State of Maryland
Department of Health and Mental Hygiene
Office of Health Services
Long-Term Supports and Services Administration

Provider Solicitation

Request for Responses

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

January 1, 2017 - December 31, 2017
Option #1: January 1, 2018 to December 31, 2018
Option #2: January 1, 2019 to December 31, 2019
Option #3: January 1, 2020 to December 31, 2020

Solicitation Summary

Description of Services

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

The current rate for these services is posted on the Department's website:
https://dhmh.maryland.gov/longtermcare/Pages/CFC-Provider-Information.aspx

Regions

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

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

Provider Agreement Term

January 1, 2017 through December 31, 2017
Option #1: January 1, 2018 to December 31, 2018
Option #2: January 1, 2019 to December 31, 2019
Option #3: January 1, 2020 to December 31, 2020

Solicitation Point of Contact

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Deadline for receipt of provider proposals: November 14, 2016 at 2:00pm EST.

Pre-Proposal Conference

To be held at The Department of Health and Mental Hygiene 201 W. Preston Street, Baltimore, Maryland 21201 Room L-3 on Friday, October 21, 2016 from 1-3 pm (EST).

Section 1. General Information

1.1 Relevant Acronyms, Terms, and Definitions

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

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

B. Area Agency on Aging (AAA) –Area Agencies on Aging address the concerns of older Americans at the local level by identifying community and social service needs and assuring that social and nutritional supports are made available to older people in communities where they live.

C. Centers for Medicare and Medicaid Services (CMS) - Federal agency which administers Medicare, Medicaid, and the Children's Health Insurance Program, including the Money Follows the Person demonstration grants.

D. COMAR – Code of Maryland Regulations available on-line at www.dsd.state.md.us

E. Community First Choice (CFC) – A program created by Section 2401 of the Patient Protection and Affordable Care Act that allows states the option to offer certain community-based services as a state plan benefit to individuals who meet an institutional level of care. Maryland's CFC program offers personal assistance, supports planning, nurse monitoring, personal emergency response systems, transition services, and items that substitute for human assistance such as technology and environmental adaptations. Services are provided in the eligible individual's home or community residence

F. Community Personal Assistance Services (CPAS) Program - Provides assistance with activities of daily living, nurse monitoring and supports planning to Medicaid recipients. Services are provided in the eligible individual's home or community residence

G. Community Options Waiver (CO) –This waiver became effective January 6, 2014 and serves adults aged 18 years and older. It provides assisted living, senior center plus, family training, behavioral consultation, and case management services.

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

I. DHMH or the Department – Maryland Department of Health and Mental Hygiene, the State Medicaid Agency.

J. Eligibility Determination Division (EDD) - EDD is responsible for determining waiver financial eligibility.

K. Home and Community-based Services (HCBS) – HCBS are an array of supports provided to individuals living in the community to assist in activities of daily living.

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

M. Local Health Department (LHD) – LHDs administer and enforce State, county and municipal health laws, regulations, and programs in Maryland's twenty-three counties and Baltimore City and are overseen by the Public Health Services of the Department of Health and Mental Hygiene.

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

O. Maryland Access Point (MAP) – Maryland's Aging and Disability Resource Centers are called MAP sites, Maryland's single-point of entry to long term supports and services.

P. Maryland Department of Aging (MDoA) – Maryland's State Unit on Aging designated to manage, design and advocate for benefits, programs and services for the elderly and their families; administers the Older Americans Act and the Aging and Disability Resource Center initiative in partnership with the local Area Agencies on Aging.

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

R. Medicaid /Medical Assistance - A program, funded by the federal and state governments, which pays for medical care for low-income individuals or families, as well as elderly or disabled individuals. To receive Medicaid, an individual must meet certain financial requirements and also must go through an application process.

S. 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 the Centers for Medicare and Medicaid Services.

T. Money Follows the Individual (MFI) - The State's Money Follows the Individual policy allows individuals, who reside in institutions and whose services are being funded by Medicaid, to apply for the waiver program regardless of budgetary caps.

U. Money Follows the Person (MFP) –Demonstration authorized by the Deficit Reduction Act of 2005 and extended through the Patient Protection and Affordable Care Act of 2010 offered through the Centers for Medicare and Medicaid Services as an opportunity for states to rebalance long-term care systems.

V. Normal State Business Hours - Normal State business hours are 8:00 a.m. – 5:00 p.m. Monday through Friday except State Holidays, which can be found at: www.dbm.maryland.gov - keyword State Holidays.

1.2 Background

Philosophy

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

Self-direction promotes personal choice and control over the delivery of waiver and state plan services, including who provides the services and how services are provided.

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

Community Options Waiver
The Community Options waiver serves individuals who are medically, technically and financially eligible for Medicaid waiver services who have been transitioned or diverted from a nursing facility under the Code of Maryland Regulations (COMAR) 10.09.54. Eligible individuals must be age 18 or over, require a nursing facility level of care, choose to receive services in the community versus a nursing facility, and have a cost neutral plan of services that supports the individual safely in the community. This waiver offers assisted living, senior center plus, family training, behavioral consultation, and case management services. Participants of the Community Options waiver are also eligible to receive services through the Community First Choice (CFC) program and many participants receive personal assistance, nurse monitoring, and other services through joint participation in CFC.

Increased Community Services
DHMH has been operating the Increased Community Services (ICS) Program since 2009. The ICS program allows individuals residing in institutions with incomes above 300 percent of Supplemental Security Income (SSI) to move into the community while also permitting them to keep income up to 300 percent of SSI. The ICS program is an expansion population and is currently capped at 30 individuals. Eligible individuals must be 18 years or older and reside (and have resided for a period of not less than 90 consecutive days) in a nursing facility. Any days that an individual resides in an institution on the basis of having been admitted solely for purposes of receiving short-term rehabilitative services for a period for which payment for such services is limited under title XVIII shall not be taken into account for purposes of determining the 90-day nursing home stay requirement; and is receiving Medicaid benefits for nursing facility services furnished by such nursing facility. The ICS program currently offers all of the services available to participants under the Community Options Waiver. ICS is governed by COMAR 10.09.81 which can be found at http://www.dsd.state.md.us/comar/. Increased Community Services is currently limited to 30 participants, and is close to this enrollment limit. The Department has requested approval from CMS to increase this program to 100 participants over the next 3 years.

