MARYLAND DEPARTMENT OF HEALTH

PRE-PROPOSAL CONFERENCE

MARYLAND MEDICAID RARE AND EXPENSIVE CASE MANAGEMENT (REM) SERVICES

Held at: Maryland Department of Health
201 W. Preston Street
Room L1
Baltimore, Maryland 21201

September 11, 2019

2:00 p.m.

ATTENDANCE:

AGENCY:

Jill Spector, Director,
Medical Benefits Management

Margaret "Mike" Berman, Division Chief,
Children's Services

ATTENDEES:

Bruce Bereano, MMARS
Renee Dain, TCC
Selena Dorman, Excel
Teresa Titus-Howard, TCC
Sharyn King, TCC
Glinna Michael, REM
Blessing Ndang, Blossom Services
Mario Newsome, Blossom Services
Alan Ofsevit, MMARS
Monchel Pridget, Medical Benefits Management
Wanda Ramirez
Jonathan Rudy
Mary Ryan, TCC
Jennifer Sears, TCC
Alfred Sesay, Blossom Services
Jim Stewart, MMARS
John Whittle, Service Coordination
Ella Wood, REM

ALSO ATTENDING:

Steven LeGendre, Assistant Attorney General
Amy Miller, MDH
Katie Neral, MDH
Maria Smith, MDH

Reported by: Carol O'Brocki, Notary Public
Hunt Reporting Company, Glen Burnie, Maryland

P R O C E E D I N G S

(2:05 p.m.)

MS. SPECTOR: Good afternoon. My name is Jill Spector. I'm the Director of Medical Benefits Management here at the Department in the Medicaid Program, and I think what we should do is start by going around and introducing ourselves and then we can get started with the Pre-Bid Conference. So why don't you go ahead?

MS. BERMAN: I'm Mike Berman. I'm the Division Chief for Children's Services.

MS. NERAL: I'm Katie Neral. I'm the Deputy Director for the Acute Care Administration.

MS. SMITH: I'm Mara Smith. I'm Mike's Co-policy Analyst.

MS. NDANG: I'm Blessing Ndang. I work with Blossom Services, Inc.

MR. NEWSOME: I'm Mario Newsome. I'm business development with Blossom Services.

MR. SESAY: Good afternoon. I'm Alfred Sesay, Director of Nursing, Blossom Services.

MS. MILLER: Amy Miller. I'm Special Assistant for Long Term Services and Supports.

MS. MICHAEL: Glinna Michael. I'm QI Coordinator for the REM Program.

MS. WOOD: Ella Wood, REM supervisor.

MR. RUDY: I'm Jonathan Rudy. I'm (indiscernible) Policy Analyst.

MS. PRIDGET: Monchel Pridget, Special Assistant, Medical Benefits Management.

MS. RAMIREZ: Wanda Ramirez (inaudible).

MS. RYAN: I'm Mary Ryan. I'm from the Coordinating Center. I'm the (indiscernible).

MS. TITUS-HOWARD: Hi. I'm Teresa Titus-Howard, President and CEO of the Coordinating Center.

MS. KING: I'm Sharyn King, Senior Vice President, Population Health with the Coordinating Center.

MS. SEARS: Jennifer Sears, Vice President, Project Management, the Coordinating Center.

MS. DAIN: Renee Dain, Vice President of Business Development at the Coordinating Center.

MR. WHITTLE: I'm John Whittle. I'm here on behalf of Service Coordination. We provide case management and other Medicaid programs in Maryland.

MR. LEGENDRE: I'm Steve LeGendre. I work for the Office of the Attorney General and I'm on assignment to the Health Department.

MR. BEREANO: Bruce Bereano, Registered Lobbyist for MMARS.

MR. STEWART: Jim Stewart, Vice President of MMARS.

MR. OFSEVIT: Alan Ofsevit, CIO for MMARS.

MS. SPECTOR: So, thanks everyone for coming. We're excited to be here today. The way we're going to do this is Mike is going to provide an

overview of the REM Program. I'm going to talk about a time line for the solicitation.

We're going to go through the questions that we've already received and the answers, and then we'll open it up for questions. So, I think we're going to get started.

MS. BERMAN: Good afternoon. I'm just going to give a brief -- I have to keep my glasses on -- a brief overview.

The REM Program is a part of Health Choice, which is Maryland Medicaid's Managed Care Program. In order to qualify for REM you have to be eligible for Health Choice. You have to have one of the REM diagnoses, and you have to meet within the age limit for that diagnosis.

Some of the examples of REM qualifying diagnoses are quadriplegia, spina bifida, ventilator dependence, congenital anomalies, metabolic disorders

including cystic fibrosis, chronic kidney disease, and blood diseases including hemophilia.

We currently have about 4,300 participants enrolled in the REM Program. REM case managers are either licensed social workers or licensed registered nurses. The REM case manager completes a face-to-face assessment to identify the recipient's needs, collaborate with their PCP, their (indiscernible) and other service providers to develop a case management plan to address those needs.

They would implement the plan, make modifications as needed, and coordinate and monitor the delivery of services. The case management content for the REM Program is a combination of face-to-face and telephonic and email contacts.

The Department is issuing this solicitation for REM case management services throughout the State of Maryland and we intend to award one contract.

MS. SPECTOR: Okay. Everyone should have an agenda. We had some for you guys when you walked in.

