Maryland Department of Health
Office of Long Term Services and Supports
Provider Solicitation - Request for Responses

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

April 1, 2021 - December 31, 2021

Option #1: January 1, 2022 to December 31, 2022
Option #2: January 1, 2023 to December 31, 2023
Option #3: January 1, 2024 to December 31, 2024

Solicitation Summary

Description of Services
The Office of Long Term Services and Support within the Maryland Department of Health (the Department) is soliciting responses from qualified providers to provide case management and supports planning services to participants of the Community Personal Assistance Services (CPAS), Community First Choice (CFC), Home and Community-Based Options Waiver (HCBOW) and Increased Community Services (ICS) programs. Supports planning services consist largely of assisting applicants and participants with accessing Medicaid and non-Medicaid home and community-based services (HCBS) and supports. Case management services also include assisting applicants and participants with waiver eligibility determination and maintenance. The Department has applied for waivers under § 1915(b)(4) of the Social Security Act (SSA) in order to engage in selective contracting for the services described in this Solicitation. The current rate for these services is posted on the Department's website: https://mmcp.health.maryland.gov/MCOupdates/Pages/Home.aspx; however, the rate for these services is subject to change during the term of this Agreement.

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 and Washington Counties
2. Northern Region - Baltimore City, Baltimore and Harford Counties
3. Eastern Region - Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico and Worcester Counties
4. Southern Region - Anne Arundel, Calvert, Charles, Prince George's and St. Mary's Counties
5. Baltimore City
6. Baltimore County
7. Montgomery County
8. Prince George's County

Provider Agreement Term
The initial term of this Agreement is April 1, 2021 through December 31, 2021. The three additional option periods are as follows:

1. January 1, 2022 to December 31, 2022
2. January 1, 2023 to December 31, 2023
3. January 1, 2024 to December 31, 2024

Solicitation Point of Contact
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Deadline for Receipt of Proposal: February 1, 2021

Pre-Proposal Conference: January 6, 2021

Section 1. General Information

1.1. Relevant Acronyms, Terms and Definitions

For purposes of this request for proposals (RFP), the following abbreviations or terms have the meanings indicated below:

A. Aging and Disability Resource Center (ADRC) - This program is a collaborative effort of the Administration on Aging and the Centers for Medicare and Medicaid Services. ADRCs serve as single points of entry into the long term services and supports system for older adults and people with disabilities.

B. Area Agency on Aging (AAA) - Area Agencies on Aging address the concerns of older adults at the local level by identifying needs and assuring that supports are made available to older people in the communities in which they live.

C. Centers for Medicare and Medicaid Services (CMS) - The federal agency that administers Medicare, Medicaid and the Children's Health Insurance Program, including the Money Follows the Person Demonstration grants.

D. Code of Maryland Regulations (COMAR) - The Code of Maryland Regulations, often referred to as COMAR, is the official compilation of all administrative regulations issued by agencies of the state of Maryland. COMAR is available on-line at www.dsd.state.md.us.

E. Community First Choice (CFC) - A program created by Section 2401 of the Affordable Care Act (ACA) 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. Services are provided in the eligible individual's home or community residence.

F. Community Personal Assistance Services (CPAS) - A program that offers certain

community-based services to individuals who meet the required level of care. Services are provided in the eligible individual's home or community residence.

G. Conflict of Interest - Any real or perceived incompatibility between an agency or agency employee's private interests and the duties of this Solicitation.

H. Eligibility Determination Division (EDD) - The Division within MDH that is responsible for determining waiver financial eligibility.

I. Home and Community-Based Options Waiver (HCBOW) - A § 1915(c) waiver that became effective January 6, 2014 and serves adults aged 18 years and older who meet a nursing facility level of care.

J. Home and Community-Based Services (HCBS) - An array of supports provided to individuals living in the community to assist in activities of daily living (ADL).

K. Increased Community Services (ICS) - A program included in the Department's 1115 waiver that allows individuals residing in institutions with incomes above 300% of Supplemental Security Income (SSI) to move into the community while also permitting them to keep income up to 300% of SSI. 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.

L. In-home Support Assurance System (ISAS) - A phone-based Integrated Voice Response (IVR) system that personal assistance providers use to log their time. The system will generate claims daily based on services provided.

M. Local Health Department (LHD) - Local health departments administer and enforce state, county and municipal health laws, regulations and programs in Maryland's 23 counties and Baltimore City and are overseen by the Public Health Services of the Department.

N. Local Time - Time in the Eastern Time Zone as observed by the State of Maryland.

O. LTSS*Maryland* - The Health Information Technology solution used by the Department, its agents, providers and program participants to participate in and conduct care management, maintain records and perform billing activities in a variety of Maryland Medical Assistance's HCBS programs.

P. Maryland Access Point (MAP) - Maryland's ADRCs are called MAP sites and serve as Maryland's single point of entry to long-term supports and services.

Q. Maryland Department of Aging (MDoA) - Maryland's State Unit on Aging designated to manage, design and advocate for benefits, programs and services for older adults and their families. MDoA administers the Older Americans Act and the ADRCs initiative in partnership with

the local AAAs.

R. Maryland Department of Disabilities (MDoD) - Authorized by Senate Bill 188 in 2004, MDoD is charged with unifying and improving the delivery of services to people with disabilities by working collaboratively with all state agencies. MDoD develops and facilitates the implementation of the State Disabilities Plan, calling for collaborative partnerships with state agencies to improve services for people with disabilities.

S. Medicaid/Medical Assistance - A program, jointly funded by the federal and state governments, which pays for medical care for low-income individuals and families, as well as older adults and individuals with disabilities. To receive Medicaid, an individual must go through an application process and meet certain financial requirements.

T. Medicaid State Plan - A written agreement 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 CMS.

U. Money Follows the Individual (MFI) - This policy allows individuals, who reside in institutions and whose services are being funded by Medicaid, to apply for a waiver program regardless of budgetary caps.

V. Money Follows the Person (MFP) - A demonstration authorized by the Deficit Reduction Act of 2005 and extended through the Affordable Care Act of 2010 offered through CMS as an opportunity for states to rebalance long-term care systems.

W. Normal State Business Hours - The hours of 8:00 a.m. – 5:00 p.m., Monday through Friday except state holidays, which can be found at www.dbm.maryland.gov.

X. Reportable Event (RE) - An allegation or actual occurrence of an incident that adversely affects or has the potential to adversely affect the health and/or welfare of an individual.

1.2. Philosophy

Medicaid's HCBS programs are based on a philosophy of self-direction, in which participants are empowered to make choices that work best for them regardless of the nature or extent of their disability. Self-direction of services means that participants, or their representatives if applicable, have decision-making authority over certain services and take direct responsibility for managing their services with the assistance of a system of available supports. Self-direction allows participants the opportunity to manage aspects of service delivery as part of the person-centered planning process. Self-direction promotes choice and control over the delivery of waiver and state plan services, including who provides the services and how the services are provided. A supports planning provider assists applicants and participants in understanding their self-direction options, maximizing their choice and control, creating a person-centered plan of service (POS), goal setting and coordinating services based on individual needs and choices.

1.3. Background

Providers identified through this Solicitation will provide supports planning services to applicants and participants of the CPAS, CFC, HCBOW and ICS programs. In addition, the providers will provide waiver case management services to HCBOW participants to assist them in the annual redetermination process. Providers will 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 will support applicants in accessing housing services, identifying housing barriers such as past credit issues, evictions or convictions and in resolving the identified barriers. The providers will assist individuals referred by the Department in developing comprehensive POS that include both state and local 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.health.maryland.gov/longtermcare/Pages/Supports-Planning-Resource-Guide.aspx.

Community Personal Assistance Services (CPAS)

The CPAS program serves individuals who are medically, technically and financially eligible and is governed by COMAR 10.09.20. Under the Medicaid State Plan, the CPAS program provides personal assistance services in an individual's home or community residence. Unlike the CFC program, which also provides personal assistance, the CPAS program does not require an institutional level of care.

Community First Choice Program (CFC)

The CFC program serves individuals who are medically, technically and financially eligible and is

governed by COMAR 10.09.84. Section 2401 of the Affordable Care Act (ACA) created the CFC program, 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. The CFC program offers personal assistance, home delivered meals, personal emergency response systems (PERS), consumer training, transition services, environmental assessments, accessibility adaptations and services that increase independence or substitute for human assistance. Under the Medicaid State Plan, these services are available to waiver and non-waiver participants.