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

Community First Choice
Section 2401 of the Patient Protection and Affordable Care Act (PPACA), created a program called Community First Choice (CFC), which provides states the option to offer certain community-based

services as a state plan benefit to individuals who meet an institutional level of care. Maryland implemented its Community First Choice program on January 6, 2014.
Maryland's CFC program offers:

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

Services offered under CFC are covered as State Plan services which are available to waiver and non-waiver participants. CFC is governed by COMAR 10.09.84 which can be found at http://www.dsd.state.md.us/comar/.

Waiver Registry
The Community Options waiver has a certain number of slots available to serve individuals in the community and reached it's cap in 2003. At that time, a waiver registry was created to collect information on individuals interested in applying for waiver services. As funding becomes available due to attrition or special funding designations, individuals from the registry are invited to apply for services. The State's Money Follows the Individual policy allows individuals, who reside in nursing facilities and whose services are being funded by Medicaid, to apply for the waiver program regardless of caps.

Program Applicant and Participant Numbers
Please see Appendix 1 for a detailed breakdown of the number of current participants per program and region. It is anticipated that approximately 300 individuals will apply from the waiver registry each year for the duration of this agreement. Approximately 850 nursing facility residents apply for waiver services each year, and approximately one-third (30%) of the applicants successfully transition and become waiver participants within the year.

Community First Choice and the CPAS program do not have caps or registries. The Department receives about 3,100 community referrals each year for these services.

Total program participation for all programs under this solicitation increased by approximately 1,400 people in the last year.

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

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

Information Technology

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

Freedom of Choice of Providers

Applicants and Participants of the CPAS, CFC, and waiver programs have free choice of eligible 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 applications in order to ensure that providers meet enhanced quality standards and are subject to additional oversight by the Department. The local Area Agencies on Aging are designated waiver case management providers and are eligible supports planning providers as well. 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 provides a packet of materials to all applicants that includes brochures from each eligible provider in their area. The applicant may choose a provider by contacting the Department or the chosen provider directly. This choice will be noted in the LTSSMaryland tracking system.

Applicants and participants may choose to change their provider as needed, but not more than every 45 calendar days. Once an applicant or participant chooses a new provider, the current provider will have 14 calendar days to complete their work with the participant. The new provider will receive 14 calendar days notice and become responsible for the provision of services on day 15. An applicant or participant may only request a change of providers after 45 calendar days with their current provider to ensure adequate transition time and continuity of services. For example, if a participant who is already working with a supports planning agency chooses a new provider on January 1st, the change would be effective on January 15th. The participant is not eligible to request another change in provider until March 1st.

Applicants and participants who do not choose a case management provider within 21 days of receipt of the provider information packet will be auto assigned to a provider via the LTSSMaryland tracking system to assure equal distribution of auto assignments among eligible providers. The applicant or participant will be able to change the auto-assigned provider at any time. However, once a provider is chosen by the participant, the 45 day limitation prior to changing providers will apply.

1.3 Description of Case Management and Supports Planning Services

Providers identified through this solicitation shall provide supports planning to applicants and participants of the CO waiver program, ICS, CPAS, and CFC. In addition, the providers shall provide waiver case management services to CO waiver participants to assist them in the annual redetermination process. Providers shall coordinate community services and supports from various programs and payment sources to aid applicants and participants in developing a comprehensive plan for community living. Providers shall support applicants in locating and accessing housing options, identifying housing barriers such as past credit, eviction, and criminal histories, and in resolving the identified barriers. The providers shall assist individuals referred by the Department in developing comprehensive plans of service that include both State and local community resources, coordinating the transition from an institution to the community, and maintaining community supports throughout the individual's participation in services. A comprehensive resource guide for supports planners is posted on the Department's website at https://mmcp.dhmh.maryland.gov/longtermcare/Resource%20Guide/Forms/AllItems.aspx.

Person-Centered Planning

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

Application Assistance for Community Applicants

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

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

When an applicant is initially assigned to a provider, the provider will be alerted via the LTSSMaryland tracking system and shall arrange a meeting with the applicant within 14 calendar days. At the initial meeting, the provider shall provide detailed information about the programs. CPAS and CFC do not require additional financial eligibility determinations and there is no additional application packet needed. Waiver applicants will receive assistance from the provider in completing the waiver application. Assistance to complete the waiver application includes gathering supporting documentation including obtaining copies of financial and identifying documents from family members, guardians, and other supporters of the referred individual. A waiver application is not considered complete until all supporting documentation is submitted with the application to the Eligibility Determination Division (EDD), the entity that determines financial eligibility. The provider shall complete and submit the waiver application with the referred individual within 5 business days of the initial meeting. The submission of the waiver application in the LTSSMaryland system is required to enable the applicant to move forward in the process. .

Application Assistance for Nursing Facility Residents

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

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

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

For individuals with no Medical Assistance benefit, the Options Counselors will complete and submit the community Medicaid application.

Coordination of Medical Eligibility Determination

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

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

Developing a Transition Plan for Nursing Facility Applicants

Once the LHD assessment is received, the provider shall review it and meet with the applicant to develop an initial plan of service (POS). The POS shall include all services and other supports that

address the applicant's medical, social, educational, employment/vocational, psychological, and other needs. Each plan shall include specific strengths, goals and action steps, risks, home and community-based services including non-Medicaid services, identified services providers, etc. The provider shall seek various resources to support the applicant. These include, but are not limited to: donated items, vocational programs, and community and faith-based services as needed. The provider shall assess the individual's transition needs such as the need for household items, accessible housing, furniture, etc. Transition needs shall be included in the POS as CFC transition services, a flexible benefit designed to provide for these needs. If the applicant does not have a community residence identified, the provider shall share information about available housing supports including subsidized housing and homeownership programs including but not limited to the Housing Choice Voucher program, Section 811 Project Rental Assistance, public housing, low-income housing opportunities, and rental assistance. The provider shall assist the applicant in identifying and overcoming potential housing barriers such as accessibility, affordability, and credit problems, evictions, and criminal convictions.

