to time amended.

## **13. Nondiscrimination in Employment**

The Contractor agrees: (a) not to discriminate in any manner against an employee or applicant for employment because of race, color, religion, creed, age, sex, marital status, national origin, ancestry, or disability of a qualified individual with a disability; (b) to

include a provision similar to that contained in subsection (a), above, in any underlying subcontract except a subcontract for standard commercial supplies or raw materials; and (c) to post and to cause subcontractors to post in conspicuous places available to employees and applicants for employment, notices setting forth the substance of this clause.

#### **14. Non-availability of Funding**

If the General Assembly fails to appropriate funds or if funds are not otherwise made available for continued performance for any fiscal period of this Contract succeeding the first fiscal period, this Contract shall be canceled automatically. The effect of termination of the Contract hereunder will be to discharge both the Contractor and the State from future performance of the Contract, but not from their rights and obligations existing at the time of termination. The Contractor shall be reimbursed for the reasonable value of any nonrecurring costs incurred but not amortized in the price of the Contract. The State shall notify the Contractor as soon as it has knowledge that funds may not be available for the continuation of this Contract for each succeeding fiscal period beyond the first.

#### **15. Termination for Cause**

If the Contractor fails to fulfill its obligations under this Contract properly and on time, or otherwise violates any provision of the Contract, the State may terminate the Contract by written notice to the Contractor. The notice shall specify the acts or omissions relied upon as cause for termination. All finished or unfinished work provided by the Contractor shall, at the State's option, become the State's property. The State shall pay the Contractor fair and equitable compensation for satisfactory performance prior to receipt of notice of termination, less the amount of damages caused by the Contractor's breach. If the damages are more than the compensation payable to the Contractor, the Contractor will remain liable after termination and the State can affirmatively collect damages.

#### **16. Termination for Convenience**

The performance of work under this Contract may be terminated by the State whenever the State determines that such termination is in the best interest of the State.

#### **17. Delays and Extensions of Time**

The Contractor agrees to prosecute the work continuously and diligently and no charges or claims for damages shall be made by it for any delays, interruptions, interferences, or hindrances from any cause whatsoever during the progress of any portion of the work specified in this Contract.

Time extensions will be granted only for excusable delays that arise from unforeseeable causes beyond the control and without the fault or negligence of the Contractor, including but not restricted to, acts of God, acts of the public enemy, acts of the State in either its sovereign or contractual capacity, acts of another Contractor in the performance of a

contract with the State, fires, floods, epidemics, quarantine restrictions, strikes, freight embargoes, or delays of subcontractors or suppliers arising from unforeseeable causes beyond the control and without the fault or negligence of either the Contractor or the subcontractors or suppliers.

#### **18. Suspension of Work**

The State unilaterally may order the Contractor in writing to suspend, delay, or interrupt all or any part of its performance for such period of time as the Contract Monitor may determine to be appropriate for the convenience of the State.

#### **19. Disputes.**

All disputes related to this contract shall be adjudicated in accordance with COMAR 10.09.36.09.

#### **20. Political Contribution Disclosure**

The Contractor shall comply with Md. Code Ann., Election Law Article, §§ 14-101 through 14-108, which requires that every person that enters into contracts, leases, or other agreements with the State, a county, or an incorporated municipality, or their agencies, during a calendar year in which the person receives in the aggregate \$100,000 or more, shall, file with the State Board of Elections a statement disclosing contributions in excess of \$500 made during the reporting period to a candidate for elective office in any primary or general election. The statement shall be filed with the State Board of Elections: (a) before a purchase or execution of a lease or contract by the State, a county, an incorporated municipality, or their agencies, and shall cover the preceding two calendar years; and (b) if the contribution is made after the execution of a lease or contract, then twice a year, throughout the contract term, on: (i) February 5, to cover the six (6) month period ending January 31; and (ii) August 5, to cover the six (6) month period ending July 31.

#### **21. Documents Retention and Inspection Clause**

The Contractor and subcontractors shall retain and maintain all records and documents relating to this contract for a period of five (5) years after final payment by the State hereunder or any applicable statute of limitations, whichever is longer, and shall make them available for inspection and audit by authorized representatives of the State, including the Contract Monitor or designee, at all reasonable times.

If the Contractor supplies services to a State residential health care facility under the Mental Hygiene Administration, the Family Health Administration, the Alcohol and Drug Abuse Administration, or the Developmental Disabilities Administration, the Contractor agrees, in addition to the requirements above:

- 21.1 That pursuant to 42 Code of Federal Regulations (C.F.R.) Part 420, the Secretary of Health and Human Services, and the Comptroller General of the United States, or their duly-authorized representatives, shall be granted access to the Contractor's contract, books, documents and records necessary to verify the cost of the services provided under this contract, until the expiration of four (4) years after the services are furnished under this contract; and
- 21.2 That similar access will be allowed to the books, documents and records of any organization related to the Contractor or controlled by the Contractor (as those terms are defined in 42 C.F.R. (420.301) if that organization is sub-contracting to provide services with a value of \$10,000 or more in a twelve (12) month period to be reimbursed through funds provided by this contract.

## **22. Compliance with Laws**

The Contractor hereby represents and warrants that:

- 22.1 It is qualified to do business in the State and that it will take such action as, from time to time hereafter, may be necessary to remain so qualified;
- 22.2 It is not in arrears with respect to the payment of any monies due and owing the State, or any department or unit thereof, including but not limited to the payment of taxes and employee benefits, and that it shall not become so in arrears during the term of this Contract;
- 22.3 It shall comply with all federal, State and local laws, regulations, and ordinances applicable to its activities and obligations under this Contract; and,
- 22.4 It shall obtain, at its expense, all licenses, permits, insurance, and governmental approvals, if any, necessary to the performance of its obligations under this Contract.

## **23. Subcontracting; Assignment**

The Contractor may not subcontract any portion of the services provided under this Contract without obtaining the prior written approval of the Department's Contract Monitor, nor may the Contractor assign this Contract or any of its rights or obligations hereunder, without the prior written approval of the Department's Contract Monitor. Any subcontracts shall include such language as may be required in various clauses contained within this contract, exhibits, and attachments. The contract shall not be assigned until all approvals, documents, and affidavits are completed and properly registered. The State shall not be responsible for fulfillment of the Contractor's obligations to its subcontractors.

## **24. Liability**

- 24.1 For breach of this Contract, negligence, misrepresentation, or any other contract or tort claim, Contractor shall be liable as follows:
- a. For infringement of patents, copyrights, trademarks, service marks, and/or trade secrets, as provided in Section 7 of this Contract;
  - b. Without limitation for damages for bodily injury (including death) and damage to real property and tangible personal property; and
  - c. For all other claims, damages, losses, costs, expenses, suits, or actions in any way related to this Contract, regardless of the form, Contractor's liability shall be limited to three (3) times the total dollar amount of the Contract value up to the date of settlement or final award of any such claim. Third party claims, arising under Section 10 "Indemnification" of this Contract, are included in this limitation of liability only if the State is immune from liability. Contractor's liability for third party claims arising under Section 10 of this Contract shall be unlimited if the State is not immune from liability for claims arising under Section 10.

**25. Parent Company Guarantee (If Applicable)**

[Corporate name of Parent Company] hereby guarantees absolutely the full, prompt and complete performance by [Contractor name] of all the terms, conditions and obligations contained in this Contract, as it may be amended from time to time, including any and all exhibits that are now or may become incorporated hereunto, and other obligations of every nature and kind that now or may in the future arise out of or in connection with this Contract, including any and all financial commitments, obligations and liabilities. [Corporate name of Parent Company] may not transfer this absolute guaranty to any other person or entity without the prior express written approval of the State, which approval the State may grant, withhold, or qualify in its sole and absolute subjective discretion. [Corporate name of Parent Company] further agrees that if the State brings any claim, action, suit or proceeding against [Contractor], [Corporate name of Parent Company] may be named as a party, in its capacity as Absolute Guarantor.

**26. Commercial Nondiscrimination**

- 26.1 As part of such compliance, Contractor may not discriminate on the basis of race, color, religion, ancestry or national origin, sex, age, marital status, sexual orientation, or on the basis of disability or other unlawful forms of discrimination in the solicitation, selection, hiring, or commercial treatment of subcontractors, vendors, suppliers, or commercial customers, nor shall Contractor retaliate against any person for reporting instances of such discrimination. Contractor shall provide equal opportunity for subcontractors, vendors, and suppliers to participate in all of its public sector and private sector subcontracting and supply opportunities, provided that this clause does not prohibit or limit lawful efforts to remedy the effects of marketplace discrimination that have occurred or are



occurring in the marketplace. Contractor understands that a material violation of this clause shall be considered a material breach of this Contract and may result in termination of this Contract, disqualification of Contractor from participating in State contracts, or other sanctions. This clause is not enforceable by or for the benefit of, and creates no obligation to, any third party.

26.2 The Contractor shall include the above Commercial Nondiscrimination clause, or similar clause approved by DBM, in all subcontracts.

## **27. Prompt Pay Requirements**

27.1 If the Contractor withholds payment of an undisputed amount to its subcontractor, the Department, at its option and in its sole discretion, may take one or more of the following actions:

- a. Not process further payments to the contractor until payment to the subcontractor is verified;
- b. Suspend all or some of the contract work without affecting the completion date(s) for the contract work;
- c. Pay or cause payment of the undisputed amount to the subcontractor from monies otherwise due or that may become due;
- d. Place a payment for an undisputed amount in an interest-bearing escrow account; or
- e. Take other or further actions as appropriate to resolve the withheld payment.

27.2 An “undisputed amount” means an amount owed by the Contractor to a subcontractor for which there is no good faith dispute. Such “undisputed amounts” include, without limitation:

- a. Retainage which had been withheld and is, by the terms of the agreement between the Contractor and subcontractor, due to be distributed to the subcontractor; and
- b. An amount withheld because of issues arising out of an agreement or occurrence unrelated to the agreement under which the amount is withheld.

27.3 An act, failure to act, or decision of a Contract Monitor or a representative of the Department, concerning a withheld payment between the Contractor and a subcontractor under this provision, may not:

- a. Affect the rights of the contracting parties under any other provision of law;
- b. Be used as evidence on the merits of a dispute between the Department and the contractor in any other proceeding; or
- c. Result in liability against or prejudice the rights of the Department.

27.4 The remedies enumerated above are in addition to those provided under COMAR 21.11.03.13 with respect to subcontractors that have contracted pursuant to the Minority Business Enterprise (MBE) program.

**28. Contract Monitor**

The work to be accomplished under this Contract shall be performed under the direction of the Contract Monitor. All matters relating to the interpretation of this Contract shall be referred to the Contract Monitor for determination.

**29. Notices**

All notices hereunder shall be in writing and either delivered personally or sent by certified or registered mail, postage prepaid, as follows:

If to the State: Margaret Berman  
Contract Monitor  
Maryland Department of Health and Mental Hygiene  
201 West Preston Street, Room 210  
Baltimore, Maryland 21201

If to the Contractor: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**30. Federal Department of Health and Human Services (DHHS) Exclusion Requirements**

The Contractor agrees that it will comply with federal provisions (pursuant to §§ 1128 and 1156 of the Social Security Act and 42 C.F.R. 1001) that prohibit payments under certain federal health care programs to any individual or entity that is on the List of Excluded Individuals/Entities maintained by DHHS. By executing this contract, the Contractor affirmatively declares that neither it nor any employee is, to the best of its knowledge, subject to exclusion. The Contractor agrees, further, during the term of this contract, to check the List of Excluded Individuals/Entities prior to hiring or assigning individuals to work on this contract, and to notify OOE immediately of any identification of the contractor or an individual employee as excluded, and of any DHHS action or proposed action to exclude the contractor or any contractor employee.

**31. Compliance with Federal HIPAA and State Confidentiality Law**

31.1 The Contractor acknowledges its duty to become familiar with and comply, to the extent applicable, with all requirements of the federal Health Insurance Portability

and Accountability Act (HIPAA), 42 U.S.C. §§ 1320d et seq. and implementing regulations including 45 C.F.R. Parts 160 and 164. The contractor also agrees to comply with the Maryland Confidentiality of Medical Records Act (MCMRA), Md. Code Ann. Health-General §§ 4-301 et seq. This obligation includes:

- (a) As necessary, adhering to the privacy and security requirements for protected health information and medical records under HIPAA and MCMRA and making the transmission of all electronic information compatible with the HIPAA requirements;
- (b) Providing training and information to employees regarding confidentiality obligations as to health and financial information and securing acknowledgement of these obligations from employees to be involved in the contract; and
- (c) Otherwise providing good information management practices regarding all health information and medical records.

31.2 Based on the determination by the Department that the functions to be performed in accordance with the scope of work set forth in Part I constitute business associate functions as defined in HIPAA, the selected offeror shall execute a business associate agreement as required by HIPAA regulations at 45 C.F.R. 164.501 and set forth in Attachment J . The fully-executed Business Associate Agreement must be submitted within five (5) working days after notification of selection, or within five (5) days after award, whichever is earlier. Upon expiration of the five (5) day submission period, if the Department determines that the selected offeror has not provided the HIPAA agreement required by this solicitation, the Contract Monitor, upon review of the Office of the Attorney General and approval of the Secretary, may withdraw the recommendation for award and make the award to the next qualified offeror.

31.3 Protected Health Information as defined in the HIPAA regulations at 45 C.F.R. 160.103 and 164.501, means information transmitted as defined in the regulations, that is individually identifiable; that is created or received by a healthcare provider, health plan, public health authority, employer, life insurer, school or university, or healthcare clearinghouse; and that is related to the past, present, or future physical or mental health or condition of an individual, to the provision of healthcare to an individual, or to the past, present, or future payment for the provision of healthcare to an individual. The definition excludes certain education records as well as employment records held by a covered entity in its role as employer.

## **32. Limited English Proficiency**

The contractor shall provide equal access to public services to individuals with limited English proficiency in compliance with Md. Code Ann., State Government Article, §§

10-1101 et seq., and Policy Guidance issued by the Office of Civil Rights, Department of Health and Human Services, and DHMH Policy 02.06.07.

**IN WITNESS THEREOF**, the parties have executed this Contract as of the date hereinabove set forth.

CONTRACTOR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND  
MENTAL HYGIENE

\_\_\_\_\_  
By:

\_\_\_\_\_  
By: Joshua M. Sharfstein, M.D.,  
Secretary

\_\_\_\_\_  
Date

Or designee:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Date

**ATTACHMENT B – BID/PROPOSAL AFFIDAVIT**

**A. AUTHORITY**

I HEREBY AFFIRM THAT:

I, \_\_\_\_\_ (print name), possess the legal authority to make this Affidavit.

**B. CERTIFICATION REGARDING COMMERCIAL NONDISCRIMINATION**

The undersigned bidder hereby certifies and agrees that the following information is correct: In preparing its bid on this project, the bidder has considered all proposals submitted from qualified, potential subcontractors and suppliers, and has not engaged in “discrimination” as defined in §19-103 of the State Finance and Procurement Article of the Annotated Code of Maryland.

“Discrimination” means any disadvantage, difference, distinction, or preference in the solicitation, selection, hiring, or commercial treatment of a vendor, subcontractor, or commercial customer on the basis of race, color, religion, ancestry, or national origin, sex, age, marital status, sexual orientation, or on the basis of disability or any otherwise unlawful use of characteristics regarding the vendor’s, supplier’s, or commercial customer’s employees or owners.

“Discrimination” also includes retaliating against any person or other entity for reporting any incident of “discrimination”. Without limiting any other provision of the solicitation on this project, it is understood that, if the certification is false, such false certification constitutes grounds for the State to reject the bid submitted by the bidder on this project, and terminate any contract awarded based on the bid. As part of its bid or proposal, the bidder herewith submits a list of all instances within the past 4 years where there has been a final adjudicated determination in a legal or administrative proceeding in the State of Maryland that the bidder discriminated against subcontractors, vendors, suppliers, or commercial customers, and a description of the status or resolution of that determination, including any remedial action taken. Bidder agrees to comply in all respects with the State’s Commercial Nondiscrimination Policy as described under Title 19 of the State Finance and Procurement Article of the Annotated Code of Maryland.

**C. AFFIRMATION REGARDING BRIBERY CONVICTIONS**

I FURTHER AFFIRM THAT:

Neither I, nor to the best of my knowledge, information, and belief, the above business, or any of its officers, directors, partners, controlling stockholders, or any of its employees directly involved in the business’s contracting activities including obtaining or performing contracts with public bodies has been convicted of, or has had probation before judgment imposed pursuant to Criminal Procedure Article, §6-220, Annotated Code of Maryland, or has pleaded nolo contendere to a charge of, bribery, attempted bribery, or conspiracy to bribe in violation of Maryland law, or of the law of any other state or federal law, except as follows (indicate the reasons why the affirmation cannot be given and list any conviction, plea, or imposition of probation before judgment with the date, court, official or administrative body, the sentence or disposition, the name(s) of person(s) involved, and their current positions and responsibilities with the business):

\_\_\_\_\_  
\_\_\_\_\_

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D. AFFIRMATION REGARDING OTHER CONVICTIONS

I FURTHER AFFIRM THAT:

Neither I, nor to the best of my knowledge, information, and belief, the above business, or any of its officers, directors, partners, controlling stockholders, or any of its employees directly involved in the business's contracting activities including obtaining or performing contracts with public bodies, has:

(1) Been convicted under state or federal statute of:

(a) A criminal offense incident to obtaining, attempting to obtain, or performing a public or private contract; or

(b) Fraud, embezzlement, theft, forgery, falsification or destruction of records or receiving stolen property;

(2) Been convicted of any criminal violation of a state or federal antitrust statute;

(3) Been convicted under the provisions of Title 18 of the United States Code for violation of the Racketeer Influenced and Corrupt Organization Act, 18 U.S.C. §1961 et seq., or the Mail Fraud Act, 18 U.S.C. §1341 et seq., for acts in connection with the submission of bids or proposals for a public or private contract;

(4) Been convicted of a violation of the State Minority Business Enterprise Law, §14-308 of the State Finance and Procurement Article of the Annotated Code of Maryland;

(5) Been convicted of a violation of §11-205.1 of the State Finance and Procurement Article of the Annotated Code of Maryland;

(6) Been convicted of conspiracy to commit any act or omission that would constitute grounds for conviction or liability under any law or statute described in subsections (1)-(5) above;

(7) Been found civilly liable under a state or federal antitrust statute for acts or omissions in connection with the submission of bids or proposals for a public or private contract;

(8) Been found in a final adjudicated decision to have violated the Commercial Nondiscrimination Policy under Title 19 of the State Finance and Procurement Article of the Annotated Code of Maryland with regard to a public or private contract; or

(9) Admitted in writing or under oath, during the course of an official investigation or other proceedings, acts or omissions that would constitute grounds for conviction or liability under any law or statute described in §§B and C and subsections D(1)-(8) above, except as follows (indicate reasons why the affirmations cannot be given, and list any conviction, plea, or imposition of probation before judgment with the date, court, official or administrative body, the sentence or disposition, the name(s) of the person(s) involved and their current positions and responsibilities with the business, and the status of any debarment):

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**E. AFFIRMATION REGARDING DEBARMENT**

**I FURTHER AFFIRM THAT:**

Neither I, nor to the best of my knowledge, information, and belief, the above business, or any of its officers, directors, partners, controlling stockholders, or any of its employees directly involved in the business's contracting activities, including obtaining or performing contracts with public bodies, has ever been suspended or debarred (including being issued a limited denial of participation) by any public entity, except as follows (list each debarment or suspension providing the dates of the suspension or debarment, the name of the public entity and the status of the proceedings, the name(s) of the person(s) involved and their current positions and responsibilities with the business, the grounds of the debarment or suspension, and the details of each person's involvement in any activity that formed the grounds of the debarment or suspension).

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**F. AFFIRMATION REGARDING DEBARMENT OF RELATED ENTITIES**

**I FURTHER AFFIRM THAT:**

(1) The business was not established and it does not operate in a manner designed to evade the application of or defeat the purpose of debarment; and

(2) The business is not a successor, assignee, subsidiary, or affiliate of a suspended or debarred business, except as follows (you must indicate the reasons why the affirmations cannot be given without qualification):

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**G. SUBCONTRACT AFFIRMATION**

**I FURTHER AFFIRM THAT:**



Neither I, nor to the best of my knowledge, information, and belief, the above business, has knowingly entered into a contract with a public body under which a person debarred or suspended under Title 16 of the State Finance and Procurement Article of the Annotated Code of Maryland will provide, directly or indirectly, supplies, services, architectural services, construction related services, leases of real property, or construction.

#### H. AFFIRMATION REGARDING COLLUSION

I FURTHER AFFIRM THAT:

Neither I, nor to the best of my knowledge, information, and belief, the above business has:

- (1) Agreed, conspired, connived, or colluded to produce a deceptive show of competition in the compilation of the accompanying bid or offer that is being submitted;
- (2) In any manner, directly or indirectly, entered into any agreement of any kind to fix the bid price or price proposal of the bidder or offeror or of any competitor, or otherwise taken any action in restraint of free competitive bidding in connection with the contract for which the accompanying bid or offer is submitted.

#### I. CERTIFICATION OF TAX PAYMENT

I FURTHER AFFIRM THAT:

Except as validly contested, the business has paid, or has arranged for payment of, all taxes due the State of Maryland and has filed all required returns and reports with the Comptroller of the Treasury, the State Department of Assessments and Taxation, and the Department of Labor, Licensing, and Regulation, as applicable, and will have paid all withholding taxes due the State of Maryland prior to final settlement.

#### J. CONTINGENT FEES

I FURTHER AFFIRM THAT:

The business has not employed or retained any person, partnership, corporation, or other entity, other than a bona fide employee, bona fide agent, bona fide salesperson, or commercial selling agency working for the business, to solicit or secure the Contract, and that the business has not paid or agreed to pay any person, partnership, corporation, or other entity, other than a bona fide employee, bona fide agent, bona fide salesperson, or commercial selling agency, any fee or any other consideration contingent on the making of the Contract.

#### K. ACKNOWLEDGEMENT

I ACKNOWLEDGE THAT this Affidavit is to be furnished to the Contract Monitor and may be distributed to units of: (1) the State of Maryland; (2) counties or other subdivisions of the State of Maryland; (3) other states; and (4) the federal government. I further acknowledge that this Affidavit is subject to applicable laws of the United States and the State of Maryland, both criminal and civil, and that nothing in this Affidavit or any contract resulting from the submission of this bid or proposal shall be construed to supersede, amend, modify or waive, on behalf of the

State of Maryland, or any unit of the State of Maryland having jurisdiction, the exercise of any statutory right or remedy conferred by the Constitution and the laws of Maryland with respect to any misrepresentation made or any violation of the obligations, terms and covenants undertaken by the above business with respect to (1) this Affidavit, (2) the contract, and (3) other Affidavits comprising part of the contract.

I DO SOLEMNLY DECLARE AND AFFIRM UNDER THE PENALTIES OF PERJURY THAT THE CONTENTS OF THIS AFFIDAVIT ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE, INFORMATION, AND BELIEF.

Date: \_\_\_\_\_

By: \_\_\_\_\_ (print name of Authorized Representative and Affiant)

\_\_\_\_\_ (signature of Authorized Representative and Affiant)

Revised August 2011

**ATTACHMENT C - CONTRACT AFFIDAVIT**

**A. AUTHORITY**

I HEREBY AFFIRM THAT:

I, \_\_\_\_\_ (print name), possess the legal authority to make this Affidavit.

**B. CERTIFICATION OF REGISTRATION OR QUALIFICATION WITH THE STATE DEPARTMENT OF ASSESSMENTS AND TAXATION**

I FURTHER AFFIRM THAT:

The business named above is a (check applicable box):

- (1) Corporation —  domestic or  foreign;
- (2) Limited Liability Company —  domestic or  foreign;
- (3) Partnership —  domestic or  foreign;
- (4) Statutory Trust —  domestic or  foreign;
- (5)  Sole Proprietorship.

and is registered or qualified as required under Maryland Law. I further affirm that the above business is in good standing both in Maryland and (IF APPLICABLE) in the jurisdiction where it is presently organized, and has filed all of its annual reports, together with filing fees, with the Maryland State Department of Assessments and Taxation. The name and address of its resident agent (IF APPLICABLE) filed with the State Department of Assessments and Taxation is:

Name and Department ID  
Number:

\_\_\_\_\_ Address: \_\_\_\_\_

and that if it does business under a trade name, it has filed a certificate with the State Department of Assessments and Taxation that correctly identifies that true name and address of the principal or owner as:

Name and Department ID Number: \_\_\_\_\_

Address: \_\_\_\_\_.

