ANNE ARUNDEL COUNTY
MENTAL HEALTH AGENCY, INC.

REQUEST FOR PROPOSALS

FOR

Mental Health Case Management: Care Coordination for Children and Youth

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I. BACKGROUND

In State Fiscal Year 2007, Maryland opted out of Medicaid coverage and the service was returned to state grant funding. Due to the flexibilities allowed by state only funding, the number of persons served did not drop dramatically, but enrollment was essentially capped. In April 2009, the State Mental Hygiene Administration (MHA) announced its intention to amend the State Medicaid Plan to return Targeted Case Management (TCM) to a Fee For Service (FFS) Medicaid reimbursable service with a small state only funding add on to serve individuals who are high service priority and not covered by Medicaid. Historically, persons in the Shelter Plus Care (SPC) Program, Supported Housing Opportunity Program (SHOP), County Detention Centers, Hospital Diversion Program, and other supported housing programs are prioritized for TCM services. Conversely, persons participating in the Psychiatric Rehabilitation Program (PRP) were excluded from eligibility. Persons transitioning from Psychiatric In-Patient Hospitalization are eligible up to 30 days prior to discharge. Both children and adults are currently eligible for TCM services at two intensity levels.

In 2009, a Psychiatric Residential Treatment Facility (PRTF) Demonstration Waiver was implemented in Maryland. The intent of the demonstration waiver was to provide treatment and services, through a home and community-based service waiver under the §1915(c) of the Social Security Act, for children and youth ages 6 through 21, who, absent the waiver, would require PRTF services. Waiver participants were served by Care Management Entities (CME) through a wraparound service delivery model that utilized child and family teams to create and implement individualized plans of care that were driven by the strengths and needs of the participants and families.

With the demonstration waiver nearing to its close, the MHA began planning for a State Medicaid Plan Amendment (SMPA) through the 1915(i) Community Choice for Children Youth & Families (CCCYF) initiative to incorporate the wraparound philosophy and imbed the philosophy into a Medicaid reimbursable service. Upon the approval of the SMPA by the Federal Centers for Medicare and Medicaid Services (CMS) the selected Mental Health Case Management provider will serve as the Care Coordination Organization (CCO) providing TCM for children and youth enrolled in the 1915i Initiative.

The Anne Arundel County Mental Health Agency (AACMHA) desires to identify vendors to provide Mental Health Case Management Care Coordination for Children and Youth, which includes young adults up to age 22 for each of the following counties: Anne Arundel, Calvert, St. Mary's and Charles counties beginning on or about November 3, 2014. Offerors must specify which county or counties they intend to serve.

Mental Health Case Management Care Coordination for Children and Youth allows for a multi-level continuum of care coordination using the Wraparound[1] practice model. This multi-level continuum of care will provide care coordination to children and youth to support a transition back to a home environment, remain in their home or current living arrangement, move to a lower intensity of services or restrictiveness of placement, or otherwise maintain and improve functioning and well-being.

II. LEVELS OF CASE MANAGEMENT

All participants shall be classified according to the following levels of service, however, the Case

[1] Throughout this document the term "Wraparound" refers to the service delivery model as defined by the National Wraparound Initiative (www.nwi.pdx.edu)

Management Services- Mental Health Case Management: Care Coordination for Children and Youth of the State Plan under chapter XIX of the Social Security Act are in draft form and are subject to change:

(A) Level I-General Case Management. For a maximum of 12 units of service per month, the participant shall meet at least two of the following conditions:

(i) The participant is not linked to behavioral health services, health insurance, or medical services;
(ii) The participant lacks basic supports for education, income, shelter, transportation and food;
(iii) The participant is transitioning from one level of intensity to another level of intensity of services;
(iv) The participant needs care coordination services to obtain and maintain community-based treatment and services; or
(v) The participant is currently enrolled in Level II or Level III Case Management Services under this chapter and has stabilized to the point that Level I is most appropriate.

(B) Level II-Moderate Case Management. For a maximum of 30 units of service per month, the participant shall meet at least three of the following conditions:
(i) The participant is not linked to behavioral health services, health insurance or medical services;
(ii) The participant lacks basic supports for education, income, food, shelter and transportation;
(iii) The participant is homeless or at-risk for homelessness;
(iv) The participant is transitioning from one level of intensity to another level of intensity including transitions out of the following levels of service:
(1) Inpatient psychiatric or substance use services;
(2) Residential treatment center; or
(3) Any service specified in section 1915(i) of Maryland's State Plan.
(v) The participant has a history of psychiatric hospitalizations or a history of repeated visits or admissions to emergency room psychiatric units, crisis beds, or inpatient psychiatric units due to multiple behavioral health stressors within the past 12 months;
(vi) The participant needs care coordination services to obtain and maintain community-based treatment and services;
(vii) The participant is currently enrolled in Level III Case Management services under this chapter and has stabilized to the point that Level II is most appropriate; or
(viii) The participant is currently enrolled in Level I Case Management services under this chapter and has experienced one of the following adverse childhood experiences during the preceding six months;
(1) Serious emotional, physical or sexual abuse;