The provider shall submit the initial POS to the Department for approval within 20 calendar days of receipt of the LHD evaluation. Plans of Service for a waiver program must be cost neutral, meaning the services provided in the community cannot exceed the cost of institutional services. The "cost" is determined annually by the Department based on a formula. If the plan of service is denied due to exceeding 125% of the cost neutrality standard, the applicant may choose to eliminate or decrease the amount or type of service(s) outlined in the plan in order to meet or equal the cost neutrality requirement. The revised POS shall then be resubmitted to the Department for reevaluation.

Transitioning Nursing Facility Applicants to the Community

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

Continuing Application for Nursing Facility Residents

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

Ongoing Supports Planning

Once an individual transitions to the community and/or is enrolled in CPAS, ICS, CFC, or a waiver program, the provider shall contact each participant at least once a month to ensure that his or her needs are being met with the services and supports outlined in the POS and complete the monthly supports planning contact form. The provider shall meet with the participant in-person at least once every 90 days to monitor the implementation of the POS and identify any unmet needs. If there is a needed or requested change in the POS, the provider shall follow Departmental guidelines to submit a POS modification for approval and assist the participant in changing his or her services. Ongoing supports planning also include quality monitoring and compliance with the Department's Reportable Events Policy, which can be found at https://mmcp.dhmh.maryland.gov/docs/Appendix_C-1_Reportable_Events.pdf. Quality monitoring includes reviewing documentation of nurse monitoring visits to identify any significant changes in the participant's support needs and reviewing ISAS reports to ensure services are being provided in a manner consistent with the POS.

Continuing Participant Eligibility

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

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

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

For financial redeterminations initiated by the local Department of Social Services for 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 provider applicants. Providers should include in their response to this solicitation a concise description detailing how these requirements are met by the organization or agency and provide relevant agency materials or document samples to demonstrate the experience or capability.

2.1.1. At least two years of successful experience providing community based case management services and/or supports planning for individuals with complex medical needs and/or older adults beyond those ancillary to the provision of other services.
2.1.2. At least two years of experience working with Medical Assistance programs including Managed Care Organizations.
2.1.3. At least two years of experience with and understanding of Medicare and private insurance programs as they relate to Medicaid.
2.1.4. Be free from conflicts of interest as defined in this Solicitation.
2.1.5. Capability of communicating in other languages.

2.2 Highly Desirable Qualifications

The following qualifications are highly desirable. Providers should describe how they meet these qualifications and provide relevant agency materials or document samples to demonstrate the experience or capability in their response to this solicitation.

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

Section 3. Provider Agreement

By submitting a proposal for this solicitation, in addition to the requirements of this proposal, the provider agrees to comply with all of the provisions of the provider agreement, all of the relevant policies of Community First Choice, Community Personal Assistance Services, and waiver programs and all applicable provisions of Maryland regulations, specifically COMAR 10.09.20, 36, 54, 81, and 84.

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

3.1 Specifications

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

3.2 Administration, Record Keeping, Management, and Staffing

The provider agrees to:

3.2.1. Enroll as a Medicaid provider;

3.2.2. Identify and remediate all potential conflicts of interest.

- A. Identify other services provided by the agency, specifically noting any long-term services and supports and/or other Medicaid-funded services.
- B. Identify the remediation and monitoring strategy to ensure applicants and participants receive conflict-free case management and have free choice of any willing provider.
- C. Submit a conflict management plan to the Department for approval as part of the final work plan.
    - i. No services may be provided prior to the Department's approval of the conflict management plan.
- D. Submit quarterly reports on conflict monitoring and remediation efforts to the Department on January 1st, April 1st, July 1st, and October 1st of each calendar year.

3.2.3. Provide an accessible environment, in compliance with the Americans with Disabilities Act (ADA) Part 36. Nondiscrimination on the Basis of Disability by Public Accommodations and in Commercial Facilities, Subpart C. Specific Requirements, Sections 36.301-36.310;

3.2.4. Provide at least one program manager and adequate supervisors/lead workers to support the day-to-day supports planning activities;

3.2.5. Hire supports planners who meet the following minimum qualifications: Bachelor's degree in a human services field, including psychology, social work, sociology, nursing, counseling, sociology, or a related field or work experience pertaining to case management for older adults or adults with chronic conditions and disabilities. Exceptions to this, including the use of interns completing Bachelor's and Master's degree programs through colleges and universities, may be approved at the Department's discretion;

3.2.6. Hire and train a sufficient number of professional supports planning staff to maintain a staff such that the minimum case ratio is 1 case manager to 20 participants/applicants and the maximum case ratio is 1 case manager to 55 applicants/participants for all direct services and responsibilities;