The CPAS and CFC programs do not have an age requirement for participation or a cost neutrality limitation.

Home and Community-Based Options Waiver (HCBOW)

The HCBOW serves individuals who are medically, technically and financially eligible for Medicaid waiver services that have been transitioned or diverted from a nursing facility and is governed by COMAR 10.09.54. Eligible individuals must be 18 years of age or older, require a nursing facility level of care, choose to receive services in the community versus a nursing facility and have a cost neutral POS that safely supports the individual in the community. This waiver offers assisted living, senior center plus, family training, behavioral consultation and case management services. Participants in this waiver are also eligible to receive services through the CFC program and many participants receive personal assistance, nurse monitoring and other services through joint participation in the HCBOW and CFC.

Increased Community Services (ICS)

The ICS program serves individuals who are medically, technically and financially eligible and is governed by COMAR 10.09.81. The ICS program serves individuals residing in institutions with incomes above 300% of Supplemental Security Income (SSI) to transition into the community while also permitting them to keep income up to 300% of SSI. The ICS program is part of the Department's 1115 waiver and is currently capped at 100 individuals. Eligible individuals must be 18 years of age or older and reside (and have resided for a period of not less than 90 consecutive days) in a nursing facility. An individual's care, while receiving services in the community, may not cost the Medicaid Program more than the individual's care in the nursing facility. Individuals that are financially over scale for HCBOW will be given the opportunity to apply for ICS by the Department. Participants in the Increased Community Services (ICS) Program receive the same services as the Home and Community-Based Options 1915(c) waiver and may be eligible to receive Community First Choice Services if living in a community setting.

Waiver Registry

The HCBOW has a certain number of slots available to serve individuals in the community. As the program reached capacity in 2003, the Department maintains a waiver registry for individuals who are interested in applying for waiver services. Maryland's MFI policy allows individuals who

reside in nursing facilities and whose services are being funded by Medicaid to apply for the HCBOW regardless of registry status. Given that CFC and CPAS operate under the Medicaid State Plan, there is no cap on enrollment; thus, registries do not need to be maintained for these programs. The ICS program has not reached capacity; thus, a registry is not needed at this time. The Department makes no assurances to the number of future participants and enrollment capacity.

Program Applicants and Participants

The Department receives over 3,000 community referrals for HCBS services each year. Currently, there are over 14,000 participants in the CPAS, CFC, HCBOW and ICS programs. Total program participation for these programs increased by approximately 1,400 people in the last year. The Department anticipates that approximately 500 individuals will apply for the HCBOW from the registry each year for the duration of this Agreement. Approximately 950 nursing facility residents apply for waiver services each year and approximately one-third of those applicants successfully transition and become HCBOW participants. Please see Appendix 1 for data regarding the number of participants per program and region. The Department makes no representations or assurances as to the number of future participants and the current numbers are provided solely for illustrative purposes.

Money Follows the Person (MFP)

Maryland's MFP Demonstration is a grant designed to rebalance long-term care systems to increase HCBS 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 MFP Operational Protocol, a document developed in cooperation with stakeholders and required by CMS. The Operational Protocol is available online at https://mmcp.health.maryland.gov/longtermcare/MFP%20BIP/MFP%20Protocols/MFP%20Operational%20Protocol%20%202017.pdf or by request via email to LTCReform@maryland.gov.

To be eligible for the MFP Demonstration, individuals must have resided in an institution for at least 90 continuous days, with Medicaid paying for their institutional stay at least one day prior to their transition. Individuals must also move to a qualified residence in the community; assisted living facilities (ALFs) licensed to serve more than four (4) individuals are excluded. Many CFC and waiver applicants will also be eligible to participate in the MFP Demonstration.

LTSS*Maryland*

The Department maintains a web-based tracking system for many long-term supports and services. This system tracks all CPAS, CFC and waiver activities and is called LTSS*Maryland*.

Supports planning providers will be required to use this system to document activities, complete required forms and submit RE.

In-Home Supports Assurance System (ISAS)

The Department maintains a call-in system used by personal assistance workers to confirm their presence in the participant's home called ISAS. Workers must call in to create an electronic timesheet for billing. The call must be initiated from the participant's phone number, which is associated with the participant's record in LTSS*Maryland*. Participants who do not have a phone will be assigned a one-time password (OTP) device. This keychain-sized device has an electronic password that changes every minute. The worker must enter the password from this device when calling in to ISAS to verify the presence of the participant. Supports planners will be responsible for training and providing information to participants on the use of ISAS, assigning and delivering OTP devices to participants and reviewing monthly ISAS claims with the participant to ensure service delivery and verify accurate billing.

Freedom of Choice of Providers

Applicants and participants of the CPAS, CFC and waiver programs have freedom of choice of eligible case management and supports planning providers. Current providers and regions of service are included in Appendix 2. The Department limits the available providers through this application process and its § 1915(b)(4) waiver application in order to ensure that providers meet enhanced quality standards and are subject to additional oversight by the Department. The local AAAs are designated waiver case management providers and are eligible supports planning providers. Eligible providers of CPAS 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 all eligible case management and supports planning providers available in the applicant's area. The applicant may choose a provider by contacting the Department or the chosen provider directly. This choice will be made in LTSS*Maryland*. Applicants and participants who do not choose a provider within 21 days of receipt of the provider information packet will be auto assigned to a provider via LTSS*Maryland* 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 the participant chooses a provider, the 45-day limitation described below will apply.

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 applicant/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 provider chooses a new provider on January 1, the change would be effective on January 15. The participant is not eligible to request another change in provider until March 1.

Person-Centered Planning (PCP)

The PCP process is essential to assure that the participant's personal strengths, goals, risks and preferences are incorporated into service planning and reflected on the POS. Providers of case management and supports planning services must engage every applicant and participant in a PCP 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 CPAS and CFC services at any time. Individuals who reside in the community may only apply for the HCBOW as capacity allows and upon receiving an invitation to apply from the waiver registry.

For applicants to the CPAS or CFC programs, the application process begins with contact to the Department or the local MAP site and completion of an assessment by the LHD. The Department will provide applicants with a packet of materials that includes brochures from all eligible supports planning providers at the time of referral. For individuals who are invited to apply for the HCBOW from the registry, the Department will provide this packet of materials when the invitation to apply is sent. The applicant may choose a provider by contacting the Department or the chosen provider directly. This choice will be noted in LTSS*Maryland*. If a provider is not selected within 21 calendar days after the packet of materials is sent to the applicant, a provider will be auto-assigned.

When an applicant is initially assigned to a provider, the provider will be alerted via LTSS*Maryland* and shall plan to meet with the applicant within 14 calendar days. When coordinating the initial meeting, all proper accommodations shall be discussed and arranged for upon request of the applicant. At the initial meeting, the provider will provide detailed information about the programs, including program eligibility and services offered. CPAS and CFC do not require additional financial eligibility determinations beyond eligibility for community Medical Assistance, therefore no application packet is needed.

Applicants to HCBOW will receive assistance from the provider in completing the waiver application. Assistance to complete the waiver application includes gathering supporting documentation and 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 EDD, the entity that determines financial eligibility. The provider will complete and submit the waiver application with the referred individual within five (5) business days of the initial meeting. The submission of the waiver application in LTSS*Maryland* is required to enable the applicant to move forward in the process.

Application Assistance for Applicants in a Nursing Facility

Options Counselors funded through the MFP Demonstration will assist nursing facility residents with accessing services and completing any required applications. MFP Options Counselors will inform residents of their service options in the community, including eligible case management and supports planning providers. For nursing facility residents with community Medical Assistance, the MFP Options Counselor will make a referral to the LHD for an assessment. For individuals with long term care Medical Assistance, the MFP Options Counselor will complete and submit a waiver application to EDD through LTSS*Maryland*, which will trigger a referral to the LHD for an assessment.