The time line for the solicitation of the REM case management solicitation is that August 5th it was originally released. On August 22nd, there was an addendum posted to the website. There is a website and the website is actually on this page. I also forgot to say Carol is here taking notes for this Pre-Proposal.

Today is the Pre-Proposal Conference. It's from 2:00 to 4:00. September 30th, responses to the solicitation must be received by 2:00 p.m., no exceptions. In November of 2019 we're expecting to award the contract and looking for a transition period from December through February, and then on March 1st the contract will begin.

The contract resulting from this solicitation will be for three years -- for a period of three years beginning on March 1st, and then there

are two one-year option periods. All of the documentation and information will be posted to the website, including the questions and answers that come up today and the questions and answers that we have already answered, and we're going to go over them in a few minutes.

Does anybody have any questions?

(No response.)

MS. SPECTOR: Okay. Great. So, next are the questions and answers.

MS. BERMAN: Yeah. I was just going to talk about just a couple of reminders about the solicitation. Section 7.4 lists all the document information and the format required with the submission, and the transmittal letter, the offeror should be submitted on the offeror's letterhead and signed by someone who's authorized to commit the offeror to the services and requirements of the solicitation.

The specifics of what needed to be included in the transmittal letter are on pages 46 and 47 of the solicitation.

Under Section 8.0, the Department -- we listed our criteria which we will evaluate each bidder's response to the solicitation. The criteria are listed in descending order of importance. In your proposals, the bidder should address each item, highlight areas of expertise in each of the requirements, and the strategies you would employ to implement the contract.

And then just a reminder of the number of technical proposals required. You need one original and four copies, one electronic version in Microsoft Word format, and a second electronic version in searchable PDF for Public Information Act requests. That searchable PDF format, that should be redacted so that your confidential and proprietary information has been removed.

So now we're going to -- anybody have any questions about that?

(No response.)

MS. BERMAN: We did receive some questions prior to today's meeting, so we're going to go through those now.

MS. SPECTOR: Everyone has a copy. Okay.

MS. BERMAN: The first question we received was of the 4,000 plus REM participants, what's the geographical prevalence of participants by county. So we provided that information in two graphs that were broken out by adults and children. So, it's fairly self-explanatory that Baltimore City, Baltimore County, Montgomery, and Prince George's counties are our most populated areas.

The next question was about a single vendor. "The current solicitation continues to make one award to a single offeror, rather than having multiple vendors to provide case management services to the

program. The program had multiple vendors since its inception in 1997 up until 2014.

Targeted case management services for all other Maryland Medicaid programs where there is sufficient volume to justify multiple vendors all currently have multiple targeted case management vendors. The REM program serves hundreds of thousands of people, not hundreds.

One of the primary concerns of having" -- and I should say, in case you didn't see that -- our response is in italics. This is all part of the original question. "One of the primary concerns of having multiple vendors for REM targeted case management services was a lack of a uniform data system and the fragmentation that this caused.

A key component of the 2019 solicitation is the introduction of the use of Maryland's LTSS platform for the REM program. Maryland has invested a tremendous amount of time and money into migrating its

Medicaid Waiver programs onto a common platform, the LTSS system. The use of the LTSS system for the REM targeted case management vendor is a requirement of the current solicitation.

The LTSS system currently supports numerous targeted case management agencies across multiple programs, without any issues requiring that there would be only a single targeted case managing vendor for a particular program. More so, potential operational and programmatic issues around having multiple agencies providing targeted case management services are also addressed by the system."

So, our response is "In the previous Request for Proposal (RFP), MedChi and the Maryland Chapter of the American Academy of Pediatrics recommended that the State consolidate care coordination services under a single statewide vendor in order to end patient and physician confusion about which company is responsible for case management, to standardize procedures, secure

required services, and facilitate communication and accountability.

Additionally, the Centers for Medicaid and Medicare Services (CMS) authorized the Department to selectively contract with a single entity for the provision of case management services. Ultimately, working with a single case managing vendor simplified care coordination for participants, for their families, and community providers such as specialists, pediatricians, family practitioners, and hospital discharge planners. A single contractor for REM case management services also streamlined the Department's contract oversight regarding referrals, trainings, and monitoring.

The Department will use LTSSMaryland to store all quantitative and qualitative data for the REM Program. We strongly believe that this will be a positive change to the Program by further enhancing care coordination."

Question 3, "Does MDH have a standard or expectation for a case manager to participant ratio? What is the average ratio currently in the REM program?"

We don't have a standard expectation. There's such a varying need for how intense case management needs to be that we have found that -- well, we don't do it. We did it a million years ago, but we don't have a maximum caseload. The average caseload for our current contractor is 54 cases per REM case manager.

Question 4, "For the case management add-on for assignment of participants from other MDH Medicaid or Medicaid waiver case management programs, what is the potential total number of assignments and what is the earliest possible time frame when this may occur?"

The potential total number of assignments is approximately 1,575 participants, and we have no time

table developed at this time to implement the add-on option.

Question 5, "Solicitation qualifications for the vendor and staff have increased and limit qualified respondents.

The current solicitation has an increased level of required and highly desirable qualifications for both staff and the vendor. The additional verbiage goes well beyond the prior and all other REM solicitations and would be difficult to impossible to meet unless you were either the incumbent, or performing similar work in a different State.

These changes include new qualifiers specific to the REM program and the incumbent, such as to pediatric and adult clients with complex medical needs; at least five years experience working with Medicaid programs including MCOs; and at least two years of demonstrated knowledge and experience with medically complex children and/or adults with

disabilities, comorbid conditions, and individuals experiencing poverty.