3.2.7. Provide an alternate case manager, who is familiar with an individual's needs, to act on behalf of the original case manager if the original case manager is unavailable. DHMH must be notified within 24 hours if a qualified alternate case manager is not available;
3.2.8. Conduct criminal background investigations of supports planning or other direct program staff to ensure that they do not have a history of behavior that is potentially harmful to program participants or offenses relating to abuse, neglect, and/or exploitation of vulnerable populations;
3.2.9. Have access to a licensed, registered nurse to review plans of service for health and safety concerns, review provider and nurse monitor's case notes, to advise case managers on issues as they arise, and to conduct visits as health concerns arise. The nurse shall have experience in psychiatric nursing, developmental disability and addictions issues;
3.2.10. Have access to a licensed clinical staff person (LGSW, LCSW, LCSW-C, LGPC, LCPC) with experience assessing and delivering services to individuals experiencing mental illness, acquired brain injury, substance abuse, and/or developmental disability
3.2.11. Submit staffing standards and qualifications for all staff roles to the Department for approval to ensure adequate knowledge and training;
3.2.12. Submit a training plan that includes a process for evaluating the competence of staff and efficacy of the training, such as testing or evaluation methods that ensure staff are competent to conduct person-centered planning and perform all other functions described in this solicitation.
3.2.13. Develop and submit to the Department, in electronic format or other format as requested by the Department, a supports planning training manual, within 30 days of award, to be approved by the Department and to include applicable Code of Maryland Regulations (COMAR), Program fact sheets, consumer direction philosophy, person-centered planning tools and training materials, program policies including Reportable Events and Fair Hearing and Appeal Rights, participant letters and forms, provider applications, provider services forms, tracking system instructions, and other documents as requested by the Department;
3.2.14. Provide training to ensure all supports planning staff become highly knowledgeable about Maryland Medicaid, including its programs, services, medical and financial eligibility criteria, complaint and fair hearing processes, and administrative processes and community resources such as: housing options, home health providers, disability-specific resources and issues, aging resources and issues, assistive technology, medical equipment and supplies, and other local area resources;
3.2.15. Ensure that all supports planners attend the Department's New Supports Planners training within 90 days of employment or at the first available training session offered by the Department if no training is offered within the 90 days;
3.2.16. Provide staff training on laws regarding guardianship and other forms of legal representation such as power of attorney and surrogate decision makers;
3.2.17. Conduct the following minimum training before supports planners render services to participants:
    A. Crisis intervention,
    B. Health Insurance Portability and Accountability Act (HIPAA),
    C. Identifying and reporting abuse/neglect/exploitation,
    D. Person-centered planning and self-direction principles, philosophy, and tools,
    E. Overview of community-based service delivery, consumer direction/empowerment, harm reduction philosophy, and person centered planning,
    F. Medicaid, Managed Care Organizations and waivers,

G. Medicaid Program Policies and Procedures, including reportable events, and the web-based tracking system,
, and
H. Other training as recommended by the Department.

3.2.18. Provide supports planning staff with on-going guidance and training related to Medicaid and waiver policies and procedures and in areas reflecting program and population changes;

3.2.19. Provide all training materials to the Department in the format requested by the Department for review prior to use with supports planning staff;

3.2.20. Establish and maintain a toll-free phone number. A representative of the contractor shall be available between the hours of 9 a.m. to 5 p.m. Monday through Friday excluding State of Maryland holidays;

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

3.2.22. Accommodate reasonable date, time, and location preferences for the individuals served under this agreement and requests for accessible communications. Similar accommodations should be made for others involved including family members, friends, guardians, legal representatives, and others as identified by the individual. This may include evenings, holidays, and weekends;

3.2.23. Establish and maintain a clear and accessible communication path for participants, providers, Local Health Departments, the Department and Department contractors to answer questions, resolve problems, and provide information;

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

3.2.25. Provide access to computers with an internet connection and e-mail addresses for all supports planning staff;

3.2.26. Ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA) and ensure access to participant's Medicaid information is limited during transportation and/or to the area of the office with a functional need for the information.

A. Take measures to prudently safeguard and protect unauthorized disclosure of the Medicaid information in its possession.
B. Maintain confidentiality of all participants' records and transactions in accordance with Federal and State laws and regulations;

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

3.2.28. Have the ability to transmit data to the Department utilizing at minimum Microsoft Office 2007 or later;

3.2.29. Attend scheduled meeting and/or training convened by the Department and ensure that the appropriate staff attend each meeting;

A. Training is typically less than one training session per month but may increase in frequency during programmatic changes and updates to the LTSSMaryland tracking system.

3.2.30. Share all policy, procedures, regulations and program changes with the appropriate staff;

3.2.31. Develop relationships and regular communication with the local Maryland Access Point sites that serve as a single point of entry for individuals seeking long-term community supports;

3.2.32. Complete all required documentation in the LTSSMaryland tracking system or other format as requested by the Department including but not limited to:

A. Logging billable case management/supports planning activities in 15 minute units, with enough descriptive text to justify the billing;

B. Document all contacts with the applicants and participants with the date, type of contact, length of time, substance of meeting, contact outcome, and a clear narration;
C. Completing monthly participant contact forms;
D. Completing and submitting Plans of Service and modification requests;
E. Registering participants for one-time password devices for use with ISAS, as needed;
F. Maintaining current addresses, phone numbers, and other contact information for applicants, participants, and their representatives; and
G. Maintaining current staff directories by adding new staff and deleting former staff within 5 business days;

3.2.33. Establish and maintain individual participant files in a locked location and in accordance with COMAR requirements;
3.2.34. Ensure case files are available for immediate review by the State or Federal Auditors;
3.2.35. Retain copies of program files for six years from contract ending date;
3.2.36. Cooperate with Federal and State inspections, reviews, audits, and appeal hearings; and
3.2.37. Develop, reproduce, and supply sufficient Department-approved agency outreach brochures for applicants and participants.

3.3 Self-Direction and Person Centered Planning

The CFC program supports the philosophy of self-direction and self-determination, including the participant's option to waive all but the annual supports planning and semi-annual nurse monitoring visits. A person centered planning process is required for plan of service development.

The Provider shall:

3.3.1. Accept training from the Department, or other Departmental designee on self-direction and person-centered planning.
3.3.2. Ask the participant to determine the level of self-direction that they would like to assume and document the participant choice in the LTSSMaryland tracking system.
3.3.3. Assist the participant in learning skills necessary to increase their level of self-direction as requested by the participant. Assistance may include training on the LTSSMaryland tracking system, person-centered planning, goal setting, and plan of service development.
3.3.4. Generate a request for a participant log-on via the LTSSMaryland tracking system to set-up access for participants upon their request.
3.3.5. Provide participants with training on the client portal and use of the LTSSMaryland system.
3.3.6. Assist participants in navigating the system, generating reports, and using data to manage their services and providers.
3.3.7. Conduct a person-centered planning process with the applicant, participant and representatives of their choice that addresses health and long-term services and support needs in a manner that reflects individual preferences and goals.
3.3.8. Complete a person-centered plan with individually identified goals and preferences, including those related community participation, employment, income and savings, health care and wellness, education and others.
3.3.9. Complete a person-centered plan that reflects the services and supports (paid and unpaid), who provides them and whether an individual chooses to self-direct services.

