Office on Mental Health/Core Service Agency of Harford County, Inc.

Request for Proposals

Mental Health Case Management: Care Coordination for Children and Youth

Issued: December 22, 2014
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Background</td>
<td>3</td>
</tr>
<tr>
<td>II. Levels of Case Management</td>
<td>4</td>
</tr>
<tr>
<td>III. Wraparound Model</td>
<td>6</td>
</tr>
<tr>
<td>IV. Offeror Qualifications</td>
<td>9</td>
</tr>
<tr>
<td>V. Scope of Work</td>
<td>9</td>
</tr>
<tr>
<td>VI. Mechanisms to Integrate with Existing System</td>
<td>14</td>
</tr>
<tr>
<td>VII. Closing Date</td>
<td>14</td>
</tr>
<tr>
<td>VIII. Duration of Offer</td>
<td>14</td>
</tr>
<tr>
<td>IX. Proposal Submission</td>
<td>15</td>
</tr>
<tr>
<td>X. Proposal Format &amp; Content</td>
<td>15</td>
</tr>
<tr>
<td>XI. Proposal Evaluation Criteria</td>
<td>18</td>
</tr>
<tr>
<td>XII. MOU Requirements</td>
<td>18</td>
</tr>
</tbody>
</table>
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 Behavioral Health Administration (BHA) 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.

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 BHA began planning for a Medicaid State Plan Amendment (SPA) through a redesign of TCM (used interchangeably with Mental Health Case Management) for children, as well as the package of services developed for the 1915(i) Intensive Behavioral Health Services For Children, Youth and Families initiative to incorporate the wraparound philosophy and embed the philosophy into a Medicaid reimbursable service. Approval of the SPAs by the Federal Centers for Medicare and Medicaid Services (CMS) the was received in October 2014, and the successful applicant for the RFP will serve as the Care Coordination Organization (CCO) providing TCM for all eligible youth, including those enrolled in the 1915(i) Initiative.

The Office on Mental Health/Core Service Agency of Harford County 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 Harford County beginning on or about April 1, 2015.

Mental Health Case Management Care Coordination for Children and Youth allows for a multi-level continuum of care coordination using the Wraparound 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.

---

1 Throughout this document the term “Wraparound” refers to the service delivery model as defined by the National Wraparound Initiative (www.nwi.pdx.edu)
II. LEVELS OF CASE MANAGEMENT

All participants shall be classified according to the following levels of service, Mental Health Case Management: Care Coordination for Children and Youth of the State Plan under chapter XIX of the Social Security Act, as per COMAR 10.09.90:

.05 Participant Eligibility — Level I — General Care Coordination.

The participant as described in 10.09.90.03A of the regulation shall meet at least two of the following conditions:

A. The participant is not linked to behavioral health, health insurance, or medical services;

B. The participant lacks basic supports for education, income, shelter, or food;

C. The participant is transitioning from one level of intensity to another level of intensity of services;

D. The participant needs care coordination services to obtain and maintain community-based treatment and services;

E. The participant:

   (1) Is currently enrolled in Level II or Level III Care Coordination services under this chapter; and
   (2) Has stabilized to the point that Level I is most appropriate.

.06 Participant Eligibility — Level II — Moderate Care Coordination.

The participant as described in Regulation 10.09.90.03A of this chapter shall meet three or more of the following conditions:

A. The participant is not linked to behavioral health services, health insurance, or medical services;

B. The participant lacks basic supports for education, income, food, or transportation;

C. The participant is homeless or at-risk for homelessness;

D. 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) RTC; or
   (3) 1915(i) services under COMAR 10.09.89;

E. Due to multiple behavioral health stressors within the past 12 months, the participant has a history of:

   (1) Psychiatric hospitalizations; or
   (2) Repeated visits or admissions to:
(a) Emergency room psychiatric units;
(b) Crisis beds; or
(c) Inpatient psychiatric units;

F. The participant needs care coordination services to obtain and maintain community-based treatment and services;

G. The participant:

(1) Is currently enrolled in Level III Care Coordination services under this chapter; and
(2) Has stabilized to the point that Level II is most appropriate;

H. The participant:

(1) Is currently enrolled in Level I Care Coordination services under this chapter; and
(2) Has experienced one of the following adverse childhood experiences during the preceding 6 months:

(a) Emotional, physical, or sexual abuse;
(b) Emotional or physical neglect; or
(c) Significant family disruption or stressors.

.07 Participant Eligibility — Level III — Intensive Care Coordination.

A. The participant shall meet at least one of the following conditions:

(1) The participant has been enrolled in the 1915(i) program for 6 months or less;

(2) The participant is currently enrolled in Level I or Level II Care Coordination services under this chapter and has experienced one of the following adverse childhood experiences during the preceding 6 months:

(a) Emotional, physical, or sexual abuse;
(b) Serious emotional or physical neglect; or
(c) Significant family disruption or stressors;

(3) The participant meets the following conditions:

(a) The participant has a behavioral health disorder amenable to active clinical treatment, resulting from a face-to-face psychiatric evaluation;
(b) There is clinical evidence the minor has a SED and continues to meet the service intensity needs and medical necessity criteria for the duration of their enrollment;
(c) A comprehensive psychosocial assessment performed by a licensed mental health professional finds that the minor exhibits a significant impairment in functioning, representing potential serious harm to self or others, across settings, including the home, school, or community;
(d) 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:
(i) 4 or 5 on the ECSII; or
(ii) 5 or 6 on the CASII;

(e) Youth with a score of 5 on the CASII also shall meet the conditions outlined in §B of this regulation; and

(f) Youth with a score of 4 on the ECSII also shall meet the conditions outlined in §C of this regulation.