**C. POLITICAL CONTRIBUTION DISCLOSURE AFFIRMATION**

I FURTHER AFFIRM THAT:

I am aware of, and the above business will comply with, Election Law Article, §§14-101 - 14-108, Annotated Code of Maryland, which requires that every person that enters into contracts, leases, or other agreements with the State of Maryland, including its agencies or a political subdivision of the State, during a calendar year in which the person receives in the aggregate \$100,000 or more shall file with the State Board of Elections a statement disclosing contributions in excess of \$500 made during the reporting period to a candidate for elective office in any primary or general election.

**D. DRUG AND ALCOHOL FREE WORKPLACE**

(Applicable to all contracts unless the contract is for a law enforcement agency and the agency head or the agency head's designee has determined that application of COMAR 21.11.08 and this certification would be inappropriate in connection with the law enforcement agency's undercover operations.)

I CERTIFY THAT:

(1) By submission of its bid or offer, the business, if other than an individual, certifies and agrees that, with respect to its employees to be employed under a contract resulting from this solicitation, the business shall:

(a) Maintain a workplace free of drug and alcohol abuse during the term of the contract;

(b) Publish a statement notifying its employees that the unlawful manufacture, distribution, dispensing, possession, or use of drugs, and the abuse of drugs or alcohol is prohibited in the business' workplace and specifying the actions that will be taken against employees for violation of these prohibitions;

(c) Prohibit its employees from working under the influence of drugs or alcohol;

(d) Not hire or assign to work on the contract anyone who the business knows, or in the exercise of due diligence should know, currently abuses drugs or alcohol and is not actively engaged in a bona fide drug or alcohol abuse assistance or rehabilitation program;

(e) Promptly inform the appropriate law enforcement agency of every drug-related crime that occurs in its workplace if the business has observed the violation or otherwise has reliable information that a violation has occurred;

(f) Establish drug and alcohol abuse awareness programs to inform its employees about:

(i) The dangers of drug and alcohol abuse in the workplace;

(ii) The business's policy of maintaining a drug and alcohol free workplace;

(iii) Any available drug and alcohol counseling, rehabilitation, and employee assistance programs; and

(iv) The penalties that may be imposed upon employees who abuse drugs and alcohol in the workplace;

(g) Provide all employees engaged in the performance of the contract with a copy of the statement required by §E(2)(b), above;

(h) Notify its employees in the statement required by §E(2)(b), above, that as a condition of continued employment on the contract, the employee shall:

(i) Abide by the terms of the statement; and

(ii) Notify the employer of any criminal drug or alcohol abuse conviction for an offense occurring in the workplace not later than 5 days after a conviction;

(i) Notify the Contract Monitor within 10 days after receiving notice under §E(2)(h)(ii), above, or otherwise receiving actual notice of a conviction;

(j) Within 30 days after receiving notice under §E(2)(h)(ii), above, or otherwise receiving actual notice of a conviction, impose either of the following sanctions or remedial measures on any employee who is convicted of a drug or alcohol abuse offense occurring in the workplace:

(i) Take appropriate personnel action against an employee, up to and including termination; or

(ii) Require an employee to satisfactorily participate in a bona fide drug or alcohol abuse assistance or rehabilitation program; and

(k) Make a good faith effort to maintain a drug and alcohol free workplace through implementation of §E(2)(a)-(j), above.

(2) If the business is an individual, the individual shall certify and agree as set forth in §E(4), below, that the individual shall not engage in the unlawful manufacture, distribution, dispensing, possession, or use of drugs or the abuse of drugs or alcohol in the performance of the contract.

#### E. CERTAIN AFFIRMATIONS VALID

I FURTHER AFFIRM THAT:

To the best of my knowledge, information, and belief, each of the affirmations, certifications, or acknowledgements contained in that certain Bid/Proposal Affidavit dated \_\_\_\_\_, 20\_\_\_\_, and executed by me for the purpose of obtaining the contract to which this Exhibit is attached remains true and correct in all respects as if made as of the date of this Contract Affidavit and as if fully set forth herein.

I DO SOLEMNLY DECLARE AND AFFIRM UNDER THE PENALTIES OF PERJURY THAT THE CONTENTS OF THIS AFFIDAVIT ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE, INFORMATION, AND BELIEF.

Date: \_\_\_\_\_

By: \_\_\_\_\_ (printed name of Authorized Representative and Affiant)

\_\_\_\_\_ (signature of Authorized Representative and Affiant)

Revised August 2011

**ATTACHMENT D – PRE-PROPOSAL CONFERENCE RESPONSE FORM**

**Rare and Expensive Case Management**

A Pre-Proposal Conference will be held at 10:30 AM, on Wednesday, January 16, 2013, at 201 West Preston Street, Room L-4, Baltimore, MD 21201. Please return this form by Monday, January 14, 2013, advising whether you plan to attend.

Return via e-mail or fax this form to the Contract Monitor:

Margaret Berman  
Office of Health Services  
Department of Health and Mental Hygiene  
201 W. Preston Street, Room 210  
Baltimore, MD 21201  
Email: margaret.berman@maryland.gov  
Fax #: (410) 333-5426

Please indicate:

\_\_\_\_\_ Yes, the following representatives will be in attendance:

- 1.
- 2.
- 3.

\_\_\_\_\_ No, we will not be in attendance.

Please specify whether any reasonable accommodations are requested (see RFP § 1.7 “Pre-Proposal Conference”):

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Signature

Title

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Name of Firm (please print)

## ATTACHMENT E – FEDERAL FUNDS ATTACHMENT

A Summary of Certain Federal Fund Requirements and Restrictions  
[Details of particular laws, which may levy a penalty for noncompliance,  
are available from the Department of Health and Mental Hygiene.]

1. Form and rule enclosed: 18 U.S.C. 1913 and section 1352 of P.L. 101-121 require prospective and present subgrantees (this includes all levels of funding) who receive more than \$100,000 in federal funds must submit the form “Certification Against Lobbying.” It assures, generally, that recipients will not lobby federal entities with federal funds, and that, as is required, they will disclose other lobbying on form SF- LLL.
2. Form and instructions enclosed: “Form LLL, Disclosure of Lobbying Activities” must be submitted by those receiving more than \$100,000 in federal funds, to disclose any lobbying of federal entities (a) with profits from federal contracts or (b) funded with nonfederal funds.
3. Form and summary of Act enclosed: Subrecipients of federal funds on any level must complete a “Certification Regarding Environmental Tobacco Smoke, required by Public Law 103-227, the Pro-Children Act of 1994. Such law prohibits smoking in any portion of any indoor facility owned or leased or contracted for regular provision of health, day care, early childhood development, education, or library services for children under the age of 18. Such language must be included in the conditions of award (they are included in the certification, which may be part of such conditions.) This does not apply to those solely receiving Medicaid or Medicare, or facilities where WIC coupons are redeemed.
4. In addition, federal law requires that:
  - A) OMB Circular A-133, Audits of States, Local Governments and Non-Profit Organizations requires that grantees (both recipients and subrecipients) which expend a total of \$500,000 or more in federal assistance shall have a single or program-specific audit conducted for that year in accordance with the provisions of the Single Audit Act of 1984, P.L. 98-502, and the Single Audit Act of 1996, P.L. 104-156, and the Office of Management and Budget (OMB) Circular A-133. All subgrantee audit reports, performed in compliance with the aforementioned Circular shall be forwarded within 30 days of report issuance to the DHMH, External Audit Division, Spring Grove Hospital-Tuerk Bldg, 55Wade Avenue, Baltimore, MD 21228.
  - B) All subrecipients of federal funds comply with Sections 503 and 504 of the Rehabilitation Act of 1973, the conditions of which are summarized in item (C).

- C) Recipients of \$10,000 or more (on any level) must include in their contract language the requirements of Sections 503 (language specified) and 504 referenced in item (B).

Section 503 of the Rehabilitation Act of 1973, as amended, requires recipients to take affirmative action to employ and advance in employment qualified disabled people. An affirmative action program must be prepared and maintained by all contractors with 50 or more employees and one or more federal contracts of \$50,000 or more. This clause must appear in subcontracts of \$10,000 or more:

- a) The contractor will not discriminate against any employee or applicant for employment because of physical or mental handicap in regard to any position for which the employee or applicant for employment is qualified. The contractor agrees to take affirmative action to employ, advance in employment, and otherwise treat qualified handicapped individuals without discrimination based upon their physical or mental handicap in all upgrading, demotion or transfer, recruitment, advertising, layoff or termination, rates of pay or other forms of compensation, and selection for training, including apprenticeship.
- b) The contractor agrees to comply with the rules, regulations, and relevant orders of the secretary of labor issued pursuant to the act.
- c) In the event of the contractor's non-compliance with the requirements of this clause, actions for non-compliance may be taken in accordance with the rules, regulations and relevant orders of the secretary of labor issued pursuant to the act.
- d) The contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices in a form to be prescribed by the director, provided by or through the contracting office. Such notices shall state the contractor's obligation under the law to take affirmative action to employ and advance in employment qualified handicapped employees and applicants for employment, and the rights of applicants and employees.
- e) The contractor will notify each labor union or representative of workers with which it has a collective bargaining agreement or other contract understanding, that the contractor is bound by the terms of Section 503 of the Rehabilitation Act of 1973, and is committed to take affirmative action to employ and advance in employment physically and mentally handicapped individuals.
- f) The contractor will include the provisions of this clause in every subcontract or purchase order of \$10,000 or more unless exempted by



rules, regulations, or orders of the [federal] secretary issued pursuant to section 503 of the Act, so that such provisions will be binding upon each subcontractor vendor. The contractor will take such action with respect to any subcontract or purchase order as the director of the Office of Federal Contract Compliance Programs may direct to enforce such provisions, including action for non-compliance.

Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. Sec. 791 et seq.) prohibits discrimination on the basis of handicap in all federally assisted programs and activities. It requires the analysis and making of any changes needed in three general areas of operation-programs, activities, and facilities and employment. It states, among other things, that:

*Grantees that provide health ... services should undertake tasks such as ensuring emergency treatment for the hearing impaired and making certain that persons with impaired sensory or speaking skills are not denied effective notice with regard to benefits, services, and waivers of rights or consents to treatments.*

- D) All subrecipients comply with Title VI of the Civil Rights Act of 1964, that they must not discriminate in participation by race, color, or national origin.
- E) All subrecipients of federal funds from SAMHSA (Substance Abuse and Mental Health Services Administration) or NIH (National Institute of Health) are prohibited from paying any direct salary at a rate in excess of Executive Level 1 per year. (This includes, but is not limited to, subrecipients of the Substance Abuse Prevention and Treatment and the Community Mental Health Block Grants and NIH research grants.)
- F) There may be no discrimination on the basis of age, according to the requirements of the Age Discrimination Act of 1975.
- G) For any education program, as required by Title IX of the Education Amendments of 1972, there may be no discrimination on the basis of sex.
- H) For research projects, a form for Protection of Human Subjects (Assurance/ Certification/ Declaration) should be completed by each level funded, assuring that either: (1) there are no human subjects involved, or that (2) an Institutional Review Board (IRB) has given its formal approval before human subjects are involved in research. [This is normally done during the application process rather than after the award is made, as with other assurances and certifications.]

- I) In addition, there are conditions, requirements, and restrictions that apply only to specific sources of federal funding. These should be included in your grant/contract documents when applicable.

Rev. 3/2008

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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Public Health Service  
Health Resources and  
Service Administration  
Rockville, MD 20857

**CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE**

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source or applicable Federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing this certification, the offeror/contractor (for acquisitions) or applicant/grantee (for grants) certifies that the submitting organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The submitting organization agrees that it will require that the language of this certification be included in any subawards that contain provisions for children's services and that all subrecipients shall certify accordingly.

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Signature of Authorized Certifying Individual

**U.S. Department of Health and Human Services**

**CERTIFICATION REGARDING LOBBYING**  
**Certification for Contracts, Grants, Loans, and Cooperative Agreements**

The undersigned certifies, to the best of his or her knowledge and belief, that:

The undersigned certifies, to the best of his or her knowledge and belief, that:

- (1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
- (2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.
- (3) The undersigned shall require that the language of this certification be included in the award documents for all sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

Award No.	Organization Entity
Name and Title of Official for Organization Entity	Telephone No. of Signing Official
Signature of Above Official	Date Signed

## DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352

Approved by  
OMB0348-0046

(See reverse for public burden disclosure.)

<b>1. Type of Federal Action:</b> <input type="checkbox"/> a. Contract <input type="checkbox"/> b. Grant <input type="checkbox"/> c. Cooperative Agreement <input type="checkbox"/> d. Loan <input type="checkbox"/> e. Loan guarantee <input type="checkbox"/> f. Loan insurance	<b>2. Status of Federal Action:</b> <input type="checkbox"/> a. Bid/offer/application <input type="checkbox"/> b. Initial award <input type="checkbox"/> c. Post-award	<b>3. Report Type:</b> <input type="checkbox"/> a. Initial filing <input type="checkbox"/> b. Material change For Material Change Only: Year _____ quarter _____ Date of last report _____	
<b>4. Name and Address of Reporting Entity:</b> <input type="checkbox"/> Prime <input type="checkbox"/> Subawardee Tier _____, if known:  Congressional District, <i>if known</i> : _____	<b>5. If Reporting Entity in No. 4 is a Subawardee, Enter Name and Address of Prime:</b>  Congressional District, <i>if known</i> : _____		
<b>6. Federal Department/Agency:</b> _____	<b>7. Federal Program Name/Description:</b>  CFDA Number, <i>if applicable</i> : _____		
<b>8. Federal Action Number, if known:</b> _____	<b>9. Award Amount, if known:</b>  \$ _____		
<b>10. a. Name and Address of Lobbying Registrant</b> <i>(if individual, last name, first name, MI):</i> _____			<b>b. Individuals Performing Services</b> <i>(including address if different from No. 10a) (last name, first name, MI):</i> _____
<b>11. Amount of Payment</b> <i>(check all that apply)</i> \$ _____ <input type="checkbox"/> actual <input type="checkbox"/> planned	<b>13. Type of Payment</b> <i>(check all that apply)</i> <input type="checkbox"/> a. retainer <input type="checkbox"/> b. one-time <input type="checkbox"/> c. commission <input type="checkbox"/> d. contingent fee <input type="checkbox"/> e. deferred <input type="checkbox"/> f. other; specify: _____		
<b>12. Form of Payment</b> <i>(check all that apply)</i> <input type="checkbox"/> a. cash <input type="checkbox"/> b. in-kind; specify: nature _____ value _____			
<b>14. Brief Description of Services Performed or to be Performed and Date(s) of Service, including officer(s), employee(s), or Member(s) contacted, for Payment Indicated in Item 11:</b>   <p style="text-align: center;"><i>(attach Continuation Sheet(s) SF-LLLA, if necessary)</i></p>			
<b>15. Continuation Sheet(s) SF-LLLA attached:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			
16. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.		Signature: _____  Print Name: _____  Title: _____	

Telephone No.: \_\_\_\_\_ Date: \_\_\_\_\_

**Federal Use Only:**

Authorized for Local  
Reproduction  
Standard Form LLL (Rev. 7-97)

### INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.
2. Identify the status of the covered Federal action.
3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.
4. Enter the full name, address, city, State, and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.
5. If the organization filing the report in item 4 checks "Subawardee," then enter the full name, address, city, State and zip code of the prime Federal recipient. Include Congressional District, if known.
6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.
7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.
8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency). Include prefixes, e.g., "RFP-DE-90-001."
9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.
10. (a) Enter the full name, address, city, State and zip code of the lobbying registrant under the Lobbying Disclosure Act of 1995 engaged by the reporting entity identified in item 4 to influence the covered Federal action.
10. (b) Enter the full names of the individual(s) performing services, and include full address if different from 10 (a). Enter Last Name, First Name, and Middle Initial (MI).
11. The certifying official shall sign and date the form and print his/her name, title, and telephone number.

According to the Paperwork Reduction Act, as amended, no persons are required to respond to a collection of information unless it displays a valid OMB Control Number. The valid OMB control number for this information collection is OMB No. 0348-0046. Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0046), Washington, DC 20503.

**ATTACHMENT F – CONFLICT OF INTEREST AFFIDAVIT AND DISCLOSURE**

**Reference COMAR 21.05.08.08**

- A. “Conflict of interest” means that because of other activities or relationships with other persons, a person is unable or potentially unable to render impartial assistance or advice to the State, or the person's objectivity in performing the contract work is or might be otherwise impaired, or a person has an unfair competitive advantage.
- B. “Person” includes an Offeror, Contractor, consultant, or subcontractor or sub-consultant at any tier, and also includes an employee or agent of any of them if the employee or agent has or will have the authority to control or supervise all or a portion of the work for which a bid or offer is made.
- C. The Offeror warrants that, except as disclosed in §D, below, there are no relevant facts or circumstances now giving rise or which could, in the future, give rise to a conflict of interest.
- D. The following facts or circumstances give rise or could in the future give rise to a conflict of interest (explain in detail—attach additional sheets if necessary):
- E. The Offeror agrees that if an actual or potential conflict of interest arises after the date of this affidavit, the Offeror shall immediately make a full disclosure in writing to the Contract Monitor of all relevant facts and circumstances. This disclosure shall include a description of actions that the Offeror has taken and proposes to take to avoid, mitigate, or neutralize the actual or potential conflict of interest. If the contract has been awarded and performance of the contract has begun, the Contractor shall continue performance until notified by the Contract Monitor of any contrary action to be taken.

I DO SOLEMNLY DECLARE AND AFFIRM UNDER THE PENALTIES OF PERJURY THAT THE CONTENTS OF THIS AFFIDAVIT ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE, INFORMATION, AND BELIEF.

Date: \_\_\_\_\_

By: \_\_\_\_\_  
(Authorized Representative and Affiant)

**SUBMIT THIS AFFIDAVIT WITH THE TECHNICAL PROPOSAL**

## ATTACHMENT G – BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement (the “Agreement”) is made by and between the Office of Health Services, a unit of the Maryland Department of Health and Mental Hygiene (herein referred to as “Covered Entity”) and \_\_\_\_\_ (hereinafter known as “Business Associate”). Covered Entity and Business Associate shall collectively be known herein as the “Parties.”

WHEREAS, Covered Entity have a business relationship with Business Associate that is memorialized in a separate agreement (the “Underlying Agreement”) pursuant to which Business Associate may be considered a “business associate” of Covered Entity as defined in the Health Insurance Portability and Accountability Act of 1996 including all pertinent regulations (45 C.F.R. Parts 160 and 64), as amended from time to time, issued by the U.S. Department of Health and Human Services as either have been amended by Subtitle D of the Health Information Technology for Economic and Clinical Health Act (the “HITECH Act”), as Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (Pub. L. 111–5) (collectively, “HIPAA”); and

WHEREAS, the nature of the contractual relationship between Covered Entity and Business Associate may involve the exchange of Protected Health Information (“PHI”) as that term is defined under HIPAA; and

WHEREAS, for good and lawful consideration as set forth in the Underlying Agreement, Covered Entity and Business Associate enter into this agreement for the purpose of ensuring compliance with the requirements of HIPAA and the Maryland Confidentiality of Medical Records Act (Md. Ann. Code, Health-General §§4-301 *et seq.*) (“MCMRA”); and

WHEREAS, this Agreement supersedes and replaces any and all Business Associate Agreements the Covered Entity and Business Associate may have entered into prior to the date hereof;

NOW THEREFORE, the premises having been considered and with acknowledgment of the mutual promises and of other good and valuable consideration herein contained, the Parties, intending to be legally bound, hereby agree as follows:

### I. DEFINITIONS.

- A. Individual. “Individual” shall have the same meaning as the term “individual” in 45 C.F.R. §164.501 and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. §164.502(g).
- B. Breach. “Breach” shall have the same meaning as the term “breach” in 45 C.F.R. § 164.402.
- C. Designated Record Set. “Designated Record Set” shall have the same meaning as the term “designated record set” in 45 C.F.R. §164.501.
- D. Privacy Rule. “Privacy Rule” shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. Part 160 and Part 164, Subparts A and E.
- E. Protected Health Information or PHI. “Protected Health Information” or “PHI” shall have the same meaning as the term “protected health information” in 45 C.F.R. §164.501, limited to the information created or received by Business Associate from or on behalf of Covered Entity.



- F. Required By Law. “Required By Law” shall have the same meaning as the term “required by law” in 45 C.F.R. §164.501.
- G. Secretary. “Secretary” shall mean the Secretary of the U.S. Department of Health and Human Services or his or her designee.
- H. Unsecured Protected Health Information. “Unsecured Protected Health Information” or “Unsecured PHI” shall mean PHI that is not secured through the use of a technology or methodology specified by the Secretary in guidance or as otherwise defined in the §13402(h) of the HITECH Act.

## **II. USE OR DISCLOSURE OF PHI BY BUSINESS ASSOCIATE.**

- A. Except as otherwise limited in this Agreement, Business Associate may use or disclose PHI to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Underlying Agreement, provided that such use or disclosure would not violate the Privacy Rule.
- B. Business Associate shall only use and disclose PHI if such use or disclosure complies with each applicable requirement of 45 C.F.R. §164.504(e).
- C. Business Associate shall be directly responsible for full compliance with the relevant requirements of the Privacy Rule to the same extent as Covered Entity.

## **III. DUTIES OF BUSINESS ASSOCIATE RELATIVE TO PHI.**

- A. Business Associate shall not use or disclose PHI other than as permitted or required by this Agreement, the MCMRA, or as Required By Law.
- B. Business Associate shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of Covered Entity.
- C. Business Associate shall immediately notify Covered Entity of any use or disclosure of PHI in violation of this Agreement
- D. In addition to its obligations in Section III.C, Business Associate shall document and notify Covered Entity of a Breach of Unsecured PHI. Business Associate’s notification to Covered Entity hereunder shall:
  - 1. Be made to Covered Entity without unreasonable delay and in no case later than fifty (50) calendar days after the incident constituting the Breach is first known, except where a law enforcement official determines that a notification would impede a criminal investigation or cause damage to national security. For purposes of clarity for this Section III.D.1, Business Associate must notify Covered Entity of an incident involving the acquisition, access, use or disclosure of PHI in a manner not permitted under 45 C.F.R. Part E within fifty (50) calendar days after an incident even if Business Associate has not conclusively determined within that time that the incident constitutes a Breach as defined by HIPAA;
  - 2. Include the names of the Individuals whose Unsecured PHI has been, or is reasonably believed to have been, the subject of a Breach;

3. Be in substantially the same form as Exhibit A hereto; and
4. Include a draft letter for the Covered Entity to utilize to notify the Individuals that their Unsecured PHI has been, or is reasonably believed to have been, the subject of a Breach that includes, to the extent possible:
  - a) A brief description of what happened, including the date of the Breach and the date of the discovery of the Breach, if known;
  - b) A description of the types of Unsecured PHI that were involved in the Breach (such as full name, Social Security number, date of birth, home address, account number, disability code, or other types of information that were involved);
  - c) Any steps the Individuals should take to protect themselves from potential harm resulting from the Breach;
  - d) A brief description of what the Covered Entity and the Business Associate are doing to investigate the Breach, to mitigate losses, and to protect against any further Breaches; and
  - e) Contact procedures for Individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an e-mail address, website, or postal address.
- E. In the event of an unauthorized use or disclosure of PHI or a Breach of Unsecured PHI, Business Associate shall mitigate, to the extent practicable, any harmful effects of said disclosure that are known to it.
- F. Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides PHI received from, or created or received by Business Associate on behalf of Covered Entity agrees to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information.
- G. To the extent applicable, Business Associate shall provide access to PHI in a Designated Record Set at reasonable times, at the request of Covered Entity or, as directed by Covered Entity, to an Individual in order to meet the requirements under 45 C.F.R. §164.524.
- H. To the extent applicable, Business Associate shall make any amendment(s) to PHI in a Designated Record Set that Covered Entity directs or agrees to pursuant to 45 C.F.R. §164.526 at the request of Covered Entity or an Individual.
- I. Business Associate shall, upon request with reasonable notice, provide Covered Entity access to its premises for a review and demonstration of its internal practices and procedures for safeguarding PHI.
- J. Business Associate agrees to document such disclosures of PHI and information related to such disclosures as would be required for a Covered Entity to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. §164.528. Should an individual make a request to Covered Entity for an accounting of disclosures of his or her PHI pursuant to 45

C.F.R. §164.528, Business Associate agrees to promptly provide Covered Entity with information in a format and manner sufficient to respond to the individual's request.

