

CALVERT COUNTY CORE SERVICE AGENCY
975 Solomons Island Road
Prince Frederick, MD 20678

REQUEST FOR PROPOSALS

FOR

**THE DEVELOPMENT OF TARGETED CASE
MANAGEMENT SERVICES**

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I. BACKGROUND

Calvert Core Service Agency (CSA), an agent of Calvert County Government, is responsible for planning, managing, and monitoring of publicly funded mental health services at the local level. To fulfill this role, Calvert County CSA announces this Request for Proposal (RFP) for the provision of Targeted Case Management services. This RFP solicits applications to provide Targeted Case Management services for both children and adults in Calvert County Maryland.

II. GOALS

The major goals of Targeted Case Management are:

A. Linking

1. Assisting consumers to access entitlements and needed medical, mental health, social, educational and other services.
2. Developing Comprehensive Assessments and Periodic Reassessments resulting in recovery oriented and dual diagnosis capable Care Plans.
3. Referrals and tracking activities to assure the consumer has applied for, has access to, and is receiving the necessary services to meet the participant's needs, such as mental health and medical services, resource procurement, transportation, or crisis intervention.

B. Monitoring and Follow-up

1. Activities and contacts that are necessary to ensure the Care Plan is implemented and adequately addresses the participant's needs, and which may be with the participant, family members, providers, or other entities or individuals and conducted as frequently as necessary, and including at least one assessment every six months, to determine whether the following conditions are met:
 - a. Services are being furnished in accordance with the participant's Care Plan,
 - b. Services in the Care Plan are adequate, and
 - c. If the needs of the participant change, and if applicable, make necessary adjustments to the Care Plan, including referrals for services.
2. Engage in ongoing interaction with the participant, and, with the participant's consent, the participant's family and friends as appropriate or, if the participant is a minor, the minor's parent or guardian, and service providers.
3. Follow-up after service referral and monitor service provision on an ongoing basis, to ensure that the agreed-upon services are provided, are adequate in quantity and quality, and meet the participant's needs and stated goals or, if the participant is a minor, the parent's or guardian's needs and stated goals for the participant.

4. Revise, if necessary, the Care Plan to reflect changing needs identified from the service monitoring.
5. Include contacts with non-eligible individuals that are directly related to identifying the needs and supports for helping the eligible individual to access services.

C. Advocacy, including:

1. Empower the participant or, if the participant is a minor, the minor's parent or guardian, to secure needed services;
2. Take any necessary actions to secure services on the participant's behalf; and
3. Encourage and facilitate the participant's informed decision making and choices leading to accomplishment of the participant's goals or, if the participant is a minor, encourage the parent or guardian to carry out these decisions.

D. Coordination of services.

III. BIDDER QUALIFICATIONS

The successful bidder shall:

- Be licensed by the Office of Health Care Quality (OHCQ) under COMAR 10.21.19, 10.21.20, 10.21.21, OR 10.21.29, by July 1, 2010.
- Be enrolled as a TCM Provider in the Public Mental Health System (PMHS).
- Be approved by the Maryland Medicaid System as a TCM Provider.
- Have at least 3 years experience providing mental health services to, including serving high risk populations, adults with serious mental illness, and/or minors with serious emotional disorders.
- Have a valid Medicaid Provider billing number by that date.

If the successful bidder is a new TCM provider in Calvert County, assurance must be provided to the CSA that arrangements will be made to transfer all consumers currently enrolled in TCM to the bidder's program, with a valid authorization for TCM, unless the consumer declines the offer or specific exemption is granted by the CSA.

IV. SCOPE OF WORK

A. Overview

The CSA is seeking a provider interested in providing TCM services, at or above the standards included in:

1. Federal Medicaid requirements and State Medicaid Plan Requirements for this service,
2. Applicable COMAR requirements, including but not limited to 10.09.45,
3. Requirements of the CSA, and
4. Statements made in the reply to this Request For Proposal (RFP).