Coordination of Medical Eligibility Determination

All applicants will be assessed for medical eligibility for the CPAS, CFC, HCBOW and ICS programs by the LHD. All referrals to the LHD for the assessment will be made via LTSS*Maryland*. For individuals interested in CPAS or CFC services, the Department or the local MAP site will complete a referral for the medical eligibility determination. For community waiver applicants, the completion of the waiver application by the supports planning provider in LTSS*Maryland* will create the referral. For nursing facility residents, the MFP Options Counselor will complete the referral to the LHD for the medical eligibility determination in LTSS*Maryland*.

The LHD will complete a comprehensive evaluation to determine if the individual meets the medical eligibility criteria for the programs (CPAS, CFC, HCBOW, ICS). The interRAI Home Care (HC) and interRAI Pediatric HC assessments are used to determine medical eligibility for the programs. The LHD will also create a recommended plan of care (POC) based on the assessment, which provides the services and supports that are recommended to ensure the individual's health and welfare in the community. The LHD will complete the assessment in LTSS*Maryland* within 15 calendar days of the referral. The supports planning provider will coordinate with the LHD to ensure that the assessment and recommended POC are completed.

Developing a POS

If the individual is determined to be medically eligible for the programs, the supports planning provider will meet with the applicant to develop a POS. The POS should include all services and supports that address the applicant's medical, social, educational, employment/vocational, psychological, access to effective communication and culturally and linguistically competent

staffing, and other needs. Each plan should include specific strengths, goals, action steps and risks, as well as the requested Medicaid and non-Medicaid services (e.g., community and faith-based services, donated items) and their associated providers. The provider will submit the initial POS to the Department for review within 20 calendar days of completion of the assessment by the LHD. The POS for a waiver program must be cost neutral, meaning the services provided in the community cannot exceed the cost of institutional services. The cost of institutional services is determined annually by the Department. If the POS is denied due to exceeding 125% of the cost neutrality standard, the applicant may choose to revise the quantity or type of service(s) outlined in the plan in order to meet the cost neutrality requirement. The revised POS will then be submitted to the Department for reevaluation.

Developing a Plan for Applicants Transitioning from a Nursing Facility

If an applicant is transitioning from a nursing facility to the community, the supports planning provider will assess the applicant's need for all items that are necessary to fully support the transition, including accessible housing, common household items and furniture. Transition items should be included in the POS as transition services under the CFC program. If the applicant does not have a community residence identified, the provider will share information about available housing supports, including subsidized housing and homeownership programs such as the Housing Choice Voucher program, Section 811 Project Rental Assistance (PRA), permanent supportive housing and other affordable housing opportunities. The provider will also assist the applicant in identifying and overcoming potential housing barriers such as accessibility, affordability and past credit issues, evictions or convictions.

Once the POS is approved by the Department and the applicant has secured community housing, the provider will work with the applicant to identify a transition date, coordinate access to the identified community services and supports in the POS; including identifying providers of Medicaid services and coordinating payment through the transition funds provider to secure needed goods and services, and facilitate a smooth transition to the community. The provider will also coordinate the day of transition, ensuring that service providers are scheduled and that essential goods, such as medications, Disposable Medical Supplies (DMS)/Durable Medical Equipment (DME), furniture and common household items have been delivered and are available to the applicant. Transition funds through the CFC program and MFP flexible funds can be administered via the transition funds provider up to 60-calendar days post transition.

Continuing Application for Applicants in a Nursing Facility

Applicants in nursing facilities who do not transition to the community within six (6) months of 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 will meet with the applicant at least one (1) month prior to the six (6) month expiration date to inquire about the applicant's interest in reapplying. If the applicant is interested in reapplying,

the provider will assist the applicant with completing a new waiver application and FOC Form, indicating the applicant's choice to receive services in the community and submit the information to EDD as noted above. Upon submission of the waiver application in LTSS*Maryland,* the provider will verify the accuracy of the most recent interRAI assessment. If the applicant has experienced a significant change in health and/or functioning since the previous assessment, the provider will alert the LHD that another assessment is needed. If needed, the provider will also update the POS. If the individual is not interested in reapplying, the provider will complete a new FOC Form indicating the person's choice to remain in the nursing facility and submit the FOC Form to EDD. The provider must ensure that the applicant meets all financial, medical and technical eligibility requirements prior to transition.

Ongoing Supports Planning

Once an individual transitions to the community and/or is enrolled in CPAS, CFC or a waiver program, the supports planning provider will contact the 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. Unless otherwise specified by the Department, the provider will meet with the participant in-person at least once every 90 days, in the community where the participant receives services to monitor the implementation of the POS and identify any unmet needs. If the participant needs or requests a change to the POS, the provider will follow the Department's guidance regarding the submission of a revised POS and assist the participant in changing his or her services.

Ongoing supports planning responsibilities include monitoring the quality of services and supports provided and monitoring the participant's health and welfare in the community, including compliance with the Department's RE Policy. The provider will also review ISAS reports to ensure services are being provided in a manner consistent with the POS.

Continuing Participant Eligibility

The supports planning provider will verify the participant's Medicaid eligibility monthly via LTSS*Maryland*. For waiver participants, EDD will verify the participant has continued financial eligibility on an annual basis. The provider will be responsible for ensuring that there is no lapse in eligibility and that each redetermination process is completed on an annual basis. The provider will monitor the redetermination time frames, initiate actions for each redetermination process and notify the Department of any barriers.

For technical and medical redeterminations, the provider will monitor the completion of the assessment by the LHD, which is triggered 10 months after the last assessment (60 calendar days prior to the annual anniversary of the last assessment). Upon completion of the assessment and recommended POC, the provider will develop the annual POS with the participant and submit the POS to the Department at least 30 calendar days prior to the expiration of eligibility.

For financial redeterminations required for waiver participants, the provider will monitor annual redetermination dates, meet with the waiver 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 (LDSS) for CPAS 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 providers under this Solicitation. Providers must include in their response to this Solicitation a concise description of how these requirements are met by the organization or agency and provide relevant materials or document samples that demonstrate the required experience and capabilities.

2.1.1. At least two (2) years of experience providing community-based case management services and/or supports planning for individuals with complex medical and/or behavioral health needs, older adults and/or adults, children and youth with disabilities beyond those ancillary to the provision of other services.

2.1.2. Knowledge of resources available for individuals with complex medical and/or behavioral health needs, older adults and/or adults, children and youth with disabilities. These resources may include private, public, non-profit, local, regional and national entities.

2.1.3. At least two (2) years of experience working with Medical Assistance programs, including Managed Care Organizations (MCOs).

2.1.4. At least two (2) years of experience working with Medicare and/or private insurance programs in conjunction with Medical Assistance programs.

2.1.5. Freedom from any conflicts of interest as defined in this Solicitation.

2.1.6. Linguistic competency, including, at a minimum, standard operating procedures that demonstrate compliance with the Department's Limited English Proficiency (LEP) Policy and a scope of work from an interpretation and translation services vendor.

2.2. Highly Desirable Qualifications

The following qualifications are considered highly desirable. If applicable, providers should describe in their response to this Solicitation how these qualifications are met by the organization

or agency and provide relevant materials or documentation that demonstrates the experience and/or capabilities.

2.2.1. Experience transitioning older adults and/or individuals with disabilities from institutions to independent housing in the community.

2.2.2. Experience with the PCP process and/or case management in the context of programs, which operate under a philosophy of self-direction.

2.2.3. Competence in communicating with individuals in alternate formats; for example, written materials in large print, digital communication, infographics and/or the use of assistive technology, including TeleTypewriter (TTY)/Telecommunications Relay Services (TRS) and qualified sign language interpreters.

2.2.4. Coordination with other organizations and/or programs that serve individuals with complex medical and/or behavioral health needs, older adults and/or adults, children and youth with disabilities in community-based settings.

2.2.5. Knowledge of other programs that serve individuals with intellectual and/or developmental disabilities, traumatic brain injury or behavioral health conditions, including mental illness and substance use disorders.

2.2.6. Competence in working with culturally, racially, ethnically and religiously diverse populations.

2.2.7. Competence in working with low-income populations, including individuals experiencing homelessness.

Section 3. Provider Agreement

By submitting a proposal for this Solicitation, the provider agrees to comply with all requirements noted in this Solicitation, as well as those noted in the Medicaid Provider Agreement. The provider also agrees to comply with all applicable regulations, specifically COMAR 10.09.20, 36, 54, 81 and 84 and all applicable CPAS, CFC, HCBOW and ICS program policies.