(2) Serious emotional , or physical neglect; or
(3) Significant family disruption or stressors

(C) Level III – Intensive Case Management. For a maximum of 60 units of service per month, the participant shall meet at least one of the following conditions:

(i) The participant has been enrolled in services provided in Section 1915(i) of Maryland's Medicaid State Plan for six months or less; or

(ii) The participant meets all of the following conditions:

(l) The participant has a behavioral health disorder amendable to active clinical treatment, determined by a face-to-face psychiatric evaluation;

(2) There is clinical evidence the child or adolescent has a serious emotional disturbance (SED) and continues to meet the service intensity needs and medical necessity criteria for the duration of their enrollment;

(3) A comprehensive psychosocial assessment performed by a licensed mental health professional finds that the child or adolescent exhibits a significant impairment in functioning, representing potential serious harm to self or others, across settings, including the home, school, and/or community.

(4) The psychosocial assessment supports the completion of the Early Childhood Service Intensity Instrument (ECSII) for youth ages 0-5 or the Child and Adolescent Service Intensity Instrument (CASII) for youth ages 6-21, by which the participant receives a score of:

a. 4 or 5 on the ECSII; or
b. 5 or 6 on the CASII.

(iii) Youth with a score of 5 on the CASII also must meet one of the following criteria to be eligible based on their impaired functioning and service intensity level:

(1) Transitioning from a residential treatment center; or
(2) Living in the community; and
(3) Be at least 13 years old and have:

a. Three or more inpatient psychiatric hospitalizations in the past 12 months; or
b. Been admitted to a residential treatment center within the past 90 days; or

(4) Be six through 12 years of age and have;

a. Two or more inpatient psychiatric hospitalizations in the past 12 months; or
b. Been admitted to a residential treatment center within the past 90 days.

(iv) Youth who are younger than six years old who have a score of a 4 on the ECSII must either;

(1) Be referred directly from an inpatient hospital unit; or

(2) If living in the community, have two or more psychiatric inpatient hospitalization in the past 12 months.

(v) The participant is currently enrolled in Level I Case Management services under this chapter and has experienced one or more of the following adverse childhood experiences during the preceding six months:

(1) Serious emotional, physical, or sexual abuse;
(2) Serious emotional or physical neglect; or
(3) Significant family disruption or stressors

III. WRAPAROUND MODEL

A. Project Description and Purpose

The elements of the Mental Health Case Management Care Coordination for Children and Youth that must be addressed in response to this RFP are defined below:

The Wraparound Model, a service delivery process that is premised upon the individual strengths and needs of each child, adolescent, and family, is often delivered at the front-line practice level. In this model, the Child and Family Team (CFT) is held accountable to the family, team members, participants, and the public for achieving the goals of the plan of care (POC). Wraparound is an ecologically based process and approach to care planning. The model builds on the collective actions of a committed group of family, friends, community, professionals, and cross-system supports mobilizing resources and talents from a variety of sources. Wraparound aims to develop the problem-solving skills, coping skills and self-efficacy of children, youth and family members.

The Wraparound Model is used to:

- Ensure caregivers and youth have ACCESS to the people and processes in which decisions are made about care, as well as access to needed resources and services.
- Ensure family's VOICES are heard and they are full decision makers in charge of their own lives.
- Ensure the family has OWNERSHIP of the planning process in partnership with the team and is in agreement and committed to carry out the plan.

B. Wraparound Principles

Offerors are expected to be familiar with, support, and promote the principles of Wraparound. The Wraparound model adheres to the "Ten Principles of Wraparound" (Bruns, Walker, & The National Wraparound Initiative Advisory Group, 2008) which are:

i. **Family voice and choice.** Family and youth/child perspectives are intentionally elicited and prioritized during all phases of the Wraparound process. Planning is grounded in family members' perspectives, and the team strives to provide options and choices such that the plan reflects family values and preferences.

ii. **Team based.** The Wraparound team consists of individuals agreed upon by the family and committed to them through informal, formal, and community support and service relationships.

iii. **Natural supports.** The team actively seeks out and encourages the full participation of team members drawn from family members' networks of interpersonal and community relationships. The Wraparound plan reflects activities and interventions that draw on sources of natural support.

iv. **Collaboration.** Team members work cooperatively and share responsibility for developing, implementing, monitoring, and evaluating a single Wraparound plan. The plan reflects a blending of team members' perspectives, mandates, and resources. The plan guides and coordinates each team member's work towards meeting the team's goals.