The CSA will oversee and monitor compliance with all contract conditions. The offeror shall ensure CSA full access and copies of any and all materials to fulfill this contract oversight role. This should include, but is not limited to: case ratios, staffing levels and patterns, organizational parameters, service requirements, budget and financial records, in order to assure procedural requirements and contract deliverables are met. An offeror that can demonstrate an ability to work closely with the CSA as a partner will be given preference. 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.

B. Project Description And Purpose

The following define the elements of the TCM model that must be addressed in this RFP.

Target Group

A recipient is eligible for mental health case management services if the recipient is in a federal eligibility category for, and is enrolled in, the Maryland Medical Assistance Program according to COMAR 10.09.24. These regulations govern the determination of eligibility for the Maryland Medical Assistance Program.

Services shall be provided to participants who are:

1. Children and adolescents, referred to as minors, with serious emotional disorders diagnosed, according to a current diagnostic and statistical manual of the American Psychiatric Association that is recognized by the Secretary and are in, or at risk of, or need continued community treatment to prevent inpatient psychiatric treatment, treatment in a Residential Treatment Center (RTC), or an out-of-home placement due to multiple mental health stressors.

AND

2. Adults who have a serious and persistent mental health disorder, diagnosed, according to a current diagnostic and statistical manual of the American Psychiatric Association that is recognized by the Secretary, and who are:
 - a. at risk of, or need continued community treatment to prevent inpatient psychiatric treatment;
 - b. at risk of, or need continued community treatment to prevent being homeless; or
 - c. at risk of incarceration or will be released from a detention center or prison.

The specific diagnostic criteria may be waived for the following two conditions:

- a. An individual, committed as not criminally responsible, who is conditionally released from a Mental Hygiene Administration facility, according to the provisions of Health General Article, Title 12, Annotated Code of Maryland; or
- b. An individual in a Mental Hygiene Administration facility or a Mental Hygiene Administration funded inpatient psychiatric hospital that requires community services. This excludes individuals eligible for Developmental Disabilities Administration's residential services.

Participants shall meet the above requirements and be classified according to the following levels of service:

Level I – General: For a maximum of 2 units of service per month and based on the severity of the participant’s mental illness, the participant must meet at least one of the following conditions:

- The participant is not linked to mental health and medical services;
- The participant lacks basic supports for shelter, food, and income;
- The participant is transitioning from one level of care to another level of care; or
- The participant needs case management services to maintain community-based treatment and services.

Level II – Intensive: For a maximum of 5 units of service per month and based on the severity of the participant’s mental illness, the participant must meet two or more of the following conditions;

- The participant is not linked to mental health and medical services;
- The participant lacks basic supports for shelter, food, and income;
- The participant is transitioning from one level of care to another level of care; or
- The participant needs case management services to maintain community-based treatment and services.

The target populations may include individuals transitioning to a community setting and case management services will be made available for up to 180 consecutive days of the covered stay in the institution.

Definition of Services

In addition to the emphasis on obtaining and maintaining entitlements, as well as coordination and monitoring of services and supports, case management services are provided to assist participants, eligible under the State Plan, in gaining access to needed medical, mental health, social, educational and other services. The Program shall reimburse for the following services under mental health case management when these services have been documented, as necessary:

1. Comprehensive Assessment and Periodic Reassessment

Assessment, or reassessment, involves the participant’s stated needs and review of information concerning a participant's mental health, social, familial, cultural, medical, developmental, legal, vocational, and economic status to assist in the formulation of a Care Plan.

The assessment, or reassessment, of the participant's service needs is conducted by the community support specialist and incorporates input from the participant, family members and friends of the participant, as appropriate. If the participant is a minor, the minor’s parent or guardian, and community service providers such as mental health providers, medical providers, social workers, and educators, if necessary, must consent to an assessment of the service needs of the participant. A home visit by the community support specialist or community support specialist associate is required.

After an initial assessment, each participant shall be reassessed every six (6) months.

2. Development (and Periodic Revision) of a Specific Care Plan

After the initial assessment is completed, a Care Plan shall be developed. Every six (6) months after that, the Care Plan shall be updated in conjunction with the participant's schedule for reassessments, to ensure that all services being provided remain sufficient. The participant, a legal guardian, the participant's family, and any significant others, with the participant's consent, or, if the participant is a minor, the minor's parent or guardian's consent, shall participate with the community support specialist, to the extent practicable, in the development and regular updating of the participant's Care Plan.