The Department may terminate this Agreement at any time by notifying the provider in writing. The provider may terminate this Agreement no less than six (6) months (180 calendar days) from the end of this Agreement by providing written notice to the Department and submitting a transition plan that clearly describes how participants will be assisted regarding the selection of a new provider, transition of files and other data in a Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant manner and the reason for termination.

3.1. Administration, Record Keeping and Management

The provider shall:

3.1.1. Enroll as a Medicaid provider;

3.1.2. Identify and remediate all potential conflicts of interest, including:

A. Disclose other services provided by the agency, specifically other long term services and supports or Medicaid-funded services,

B. Develop and implement a conflict monitoring strategy to ensure applicants and participants receive conflict-free case management and have freedom of choice of any willing provider,

C. Submit a conflict management plan to the Department as part of the work plan required under this Solicitation, which must be approved prior to services being rendered. The plan must include the process by which conflicts identified through the above strategy will be remediated and the timeframes for doing so, and

D. Submit reports on conflict monitoring and remediation efforts to the Department on January 1st, April 1st, July 1st and October 1st of each calendar year;

3.1.3. 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;

3.1.4. Establish and maintain a toll-free phone number. A representative of the provider shall be available between the hours of 8:00 a.m. and 5:00 p.m. Monday through Friday, excluding state holidays;

3.1.5. Return all routine, non-emergency calls within one (1) business day from the time the message is recorded;

3.1.6. Accommodate reasonable date, time and location preferences for the applicants and participants served under this Agreement. Similar accommodations should be made for individuals supporting applicants and participants, including family members, friends, legal guardians, authorized representatives and others as identified by the applicant/participant;

3.1.7. Accommodate all requests for accessible communications, including written materials in large print, digital communication, infographics various languages, and/or the use of assistive technology, including TeleTypewriter (TTY)/Telecommunications Relay Services (TRS) and qualified sign language interpreters;

A. Submit an Interpretation and Translation Services Utilization Report to the Department on January 1st, April 1st, July 1st and October 1st of each calendar year.

3.1.8. Establish and maintain clear channels for communication with applicants, participants, other providers and the Department in order to effectively answer questions, resolve problems and exchange information;

3.1.9. Operate, at a minimum, a 28.8 speed fax machine 24 hours each day;

3.1.10. Provide access to a computer, with internet connection and individual email addresses

for all supports planners:

A. Ensure that any provider-owned systems and devices responsible for sending, retrieving or storing data from a system owned by the Department are in compliance with the State of Maryland Information Security Policies and guidance published by the Department of Information Technology;

3.1.11. Ensure compliance with HIPAA in the use, storage and transportation of data, including:

A. Take measures to prudently safeguard and protect unauthorized disclosure of applicant and participant information in the provider's possession,

B. Maintain confidentiality of all applicant/participant records and transactions in accordance with all federal and state laws and regulations, and

C. Not disseminate or use Personally Identifiable Information (PII) or Protected Health Information (PHI) outside of their duties as a covered entity;

3.1.12. Develop and implement an effective disaster recovery plan for restoring software, master files and hardware if information management systems are disabled, which includes the timeframe anticipated to restore all functions;

3.1.13. Establish and maintain the ability to transmit data to the Department utilizing, at minimum, Microsoft Office 2007 or later;

3.1.14. Distribute all regulations, policies and procedures to the appropriate staff;

3.1.15. Develop a relationship and communication channel with the local MAP site and LHD in order to better coordinate supports and center the applicant/participant in the delivery of services;

3.1.16. Complete all required documentation in LTSS*Maryland* or other systems as requested by the Department. This documentation includes, but is not limited to:

A. Case management and/or supports planning activities that are eligible for payment. Activities should be entered with enough descriptive text to justify the activity,

B. All contacts with the applicant/participant, including the date, type, length, substance, outcome and an accurate and clear narration of events,

C. Monthly contact forms,

D. Completion and submission of provisional, initial, annual and revised POS, and

E. Maintenance of the applicant/participant record, including current address, phone numbers and other contact information;

3.1.17. Establish and maintain individual applicant/participant files in accordance with applicable COMAR;

3.1.18. Ensure applicant/participant files maintained outside of LTSS*Maryland* are available for immediate review by state or federal auditors;

3.1.19. Retain applicant/participant files for six (6) years from the end date of this Agreement;

3.1.20. Maintain an accurate and current staff directory and update the directory with any staffing changes within five (5) business days of the change;

3.1.21. Cooperate fully with federal and state inspections, reviews and audits; and

3.1.22. Develop, reproduce and supply sufficient Department-approved agency outreach materials for applicants and participants.

3.2. Staffing and Training

The provider shall:

3.2.1. Hire at least one (1) program manager and at least one (1) supervisor or lead worker to support the daily operations of supports planning and case management;

3.2.2. Hire supports planners who meet the following minimum qualifications:

A. Bachelor's degree in a human services field, including psychology, social work, sociology, nursing, counseling, sociology or a related field, or

B. Work experience pertaining to case management for individuals with complex medical and/or behavioral health needs, older adults and/or adults, children and youth with 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;

3.2.3. Hire and train a sufficient number of supports planners to maintain a staff such that the minimum case ratio is one (1) supports planner to 20 applicants/participant and the maximum case ratio is one (1) supports planner to 55 applicants/participants;

3.2.4. Provide an alternate supports planner, who is familiar with the applicant/participant's needs, to act on behalf of the assigned supports planner if the assigned supports planner is unavailable. Applicants/participants must be notified within 24 hours regarding a change in supports planner if a qualified alternate supports planner is not available;

3.2.5. Conduct a background check through Maryland Criminal Justice Information Systems (CJIS) for all supports planning and other direct service staff to ensure that they do not have a history of behavior that could potentially harm applicants/participants or convictions relating to the abuse, neglect and/or exploitation of vulnerable populations;

3.2.6. Establish and maintain access to a licensed registered nurse (RN) to review POS for health and welfare concerns, review other providers' progress notes, and advise supports planners on the complex medical and/or behavioral health needs of applicants/participants and to conduct visits if concerns arise. The RN shall have experience in psychiatric nursing, intellectual and/or developmental disabilities and substance use disorders;

3.2.7. Establish and maintain access to a licensed clinician with education and training in a behavioral health discipline (e.g., LGSW, LCSW, LCSW-C, LGPC, LCPC). The licensed clinician shall have experience working with individuals with mental illness and/or substance use disorders, individuals with a traumatic brain injury and/or individuals with an intellectual and/or developmental disability;

3.2.8. Submit to the Department for approval, staffing standards and qualifications for all roles to ensure adequate education, training and/or experience;

3.2.9. Develop and submit to the Department for approval, a training plan that includes a process for evaluating the competency of staff and efficacy of the training;

3.2.10. Develop and submit to the Department for approval, in electronic format or other format as requested by the Department, a supports planning training manual within 30 days of award. The training manual should include:

A. Applicable regulations, including but not limited to: COMAR 10.09.20, 36, 54, 81 and 84,
B. CPAS, CFC, HCBOW and ICS program eligibility and service offerings,
C. Self-direction philosophy, PCP and applicant/participant empowerment,
D. Identifying and reporting abuse, neglect and/or exploitation and the RE Policy,
E. Fair Hearing and Appeal Rights,
F. Applicant/Participant letters and forms,
G. Provider applications and service forms,
H. Train all staff members registered as system users on proper protocols for conducting system activities, including training for accurate entry of information into LTSS*Maryland*,
I. Strategies for de-escalation and appropriate crisis intervention,
J. All applicable federal and state regulations pertaining to privacy and confidentiality,
K. Community-based service delivery and harm reduction philosophy,
L. Guardianship and other forms of legal representation,
M. Medical Assistance Program, Managed Care Organizations and waivers, and
N. Community-based resources, including housing options, disability-specific resources, aging resources, behavioral health resources, assistive technology, medical equipment and supplies and other local resources;
O. Reasonable Accommodation Policy and Procedures

3.2.11. Provide training to all supports planners in accordance with the approved training manual above upon hire and at least annually thereafter;

3.2.12. Ensure that all supports planners attend the Department's training for new supports planners within 90 days of hire or at the first available training session offered by the Department if no training is offered within those 90 days. This training must be completed prior to the supports planner rendering services;

A. Ensure all applicable staff attend all scheduled meetings and/or training convened by the Department. Training is typically less than one (1) session per month, but may increase in frequency during programmatic changes and/or updates to LTSS*Maryland.*

3.3. Self-Direction and PCP

The CPAS, CFC, HCBOW and ICS programs support the philosophy of self-direction and PCP and self-determination, including the applicant/participant's option to waive all but the annual supports planning and semi-annual nurse monitoring visits. A PCP process is required for the POS development. The process includes selecting and organizing the services and support preferences for applicants/participants who need assistance in making informed choices to live in the community.