v. **Community-based.** The Wraparound team implements service and support strategies that take place in the most inclusive, most responsive, most accessible, and least restrictive settings possible; and that safely promote child and family integration into home and community life.

vi. **Culturally competent.** The Wraparound process demonstrates respect for and builds on the values, preferences, beliefs, culture, and identity of the child/youth and family, and their community.

vii. **Individualized.** To achieve the goals laid out in the Wraparound plan, the team develops and implements a customized set of strategies, supports, and services.

viii. **Strengths based.** The Wraparound process and the Wraparound plan identify, build on, and enhance the capabilities, knowledge, skills, and assets of the child and family, their community, and other team members.

ix. **Persistence.** Despite challenges, the team persists in working toward the goals included in the Wraparound plan until the team reaches agreement that a formal wraparound process is no longer required.

x. **Outcome based.** The team ties the goals and strategies of the Wraparound plan to observable or measurable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly.

C. Key Elements of the Wraparound Process

i. Grounded in a Strengths Perspective

Strengths are defined as interests, talents, and unique contributions that make things better for the family. Within an entire process that is grounded in a strengths perspective, the family story is framed in a balanced way that incorporates family strengths rather than a focus solely on problems and challenges. A strengths perspective should be overt and easily recognized, promoting strengths that focus on the family, team, and community, while empowering and challenging the team to use strengths in a meaningful way.

ii. Driven by Underlying Needs

Needs define the underlying reasons why behaviors happen in a situation. In a needs-driven process, the

set of underlying conditions that cause a behavior and/or situation to exist are both identified and explored in order to understand why a behavior and/or situation happened. These needs would be identified across family members in a range of life areas beyond the system defined areas. These underlying conditions would be articulated and overt agreement with the family and all team members about which to select for action or attention would occur. The process involves flexibility of services and supports that will be tailored to meet the needs of the family.

iii. Supported by an Effective Team Process

Wraparound is a process that requires active investment by a team, comprised of both formal and informal supports willing to be accountable for the results. Measurable target outcomes are derived from multiple team member perspectives. The team's overall success is demonstrated by how much closer the family is to their vision and how well the family needs have been addressed.

iv. Determined by Families

A family-determined process includes both youth and caregivers and the family has authority to determine decisions and resources. Families are supported to live a life in a community rather than in a program. The critical process elements of this area include access, voice, and ownership. Family access is defined as inclusion of people and processes in which decisions are made. Inclusion in decision making implies that families should have influence, choice and authority over services and supports identified in the planning process. This means that they should be able to gain more of what is working and less of what they perceive as not working. Family voice is defined as feeling heard and listened to, and team recognition that the families are important stakeholders in the planning process. Therefore, families are critical partners in setting the team agenda and making decisions. Families have ownership of the planning process in partnership with the team when they can make a commitment to any plans concerning them. In Wraparound, the important role of families is confirmed throughout the duration of care.

IV. OFFEROR QUALIFICATIONS

To be awarded this contract, all of the following criteria **must** be met:

- Be licensed by the Office of Health Care Quality (OHCQ) as the Mental Health Case Management Care Coordination for Children and Youth by November 3, 2014.
- Be enrolled as a Mental Health Case Management Care Coordination for Children and Youth Provider in the Public Mental Health System (PMHS) by November 3, 2014.
- Be approved by the Maryland Medicaid System as a Mental Health Case Management Care Coordination for Children and Youth Provider.
- Be enrolled in the Wraparound Training provided by the University of Maryland
- Be approved as a 1915(i) provider
- Provide a narrative demonstrating at least 3 years experience providing mental health services to, including serving high risk populations and children and youth with serious emotional disorders.
- Have a valid Medicaid Provider billing number by November 3, 2014.
- Provide a narrative demonstrating a strong understanding of the unique needs of children, youth and families.

- Provide the Offeror's audited statements for the last two years, or demonstrate that organization is sound and its business practices are consistent with general accounting principles
- Must have the ability to bill the PMHS as evidenced by providing an MA billing number and willingness to apply for additional billing numbers if necessary to serve additional counties.
- Provide proof of good standing status with the Maryland State Department of Assessments and Taxation

The successful Offeror will provide assurance to the local Core Service Agency of the county in which the provider is awarded the contract and that arrangements will be made to transfer all child and adolescent consumers currently enrolled in TCM to the Offeror's program, unless the consumer declines the offer.

V. SCOPE OF WORK

A. Overview

The AACMHA is seeking providers to serve Anne Arundel, Calvert, St. Mary's and Charles Counties, that is interested in providing Mental Health Case Management Care Coordination for Children and Youth services in one or more of these counties, at or above the standards included in the:

i. Federal Medicaid requirements and State Medicaid Plan Requirements for this service,
ii. Meet the requirements for COMAR 10.09.90 and 10.09.89,
iii. Requirements of the local Core Service Agency of each respective county for this service, and
iv. Statements made in the reply to this RFP.