The specific Care Plan is developed with the participant and is based on the assessment. It specifies the goals and actions to address the medical, mental health, social, educational, and other services needed by the participant. It includes the active participation and agreement of the participant, and/or the participant's authorized health care decision maker, and others designated by the participant, and for minors, a parent or guardian. It also identifies strategies to meet the goals and needs of the participant.

The Care Planning process promotes consistent, coordinated, and timely service provision. Care Planning may include, as necessary and appropriate:

- a. The Care Planning meeting, which includes the participant and with the participant's consent, providers, family members, other interested persons, as appropriate, for the purpose of establishing, coordinating, revising, and reviewing the Care Plan;
- b. The development and periodic updating of the written individualized Care Plan based on the participant's needs, progress, and stated goals;
- c. Transitional Care Planning that involves contact with the participant or, if the participant is a minor, the minor's parent or guardian, or the staff of a referring agency or a service provider who is responsible to plan for continuity of care from inpatient level of care or an out of home placement to another type of community service; and
- d. Discharge planning from mental health case management services, when appropriate, or when goals for case management have been achieved.

Case management services are coordinated with and do not duplicate activities provided as part of institutional services and discharge planning activities.

3. Referral and Related Activities

Community support specialists associates, under the direction of community support specialists, shall assure that the participant or, if the participant is a minor, the minor's parent or guardian, has applied for, has access to, and is receiving the necessary services to meet the participant's needs, such as mental health and medical services, resource procurement, transportation, or crisis intervention. The community support specialist shall take the necessary action when this has not occurred.

Included in the referral process are:

- a. Community support development by contacting, with the participant's consent, members of the participant's support network, including, family, friends, and neighbors, as appropriate, or, if the participant is a minor, the minor's parent or guardian, to mobilize assistance for the participant.
- b. Crisis intervention by referral of the participant or, if the participant is a minor, the minor's parent or guardian, to services on an emergency basis when immediate intervention is necessary.

- c. Arrangements for the participant's transportation to and from services.
- d. Outreach in an attempt to locate service providers which can meet the participant's needs.
- e. Review of the Care Plan with the participant and with the participant's consent, the participant's family and friends, as appropriate, or, if the participant is a minor the minor's parent or guardian, in order to facilitate their participation in the Care Plan's implementation.

4. Monitoring and Follow-up Activities

Monitoring and follow-up includes activities and contacts that are necessary to ensure the Care Plan is implemented and adequately addresses the participant's needs. They may include the participant, family members, providers, or other entities, and may be conducted as frequently as necessary. At least one assessment must be conducted every six months, to determine whether the following conditions are met.

- a. Services are being furnished in accordance with the participant's Care Plan.
- b. Services in the Care Plan are adequate.
- c. If the needs of the participant change, and if applicable, necessary adjustments are made to the Care Plan including referrals for services.

The Provider must:

- a. Engage in ongoing interaction with the participant, and, with the participant's consent, the participant's family and friends as appropriate or, if the participant is a minor, the minor's parent or guardian, and service providers.
- b. Follow up after service referral and monitor service provision on an ongoing basis, to ensure that the agreed-upon services are provided, are adequate in quantity and quality, and meet the participant's needs and stated goals or, if the participant is a minor, the parent's or guardian's needs and stated goals for the participant.
- c. Revise the Care Plan to reflect changing needs identified from the service monitoring.

Case management may include contacts with non-eligible individuals that are directly related to identifying the needs and supports for helping the eligible individual to access services.

Advocacy, including:

- a. Empower the participant or, if the participant is a minor, the minor's parent or guardian, to secure needed services;
- b. Take any necessary actions to secure services on the participant's behalf; and
- c. Encourage and facilitate the participant's informed decision making and choices leading to accomplishment of the participant's goals or, if the participant is a minor, encourage the parent or guardian to carry out these decisions.