A number of roles now require a licensed registered nurse or licensed social worker that did not require this before. For case managers, a nationally recognized certification in case management is now required for all case managers, not just social workers. This models the incumbent's current structure and was never required before.

As the scope of work for the solicitation is functionally the same, an increase in the staff and vendor requirements to match the incumbent's qualifications would appear to set an artificial bar that limits qualified respondents."

Our response was "The Department continuously strives to improve its programs and services offered to the Medicaid population. We want to ensure that REM participants receive the services they need from the best possible providers. Due to

the complex medical needs of many of the REM participants, the Department believes these additional requirements will improve the delivery of REM case management services."

Question 6, "Does MDH anticipate that transitioning 4,000+ participants to a new vendor will occur all at one time, or does MDH anticipate that the transition will be phased in over a period of time?"

"MDH anticipates the transfer of all REM participants by March 1, 2020."

Question 7, "Further consolidation of the targeted case management services across multiple programs beyond REM: Section 6.3 of the current solicitation details an add-on option that if invoked, consolidates all targeted case management services for the CFC and DDA programs to the single REM targeted case management provider for people in multiple programs who have REM.

The add-on option assumes that the REM case manager is the only required case manager for a person in any of these programs. The one REM case manager would need to be able to provide not only REM case management, but also coordinate all DDA services as well as CFC services.

It should be noted that REM services are "fee for service" and without referral. DDA and CFC services are by approval only and have a complex and detailed authorization process that is managed by the coordinator and supports planner. The roles are not one in the same. The waiver programs are all quite different, and while the title of targeted case management may imply significant redundancy, this is not the case.

There are also a number of other issues that the add-on causes, but most importantly, this consolidation removes choice from the person in these programs.

While MDH and the State have clearly defined choice not as a "choice of provider," but as a choice of "case manager," the add-on's consolidation clearly eliminates choice amongst the case managers that a person currently has. The coordinator or supports planner who may be serving a person best and have worked with them for years will be removed as a choice. It is disingenuous to think that the REM case manager will perform all roles and that the REM targeted case management provider will not simply assign the equivalent of a coordinator or a support planner from their organization to replace the person's existing and potentially preferred choices for these programs. Choice and person-centeredness are the two key tenants of both CFC and DDA programs, and this consolidation is clearly neither.

It should also be noted that the add-on rate is an additional capitation amount of $350 per person per month in addition to the REM rate. Both the CFC

and DDA targeted case management vendors have been told that capitation for targeted case management for these programs was impossible. A capitated rate of $350 is more than the existing costs incurred per person per month for targeted case management services for the current CFC and DDA programs. Any efficiencies or savings for reducing a perceived redundancy of targeted case management services somehow seems to incur the opposite, as the add-on will simply cost more than how things currently are. If offered a capitated rate similar to the add-on of $350 per person per month, the existing targeted case management vendors of both DDA and CFC programs would gladly be the sole case manager for the people that they serve."

Our response, "Over the years, the Department received feedback that there is duplication of case management services for participants enrolled in multiple case management or waiver programs. The

Department is committed to working with the various programs to streamline the program requirements to facilitate one case manager coordinating the participant's plan care. The Department is aware of the extensive collaboration and training that would be required before this add-on could ever be implemented.

Section 6.3.2 in the solicitation states "This Maryland Medicaid Case Management Add-On Option shall be invoked at the Department's discretion and at an additional monthly rate, not to exceed $350.00." The final rate has not yet been established."

MS. SPECTOR: So these are the questions that we received up until today, and we wanted to make sure everyone was on the same page, got the questions and answers. Of course, as I said earlier, we'll post them and post any other questions that we get today.

So, I want to open it up for other questions, and if you do have a question, just please

say your name and what organization you're with before you ask your question.

MR. WHITTLE: I'll go first. It's kind of quiet in here.

MS. SPECTOR: It is quiet.

MR. WHITTLE: Sometimes it's hard to go first. You have three tiers of rates if I recall correctly.

MS. BERMAN: Could you identify yourself first?

MR. WHITTLE: I'm sorry. I'm John Whittle. I'm with Service Coordination. Three tiers and they each have a separate monthly rate. Do you know or can you provide to us the number of people that are currently in each of those three tiers?

MS. BERMAN: Yes, we will.

MR. WHITTLE: Okay.

MS. SPECTOR: (Indiscernible) that question?

MS. BERMAN: I remember doing it.

MR. WHITTLE: Yeah. That was the one that I had submitted. I didn't see it in here.

MS. BERMAN: Yeah. Well, we will get that information to you, and to everyone.

MR. WHITTLE: Yes. I have one. We talked about -- number 6 was the one that I had sent and thank you for the answer to that. So, all transferred by March 1st. Could that still mean being transferred in one day, or will it be phased in between now and March 1st?

MS. SPECTOR: I think at this point we're not exactly sure. Everyone will be in -- you know, everyone will be transferred by March 1st. It sometimes depends on the system and what day of the week March 1st falls on, but everyone will be in by March 1st.

MR. WHITTLE: Because when I read the RFP it didn't talk to that, and people could have taken it if they aren't here, they are here, that they'll all be

switched one day. It wasn't in the project plan. A description -- please describe what your phase-in plan might be or your transition plan and how you'll do that. So I walked away thinking there was no transition time, that there was no plan needed to make that occur. It's a lot of records. You guys know.