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,
   D. Freely chooses to sign the MFP consent form;

3.4.2. Document MFP eligibility verification on the MFP questionnaire in the LTSSMaryland tracking system;

3.4.3. Secure the applicant's signature on the MFP consent form and submit the paper form with original signature to the Department within 2 business days of completion;

3.4.4. Ensure MFP eligibility criteria will be met prior to transition and that the MFP questionnaire is accurate and submitted via the LTSSMaryland tracking system.

3.4.5. 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. Maintain and upload to the LTSSMaryland tracking system any receipts or documentation related to the expenditure of MFP flexible funds.

3.4.7. Update the MFP questionnaire upon transition to assure the correct MFP eligibility status is reflected in the LTSSMaryland tracking system at the time of transition.

3.5 Supports Planning Services

The provider agrees to:

3.5.1. Receive and accept all referrals from the Department and participants via the LTSSMaryland web-based tracking system.

3.5.2. Receive and accept self-referrals from applicants and participants;

3.5.3. Document the referral and provider selection in the LTSSMaryland tracking system.

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

3.5.5. For community waiver applicants applying from the registry,
   A. Provide assistance with completing waiver applications within 14 calendar days of Departmental referral or selection of supports planning provider indicated by an alert in the LTSSMaryland tracking system;
   B. Confirm or verify the basic waiver technical eligibility requirements including age and residency;
   C. Assist the individual in obtaining supporting documentation as required for applications such as copies of birth certificates and bank statements;
   D. Secure signatures of the individual, the legal representative or guardian, and others as needed to complete applications;
   E. Submit the signed waiver application and consent for waiver services to the Eligibility Determinations Division within 5 business days of the initial meeting with the applicant;
   F. Retain paper copies of all completed applications and waiver consent forms for reference;
   G. Document application completion and related activities in the LTSSMaryland tracking system. This documentation generates a referral to the Local Health Department (LHD) for a medical eligibility determination.

3.5.6. Monitor the LTSSMaryland tracking system for completion of the medical assessment by the LHD;

3.5.7. If the medical assessment and recommended plan of care are not received by the 15th day after the LHD referral date, contact the local health department regarding the status of the assessment to attempts to resolve any barriers to its completion and document the contact in the Activities module of the LTSSMaryland tracking system;

3.5.8. If the medical assessment and recommended plan of care are not received by the 20th calendar day after the LHD referral date, contact the Department via email to report issues and reasons for the delay as discussed with the LHD;

3.5.9. Upon receipt of the medical assessment and recommended plan of care from the LHD via the LTSSMaryland system, review the documents to identify applicant needs;

3.5.10. Conduct a "face-to-face" meeting with the applicant after receipt of the LHD assessment to:

A. Engage in a person-centered planning process with the applicant;
B. Educate the applicant about self-directed options;
C. Identify the applicant's strengths, goals, and preferences;
D. Review the medical assessment with the applicant; If applicable, assess the individual's transition needs such as the need for household items, accessible housing, furniture, etc.;
E. Identify various resources to support the applicant in the community to include, but not be limited to: Medicaid services, family support, non-Medicaid funded community resources, donated items, vocational programs, and faith-based services; and
F. Complete the initial Plan of Service (POS).

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

3.5.12. Provide information about available housing supports including subsidized housing and homeownership programs including but not limited to the Housing Choice Voucher program, public housing, low-income housing opportunities, senior housing, and rental assistance programs;

3.5.13. Provide housing assistance to meet housing needs including the following:

A. Assist the applicant in identifying and overcoming potential housing barriers such as accessibility, affordability, and credit, evictions, and convictions;
B. Refer the applicant to programs and/or services to overcome credit and conviction barriers to accessing housing;
C. Assist the applicant in completing applications for preferred housing options;
D. Facilitate communication with housing managers to ensure applications are received and to monitor placement on waiting lists;
E. 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.
F. 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.
G. Assist the applicant with pre-tenancy planning to identify the applicant's monthly budget, plan for moving related expenses, arrange for the details of the move, understand the terms of the lease and the rights and responsibilities of tenancy.
H. 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.

3.5.14. Assist applicants in applying for Section 811 Project-based Rental Assistance (PRA).

A. Receive training from the Maryland Department of Disabilities and/or other Department designee regarding the Section 811 PRA program.
B. Train all case managers on the Section 811 PRA Users Guide and My Own Front Door tenant training handbook.
C. Inform applicants and participants of the availability of 811 PRA funding and the location of units.
D. Enter information about outreach conducted related to the 811 PRA housing opportunities into a web-based tracking system.
E. Enter applicants/participants on the 811 PRA waiting list via a web-based tracking system as needed.
F. Collaborate with the Maryland Department of Disabilities and/or other Department designee to help applicants and participants apply for and access 811 PRA units when they are contacted from the waitlist; including participating on property-specific monthly calls.
G. Designate an agency contact to serve as the back-up contact to facilitate responses to time sensitive requests for information related to applicants/participants on the 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.
I. Have an agency representative participate in quarterly meetings of the Maryland Partnership for Affordable Housing's Case Management Sub-committee.

3.5.15. Complete the POS in accordance with policies and procedures outlined in the Plan of Service Development Manual.

3.5.16. Submit schedules and other documents to support the services requested on the POS as needed or requested by the Department.

3.5.17. Complete the Community Settings Questionnaire and validate results through a home visit upon initial application to a program, annually, and upon change in residence or living situation, including new roommates or new rules or regulations in the residence.

3.5.18. Document via photographs or other evidence instances of non-compliance with the Community Settings Questionnaire, or in settings considered under heightened scrutiny.

3.5.19. Note all needed services on the POS (i.e. waiver, Medicaid State Plan, other services regardless of funding source), emergency back-up plan for services vital to health and safety, service start date, duration, frequency, units, and costs in plan;

3.5.20. Note the costs for all Medicaid-funded services (i.e. skilled nursing, occupational therapy, physical therapy, speech therapy, disposable medical supplies, and durable medical equipment);

3.5.21. For waiver and ICS applicants, note if the POS is cost neutral using the current cost neutrality figures provided by the Department;

A. If the individual's POS exceeds cost neutrality, assist the individual to examine options to reduce the cost of the plan of service, including eliminating or reducing services;
B. If the individual chooses to change the POS, assist the individual in modifying the plan to their satisfaction;

3.5.22. Obtain the individual's signature and any additional signatures needed on the POS such as those of the guardian, legal representative, providers, etc.