Qualification of Providers

Providers of case management services shall be:

1. approved or licensed in Maryland as a community mental health program under Mental Hygiene Administration's community mental health regulations and have three years experience providing mental health case management services, and
2. have at least 3 years experience providing services to individuals with serious mental illness and children and adolescents with emotional disorders including managing high risk populations.

After the CSA selects a qualified case management provider, the selected case management provider submits an application to the Department of Mental Hygiene Administration in order to demonstrate compliance with case management regulations. The Department reviews the application, and, if warranted, approves the program as a mental health case management program. Before a participant receives case management services, the Department's Mental Hygiene Administration's (MHA) Administrative Services Organization (ASO) reviews the authorization request, determines if the participant meets medical necessity criteria, and if the participant meets the criteria, the participant is authorized for case management services. The participant has the option to choose from a variety of case managers hired by the case management program.

General requirements for participation in the Program are that a case management program shall be enrolled as a Medicaid provider and meet all the conditions for participation as set forth in COMAR 10.09.36.03. These regulations describe the condition to participate in the Program, and with which the provider shall comply and ensure compliance with all the Medical Assistance provisions listed in the Code of Maryland Regulations (COMAR) designated for the provider type.

Specific requirements for participation in the Program as a mental health case management program include all of the following:

1. No restrictions placed on the qualified participant's right to elect to or decline to receive mental health case management services as authorized by the Department or the Department's designee, or to choose a community support specialist or associate as approved by the Department or the Department's designee.
2. Employ appropriately qualified individuals as community support specialists and community support specialist associates with relevant work experience, including experience with the populations served by the program, including but not limited to adults with serious and persistent mental disorder and children and adolescents with serious emotional disorders.
 - a. Assure that a participant's initial assessment shall be completed within 20 days after the participant has been authorized by the ASO and determined eligible for, and has elected to receive, mental health case management services, An initial Care Plan shall be completed within 10 days after completion of the initial assessment.
 - b. Maintain a file for each participant which includes all of the following:
 - i. An initial referral and intake form with identifying information;
 - ii. A written agreement for services signed by the participant or the participant's legally authorized representative and by the participant's community support specialist;
 - iii. An assessment, documented according to the Administration's requirements;
 - iv. A Care Plan, updated, at a minimum of every six (6) months, which contains at a minimum:
 - (a) A description of the participant's strengths and needs,
 - (b) The diagnosis established as evidence of the participant's eligibility for services under this chapter,
 - (c) The goals of community support services, with expected target dates,
 - (d) The proposed intervention,
 - (e) Designation of the community support specialist with primary responsibility for implementation of the Care Plan, and

- (f) Signatures of the community support specialist, participant or the participant's legally authorized representative, and significant others if appropriate.
- v. An ongoing record of contacts made in the participant's behalf, which includes all of the following:
 - (a) Date and subject of contact;
 - (b) Individual contacted;
 - (c) Signature of Community Support Specialist or Community Support Specialist Associate making the contact;
 - (d) Nature, content, and unit or units of service provided;
 - (e) Place of service;
 - (f) Whether goals specified in the Care Plan have been achieved; and
 - (g) The timeline for obtaining needed services.
- vi. Monthly summary notes, which reflect progress made towards the participant's stated goals.
- c. Have formal written policies and procedures, approved by the Department, which specifically address the provision of mental health case management services to participants in accordance with these requirements.
- d. Be available to participants and, as appropriate, the participant's families or, if the participant is a minor, the minor's parent or guardian, for 24 hours a day, 7 days a week in order to refer participants to needed services and supports and in a psychiatric emergency, to refer to mental health treatment and evaluation services in order to prevent the participant from accessing a higher level of care.
- e. Participants may decline case management services. This will be documented in the participant's case management record.
- f. Designate specific qualified staff to provide mental health case management services that shall include at least one Community Support Specialist per agency and also may include a Community Support Specialist Associate.