The provider shall:

3.3.1. Accept training from the Department, or its designee on self-direction and PCP;

3.3.2. Assist the participant in determining the degree of self-direction in which he or she would like to participate and document the participant's choice in LTSS*Maryland*;

3.3.3. Engage in a PCP process with the applicant/participant and representatives of his or her choice that addresses the requested long term services and supports in a manner that reflects his or her individual preferences and goals;

3.3.4. Assist the participant in learning skills necessary to increase his or her degree of self-direction as requested by the participant. Assistance may include training on LTSS*Maryland*, PCP, goal setting and/or POS development;

3.3.5. Assist participants in accessing MyLTSS, the participant portal, upon their request and provide training on using the system;

3.3.6. Assist participants in generating reports and using service data to manage their services and providers via MyLTSS, including reviewing and resolving services by the participant in MyLTSS through the submission of an RE;

3.3.7. Complete a PCP with identified strengths, goals and preferences, including those related to community participation, employment, income and savings, health care and wellness, education and others; and

3.3.8. Complete a PCP that reflects the requested services and supports (paid and unpaid) and the providers of those services and supports.

3.4. Money Follows the Person

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

3.4.1. 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, and

D. Freely chooses to sign the MFP Consent Form;

3.4.2. Document MFP eligibility verification on the MFP questionnaire in LTSS*Maryland*;

3.4.3. Obtain the applicant's signature on the MFP Consent Form and submit the form with an original signature to the Department within two (2) business days of completion;

3.4.4. Ensure MFP eligibility criteria will be met prior to transition and that the MFP questionnaire is accurate and submitted in LTSS*Maryland* prior to transition;

3.4.5. 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;

3.4.6. Obtain and upload to LTSS*Maryland* any receipts or documentation related to the expenditure of MFP flexible funds; and

3.4.7. Update the MFP questionnaire upon transition to assure the correct MFP eligibility status is reflected in LTSS*Maryland* at the time of transition.

3.5. Supports Planning Services

The provider shall:

3.5.1. Accept all referrals from the Department in LTSS*Maryland*;

3.5.2. Accept all self-referrals from applicants and participants;

3.5.3. Document the referral and provider selection in LTSS*Maryland*;

3.5.4. Establish contact and perform an initial visit with the referred applicant or participant within 14 calendar days of receipt of the referral:

A. If an applicant or his or her representative cannot be successfully contacted after 30 days from the referral, a certified letter must be mailed to the applicant and his or her representative,

B. If an applicant or his or her representative cannot be successfully contacted after 45 days from the referral, a home visit must be attempted, and

C. If an applicant or his or her representative cannot be contacted after 90 days from the referral, the case can be referred to the Department for closure;

3.5.5. For community waiver applicants applying from the registry:

A. Provide assistance with completing a waiver application within 14 calendar days of Departmental referral or selection of a supports planning provider indicated by an alert in LTSS*Maryland*,

A. Verify waiver technical eligibility requirements, including age and residency,

B. Assist the individual in obtaining supporting documentation, such as a birth certificate or bank statements, as required for an application,

C. Secure signatures from the individual, his or her guardian or other legal representative and others as needed to complete the application,

D. Submit the signed waiver application and consent for waiver services to the Department within five (5) business days of the initial meeting with the applicant,

E. Retain copies of completed applications and documentation, and

F. Document application assistance and all related activities in LTSS*Maryland*. This documentation generates a referral to the LHD for a medical eligibility determination;

3.5.6. Monitor LTSS*Maryland* for completion of the assessment by the LHD:

A. If the assessment and recommended POC are not completed by the 16th day after the referral, contact the LHD to offer assistance resolving any barriers to completion of the assessment and document the contact in the Activities module in LTSS*Maryland*, and

B. If the assessment and recommended POC are not completed by the 21st calendar day after the referral, contact the Department via email to request assistance;

3.5.7. Upon completion of the initial assessment and recommended POC by the LHD, review the documents to identify the applicant's needs;

3.5.8. Unless directed otherwise by the Department, conduct a “face-to-face” meeting with the applicant after receipt of the LHD assessment:

A. Engage in a PCP process with the applicant,

A. Provide information about the range and scope of individual choices and options,

B. Identify the applicant’s goals, strengths, risks and preferences,

C. Review the assessment with the applicant,

D. Provide assistance in accessing various resources to support the applicant in the community to include, but not be limited to Medicaid services, non-Medicaid services, donated items and community and faith-based services,

E. Assess the individual’s transition needs such as accessible housing, common household items and/or furniture, and

F. Complete and submit the initial POS in accordance with all policies and procedures set forth by the Department and outlined in the POS Development Manual;

3.5.9. Discuss housing and living arrangements with the applicant to determine if there are unmet housing needs;

3.5.10. Provide information about available housing options such as the Housing Choice Voucher program, Section 811 PRA, permanent supportive housing and other affordable housing opportunities;

3.5.11. Provide housing assistance to meet housing needs, including:

A. Assist the applicant in identifying and overcoming potential housing barriers such as accessibility, affordability and past credit issues, evictions or convictions,

B. Assist the applicant in completing applications for preferred housing options,

C. Facilitate communication with property managers to ensure applications are received and to monitor placement on waiting lists,

D. Assist the applicant with gathering documentation required for housing applications, such as a current State ID or driver’s license, birth certificate, social security card, social security benefit award letter and documentation of any other sources of income,

E. Assist the applicant with requesting reasonable accommodations in rules, policies, practices or services in accordance with the Fair Housing Act, when such accommodations may be necessary to afford a person with a disability an equal opportunity to use and enjoy a dwelling,

F. Assist the applicant with pre-tenancy planning to identify the applicant’s monthly budget, plan for moving-related expenses, arrange the details of the move and understand the terms of the lease and the rights and responsibilities of tenancy, and

G. Provide ongoing support and assistance to sustain successful tenancy by providing training on being a good tenant and lease compliance, coaching on developing relationships with property managers, early intervention to resolve lease violations or other behavior that jeopardizes housing, advocacy or linkage to community resources to prevent eviction and assistance with the housing recertification process;

3.5.12. Assist applicants and participants in applying for Section 811 PRA:

A. Attend training by MDoD and/or other Department designee regarding Section 811 PRA,

B. Train all supports planners on the Section 811 PRA User's Guide and My Own Front Door tenant training handbook,

C. Inform applicants and participants of the availability of Section 811 PRA funding and the location of units,

D. Document outreach conducted related to the Section 811 PRA housing opportunities in LTSS*Maryland*,

E. Enter applicants/participants on the Section 811 PRA waiting list as needed,

F. Collaborate with MDoD and/or other Department designee to help applicants and participants apply for and access Section 811 PRA units when they are contacted from the waitlist, including participating on property-specific monthly calls,

G. Designate staff to serve as back-up to the assigned supports planner in order to facilitate responses to time-sensitive requests for information related to applicants/participants on the Section 811 PRA waiting list, or current tenants,

H. Report lease violations or other behaviors that jeopardize housing for current 811 PRA tenants to the Department in accordance with the programs tenant issue process, and

I. Designate an agency representative to participate in quarterly meetings of the Maryland Partnership for Affordable Housing’s Case Management Sub-committee;

3.5.13. Complete the Community Settings Questionnaire (CSQ) with the applicant and validate the results through a face-to-face visit. This should be done initially for applicants, at least annually for participants and upon any change in residence or living situation, including new roommates, or a change to the rules by which residents must abide;

3.5.14. Document via photographs or other evidence instances of non-compliance with the CSQ or in settings considered to warrant heightened scrutiny;

3.5.15. Submit a task schedule and other documentation to support the services and supports requested on the POS as needed or requested by the Department;