The local Core Service Agency of each respective county will oversee and monitor compliance with all contract conditions in order to ensure procedural requirements and contract deliverables are met. The Offeror shall ensure that the local Core Service Agency will have full access and copies of any and all materials to fulfill this contract oversight role. This should include, but is not limited to: consumer records, case ratios, staffing levels and patterns, organizational parameters, service requirements, budget and financial records.

B. Overview of Project

The Mental Health Case Management Care Coordination for Children and Youth will serve children, adolescents and young adults up to 18 years of age and up to the age of 22 years of age if the individual is enrolled in the 1915(i) CCCYF initiative. In recognition of the emerging needs specific to Transition-Age Youth (TAY), the Offeror shall support further development of a system of seamless services that can follow youth as they "age out" of the children's service system. To ensure that youth between18-22 years of age continue to access services through providers with specialized expertise in developmentally-

appropriate, youth-oriented services, any applicant under this RFP is required to have capacity to support youth in the transition phase or may transition youth into additional support services. Additionally, the Mental Health Case Management Care Coordination provider will ensure that youth are transitioned into the adult system services with a clearly defined plan with assistance from the local Core Service Agencies when needed.

The Offeror will serve all three levels of Mental Health Case Management Care Coordination for Children and Youth and will additionally serve as the CCO for children and youth enrolled in the 1915(i) CCCYF initiative. The CCO will assure that for each enrolled youth, the same CCO staff will be assigned to work with the youth through all 3 levels of service for at least 80% of the time in each year the youth is enrolled in the CCO.

C. Participant Eligibility

Level 1, 2 and 3

Level 1, 2 and 3 will require authorization through the ASO based on medical necessity criteria.

Level 3 and enrolled in the 1915(i) CCCYF Initiative - Certificate of Need

The Certificate of Need (CON) is a collection of documentation that summarizes, describes and explains the youth's current state of behavioral health, history of presenting behaviors and treatment interventions. At a minimum the CON must consist of a psychosocial assessment written by a licensed mental health professional in the State of Maryland and a psychiatric evaluation written by a licensed psychiatrist under the Health Occupations Article, Annotated Code of Maryland. The CON should include information about the youth's functional status, risk of harm, co-occurrence of other conditions (health, developmental disabilities, and substance abuse), the youth's living environment and its ability to support the youth, and resiliency. Additionally, information about the youth and caregiver involvement in treatment is useful. The CON will be evaluated to ensure the youth meets the medical necessity criteria (MNC) for this level of care, see Attachment 3.

Quality Assurance

The Mental Health Case Management Care Coordination for Children & Youth provider shall have a written quality assurance (QA) plan. The QA plan shall address, at minimum, the following:

i. Health, safety and welfare of the children and youth, including critical incidents and crisis service management protocols;
ii. Child/youth and family satisfaction;
iii. Complaints and grievances processes;
iv. Utilization and outcomes management

The QA plan must describe how key stakeholders (*e.g.*, families and children/youth, providers, State purchasers) will be engaged in QA processes.

D. Deliverables

The major outcome for this population may be measured by reducing the use of in-patient and other institutional-based care, obtaining and maintaining entitlements, consumer satisfaction, gaining employment, and having a safe, clean, and stable living situation.

i. Program-wide Deliverables

1. Submit required data and reports through TMS WrapLogic or other Electronic Health Record approved by Behavioral Health Administration (BHA) as appropriate.
2. Submit fiscal and programmatic reports to the respective local Core Service agency on a schedule as requested by the local Core Service Agency.
3. Submit critical incident reports to respective local Core Service agency as well as BHA
4. Develop a network of community-based resources to address youth/family needs
5. Track linkages to community-based resources by resource type (e.g. housing, food, recreation, mental health services, substance abuse)
6. Track number of youth stepped up from a lower level of Mental Health Case Management Care Coordination for Children & Youth
7. Track number of youth stepped down from a higher level of Mental Health Case Management Care Coordination for Children & Youth
8. Track number of youth stepped up to higher level of care through inpatient hospitalization and/or residential treatment center placement
9. Communicate eligibility determinations with family as per COMAR 10.09.90 and 10.09.89
10. Conduct yearly consumer satisfaction surveys with youth/families for continuous quality improvement (CQI) purposes
11. Develop and implement an outreach plan to residential treatment centers, public schools, ER's and other Public Mental Health System levels of care to ensure that providers can refer youth and youth have access to additional treatment options
12. Attend trainings specified by the local Core Service Agencies, the University of Maryland Institute for Implementation and Innovation and BHA – specifically, CASII, ESCII, Child and Adolescent Needs & Strengths (CANS) and Wraparound Certification
13. Report to the respective CSA on compliance with required staffing pattern
14. Attend 1915(i) CCCYF Implementation Meetings
15. Attend Provider meetings organized by the local Core Service Agencies
16. The CCO will assure that for each enrolled youth, the same CCO staff will be assigned to work with the youth through all 3 levels of service for at least 80% of the time in each year the youth is enrolled in the CCO.