A Community support specialist is an individual who is employed by the case management program to provide case management services to participants, is chosen as the case manager by the participant or the participant's legally authorized representative. This person must have at least a Bachelor's degree in a mental health field and one year of mental health experience including mental health peer support, or a Bachelor's degree in a field other than mental health and two years of mental health experience including mental health peer support.

A Community Support Specialist Associate is an individual who is employed by the case management program to assist Community Support Specialists in the provision of mental health case management services to participants, and works under the supervision of a Community Support Specialist who delegates specific tasks to the associate. This person has at least a high school degree or the equivalent, and two years of experience with individuals with mental illness including mental health peer support.

A Community Support Specialist Supervisor is an individual who is employed or contracted to supervise case management services at a ratio of one supervisor for every eight Community Support Specialists or Associates, and who provides clinical oversight of assessments and case management services rendered, and consultation and training to Community Support Specialists and Community Support Specialist Associates regarding mental illness. This person is a mental health professional who is authorized and licensed

under Maryland Practice Boards in the profession of Social Work, Professional Counseling, Psychology, Nursing, Occupational Therapy, or Medicine, and has one year experience in mental health working as a supervisor.

- g. Refrain from providing other services to participants which would be viewed by the Department as a conflict of interest.
- h. Be knowledgeable of the eligibility requirements and application procedures of federal, State, and local government assistance programs which are applicable to participants.
- i. Maintain information on current resources for mental health, medical, social, financial assistance, vocational, educational, housing, and other support services.
- j. Safeguard the confidentiality of the participant's records in accordance with State and federal laws and regulations governing confidentiality.
- k. Comply with the Department's fiscal reporting requirements and submit reports in the manner specified by the Department.
- l. Comply with the requirements for the delivery of mental health services outlined by the Department.

Required Staff

The mental health case management provider shall have staff that is sufficient in numbers and qualifications to provide appropriate services to the participants served and shall include, at a minimum:

1. A Community Support Specialist Supervisor who:
 - a. Is a mental health professional who is licensed and legally authorized to practice under the Health Occupations Article, Annotated Code of Maryland, and who is licensed under Maryland Practice Boards in the profession of either Social work, Professional Counseling, Psychology, Nursing, Occupational Therapy, or Medicine.
 - b. Has one year of experience in mental health working as a supervisor.
 - c. Provides clinical consultation and training to community support specialists or associates regarding mental illness.
 - d. Is employed or contracted to supervise case management services at a ratio of one supervisor to every eight community support specialists or associates.
2. A Community Support Specialist who has at least a:
 - a. Bachelor's degree in a mental health field and one year of mental health experience, including mental health peer support; or
 - b. Bachelor's degree in a field other than mental health and two years of mental health experience, including mental health peer support;
 - c. Is chosen as the case manager by the participant or the participant's legally authorized representative; and
 - d. Is employed by the mental health case management provider to provide case management services to participants.
3. A Community Support Specialist Associate who:
 - a. Has at least a high school diploma or the equivalent, and 2 years of experience with individuals with mental illness, including mental health peer support;
 - b. Is employed by the mental health case management provider to assist Community Support Specialists in the provision of mental health case management services to participants; and
 - c. Works under the supervision of a Community Support Specialist who delegates specific tasks to the Associate.

Freedom of Choice

The successful bidder shall assure that the provision of case management services will not restrict a participant's free choice of providers in violation of 1902 (a) (23) of the Medicaid Act.

1. Eligible participants shall have free choice of the providers of case management services.
2. Eligible participants shall have free choice of the providers of other medical care under the Care Plan.

Case Records

The successful bidder shall maintain a file for each participant which includes all of the following:

