Q. The first sentence of paragraph 4.3.2(B) talks about duty described in the Provider Agreement
Is this an agreement between State and Supports Planning Agency? If so, can you please forward blank copy of said agreement?

A. Yes. Selected providers will enter into a provider agreement. The Agreement between the Provider and DHMH shall consist of: the provider solicitation; the accepted proposal, including any subsequent revisions and written responses to DHMH questions; the Provider Agreement and Acknowledgement of Provider Agreement and Responsibilities form; and applicable regulations, including payment rates established by regulation. The provider agreement will be posted online with the solicitation questions.

Q. On page 7, Freedom of Choice of Providers, it states that:
"The local Area Agencies on Aging are designated waiver case management providers and will be eligible supports planning providers as well. Eligible providers of MAPC and CFC supports planning services will be limited to providers who are also enrolled to provide waiver case management services."
Does accepted as a provider under this solicitation also enroll the provider as a case management services?

A. Yes. As noted on page 2 of the solicitation under the Description of services, providers identified through this solicitation process will be enrolled to provide supports planning and case management services.

Q. Can a group of organizations form a conglomerate? If so, how does the LTSS billing work?

A. A group of providers may partner to submit a single proposal. The proposal should clearly explain how the different organizations will be managed and how each of the criteria in the solicitation will be met through the conglomeration. A single provider number would be assigned to the conglomeration if selected through the solicitation process. There are reports in the tracking system that can sort billed activities down to the level of the individual supports planner. However, the system is not designed to sub-divide payments among subcontractors or conglomerates. It would be the responsibility of the provider to distribute payments made to a single provider number accordingly. All requirements related to billing as stated in Section 3.11 would still apply.

Q. Can the qualifications of the staff that will be starting a new organization be used to meet the organizational experience requirements as well as the staff experience?

A. The experience of the proposed staff may count towards the organizational experience requirement. The proposal should clearly explain how the offeror meets the experience qualifications. Letters of commitment for new staff should be submitted if there is no employment relationship with the proposed staff, particularly if the offeror needs those staff in order to meet the qualifications.

Q. This question is in reference to Section 3.2.6. “Hire and train a sufficient number of professional supports planning staff to maintain a staff such that the minimum case ratio is 1 case manager to 20 participants/applicants and the maximum case ratio is 1 case manager to 45 applicants/participants for

all direct services and responsibilities." Can we assign a case manager to work less than full-time? Are you referring to full-time equivalents?

A. Yes, this requirement refers to full-time equivalents. Individual staff members may work less than full-time and the case load should be reduced accordingly. For example, a person who works half-time would be limited to a case load ration between 10 and 22, half of the full-time ratio.

Q. How flexible is the DHMH on requiring the provider having conference space, an RN for all cases and an interpreter?

A. The requirements are not flexible. Each interested provider should develop pa proposal that clearly describes how and to what extent they meet each of the requirements. Please carefully read the requirements, as some require that a provider "have access to" rather than own, rent, or employ certain resources. The solicitation states the following on page 27 in 4.3.2.B.

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.

Q. In the section: 'Identify other services provided by the agency, specifically noting any long-term services and supports and/or other Medicaid-funded services.' Is Options Counseling in Nursing Facilities considered a Medicaid-funded service?

A. Yes.

Q. In section 3.10 Provider Termination and Transition Plan – Does a plan have to be submitted as part of the response? I wasn't sure as it seems as though that plan might be different if a time came when a provider terminated services.

A. Yes, an outline of the plan that highlights the basic plan and action steps for the transition are necessary to address the requirement.

Q. Is your office open on Friday, November 24th? Are you accepting the submissions via FedEx or USPS? I am concerned about the upcoming weather and timeliness of getting it to your office.

A. No. The State offices are closed on Friday and cannot accept deliveries. Submissions via FedEx or USPS are accepted but must be received by the deadline on Monday, December 1st.

Q. Question about volume and ramping up staff...any way to predict how many referrals the program will have in the first quarter?

A. The program cannot predict or guarantee the number of referrals to any single provider given that applicants and participants have freedom of choice among enrolled providers, both when

first enrolling and on an ongoing basis during their participation. Question 4 in the pre-proposal meeting notes states “The current providers are assigned approximately 9,000 people. There are an additional 1,000 MAPC participants who need supports planners and we receive 3-400 new referrals per month. There is no guarantee of a minimum number of participants to any agency.”

Q. After the Supports Planners are hired, will they have the opportunity to attend the LTSSMaryland training? How often will this be offered?

A. Yes, newly enrolled supports planning agencies will have the opportunity to receive initial training on the LTSS. However, not all individual supports planners will be able to attend the Department-sponsored training and enrolled providers must develop the expertise to provide the training to their staff on an ongoing basis.

Q. Section 3.11 - does the LTSSMaryland system do the actual billing for the program entirely? If our Accounting Dept will need to submit anything additional, we will have to plan for that.

A. The LTSS system captures activities entered by providers then generates and sends claims to MMIS for processing each week. Payments are made by the State outside of the LTSS. Providers would only need to submit additional documentation if proposing an interface with the LTSS.