E. Staffing Requirements

Shall meet the standards in COMAR 10.09.89 and 10.09.90.

VI. MECHANISMS TO INTEGRATE WITH EXISTING SYSTEM

The selected vendor will be required to sign Memorandums of Understanding (MOUs) with the local Core Service Agency. In these MOUs, at a minimum, the parties will specifically address collaboration, sharing of information in conformance with applicable laws and regulations, grievances and complaints, dealing with non-compliance of children, youth and families, and consumer and family input into treatment plans. Involvement in hospitalizations must be addressed.

VII. PROCUREMENT PROCESS (Attachment 2)

A. Issuing Agency:

Adrienne Mickler
Executive Director
Anne Arundel County Mental Health Agency, Inc.
1 Harry S Truman Parkway, Suite 101
Annapolis, Maryland 21401
410 222-7858

VIII. PRE-BID CONFERENCE

A pre-bid conference will be held on August 28, 2014 at 10a.m. at AACMHA, 1 Truman Pkwy, Partnership Conference Room, Annapolis, Md. 21401.The purpose of the conference is to address questions concerning the expectations of the project. All interested parties should register with the AACMHA by August 22, 2014 via email to mhaaac@aol.com.

IX. CLOSING DATE

The deadline for submission of proposals is 3:00 pm Eastern Daylight Saving Time, September 26, 2014 at AACMHA 1 Truman Pkwy Suite 101, Annapolis, Md. 21401. Please submit six (6) copies each of both the Offeror Qualifications, Technical Proposals and Budget Analysis.

X. DURATION OF OFFER

The Offeror agrees to be bound by its Offeror Qualifications, Technical Proposal and Budget Analysis for a period of 60 days from the proposal closing date during which time AACMHA may request clarification or corrections for the purpose of evaluation. Amendments or clarifications requested by AACMHA shall not affect the remainder of the proposals, but only that portion so amended or clarified.

A. Timetable

If it is deemed appropriate, Offerors submitting proposals in response to this RFP may be required to make oral presentations or negotiations of their proposals. AACMHA will schedule the time and place for such discussions, if any. It is expected that this will take

place approximately two weeks after the proposal deadline, depending on the number of proposals received. It is planned that the selection of the contractor will be announced on October 29, 2014, and a contract will be executed within a week of the announcement. The announcement will also be available to Offerors on the following websites: AACMHA - website at www.aamentalhealth.org, Calvert, Charles, and St. Mary's under latest news. The project will commence on or about November 3, 2014.

B. Cost of Proposal Preparation

Any costs incurred by Offerors in preparing or submitting proposals are the sole responsibility of the Offerors. AACMHA will not reimburse any Offeror for any costs incurred in making a proposal or subsequent pre-contract discussions, presentations, or negotiations.

C. Selection and Ad Hoc Committee

A committee will be formed to review the proposals. The proposals will be presented to the local Core Service Agency Directors.

Contract award will be made by AACMHA in conjunction with the local Core Service Agency of the respective county.

XI. PROPOSAL SUBMISSION

A. Form of Proposal

Proposals must be submitted by each Offeror in separate sealed packages, grouped and marked as follows:

1. *Mental Health Case Management Care Coordination for Children and Youth – Offeror Qualifications*

   Offeror's name and date of offer

2. *Mental Health Case Management Care Coordination for Children and Youth – Technical Proposal*

   Offerors name and date of proposal

3. *Mental Health Case Management Care Coordination for Children and Youth – Budget Analysis*

   Offerors name and date of analysis

B. Freedom of Information

Offerors should give specific attention to the identification of those portions of their proposals

that they deem to be confidential proprietary information or trade secrets and provide any justification why such material, upon request, should not be discussed by AACMHA under the Maryland Public Information Act, State Government Article, Sections 10-611 et seq. annotated Code of Maryland.

Offerors are advised that the mere assertion of confidentiality is not sufficient to make matters confidential under the act. Information is confidential only if it is customarily so regarded in the trade and/or the withholding of the data would serve an objectively recognized private interest sufficiently compelling as to override the general disclosure policy of the act. In determining whether information designated as such is proprietary, AACMHA will follow the direction provided by the AACMHA attorney when responding to requests for information contained in proposals.

It may be necessary that the entire contents of the proposal of the selected Offeror be made available and reproduced for the purpose of examination and discussion by a broad range of interested parties.