3.5.16. Include in the POS all services and supports (i.e. Medicaid State Plan, waiver and non-Medicaid services) requested by the participant and necessary to ensure the participant’s health and welfare in the community. This includes, but is not limited to an emergency back-up plan and start date, duration, frequency, units and costs of services;

3.5.17. For waiver applicants and participants, ensure the POS is cost neutral using the current cost neutrality calculation provided by the Department. If the individual’s POS exceeds cost neutrality, assist the individual in revising the quantity or type of service(s) outlined in the plan;

3.5.18. Obtain all required signatures on the POS, including that of the applicant/participant, his or her guardian or other legal representative, supports planner, LHD and other relevant providers;

3.5.19. Submit the POS to the Department within 20 calendar days of completion of the

assessment and recommended POC by the LHD;

3.5.20. Coordinate service start and end dates through written referrals to enrolled Medicaid providers;

3.5.21. Ensure the Department has approved the individual's POS and enrolled the applicant prior to the delivery of Medicaid services by providers;

3.5.22. Send the Community Options Notification Form to the personal assistance provider upon any initiation, termination or change in personal assistance service (PAS);

3.5.23. For all waiver applicants, complete an FOC Form indicating the individual's choice to receive services in the community and upload the form in LTSS*Maryland*;

3.5.24. For applicants transitioning from a nursing facility, coordinate the transition to the community, including but not limited to:

A. Ensure financial eligibility is confirmed by EDD via the Advisory Opinion Letter (AOL) prior to the transition,

B. Coordinate the final discharge transition meeting with the applicant and others as applicable and identified by the individual, such as the guardian or other legal representative and nursing facility staff,

C. Coordinate with institutional staff the continuation of services such as occupational, speech and physical therapy and DMS/DME,

D. Coordinate with the transition funds provider to procure approved goods and services such as housing security deposits, utility hook-ups, common household items and furniture using transition funds from the CFC program and, where applicable, MFP flexible funds,

E. Provide all required information to the fiscal intermediary regarding transition services, which includes the Payment Request Form, approved POS and the 257 Level of Care Form or the Advisory Opinion Letter,

F. Obtain and upload to LTSS*Maryland* copies of receipts and other documents related to the expenditure of transition funds,

G. Ensure that all essential goods such as medications, DMS/DME, furniture and common household items are available on the day of transition,

H. Ensure providers have been scheduled and ready to begin services on the date of discharge, and;

I. Be present on the day of transition to ensure its success and the individual's satisfaction with his or her living conditions in the community residence;

3.5.25. Provide orientation for participants and their representatives, including an explanation of the responsibilities of the participant, supports planner and the Department:

A. Inform participants of the provider's PCP methodology,

B. Inform participants about self-direction options, including the ability to waive all but the minimum requirements for nurse monitoring and supports planning services,

C. Train participants on the use of ISAS, and

D. Inform participants of all relevant program policies, including, but not limited to those pertaining to service definitions and limitations and the POS review and on-going program eligibility process;

3.5.26. Make contact with participants or their representatives as applicable:

A. Unless waived, contact the participant, or his or her representative as applicable, at least once per month by phone or via email,

B. If the supports planner is unable to make contact with the participant or his or her representative for a period of 30 days, send a certified letter to the participant and his or her representative to establish contact or conduct a drop-in visit to the participant's home,

C. If the supports planner is unable to make contact with the participant or his or her representative for a period of 60 days, conduct a home visit,

D. Unless waived, meet with the participant in-person, or if directed by the Department, virtually, at the location where he or she receives services at least every 90 days, and

E. Document all contacts and attempts to contact in LTSS*Maryland* appropriately;

3.5.27. Unless waived, complete the monthly contact form in LTSS*Maryland* to verify:

A. Participant eligibility for the program in which the individual is participating, including Medical Assistance eligibility and medical and technical eligibility. The supports planner should follow up as needed to correct any eligibility issues discovered during the monthly contact,

B. Ensure that PAS have been rendered appropriately by reviewing the applicable ISAS reports to compare the services received to the active POS. The supports planner should follow up as needed regarding any discrepancies identified during the monthly contact,

C. Services authorized in the POS are being received, that the quality of those services is high and that the selected services continue to meet the participant's needs. The supports planner should note any needed modifications to the POS on the monthly contact form and submit a revised POS to the Department within 30 days of the contact, and

D. Complete and submit the monthly contact form before the end of each month; as applicable;

3.5.28. Assist participants in identifying local emergency services providers such as emergency medical services and the local fire department;

3.5.29. Identify through monthly contacts and/or quarterly visits, if the applicant has experienced a significant change in health and/or functioning since the previous assessment and alert the LHD if another assessment is needed;

3.5.30. If there is a needed or requested change to the POS, complete and submit a revised POS using the process designated in 3.5.8. and in accordance with all policies and procedures set forth by the Department and outlined in the POS Development Manual;

3.5.31. Assist the participant in accessing new services or providers as indicated on the revised POS approved by the Department;

3.5.32. Review documentation of nurse monitoring visits in LTSS*Maryland*:

A. Monitor the completion of nurse monitoring visits to ensure visits are conducted at the frequency recommended by the LHD,

B. Review all activities completed during the visit, including the Nurse Monitoring Participant Assessment, Residential Service Agency (RSA) checklist and visit notes, and

C. Discuss any issues or concerns identified during the nurse monitoring visits with the participant, or his or her representative if applicable, during upcoming monthly and/or quarterly contacts;

3.5.33. Meet with all participants annually to facilitate the medical and technical validation of continued eligibility:

A. Verify that LTSS*Maryland* has generated a referral for a new assessment by the LHD at least 60 days before the participant's annual medical eligibility expires,

B. Review the new assessment and recommended POC with the participant,

C. Conduct a face-to-face visit with the participant, unless otherwise specified by the Department,

D. Complete and submit an updated annual CSQ,

E. Engage in a PCP process with the participant,

F. Provide assistance in accessing and maintaining non-Medicaid services by making referrals, providing information, or providing other assistance as requested by the individual, and

G. Complete and submit the annual POS in accordance with all policies and procedures set forth by the Department and outlined in the POS Development Manual at least 30 days prior to the participant's eligibility expiring;

3.5.34. Meet with waiver participants at least annually to facilitate continued financial eligibility:

A. Assist the participant with completing a new waiver application, and

B. Submit the new application to EDD no more than 60 days prior to the participant's waiver eligibility expiring;

3.5.35. Ensure approval of an annual POS by the Department;

3.5.36. If a waiver participant indicates that he or she no longer wishes to receive services in the community, complete a new FOC Form indicating his or her choice to decline services and document the expressed reason for declining services;

3.5.37. When an incident occurs that poses an immediate and serious threat of injury, impairment and/or death to the participant, complete and submit an RE to the Department within 24 hours of knowledge or discovery, using the urgent request feature;

3.5.38. Be responsible for the cost of any and all services initiated by the provider without prior approval from the Department and enrollment of the participant or for failing to cease services after being notified that a participant is no longer eligible for services;

3.5.39. Notify the participant, his or her representative, if applicable, and service providers of any loss of eligibility determined during 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 as applicable.

The supports planner may attend hearings only as a representative of the Department with prior authorization from the Department.

3.6. ISAS

The provider shall:

3.6.1. Accept training from the Department or its designee on the ISAS system;

3.6.2. Inform applicants and participants that ISAS to be used by providers to verify service provision;

3.6.3. Issue OTP devices to participants who:

A. Do not have a reliable phone,

B. Share a phone and/or live in the same home, or

C. Often receive services at a location other than their primary residence;

3.6.4. Verify the presence of the OTP device during supports planning contacts and in-person home visits and document the verification on the monthly contact form;

3.6.5. Report lost or stolen OTP devices to the Department within 24 hours of knowledge or discovery and return any broken or malfunctioning OTP devices to the Department;

3.6.6. Issue a new OTP device to the participant within 72 hours of notification of the loss of a device;

3.6.7. Provide information to applicants, participants and providers upon request regarding the provider enrollment system related to ISAS;

3.6.8. Cooperate with the Department to resolve billing exceptions generated by ISAS, including but not limited to verifying the current providers, remediating errors on the POS, locating and contacting a participant to verify service provision and identifying any gaps in service;

3.6.9. Document and track authorized emergency hours if under seven (7) days; and

3.6.10. Generate participant-specific ISAS reports from LTSS*Maryland* to review with the participant at monthly and annual contacts to ensure service delivery and appropriate billing.