3.5.23. Submit the POS to the Department within 20 calendar days of receipt of the LHD assessment and recommended Plan of Care;

3.5.24. Coordinate service start dates by making verbal and written referrals to enrolled Medicaid providers and forwarding any necessary information for their review;

3.5.25. Ensure POS approval and program enrollment prior to delivering or accessing Medicaid services.

3.5.26. Send the Community Options Notification form to the personal assistance provider upon any initiation, termination or change in personal assistance service;

3.5.27. For waiver and ICS applicants, ensure waiver eligibility is confirmed by EDD via the Advisory Opinion Letter prior to the transition;

3.5.28. For nursing facility applicants, coordinate the transition to the community, including but not limited to the following tasks:

A. Coordinate the final discharge transition meeting with the applicant and others as applicable and identified by the individual, such as the guardian, authorized representative, and nursing facility staff;

B. Coordinate with institutional staff the continuation of services such as occupational, speech, and physical therapy and durable medical equipment and disposable medical supplies;

C. Coordinate with the transition funds provider to procure approved goods and services such as security deposits, utility hook-ups, household items, furniture, etc. using CFC transition funds;

D. Maintain and upload to the LTSSMaryland tracking system copies of receipts and other documents related to the expenditure of transition funds.

E. Ensure that all vital household items including furnishings, toiletries, medical equipment and supplies, food, and medication are available on the day of transition;

F. Ensure service providers are available and ready to begin services on the discharge date,

G. Perform coordination of the transition and be present on the day of the move to assure success of the transition and participant satisfaction with living conditions in the community residence.

3.5.29. Submit the discharge form 257 to the Department within 5 business days of discharge.

3.5.30. Provide program orientation for participants and their representatives, including an explanation of the responsibilities of the participant, the case manager/supports planning provider, and the Department.

A. Train participants on the In-home Supports Assurance System and related program policies.

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

C. Inform participants of the provider's person-centered planning methodology.

3.5.31. Make direct contact with participants as needed and as follows:

A. Contact participants no less frequently than once per month by phone or e-mail;

B. If a participant cannot be contacted within 30 days, send a certified letter to the participant to establish contact and/or conduct a drop in visit where feasible.

C. If a participant has not been contacted within 60 days, conduct a home visit.
D. Meet with participants in person at the participant's home where they receive services at least every 90 days;
E. Document all contacts and attempts to contact in the LTSSMaryland tracking system.

3.5.32. Assist participants in registering with local emergency services providers such as the local Fire Department (as appropriate);

3.5.33. Assist each participant with the development of an Emergency Back-Up Plan that is documented in the Plan of Service and includes emergency contacts and steps to follow in the event of an emergency.

3.5.34. Issue One-Time Password (OTP) devices to participants who do not have a land line phone or who may begin services at a location other than their primary residence.

A. Use the LTSS Maryland tracking system to assign OTPs to participants.

3.5.35. Verify the presence of the OTP device during participant contacts and in-home visits.

A. Report lost or stolen OTPs to the Department within 24 hours of knowledge.
B. Issue a new OTP to the participant within 72 hours of notification of the loss of an OTP.

3.5.36. Complete monthly contact forms in the LTSSMaryland tracking system to verify contact or attempts to contact each participant each month.

A. Verify participant eligibility for the program in which they are participating, including Medicaid eligibility, active special program codes, level of care and med/tech date status.
B. Follow up as needed to correct any eligibility issues discovered during the monthly contact.
C. Review the ISAS Services Rendered report and compare the services received to the active POS and discuss any discrepancies with the participant and provider.
D. Note any needed POS modifications on the monthly contact form and submit the revised POS to the Department within 30 days of the contact.
E. For waiver participants who receive only CFC services complete the monthly waiver eligibility verification via the monthly case management contact form.
F. Completed the monthly contact form within the LTSSMaryland tracking system by the end of each month.

3.5.37. When critical issues of health and safety are identified, notify the Department by phone within 24 hours of knowledge;

3.5.38. Monitor participants' service utilization to ensure services authorized in the POS are received, acceptable, and adequate.

3.5.39. Identify any need to reassess services through monitoring visits and participant contact and refer the participant for a new medical assessment when the participant experiences a significant change in health, medical conditions, or disability;

3.5.40. If there is a needed or requested change to the POS, follow Departmental guidelines to submit a POS modification to modify services and notify affected providers;

3.5.41. Assist the individual in accessing new services or providers as approved on a POS modification;

3.5.42. Review documentation of nurse monitoring visits logged into the LTSSMaryland tracking system;

A. Monitor the completion of nurse monitoring visits and assure visits are conducted at the frequency recommended by the LHD and follow up with the participant with any concerns.
B. Review visit notes, assessment and other nurse monitoring forms.
C. Discuss any issues identified in the nurse monitoring visits with the participant during contacts.

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

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

A. Verify that the system generates a referral for a new medical assessment by the LHD at least 60 days before the individual's waiver eligibility expires;
B. Review the new medical assessment and recommended plan of care with the participant.
C. Update the Community Settings Questionnaire.
D. Conduct a person-centered planning process to update the participant's POS.
E. Submit the updated POS to the Department at least 30 days before the individual's eligibility expires;

3.5.45. Meet with waiver participants at least annually to facilitate continued financial eligibility by completing the following:

A. Assist the individual with completing a new waiver application;
B. Forward the new application information to the Eligibility Determination Division (EDD) 60 days before the individual's waiver eligibility expires;

3.5.46. Ensure approval of the annual POS and verification of continuing eligibility is completed.

3.5.47. If a participant in a waiver program indicated that they will no longer accept services, complete a new waiver freedom of choice form indicating the individual's choice to decline services and document the expressed reason for declining services;

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

3.5.49. Notify the participant, their representatives, and providers of any loss of eligibility determined by the annual process or discovered during routine eligibility monitoring.