1. An initial referral and intake form with identifying information, including, but not limited to, the individual's name and Medicaid identification number;
2. A written agreement for services signed by the participant or the participant's legally authorized representative and by the participant's community support specialist;
3. An assessment as specified in Regulation .06 of this chapter;
4. A Care Plan, updated at a minimum of every 6 months, which contains at a minimum:
 - a. A description of the participant's strengths and needs;
 - b. The diagnosis established as evidence of the participant's eligibility for services under this chapter;
 - c. The goals of case management services, with expected target dates;
 - d. The proposed intervention;
 - e. Designation of the community support specialist with primary responsibility for implementation of the Care Plan; and
 - f. Signatures of the community support specialist, participant, or the participant's legally authorized representative, and significant others, if appropriate.
5. An ongoing record of contacts made on the participant's behalf, which includes all of the following:
 - a. Date and subject of contact;
 - b. Individual contacted;
 - c. Signature of community support specialist or community support specialist associate making the contact;
 - d. Nature, content, and unit or units of service provided;
 - e. Place of service;
 - f. Whether goals specified in the Care Plan have been achieved;
 - g. The timeline for obtaining needed services;
 - h. The timeline for reevaluation of the plan;
 - i. The need for and occurrences of coordination with other case managers; and
 - j. Monthly summary notes, which reflect progress made towards the participant's stated goals.

Limitations

Case Management does not include the following:

1. Mental health case management services that are advisory in nature.
2. A restriction may not be placed on a qualified recipient's option to receive mental health case management services.

3. Mental health case management services do not restrict or otherwise affect:
 - a. Eligibility for Title XIX benefits or other available benefits or programs, except as limited by §E of this regulation.
 - b. The freedom of a participant or, if the participant is a child or adolescent, the child's or adolescent's parent or guardian, to select from all available services for which the participant is found to be eligible.
 - c. A participant's free choice among qualified providers or, if the participant is a child or adolescent, the child's or adolescent's parent or guardian's free choice among qualified providers.
4. Mental health case management providers may not bill the Program for:
 - a. The direct delivery of an underlying medical, educational, social, or other service to which a participant has been referred;
 - b. Activities integral to the administration of foster care programs;
 - c. Activities not consistent with the definition of case management services under Section 6052 of the federal Deficit Reduction Act of 2005 (P.L. 109-171);
 - d. Activities for which third parties are liable to pay; or
 - e. Activities delivered as part of institutional discharge planning.
5. Reimbursement may not be made for mental health case management services if the participant is receiving a comparable case management service under another Program authority.
6. A participant's case manager may not be the participant's family member or a direct service provider for the participant.

C. Preauthorization

All covered services under this chapter shall be preauthorized and comply with the requirements of COMAR 10.09.70.07.

D. Payment Procedures

The Program shall reimburse the provider according to the requirements in this chapter and the fees established under COMAR 10.21.25 .

V. **MECHANISMS TO INTEGRATE WITH EXISTING SYSTEM**

The applicants must address their financial ability to provide the scope of services requested and at the quality desired, and address the legal liability issues associated with the operation of the proposed services. Applicants having current contracts with MHA or CSA's must have demonstrated success in meeting outcome and contract requirements.

VI. PROCUREMENT PROCESS

Issuing Office

Calvert County Core Service Agency.
975 Solomons Island Road, N
Prince Frederick, Maryland 20678
410 535-5400 ext 313

Issuing Officer

Douglas Weems, Director

VII. PRE-BID CONFERENCE

A pre-bid conference will be held on Wednesday, March 31, 2010 at 9:00 a.m. in the Conference Room of the Calvert County Health Department, 975 Solomons Island Road, Prince Frederick, Maryland 20678. The purpose of the conference is to address questions concerning the expectations of the project. All interested parties should register with the Calvert County Core Service Agency no later than close of business on Wednesday, March 24, 2010.

VIII. PROPOSAL SUBMISSION AND CLOSING DATE

The deadline for submission of proposals is 3:00 pm Friday, April 23, 2010, at Calvert County Core Service Agency. (CSA). Please submit five (5) copies of the proposal.

IX. DURATION OF OFFER

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

A. Timetable

The project will commence on July 1, 2010.

B. Cost of Proposal Preparation

Any costs incurred by offerors in preparing or submitting proposals are the sole responsibility of the offerors. CSA 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, recommend the consultant and to review

the content, findings, recommendations and other pertinent items during the course of the study.

Final acceptance of the deliverables will be made by CSA.

X. PROPOSAL SUBMISSION

A. Form of Proposal

Proposals will be received from each offeror in a sealed package.