3.7. RE

The provider shall:

3.7.1. Fully implement the Department's RE Policy for reporting incidents and/or participant complaints. In accordance with this policy, all incidents that are negatively impacting or have the potential to negatively impact the health and/or welfare of a participant must be reported;

3.7.2. Utilize LTSS*Maryland* to complete and submit RE, as well as monitor the participant's health and welfare by reviewing all RE submitted by nurse monitors and the Department;

3.7.3. Enter the date the incident and/or complaint occurred, as well as the date of notification to allow the Department to evaluate compliance with the RE Policy;

3.7.4. Complete and submit an event report within three (3) business days of knowledge or discovery of the incident and/or complaint;

3.7.5. Develop and implement an intervention and action plan, in collaboration with any and all appropriate parties, to address the root cause(s) of the incident and/or complaint. This should be submitted to the Department within 10 business days of the submission of the event report;

3.7.6. Alert the nurse monitor to all RE relevant to his or her scope of work, including but not limited to RE related to PAS, unanticipated hospitalizations and death;

3.7.7. Complete and submit an RE within 24 hours of knowledge or discovery, using the urgent request feature, when the incident poses an immediate and serious threat of injury, impairment and/or death;

3.7.8. Maintain data on applicant complaints and issues that require remediation and develop and implement a corrective action plan to resolve the complaint and/or issue within five (5) business days of knowledge or discovery of the complaint and/or issue. These data should be maintained outside of LTSS*Maryland*;

3.7.9. Respond to all requests from the Department for additional information and/or an update regarding the status of the participant within three (3) business days;

3.7.10. Report all allegations of abuse, neglect and/or exploitation to Adult Protective Services (APS), Child Protective Services (CPS) and law enforcement as applicable. If the allegation also represents an IJ RE, the report must be made to APS/CPS within 24 hours of knowledge or discovery; and

3.7.11. Train participants and their representatives on the RE policy and how to identify and respond to allegations of abuse, neglect and/or exploitation, including local, state and federal authorities to contact if the participant experiences abuse, neglect and/or exploitation.

3.8. Quality Improvement (QI) and Quality Assurance (QA)

The provider shall:

3.8.1. Develop and implement a QI/QA plan, approved by the Department, to evaluate:

A. Compliance with all responsibilities and their associated timeframes contained in this Solicitation,

B. Achievement of the standards for each responsibility outlined in this Solicitation, and
C. Applicant and participant experience with the supports planning services provided;

3.8.2. Include as part of the QI/QA plan how data collected through evaluation activities delineated in the plan will be used to achieve full compliance with all requirements of this Solicitation and continuously improve the quality of supports planning services provided;

3.8.3. Review the QI/QA plan at least annually to evaluate its effectiveness in achieving the requirements noted in 3.8.1. and 3.8.2. and incorporate into the plan any additional performance measures requested by the Department as part of its comprehensive quality program;

3.8.4. Notify the Department, in writing, of any actual or potential misuse of services and/or funds, including fraud, waste and abuse within two (2) business days of knowledge or discovery; and

3.8.5. As part of the QI/QA plan, ensure compliance with all performance measures included in the Department's waiver applications.

3.9. Conflict Free Case Management

The provider shall:

3.9.1. Disclose and report any real or perceived conflict of interest, meaning any real or perceived incompatibility between any agency or agency employee's private interests and duties of the Solicitation;

3.9.2. Refuse gifts or incentives of any kind from another provider, including incentives for over or under utilization of services;

3.9.3. Report any knowledge of behavior that would violate conflict free case management or that would interfere with the right of a participant to have free choice of provider;

3.9.4. Place no restriction on an applicant or participant's right to select providers of their choice; and

3.9.5. Remediate all identified conflicts in line with the processes outlined in the conflict management plan described in 3.1.2.

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 this Agreement with written notice to the Department no less than 6 months (180 calendar days) prior to the termination of services and prior to the end of this Agreement.

The provider shall:

3.10.1. Submit a transition plan that clearly describes the assistance that will be provided to applicants/participants regarding the selection of a new provider, transition of files and other data in a HIPAA-compliant manner and the reason for termination. The transition plan must be approved by the Department and shall include:

A. An example of a written notice to participants and their representatives, if applicable, notifying them of the termination to be sent no less than 90 days prior to the termination,

B. The process by which other program providers will be notified of the termination,

C. The process by which data will be securely transmitted to new providers,

D. The process to ensure that all data is entered in LTSS*Maryland* prior to the transition, and

E. The assurance that staffing will remain adequate during the transition.

3.11. Billing

The provider shall:

3.11.1. Submit to the Department for payment all case management and supports planning services provided to applicants and participants in accordance with the guidance outlined in the solicitation and any additional guidance issued by the Department;

3.11.2. Submit to the Department for payment all transitional case management and/or supports planning activities provided to applicants up to 180 days prior to their transition and on or after the date of discharge and the applicant's enrollment in services;

3.11.3. Submit to the Department for payment activities totaling no more than seven (7) hours per day, per participant, and no more than 35 hours per week, per supports planner;

3.11.4. Receive authorization from the Department to submit for payment activities totaling more than 35 hours per week, per supports planner;

3.11.5. Utilize LTSS*Maryland* to submit all allowable activities for payment and monitor the status of claims;

3.11.6. Maintain accurate records which fully demonstrate the extent, nature and medical necessity of services provided to applicants and participants;

3.11.7. Enter allowable activities in LTSS*Maryland* with descriptions that include the date, type, length, substance, outcome and an accurate and clear narration of events;

3.11.8. Submit only allowable activities to the Department for payment. Non-billable activities include, but are not limited to:

A. Those that are less than eight (8) minutes in duration (See Appendix 3 for examples),

B. Routine eligibility verification,

C. Time spent engaged in activities required by a credentialing, certification or oversight

entity such as gathering and submitting care plan, service data or other information,

D. Contact with the Department or its designee for the purpose of requesting or reviewing authorization of services,

E. Completion of activities for the purpose of payment and any associated documentation, as well as the completion of progress notes and required forms,

F. Individual or group supervision, routine case reviews and ad hoc consultation, including for the purpose of treatment planning, unless the participant is present,

G. Time spent in staff training,

H. Travel time,

I. Attempted contacts or leaving messages, including but not limited to missed or cancelled appointments and visits to the participant when the participant is not present, and

J. Services provided by staff who do not meet the definition of and minimum qualifications for a supports planner;

3.11.9. Review activities on a weekly basis to verify compliance with the Department's guidance and adjust any non-compliant activities; and

3.11.10. Submit an activity audit to the Department weekly that details the process by which activities are monitored for compliance, any relevant findings and any activity adjustments that were (or will be) made due to non-compliance.

3.12. Required Documentation

The provider shall:

3.12.1. Submit a final work plan within 30 days of the initiation of this Agreement that includes:

A. Methods and timelines for meeting all requirements in this Solicitation related to staffing, training, information technology and any other logistics that must proceed service delivery,

B. How supports planners will engage with applicants and participants, as well as their family members, guardians or other legal representatives and other persons requested by the applicant/participant,

C. How supports planners will engage with other service providers, including but not limited to local MAP sites and LHD to support the coordination of services,

D. Incorporating a philosophy of self-direction into all policies, procedures and activities,

E. Creating staffing standards for all staff roles,

F. Creating training materials and method of delivering training to staff,

G. Creating participant orientation materials,

H. Developing and implementing a disaster recovery plan,

I. Developing and implementing a conflict free case management plan,

J. Developing and implementing a QI/QA plan,

K. Auditing activities submitted for payment to determine billing compliance and

L. Submitting the Interpretation and Translation Services Utilization Report to the Department on a quarterly basis.

Section 4. Provider Selection Process

4.1. Provider Agreement

4.1.1. The Agreement between the provider and the Department shall consist of:

A. This Solicitation,

B. Offeror's proposal, including any subsequent revisions and written responses to questions,

C. The Medicaid Provider Agreement and Acknowledgement of Provider Agreement and Responsibilities Form,

D. Applicable regulations, including rates established by regulation, and

E. Written guidance issued by the Department.

4.1.2. 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 (i.e., one (1) is more important than two (2) and two (2) is more important than three (3)):

A. Quality of Proposed Work Plan

i. How well the Offeror proposes to perform each duty described in the Agreement

B. Qualifications and Experience

i. The extent to which the Offeror demonstrates that it meets each of the Minimum Qualifications

ii. The extent to which the Offeror demonstrates that it 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.