A. Assist the individual with identifying and accessing alternate community resources, and
B. Provide information about the appeals process.
C. Attend hearings only as a representative of the Department with prior authorization from the Department.

3.5.50. Train participants and their representatives on the Reportable Events policy and protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experiences abuse, neglect or exploitation.

3.6 In-Home Supports Assurance System (ISAS)

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

3.6.2. Inform applicants and participants of the ISAS to be used by providers to verify service provision.

3.6.3. Issue One-Time Password (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. Use the LTSS Maryland tracking system to assign and unassign OTPs to participants.
3.6.5. Verify the presence of the OTP device during supports planning contacts and in-home visits and document the verification on the monthly contact form.
3.6.6. Report lost or stolen OTPs to the Department within 24 hours of knowledge and mail any broken or malfunctioning OTP devices back to the Department.
3.6.7. Issue a new OTP to the participant within 72 hours of notification of the loss of an OTP.
3.6.8. Provide information to providers and participants upon request regarding the provider enrollment system related to ISAS.
3.6.9. Provide participant training on the use of the ISAS web-based interface as a means to review and approve requests for billing submitted via ISAS by their providers.
3.6.10. Cooperate with the Department to resolve billing exceptions generated by ISAS, including but not limited to verifying the current providers, remediating errors on the plan of service, locating and contacting a participant to verify service provision, and identifying any gaps in service.
3.6.11. Generate participant-specific ISAS reports from the LTSSMaryland tracking system to review with the participant at monthly and annual contacts to assure service delivery and appropriate billing.

3.7 Reportable Events

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

3.8 Quality

3.8.1. Develop and implement a Quality Assurance Plan, to be approved by the Department to monitor and ensure:
   A. All responsibilities and timeframes contained in this provider solicitation are accomplished.
   B. The provider has clearly defined goals and standards for each responsibility outlined in this solicitation.
3.8.2. Review and amend the Quality Assurance Plan at least bi-annually to evaluate effectiveness in meeting supports planning responsibilities;

3.8.3. Ensure compliance with all statutes, regulations, program policy and procedures, codes, ordinances, licensure or certification requirements that pertain to the waiver, ICS, CPAS, and CFC programs;
3.8.4. Report to the Department potential misuse of program services, suspected program abuse, and other information deemed as critical by the Department in writing within two business days;
3.8.5. Ensure compliance with all performance measures noted in the Department's waiver applications to the Centers for Medicare and Medicaid Services.

3.9 Conflict Free Case Management

3.9.1. Disclose 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.

3.10 Provider Termination and Transition Plan

The Department may terminate this agreement at any time by notifying the provider in writing.

3.10.1. Terminate the agreement with written notice to the Department no less than 6 months (180 calendar days) prior to the termination of services or prior to the agreement end date.
3.10.2. Submit a transition plan that clearly describes assistance to be provided to participants regarding the selection of new provider, transition of files and other data, and the reason for termination.
3.10.3. Describe the transition plan to ensure the continuity of services for all applicants and participants at the end of the term of this provider agreement. The transition plan shall include:
   A. Time line for notification to the Department, participants and their representatives, and other providers;
   B. Written notice, to be approved by the Department in advance, to participants and their representatives no less than sixty days prior to termination;
   C. A plan to notify other providers of the termination of services;
   D. Secure transmission of paper files to new providers identified by the participant;
   E. Ensuring adequate staffing during the transition;
   F. Creating a plan to ensure the timeliness of data entry into the LTSSMaryland tracking system.

3.11 Billing

The provider agrees to:

3.11.1. Bill the Department for supports planning services provided to applicants according to Departmental guidelines.
3.11.2. Bill the Department for comprehensive transitional case management/supports planning activities provided to applicants up to 180 days prior to their transition on or after the date of discharge and the applicant's enrollment in services according to Departmental guidelines.

3.11.3. Bill for no more than 7 hours a day per participant and no more than 35 hours a week per supports planner.
3.11.4. Provide written notification of supports planner who work a non-traditional schedule for approval prior to billing greater than 35 hours per week.
3.11.5. Utilize the LTSSMaryland tracking system to track all billable activities.
3.11.6. Utilize electronic billing functionality in the LTSSMaryland tracking system.
3.11.7. Maintain records which fully demonstrate the extent, nature and medical necessity of services provided to Medicaid recipients.
3.11.8. Enter billable activities into the LTSSMaryland tracking system with descriptions that include the duration of the activity, actions taken, outcomes and planned follow up.
3.11.9. Bill only for allowable activities. Non-billable activities include:
   A. Supports planning activities of less than 8 minute in duration (please see Appendix 3 for examples of billing total minutes as 15 minute unites of service ;
   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 or service data or other information;
   D. Completion of billing documentation; Individual or group supervision, routine case reviews and rounds, ad hoc consultation with supervisors and discussion or consultation among team members;
   E. Time spent in staff training, clinical supervision or case reviews including for the purpose of treatment planning, unless the participant is present;
   F. Travel time;
   G. Attempted contacts or leaving messages; and
   H. Services provided by individuals who do not meet the definition of and minimum qualifications for a case manager.
3.11.10. The provider shall review activities on a weekly basis to verify compliance with Department issued billing guidance and adjust any non-compliant activities.
3.11.11. Track internal billing compliance and submit a billing auditing report that details findings from internal quality oversight process to the Department weekly, including any activity adjustments made due to for compliance with billing guidelines.