- K. Business Associate shall, upon request with reasonable notice, provide Covered Entity with an accounting of uses and disclosures of PHI provided to it by Covered Entity.
- L. Business Associate shall make its internal practices, books, records, and any other material requested by the Secretary relating to the use, disclosure, and safeguarding of PHI received from Covered Entity available to the Secretary for the purpose of determining compliance with the Privacy Rule. The aforementioned information shall be made available to the Secretary in the manner and place as designated by the Secretary or the Secretary's duly appointed delegate. Under this Agreement, Business Associate shall comply and cooperate with any request for documents or other information from the Secretary directed to Covered Entity that seeks documents or other information held by Business Associate.
- M. Business Associate may use PHI to report violations of law to appropriate Federal and State authorities, consistent with 42 C.F.R. §164.502(j)(1).
- N. Except as otherwise limited in this Agreement, Business Associate may disclose PHI for the proper management and administration of Business Associate, provided that disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

#### **IV. TERM AND TERMINATION.**

- A. Term. The Term of this Agreement shall be effective as of as of the effective date of the Contract entered into following the solicitation for Rare and Expensive Case Management, and shall terminate when all of the PHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy PHI, protections are extended to such information, in accordance with the termination provisions in this Section IV.
- B. Termination for Cause. Upon Covered Entity's knowledge of a material breach of this Agreement by Business Associate, Covered Entity shall:
  - 1. Provide an opportunity for Business Associate to cure the breach or end the violation and, if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity, terminate this Agreement;
  - 2. Immediately terminate this Agreement if Business Associate has breached a material term of this Agreement and cure is not possible; or
  - 3. If neither termination nor cure is feasible, report the violation to the Secretary.
- C. Effect of Termination.

1. Except as provided in paragraph C(2) of this section, upon termination of this Agreement, for any reason, Business Associate shall return or destroy all PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate. Business Associate shall not retain any copies of the PHI.
2. In the event that Business Associate determines that returning or destroying the PHI is infeasible, Business Associate shall provide to Covered Entity written notification of the conditions that make return or destruction infeasible. After written notification that return or destruction of PHI is infeasible, Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI.
3. Should Business Associate make an intentional or grossly negligent Breach of PHI in violation of this Agreement or HIPAA or an intentional or grossly negligent disclosure of information protected by the MCMRA, Covered Entity shall have the right to terminate immediately any contract, other than this Agreement, then in force between the Parties, including the Underlying Agreement.

#### **V. CONSIDERATION**

Business associate recognizes that the promises it has made in this agreement shall, henceforth, be detrimentally relied upon by covered entity in choosing to continue or commence a business relationship with business associate.

#### **VI. REMEDIES IN EVENT OF BREACH**

Business Associate hereby recognizes that irreparable harm will result to Covered Entity, and to the business of Covered Entity, in the event of breach by Business Associate of any of the covenants and assurances contained in this Agreement. As such, in the event of breach of any of the covenants and assurances contained in Sections II or III above, Covered Entity shall be entitled to enjoin and restrain Business Associate from any continued violation of Sections II or III. Furthermore, in the event of breach of Sections II or III by Business Associate, Covered Entity is entitled to reimbursement and indemnification from Business Associate for Covered Entity's reasonable attorneys' fees and expenses and costs that were reasonably incurred as a proximate result of Business Associate's breach. The remedies contained in this Section VI shall be in addition to (and not supersede) any action for damages and/or any other remedy Covered Entity may have for breach of any part of this Agreement.

#### **VII. MODIFICATION; AMENDMENT**

This Agreement may only be modified or amended through a writing signed by the Parties and, thus, no oral modification or amendment hereof shall be permitted. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy Rule and HIPAA.

#### **VIII. INTERPRETATION OF THIS AGREEMENT IN RELATION TO OTHER AGREEMENTS BETWEEN THE PARTIES**

Should there be any conflict between the language of this Agreement and any other contract entered into between the Parties (either previous or subsequent to the date of this Agreement), the language and provisions of this Agreement shall control and prevail unless the Parties specifically refer in a subsequent written agreement to this Agreement by its title and date and specifically state that the provisions of the later written agreement shall control over this Agreement.

#### **IX. COMPLIANCE WITH STATE LAW**

The Business Associate acknowledges that by accepting the PHI from Covered Entity, it becomes a holder of medical records information under the MCMRA and is subject to the provisions of that law. If the HIPAA Privacy or Security Rules and the MCMRA conflict regarding the degree of protection provided for protected health information, Business Associate shall comply with the more restrictive protection requirement.

#### **X. MISCELLANEOUS.**

- A. Ambiguity. Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy Rule.
- B. Regulatory References. A reference in this Agreement to a section in the Privacy Rule means the section as in effect or as amended.
- C. Notice to Covered Entity. Any notice required under this Agreement to be given Covered Entity shall be made in writing to:

Ramiek James, Privacy Officer  
Department of Health & Mental Hygiene  
Office of the Inspector General  
201 W. Preston Street, 5th Floor  
Baltimore, MD 21201  
Phone: (410) 767-5411

D. Notice to Business Associate. Any notice required under this Agreement to be given Business Associate shall be made in writing to:

Address: \_\_\_\_\_  
\_\_\_\_\_  
Attention: \_\_\_\_\_  
Phone: \_\_\_\_\_

**IN WITNESS WHEREOF** and acknowledging acceptance and agreement of the foregoing, the Parties affix their signatures hereto.

**COVERED ENTITY:**

**BUSINESS ASSOCIATE:**

By: \_\_\_\_\_

By: \_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

**ATTACHMENT G-1 - BREACH OF UNSECURED PROTECTED HEALTH INFORMATION**

**NOTIFICATION TO THE  
MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
ABOUT A BREACH OF UNSECURED PROTECTED HEALTH INFORMATION**

This notification is made pursuant to Section IIID(3) of the Business Associate Agreement between the Office of Health Services, a unit of the Maryland Department of Health and Mental Hygiene (DHMH), and \_\_\_\_\_ (Business Associate).

Business Associate hereby notifies DHMH that there has been a breach of unsecured (unencrypted) protected health information (PHI) that Business Associate has used or has had access to under the terms of the Business Associate Agreement.

Description of the breach: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of the breach: \_\_\_\_\_

Date of discovery of the breach: \_\_\_\_\_

Does the breach involve 500 or more individuals? Yes / No

If yes, do the people live in multiple states? Yes / No

Number of individuals affected by the breach: \_\_\_\_\_.

Names of individuals affected by the breach: (attach list)

The types of unsecured PHI that were involved in the breach (such as full name, Social Security number, date of birth, home address, account number, or disability code):  
\_\_\_\_\_

Description of what Business Associate is doing to investigate the breach, to mitigate losses, and to protect against any further breaches:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Contact information to ask questions or learn additional information:

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Address: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**ATTACHMENT H – NON-DISCLOSURE AGREEMENT (AWARD)**

**THIS NON-DISCLOSURE AGREEMENT** (the “Agreement”) is made this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, by and between the State of Maryland (the “State”), acting by and through its Department of Health and Mental Hygiene (the “Department”) and \_\_\_\_\_ (the “Contractor”).

**RECITALS**

**WHEREAS**, the Contractor has been awarded a contract (the “Contract”) following the solicitation for Request for Proposals (“RFP”) Rare and Expensive Case Management; and

**WHEREAS**, in order for the Contractor to perform the work required under the Contract, it will be necessary for the State at times to provide the Contractor and the Contractor’s employees, agents, and subcontractors (collectively the “Contractor’s Personnel”) with access to certain information the State deems confidential information (the “Confidential Information”).

**NOW, THEREFORE**, in consideration of being given access to the Confidential Information in connection with the RFP and the Contract, and for other good and valuable consideration, the receipt and sufficiency of which the parties acknowledge, the parties do hereby agree as follows:

1. Confidential Information means any and all information provided by or made available by the State to the Contractor in connection with the Contract, regardless of the form, format, or media on or in which the Confidential Information is provided and regardless of whether any such Confidential Information is marked as such. Confidential Information includes, by way of example only, information that the Contractor views, takes notes from, copies (if the State agrees in writing to permit copying), possesses or is otherwise provided access to and use of by the State in relation to the Contract.
2. Contractor shall not, without the State’s prior written consent, copy, disclose, publish, release, transfer, disseminate, use, or allow access for any purpose or in any form, any Confidential Information provided by the State except for the sole and exclusive purpose of performing under the Contract. Contractor shall limit access to the Confidential Information to the Contractor’s Personnel who have a demonstrable need to know such Confidential Information in order to perform under the Contract and who have agreed in writing to be bound by the disclosure and use limitations pertaining to the Confidential Information. The names of the Contractor’s Personnel are attached hereto and made a part hereof as Exhibit A. Each individual whose name appears on Exhibit A shall execute a copy of this Agreement and thereby be subject to the terms and conditions of this Agreement to the same extent as the Contractor. Contractor shall update Exhibit A by adding additional names (whether Contractor’s personnel or a subcontractor’s personnel) as needed, from time to time.
3. If the Contractor intends to disseminate any portion of the Confidential Information to non-employee agents who are assisting in the Contractor’s performance of the RFP or who will otherwise have a role in performing any aspect of the RFP, the Contractor shall first obtain the written consent of the State to any such dissemination. The State may grant, deny, or condition any such consent, as it may deem appropriate in its sole and absolute subjective discretion.



4. Contractor hereby agrees to hold the Confidential Information in trust and in strictest confidence, to adopt or establish operating procedures and physical security measures, and to take all other measures necessary to protect the Confidential Information from inadvertent release or disclosure to unauthorized third parties and to prevent all or any portion of the Confidential Information from falling into the public domain or into the possession of persons not bound to maintain the confidentiality of the Confidential Information.
5. Contractor shall promptly advise the State in writing if it learns of any unauthorized use, misappropriation, or disclosure of the Confidential Information by any of the Contractor's Personnel or the Contractor's former Personnel. Contractor shall, at its own expense, cooperate with the State in seeking injunctive or other equitable relief against any such person(s).
6. Contractor shall, at its own expense, return to the Department all copies of the Confidential Information in its care, custody, control or possession upon request of the Department or on termination of the Contract. Confidential Information returned to the State shall be accompanied by the Certification that is attached hereto and made a part hereof as Exhibit B and shall be signed by an officer of the Contractor authorized to bind the Contractor.
7. A breach of this Agreement by the Contractor or by the Contractor's Personnel shall constitute a breach of the Contract between the Contractor and the State.
8. Contractor acknowledges that any failure by the Contractor or the Contractor's Personnel to abide by the terms and conditions of use of the Confidential Information may cause irreparable harm to the State and that monetary damages may be inadequate to compensate the State for such breach. Accordingly, the Contractor agrees that the State may obtain an injunction to prevent the disclosure, copying or improper use of the Confidential Information. The Contractor consents to personal jurisdiction in the Maryland State Courts. The State's rights and remedies hereunder are cumulative and the State expressly reserves any and all rights, remedies, claims and actions that it may have now or in the future to protect the Confidential Information and to seek damages from the Contractor and the Contractor's Personnel for a failure to comply with the requirements of this Agreement. In the event the State suffers any losses, damages, liabilities, expenses, or costs (including, by way of example only, attorneys' fees and disbursements) that are attributable, in whole or in part to any failure by the Contractor or any of the Contractor's Personnel to comply with the requirements of this Agreement, the Contractor shall hold harmless and indemnify the State from and against any such losses, damages, liabilities, expenses, and costs.
9. Contractor and each of the Contractor's Personnel who receive or have access to any Confidential Information shall execute a copy of an agreement substantially similar to this Agreement and the Contractor shall provide originals of such executed Agreements to the State.
10. The parties further agree that:
  - a. This Agreement shall be governed by the laws of the State of Maryland;
  - b. The rights and obligations of the Contractor under this Agreement may not be assigned or delegated, by operation of law or otherwise, without the prior written consent of the State;
  - c. The State makes no representations or warranties as to the accuracy or completeness of any Confidential Information;
  - d. The invalidity or unenforceability of any provision of this Agreement shall not affect the validity or enforceability of any other provision of this Agreement;

- e. Signatures exchanged by facsimile are effective for all purposes hereunder to the same extent as original signatures;
- f. The Recitals are not merely prefatory but are an integral part hereof; and
- g. The effective date of this Agreement shall be the same as the effective date of the Contract entered into by the parties.

**IN WITNESS WHEREOF**, the parties have, by their duly authorized representatives, executed this Agreement as of the day and year first above written.

Contractor: _____	Maryland Department of Health and Mental Hygiene
By: _____(SEAL)	By: _____
Printed Name: _____	Printed Name: _____
Title: _____	Title: _____
Date: _____	Date: _____

**NON-DISCLOSURE AGREEMENT - EXHIBIT A**

**LIST OF CONTRACTOR'S EMPLOYEES AND AGENTS WHO WILL BE GIVEN ACCESS TO THE  
CONFIDENTIAL INFORMATION**

<b>Printed Name and Address of Individual/Agent</b>	<b>Employee (E) or Agent (A)</b>	<b>Signature</b>	<b>Date</b>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
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_____	_____	_____	_____

**NON-DISCLOSURE AGREEMENT - EXHIBIT B**

**CERTIFICATION TO ACCOMPANY RETURN OF CONFIDENTIAL INFORMATION**

I AFFIRM THAT:

To the best of my knowledge, information, and belief, and upon due inquiry, I hereby certify that: (i) all Confidential Information which is the subject matter of that certain Agreement by and between the State of Maryland and \_\_\_\_\_ (“Contractor”) dated \_\_\_\_\_, 20\_\_\_\_ (“Agreement”) is attached hereto and is hereby returned to the State in accordance with the terms and conditions of the Agreement; and (ii) I am legally authorized to bind the Contractor to this affirmation.

**I DO SOLEMNLY DECLARE AND AFFIRM UNDER THE PENALTIES OF PERJURY THAT THE CONTENTS OF THIS AFFIDAVIT ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE, INFORMATION, AND BELIEF, HAVING MADE DUE INQUIRY.**

DATE: \_\_\_\_\_

NAME OF CONTRACTOR: \_\_\_\_\_

BY: \_\_\_\_\_  
(Signature)

TITLE: \_\_\_\_\_  
(Authorized Representative and Affiant)

## **SECTION 7 – APPENDICES A - DD**

**APPENDIX A** – Rare and Expensive Disease List

**APPENDIX B** – Current REM Diagnostic Groupings

**APPENDIX C-1** – Assessment Form

**APPENDIX C-2** – Emergency Information Form for Children with Special Needs (Form is accessible at <http://www.childrensnational.org/files/PDF/EMSC/PubRes/EIForm.pdf>; © American College of Emergency Physicians and American Academy of Pediatrics. Permission to reprint granted with acknowledgement.)

**APPENDIX C-3** – REM Service Coordination Form

**APPENDIX D** – Maryland EPSDT Healthy Kids Preventive Health Schedule

**APPENDIX E** – Interdisciplinary Plan of Care

**APPENDIX F** – Case Management Plan

**APPENDIX G** – Level of Care Guidelines

**APPENDIX H** – REM Case Manager Minimum Reporting and Contact Requirements

**APPENDIX I** – Provider Relations Activity Report

**APPENDIX J** – Contact Record

**APPENDIX K** – Case Rate Schedule

**APPENDIX L-1** – Request for Case Closure

**APPENDIX L-2** – REM Closure Report

**APPENDIX M** – REM Participant Roster

**APPENDIX N** – Case Management Activity Summary

**APPENDIX N-1** – Level of Care Abbreviations, Payment Code Abbreviations, and Billing Procedure Codes

**APPENDIX O** – Case Management Organization Quality Improvement Program Requirements

**APPENDIX P** – Consent to Release Information

**APPENDIX Q** – REM Participant Visit Form

**APPENDIX R** – Real Time Significant Events Reporting Form

**APPENDIX S** – Monthly Significant Events Report Format

**APPENDIX T** – REM Reporting of Significant Events: Categories & Descriptions

**APPENDIX U** – REM Case Manager, Case Load, and Supervisor Monthly Report Format

**APPENDIX V** – Unmet Case Management Contact and Reporting Requirements Template

**APPENDIX W** – Private Duty Nursing Assessment Form

**APPENDIX X** – Breakdown of REM Native Languages

**APPENDIX Y** – Monthly Complaint Log Format

**APPENDIX Z** – Current FFS Services Form

**APPENDIX AA** – Current MCO Services Form

**APPENDIX BB** – Current Performance Measures of REM Participant Population

**APPENDIX CC** – Provider Agreement for Participation in Maryland Medical Assistance Program

**APPENDIX DD** – Notification of Unable to Locate or Non-Responsive REM Participant

**Appendix A**

**Rare and Expensive Disease List (Updated December 27, 2010)**

ICD-9 Code	Disease	Age Group	Guidelines
042.	Symptomatic HIV disease/AIDS (pediatric)	0-20	<p>(A) A child &lt;18 mos. who is known to be HIV seropositive or born to an HIV-infected mother <b>and:</b></p> <ul style="list-style-type: none"> <li>* Has positive results on two separate specimens (excluding cord blood) from any of the following HIV detection tests:               <ul style="list-style-type: none"> <li>--HIV culture (2 separate cultures)</li> <li>--HIV polymerase chain reaction (PCR)</li> <li>--HIV antigen (p24)</li> </ul> </li> </ul> <p>N.B. Repeated testing in first 6 mos. of life; optimal timing is age 1 month and age 4-6 mos.</p> <p style="text-align: center;"><b>or</b></p> <ul style="list-style-type: none"> <li>* Meets criteria for Acquired Immunodeficiency Syndrome (AIDS) diagnosis based on the 1987 AIDS surveillance case definition</li> </ul>
V08	Asymptomatic HIV status (pediatric)	0-20	<p>(B) A child &gt;18 mos. born to an HIV-infected mother or any child infected by blood, blood products, or other known modes of transmission (e.g., sexual contact) who:</p> <ul style="list-style-type: none"> <li>* Is HIV-antibody positive by confirmatory Western blot or immunofluorescence assay (IFA)</li> </ul> <p style="text-align: center;"><b>or</b></p> <ul style="list-style-type: none"> <li>* Meets any of the criteria in (A) above</li> </ul>
795.71	Infant with inconclusive HIV result	0-12 months	<p>(E) A child who does not meet the criteria above who:</p> <ul style="list-style-type: none"> <li>* Is HIV seropositive by ELISA and confirmatory Western blot or IFA and is 18 mos. or less in age at the time of the test</li> </ul> <p style="text-align: center;"><b>or</b></p> <ul style="list-style-type: none"> <li>* Has unknown antibody status, but was born to a mother known to be infected with HIV</li> </ul>
270.0	Disturbances of amino-acid transport Cystinosis Cystinuria Hartnup disease	0-20	Clinical history and physical exam; laboratory studies supporting diagnosis. Subspecialist consultation note may be required.

**Appendix A**

**Rare and Expensive Disease List (Updated December 27, 2010)**

ICD-9 Code	Disease	Age Group	Guidelines
270.1	Phenylketonuria – PKU	0–20	Clinical history and physical exam; laboratory studies supporting diagnosis. Subspecialist consultation note may be required. Lab test: high plasma phenylalanine and normal/low tyrosine
270.2	Other disturbances of aromatic-acid metabolism	0–20	Clinical history and physical exam; laboratory studies supporting diagnosis. Subspecialist consultation note may be required.
270.3	Disturbances of branched-chain amino-acid metabolism	0–20	
270.4	Disturbances of sulphur-bearing amino-acid metabolism	0–20	
270.5	Disturbances of histidine metabolism Carnosinemia Histidinemia Hyperhistidinemia Imidazole aminoaciduria	0–20	Clinical history and physical exam; laboratory studies supporting diagnosis. Subspecialist consultation note may be required.
270.6	Disorders of urea cycle metabolism	0–20	Clinical history and physical exam; laboratory studies supporting diagnosis. Subspecialist consultation note may be required.
270.7	Other disturbances of straight-chain amino-acid Glucoglycinuria Glycinemia (with methylmalonic acidemia) Hyperglycinemia Hyperlysinemia Pipecolic acidemia Saccharopinuria Other disturbances of metabolism of glycine, threonine, serine, glutamine, and lysine	0–20	Clinical history and physical exam; laboratory studies supporting diagnosis. Subspecialist consultation note may be required.

**Appendix A**

**Rare and Expensive Disease List (Updated December 27, 2010)**

ICD-9 Code	Disease	Age Group	Guidelines
270.8	Other specified disorders of amino-acid metabolism Alaninemia Ethanolaminuria Glycoprolinuria Hydroxyprolinemia Hyperprolinemia Iminoacidopathy Prolinemia Prolinuria Sarcosinemia	0-20	Clinical history and physical exam; laboratory studies supporting diagnosis. Subspecialist consultation note may be required.
271.0	Glycogenosis	0-20	Clinical history and physical exam; laboratory studies supporting diagnosis. Subspecialist consultation note may be required.
271.1	Galactosemia	0-20	Clinical history and physical exam; laboratory studies supporting diagnosis. Subspecialist consultation note may be required.
271.2	Hereditary fructose intolerance	0-20	Clinical history and physical exam; laboratory studies supporting diagnosis. Subspecialist consultation note may be required.
272.7	Lipidoses	0-20	Clinical history and physical exam; laboratory studies supporting diagnosis. Subspecialist consultation note may be required.
277.00	Cystic fibrosis without ileus.	0-64	Clinical history and physical exam; laboratory studies supporting diagnosis. Subspecialist consultation note may be required.
277.01	Cystic fibrosis with ileus.	0-64	Clinical history and physical exam; laboratory studies supporting diagnosis. Subspecialist consultation note may be required.
277.02	Cystic fibrosis with pulmonary manifestations	0-64	Clinical history and physical exam; laboratory studies supporting diagnosis. Subspecialist consultation note may be required.
277.03	Cystic fibrosis with gastrointestinal manifestations	0-64	Clinical history and physical exam; laboratory studies supporting diagnosis. Subspecialist consultation note may be required.
277.09	Cystic fibrosis with other manifestations	0-64	Clinical history and physical exam; laboratory studies supporting diagnosis. Subspecialist consultation note may be required.