XII. PROPOSAL FORMAT & CONTENT

A. Overview

The proposal should address all points outlined in this RFP, and should be clear and precise in response to the information and requirements described. A transmittal letter should accompany the proposal. The sole purpose of this letter is to transmit the proposal. It should be brief and signed by an individual who is authorized to commit the Offeror to the services and requirements as stated in this RFP.

B. Offeror Qualification Format

i. Each Offeror's submission must bear the Offeror's name, the closing date for proposals and "Mental Health Case Management Care Coordination for Children and Youth – Offeror Qualifications" on the outside of the package. Inside this package (an original and five copies) shall be the Offeror's Qualification submission.

C. Qualification Content

i. Response to each qualification required

D. Technical Proposal Format

i. Each Offeror's submission must bear the Offeror's name, the closing date for proposals and "Mental Health Case Management Care Coordination for Children and Youth – Technical Proposal" on the outside of the package. Inside this package (an original and five copies) shall be the Offeror's Technical Proposal.

E. Technical Proposal Content

i. Executive Summary -The Offeror shall condense and highlight the contents of the technical Proposal in a separate section entitled "Executive Summary." The summary shall provide a description of the objectives of the RFP, the scope of work, the contents of the proposal, and any related issues which should be addressed.

ii.Proposed Services - Work Plan

The Offeror shall provide a detailed discussion of the Offeror's approach, methods, techniques, tasks, work plan for addressing the requirements outlined in the scope of work, and any additional requirements that might be identified by the Offeror.

The Offeror shall fully explain how the proposed services will satisfy the requirements of this RFP. It shall also indicate all significant tasks, aspects, or issues that will be examined to fulfill the scope of work, as well as, include a time-phased schedule by tasks for meeting the proposed objective, a breakdown of proposed staff assignments, and time requirements by task.

An Offeror that can demonstrate an ability to work closely with the local Core Service Agency as a partner may be given preference.

The Offeror shall demonstrate a full understanding of the purpose, expectations and complexities of the project and how the objective may best be accomplished. The total scope of effort and resources proposed by the Offeror should be convincing and consistent with the view and nature of the engagement.

iii. Project Organization and Management

The Offeror shall demonstrate the capability to successfully manage and complete the contract, including an outline of the overall management concepts and methodologies to be employed by the Offeror, and a project management plan including project control mechanisms, and describe the quality control procedures of the Offeror. Key management individuals responsible for coordinating with the respective local Core Service agency should be identified. The Offeror must meet periodically with respective local Core Service agency staff and render periodic progress reports for the purpose of administering the contract. The Offeror shall also participate in the client tracking process approved by the BHA, collecting and submitting relevant data as required by BHA. The Offeror also shall address the transition and employment of existing agency-based case managers.

iv.Experience and Qualification of Offeror

References and descriptions of previous similar engagements should be provided (All references should include a contact person familiar with the Offeror's work and the appropriate telephone number, with authorization for AACHMA to contact any

reference provided.).

v.Personnel Capability

The Offeror shall clearly identify the proposed project team, the assignment of work activities, and the experience, qualifications, and education of the staff to be assigned. It is essential that the Offeror assign and provide sufficient qualified staff assigned in an appropriate mix who has experience in aspects related to the objectives and scope of the proposal. The Offeror should explain to what extent backup professional personnel are available to substitute for loss of professional personnel identified as necessary in the proposal.

vi.Response To Case Vignette- Attachment 4

F. Overview

The proposal should address all points outlined in this RFP, and should be clear and precise in response to the information and requirements described. A transmittal letter should accompany the budget analysis. The sole purpose of this letter is to transmit the budget analysis; it should be brief and signed by an individual who is authorized to commit the Offeror to the services and requirements as stated in this RFP.

The Offerors must address their financial ability to provide the scope of services requested at the quality desired, and address the legal liability issues associated with the provision of the proposed services. Applicants having current contracts with BHA or Core Service Agencies must have demonstrated success by meeting deliverables in current contracts.

G. Format of Proposal

Each Offeror's submission must bear the Offeror's name, the closing date for proposals and "Mental Health Case Management Care Coordination for Children and Youth – Budget Analysis" on the outside of the package. Inside this package (an original and five copies) shall be the Offeror's budget analysis. The budget analysis should be submitted on a DHMH 432, which can be downloaded at www.aamentalhealth.org, click rfp/rfi.

1. Budget Analysis Content

a. Overall Budget

An overall budget (on the appropriate forms) shall be submitted. All sources of revenues anticipated should be detailed in the submitted budget. The DHMH 432 packet is available at AACMHA, which can be downloaded at www.aamentalhealth.org, click on rfp/rfi.

b. Personnel Detail Page

A personnel detail page (DHMH 432 D), including the qualifications and titles of staff, the hours/days of employment anticipated, the salary per hour/day, and any agency adjustments should be detailed. All consultant costs should be detailed including type of consultant (if known) and an hourly rate for each consultant hired.

c. Start-up Costs

Although there is no funding for start-up costs, start-up costs are anticipated and they should be submitted as a separate budget and supported with supplemental schedules of start up costs. All equipment and start-up staff and training costs should be detailed on a separate DHMH 432 packet.

d. Collections

Use of, and ability to bill and collect "Medicare, Medicaid, and third party payments" should be documented.