MS. SPECTOR: Right.

MR. WHITTLE: Probably some of the people have been through this before. When a lot of people try to move at one time it doesn't work. So, that's why I brought it up. Thank you.

MS. SPECTOR: I'm sorry. Our goal is to award the contract in the next couple of months to allow for, you know, a robust transition time so that you can, you know, just have the time to make sure our i's are dotted and t's are crossed. And part of that will be getting everyone in to the new, you know, contract.

MR. WHITTLE: Okay. Thanks, guys.

MR. OFSEVIT: Can I kind of piggyback on that for a moment? IT guy here. Alan Ofsevit from MMARS. Is the REM LTSS platform ready at this time and will it be ready ahead of the launch date to allow not only the transition of the participants but also potentially vendor to be able to be trained and receive all the required documentation so they can review cases and take service in place properly?

MS. SPECTOR: I mean, you know best, but it -- we are scheduled to have the REM LTSS ready to go in advance of March. And there will be time for training and we're hoping it will be ready by the end of the year.

MR. OFSEVIT: Okay.

MS. BERMAN: We anticipate training the new contractor prior to March 1st.

MR. OFSEVIT: Okay. And if there were delays then it would basically be some transition until it went live then, or --

MS. BERMAN: We aren't anticipating a delay. But, I mean --

MR. OFSEVIT: Okay. Thank you.

MR. SESAY: Alfred Sesay, Director of Blossom Services. I wanted to elaborate on the section of REM and what has been the sequence in terms of contracting vis-a-vis the incumbent?

MS. SPECTOR: Can you repeat that?

MR. SESAY: I'm looking at -- when did it come into existence? What type of contracting out -- so what I'm looking at here is whoever is the new vendor having to be contracted versus the incumbent.

MS. SPECTOR: So, REM -- the REM program started with the inception of Health Choice in 1997, and the Department changed to a single case manager in 2013. Prior to that time there were multiple case managers throughout the State. And what other question was there? Did I answer your question?

MR. SESAY: I'm looking at the chance of how it is over the years for a new person to be contracted.

MS. SPECTOR: So --

MS. SMITH: So you're asking what are the chances of a new vendor being selected?

MR. SESAY: Uh-huh. Based on --

MS. SPECTOR: It's an open procurement. I mean --

MR. SESAY: Based on these things.

MS. NEVAL: Based on the evaluation of the proposal.

MR. SESAY: Thank you.

MR. BEREANO: Bruce Bereano with MMARS. Previously the Department, under a previous gubernatorial administration consolidated all the providers for the REM program into one provider.

MS. SPECTOR: You mean case management?

MR. BEREANO: Provider. But it allowed for multiple case managers, which is currently the situation.

MS. SPECTOR: Prior to 2013 then.

MR. BEREANO: But there are now presently more than one case manager -- providers.

MS. SPECTOR: There's one case management agency with multiple case managers inside that agency.

MR. BEREANO: Right. Exactly. And other Medicaid programs have multiple case management vendors. Why is this contract limited to a single vendor?

MS. SPECTOR: So, I think in the answers that Mike just read there was --

MR. BEREANO: But that's -- respectfully, that's government ease. I mean, really why --

MS. SPECTOR: It was easier for the people in the program -- the participants, as well as the providers. There was a lot of confusion about who to

call, which company should they call. Providers weren't sure which case management company to call. It was just confusion -- confusing.

MR. BEREANO: Well, MMARS, in their proper (phonetic) they have not experienced or witnessed any of this confusion at all. Where is the documentation of this to justify there being just a single vendor as, you know, in this contract?

MS. SPECTOR: We have some letters from the American Academy of Pediatrics and MedChi, but that was from, you know, 2013.

MR. BEREANO: Right. It was quite a while ago.

MS. SPECTOR: Yeah. Yeah.

MR. BEREANO: So what makes you think that that situation then is still applicable now to have this procurement which will only allow for one vendor?

MS. BERMAN: I can speak as far as our internal REM staff here. We used to be inundated with

phone calls at times from doctors or DIV (phonetic) providers trying to find -- trying to locate a REM case manager.

So, first they didn't know which of the contracting companies they were with, and then they -- so they'd call us to get that narrowed down, because they'd say "Well, I tried three of them and they don't know this patient."

MR. BEREANO: You're saying this is currently? This is currently going on?

MS. BERMAN: No, this was when -- this was --

MR. BEREANO: Back in 2013?

MS. BERMAN: Yes, sir, and prior.

MR. BEREANO: That's a good six years ago.

MS. SPECTOR: Yeah. And I think --

MS. BERMAN: And what I was going to say is we -- like for the most part, the providers that are working with our own clients know that the current

vendor, they'd contact them. They find it easier to find a case manager because they don't have to go through that initial vetting process.

MR. BEREANO: So, the situation today is better than it was in 2013? There's no more confusion, people know things. I assume the Department is doing its job and letting people know as you administer the REM program. Then why does this contract push for the one provider, but then also have the opportunity to be the one case manager?

MS. SPECTOR: Are you talking about the add-on?

MR. BEREANO: Yes.

MS. SPECTOR: Okay. Oh, I'm sorry. I didn't understand what you were talking about.

MR. BEREANO: It's your procurement, yeah.

MS. SPECTOR: Yeah, I know.

MR. BEREANO: It's all one thing. It's all one thing, yeah.

MS. SPECTOR: I totally understand that.