**Appendix A**

**Rare and Expensive Disease List (Updated December 27, 2010)**

ICD-9 Code	Disease	Age Group	Guidelines
277.2	Other disorders of purine and pyrimidine metabolism	0-64	Clinical history and physical exam; laboratory studies supporting diagnosis. Subspecialist consultation note may be required. Demonstration of deficient enzyme such as: alpha-L-Iduronidase, Iduronosulfate sulfatase, Heparan sulfate sulfatase, N-Acetyl-alpha-D-glucosaminidase, Arylsulfatase B, Beta-Glucuronidase, Beta-Galactosidase, N-Aacetylhexosaminidase-6-SO4 sulfatase.
277.5	Mucopolysaccharidosis	0-64	
277.81	Primary Carnitine deficiency	0-64	Clinical history and physical exam; laboratory or imaging studies supporting diagnosis. Subspecialist consultation note may be required.
277.82	Carnitine deficiency due to inborn errors of metabolism	0-64	Clinical history and physical exam; laboratory or imaging studies supporting diagnosis. Subspecialist consultation note may be required.
277.89	Other specified disorders of metabolism	0-64	Clinical history and physical exam; laboratory or imaging studies supporting diagnosis. Subspecialist consultation note may be required.
284.01	Constitutional red blood cell aplasia	0-20	Clinical history and physical exam; laboratory studies supporting diagnosis. Subspecialist consultation note may be required.
284.09	Other constitutional aplastic anemia	0-20	
286.0	Congenital factor VIII disorder	0-64	
286.1	Congenital factor IX disorder	0-64	
286.2	Congenital factor XI deficiency	0-64	
286.3	Congenital deficiency of other clotting factors	0-64	
286.4	von Willebrand's disease	0-64	
330.0	Leukodystrophy	0-20	Clinical history and physical exam; laboratory or imaging studies supporting diagnosis. Subspecialist consultation note may be required.
330.1	Cerebral lipidoses	0-20	
330.2	Cerebral degenerations in generalized lipidoses	0-20	
330.3	Cerebral degeneration of childhood in other diseases classified	0-20	
330.8	Other specified cerebral degeneration in childhood	0-20	

**Appendix A**

**Rare and Expensive Disease List (Updated December 27, 2010)**

ICD-9 Code	Disease	Age Group	Guidelines
330.9	Unspecified cerebral degeneration in childhood	0-20	
331.3	Communicating hydrocephalus	0-20	Clinical history and physical exam; imaging studies supporting diagnosis. Sub specialist consultation note may be required.
331.4	Obstructive hydrocephalus	0-20	
333.2	Myoclonus	0-5	Clinical history and physical exam. Subspecialist consultation note may be required.
333.6	Idiopathic torsion dystonia	0-64	Clinical history and physical exam; laboratory or imaging studies supporting diagnosis. Subspecialist consultation note may be required.
333.7	Symptomatic torsion dystonia	0-64	
333.90	Unspecified extrapyramidal disease and abnormal movement disorder	0-20	Clinical history and physical exam; laboratory or imaging studies supporting diagnosis. Subspecialist consultation note may be required.
334.0	Friedreich's ataxia	0-20	Clinical history and physical exam. Neurology consultation note.
334.1	Hereditary spastic paraplegia	0-20	
334.2	Primary cerebellar degeneration	0-20	
334.3	Cerebellar ataxia NOS	0-20	
334.4	Cerebellar ataxia in other diseases	0-20	
334.8	Other spinocerebellar diseases NEC	0-20	
334.9	Spinocerebellar disease NOS	0-20	
335.0	Werdnig-Hoffmann disease	0-20	
335.10	Spinal muscular atrophy unspecified	0-20	
335.11	Kugelberg-Welander disease	0-20	
335.19	Spinal muscular atrophy NEC	0-20	
335.20	Amyotrophic lateral sclerosis	0-20	
335.21	Progressive muscular atrophy	0-20	
335.22	Progressive bulbar palsy	0-20	
335.23	Pseudobulbar palsy	0-20	
335.24	Primary lateral sclerosis	0-20	
335.29	Motor neuron disease NEC	0-20	
335.8	Anterior horn disease NEC	0-20	

**Appendix A**

**Rare and Expensive Disease List (Updated December 27, 2010)**

ICD-9 Code	Disease	Age Group	Guidelines
335.9	Anterior horn disease NOS	0-20	
341.1	Schilder's disease	0-64	Clinical history and physical examination; supporting imaging studies and neurologic consultation note may be required.
343.0	Diplegic infantile cerebral palsy	0-20	Clinical history and physical exam. Neurology consultation note may be required.
343.2	Quadriplegic infantile cerebral palsy	0-64	(See next page for Guideline description)
344.00	Quadriplegia, unspecified	0-64	
344.01	Quadriplegia, C1-C4, complete	0-64	
344.02	Quadriplegia, C1-C4, incomplete	0-64	
344.03	Quadriplegia, C5-C7, complete	0-64	
344.04	Quadriplegia, C5-C7, incomplete	0-64	
344.09	Quadriplegia, Other	0-64	
359.0	Congenital hereditary muscular dystrophy	0-64	Clinical history and physical examination; supporting imaging studies and neurologic consultation note may be required.
359.1	Hereditary progressive muscular dystrophy	0-64	Clinical history and physical examination; supporting imaging studies and neurologic consultation note may be required.
359.21	Myotonic muscular dystrophy (Steinert's only)	0-64	Clinical history and physical examination; supporting imaging studies and neurologic consultation note may be required.
437.5	Moyamoya disease	0-64	Clinical history and physical examination; supporting imaging studies and neurologic consultation note may be required.
579.3	Short gut syndrome	0-20	Clinical history and imaging studies supporting diagnosis. Gastrointestinal subspecialist consultation note may be required.
582.0	Chronic glomerulonephritis with lesion of proliferative glomerulonephritis	0-20	
582.1	Chronic glomerulonephritis with lesion of membranous glomerulonephritis	0-20	

**Appendix A**

**Rare and Expensive Disease List (Updated December 27, 2010)**

ICD-9 Code	Disease	Age Group	Guidelines
582.2	Chronic glomerulonephritis with lesion of membranoproliferative glomerulonephritis	0-20	Clinical history, laboratory evidence of renal disease. Nephrology subspecialist consultation note may be required.
582.4	Chronic glomerulonephritis with lesion of rapidly progressive glomerulonephritis	0-20	
582.81	Chronic glomerulonephritis in diseases classified elsewhere	0-20	
582.89	Other Chronic glomerulonephritis with lesion of exudative nephritis interstitial (diffuse) (focal) nephritis	0-20	
582.9	With unspecified pathological lesion in kidney Glomerulonephritis: NOS specified as chronic hemorrhagic specified as chronic Nephritis specified as chronic Nephropathy specified as chronic	0-20	
585.1	Chronic kidney disease, Stage I (diagnosed by a pediatric nephrologists)	0-20	Clinical history, laboratory evidence of renal disease. Nephrology subspecialist consultation note may be required.
585.2	Chronic kidney disease, Stage II (mild) (diagnosed by a pediatric nephrologists)	0-20	
585.3	Chronic kidney disease, Stage III (moderate) (diagnosed by a pediatric nephrologists)	0-20	
585.4	Chronic kidney disease, Stage IV (severe) (diagnosed by a pediatric nephrologists)	0-20	
585.5	Chronic kidney disease, Stage V (diagnosed by a pediatric nephrologists)	0-20	

**Appendix A**

**Rare and Expensive Disease List (Updated December 27, 2010)**

ICD-9 Code	Disease	Age Group	Guidelines
585.6	End stage renal disease (diagnosed by a pediatric nephrologists)	0-20	
585.9	Chronic kidney disease, unspecified (diagnosed by a pediatric nephrologists)	0-20	
585.6, V45.11	Chronic kidney disease with dialysis	21-64	Clinical history, laboratory, evidence of renal disease. Nephrology subspecialist consultation note may be required.
741.00	Spina bifida with hydrocephalus NOS	0-64	Clinical history and physical exam, imaging studies supporting diagnosis. Subspecialist consultation may be required.
741.01	Spina bifida with hydrocephalus cervical region	0-64	
741.02	Spina bifida with hydrocephalus dorsal region	0-64	
741.03	Spina bifida with hydrocephalus lumbar region	0-64	
741.90	Spina bifida unspecified region	0-64	
741.91	Spina bifida cervical region	0-64	
741.92	Spina bifida dorsal region	0-64	
741.93	Spina bifida lumbar region	0-64	
742.0	Encephalocele Encephalocystocele Encephalomyelocele Hydroencephalocele Hydromeningocele, cranial Meningocele, cerebral Menigoencephalocele	0-20	Clinical history and physical examination, radiographic or other neuroimaging studies. Neurology or neurosurgery consultation note may be required.
742.1	Microcephalus Hydromicrocephaly Micrencephaly	0-20	Clinical history and physical examination, radiographic or other neuroimaging studies. Neurology or neurosurgery consultation note may be required.
742.3	Congenital hydrocephalus	0-20	
742.4	Other specified anomalies of brain	0-20	
742.51	Other specified anomalies of the spinal cord Diastematomyelia	0-64	Clinical history and physical examination, radiographic or other neuroimaging studies.

**Appendix A**

**Rare and Expensive Disease List (Updated December 27, 2010)**

ICD-9 Code	Disease	Age Group	Guidelines
742.53	Other specified anomalies of the spinal cord Hydromyelia	0-64	Neurology or neurosurgery consultation note may be required
742.59	Other specified anomalies of spinal cord Amyelia Congenital anomaly of spinal meninges Myelodysplasia Hypoplasia of spinal cord	0-64	
748.1	Nose anomaly – cleft or absent nose ONLY	0-5	Clinical history and physical examination. Radiographic or other imaging studies and specialist consultation note (ENT, plastic surgery) may be required.
748.2	Web of larynx	0-20	Clinical history and physical exam; laboratory or imaging studies supporting diagnosis. Subspecialist consultation note may be required.
748.3	Laryngotracheal anomaly NEC– Atresia or agenesis of larynx, bronchus, trachea, only	0-20	
748.4	Congenital cystic lung	0-20	Clinical history and physical exam; laboratory or imaging studies supporting diagnosis. Subspecialist consultation note may be required.
748.5	Agenesis, hypoplasia and dysplasia of lung	0-20	
749.00	Cleft palate NOS	0-20	Clinical history and physical examination. Supporting consultation note from ENT/plastic surgery may be required.
749.01	Unilateral cleft palate complete	0-20	
749.02	Unilateral cleft palate incomplete	0-20	
749.03	Bilateral cleft palate complete	0-20	
749.04	Bilateral cleft palate incomplete	0-20	
749.20	Cleft palate and cleft lip NOS	0-20	
749.21	Unilateral cleft palate with cleft lip complete	0-20	
749.22	Unilateral cleft palate with cleft lip incomplete	0-20	
749.23	Bilateral cleft palate with cleft lip complete	0-20	
749.24	Bilateral cleft palate with cleft lip incomplete	0-20	
749.25	Cleft palate with cleft lip NEC	0-20	

Appendix A

Rare and Expensive Disease List (Updated December 27, 2010)

ICD-9 Code	Disease	Age Group	Guidelines
750.3	Congenital tracheoesophageal fistula, esophageal atresia and stenosis	0-3	Clinical history and physical exam; imaging studies supporting diagnosis. Subspecialist consultation note may be required.
751.2	Atresia large intestine	0-5	Clinical history and physical exam; laboratory or imaging studies supporting diagnosis. Subspecialist consultation note may be required.
751.3	Hirschsprung's disease	0-15	
751.61	Biliary atresia	0-20	
751.62	Congenital cystic liver disease	0-20	
751.7	Pancreas anomalies	0-5	
751.8	Other specified anomalies of digestive system NOS	0-10	
751.8	Other specified anomalies of digestive system NOS	0-10	
753.0	Renal agenesis and dysgenesis, <b>bilateral only</b> Atrophy of kidney: congenital infantile Congenital absence of kidney(s) Hypoplasia of kidney(s)	0-20	Clinical history, physical examination, radiographic or other imaging studies. Subspecialist consultation note may be required.
753.10	Cystic kidney disease, <b>bilateral only</b>	0-20	
753.12	Polycystic kidney, unspecified type, <b>bilateral only</b>	0-20	
753.13	Polycystic kidney, autosomal dominant, <b>bilateral only</b>	0-20	
753.14	Polycystic kidney, autosomal recessive, <b>bilateral only</b>	0-20	
753.15	Renal dysplasia, <b>bilateral only</b>	0-20	
753.16	Medullary cystic kidney, <b>bilateral only</b>	0-20	
753.17	Medullary sponge kidney, <b>bilateral only</b>	0-20	
753.5	Exstrophy of urinary bladder	0-20	

**Appendix A**

**Rare and Expensive Disease List (Updated December 27, 2010)**

ICD-9 Code	Disease	Age Group	Guidelines
756.0	Musculoskeletal--skull and face bones Absence of skull bones Acrocephaly Congenital deformity of forehead Craniosynostosis Crouzon's disease Hypertelorism Imperfect fusion of skull Oxycephaly Platybasia Premature closure of cranial sutures Tower skull Trigonocephaly	0-20	Clinical history, physical examination, radiographic or other imaging studies supporting diagnosis. Subspecialist consultation note may be required.
756.4	Chondrodystrophy	0-1	
756.50	Osteodystrophy NOS	0-1	
756.51	Osteogenesis imperfecta	0-20	Clinical history, physical exam; imaging studies supporting diagnosis. Subspecialist consultation note may be required
756.52	Osteopetrosis	0-1	Clinical history and physical exam; laboratory or imaging studies supporting diagnosis. Subspecialist consultation note may be required.
756.53	Osteopoikilosis	0-1	
756.54	Polyostotic fibrous dysplasia of bone	0-1	
756.55	Chondroectodermal dysplasia	0-1	
756.56	Multiple epiphyseal dysplasia	0-1	
756.59	Osteodystrophy NEC	0-1	
756.6	Anomalies of diaphragm	0-1	Clinical history, physical examination, imaging studies supporting diagnosis. Subspecialist consultation note may be required.
756.70	Anomaly of abdominal wall	0-1	
756.71	Prune belly syndrome	0-1	
756.72	Omphalocele	0-1	
756.73	Gastrochisis	0-1	



**Appendix A****Rare and Expensive Disease List (Updated December 27, 2010)**

<b>ICD-9 Code</b>	<b>Disease</b>	<b>Age Group</b>	<b>Guidelines</b>
756.79	Other congenital anomalies of abdominal wall	0-1	
759.7	Multiple congenital anomalies NOS	0-10	Clinical history, physical exam; laboratory or imaging studies supporting diagnosis. Subspecialist consultation note may be required.
V46.1	Dependence on respirator	1-64	Clinical history and physical exam. Subspecialist consultation note required.

## Current REM Diagnostic Groupings

Diagnostic Category	Percentage of Total REM	Number of REM Participants Under 21	Number of REM Participants Over 21	ICD-9 Codes
Cerebral Palsy/Diplegia/Quadriplegia	30%	740	491	343.0, 343.2, 344.00, 344.01, 344.02, 344.03, 344.04, 344.09
Congenital Anomalies of the Nervous System	14%	567	4	742.0, 742.1, 742.3, 742.4, 742.51, 742.53, 742.59
Hereditary Degenerative Central Nervous System Disorders	9%	365	3	330.0, 330.1, 330.2, 330.3, 330.8, 330.9, 331.3, 331.4, 333.2, 333.6, 333.7, 333.90, 334.0, 334.1, 334.2, 334.3, 334.4, 334.8, 334.9, 335.0, 335.10, 335.11, 335.19, 335.20, 335.21, 335.22, 335.23, 335.24, 335.29, 335.8, 335.9, 341.1
Pediatric HIV Disease	6%	260	0	042, V08, 795.71
Spina Bifida	6%	156	87	741.00, 741.01, 741.02, 741.03, 741.90, 741.91, 741.92, 741.93,
Congenital Musculoskeletal Disorders	6%	254	0	756.0, 756.4, 756.50, 756.51, 756.52, 756.53, 756.54, 756.55, 756.56, 756.59, 756.6, 756.70, 756.71, 756.79, 759.7
Cleft Lip/Palate	6%	238	0	749.00, 749.01, 749.02, 749.03, 749.04, 749.20, 749.21, 749.22, 749.23, 749.24, 749.25
Metabolic Disorders	6%	213	19	270.0, 270.1, 270.2, 270.3, 270.4, 270.5, 270.6, 270.7, 270.8, 271.0, 271.1, 271.2, 272.7, 277.00, 277.01, 277.02, 277.03, 277.09, 277.2, 277.5, 277.81, 277.82, 277.89
Urinary System Anomalies	5%	81	151	582.0, 582.1, 582.2, 582.4, 582.81, 582.89, 582.9, 585.1, 585.2, 585.3, 585.4, 585.5, 585.6, 585.9, 585.6 & V45.11, 753.0, 753.10, 753.12, 753.13, 753.14, 753.15, 753.16, 753.17, 753.5,
Congenital Digestive Disorders	4%	151	0	579.3, 750.3, 751.2, 751.3, 751.61, 751.62, 751.7, 751.8
Peripheral Nervous System Disorders	3%	60	53	359.0, 359.1, 359.21
Machine Dependent Respiratory Problem	2%	38	21	V46.11
Hematologic Disorders	2%	85	17	284.01, 284.09, 286.0, 286.1, 286.2, 286.3, 286.4, 437.5
Respiratory Anomalies	1%	21	0	748.1, 748.2, 748.3, 748.4, 748.5

**4,075 REM Participants**  
**Updated July 2012**

<b>REM PARTICIPANT NAME</b>
<b>CURRENT MA#</b>
<b>DOB</b>
<b>CM</b>
<b>DATE MM/DD/YYYY</b>
<b>REM QUALIFYING DX</b>
<b>AGENCY CODE</b>

**Assessment Form**

<b>Demographic Data</b>				
Aliases				
Address1				
Address2				
City	State	Zip	County	
DOB	Age	Sex	SSN#	
REM Enrollment Date	REM End Date	LOC		
Caregiver Name		Relationship	Phone #	Phone Type (home, work, cell, pager)
			Phone #	
Emergency Contact Name		Relationship	Phone #	Phone Type
			Phone #	

<b>REM Intake Information (from REM Intake Form)</b>		
Referring Physician	Phone	Specialty
Primary Physician	Phone	Specialty
REM Qualifying Dx	REM Qualifying ICD-9	
Additional Diagnoses	ICD-9 (if known)	

<b>REM PARTICIPANT NAME</b>
<b>CURRENT MA#</b>
<b>DOB</b>
<b>CM</b>
<b>DATE MM/DD/YYYY</b>
<b>REM QUALIFYING DX</b>
<b>AGENCY CODE</b>

<b>Health Profile</b>			
<b>Current Health Status</b>			
1. Recent Illness			
2.Changes in symptoms			
<b>Significant Past Health History</b>			
1.Surgeries			
2. Major illnesses, traumas			
<b>Routine Care</b>			
<b>Growth and Development</b>			
<b>Observations of Physical Status</b>			
<b>Observations of Cognitive Functioning</b>			
<b>Physician Notification and Emergency Plan</b>			
<b>Hospitalization /ER Visits within Past Year</b>			
<b>Facility</b>	<b>Date</b>	<b>LOS</b>	<b>Reason For Admission</b>

<b>REM PARTICIPANT NAME</b>
<b>CURRENT MA#</b>
<b>DOB</b>
<b>CM</b>
<b>DATE MM/DD/YYYY</b>
<b>REM QUALIFYING DX</b>
<b>AGENCY CODE</b>

<b>Support Systems</b>
<b>Family Composition</b>
<ol style="list-style-type: none"> <li>1. Individuals living in household</li> <li>2. Family members living outside household (siblings, parents)</li> </ol>
<b>Caregiver/ Support Systems</b>
<ol style="list-style-type: none"> <li>1. Adult Caregiver in Home</li> <li>2. Supports to Caregiver</li> <li>3. Supports to Patient:</li> <li>4. Legal / CPS / APS Supports</li> <li>5. Finance / Income</li> </ol>
<b>Environment</b>
<b>Current Living Arrangements</b>
<ol style="list-style-type: none"> <li>1. Type of Housing</li> <li>2. Limitations</li> <li>3. Safety Issues</li> <li>4. Accessibility Issues</li> <li>5. Health Issues</li> <li>6. Housing Issues</li> </ol>

Appendix C-1

<b>REM PARTICIPANT NAME</b>
<b>CURRENT MA#</b>
<b>DOB</b>
<b>CM</b>
<b>DATE MM/DD/YYYY</b>
<b>REM QUALIFYING DX</b>
<b>AGENCY CODE</b>

<b>Education</b>
Level/Grade
Health Care Management
Transportation
IEP / IFSP issues

<b>Occupation/Vocation</b>
Employer & Type of Work
Health Care Management
Transportation
Vocational Plan

<b>Transportation</b>

<b>Social &amp; Community Issues</b>

<b>Non-Medicaid Reimbursed Services</b>

## **Emergency Information Form for Children with Special Needs**

The Emergency Information Form for Children with Special Needs is accessible at <http://www.childrensnational.org/files/PDF/EMSC/PubRes/EIForm.pdf>.

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## REM Service Coordination Form

I. To be completed by REM Intake and Referral:

Client: \_\_\_\_\_

Date to Case Manager: \_\_\_\_\_

Current MA#: \_\_\_\_\_

This Client is receiving ongoing medical support services or supplies through the MCO as noted below. Please assess the specific service needs of the participant and determine the participant's preference of providers. Contact the designated provider and educate them regarding the REM transition process. Determine if the current amount of supplies is adequate for the transition. Communicate to the REM Unit the status of the service coordination. Ensure that supplies are re-ordered under the fee-for-service system once the participant has been enrolled in REM. **The client will not be enrolled in REM until the services are arranged and the Case Manager confirms any necessary preauthorizations. REM Intake will then send you a copy of the enrollment form with the REM begin-date.**

II. To be completed by the case manager and returned to REM Intake:

\* Fill in or check **ALL** columns\*

Participant's Supplies Services/Equipment PDN/Home Health Services/Specialized Medications	Designated Provider, MA Provider #, Phone #, Contact Persons Name	Adequate supplies on hand for transition (should have at least 3-4 weeks on hand)	Not currently using service	Requires Pre-Authorization (check one)	
				YES	NO

I have arranged for the above services to continue.

Case Manager: \_\_\_\_\_

Printed Name

\_\_\_\_\_

Signature

Date Form Completed \_\_\_\_\_

For questions, please call the REM Intake Unit 1-800-565-8190.

When this form is complete, fax to the REM Intake Unit 410-333-5426. We will then send you a copy of the REM enrollment form with the REM begin date.



**REM Service Coordination Form**  
**Page 2**

To be completed by the case manager and returned to REM Intake:

\* Fill in or check all columns\*

Participant's Supplies Services/Equipment PDN/Home Health Services	Designated Provider, MA Provider #, Phone #, Contact Persons Name	Adequate supplies on hand for transition (should have at least 3-4 weeks on hand)	Not currently using service	Requires Pre-Authorization (check one)	
				YES	NO

Revised 1/26/2012

# Maryland EPSDT Healthy Kids Preventive Health Schedule

Components		Infancy (months)						Early Childhood (months)						Late Childhood (yrs)						Adolescence (yrs)								
		Birth	3-5 d	1	2	4	6	9	12	15	18	24	30	36	48	5	6	7	8	9	10	11	12	13	14	15	16	17
<b>Health History and Development</b>																												
Medical and family history/update		X	X	X	→	→	→	→	X	→	→	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Peri-natal history		X	X	X	→	→	→	→	→	→	→																	
Psycho-social/environmental assessment/update		X	X	X	→	→	→	→	X	→	→	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Developmental Surveillance (Subjective)			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Developmental Screening (Standard Tools) <sup>1</sup>								X	→	→	X	X	→	→	→	→												
Autism Screening											X	X	→															
Mental health/behavioral assessment														X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Substance abuse assessment																							X	X	X	X	X	X
<b>Physical Exam</b>																												
Systems exam		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Vision/hearing assessments <sup>2</sup>		O <sup>2</sup>	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S
Oral/dentition assessment		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Nutrition assessment		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Measurements and graphing:	Height and Weight	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	Head Circumference	X	X	X	X	X	X	X	X	X	X																	
	BMI										X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
Blood Pressure <sup>3</sup>														X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
<b>Risk Assessments by Questionnaire</b>																												
Lead assessment by questionnaire							X	X	X	X	X	X	X	X	X													
Tuberculosis *			X	X	X	X	→	X	→	→	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Heart disease/cholesterol *											X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Sexually transmitted infections (STI) *																						X	X	X	X	X	X	X
<b>Laboratory Tests</b>																												
Hereditary/metabolic hemoglobinopathy		X		X	→																							
Blood lead Test								X	→	→	X	→	→	→	→													
Anemia Hgb/Hct								X	→	→	X	→	→	→	→													
<b>Immunizations</b>																												
History of immunizations		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Vaccines given per schedule		X	→	→	X	X	X	→	X	X	X	→	→	→	→	→	→	→	→	→	→	X	X	→	→	→	→	→
<b>Health Education</b>																												
Age-appropriate education/guidance		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Counsel/referral for identified problems		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Dental education/referral									X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Scheduled return visit		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

**Key :** X Required  
 → Required if not previously done  
 S Subjective by history /observation  
 O Objective by standardized testing  
 \* Counseling/testing required when positive

The Schedule reflects minimum standards required for all Maryland Medicaid recipients from birth to 21 years of age. The Maryland Healthy Kids Program requires yearly visits between ages 2 years through 20 years. <sup>1</sup>Refer to AAP 2006 Policy Statement referenced in the Healthy Kids Program Manual. -Screening required using standardized <sup>2</sup>Newborn Hearing Screen follow-up required for abnormal results. <sup>3</sup>Blood Pressure measurement in infants and children with specific risk conditions should be performed at age 3 years.