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 CSA 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 or not information designated as such is proprietary, CSA will follow the direction provided by the 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.

C. Proposal Content Requirements

The proposal contents are contained in section XI of this RFP.

D. Proposal Evaluation Criteria

The Proposal Evaluation Criteria is contained in section XII of this RFP.

XI. TECHNICAL AND FINANCIAL PROPOSAL CRITERIA

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 technical 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. Format of Proposal

Each offeror is required to submit a package and must bear the name of the offeror and the closing date for proposals on the outside of the package. Inside this package (an original and four copies) shall be the offeror's Technical Proposal.

a. Technical Proposal Content

a. 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 broad understanding of the objectives of the study, the requirements of the RFP, the scope of work, the contents of the proposal, and any related issues, which should be addressed.

b. 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.

Fully explain how the proposed services will satisfy the requirements of this RFP. Indicate all significant tasks, aspects, or issues that will be examined to fulfill the scope of work. Include a time-phased schedule by tasks for meeting the proposed objective, a breakdown of proposed staff assignments, and time requirements by task.

The offeror should demonstrate a full understanding of the purpose and 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. The offeror should demonstrate the required objectivity.

c. Project Organization and Management

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 CSA should be identified. The offeror must meet periodically with CSA staff and render periodic progress reports for the purpose of administering the contract. Offeror shall also participate in the client tracking process developed by CSA, collecting and submitting relevant data as required. The offeror also shall address the transition and employment of existing agency-based case managers.

d. 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) as well as demonstrate the ability of the offeror to successfully provide sufficient qualified backup staff.

e. Personnel Capability

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.

f. Submit a line item budget.

XII. PRICE PROPOSAL CRITERIA (not applicable)

XIII. PROPOSAL EVALUATION CRITERIA (see Attachment I)

XIV. CONTRACT REQUIREMENTS

The selected offeror will be required to enter into a contractual agreement with CSA. A sample contract packet is available at CSA for your information. The contents of this RFP and the proposal of the successful offeror will be incorporated by reference into the resulting agreement. CSA will 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.

TARGETED CASE MANAGEMENT SERVICES PROGRAM RATING SHEET

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

A. TRANSMITTAL LETTER

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

B. DOCUMENTATION OF CORPORATE STRUCTURE

1. Current legal status (e.g. Articles of Incorporation).
2. Board resolution approving submission of proposal.
3. Copy of 501C(3) status.

C. FINANCIAL CAPABILITY TO PERFORM

1. Description of Offeror's financial capability to carry out work of RFP.
2. Audited financial statement from the previous year.

D. SUMMARY OF RELEVANT EXPERIENCE

1. Specific documentation of experience with other similar projects.

E. ORGANIZATION STRUCTURE/CHART

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

F. 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.

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

1. Basic values and beliefs about mental health services.
2. Knowledge of population and TCM concept.
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.

III. QUALITY AND OUTCOMES (20%)

1. Clearly stated outcomes.
2. Listed mission, goals, and objectives.
3. Clearly lists how progress will be measured and recorded.
4. Efforts or method to ensure participant involvement.
5. Confidentiality and record security.
6. Use of technologies to improve quality and efficiency.

IV. IMPLEMENTATION AND OPERATIONS STRATEGY (40%)

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.

Case Management Proposal Timeline

<u>STEPS TO COMPLETION</u>	<u>COMPLETION DATE</u>
Advertise/E-mail	Wed., 03/03/2010
Register for Pre-Bid Conference RSVP Ann Klein 410-535-5400 x313 before	Wed., 03/24/2010
Pre-Bid Conference 9:00 a.m. Conference Room, Calvert County Health Department, 975 Solomons Island Road, Prince Frederick, MD 20678	Wed., 03/31/2010
Proposal Submission Deadline Delivered to: Calvert County CSA Attn: Ann Klein 975 Solomons Island Road Prince Frederick, MD 20678	Fri., 04/23/2010, 3:00 p.m.
Review Committee	Fri., 04/30/2010
Contract Award Announcement	Wed., 05/05/2010
Work to Begin	Thurs., 07/01/2010