XIII. PROPOSAL EVALUATION CRITERIA

A. Overview

An Ad Hoc Committee shall first review Offeror Qualification package to determine that the Offeror meets qualification criteria. Proposals from qualified Offerors will then be studied in depth and evaluated. Qualification requirements will receive 20% in relative weight, Technical proposals will receive 75% relative weight in the evaluation process and budget analysis will carry 5% relative weight. The proposals and scores, along with the Ad Hoc Committee recommendations will be forwarded to the local Core Service Agency Directors for review and final determination.

B. Evaluation Method

i. Acceptable Offers (Attachment 1)

Each member of the Ad Hoc Committee will complete a preliminary technical evaluation. All Offerors who receive a rating of 80% or more of total points possible on the technical proposal evaluation will be considered to have an acceptable offer and will receive consideration of their budget analysis. The following is the weighted scale for each component:

1. Qualifications of Offeror 20%

2. Technical Proposal 75%
   a. Philosophy & Approach to Service Delivery
   b. Implementation and Operations
   c. Response to Case Vignette

5. Response to budget 5%

ii. Unacceptable Offers

Those proposals with a technical rating of less than 80% of the total possible points will be considered unacceptable and will not be considered further.

iii. Qualification Scores

Relative value will be established by meeting all of the required Offeror qualifications.

iv. Technical Scores

Proposals will be given a score based on the qualifications of the offeror, the philosophy and approach to service delivery, implementation and operations and the response to the vignette.

a. Budget Analysis Score

There is no price associated with this RFP. Funding will be through the Public Mental Health System (PMHS) Fee for Service (FFS) billings. The selected provider will comply with COMAR 10.09.89 and 10.09.90 and any other COMAR regulations that may apply.

Up to five points will be added to the total score, if the following criteria are met:

b. Program Budget/Technical Proposal – Personnel Reconciliation

1. Staff positions in programmatic budget must be outlined and reconciled with technical proposal, citing corresponding page numbers in the technical proposal
2. Salary should be calculated and displayed as both hourly and annual rates with percentage attributed to this project included
3. Specific licenses should be listed for personnel that match the technical proposal, citing corresponding page numbers in the technical proposal, e.g. LCSW, LCSW-C, LCPC

c. Revenue must be broken out by CPT code:

Example:	90801	$ 40,000
	90802	60,000
	90791	20,000

T1016	250,000
In-kind	50,000
Total Budget	$420,000

XIV. CONTRACT REQUIREMENTS

The selected Offeror will be required to enter into a contractual agreement with the respective local Core Service agency. A sample contract packet is available at respective local Core Service agency for your information. The contents of this RFP and the proposal of the successful Offeror will be incorporated by reference into the resulting agreement. The local Core Service Agency shall enter into a contract only with the selected Offeror and the selected Offeror will be required to comply with, and provide assurance of, certification as to certain contract requirements and provisions.

Attachment 1

MENTAL HEALTH CASE MANAGMENT CARE COORDINATION FOR CHILDREN AND YOUTH PROGRAM RATING SHEET

Transmittal Letter should include:

1. Letter signed by authorized official.
2. Letter on Offeror's stationary.

I. QUALIFICATIONS OF OFFEROR AND PROPOSED STAFF (20%)

A. DOCUMENTATION OF CORPORATE STRUCTURE

1. Current legal status (e.g. Articles of Incorporation).
2. Board resolution approving submission of proposal.

B. FINANCIAL CAPABILITY TO PERFORM

1. Description of Offeror's financial capability to carry out work of RFP.
2. Audited financial statements for the last two years.

C. SUMMARY OF RELEVANT EXPERIENCE

1. Specific documentation of experience with other similar projects.

D. ORGANIZATION STRUCTURE/CHART

1. Description of organizational structure.
2. Explanation of how project will relate to the whole.
3. Table of Organization/organizational relationships.

E. STAFFING

1. Resumes of administrative/supervisory staff.
2. Description of staff assigned.
3. Description of duties and qualifications.
4. Names and resumes for all staff and consultants, if to be reassigned or already committed to the project.
5. Number and credentials of staff indicates high probability of meeting project outcomes.
6. Supervisory/administrative support adequate to meet project outcomes.

All elements of the Offeror Qualifications are being rated equally.