<b>NAME</b>
<b>MA#</b>
<b>DOB</b>
<b>CM</b>
<b>DATE FROM MM/DD/YYYY TO MM/DD/YYYY</b>
<b>REM QUALIFYING DIAGNOSIS</b>
<b>LEVEL OF CARE</b>
<b>REM AGENCY CODE</b>
<b>REM ENROLLMENT DATE</b>
<b>REM END DATE</b>

### Interdisciplinary Plan of Care

#### Health Profile

<b>Current Health Status</b>
Recent illness:
Change in symptoms:

#### Support Systems

<b>Family Composition</b>
1. Individuals living in household and relationship: 2. Family members living outside household (siblings, parents):
<b>Caregiver/ Support Systems</b>
1. Adult caregiver(s) in Home (including address and phone numbers): 2. Supports to caregiver, including phone numbers: 3. Supports to Patient: 4. Legal/CPS/APS Supports: 5. Finance/Income: 6. DSS Case Worker Name and Phone Number: 7. Community Support Services: Provider Name: Contact Name and Phone Number/Relationship:

Appendix E

<b>NAME</b>
<b>MA#</b>
<b>DOB</b>
<b>CM</b>
<b>DATE FROM MM/DD/YYYY TO MM/DD/YYYY</b>
<b>REM QUALIFYING DIAGNOSIS</b>
<b>LEVEL OF CARE</b>
<b>REM AGENCY CODE</b>
<b>REM ENROLLMENT DATE</b>
<b>REM END DATE</b>

**Primary Care Provider**

Name	Address	Phone Number	Last Appt	Next Appt	D/S	Assessment of Services & Recommendations

**Specialist/ Specialty Clinic**

Name and Location	Phone Number	Type of clinic	Frequency of Visits	Last Appt	Next Appt	D/S	Assessment of Services & Recommendations

**Home Care**

Provider Name	Provider Contact	Phone Number	Type of Service	Frequency	Assessment of Services & Recommendations (Goals Met/Unmet)

**Therapies**

Provider Name	Provider Contact	Phone Number	Type of Service	Frequency	Assessment of Services & Recommendations (Goals Met/Unmet)

Appendix E

<b>NAME</b>
<b>MA#</b>
<b>DOB</b>
<b>CM</b>
<b>DATE FROM MM/DD/YYYY TO MM/DD/YYYY</b>
<b>REM QUALIFYING DIAGNOSIS</b>
<b>LEVEL OF CARE</b>
<b>REM AGENCY CODE</b>
<b>REM ENROLLMENT DATE</b>
<b>REM END DATE</b>

**School**

<b>School name</b>	<b>Address</b>	<b>Phone Number</b>	<b>County</b>
<b>Contact</b>	<b>Phone Number</b>	<b>Position</b>	
<b>IFSP/IEP/Transition plan</b>	<b>Date of last IFSP/IEP</b>	<b>Next Review</b>	

**Occupation/Vocation**

<b>Employer Name</b>	<b>Phone Number</b>	<b>Position</b>	<b>Assessment of Services &amp; Recommendations</b>
<b>Contact</b>			
<b>Vocation Plan</b>	<b>Date</b>	<b>Next Review</b>	

**Equipment and Supplies**

<b>Provider Name</b>	<b>Provider Contact</b>	<b>Phone Number</b>	<b>Equipment / Supplies</b>	<b>Rent or Purchase</b>	<b>Assessment of Service &amp; Recommendations</b>

**Medications/ Nutritional**

<b>Provider Name</b>	<b>Provider contact</b>	<b>Phone Number</b>	<b>Drug/ nutritional product</b>	<b>Assessment of Services &amp; Recommendations</b>

<b>NAME</b>
<b>MA#</b>
<b>DOB</b>
<b>CM</b>
<b>DATE FROM MM/DD/YYYY TO MM/DD/YYYY</b>
<b>REM QUALIFYING DIAGNOSIS</b>
<b>LEVEL OF CARE</b>
<b>REM AGENCY CODE</b>
<b>REM ENROLLMENT DATE</b>
<b>REM END DATE</b>

**Lab and Diagnostic Outpatient Technology Services**

Provider Name	Provider contact	Type of service	Frequency of service	Last Service	Next Service

**Optional Services**

Provider Name	Provider Contact	Phone Number	Type of service	Frequency	Assessment of Services and Recommendations

**Hospitalizations /ER visits since last update**

Facility	Date	LOS	Reason for Admission

**REM Qualifying Diagnosis**

Does participant still meet the criteria for their REM qualifying diagnosis? Yes ___ No ___ If no, please explain and report to DHMH.

**Case Management Interaction with Multidisciplinary Team/ Outcome**

Summary of CM activities and results:
---------------------------------------

<b>NAME</b>
<b>MA#</b>
<b>DOB</b>
<b>CM</b>
<b>DATE FROM MM/DD/YYYY TO MM/DD/YYYY</b>

**CASE MANAGEMENT PLAN**

<b>ISSUE</b>	<b>AREA FOR INTERVENTION</b>	<b>EXPECTED OUTCOME (GOAL)</b>	<b>INTERVENTION</b>	<b>GOAL MET DATE/VARIANCE</b>

### LEVEL OF CARE GUIDELINES

<p align="center"><b>LOC 1</b> <b>Acutely Ill</b></p>	<p align="center"><b>LOC 2</b> <b>Unstable</b></p>	<p align="center"><b>LOC 3</b> <b>Stable</b></p>
<p><b>Case Management level of intervention:</b> The emergent change in the REM participant’s medical condition or service utilization requires intensive case management intervention and follow-up.</p> <p align="center"><b><u>Examples</u></b></p> <p>REM participant has history (within past 6 mos.) of frequent hospitalizations and ER visits.</p> <p>Unstable clinical condition, an exacerbation of chronic illness or a newly diagnosed condition.</p> <p>Unstable psychosocial issues that have a significant negative impact on the health of the participant. History of highest service utilization.</p> <p>Participant receives new or on-going nursing services requiring intense CM assessment of the need for services.</p>	<p><b>Case Management level of intervention:</b> The instability in the REM participant’s medical condition or service utilization requires Case Management intervention on an ongoing basis to attain stable service/treatment plans.</p> <p align="center"><b><u>Examples</u></b></p> <p>REM participant has a history of exacerbations of medical issues requiring case management assessment of stability.</p> <p>Recently diagnosed with a new condition and that condition is stabilizing. Demonstrating understanding of condition but requires CM f/u to maintain level of understanding.</p> <p>Continues with high utilization of services, but appropriateness has been determined by CM and participant and participant/caregiver is demonstrating some level of independence in managing services.</p> <p>Participant sees multiple specialists. CM assistance is required with coordination of care between multiple specialists. Attendance at some of the appointments by the CM is required.</p> <p>Receives on-going nursing services not requiring intensive CM assessment of the need for services. (Includes those requiring the nursing assessment form every 12 months for participants receiving ongoing pdn or SHHA services.)</p> <p>Has presented with obstacles to accessing services requiring CM intervention and coordination.</p>	<p><b>Case Management level of intervention:</b> Case management intervention is required on an ongoing basis to monitor participant’s stable service/treatment plans.</p> <p align="center"><b><u>Examples</u></b></p> <p>REM participant has a stable service/treatment plan. Requires ongoing monitoring of ability to access services.</p> <p>Requires on-going assessment of clinical stability.</p> <p>Receives on-going monitoring of routine specialty and primary care.</p> <p>Utilization of services is moderate and appropriateness has been determined by CM.</p> <p>Participant/caregiver is demonstrating independence in managing services.</p>



**LEVEL OF CARE GUIDELINES**

REM Case Manager Minimum Reporting and Contact Requirements

<b>Participant Level of Care</b>	<b>General Criteria</b>	<b>Documentation</b>	<b>Reporting Schedule</b> (Minimum if no change in level of care)	<b>Participant Contact</b>	<b>PCP Contact</b>	<b>Cost and Utilization Data Review</b>
Assessment	New to REM	Assessment Form Interdisciplinary plan of care (IPOC) CM Plan Emergency Information Form	Initial assessment report completed within 30 calendar days of date referral sent to CM Agency <b>and</b> updated once every 12 months.	1. Phone contact within 24 hours 2. Face to face visit within 10 calendar days of receipt of referral.	Prior to first report	N/A
Level of Care 1	Acutely ill and/or history of highest service utilization requiring intensive CM assessment and coordination.	IPOC and CM Plan  Assessment Report	Reviewed/updated and completed at least every 3 months from date of previous report.  Once every 12 months	1. Phone contact every month. 2. Face to face visit every 3 months	Once every 3 months	Every 3 months
Level of Care 2	Unstable service and treatment plans requiring on-going CM assessment and coordination.	IPOC and CM Plan  Assessment Report	Reviewed/updated and completed at least every 6 months from date of previous report.  Once every 12 months	1. Phone contact every month. 2. Face to face visit every 6 months	Once every 6 months	Every 3 months
Level of Care 3	Stable service and treatment plans requiring periodic CM assessment and coordination	IPOC and CM Plan  Assessment Report	Reviewed/updated and completed at least every 6 months from date of previous report.  Once every 12 months	1. Phone contact every month. 2. Face to face visit once per 12 months.	Once every 6 months	Every 3 months

**Provider Relations Activity Report**

Provider Relations Representatives shall present monthly reports using the format provided.

<b>Caller Last Name</b>	<b>Caller First Name</b>	<b>Date of Call</b>	<b>Description of Inquiry</b>	<b>Actions Taken to Address Inquiry</b>
-------------------------	--------------------------	---------------------	-------------------------------	---

In addition, the report should include a total of overall calls received by the Provider Relations Representative each month.

**Contact Record  
(Format for Portal)**

All case notes must include the fields identified below.

- Date refers to the date the contact is made.
- Type of contact refers to the category of contact: phone call, visit, letter, file review, etc.
- Face-to-face visits with the REM participant must be distinct entries and not include travel time.
- Travel time may be included as professional time.
- Phone contacts with the REM participant must also be able to be distinguished as unique events.
- Contact with the Primary Care Provider must be able to be distinguished as a unique event.
- Documentation for all case manager contacts should include a summary of what was discussed during that contact.
- The summary should include sufficient detail to allow the reader to be able to identify the issues discussed, and the case management interventions planned.
- The need for any follow-up or future evaluations should also be documented.

Date	Type of contact	Contact	Duration of Contact	Comments

**CASE RATE FEE SCHEDULE**

The case rates provided reflect the monthly individual payment to the contractor for case management services associated with REM participants in the Rare and Expensive Case Management program. The Department reserves the right to amend the rates through regulations during the course of this Contract.

**Monthly Case Rates Effective January 1, 2013**

<b>Initial* Month including Assessment Case Rate</b>	<b>\$388.55</b>
<b>Level of Care 1</b>	<b>\$286.90</b>
<b>Level of Care 2</b>	<b>\$171.00</b>
<b>Level of Care 3</b>	<b>\$90.25</b>

\* "Initial" is defined as a participant's first enrollment in REM or enrollment after being terminated from MA or REM for more than 12 months.

## Request for Case Closure

Participant Name: \_\_\_\_\_  
 Medicaid Number: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_  
 Case Manager / Agency: \_\_\_\_\_  
 Date of Request: \_\_\_\_\_

**Reason for Case Closure Request:**

Participant aged out of REM	Participant Receiving Medicare
Participant deceased	Participant is no longer HealthChoice eligible
Participant is no longer MA eligible	Participant requests placement in an MCO
Participant is in long-term care over 30 days	Participant no longer has a REM eligible diagnosis
Participant has moved out of the state	Other

Is/Was the participant receiving Private Duty Nursing Services or Shift Home Health Aide services at the time of Request for Case Closure?

Yes       No

Summary of Case Manager (CM) activities to confirm need for case closure:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 CM Supervisor's Signature

A closure report is due within 14 calendar days of the DHMH approval of request. Please fax the closure report to the REM Intake Unit at (410) 333-5426.

\_\_\_\_\_  
 \_\_\_\_\_

<b>REM INTAKE USE ONLY</b>	
<b><u>Response:</u></b>	
<input type="checkbox"/> Approved	<input type="checkbox"/> Denied
REM Disenrollment Date:	_____
REM Signature:	_____
Date:	_____

## REM Closure Report

<b>Participant Name:</b>		<b>Date of Report:</b>	
<b>Medicaid Number:</b>		<b>Closure Date:</b>	
<b>Date of Birth:</b>		<b>REM Disenrollment Date:</b>	
<b>CM Name:</b>		<b>Enrollment Broker Contact Date:</b>	
<b>CM Contractor Code:</b>			
<b>MCO Special Needs Coordinator's Name:</b>		<b>MCO Special Needs Coordinator Contact Date:</b>	
		<b>Date IPOC Sent:</b>	

**Reason for Closure (check one):**

<b>Participant aged out of REM</b>	<b>Participant receiving Medicare</b>
<b>Participant deceased</b>	<b>Participant is no longer HealthChoice eligible</b>
<b>Participant is no longer MA eligible</b>	<b>Participant requests placement in an MCO</b>
<b>Participant in long-term care (LTC) over 30 days</b>	<b>Participant no longer has a REM eligible diagnosis</b>
<b>Participant moved out of state</b>	<b>Other</b>

**Status of participant at time of referral:** \_\_\_\_\_  
 \_\_\_\_\_

**Case management interventions:** \_\_\_\_\_  
 \_\_\_\_\_

**Status of participant at time of closure:** \_\_\_\_\_  
 \_\_\_\_\_

**Case Manager Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_

**Case Manager's Supervisor:** \_\_\_\_\_ **Date** \_\_\_\_\_

**REM Intake Unit – DHMH – 201 W. Preston Street, Room 210 – Baltimore, MD 21201**  
**Phone: 1-800-565-8190 Fax: 410-333-5426**



## REM Participant Roster

The Contractor must submit the REM Participant Roster in electronic tab delimited ASCII format using the following template. The file name will be specified by DHMH and should include the type of file, month, and year of the file.

Data rows will consist of the following elements:

<b>Element</b>	<b>Type/size</b>	<b>Definition</b>
REM Participant Medicaid Number	11 characters	Current MA number
First Date of Service	10 characters, mm/dd/yyyy	Normally first day of the month, unless participant's first active month
Last Date of Service	10 characters, mm/dd/yyyy	Normally last day of the month, unless participant disenrolled during the month
Contractor Name	1-8 characters	Abbreviations supplied
REM Participant Last Name	1-20 characters	
REM Participant First Name	1-20 characters	
REM Participant Middle Initial	0-2 characters	
REM Participant Date of Birth	10 characters, mm/dd/yyyy	
REM Participant Sex	1 character	M or F
Address 1	Up to 50 characters	House number & street name with USPS abbreviations
Address 2	Up to 50 characters	
City	1-20 characters	
State	2 characters	Usually MD
Zip code	5 or 9 characters	5 digit zip code or zip + 4
Indicator for Initial month Assessment rate	1 character	A, blank
Case Rate Payment Code	1 character	Abbreviations supplied
CM Last Name	1-20 characters	Based on CM assigned as of last day of the month
CM First Name	1-20 characters	Based on CM assigned as of last day of the month
CM Supervisor Last Name	1-20 characters	
CM Supervisor First Name	1-20 characters	
Total Time	Up to 4 characters	Hours and tenths of hours, no leading zeros required

**Level of Care Abbreviations, Payment Code Abbreviations, and Billing Procedure Codes****Level of Care Abbreviations for Use in Activity Summary  
Effective January 1, 2013**

Assessment	A
Level of Care 1	1
Level of Care 2	2
Level of Care 3	3
Closure	C

**Payment Code Abbreviations for Use in Monthly Participant Roster  
Effective January 1, 2013**

Assessment	X
Level of Care 1	Y
Level of Care 2	W
Level of Care 3	Z

**Billing Procedure Codes  
Effective January 1, 2013**

Assessment	G9001
Level of Care 1	G9003
Level of Care 2	G9002
Level of Care 3	G9009

### Case Management Activity Summary

The format for the Contact Encounter Summary is listed below. Data must be submitted in electronic ASCII tab delimited format.

#### Encounter Summary

<b>Element</b>	<b>Type/Size</b>	<b>Definition – Acceptable Values</b>
Start Date	10 characters, Date format mm/dd/yyyy	Start date for report, Normally first day of month
End Date	10 characters, Date format mm/dd/yyyy	End date of report, Normally last day of month
Contractor Last Name	1-8 characters	Abbreviation or acronym provided.
First Name	1-20 characters	Client's Last Name, Suffix
Middle Initial	0-2 characters	Client's First Name
Current MA	11 numeric characters	Client's Middle Initial (optional)
CM First Name	1-20 characters	Text
Level of Care	1-3 characters	First name of case manager making contact
Date of contact	10 characters mm/dd/yyyy	Level of Care Abbreviations (Appendix N-1)
Type of contact	1-6 characters	Date CM performed the contact
Contact with	1-6 characters	Abbreviations below.

#### Abbreviation

Exm  
Ema  
Ltr  
Ph  
PhA  
Rpt  
Vis  
VsA

#### Abbreviation

CMP  
CUD  
EB  
ELG  
EVS  
OPD  
OPN  
PCP  
PRV  
Pt  
SNC  
UAS

#### Type of Contact

Examined  
E-mail  
Letter  
Phone call  
Phone call Attempted  
Report  
Visit  
Visit Attempted

#### Contact with

IPOC & CMP Completed  
Cost and Utilization Data  
MCO Enrollment Broker  
Eligibility Worker (DSS or Health Dept)  
Eligibility Verification System  
Other Provider-DME/DMS  
Other Provider Nursing-HHA/PDN  
Primary Care Provider  
Provider  
Participant (i.e., Patient or Family)  
MCO Special Needs Coordinator  
Assessment Completed

## Quality Improvement Program Requirements

Each Contractor will provide documentation of a Quality Improvement Program that is comprehensive in scope.

### **A. The Quality Improvement Plan**

The Quality Improvement Plan will document processes to manage internal quality improvement activities as well as REM Quality Improvement activity requirements.

1. The Contractor will provide an illustration of the current organizational structure.
2. The Contractor will provide job descriptions for case management staff, supervisory staff, and medical director and/or case management consultants.
3. The Contractor will provide policies detailing professional licensures required for staff.
4. The Contractor will provide evidence of state agency licensure and any other regulatory licensure requirements as appropriate to the organization.
5. The Contractor will provide a case manager's scope of practice (a document that defines knowledge and skills expected for management of clients within their care).
6. The Contractor will provide staffing standards including expected number of cases per full time employee (FTE), expected case management responsibilities, and outcomes based on participant acuity and staff expertise.
7. The Contractor will provide supervisory and administrative policies and procedures for management of staff.
8. The Contractor will provide criteria for accessing medical and case management consultants.

### **B. Policies and Procedures**

1. The Contractor will provide Policies and Procedures related to Quality Improvement. Policies and procedures will be maintained to reflect current standards of case management practice.
2. The Contractor will provide the structure of the formal Quality Improvement Committee including a description of how all departments within the organization are represented to serve as a forum in order to evaluate services and operations.
3. The Contractor will describe the process for report review and recommendation of actions to improve case management outcomes within the Quality Improvement Committee.
4. The Contractor will have a designated and qualified Quality Improvement Manager.

## Appendix O

5. The Contractor will provide procedures for reviewing Assessment, Interim, and Closure reports and the Interdisciplinary Plan of Care and Case Management Plan to recommend actions to improve case management outcomes.
6. The Contractor will identify the processes by which case management activities are established, monitored and evaluated.
7. The Contractor will provide procedures to identify, review, and resolve complaints and grievances.
8. The Contractor will provide procedures to review aggregated grievances and complaints.
9. The Contractor will provide procedures to monitor internal, contract and subcontract staff in relationship to REM requirements.
10. The Contractor will provide procedures to develop, implement, and track corrective action plans.
11. The Contractor will provide procedures to identify and review customer service quality indicators.
12. The Contractor will provide procedures to identify and evaluate areas requiring focused review.
13. The Contractor will provide procedures for annual review of the quality improvement program policies and procedures, its results and an analysis of its effectiveness.
14. The Contractor will develop procedures for identification of opportunities for improvement and implementation of changes to the quality improvement program as needed.
15. The Contractor will review case management practice and prevention guidelines annually and revise the guidelines as necessary to reflect current practice.

### **C. Quality Improvement Reports**

1. The Quality Improvement Program will contain an outline of the frequency and expected types of reports and summarized material used by internal management staff and an outline of reports to be submitted to DHMH as specified, or as needed. Refer to Section 3.2.12 for reporting requirements.
2. Reports will include but not be limited to the following:
  - a. Significant Events: The Contractor will report significant events to DHMH within 24 hours of the initial event and report subsequent changes in event status. Significant events are broadly defined as those situations where a REM participant, family member, or provider notifies the REM case manager of an urgent or potential problem requiring immediate notification and/or assistance from the case manager or DHMH. DHMH staff will document and provide assistance with case management regarding these events.

## Appendix O

Examples of significant events may include but are not limited to: Protective Services referrals, state agency coordination problems, delays in authorizations, service appeals, safety issues, sudden loss of caregiver, services that are authorized but not delivered in a timely manner, unanticipated deaths, record requests or subpoenas, concerns that are reported or threatened to be reported to a state official, a member of the media, or an advocacy organization.

- b. Case Load and Supervisor Ratios: The Contractor will provide a monthly report listing case management supervisors with their case managers and the REM participants assigned to those case managers. The report will also include the levels of care assigned to the case manager's REM participants.
- c. Complaints: The Contractor will provide a monthly report of complaints from REM participants, families or providers regarding case manager or medical service issues and how they were resolved.
- d. Internal Auditing: The Contractor will supply a monthly narrative and quantitative report detailing internal quality audits of case management services. These reports will be reviewed as part of the on site auditing process.
- e. Ad Hoc Reports:, The Contractor will also provide any ad hoc information required to complete reports for DHMH.

## CONSENT TO RELEASE INFORMATION

**To Families:** We can better serve you if we are able to work with other State and local agencies that know you. When you sign this form, you give permission for agencies to share information about you. You will still get services for which you are eligible, even if you choose not to sign this form.

**SECTION I. IDENTIFICATION**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_

Social Security Number: \_\_\_\_\_

**SECTION II. IDENTIFICATION OF PARENT/GUARDIAN (FOR MINORS ONLY)**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_

Relationship to Child:     Self (minor child)     Legal Custodian/Guardian/Surrogate  
                                     Parent                            Other caretaker: \_\_\_\_\_

**SECTION III. INFORMATION RELEASE**

- A. Agencies Sharing Information** (Check all that apply)
- I authorize the release of information and records on the above individual between or among the following public agencies.
- |  |  |
|--|--|
| <input checked="" type="checkbox"/> _____ Dept. of Social Services<br>(Name of Jurisdiction) | <input type="checkbox"/> Maryland State Dept. of Education           |
| <input type="checkbox"/> _____ Local Health Department<br>(Name of Jurisdiction)             | <input type="checkbox"/> Maryland Dept. of Health and Mental Hygiene |
| <input type="checkbox"/> _____ Public School System<br>(Name of Jurisdiction)                | <input type="checkbox"/> Maryland Dept. of Juvenile Service (DJS)    |
| <input type="checkbox"/> Local Planning Entity Designated by Article 49D §11                 | <input type="checkbox"/> Other Public Agencies: _____                |

- B. Information to be Released** (Check all that apply)
- |   |  |
|---|--|
| <input type="checkbox"/> Reports/records about psychological or cognitive abilities | <input type="checkbox"/> Educational reports or records                              |
| <input type="checkbox"/> Early intervention reports/records                         | <input type="checkbox"/> Medical health needs/treatment/history                      |
| <input type="checkbox"/> Recommendation for intervention or treatment               | <input type="checkbox"/> Mental health needs/treatment/history                       |
| <input type="checkbox"/> Assessment of family situation<br>shared <sup>1</sup> ):   | <input type="checkbox"/> Alcohol/drug treatment (Identify information to be shared): |
- Other (specify): **R1 Authorized Representative** \_\_\_\_\_

Appendix P

**Valid ONLY for Medical Assistance representative to receive notices**

REM Case Manager Name: \_\_\_\_\_

REM Case Manager Address: \_\_\_\_\_

\_\_\_\_\_  
REM Case Manager Phone: \_\_\_\_\_

<sup>1</sup>Information from drug and alcohol abuse patient records can be obtained only when the patient signs this form and specifically designates how much and what kind of information is to be released, in accordance with 42 CFR Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records. A general authorization for the release of medical or other information is not sufficient for this purpose.

For Minor Children:

yes  no If consenting to release of protective services records collected prior to October 1, 1993, do you wish to review the Child Protective Services' records, if any exist, at the local department prior to release of the information? I understand that I may cancel this consent in whole or in part after reviewing any existing pre-October 1, 1993, Child Protective Services' record.

**SECTION IV. SIGNATURE**

I understand that the purpose of this authorization is to allow agencies to share information and records to provide services to me in a coordinated and effective way. I agree that the agencies above may share and exchange information about me. Information and records released under this authorization shall remain confidential and may not be disclosed to any party not identified on this form without specific written consent in accordance with state and federal law. Criminal penalties may apply to illegal disclosure. This authorization can be cancelled in writing at any time. I understand that the cancellation will not affect any information that was already released before the cancellation. I approve the release of this information. I understand what this agreement means. I am signing on my own and have not been pressured to do so.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature (Parent/Guardian Signature for Minors only)

\_\_\_\_\_  
Date

For Worker Use:

This authorization is good for one year from the date it is signed: \_\_\_\_\_  
(Expiration Date)



## Appendix P

1. Fill out this form for any individual for whom information is requested.
2. Be specific about why you need information released to you. You may want to use a cover letter to explain your request. The clearer you are in your request, the more likely you are to receive a prompt and accurate response. Do not ask for information you do not need.
3. Alcohol/Drug, Mental Health and Medical Records include all aspects of diagnosis, treatment and prognosis. Education Records include both behavioral and progress reports.
4. **CANCELLATION.** If the authorization is cancelled by a person having authority to cancel, write “cancelled” and date of the cancellation letter boldly across the CONSENT TO RELEASE INFORMATION form. Date and initial it and keep it in the file.
5. **DURATION.** The authorization is valid for one year unless otherwise specified. Check to be sure that the release you are using is current.
6. **PERSON-IN-INTEREST FOR THE MINOR CHILD**  
The requesting agency should seek consent to share information from the person-in-interest as defined in Article 49D§20. If there is more than one reasonably available person-in-interest, the requesting agency should approach one of the following persons in the following descending order of priority:

- (1) minor child if the child is allowed to consent;
- (2) a parent with legal custody;
- (3) a noncustodial parent, if the custodial parent is not available;
- (4) a guardian, custodian or a representative of the minor designated by the court;
- (5) an individual authorized to act as a surrogate for the parents or guardian pursuant to the Individuals with Disabilities Education Act, 20 USC §1415 (b)(1)(B) and § 1480(5).

If a person-in-interest affirmatively refuses consent, the requesting agency may not seek consent for the release of the same information from another person-in-interest.