MR. BEREANO: The add-on's real. The add-on's real and the add-on establishes a monopoly. I know you say it's within the Department's discretion. There's no guarantees with that. There's no safety.

MS. SPECTOR: Okay.

MR. BEREANO: Should the Department do that, you're going to get rid of other vendors, like MMARS, like this gentleman over here. What's the justification of that?

MS. SPECTOR: The justification of that is the add-on is the idea that the State is paying for multiple case managers for the same person in multiple programs, and that there's an efficiency that is lost by doing that.

So, we have had -- we had a report done by PCG Consulting that suggested that we move to one case manager for these kinds of folks who are in these programs, and it's been suggested by other people

before that there really are efficiencies when you have one case manager working with one participant and looking at their plan of care across the multiple programs, because there are cases where there are services that are duplicated, and it just -- you know, it just doesn't make sense to have it otherwise.

MR. BEREANO: Let me carry this forward a little further, and I'm being serious about this. So what is the purpose of having a case manager? I mean, I think I know, but I want to hear the Department. What is the purpose of case management in these programs?

MS. SPECTOR: The purpose of case management is to work with a participant, to coordinate their services, make sure they get their services, be available for questions, help with providers.

MR. BEREANO: Okay. And so your current provider is TCC, correct?

MS. SPECTOR: Uh-huh.

MR. BEREANO: Okay. So your case manager is an independent separate entity assisting the Department, making sure that the participants get proper services and things are going well in the administration of what these programs are all about. They're a separate entity from the provider who is providing these services under the current system, okay?

For the add-on at the discretion of the Department, let's just assume hypothetically the current vendor remains the winner for this new procurement. I'm just talking hypothetically, okay? I mean, it's hypothetical, and then you exercise your discretion and say TCC which is doing REM now picks up other programs or other services that they provide so that they can qualify.

MS. SPECTOR: But they're going to have the same person. If I'm in REM and I'm also in CFC,

they're still going to coordinate -- it will be my total plan of care.

MR. BEREANO: But they'll not only be providing the services, this entity. I mean, who is the provider, will not only be providing the services but they'll be doing the case management; is that correct? Say you exercise your option --

MS. SPECTOR: No, it's not correct. They'll be providing case management services --

MR. BEREANO: Right. And they'll be overseeing and looking at the work they're doing and providing.

MS. BERMAN: But they're not providers.

MS. SPECTOR: They're not providers.

MR. BEREANO: I know, but they're doing dual functions --

MS. SPECTOR: I don't understand.

MR. BEREANO: The same entity.

MS. SPECTOR: I don't understand what you mean. The entity that wins this solicitation will be providing case management services. They won't be also providing DMS, DME, or nursing or the other services that a REM participant would get. The entity that wins the solicitation provides case management services only.

MR. BEREANO: And then there will just be one case management provider?

MS. SPECTOR: Correct.

MR. BEREANO: Right. So, the participants, who very sincerely we're all supposed to be -- I mean, they really are the ones that are the most important in all of this.

MS. SPECTOR: For sure.

MR. BEREANO: And we all know that. That's the way it's supposed to be. So they'll have no choice as to what case management provider they want to use. They won't have a choice, correct?

MS. SPECTOR: So, if a REM participant has a case manager that they're not happy with they can choose another case manager within --

MR. BEREANO: Not if you exercise the option.

MS. BERMAN: No, they can still change case managers.

MS. SPECTOR: But this is the way we designed it. So they can still --

MR. BEREANO: But say they're with another company?

MS. SPECTOR: There's only one case management company --

MR. BEREANO: Under this procurement?

MS. SPECTOR: Under this procurement.

MR. BEREANO: Well, that's my whole point. You are whittling down the number of case management companies, and the individual seeking the services, they're going to lose their choice. Say they're

content with who is their -- you know, you're relying on things that happened back six years ago.

There's no recent data or information that -- you have made clear that there's confusion in people not knowing, you know, who they're with. That was back then. That was your justification for just going to one provider of services.

MS. SPECTOR: Okay.

MR. BEREANO: But I just don't see any justification for consolidating who is the -- you know, you're going for a monopoly. You now will now have a monopoly on who's providing the services. And you then -- you go now on this procurement, you have a monopoly of who's going to be overseeing that.

MS. SPECTOR: Right. I don't see it that way.

MR. BEREANO: But that's the way -- a monopoly.

MS. SPECTOR: There are 4,500 current case -- I'm sorry. There are 4,500 current REM participants, some of which are in multiple programs that have case managers. The idea is to have one case manager --

MR. BEREANO: But they're different programs. They're different programs. They're different needs.

MS. SPECTOR: Right. Per participant. Looking, for sure.

MR. BEREANO: So consolidation may be nothing --

MS. SPECTOR: Looking at the whole plan of care, so if someone gets certain services in the REM program and they're also getting community option services, it would be the one case manager coordinating the whole plan of care, so that there's one set of eyes working with the participant and helping them through --

MR. BEREANO: Has there been a survey currently of the services? I mean, a survey of the recipients of these services from these multiple providers in terms of are they satisfied having several different case managers, they're receiving different services and what have you. Where are they complaining? Where are they complaining?

MS. SPECTOR: I don't think that they are complaining.

MR. BEREANO: Well, then it shouldn't have any relevance because then a recipient of the services, if they're satisfied, they're comfortable with multiple case managers, why is the Department scrambling it all up?

MS. BERMAN: We do get complaints at times from participants.