3.12 Required Documentation
The provider shall submit to the Department:

3.12.1. A Final Work Plan within 30 days of the initiation of the provider agreement, to meet all provider agreement requirements including:
   A. Proposed start-up work plan including methods and timelines for meeting requirements for staffing, training, technology, and securing agency worksites.
   B. Working with family, guardians, legal representatives, and other involved persons as needed and as requested by the applicant;
   C. Establishing a person-centered planning process for POS development;
   D. Incorporating consumer-direction into policies, procedures, training, and activities;
   E. Creating Staffing standards for all staff roles;
   F. Creating staff training materials and training schedule;
   G. Creating participant orientation materials;
   H. Creating a Disaster Recovery Plan;

I. Creating a plan to ensure the timeliness of data entry into the LTSSMaryland tracking system;

3.12.2. Submit the 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 Provider and DHMH shall consist of:

A. This solicitation;

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

C. The Provider Agreement and Acknowledgement of Provider Agreement and Responsibilities form;

D. Applicable regulations, including payment 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 (1 is more important than 2 and 2 is more important than 3, etc.) according to the following criteria:

A. Quality of Proposed Work Plan

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

B. Corporate Qualifications and Experience

i. The organization documents that it meets each of the Minimum Qualifications

ii. The extent to which the organization meets the Highly Desirable Qualifications

C. Experience and Qualifications of Proposed Staff

i. Experience and qualifications of proposed staff

ii. Quality of the proposed training plan

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

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

4.2 Pre-Submission Processes

Pre-Proposal Conference

While attendance at the pre-proposal conference is not mandatory, the information presented may be informative. All interested offerors are encouraged to attend in order to be better able to prepare an acceptable proposal. In order for the Department to prepare for this conference, prospective attendees are requested to send an email, at least 24 hours in advance of the pre proposal conference, to the Department at dhmh.cfc@maryland.gov. The email should provide notice of the anticipated number of individuals who will attend, as well as to provide an acknowledgement of receipt of the solicitation. Any individual interested in attending the pre-proposal conference who is in need of an accommodation due

to his/her disability should contact the Issuing Office a minimum of five working days prior to the conference to request the necessary accommodation.

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

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

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

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

Proposal Submission Guidelines

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

Christin Whitaker Diehl, Chief
Community Options Administration Division
201 W. Preston Street, Room 136
Baltimore, MD 21201

Deadline for receipt of proposals: Monday, November 14th at 2:00pm EST.

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

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

4.3 Components of a Complete Proposal

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

4.3.1 A complete proposal packet contains:

A. Two (2) original copies of the proposal with signatures, marked "Original" on each cover page;
B. Four (4) copies, marked "Copy" on each cover page;
C. If the proposal contains confidential or proprietary information, include one (1) copy with this information removed, marked "PIA Copy" to be used for Public Information Act requests; this copy must also include a statement by the offeror regarding the rationale for the removal – a blanket statement by an offeror that its entire proposal is confidential or proprietary is unacceptable.
D. A draft final work plan as described in Section 3.12.1.
E. A draft training plan as described in Section 3.2.12.
F. A draft billing audit process as described in 3.11.11.

4.3.2 Each proposal must contain:

A. A cover page that includes:
    i. Name of the offering organization;
    ii. Address of the offering organization;
    iii. Contact information 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. Region or regions for which the proposal is offered, list the names of the individual regions or "Statewide" for a proposal to provide services in all regions. Note: An offeror may be selected to provide services in any of the regions for which the proposal is offered, and will not necessarily be selected in all regions covered by the proposal.
    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 the Provider Agreement. The statement "Agreed" or "Will comply" is not a sufficient response and offerors will be rated on their description of how they meet each requirement. The Offeror shall address each requirement in its proposal and describe how its proposed services will meet or exceed the requirement(s). Any paragraph in the proposal that responds to a Provider Agreement Specification shall include an explanation of how the work will be done. Any exception to a requirement, term, or condition may result in having the proposal classified as not reasonably susceptible of being selected for award or the Offeror deemed not responsible.
C. In proposals covering multiple regions, clearly identify any aspect of the Proposed Work Plan that does not pertain to all regions covered by the proposal.
D. A concise description of Corporate Qualifications and Experience that:
    i. Specifically explains how the organization meets each of the Minimum Qualifications;

ii. Explains the extent to which the organization meets the Highly Desirable Qualifications;
iii. Identifies programs for which the organization has provided case management or supports planning services including:
iv. The scope of services provided;
v. The types of individuals served; and
vi. Internal program monitoring activities.

E. A section describing the Experience and Qualifications of Proposed Staff, including:
   i. A list of proposed staff and their proposed roles;
   ii. The relevant experience and qualifications of each proposed staff member
   Note: A short summary of each staff person's most relevant experience and qualifications is preferred over attaching resumes.
F. A draft training plan as described in Section 3.2.12.
G. A draft billing audit process as described in 3.11.11.
H. At least three (3) professional reference letters that include:
   i. Name of reference
   ii. Organization of reference
   iii. Phone number and email address of reference
   iv. A signed letter of reference that includes the nature and extent of the relationship with the offeror.
I. A complete and signed Acknowledgement of Provider Agreement and Responsibilities form (see below).

Acknowledgement of Provider Agreement and Responsibilities
Replace all underlined and bracketed sections with the requested information.

Provider Organization
[Name of Offeror's Organization]
[Address of Organization]
[Address of Organization]

Tax ID Number: [Insert Tax ID Number]

Offeror's Contact Information
[Name of Representative]
[Title of Representative]
[Mailing Address]
[Mailing Address]
[Telephone Number(s)]
[Email Address]

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

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

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

_____ _____
(Signature) Date

Appendix 1-Enrolled Participants by Program

Jurisdiction	CFC	CO	CPAS	ICS	Program Total
Allegany County	151	65	6	0	222
Anne Arundel	288	221	10	1	520
Baltimore County	943	747	45	5	1740
Baltimore City	1532	880	131	1	2544
Calvert County	57	29	6	1	93
Caroline County	79	34	1	0	114
Carroll County	65	90	3	0	158
Cecil County	100	56	4	1	161
Charles County	135	99	4	3	241
Dorchester County	60	39	1	0	100
Frederick County	123	50	7	0	180
Garrett County	92	25	8	1	126
Harford County	206	75	6	0	287
Howard County	295	188	20	0	503
Kent County	22	28	0	0	50
Montgomery County	1616	485	83	6	2190
Prince George's County	545	447	27	2	1021
Queen Anne's County	19	35	0	0	54
Somerset County	70	39	4	0	113
St. Mary's County	60	22	5	1	88
Talbot County	36	11	2	0	49
Washington County	87	43	5	1	136
Wicomico County	120	81	2	1	204
Worcester County	36	48	3	0	87
TOTAL	**6737**	**3837**	**383**	**24**	**10981**

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
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)