### 7. IF THE PERSON-IN-INTEREST IS THE MINOR CHILD

Under certain circumstances, minors can consent to treatment. If the minor has consented to the advice or treatment as described in paragraphs (a) through (e) below, then only the minor child may consent to the release of the information. Parents may not consent to release of information, which the minor child consented, to the advice or treatment. Below is a listing of the appropriate authority for a minor to consent to release of the minor’s own medical information.

- (a) Health Gen. Code § 20-101: - Blood donations
  - (b) Health Gen. Code § 20-102: If the minor is married or the parent of a child, the minor may consent to release of information concerning medical treatment provided.
  - (c) Health Gen. Code §20-102(b) : A minor may consent to release of information concerning the following provided that the minor gave consent to the treatment itself; Emergency medical treatment, Treatment for or advice about drug abuse, alcoholism, venereal disease, pregnancy, contraception other than sterilization; Physical examination and treatment of injuries from an alleged rape or sexual offense, physical examination to obtain evidence of an alleged rape or sexual offense.
  - (d) Health Gen. Code §20-103: Abortion, if; the minor is married or the un-married minor consented to the procedure.
  - (e) Health Gen. Code §20-104: If the minor is 16 years old or older, the minor may consent to release of information concerning consultation, diagnosis, and treatment of a mental or emotional disorder by a physician or a clinic provided that the minor consented to the treatment.
8. **TERMINATION OF PARENTAL RIGHTS FOR THE MINOR CHILD.** If the parent’s rights have been terminated, the parent may not consent to the release of information.
  9. **IF THE PERSON-IN-INTEREST IS NOT A NATURAL OR ADOPTIVE PARENT OF THE MINOR CHILD,** then attach to this form a copy of one of the following:

## Appendix P

- (a) A copy of the court order appointing the person as guardian, custodian or legal representative of the minor with authority to act on behalf of or in lieu of a parent; or
- (b) Documentation appointing the person giving consent the authority to act as a surrogate for the parent or guardian in accordance with the Individuals With Disabilities Act, 20 U.S.C. §1415(b)(1)(B) and §1480(5).

10. **IF THE PERSON-IN-INTEREST IS NOT AVAILABLE TO GIVE WRITTEN CONSENT FOR THE MINOR CHILD**

The requesting agency must attach a court order or provide a written explanation why the parent, legal custodian/guardian or surrogate was unavailable to authorize this disclosure and what reasonable efforts were made by the requesting agency to contact the person in interest.

Substituted consent may be given by:

- (1) A person having care and control of the minor, but who is not merely a babysitter or a teacher;
- (2) A court that has jurisdiction over a suit affecting the parent-child relationship of which the minor is the subject (attach a copy of any court order/other document describing the nature of court proceeding and the information sought by the court); or
- (3) The Department of Health and Mental Hygiene, Department of Juvenile Services or a local Department of Social Services when the minor is in that agency's care and custody.

If an agency requests information and has not been able to secure the signature/authorization from a parent or legal guardian/surrogate, an explanation must accompany the request as to why an adult having care or control, or why the public agency, is authorizing consent.

11. **DISCLOSURE.** Information received under this authorization shall not be disclosed to any party not identified on this form without specific written consent. Criminal penalties may apply to illegal disclosure. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of alcohol and drug information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.
12. **CANCELLATION.** If the authorization is cancelled by a person having authority to cancel, write "cancelled" and date of the cancellation letter boldly across the CONSENT TO RELEASE INFORMATION form. Date and initial it and keep it in the file.
13. **DURATION.** The authorization is valid for one year unless otherwise specified. Check to be sure that the release you are using is current.
14. **COURT ORDER.** A copy of the court order must accompany this form in the following situations:
  - (a) If the signer is a guardian/legal custodian appointed by the court;
  - (b) If a public agency has custody and the agency's representative signs; or
  - (c) If a court has jurisdiction over a suit affecting the parent-child relationship in which the minor is the subject.
15. **CHILD PROTECTIVE SERVICES (CPS).** If a person-in-interest consents to the release of CPS records collected prior to October 1, 1993, the person-in-interest must have an opportunity to review the CPS record on the minor at the local department. Upon receipt of a request for the release of information concerning a CPS record collected prior to October 1, 1993, the local department shall contact the person-in-interest and advise the person of his or her right to review the record on the child prior to sending the information to the requesting agency. The local department shall provide access to the information to the person-in-interest without disclosing information about the reporter, or any other person whose life or safety is likely to be endangered by disclosure. If the consenting person is not a person-in-interest, he or she may not review the record.

Appendix Q

<b>REM Participant Name</b>		
MA Number		
DOB		
REM Case Manager		
Date		
Interpreter Services Utilized	Y	N

**REM Participant Visit Form**

REM participant \_\_\_\_\_ had a face-to-face visit with REM case manager \_\_\_\_\_ on \_\_\_/\_\_\_/20\_\_.

Parent/Guardian (if applicable) \_\_\_\_\_ was present for the visit.

The visit took place at \_\_\_\_\_ on \_\_\_/\_\_\_/20\_\_.

REM participant/Parent/ Guardian Signature

REM Case Manager Signature

\_\_\_\_\_

\_\_\_\_\_

**Maryland Department of Health & Mental Hygiene**  
**REM Program**

**REAL TIME REM SIGNIFICANT EVENT REPORT**

**Report Date:**

**Case Manager:**

**Client Name:**

**MA#:**

**REM DX:**

**DOB:**

**SE Category:**

**Summary of Event:**

**Actions taken to date to resolve issue:**

## Appendix S

### Monthly Significant Events Report Format

Monthly Significant Events reports are to be submitted in Microsoft Excel format to the Department and must have the following columns:

1. REM Participant Last Name
2. REM Participant First Name
3. REM Participant Middle Initial
4. Case Manager Last Name
5. Case Manager First Name
6. Current MA Number
7. Significant Event
8. Date Reported
9. Status of Significant Event
10. Description of Significant Event and Resolution (if applicable)

## **REM Reporting of Significant Events** Categories & Descriptions

<b>Category Name</b>	<b>Reporting to REM</b>	<b>Description</b>
DMS / DME (ASD)	- Monthly - Monthly - Real-time QI	- Delays in service - Delays in authorization - Safety issues
Legal (ASL)	- Real-time QI  - Monthly - Real-time QI	- Any request from an attorney &/or subpoena for the case record or the case manager - Issues pertaining to legal custody/guardianship of the participant - Participant/caregiver threats to call an attorney, MDLC
Media (ASM)	- Real-time QI	- Threats to contact a media source: TV, newspaper
Protective Services (ASP)	- Monthly - Real-time QI	- Referrals that have had action taken by CPS, DSS, APS, etc. - REM CM referrals to CPS, etc.
Service (ASV)	- Monthly	- Problems accessing services
Appeals (ASA)	- Monthly - Real-time Intake	- Services have been denied and the participant wishes to appeal - MA/Medicare eligibility appeals
Other (ASE)	- Real-time for QI Unexpected - Monthly for Expected	- Unexplained participant morbidity or mortality - Participant with known condition, expected mortality

REM Case Manager, Case Load, and Supervisor Monthly Report Format

Supervisor Name	Case Manager Name	CM FTE	Number of REM Cases
	Total of number of CMs per Supervisor	Total FTEs	Total of Cases

**Un-met Quality Improvement Indicators for  
For the Month of March 2012 [SAMPLE FORMAT]**

**Invoice LOC 2**

[Number of Patients] patients in Invoice LOC 2    2% 7 Flagged  
98% 361 Not Flagged

Patient	MA Number	Referred	Patient	(Attempt)	PCP	(Attempt)	OPD	OPN	Exm-CUD	Rpt-UAS	Rpt-CMP
		03/07/11	<b>Letter</b>	03/19/12		07/19/11	_____	_____	01/26/12	04/06/11	01/06/12
			<b>Phone</b>	03/22/12	03/22/12	01/06/12	_____	_____			
			<b>Visit</b>	09/14/11	05/11/11	_____	_____	_____			
<b>Discrepancies</b>		Missed visit to patient									
		08/18/06	<b>Letter</b>	03/28/12		_____	_____	_____	11/18/11	_____	10/07/11
			<b>Phone</b>	01/20/12	03/15/12	10/07/11	_____	_____			
			<b>Visit</b>	09/15/11	_____	_____	_____	_____			
<b>Discrepancies</b>		Missed visit to patient									
		03/09/11	<b>Letter</b>	10/26/11		_____	_____	_____	03/28/12	04/06/11	12/29/11
			<b>Phone</b>	03/26/12	03/22/12	12/29/11	_____	_____			
			<b>Visit</b>	09/27/11	_____	_____	_____	_____			
<b>Discrepancies</b>		Missed visit to patient									
		05/16/07	<b>Letter</b>	03/09/12		_____	_____	_____	11/28/11	_____	03/16/12
			<b>Phone</b>	03/20/12	03/09/12	09/16/11	_____	_____			
			<b>Visit</b>	03/20/12	_____	_____	_____	_____			
<b>Discrepancies</b>		No PCP contact									
		09/19/06	<b>Letter</b>	_____		_____	_____	_____	07/16/11	_____	03/23/12
			<b>Phone</b>	03/09/12	03/09/12	04/27/11	_____	_____			
			<b>Visit</b>	02/09/12	_____	_____	_____	_____			
<b>Discrepancies</b>		No PCP contact									
		06/15/09	<b>Letter</b>	07/05/11		_____	_____	_____	03/28/12	_____	01/11/12
			<b>Phone</b>	03/09/12	03/06/12	01/11/12	_____	_____			
			<b>Visit</b>	09/15/11	_____	_____	_____	_____			
<b>Discrepancies</b>		Missed visit to patient									



**Private Duty Nursing Assessment**

**Reason for Assessment:**     New Request     DHMH Request     Semi-annual     Change in Services

**REM Participant Name:** \_\_\_\_\_

Information Obtained:  Telephonically

**Current MA #:** \_\_\_\_\_

Visit Date

**DOB:** \_\_\_\_\_

**CM Name and Phone Number:** \_\_\_\_\_

**CM Agency:** \_\_\_\_\_

Other Insurance Available:  Yes     No

**Date Nursing Assessment Completed:** \_\_\_\_\_

Name of Insurance: \_\_\_\_\_

If yes, denial letter attached?  Yes     No

**REM Qualifying Dx:**

\_\_\_\_\_

**Additional DX:** \_\_\_\_\_

**Type of Nursing Service:**     REM     REM-OPT     MW     HHA

**Nursing Services**

Provider	Provider Contact	Phone	Frequency of Services	Assessment of Services	Request for Change in Services to: Reason:

**Name of physician ordering the nursing service and the date of last visit:** \_\_\_\_\_

**Current Medical Condition**

--

**Hospitalizations / ED visits since last Nurse Assessment update**

Facility	Adm. Date	D/C Date	LOS	Reason for Admission

Appendix W – Private Duty Nursing Assessment Form

**Support Systems:**  LAH  DD Waiver  Personal Care  Respite  School/Day Care

<b>Family Composition:</b>	
Name of Primary Caregiver:	Primary Caregiver Work Schedule:
Name of others living in the home and relationship to participant:	
Names and ages of siblings residing in the home. (Please provide information on any siblings who also have special needs or receive services.)	
Are caregivers able to provide care? <input type="checkbox"/> Yes <input type="checkbox"/> No (If No, please explain.)	Name of trained back up caregiver:
Name of School or Medical Day Program and times participant attends:	
List other support services being provided in the home: (i.e. personal care etc.)	

**Nutritional Status**

Tube feeding <input type="checkbox"/> Yes Type: <input type="checkbox"/> NGT <input type="checkbox"/> GT <input type="checkbox"/> JT	<input type="checkbox"/> No
Bolus <input type="checkbox"/> Yes Times administered:	<input type="checkbox"/> No
Continuous <input type="checkbox"/> Yes Times administered:	<input type="checkbox"/> No
Plan to transition to bolus feedings?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Oral Feedings	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last Swallow Test: _____ Result: -	
<input type="checkbox"/> History of aspiration <input type="checkbox"/> Documented high risk of aspiration <input type="checkbox"/> NG tube/active infant <input type="checkbox"/> Irritable/active and pulls at tube feeding <input type="checkbox"/> Other (Explain) _____	

**Respiratory Status**

<b>Ventilator?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequency:
Date of last sleep study:	Result:
Wean schedule:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Apnea Monitor ordered?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Trach?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
Tracheal suctioning frequency:	

Appendix W – Private Duty Nursing Assessment Form

Oral suctioning frequency:	
<b>BIPAP?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>CPAP?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please provide frequency:	Date initiated:

**Intravenous Therapy**

Intravenous therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type/Site:
Treatment:	
Frequency:	

**Mental Status**

Participant's cognitive status: <input type="checkbox"/> Alert & Oriented <input type="checkbox"/> Lethargic <input type="checkbox"/> Doesn't follow commands <input type="checkbox"/> Combative <input type="checkbox"/> Unresponsive		
<input type="checkbox"/> Other:		
Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, Type:	Frequency:

**Other skilled needs** (i.e. wound care, urinary tubes, ostomy appliances, rods or other orthopedic appliances, contractures, ROM, etc.)

--

**Comments:**

--

**This assessment was completed by:** \_\_\_\_\_

Appendix X

<b>Breakdown of REM Native Languages as of April 2012</b>		
<b>Language</b>	<b># of Participants</b>	<b>Percentage</b>
Arabic	5	2%
Bengali	1	0%
Bravins (Somalia)	1	0%
Burmese	4	1%
Cambodian	1	0%
Chinese	1	0%
Ethiopian	2	1%
French	4	1%
Japanese	1	0%
Korean	5	2%
Nepalese	3	1%
Portuguese	1	0%
Punjabi	2	1%
Russian	1	0%
Spanish	234	82%
Swahili	4	1%
Tagalog	1	0%
Urdu	11	4%
Uzbek	1	0%
Yoruba	2	1%
<b>Total</b>	<b>285</b>	<b>100%</b>

## Appendix Y

### Monthly Complaint Log Format

Monthly Complaint Logs are to be submitted in Microsoft Excel format to the Department and must have the following columns:

1. Agency Name
2. REM Participant Last Name
3. REM Participant First Name
4. REM Participant Middle Initial
5. Case Manager Last Name
6. Case Manager First Name
7. Current MA Number
8. Date Reported
9. Status of Complaint
10. Complaint Description
11. Actions Taken to Resolve Complaint

Appendix Z

Current FFS Services Form

Service Description	Provider Name and Contact Person	Provider Phone Number	Provider NPI	Quantity/Freq.	Open Pre-Auth Dates	Rent or Purchase (DME Only)

Appendix AA

Current MCO Services Form

Service Description	Provider Name and Contact Person	Provider Phone Number	Provider NPI	Quantity/Freq.	Open Pre-Auth Dates	Rent or Purchase (DME Only)

**Baseline Performance Indicators**

The following measures are similar to measures found in Healthcare Effectiveness and Data Information Set (HEDIS®). They will be calculated by the Department utilizing a similar reporting methodology using claims data only.

**Well-Child Visits in the First 15 Months of Life**

Description: The percentage of participants who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life:

	<b>CY 09</b>	<b>CY 10</b>	<b>CY 11</b>
No visits	4%	5%	2%
One visit	1%	1%	1%
Two visits	2%	2%	2%
Three visits	2%	5%	2%
Four visits	3%	2%	2%
Five visits	4%	2%	2%
Six or more visits	84%	82%	89%
Total	100%	100%	100%

**Well-Child Visits in the Third through Sixth Years of Life**

Description: The percentage of participants 3-6 years of age who had one or more well-child visits with a PCP during the measurement year.

	<b>CY 09</b>	<b>CY 10</b>	<b>CY 11</b>
3-4 years	72.3%	78.0%	70.8%
5-6 years	64.4%	71.0%	65.6%

**Adolescent Well Care Visit**

Description: The percentage of participants 12-21 years of age who had one comprehensive well care visit with a PCP during the measurement year.

	<b>CY 09</b>	<b>CY 10</b>	<b>CY 11</b>
12-21 years	44.8%	47.4%	45.2%

**Ambulatory Care Services for Social Security Income Participants**



## Appendix BB – Current REM Participant Care Measures & Definitions

Description: The percentage of participants receiving social security income (SSI) who had at least one ambulatory service during the measurement year.

	<b>CY 09</b>	<b>CY 10</b>	<b>CY 11</b>
0-20 years	91.2%	91%	95.4%
21-64 years	87.7%	87%	89.5%

### **Childhood Immunization Status- Combination 6**

Description: The percentage of participants two years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); four Pneumococcal Conjugate (PCV); and two influenza vaccines by their second birthday. The measure calculates a single rate for the combination.

	<b>CY 09</b>	<b>CY 10</b>	<b>CY 11</b>
Combo 6	4%	4%	8%

### **Immunizations for Adolescents**

Description: The percentage of participants 13 years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday.

	<b>CY 09</b>	<b>CY 10</b>	<b>CY 11</b>
13 years			
Combo 1	35%	38%	42%

### **Flu Immunization**

Description: The percentage of participants that had at least one influenza immunization during the measurement year.

	<b>CY 09</b>	<b>CY 10</b>	<b>CY 11</b>
3-20 years	7%	9%	10%
21-40 years	0%	1%	1%
41-64 years	1%	1%	2%

### **Lead Screening in Children**

Description: The percentage of children 12-35 months of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.

	<b>CY 09</b>	<b>CY 10</b>	<b>CY 11</b>
1-2 years	60%	58%	67%

## Appendix BB – Current REM Participant Care Measures & Definitions

### **Adults' Access to Preventive/Ambulatory Health Services**

Description: The percentage of participants 20 years of age and older who had an ambulatory or preventive care visit during the measurement year.

	<b>CY 09</b>	<b>CY 10</b>	<b>CY 11</b>
20-44 years	85.4%	86.2%	86.2%
45-64 years	94.2%	89.3%	92.3%



## **Provider Agreement for Participation in Maryland Medical Assistance Program**

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This Agreement (the "Agreement"), entered into between the Maryland State Department of Health and Mental Hygiene (the "Department") and

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the undersigned Provider or Provider Group and its members or Practitioner(s) (hereinafter called the "Provider"), is made pursuant to Title XIX and Title XXI of the Social Security Act, Health-General, Title 15, Annotated Code of Maryland and state regulations promulgated thereunder to provide medical, healthcare, home- and community-based services and/or remedial care and services ("Service(s)") to eligible Maryland Medical Assistance recipients ("Recipient(s)"). On its effective date, this Agreement supersedes and replaces any existing contracts between the parties related to the provision of Services to Recipients.

### **I. THE PROVIDER AGREES:**

- A. To comply with all standards of practice, professional standards and levels of Service as set forth in all applicable federal and state laws, statutes, rules and regulations, as well as all administrative policies, procedures, transmittals, and guidelines issued by the Department, including but not limited to, verifying Recipient eligibility, obtaining prior authorizations, submitting accurate, complete and timely claims, and conducting business in such a way the Recipient retains freedom of choice of providers. The Provider acknowledges his, her or its responsibility to become familiar with those requirements as they may differ significantly from those of other third party payor programs;
  
- B. To maintain adequate medical, financial and administrative records that fully justify and describe the nature and extent of all goods and Services provided to Recipients for a minimum of six years from the date of payment or longer if required by law. The Provider agrees to provide access upon request to its business or facility and all related Recipient information and records, including claims records, to the Department, the Medicaid Fraud Control Unit (MFCU) of the Maryland Attorney General's Office, the U.S. Department of Health and Human Services, and/or any of their respective employees, designees or authorized representatives. This requirement does not proscribe record requirements by other laws, regulations, or agreements. It is the Provider's responsibility to obtain any Recipient consent required to provide the Department, its designee, the MFCU, federal employees, and/or designees or authorized representatives with requested information and records or copies of records. Failure to timely submit or failure to retain adequate documentation for services billed to the Department may result in recovery of payments for Services not adequately documented, and may result in the termination or suspension of the Provider from participation as a Medical Assistance provider.
  - I. Original records must be made available upon request during on-site visits by Department personnel or personnel of the Department's designee.
  2. Copies of records must be timely forwarded to the Department upon written request;



## **Provider Agreement for Participation in Maryland Medical Assistance Program**

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- C. To protect the confidentiality of all Recipient information in accordance with the terms, conditions and requirements of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, as amended, and regulations adopted thereunder contained in 45 CFR 160, 162 and 164, and the Maryland Confidentiality of Medical Records Act (Md. Ann. Code, Health-General §§4-301 *et seq.*);
- D. To provide services on a non-discriminatory basis and to hold harmless, indemnify and defend the Department from all negligent or intentionally detrimental acts of the Provider, its agents and employees. The Provider will not discriminate on the basis of race, color, national origin, age, religion, sex, disabilities, or sexual orientation;
- E. To provide Services in compliance with the Americans with Disabilities Act of 1990, Section 504 of the Rehabilitation Act of 1973, and their respective accompanying regulations, and ensure that qualified individuals with disabilities are given an opportunity to participate in and benefit from its Services, including providing interpretive services for the deaf and hard of hearing when required;
- F. To check the Federal List of Excluded Individuals/Entities on the Health and Human Services (HHS) Office of Inspector General (OIG) website prior to hiring or contracting with individuals or entities and periodically check the OIG website to determine the participation/exclusion status of current employees and contractors. To check the General Service Administration's Excluded Parties List System (EPLS) prior to hiring or contracting with individuals or entities and periodically check the EPLS website to determine the participation/exclusion status of current employees and contractors. To check the Maryland Medicaid List of Excluded Providers and Entities prior to hiring or contracting with individuals or entities and periodically check the website to determine the participation/exclusion status of current employees and contractors. The Provider further agrees to not knowingly employ, or contract with a person, partnership, company, corporation or any other entity or individual that has been disqualified from providing or supplying services to Medical Assistance Recipients unless the Provider receives prior written approval from the Department;
- G. To accept the Department's payments as payment in full for covered Services rendered to a Recipient. The Provider agrees not to bill, retain, or accept any additional payment from any Recipient. If the Department denies payment or requests payment from the Recipient, or if the Department denies payment or requests repayment because an otherwise covered Service was not medically necessary or was not preauthorized (if required), the Provider agrees not to seek payment from the Recipient for that Service. The Provider further agrees to immediately repay the Department in full for any claims where the Provider received payment from another party after being paid by the Department;
- H. With the exception of prenatal care or preventive pediatric care, to seek payment from a Recipient's other insurances and resources of payment before submitting claims to the Department, which includes but is not limited to seeking payment from Medicare, private insurance, medical benefits provided by employers and unions, worker compensation, and any



## **Provider Agreement for Participation in Maryland Medical Assistance Program**

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other third party insurance. If payment is made by both the Department and the Recipient's other insurance, the Provider shall refund the Department, within 60 days of receipt, the amount paid by the Department;

- I. To accept responsibility for the validity and accuracy of all claims submitted to the Department, whether submitted on paper, electronically or through a billing service;
- J. That all claims submitted under his, her or its provider number shall be for medically necessary Services that were actually provided as described in the claim. The Provider acknowledges that the submission of false or fraudulent claims could result in criminal prosecution and civil and administrative sanctions. This may include his, her or its expulsion from the Maryland Medical Assistance Program and/or referrals by the Department to the HHS OIG for expulsion from the Medicare program;
- K. That if Provider is a physician, he or she will, upon request, submit the name and applicable licensure for each physician extender in his or her employment. The Provider is responsible for knowing and complying with the Maryland Medical Assistance Program's definition of an eligible physician extender and for providing supervision as required by the Maryland Medical Assistance Program;
- L. That in case of a group provider, the individual Provider rendering the service shall include his or her own provider number, as well as the group provider number, on any claim;
- M. To furnish the Department, within 35 days of the Department's request, full and complete information about:
  1. The ownership of any subcontractor with whom the Provider has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of the request;
  2. Any significant business transaction between the Provider and any wholly-owned supplier, or between the Provider and any subcontractor, during the 5-year period ending on the date of the request; and
  3. Any ownership interest exceeding 5 percent held by the Provider in any other Medical Assistance Provider;
- N. That before the Department enters into or renews this Agreement, the Provider agrees to disclose the identity of any person who:
  - I. Has an ownership or control interest in the Provider, or is an agent or managing employee of the Provider; and
  2. Has been convicted of a criminal offense related to that person's involvement in the Medicaid or Medicare programs;



## **Provider Agreement for Participation in Maryland Medical Assistance Program**

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- O. To exhaust all administrative remedies prior to initiating any litigation against the Department;
- P. Upon receipt of notification that the Provider is disqualified through any federal, state and/or Medicaid administrative action, to not submit claims for payment to the Department for Services performed after the disqualification date;
- Q. Any excessive payments to a Provider may be immediately deducted from future Department payments to any payee with the Provider's tax identification number, at the discretion of the Department;
- R. Continuation of this Agreement beyond the current term is subject to and contingent upon sufficient funds being appropriated, budgeted, and otherwise made available by the State legislature and/or federal sources. The Department may terminate this Agreement, and the Provider waives any and all claim(s) for damages, effective immediately upon receipt of written notice (or any date specified therein) if for any reason the Department's funding from State and/or federal sources is not appropriated or is withdrawn, limited or impaired;
- S. To comply with the Deficit Reduction Act of 2005 (ORA) employee education requirement imposed upon any entity, including any governmental agency, organization, unit, corporation, partnership or other business arrangement (including any Medicaid MCO), whether for profit or not for profit, which receives annual Medicaid Payments of at least \$5,000,000.
- T. For Provider Groups Only: The Provider Group affirms that it has authority to bind all member Providers to this Agreement and that it will provide each member Provider with a copy of this Agreement. The Provider Group also agrees to provide the Department with names and proof of current licensure for each member Provider as well as the name(s) of individual(s) with authority to sign billings on behalf of the group. The Provider Group agrees to be jointly responsible with any member Provider for contractual or administrative sanctions or remedies including, but not limited to, reimbursement, withholding, recovery, suspension, termination or exclusion on any claims submitted or payment received. Any false claims, statements or documents, concealment or omission of any material facts may be prosecuted under applicable federal or state laws.
- U. To notify the Department within five (5) working days of any of the following:
  - 1. Any action which may result in the suspension, revocation, condition, limitation, qualification or other material restriction on a Provider's licenses, certifications, permits or staff privileges by any entity under which a Provider is authorized to provide Services including indictment, arrest, felony conviction or any criminal charge;
  - 2. Change in corporate entity, servicing locations, mailing address or addition to or removal of practitioners or any other information pertinent to the receipt of Department funds; or
  - 3. Change in ownership including full disclosure of the terms of the sales Agreement. When there is a change in ownership, this Agreement is automatically assigned to the new



## **Provider Agreement for Participation in Maryland Medical Assistance Program**

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owner, and the new owner shall, as a condition of participation, assume liability, jointly and severally with the prior owner for any and all amounts that may be due, or become due to the Department, and such amounts may be withheld from the payment of claims submitted when determined. (NOTE: Section I.S.3 does not apply to Nursing Home Providers)

### **II. THE DEPARTMENT AGREES:**

- A. To reimburse the Provider for medically necessary Services provided to Recipients that are covered by the Maryland Medical Assistance Program. Services will be reimbursed in accordance with all Program regulations and fee schedules as reflected in the Code of Maryland Regulations or other rules, action transmittals or guidance issued by the Department; and
- B. To provide notice of changes in Program regulations through publication in the Maryland Register.