MR. BEREANO: How often? I mean, this is very serious stuff. It's going to affect businesses in Maryland that have had longstanding relationships

with this department that are providing case management services.

And very respectfully, I just think it's more internal bureaucratic looking at, you know, efficiency and making it easier and not having to deal with multiple people, as opposed to really surveying what is best for the recipients of these services.

MS. SPECTOR: Well, some of --

MR. BEREANO: You don't have any impairable (phonetic) data on that or a survey, at all.

MS. SPECTOR: So, it's also about taxpayer money. It's also about that there are efficiencies to be gained by having one case manager and not multiple case managers and multiple programs.

MR. BEREANO: Respectfully, that's a convenient government response.

MS. BERMAN: There's also involved --

MR. BEREANO: Respectfully, it is. You get a lot of federal money. You know, do you get any federal taxpayers complaining to you? No.

MS. SPECTOR: No.

MS. BERMAN: Sir, there's also involved -- with just one case manager involved, that she would be aware of the services that the recipient is receiving from CFC, from DDA, from REM, and to be able to identify a need of where there's a gap, in addition to where there might be a duplication.

MR. BEREANO: But you don't know it's a duplication. What you're doing is, you did years ago with the REM program, you created a monopoly. Now you're going to create another monopoly. I don't think that's good for business. I don't think that's consistent with Maryland's Open for Business. I see it everywhere. I'm happy to see it. And I commend seeing it.

But the realities of this RFP, and I understand you can exercise your option, if you're going to -- I put my money down you're going to exercise your option if we were placing bets, and what that's going to do is be devastating from a business standpoint to businesses that are dealing with this department in a good faith, and a very quality fashion, and they're going to be out. And there's no justification for that. Absolutely none.

And I think it's rather telling that the recipients of the services, really there's been no survey of them. I mean, isn't that what this is all about? It's going to be quite a disruption on them. They've probably established relationships with people, and a comfort zone, and what have you.

I just -- I think the Department is not emphasizing that and taking that into account and looking more at governmental efficiencies as opposed

to what's really best for the recipients of the services.

I mean this. I'm not here to give a speech. This is all going down a very bad road, a very bad road.

MS. SPECTOR: Okay. Does anyone else have any other questions?

MR. NEWSOME: Yes, I do. My name is Mario. I'm with Blossom Services. This is more of a -- not a question for now, because I want to kind of piggyback off of what he was talking about a little bit.

And I understand that the government has the intention of consolidating for budgetary reasons. You know, you have to give an answer for taxpayers, and one of the primary concerns of taxpayers is to save money, and I can completely understand from ut a short-term perspective the reasoning for the consolidation.

But I guess the question and the suggestion that I would have is it's more of a long-term consequence for this type of movement in that once there is a monopoly, the barrier to entry for new contractors to be able to bid on this in the long-term, in the future becomes more and more difficult, because the amount of areas to get in case management type of experience will basically shrink.

And the concern is for medium-sized or even small business to be able to get into the market and to gain experience and to potentially grow becomes more difficult with this consolidation.

So, the suggestion that I wish to suggest now and to see what the agency's response is later is it seems like part of the reason for the consolidation in the first place was the confusion as to which provider was covering which patient, and if you can see on this map you guys have, on the first page of the questions and answers.

The suggestion that I would have is maybe if it was possible that a particular vendor could cover a particular zone, like a smaller vendor, you know, would maybe handle a very small caseload, like, you know, Calvert County or something like that, and a more established and a seasoned case manager company could handle a larger one like Baltimore or Baltimore City, and you could still have the consolidation between the various programs, the TCM and CSC, which would still be for budgetary reasons a savings that could be passed on to taxpayers.

But at the same time you could allow for competition and growth of potential small businesses, a way of kind of addressing and compromising the two main problems that I can see. So, that's just a question. Not for now, but --

MS. SPECTOR: Well, thank you for your question. I just want to say -- I want to make sure -- I just want to clarify that what we're talking about

is the REM participants. There are 4,500 REM participants. About 1,700 of those participants are in multiple case management programs.

We are not talking about -- in terms of a monopoly I just want to clarify we're not talking about this -- whomever wins the solicitation being the case manager for the thousands and thousands of people who are in DDA, CFC, Community First Choice, Community Options Support. All of the other programs. We're not talking about that. We're talking about a portion of the folks who are in the REM program.

So I just want to make sure that everybody understands that.

MR. OFSEVIT: I'm just going to piggyback on what you said. So, if you're the respondent, is the expectation that someone would then have to apply and respond to a CFC RFP and get licensed in DDA? Or if that's not the expectation, how do you do the add-on? And with the Department in this RFP, you would -- is

it desirable that someone is already licensed and already able to provide services to these two programs?

Because then certainly a new vendor who's not is going to be further down the option choice because it's not as attractive necessarily to the Department as opposed to someone that can just step right in and do the I'm going to need you today.

MS. SPECTOR: I think in order to take up the option, there is going to be an extreme amount of work that needs to happen -- an extreme amount of work that needs to happen here at the Department to be able to somehow have -- to change our systems to make sure that all of these programs are together in the LTSS, to make sure that the different requirements align, because they are not aligned now.

And then to have a robust training for the case managers in order to provide the case management service. So, to answer your question, I don't think

that you have a leg up if you're already a provider of those services. I think we are -- there is a ways to go in order to take this option up.

MR. OFSEVIT: But is the incumbent currently -- are they providing services in these other programs?

MS. SPECTOR: I have no idea.