C. Experience and Qualifications of Proposed Staff

i. Experience and qualifications of proposed staff

4.1.3. For each region, the committee will evaluate each Offeror's technical proposal based on the criteria set forth above. As part of this evaluation, the committee may hold discussions with

Offerors. Discussions may be conducted via teleconference or may take the form of questions to be answered by the Offeror via email. Following the completion of the evaluation of all Offerors' technical proposals, the committee will rank each qualified Offeror's proposal. One or more Offerors from each region may be selected to provide services under the terms of this Agreement.

4.2. Pre-Proposal Conference

While attendance at the pre-proposal conference is not mandatory, the information presented may be helpful to Offerors in developing their proposals. All prospective Offerors are encouraged to attend in order to better prepare a robust proposal. In order for the Department to prepare for this conference, prospective Offerors should indicate their interest by sending an email to the Solicitation Point of Contact at mdh.cfc@maryland.gov noting their attendance at least 24 hours in advance of the pre-proposal conference. The email should provide the anticipated number of individuals who will attend on behalf of the Offeror. Any Offeror attending the pre-proposal conference that is in need of an accommodation due to an individual's disability should contact the Department at least five (5) business days in advance of the pre-proposal conference to allow sufficient time to ensure appropriate accommodations.

Questions and Inquiries
Questions should be submitted in writing to the Solicitation Point of Contact via email at mdh.cfc@maryland.gov at least 72 hours in advance of the pre-proposal conference. As practical and appropriate, the answers to questions submitted in advance by prospective Offerors will be provided at the pre-proposal conference. Additionally, questions, both oral and written, will be accepted from prospective Offerors attending the pre-proposal conference and will be answered at the conference or in a subsequent transmittal. Telephone inquiries will not be accepted. Subsequent to the pre-proposal conference, the Department will accept written questions until January 6, 2021.

Revisions to the Solicitation
If it becomes necessary for the Department to revise any part of this Solicitation, amendments and/or addenda will be provided to all prospective Offerors. Acknowledgement of the receipt of all amendments and/or addenda will be required from all prospective Offerors. Failure to acknowledge receipt of amendments and/or addenda will not excuse any failure to comply with the contents of those amendments and/or 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 submit their proposals by mail or to the Solicitation Point of Contact via email at mdh.cfc@maryland.gov. If submitting the proposal by mail, the Offeror should do so via certified mail so that an acknowledgement of receipt is generated. If submitting the proposal via email, the Offeror should apply a read receipt to the email. Additionally, the Department will confirm with the Offeror receipt of all proposals via email.

Proposal Submission Guidelines

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

Mansi Shukla
Maryland Department of Health
Office of Long Term Services and Supports
201 W. Preston St, Room 136
Baltimore, MD 21201

An Offeror may submit a single proposal for multiple regions, but may not submit multiple proposals for a single region. Proposals will be evaluated for each region independently.

Deadline for Receipt of Proposals

Incomplete proposals and proposals received after the deadline of February 1, 2021 will not be evaluated and will be returned to the Offeror.

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. The proposal packet must contain:

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, and

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:

i. Name of the Offeror,

ii. Address of the Offeror,

iii. Contact information of offeror for correspondence related to the proposal,

iv. Title of the solicitation,"Comprehensive Case Management and Supports Planning Services for Medicaid Long Term Services and Supports",

v. The region or regions for which the proposal is offered or indicate "Statewide" for a proposal to provide services in all regions. 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, and

vi. The date of submission

B. A proposed work plan as described in Section 3.12.1 that affirmatively addresses how the Offeror proposes to perform each duty described in this Solicitation, as well the training plan and proposed activity auditing methodology. In addition to the work plan, the Offeror shall address each requirement in the Solicitation and describe how its proposed services will meet or exceed those requirement(s). The statement "Agreed" or "Will comply" is not a sufficient response and Offerors will be rated on their description of how they will meet each requirement. 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, a clear identification of any aspect of the proposed work plan that does not pertain to all regions covered by the proposal,

D. A concise description of the Offeror's qualifications and experience that demonstrate:

i. The extent to which the Offeror meets each of the Minimum Qualifications,

ii. The extent to which the Offeror 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 concise description of the experience and qualifications of proposed staff, including:

i. A list of proposed staff and their roles,

ii. The relevant experience and qualifications of each proposed staff member. A short summary of each proposed staff member's relevant experience and qualifications is preferred over attaching resumes,

F. At least three (3) professional reference letters that include:

i. Name of the individual providing the reference,

ii. Organization which the individual represents,

iii. Contact information for the individual reference, and

iv. The nature and extent of the organization's relationship with the Offeror, and

G. A complete and signed Acknowledgement of Provider Agreement and Responsibilities form (see below).

Replace all underlined and bracketed sections with the requested information.

Acknowledgement of Provider Agreement and Responsibilities

Provider Organization
[Name Of Offeror's Organization]
[Address of Organization]
[Tax ID Number]

Offeror's Contact Information
[Name of Representative]
[Title of Representative]
[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 (EFT) unless the State Comptroller's Office grants an exemption. The selected Offeror shall register using form COT/GAD X-10 Vendor 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 Agreement included in this Solicitation. If the Offeror fails to meet all requirements, the Department may withhold payment or terminate this Agreement 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 referenced in the Solicitation titled "Comprehensive Case Management and Supports Planning Services for Medicaid Long Term Services and Supports."

[Signature] [Date]

Appendix 1-Enrolled Participants by Program and Region

Client Current Jurisdiction	CFC	CO	CPAS	ICS	Total
Allegany	159	57	11		227
Anne Arundel	491	224	14	3	732
Baltimore	1561	851	80	4	2496
Baltimore City	2029	1019	196	5	3249
Calvert	96	25	8		129
Caroline	87	25	6		118
Carroll	114	89	3		206
Cecil	143	46	8	1	198
Charles	195	102	10	4	311
Dorchester	70	46	11		127
Frederick	192	74	10		276
Garrett	88	44	10		142
Harford	295	92	28		415
Howard	547	256	16		819
Kent	21	22	4		47
Montgomery	2025	630	83	4	2742
Other	1	3			4
Prince George's	1078	522	36	2	1638
Queen Anne's	29	15	1		45
Somerset	80	40	8		128
St. Mary's	99	33	16		148
Talbot	40	17	4		61
Washington	156	40	7	1	204
Wicomico	172	101	6	1	280
Worcester	72	51	8		131
Total	9840	4424	584	25	14873

Appendix 2 - Currently Enrolled Supports Planning Agencies

Supports Planning Agency	Jurisdiction
Area Agencies on Aging	Statewide
Bay Area Center for Independent Living (BACIL)	Eastern Shore
Beatrice Loving Heart	Baltimore City; Baltimore, Harford, Prince George's and Montgomery Counties and the Southern and Western Regions.
Independence Now	Montgomery County
Medical Management and Rehabilitation Services (MMARS)	Statewide
Service Coordination Inc (SCI)	Baltimore City; Baltimore, Harford, Prince George's and Montgomery Counties and the Southern and Western Regions.
The Coordinating Center (TCC)	Statewide

Appendix 3- Minutes of Service as Units

Units	Minutes of Service
1	Greater than or equal to 8 minutes, but less than 23 minutes (8-22 min)
2	Greater than or equal to 23 minutes, but less than 38 minutes (23-37 min)
3	Greater than or equal to 38 minutes, but less than 53 minutes (38-52 min)
4	Greater than or equal to 53 minutes, but less than 68 minutes (53-67 min)
5	Greater than or equal to 68 minutes, but less than 83 minutes (68-82 min)
6	Greater than or equal to 83 minutes, but less than 98 minutes (83-97 min)
7	Greater than or equal to 98 minutes, but less than 113 minutes (98-112 min)
8	Greater than or equal to 113 minutes, but less than 128 minutes (113-127 min)