### **III. THE DEPARTMENT AND PROVIDER MUTUALLY AGREE:**

- A. That except as specifically provided otherwise in applicable law and regulations, either party may terminate this Agreement by giving thirty (30) days notice in writing to the other party. After termination, the Provider shall notify Recipients, before rendering additional Services, that he or she is no longer a Maryland Medical Assistance participating Provider;
- B. That the effective date of this Agreement shall be \_\_\_\_\_, provided that the Department verifies the information in the Provider's application. This Agreement shall remain in effect until either party terminates the Agreement (as described in Section III A). Following termination of this Agreement, the Provider must continue to retain records and reimburse the Maryland Medical Assistance Program for overpayments as described in this Agreement and as required by law, including but not limited to Maryland Health-General § 4-403;
- C. That no employee of the State of Maryland, whose duties include matters relating to this Provider's Agreement, shall at the same time become an employee of the Provider without the written permission of the Department;
- D. That this Agreement is not transferable or assignable;



## Provider Agreement for Participation in Maryland Medical Assistance Program

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- E. That the Provider Enrollment Application submitted and signed by the Provider is incorporated by reference into this Agreement and is a part hereof as though fully set forth herein; and

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Date

*Susan J. Tucker*  
\_\_\_\_\_

Department Authorization

\_\_\_\_\_  
Date

\_\_\_\_\_  
Provider Name (Typed)

\_\_\_\_\_  
Date

*W. Travis*  
\_\_\_\_\_

Assistant Attorney General

\_\_\_\_\_  
Date

\_\_\_\_\_  
Provider Signature Address (Typed)



**Notification of Unable to Locate or Non-Responsive REM Participant**

REM Participant Name: \_\_\_\_\_  
Medicaid Number: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Current Level of Care: \_\_\_\_\_  
Case Manager Name: \_\_\_\_\_  
Date of Request to Refer to DHMH: \_\_\_\_\_

**Reason for Notification:**

	Unable to Locate for $\geq$ 60 days		Non-responsive to CM contacts

Is the recipient receiving Private Duty Nursing Services or Shift Home Health Aide services at this time?  
Yes  No

Date of last phone contact \_ / \_ / \_

Date of last face to face visit \_ / \_ / \_

Summary of Case Manager (CM) attempts to make contact:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**REM Program Use Only**

<b><u>Response:</u></b>	
<input type="checkbox"/> Approved	<input type="checkbox"/> Denied
REM Signature:	_____
Decision Date:	_____

Appendix DD

Rev. 01/2013

# Attachment 2



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**

Lorraine Nawara, Deputy Director  
Community Integration Programs  
201 W. Preston Street, Room 135  
Baltimore, MD 21201  
Dhnh.cfc@maryland.gov  
(410) 767-1739

**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](http://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](http://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](mailto: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.dhmh.maryland.gov/docs/Appendix\\_C-1\\_Reportable\\_Events.pdf](https://mmcp.dhmh.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 20<sup>th</sup> 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 10<sup>th</sup> 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 10<sup>th</sup> 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**

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



# Attachment 3



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

January 1, 2015 - 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 \$15.005 per 15 minute unit, which equates to \$60.02 per hour.

### **Regions**

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

1. Western Region - Allegany, Carroll, Frederick, Garrett, Howard, Montgomery & Washington Counties
2. Northern Region - Baltimore City, Baltimore & Harford Counties
3. Eastern Region - Caroline, Cecil, Dorchester, Kent, Queen Anne’s, Somerset, Talbot, Wicomico & Worcester Counties
4. Southern Region - Anne Arundel, Calvert, Charles, Prince George’s & St. Mary’s Counties
5. Baltimore City
6. Baltimore County
7. Montgomery County
8. Prince George’s County

### **Provider Agreement Term**

January 1, 2015 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**

Lorraine Nawara, Deputy Director  
Community Integration Programs  
201 W. Preston Street, Room 135  
Baltimore, MD 21201  
Dhnh.cfc@maryland.gov  
(410) 767-1739

**Deadline for receipt of provider proposals: December 1, 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-1 on Monday, November 3, 2014 from 1-3 pm (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](http://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. Maryland's CFC program offers personal assistance, supports planning, nurse monitoring, personal emergency response systems, transition services, and items that substitute for human assistance such as technology and environmental adaptations.
- F. Community Options Waiver (CO) – The waiver program that combined the former Living at Home and Waiver for Older Adults. This waiver became effective January 6, 2014 and serves adults aged 18 years and older. It provides 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. Eligibility Determination Division (EDD) - EDD 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 ended on January 5, 2014 and formerly served 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. Participants of this historical program are now served through the Community Options Waiver and Community First Choice.

- 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. This program will be renamed as Community Personal Assistance Services in calendar year 2015.
- T. Money Follows the Individual (MFI) - 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](http://www.dbm.maryland.gov) - keyword State Holidays.
- W. Waiver for Older Adults (WOA) – This former program ended on January 5, 2014 and served adults 50 and older who met nursing facility level of care, in their own home or assisted living, rather than a nursing facility. Services included: personal care, respite care, assisted living

services, senior center plus, and other services. Participants of this historical program are now served through the Community Options Waiver and Community First Choice.

## **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.

### **Community Options Waiver**

Effective January 6, 2014, the former Waiver for Older Adults and the Living at Home Waiver programs were merged in to one waiver program. Community Options 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. 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 offers assisted living, senior center plus, family training, behavioral consultation, and case management services. Participants of the Community Options waiver are also eligible to receive services through the Community First Choice (CFC) program and many participants receive personal assistance, nurse monitoring, and other services through joint participation in CFC.

### **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 Community Options

Waiver . ICS is governed by COMAR 10.09.81 which can be found at <http://www.dsd.state.md.us/comar/>.

### **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 implemented its Community First Choice program on January 6, 2015 and consolidated personal care services across three existing programs; the State Plan Medical Assistance Personal Care program, Living at Home Waiver, and Waiver for Older Adults. Maryland's CFC program offers both self-direction and agency-based services.

Specifically, CFC offers:

- 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 are no longer covered as waiver services because they are covered as State Plan services which are available to waiver and non-waiver participants. . CFC is governed by COMAR 10.09.84 which can be found at <http://www.dsd.state.md.us/comar/>.

### **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](mailto: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 have free choice of eligible supports planning providers. Current providers and regions of service are included in Attachment 1. . The Department limits 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 waiver 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 provides a packet of materials to all applicants that includes brochures from each eligible provider in their area. The applicant may choose a provider by contacting the Department or the chosen provider directly. This choice will be noted in the LTSSMaryland tracking system..

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. For example, if a participant who is already working with a supports planning agency chooses a new provider on January 1<sup>st</sup>, the change would be effective on January 15<sup>th</sup>. The participant is not eligible to request another change in provider until February 15<sup>th</sup>.

Applicants and participants who do not choose a case management provider within 21 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 CO waiver program, 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. A comprehensive resource guide for supports planners is posted on the Department's website at

<https://mmcp.dhmd.maryland.gov/longtermcare/Resource%20Guide/Forms/AllItems.aspx>.

#### **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 community 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 or the local Maryland Access Point (MAP) site 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. 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 is required to enable the applicant to move forward in the process. .

#### **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.

#### **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 or the MAP site 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 LTSS Maryland 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 in nursing facilities 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 include 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](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 monitor the completion of the medical assessment and confirmation of continued medical eligibility from the local health department, which is triggered 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, 54, 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. If providing other Medicaid-funded services, identify and remediate potential conflicts of interest.
  - A. Identify other services provided by the agency, specifically noting any long-term services and supports and/or other Medicaid-funded services.
  - B. Identify the remediation and monitoring strategy to ensure applicants and participants receive conflict-free case management and have free choice of any willing provider.
  - C. Submit a conflict management plan to the Department for approval as part of the final work plan.
    - i. No services may be provided prior to the Department's approval of the conflict management plan.
  - D. Submit quarterly reports on conflict monitoring and remediation efforts to the Department on January 1<sup>st</sup>, March 1<sup>st</sup>, July 1<sup>st</sup>, and October 1<sup>st</sup> of each calendar year.
- 3.2.3. 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;
- 3.2.4. Provide at least one program manager and adequate supervisors/lead workers to support the day-to-day supports planning activities;
- 3.2.5. 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;
- 3.2.6. 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;

- 3.2.7. 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;
- 3.2.8. 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;
- 3.2.9. 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;
- 3.2.10. 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
- 3.2.11. Submit staffing standards and qualifications for all staff roles to the Department for approval to ensure adequate knowledge and training;
- 3.2.12. 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.
- 3.2.13. Develop and submit to the Department 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;
- 3.2.14. 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;
- 3.2.15. Provide staff training on laws regarding guardianship and other forms of legal representation such as power of attorney and surrogate decision makers;
- 3.2.16. 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.

- 3.2.17. 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;
- 3.2.18. Provide all training materials to the Department in the format requested by the Department for review prior to use with supports planning staff;
- 3.2.19. 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;
- 3.2.20. 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.
- 3.2.21. Return all routine, non-emergency calls within one business day from the time the message is recorded;
- 3.2.22. 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;
- 3.2.23. 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;
- 3.2.24. Operate, at a minimum, a 28.8 speed fax machine 24 hours each day;
- 3.2.25. Provide access to computers with an internet connection and e-mail addresses for all supports planning staff;
- 3.2.26. 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;
- 3.2.27. 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;
- 3.2.28. Have the ability to transmit data to the Department utilizing at minimum Microsoft Office 97;
- 3.2.29. 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.
- 3.2.30. Share all policy, procedures, regulations and program changes with the appropriate staff;
- 3.2.31. Develop relationships and regular communication with the local Maryland Access Point sites that serve as a single point of entry for individuals seeking long-term community supports;
- 3.2.32. 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;
- 3.2.33. 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;
- 3.2.34. Establish and maintain individual participant files in a locked location and in accordance with COMAR requirements;
- 3.2.35. Ensure case files are available for immediate review by the State or Federal Auditors;
- 3.2.36. Retain copies of program files for six years from contract ending date;
- 3.2.37. Cooperate with Federal and State inspections, reviews, audits, and appeal hearings; and
- 3.2.38. 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.

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 20<sup>th</sup> 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. Note 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, note 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, providers, 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 EDD 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.
- 3.4.24. Submit the discharge form 257 to the Department within 5 business days of discharge; Make direct contact with applicants as needed and as follows:
- A. Contact applicants no less frequently than once per month by phone or e-mail;
    - i. If an applicant has not been contacted within 60 days, conduct a home visit.
    - ii. Meet with applicants in person at least every 180 days;
  - B. Document all contacts and attempts to contact in the LTSSMaryland tracking system.

### **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. Verify that the system generates 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 Eligibility Determination Division (EDD) 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 LTSS Maryland 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 and timeframes 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 Provider Termination and Transition Plan**

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.

- 3.10.1. 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 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 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.
- 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**

##### **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 Wednesday, October 29, 2014** 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 via the CFC email box at dhmh.cfc@maryland.gov in advance of the pre-proposal conference. Telephone inquiries will not be accepted. 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.

#### **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.

#### **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.

#### **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.

#### **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: Monday, December 1, 2014 at 2:00pm 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.**

#### **4.3 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.

- 4.3.1. 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.
  
- 4.3.2. 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).

**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 ]

**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.

**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 - Currently Enrolled Supports Planning Agencies**

<b>Supports Planning Agency</b>	<b>Jurisdiction</b>
Area Agencies on Aging	Statewide
Bay Area Center for Independent Living (BACIL)	Eastern Shore
Beatrice Loving Heart	Baltimore City; Baltimore, Prince George's and Montgomery Counties
Foundations Care Management	Statewide
Medical Management and Rehabilitation Services (MMARS)	Statewide
The Coordinating Center (TCC)	Statewide

# Attachment 4



State of Maryland  
Department of Health and Mental Hygiene  
Office of Health Services  
Living at Home Waiver Division

**Provider Solicitation**  
Request for Proposals

Comprehensive Case Management Services for the  
Living at Home Waiver

November 2009 - December 2011

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# 1. Solicitation Summary

## Description of Services

The Living at Home Waiver Division within the Office of Health Services within the Department of Health and Mental Hygiene an agency of the State of Maryland is soliciting proposals from qualified providers to provide comprehensive case management services to Living at Home Waiver applicants and participants. Case management services include assisting participants with eligibility determination and accessing all waiver services, non-waiver services, benefits and entitlements needed to maintain healthy and safe community living.

## Regions

There are four regions designated in this solicitation. One provider will be selected per region; providers may submit a single proposal for multiple regions. Proposals will be evaluated for each region independently. The regions are:

Western Region - Allegany, Carroll, Frederick, Garrett, Howard & Washington Counties

Northern Region - Anne Arundel, Baltimore City, Baltimore & Harford Counties

Eastern Region - Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico & Worcester Counties

Southern Region - Calvert, Charles, Montgomery, Prince George's & Saint Mary's Counties

## Provider Agreement Term

November 1, 2009 through December 31, 2011

Option #1: January 1, 2012 to December 31, 2012

Option #2: January 1, 2013 to December 31, 2013

## Solicitation Point of Contact

Kevin Patterson

Living at Home Waiver Division

201 W. Preston Street, Room 121 B

Baltimore, MD 21201

(410) 767-5696

**Deadline for receipt of provider applications: August 28, 2009 at 3:00pm EST.**

## Pre-Proposal Conference

To be held at The Department of Health and Mental Hygiene 201 W. Preston Street, Baltimore, Maryland 21201 Room L-1 on August 17, 2009 10 AM (EST).

## **2. Background Information**

### **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 de-institutionalized or diverted from a nursing facility under the Code of Maryland Regulations (COMAR) 10.09.55 available at [www.dsd.state.md.us](http://www.dsd.state.md.us). These 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 safely in the community.

The LAH waiver has a set amount of funding to serve individuals in the community and reached its budgetary cap 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, individuals from the registry are invited to apply for services. It is anticipated that less than 5 individuals will apply from the registry each year for the duration of this agreement due to budgetary limitations. However, the State's Money Follows the Individual policy allows individuals who reside in nursing facilities where their care is being funded by Medicaid, to apply for the waiver regardless of budgetary caps. Approximately 200 nursing facility residents apply for waiver services each year, and approximately 80-100 successfully transition and become waiver participants within the year. Currently there are approximately 550 individuals receiving services through the waiver.

The LAH waiver is based on a philosophy of consumer direction, where program participants are empowered to make choices that work best for them regardless of the nature or extent of their disability. Consumer direction is different from the traditional model of care because the participant is at the center of the planning process. The case management provider assists participants and applicants in creating a person-centered plan of service (POS), goal setting and coordinating services based on their individual needs and choices.

In 2008, the LAHWD implemented the use of a web-based tracking system for LAH waiver activities. The case management providers use this system to document case management activities and other data used for reporting.

### **Money Follows the Person**

Maryland's Money Follows the Person (MFP) demonstration is a five year grant that began in January 2007 and will end December 31, 2011. The Department of Health and Mental Hygiene (DHMH) has overall responsibility for the MFP demonstration. Maryland's MFP program builds on past efforts and focuses on increasing the use of home and community-based services by streamlining and supporting transitions from institutions to the community. The MFP demonstration in Maryland will improve the process of transitioning from an institution to the community by increasing outreach and decreasing barriers to transition. New efforts under MFP include peer outreach, flexible transition funds, and the addition of services to existing waivers.

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://dhmh.state.md.us/mma/mfp/> or by request via email to [MFP@dhmh.state.md.us](mailto:MFP@dhmh.state.md.us).

To be eligible for the MFP demonstration, applicants must have resided in a qualified institution such as a nursing facility for at least 6 continuous months, have Medicaid paying for their institutional stay at least one month prior to their transition, and move to a qualified residence in the community. Because eligibility requirements for the two programs overlap, all individuals who transition into the LAH waiver will be eligible to participate in the MFP demonstration provided they resided in an institution for at least six months prior to their transition. MFP offers eligible individuals who transition a one-time benefit of \$700 in flexible funds. This flexible benefit is designed to pay for goods and services not customarily provided through Medicaid such as non-medical transportation, an initial supply of groceries, and rent. The flexible benefit can not be used for goods or services available through Medicaid or the Living at Home waiver and must be directly related to a successful transition to community living. The Living at Home waiver case management provider shall be responsible for screening all LAH applicants for MFP eligibility, completing the MFP form on the LAH tracking system, and administering MFP flexible funds for Living at Home waiver applicants at the time of transition to the community.

### **Case Management Services**

Waiver case managers shall coordinate community services and supports from various programs and payment sources to aid LAH waiver applicants and participants in developing a comprehensive plan for community living. Case managers 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 case management providers identified through this solicitation shall assist individuals referred by the Department in developing a comprehensive plan of services that includes both State and local community resources, coordinating the transition from a nursing facility to the community, and maintaining community supports throughout the individual's participation in the waiver program.

### **Application Assistance**

The Department will serve individuals from the waiver registry as funds become available and will refer these individuals to the case management provider for application assistance. It is estimated that less than 5 people per year will be referred for application assistance due to limited funding opportunities. However, when an individual is referred for application assistance, the provider shall arrange a meeting with the referred within 10 business days of the referral. At the initial meeting, the provider shall provide detailed information about the LAH waiver program and assist the referred individual in completing the waiver application and consent forms. Assistance to complete the application includes gathering supporting documentation including obtaining copies of financial and identifying documents from family members, guardians, and other supporters of the referred individual. An 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 application with the referred individual within 5 business days of the initial meeting. These activities shall be documented in the LAH waiver's web-based . . .

tracking system. Once an application is submitted, the referred individual becomes a waiver applicant.

### **Coordination of Medical Eligibility Determination**

The Department contracts with another entity to complete initial waiver applications for nursing facility residents. Once an application is received for a nursing facility resident, the Department will make a referral to the case management provider identified through this solicitation for further assistance in accessing the waiver. It is estimated that 400 people per year will apply for the Living at Home waiver from nursing facilities and be referred to the provider.

Upon receipt of an application or after assisting a registry applicant in completing the application, the CM provider shall send a referral within one business day through the LAH tracking system to the local Adult Evaluation and Review Services (AERS) office. AERS is obligated to perform a comprehensive medical assessment of the applicant and send their completed assessment form DHMH 4286 to the case management provider within 15 calendar days. The case management provider shall be responsible for following up with the local AERS to ensure that deadlines are met and the assessment is completed.

### **Developing a Transition Plan**

Once the AERS assessment is received, the case management provider shall review it and meet again with the applicant to develop an initial waiver plan of service (POS). The POS shall include waiver services and other supports that address the applicant's medical, social, educational, vocational, psychological, and other needs. Each plan shall include specific goals and action steps, 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 waiver 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, 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 AERS evaluation. Plans of Service must be cost neutral meaning the services provided in the community can not 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 individual 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.

### **Transition 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 waiver services and administering transition funds to secure needed goods and services, and facilitate a smooth transition to the community. The provider shall coordinate the day of transition including assuring that waiver providers are scheduled and that essential goods, such as a hospital bed or power wheelchair, are delivered and available to the applicant. Waiver transition funds and MFP flex funds can be administered up to 60 days post transition.

### **Continuing Applicant Eligibility**

Individuals that 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 individuals that need to reapply, the case management 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 provider shall make a referral for a new AERS assessment once each year or if there have been significant changes to the individual's health. The provider shall update the POS as needed and no less than annually. If the individual is not interested in reapplying, the provider shall complete a new consent form indicating the person's choice to remain in the nursing facility or "other" category and forward the consent form to DEWS.

### **Ongoing Case Management**

Once an individual transitions to the community with waiver services, they become a waiver participant. 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. The provider shall meet with the participant face-to face 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. Modifications shall be submitted when the participant wishes to change providers, increase or decrease the amount of services and add or delete services. If there is a change in the participant's medical needs, a new AERS evaluation shall be requested to document the increased need for services. Ongoing case management also includes quality monitoring and compliance with the Department's Reportable Events Policy (See Attachment 1). Quality monitoring also includes receiving and reviewing documentation of required nurse monitoring visits. The case management provider shall receive and review the DHMH 4658 Participant Assessment and Caregiver Service Plan to ensure that nurse monitoring visits occur according to schedule and that there are no significant changes in the participant's support needs.

### **Continuing Participant Eligibility**

The provider shall verify the participant's Medicaid eligibility each month via the Eligibility Verification System (EVS). A waiver participant must also redetermine his or her eligibility on an annual basis. The case management provider shall be responsible for ensuring that there is no lapse in waiver eligibility and that the redetermination process is completed each year. The provider shall monitor the redetermination time frame, request an AERS evaluation and level of

care redetermination at least 60 days prior to expiration of eligibility, meet with the applicant to complete redetermination paperwork, facilitate the gathering of required information for the redetermination, review and revise the plan of service, submit all supporting documentation for the application to DEWS no less than 60 days prior to the expiration of eligibility, and submit the revised POS to the Department at least 30 days prior to the expiration of eligibility.

### **3. Provider Qualifications**

#### **Minimum Qualifications**

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

1. At least two years of successful experience providing community based case management services and/or care coordination for individuals with complex medical needs, co-occurring disabilities such as acquired brain injury, substance abuse, mental health or developmental challenges, and individuals experiencing poverty.
2. At least two years of experience working with the Maryland Medical Assistance program including Managed Care Organizations.
3. At least two years of experience with and understanding of Medicare and private insurance programs as they relate to Medicaid.

#### **Highly Desirable Qualifications**

The following qualifications are highly desirable for prospective providers. Providers must address these qualifications in their responses to this solicitation.

1. Demonstrated knowledge of resources available for 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. Prior experience transitioning individuals with disabilities out of institutions to independent housing in the community.
3. Demonstrated understanding of and experience with consumer direction, client empowerment and harm reduction philosophy.
4. Demonstrated ability to maximize funding by providing services in a time efficient and cost-effective manner.
5. Capability of communicating and providing written materials in alternative formats, if requested, including large print, electronic copies, Braille, translators, and interpreters.
6. Capability of communicating in other languages.
7. Demonstrated ability to be culturally sensitive in all business practices and effectively relate to the cultural/ethnic diversity of participants. Offerors may provide relevant agency materials or activities.
8. Demonstrated communication and/or coordination with other programs and groups serving individuals with disabilities in community based services.