II. TECHNICAL PROPOSAL

A. PHILOSOPHY AND APPROACH TO SERVICE DELIVERY (20%)

1. Basic values and beliefs about mental health services.
2. Knowledge of population and Wraparound approach.
3. Knowledge of Maryland public mental health system.
4. Importance of active participant involvement & recovery.

5. Demonstrated ability to bill and collect for eligible services.
6. Clear priority for most vulnerable populations and entitlements as a means to recovery and self direction.
7. Strength of Disaster Plan.

B. IMPLEMENTATION AND OPERATIONS STRATEGY (45%)

1. Clear and concise timelines.
2. Clear and concise work plan.
3. Ability to cover for staff turnover and leave.
4. Orientation, training and supervision.
5. Process and content of Individualized Service Plans.
6. Record keeping.
7. Report requirements.
8. Problem solving if encountered.
9. Grievance procedures.
10. Clearly stated outcomes
11. Listed mission, goals, and objectives
12. Clearly lists how progress will be measured and recorded.
13. Efforts or method to ensure participant involvement.
14. Confidentiality and record security.
15. Use of technologies to improve quality and efficiency.

C. RESPONSE TO CASE VIGNETTE (10%)

1. Clearly explain how you would engage the family using the wraparound process.
2. Identify youth and family strengths.
3. Identify the underlying need that may be driving the behavior both on the part of the youth and on the part of the family.
4. Clearly indicate how you would develop and implement a Plan of Care.
5. Clearly indicate how you would evaluate the progress of the Plan of Care.
6. Indicate how eligibility will be determined.
7. Indicate our ability to bill for services under the Fee For Service System

III. BUDGET ANALYSIS (5%)

A. Overall budget
B. Personnel Detail Page
C. Start-up Costs
D. Collections

Attachment #2

Mental Health Case Management Care Coordination for Children and Youth Proposal Timeline

STEPS TO COMPLETION	COMPLETION DATE
Advertise/E-mail/webpage	August 12, 2014
Register for Pre-Bid Conference **RSVP Jane Murphy at mhaaac@aol.com** **before**	**August 22, 2014**
Pre-Bid Conference **10 a.m. at The Partnership Conference Room**	**August 28, 2014**
Proposal Submission Deadline **Delivered to: AACMHA** **Attn: CCO RFP** **1 Truman Pwky, Suite 101** **Annapolis, MD 21401**	**September 26, 2014**
Review Committee Packet Pick Up	September 29, 2014
Review Committee 10 a.m. at The Partnership Conference room	October 9, 2014
Contract Committee 10 a.m. at The Partnership Conference room	October 17, 2014
Core Service Agencies Board of Directors' Approval	October 28, 2014
Contract Award Announcement Email/call to successful bidder and notice to be placed on AAACMHA website	October 29, 2014
Work to Begin on or about	November 3, 2014

Attachment #3

CON Guideline Information

Psychiatric Evaluation

Reason for Psychiatric Assessment
Past Psychiatric History and Other Relevant History
Current Medications
Past medications
Substance Use History
Medical History
Developmental history
Social History
Educational History
Legal History
Family History
DSM IV Diagnosis
Other Agencies Involved
Recommendations

Psychosocial Assessment

Presenting Problems
Family/Social Assessment
Legal History
Emotional Assessment
Past Efforts to Maintain Client in the Community
Placement History
Hospitalizations
Recommendations

Attachment 4

Case Vignette

Susan is a 16 year old Caucasian female living with her father and stepmother. She moved in with her father last year after she reported that she was being verbally abuse by her biological mother. Father reports that there is tension between Susan and her stepmother because of the 2 children father and stepmother have together. Susan reports that she is treated differently than the other children in the home. Since moving in, she has made 3 significant suicide attempts. The first was an overdose on Tylenol after an argument, which resulted in a coma, liver and kidney failure and swelling in the brain. It would seem that the liver and kidney have recovered from the overdose. She does have ongoing seizures as a result of the overdose. Her second attempt was after she ran away with a boy and was found in a hotel room in West Virginia. Her most recent attempt was after being caught having sex with a boy in the home. Susan stabbed herself in the chest with a butcher knife in front of the stepmother. She had 6 treatment sessions in an OMHC and refused to return.
Susan had been a good student in elementary and middle school, but since entering high school, she has experienced more social difficulties in school. Susan is in a regular high school and has no 504 plan or IEP. She reports that the other students tease her and call her names. Susan has an upcoming intake hearing for an assault charge at school. She indicated that she was tired of the other children calling her names and hit one of the students. Susan as expressed that she would like to drop out of high school and has admitted to periodic binge drinking.

Diagnosis
Axis I- Major Depression, recurrent. Status post suicide attempt. ADHD, Rule out bipolar D/O,
Axis II- Deferred
Axis III- None
Axis IV- Severe. Family, school and social problems
Axis V- Current GAF 20 past year 50

Current Medication
Effexor 100mg
Abilify 10 mg