MR. OFSEVIT: So, the other programs that have multiple vendors -- REM only has one vendor right now, so again it kind of creates kind of an obstacle or a problem for someone new coming in where this is -- is an expectation. Not today, but at some point that's what the goal would be.

MS. SPECTOR: I think it's going to be difficult. It's going to be a lift for anyone when -- you know, it's going to be a lift.

MR. BEREANO: Okay. You may think I'm being argumentative but I'm not trying to be, but what you said earlier in your response, it's not really

completely accurate, or at least it's not really the whole story. Because if someone's doing REM now and they pick up licensure doing the other programs, and they are the winner of this RFP, and then you do the add-on, well, then they can go and take business away from other case managers in these other areas, and we will lose business.

And the recipient will not have any choice as to whether they want to stay or be forced to go with whoever's the winner here, and that is -- respectfully, you need to jettison this add-on piece. It is fraught with monopolistic problems. It gives encouragement to whoever's going to win this procurement to then pick up these other services so that they can broaden.

It's going to take folks, like these fine folks, not really be able to get in the game at all. Let's not kid ourselves. And that's not good. That's

not good. That's not what this Department or this administration's all about.

And, I'm sorry. I don't see any justification for that add-on, and the consequences. I know you may say it's down the road, it's a heavy lift, but I've been around the government for 47 years, and it's in here for a reason. It is in this RFP for a reason. It's in here because it's going to be done. I'm not a cynic. I'm not, but I've just -- I've seen too many RFPs in my life.

And I think it should be jettisoned. I think it should be cut out because the consequences of it, as the current good vendors with this Department, like MMARS, and the fine folks like these and others, maybe in the room or maybe not, they're just going to be out of the game, and that's wrong. Very, very, wrong. And, you know, I don't think you have the justification for allowing that.

If you really think too objectively, the add-on and the power and the position that it's going to give whoever is the winner of this, then have the add-on, it's not going to be procured again. It's going to be on this procurement, and they and can do these other services.

And then if they broaden it, it can result in these other services that you mentioned, which you said they're not affected. They are affected. These other services which have multiple case managers, they will not have multiple case managers at all in the future, because based upon the add-on, for the three to five year period, if they expand their activities, they're going to have the whole bowl of wax.

That's wrong. That's called a monopoly. And you should not have that. And it's a real thing. And very respectfully, I don't think it's going to end by a conversation in this room. I really don't. It's a very serious impact on people that want to do

business in Maryland and come into this, as well as your current vendors in other areas that really have been fabulous partners with this Department and doing a very fine job.

And you can ignore my comments --

MS. SPECTOR: I'm not ignoring them.

MR. BEREANO: You know, and I'm not making a --

MS. SPECTOR: I'm not ignoring your comments. I don't agree with them. I don't think that it will --

MR. BEREANO: Well, maybe others will.

MS. SPECTOR: I don't think it will be a monopoly. I don't think it will --

MR. BEREANO: Why will it not be a monopoly?

MS. SPECTOR: I don't think it will allow others not to apply for the contract. I just don't agree.

MR. BEREANO: Why would it not be a monopoly if the winner of this --

MS. SPECTOR: I just don't --

MR. BEREANO: -- expands their -- they not only do REM but they do, you know, but they do others.

MS. BERMAN: But the people that they're -- they have to have REM first.

MS. SPECTOR: Right.

MS. BERMAN: They have to have REM --

MR. BEREANO: I mean, common (phonetic) management.

MS. BERMAN: No. What I mean is if they do the add-on, sir, they have be involved in REM and involved in CFC, Community Options, DDA. There's 1,700 people around that that fit that criteria right now. I believe there's thousands of people that are getting services through DDA, and thousands and thousands through DDA and Community Options and CFC.

This is just one little -- one little population. The rest of the people will still be --

MR. BEREANO: But, why? I follow what you're saying, but why? Why then take that little population and take their choices away and tell them who their case manager is going to be? If the option and, you know, if they stand to do that.

MS. SPECTOR: Because it makes sense in terms of someone's planned care. It makes sense in terms of having a case manager responsible for all of the different services that someone needs.

Right now there's duplication for, you know, one hand -- you know, one program doesn't necessarily know what the other program's doing. And to have one set of eyes on that, it's better --

MS. BERMAN: It happens all the time.

MR. BEREANO: You have it -- you know, it's been going on for a long time?

MS. SPECTOR: Yeah.

MR. BEREANO: And been running well? You haven't spoken to the recipients and really get their views. You haven't. And I think the Department has a responsibility to do that, because that's what these programs are all about, serving these folks, and I think it's important what they think. And the Department hasn't done that.

MR. STEWART: Could I just ask a question? So, I understand the philosophy of all of this, and I guess the only thing that I would say is right now we do a DDA and CFC, and right now what you're saying is that so if a REM case manager has a participant who also has DDA and they'll come in underneath this case manager person --

MS. BERMAN: If and when the add-on is executed.

MR. STEWART: Right. And so that expectation is that case manager, that person who is now managing everything, I understand that would be

nice. But are they -- do they have the expertise really to do that?

I mean, what I see is that DDA is a very complex system and we don't cross-pollinate at all. We have CFC people, and we have DDA people, and I don't know that you could have somebody -- and maybe there's folks that are a lot smarter than we are that are case managers that can do REM and also do DDA efficiently. And if the sense -- is that what the idea is, that you're going to -- having the same person --

MS. BERMAN: The idea is that there's going to be one plan that is going to address the DDA, the Community Options, and REM.