## 4. Requirements

By submitting a proposal for this solicitation, the provider agrees to comply with all of the provisions of the solicitation, all of the relevant policies of the Living at Home Waiver Division (LAHWD), and all applicable provisions of Maryland regulations, specifically COMAR 10.09.36.

These requirements are for the provision of services from November 1, 2009 through December 31, 2011.

The Department may at its discretion extend this agreement up to two times:

Option #1: January 1, 2012 to December 31, 2012

Option #2: January 1, 2013 to December 31, 2013

The Department may terminate this agreement at any time at its sole discretion by notifying the provider in writing.

### **Administration, Management and Staffing**

The provider shall:

- A. Enroll as a Medicaid provider;
- B. 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;
- C. Provide at least one program manager and adequate supervisors/lead workers to support the day-to-day case management activities;
- D. Hire case managers who meet the following minimum qualifications: Bachelors degree in a human services field, including psychology, social work, sociology, nursing, counseling, sociology, or a related field with work pertaining to 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;
- E. Hire and train a sufficient number of professional case management staff to maintain a staff such that the minimum case ratio is 1 case manager to 20 applicants/participants and the maximum case ratio is 1 case manager to 30 applicants/participants for all direct services and responsibilities. All direct case management activities shall be conducted by a professional case manager or trained intern;
- F. 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. LAH must be notified within 24 hours if a qualified alternate case manager is not available;
- G. Conduct criminal background investigations of case management 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;



- H. 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 delay and addictions issues;
- I. Hire a licensed clinical staff person (LGSW, LCSW, LCSW-C, LGPC, LCPC,) or person with advanced degree in Social Work, Counseling or Psychology with experience assessing and delivering services to individuals experiencing mental illness, acquired brain injury, substance abuse, and/or developmental delay;
- J. Submit staffing standards and qualifications for all staff roles to the Department for approval to ensure adequate knowledge and training;
- K. Develop a case management training manual, within 60 days of contract award, including applicable Code of Maryland Regulations (COMAR), LAH Fact Sheets, consumer direction philosophy, 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;
- L. Provide training to ensure all case management 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, assistive technology, medical equipment and supplies, and other local area resources;
- M. Provide staff training on laws regarding guardianship and other forms of legal representation such as power of attorney and surrogate decision makers;
- N. Conduct the following minimum training before case managers render services to participants:
  1. Universal Precautions/Blood borne pathogens,
  2. Crisis intervention,
  3. Health Information Protection and Portability Act (HIPPA),
  4. Identifying and reporting abuse/neglect/exploitation,
  5. Overview of community based service delivery, consumer direction/empowerment, harm reduction philosophy, and person centered planning,
  6. Medicaid, Managed Care Organizations and waivers,
  7. LAH Program Policies and Procedures, including reportable events, and the web-based tracking system,
  8. Overview of population characteristics including acquired brain injury, co-morbidity, mental illness, substance abuse, developmental delay, and
  9. Other training as recommended by the Department.
- O. Provide case management staff with on-going guidance and training related to Medicaid and LAH waiver policies and procedures and in areas reflecting program and population changes;
- P. Provide training materials to the Department for review prior to use with case management staff;

- Q. 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;
- R. 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;
- S. Return all routine, non-emergency calls within one working day from the time the message is recorded;
- T. Accommodate reasonable date, time, and location preferences for the individuals served under this contract 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;
- U. 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;
- V. Operate, at a minimum, a 28.8 speed fax machine 24 hours each day;
- W. Provide access to computers with an internet connection and e-mail addresses for all case management staff;
- X. Ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA) and ensure access to participant's Medicaid information is limited to the area of the office with a functional need for the information.
  - 1. Take measures to prudently safeguard and protect unauthorized disclosure of the Medicaid information in its possession.
  - 2. Maintain confidentiality of all participants' records and transactions in accordance with Federal and State laws and regulations;
- Y. 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;
- Z. Have the ability to transmit data to the Department utilizing at minimum Microsoft Office 97;
- AA. Attend no more than one monthly scheduled meeting and/or training convened by the Department and ensure that the appropriate staff attend each meeting;
- BB. Share all policy, procedures, regulations and program changes with the appropriate staff; and
- CC. 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.

### **Administrative Transitional and Initial Case Management Services**

For all individuals referred by the Department for transitional case management services, the provider shall:

- A. Provide assistance with completing initial applications to the Living at Home waiver program for individuals referred by the Department within 10 days of referral;
- B. Confirm or verify the basic Waiver technical eligibility requirements:
  - 1. Individual is 18 through 64 years of age when enrolled in the waiver;

2. Individual is currently eligible for long-term care Medicaid; and
  3. Individual is not enrolled in another Medicaid waiver program;
- C. Assist the individual in obtaining supporting documentation as required for applications such as copies of birth certificates and bank statements;
  - D. Complete monthly verifications of participant eligibility via the eligibility verification system or other data system provided via the Department and complete monthly reports regarding participant eligibility status;
    1. If an applicant is not currently eligible, notify the Department within 24 hours;
    2. Notify the applicant within 2 business days and facilitate communication with the local Department of Social Services to resolve issues related to continuing eligibility;
  - E. Secure signatures of the individual, the legal representative or guardian, and others as needed to complete applications;
  - F. Submit the signed Waiver application and consent for waiver services to the Division of Eligibility Waiver Services within 15 business days of the referral;
  - G. Submit the signed consent form to the Department within 15 business days of the referral;
  - H. Complete the preceding activities A – G within 15 business days of the initial referral;
  - I. Retain copies of all completed applications and waiver consent forms in the individual's file for reference;
  - J. Document application completion and related activities in the waiver tracking system;
  - K. Follow up with AERS within two (2) days of the referral to AERS in order to offer assistance to coordinate the scheduling of the interview with the applicant;
  - L. Document in the waiver tracking system if the assessments are not received by the 15th day and document communications with AERS regarding the status of the assessment, including attempts to resolve any barriers to its completion;
  - M. Review the AERS assessments upon receipt to identify applicant needs which include, but are not limited to: medical, social, educational, vocational, psychological, and other services;
  - N. Conduct a "face-to-face" meeting with the applicant within 10 days after receipt of the AERS assessment to:
    1. Review the AERS assessment with the applicant;
    2. Determine the applicant's service preferences,
    3. Assess the individual's transition needs such as the need for household items, accessible housing, furniture, etc.,
    4. Identify various resources to support the applicant's needs to include, but not be limited to: family support, donated items, vocational programs, and faith-based services,
    5. Complete the initial waiver POS including sufficient Transition Services to meet the applicant's assessed needs;
  - O. 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;
  - P. Calculate the costs for all waiver services and designated Medicaid State Plan services (i.e. Skilled Nursing, Medical Assistance Personal Care, Occupational Therapy, Physical Therapy, Speech Therapy, Disposable Medical Supplies and Durable Medical Equipment);

- Q. Determine if POS is cost neutral using the current cost neutrality figures provided by the Department;
  - 1. 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;
  - 2. If the individual chooses to change the POS, assist the individual in modifying the plan to their satisfaction;
- R. Obtain the individual's signature and any additional signatures needed on the POS such as those of the guardian, legal representative, etc.
- S. Submit the POS, a copy of Comprehensive Evaluation and Recommended Plan of Care Form, DHMH 4286; and a copy of Medical Eligibility Review Form, to the Living at Home Waiver Division within 10 days of the face to face meeting with the applicant;
- T. Coordinate a final discharge transition meeting with the applicant, guardian, authorized representative, or nursing facility staff, as applicable, and others identified by the individual;
- U. Coordinate initial waiver services start dates by making verbal and written referrals for waiver services to enrolled waiver providers and forwarding any necessary information, such as the AERS medical assessment, for their review;
- V. Complete and submit Fiscal Intermediary Referral Form, if applicable;
- W. Ensure waiver eligibility is confirmed by DEWS via the Advisory Authorization to Participate letter prior to expending waiver transition funds. Costs incurred due to noncompliance with eligibility and policy shall be the responsibility of the contractor. Costs incurred for individuals who do not transition will not be reimbursed and will be the responsibility of the contractor;
- X. Ensure POS approval prior to delivering or accessing program services;
- Y. Coordinate the transition to community living by:
  - 1. Coordinating with institutional staff the continuation of services such as occupational, speech, and physical therapy and durable medical equipment and disposable medical supplies;
  - 2. Administering waiver transition funds and services;
  - 3. Facilitate the identification and purchase of approved goods and services such as security deposits, utility hook-ups, household items, furniture, etc. using waiver transition funds;
  - 4. Ensuring that all vital household items including furnishings, toiletries, medical equipment and supplies, food, and medication are available on the day of transition;
  - 5. Document all waiver transition fund expenditures and maintain receipts for expenditures. Document the date of expenditure, goods or services purchased and received, provider approval of expense, and related contacts. Costs incurred by the provider without proper documentation will not be reimbursed.
  - 6. Ensure service providers, such as personal care attendants, are available and ready to begin services on the discharge date, and
  - 7. Submit the discharge form 257 and the AC-12 to the Living at Home Waiver Division within 5 days of discharge;

## **Comprehensive Transitional and Initial Case Management Services**

For all individuals referred by the Department for transitional case management services, the provider shall:

- A. 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;
- B. Assist the applicant in identifying and overcoming potential housing barriers such as accessibility, affordability, and credit, evictions, and convictions;
- C. Refer the applicant to programs and/or services to overcome credit and conviction barriers to accessing housing;
- D. Assist the applicant in completing applications for preferred housing options;
- E. Facilitate communication with housing managers to ensure applications are received and to monitor placement on waiting lists.
- F. Provide assistance in accessing non-Medicaid services by making referrals, providing information, or providing other assistance as requested by the individual;
- G. Provide information about, and referrals to, alternative resources including non-Medicaid resources that may meet some of the individual's needs; and
- H. Assist the individual in coordinating transportation to transition-related activities as necessary and on the date of discharge.

## **Money Follows the Person**

For all LAH applicants transitioning out of a nursing facility, the provider shall:

- A. Confirm and document MFP eligibility by verifying that the applicant:
  - 1. Is Medicaid eligible one month prior to transitioning,
  - 2. Resided in a qualified institutional setting (or settings) for a period of six months prior to transitioning,
  - 3. Transitions to a qualified residence in the community,
  - 4. Freely chooses to sign the MFP consent form;
- B. Document MFP eligibility verification on the MFP form of the LAH waiver tracking system;
- C. Secure the applicant's signature on the MFP consent form and submit the form to the Department within 2 days of completion;
- D. Ensure MFP eligibility criteria are met and the MFP consent form is signed prior to expending MFP flexible funds. Costs incurred due to noncompliance with eligibility and policy shall be the responsibility of the contractor. (Costs incurred for individuals who do not transition will not be reimbursed and will be the responsibility of the contractor);
- E. Administer MFP Flexible Funds by facilitating the identification and purchase of goods and services such as non-medical transportation or an initial supply of groceries using MFP flexible funds;
- F. Document all MFP flexible fund expenditures in the MFP tracking system; and
- G. Maintain receipts for MFP flexible fund expenditures. (Records should include date of expenditure, goods or services purchased and received, contractor staff approval of

expense, and related contacts. Costs incurred by the contractor without proper documentation will not be reimbursed.)

### **Ongoing Case Management Services**

For all LAH Participants, the provider shall:

- A. Receive and accept referrals from the Department for ongoing case management services;
- B. Establish contact and perform an initial home visit with referents within 10 days of referral;
- C. Complete monthly verifications of participant eligibility via the eligibility verification system or other data system provided via the Department and complete monthly reports regarding participant eligibility status;
- D. Provide waiver program orientation for participants and their representatives, including an explanation of the responsibilities of the participant case manager, and the Department.
- E. Assist participants in registering with local emergency services providers such as the local Fire Department;
- F. Assist each participant with the development of an Emergency Attendant Care Back-Up Plan (a plan to follow if personal assistant services are unavailable) that is documented in the Plan of Service;
- G. Make direct contact with participants as needed and as follows:
  - 1. Contact participants no less frequently than once per month by phone or e-mail
    - a. 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. (Use tracking system to note attempts and alert the Department);
    - b. If a participant has not been contacted within 60 days and their whereabouts cannot be confirmed via the attendant care provider, conduct a well check visit and use the tracking system to note attempts and alert the Department via phone or e-mail.;
  - 2. Contact participants no less than quarterly, in person, at the participant's home where they receive services;
  - 3. Contact representatives as appropriate, but representatives should be the primary contact only in the event that there is a documented reason that the participant is not able to directly communicate with the CM;
- H. Discuss the back-up plan with the participant/representative at least once each month, ensuring that the plan continues to be accurate and effective. (Document and maintain in the waiver tracking system the number of times a back-up plan has been used for the month);
- I. Where critical issues of health and safety are involved, notify the Department by phone within 24 hours of knowledge;
- J. Monitor participants' service utilization to ensure services authorized in the POS are received;
  - 1. Ensure timely completion of environmental modifications;
  - 2. Ensure timely delivery of assistive technology; and

3. Ensure combined cost for environmental accessibility adaptations and assistive technology do not exceed the annual cap established by the Department;
- K. Identify any need to reassess services through monitoring visits and participant contact and refer the participant for a new AERS evaluation when the participant experiences a significant change in medical conditions or disability;
- L. If there is a needed or requested change to the POS, follow Departmental guidelines to submit a POS modification to modify services;
- M. Assist the individual in accessing new services or providers as approved on a POS modification;
- N. Receive and Review Nurse Monitoring Form DHMH 4658 and review the Participant Assessment and Caregiver Service Plan as follows:
  1. Record the dates of nurse monitoring visits and verify that visits occur according to the schedule in the participant's plan of service;
  2. Ensure services are utilized in accordance with the plan of service by follow-up with the nurse monitor and participant;
  3. Complete a referral to AERS for reassessment as needed or if indicated by nurse monitor; and
  4. Report any critical incidents to the Department according to the Reportable Events policy;
- O. Provide assistance in accessing and maintaining non-Medicaid services by making referrals, providing information, or providing other assistance as requested by the individual;
- P. Meet with the individual at least annually to facilitate continued eligibility for the waiver program by completing the following:
  1. Assist the individual with completing a new waiver application;
  2. Forward the new application information to the Division of Eligibility Waiver Services (DEWS) 60 days before the individual's waiver eligibility expires;
  3. Make a referral for a new medical assessment by AERS at least 60 days before the individual's waiver eligibility expires;
  4. Update the POS as needed and submit the updated POS to the Department at least 30 days before the individual's eligibility expires;
  5. If the individual is not interested in reapplying for the LAH waiver program, complete a new waiver consent form indicating the individual's choice to decline services and document the expressed reason for declining services;
- Q. Ensure approval of program participant's POS and annual redetermination;
- R. Be responsible for the cost for any and all services accessed without prior approval from the Department or for failing to cease services after being notified that a participant is no longer eligible for LAH Waiver services;
- S. If a participant loses his or her waiver eligibility at any time:
  1. Assist the individual with identifying and accessing alternate community resources; and
  2. Provide information about the appeals process;

### **Reportable Events**

For all LAH waiver applicants and participants, the provider shall:

- A. Implement the Department approved Reportable Events policy and procedure (See Attachment 1) for reporting critical incidents, complaints, service interruption, and grievances;
- B. Report to the Department within 24 hours any complaints, incidents, etc., including 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;
- C. Maintain a registry identifying complaints of applicants and participants;
- D. Develop corrective action plans that resolve complaints described in reportable events and provide corrective action plans to the Department within required time frames;
- E. Implement corrective action plans within five business days of the report and record actions in the registry of reportable events;
- F. Notify the Department by fax within 24 hours of knowledge if the complaint cannot be resolved;
- G. Report all suspected abuse, neglect, and exploitation immediately upon knowledge to Adult Protective Services;
- H. Utilize any tracking system developed by the Department to track and monitor reportable events.

### **Record Keeping, Reporting, and Audits**

For all LAH waiver applicants and participants, the provider shall:

- A. Develop and implement a process the agency shall use to establish, manage, and maintain case files for each participant served;
- B. Document all contacts with the participant with a clear narration;
- C. Document the date, type of contact, length of time, substance of meeting, and contact outcome in the waiver tracking system or other format as requested by the Department;
- D. Document all case management activities in 15 minute increments in the waiver tracking system or other format as requested by the Department;
- E. Establish and maintain individual participant files in a locked location and in accordance with COMAR requirements;
- F. Ensure case files are available for immediate review by the State or Federal Auditors;
- G. Retain copies of program files for six years from contract ending date;
- H. Cooperate with Federal and State inspections, reviews, audits, and appeal hearings;
- I. Complete a monthly report, developed by the Department, summarizing activities completed that month.

### **Quality**

For all LAH waiver applicants and participants, the provider shall:

- A. Develop a client satisfaction survey for participants to evaluate case management services within 90 days of contract award;



1. The survey and all policies related to implementation shall be approved by the Department prior to implementation;
  2. Implement the survey within six months of contract award; and
  3. Complete the survey with an established percentage of participants at least annually;
- B. Develop a "Case Management Satisfaction Survey Report" that includes a summary and analysis of the participants' satisfaction with services based on the contractor's annual satisfaction survey;
  - C. Develop and implement a Quality Assurance Plan to monitor and ensure all responsibilities contained in this RFP are accomplished. (The plan shall be approved by the Department before implementation and contain clearly defined goals and standards for each service and/or responsibility);
  - D. Review and amend the Quality Assurance Plan at least bi-annually to evaluate effectiveness in meeting case management responsibilities;
  - E. 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;
  - F. Ensure compliance with all statutes, regulations, program policy and procedures, codes, ordinances, licensure or certification requirements that pertain to the LAH Waiver Program;
  - G. Report to the Department potential misuse of program services, suspected program abuse, and other information deemed critical by the Department in writing within two business days;
  - H. Ensure compliance with all performance measures noted in the Department's waiver application to the Centers for Medicare and Medicaid Services.

## **Billing**

The provider shall:

- A. Bill the Department for administrative transitional case management services provided to LAH applicants on a monthly basis, no later than the 15<sup>th</sup> of each month, according to Departmental guidelines;
  1. Submit a monthly "Administrative Invoice" to the Department by the 15<sup>th</sup> of the month following the service month for the total amount billed for administrative case management services provided to waiver applicants. (The invoice shall include a report listing each applicant, identification number, and contractor's signature attesting to services being rendered.);
- B. Bill the Department for comprehensive transitional case management activities provided to LAH applicants up to 180 days prior to their transition on or after the date of discharge and the applicant's enrollment in the LAH waiver program according to Departmental guidelines;
- C. Bill the Department for MFP Flex Funds provided prior to and up to 60 days after the participant's transition according to Departmental guidelines on or after the date of discharge and the applicant's enrollment;

1. Submit an MFP Flex Fund Invoice to DHMH by the 15th of the month following the month of service for the total amount of MFP flexible fund purchases made on behalf of each applicant. The contractor shall provide documentation of the Department approval, a receipt for the purchased item, and participant/applicant acknowledgement of receipt of the item purchased;
- D. Bill for waiver transition services provided prior to and up to 60 days after the participant's transition according to Departmental guidelines on or after the date of discharge and the applicant's enrollment in the LAH waiver program;
  1. Submit a monthly "Transition Services Invoice" to the Department by the 15th of the month following the service month for the total amount spent to purchase LAH approved transition fund purchases made on behalf of each participant/applicant. (The contractor shall provide documentation of the Department approval, a receipt for the purchased item, and participant/applicant acknowledgement of receipt of the item purchased.)
- E. Bill the Department for ongoing case management services provided to LAH participants on a monthly basis, no later than the 15<sup>th</sup> of each month, according to Departmental guidelines.

### **Required Documentation**

The provider shall submit to the Department:

- A. A Final Work Plan within 30 days of the initiation of the provider agreement, to meet all provider agreement requirements including:
  1. Working with family, guardians, legal representatives, and other involved persons as needed and as requested by the applicant;
  2. Establishing a person-centered planning process for POS development;
  3. Incorporating consumer-direction into policies, procedures, training, and activities;
  4. Creating a detailed plan to account for the administration of waiver transition and MFP flexible funds;
  5. Creating Staffing standards for all staff roles;
  6. Creating staff training materials and training schedule;
  7. Creating participant orientation materials;
  8. Creating a client satisfaction survey;
  9. Creating a Disaster Recovery Plan;
  10. Creating a plan to ensure the timeliness of data entry into the LAH tracking system;
- B. Submit the Participant Eligibility Verification Report to the Department by the 15th of the current month;
- C. 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).
- D. Submit "Monthly Reports" designed by the Department through the LAH tracking system by the 10th of the month following service delivery. (This report details case management activities for the previous month and is used as the basis for payment of

- services. This data will also be used to track program trends, identify areas of improvement and prioritize practical and policy based resolution to issues.)
- E. Submit "Service Utilization Monitoring Reports" by the 15th of the month after the end of each quarter. (This report monitors service utilization for each participant based on the approved POS. This report shall list each participant, identification number, approved POS services versus services used, and the contractor's signature attesting to the accuracy of the services reported.);
  - F. Submit Case Management Satisfaction Survey Report to the Department by June 15th of every year for the previous year;
  - G. Submit a Quality Assurance Report twice annually, within 30 days of the completion of the Quality Assurance Plan biannual review.

**The Agreement between Provider and DHMH shall consist of:**

- 1. This solicitation;**
- 2. Offeror's proposal, including any subsequent revisions and written responses to DHMH questions; and**
- 3. Applicable regulations, including payment rates established by regulation.**

**To the extent any other provision of the solicitation or proposal conflicts with the requirements set forth in Section 4, above, the requirements of Section 4 shall govern.**

## 5. Provider Selection Process

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
2. Corporate Qualifications and Experience
3. Experience and Qualifications of Proposed Staff

For each region, the committee will evaluate each 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 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 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, the provider with the highest ranked proposal will be selected to provide the services detailed in this solicitation.

Providers will be selected for four regions, divided as follows:

Western Region - Allegany, Carroll, Frederick, Garrett, Howard & Washington Counties

Northern Region - Anne Arundel, Baltimore City, Baltimore & Harford Counties

Eastern Region - Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico & Worcester Counties

Southern Region - Calvert, Charles, Montgomery, Prince George's & Saint Mary's Counties

### Pre-Submission Processes

#### 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 Kevin Patterson at (410) 767-4003 no later than 3pm on August 14, 2009 to provide notice of the anticipated number of individuals who will attend, as well as to provide an acknowledgement of receipt of the RFP. Any individual interested in attending the pre-proposal conference who is in need of an accommodation due to his or her disability should contact the Issuing Office a minimum of five working days prior to the conference to request the necessary accommodation.

### **Questions and Inquiries**

Questions may be submitted in writing to the Issuing Office 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.

### **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.

### **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 RFP.

### **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.

## 6. Proposal Submission Guidelines

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

Kevin Patterson  
Living at Home Waiver Division  
201 W. Preston Street, Room 121 B  
Baltimore, MD 21201  
(410) 767-5696

**Deadline for receipt of proposals: August 28, 2009 at 3:00pm EST.**

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

**Offerors may not submit multiple proposals for evaluation. Only a single proposal from a given offeror will be evaluated in each region. A single proposal may be offered for one or more regions. All complete proposals received for a given region will be evaluated for that region and the highest ranked proposal for that region will be selected. An offeror with a proposal to provide case management statewide could receive an award in one or more regions.**

### Components of a Complete Proposal

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.

Each proposal must contain:

- A. A cover page that includes:
  - a. Name of the offering organization;
  - b. Address of the offering organization;
  - c. Contact information for correspondence related to the proposal;
  - d. Title of the solicitation, "Comprehensive Case Management Services for the Living at Home Waiver";
  - e. 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.*

- f. The date of submission.
- B. A Proposed Work Plan that affirmatively addresses how the offeror proposes to perform all duties described in the solicitation.
- C. In proposals covering multiple regions, a Proposed Work Plan that clearly identifies 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:
  - a. Specifically explains how the organization meets each of the Minimum Qualifications;
  - b. Explains the extent to which the organization meets the Highly Desirable Qualifications;
  - c. Identifies programs for which the organization has provided case management including:
    - i. The scope of services provided;
    - ii. The types of individuals served; and
    - iii. Internal program monitoring activities.
- E. A section describing the Experience and Qualifications of Proposed Staff, including:
  - a. A list of proposed staff and their proposed roles;
  - b. 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. A list of at least three (3) professional references that include:
  - a. Name of reference;
  - b. Organization of reference;
  - c. Phone number and email address of reference.
- G. A complete and signed Acknowledgement of Requirements and Responsibilities form (see below).

## 7. Acknowledgement of Requirements 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 ]

### 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 the attached form COT/GAD X-10 Vendor Electronic Funds (EFT) Registration Request Form (Appendix B). 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.

### Acknowledgement of Provider Agreement

By submitting a response to this solicitation, the offeror agrees to perform all duties and comply with all requirements identified and referenced in Section 4. Requirements (above). 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 Services for the Living at Home Waiver".

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(Signature)

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Date