MR. STEWART: Right.

MS. BERMAN: It hasn't been -- it hasn't been developed yet.

MR. OFSEVIT: Alan from MMARS. So, what I've not heard anywhere is is the participant going to

be asked, giving up two or three case managers, which is the one that you want to have being your case manager? Three qualified case managers that are serving one or two or three of the programs. And for REM, because it's a single vendor, they will not have a choice now as opposed to being able to say, you know what? I want the DDA coordinator, who may very well be qualified to be able to do REM in terms of meeting the qualification of being a CCM or being a licensed clinical social worker.

But that person will no longer have the choice to choose the qualified case manager that they want, that they feel the best connection with, that they are getting -- for their most intense services, they're getting the most wrap-around case management that helps them the most.

A lot of people, even though they're in REM are fairly stable medically, but they have a lot of social, housing, and other issues around why they're

enrolled in DDA or in CFC. So now they're not going to have that choice to pick the case manager that is serving them best and who they would choose and they could, and that's the problem I know I certainly have.

MS. DORMAN: I have a question. My name is Selena Dorman with Excel. For these prior people's part, is there any way you can put in enforceable ways that the vendor -- because it really does create a monopoly -- is there any way you can put in these bids? I know of them that were mentioned, MBEs, but there are goals and they're not enforceable, or like if the client has an agency, the business contract is so large that the vendor should be able to put things in place to make sure they would use a subcontractor with that same vendor who's been providing that service, participating or something else, to make sure that you're still incorporating other agencies other than the Department.

I mean, it seems to me that you could at least, because this is probably doesn't address this RFP, if you could at least put things in that could still include other vendors that your prime has to use, and at least that will keep some of the vendors still providing services that they're providing. But it has to be something that you would enforce and tell that client, because just to have a goal and say, well, we don't enforce this, what would you like, doesn't do it. It's something to consider, to put it into this and probably some of the other RFPs because it does create this environment where, I noticed most of the RFPs are similar to this in that it's set up so that whoever is doing -- or it's going to still be doing this.

So, that's a suggestion, but whatever you come up with should be enforceable.

MS. SPECTOR: Thank you for your suggestion. We'll put all of this and, you know -- yes?

MR. BEREANO: Has the scope of work changed significantly from the prior or at least the current contract?

MS. BERMAN: It's changed some.

MR. BEREANO: Significantly, or not?

MS. BERMAN: Probably not significant, but some.

MR. BEREANO: That's why I -- so I wanted to ask can the Department explain why the agency and the individual staff requirements have been dramatically changed from the last solicitation?

In other words, you've gone -- for example, the supervisor in the case management, I see a ratio from one to seven. I mean, if the work scope is the same, why have you ramped up the corporate (phonetic), you know, requirements in this solicitation, which to

me suggests something, but I'll try and be objective. I mean, and it's going to shut out people, and it's something that the current incumbent can do but others cannot do, or are not going to be able to do, you know.

MS. SPECTOR: Well, the participants in this program are complex medically, and I think that, you know, it's important that we have really qualified case managers, you know, providing the services.

We want to make sure that the providers that we have are the best that they can be, and I don't think we've ramped up the qualifications too much. I don't --

MR. BEREANO: You've ramped them up, then. Too much is the subjective term, but you've changed some in here in the scope of work --

MS. SPECTOR: They are different. Like, I don't --

MR. BEREANO: Well, it's going to limit the people that will be able to bid on this again, but potentially do to them. Not the incumbent, but others that would like to be considered.

MS. SPECTOR: Any other questions?

(No response.)

MS. SPECTOR: Going once?

MR. BEREANO: I may have one other one. I think I've worn out my welcome here so far.

MS. SPECTOR: So, thank you everyone for coming. We really, really appreciate it. We will be posting the minutes and the questions and the answers on the website that is on the agenda that everyone should have. We also have an email address for other questions.

MS. NERAL: We've given it to them, though. You guys RSVP'd here this way.

MS. SPECTOR: Right. If anybody has any additional questions, again the responses are due by

September 30th, 2:00. Thank you all so much for coming. We really appreciate it.

MR. BEREANO: Are you going to be sending us a list of people attending?

MS. BERMAN: Yes. Those attending will be included in the minutes.

MS. SPECTOR: We'll post it on the website.

MS. BERMAN: And if you didn't sign the sign-in sheet on your way in, would you please make sure you signed it on the way out? And also make sure we can read your email addresses so that we can make sure you get this information.

MS. SPECTOR: Thank you again.

(At 3:07 p.m. the meeting concluded.)

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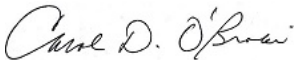
CERTIFICATE OF NOTARY

I, Carol O'Brocki, Notary Public, before whom the foregoing testimony was taken, do hereby certify that the witness was duly sworn by me; that said testimony is a true record of the testimony given by said witness; that I am neither counsel for, related to, nor employed by any of the parties to this action, nor financially or otherwise interested in the outcome of the action; and that the testimony was reduced to typewriting by me or under my direction.

This certification is expressly withdrawn upon the disassembly or photocopying of the foregoing transcript, including exhibits, unless disassembly or photocopying is done under the auspices of Hunt Reporting Company, and the signature and original seal is attached thereto.



CAROL O'BROCKI, Notary Public
in and for the State of
Maryland

My Commission Expires: January 15, 2023