B. Youth with a score of 5 on the CASII shall 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:
   
   (a) Be at least 13 years old and have:
      
      (i) 3 or more inpatient psychiatric hospitalizations in the past 12 months; or
      (ii) Been in an RTC within the past 90 calendar days; or
   
   (b) Be 6 through 12 years old and have:
      
      (i) 2 or more inpatient psychiatric hospitalizations in the past 12 months; or
      (ii) Been in an RTC within the past 90 calendar days.

C. Youth who are younger than 6 years old who have a score of a 4 on the ECSII shall either:

1. Be referred directly from an inpatient hospital unit; or
2. If living in the community, have two or more psychiatric inpatient hospitalizations in the past 12 months.

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.
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 eligible for approval or already approved as a provider for the 1915(i) Intensive Behavioral Health Services for Children, Youth and Families Program.
- Provide a narrative demonstrating at least 3 years of experience providing behavioral health services to, including serving high risk populations and children and youth with serious emotional disorders.
- Provide a narrative demonstrating a strong understanding of the unique needs of children, youth and families.
- Provide the Offeror’s audited financial statements for the last three years, or demonstrate that organization is sound and its business practices are consistent with general accounting principles.
- Must have a valid Medicaid Provider billing number or meet all criteria necessary to obtain such number in order to be able to bill the PBHS.
- 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 Office on Mental Health/Core Service Agency of Harford County, Inc. is seeking providers to serve Harford County that is interested in providing Mental Health Case Management Care Coordination for Children and Youth services 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 Maryland Department of Health and Mental Hygiene (DHMH) has received approval for two State Plan Amendments (SPA) – one encompassing the redesign for children’s Targeted Case Management (TCM, or MHCM), and the other for a specialized package of services for 1915(i) SPA from the Centers for Medicare & Medicaid Services (CMS) to serve youth in the community who meet or are just below the residential treatment center level of care. The 1915(i) SPA is premised on the utilization of intensive care coordination provided through the Wraparound service delivery model via a CCO. The 1915(i) SPA for children and youth with serious behavioral health challenges makes available additional home- and community-based services currently not currently available through the Maryland Medicaid State Plan. Care coordination for children and adolescents will be provided through a Care Coordination Organization (CCO) that is also approved under new COMAR regulations (10.09.89 and 10.09.90). CCO providers selected through this RFP process will provide all levels of care as defined in this RFP, including care coordination for 1915(i) participants.

DHMH has designed three levels of care coordination, including Level 3: Intensive Care Coordination. Level 3 is a benefit available to any Medicaid-enrolled child or youth who meets the medical necessity criteria, along with 1915(i) financial eligibility (family income at or below 150% of federal poverty limit). If the youth is not financially eligible for the 1915(i) SPA, despite being a Medicaid enrollee, he or she still will be able to access the Level 3 Intensive Care Coordination, even though he or she will not be eligible for the other 1915(i) SPA benefits due to federal Medicaid restrictions. Two additional lower levels of intensity are also available within the care coordination array: General and Moderate.

The CCO will serve children, adolescents and young adults up to 22 years of age. A youth may remain in TCM through the CCO up to the age of 22 years if he/she consents to do so. If a youth over 18 years of age disenrolls from the CCO, he or she has 120 days following disenrollment to re-enroll with the CCO. 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 between 18-22 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 CCO 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 and will additionally serve as the CCO for children and youth enrolled in the 1915(i) Program. 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. Training Requirements

The training program for Maryland CCOs is fully outlined in the Maryland Wraparound Supervisory Certification manual (link below). Below are the core training courses required for CCO supervisors and care coordinators.

Wraparound Certificate Program

**Care Coordinators working in Wraparound will be required to attend the core trainings described below except:**

Advanced Wraparound Practice—Supervision in Wraparound: Managing to Quality and Introduction to Training and Coaching Tools

Over the course of a minimum of 12 months and no more than 24 months, applicants will need to meet certain requirements in order to receive certification. These requirements consist of:

1. Completion of core training requirements
   - Introduction to Wraparound Brief Overview (prior to serving children) *(available online)*
   - Child & Adolescent Needs & Strengths (CANS) Assessment *(available online)*
   - System of Care Overview *(available online)*
   - Oral Health Care for Children and Adolescents *(available online)*
   - Somatic Health Care for Children and Adolescents *(available online)*
   - Introduction to Wraparound (3-day training)
   - Engagement in the Wraparound Process (1-day Training)
   - Intermediate Wraparound: Improving Wraparound Practice (2-day Training)
   - Advancing Wraparound Practice: Supervision and Managing to Quality (2-day Training)
   - Introduction to Coaching and Training Tools (1-day Training)

2. A supervisor must participate in every coaching session

Supervisors are also required to demonstrate proficiency with the Coaching Observation Measure for Effective Teams (COMET) and will participate in coaching with the Wraparound Trainer/Coach to gauge progress and receive feedback.

Please review the additional requirements for supervisors outlined in the full document found here: https://theinstitute.umaryland.edu/topics/ebpp/docs/wraparound/MD%20Supervisory%20Certification%20Guide.pdf

D. Participant Eligibility

Level 1, 2 and 3

Level 1, 2 and 3 will require authorization through the ASO based on medical necessity criteria.
Certificate of Need – Enrollment in Level 3 Care Coordination or Level 3 Care Coordination/1915(i) Program

Youth seeking enrollment in either Level 3 Intensive Care Coordination or Level 3 Care Coordination/1915(i) will be reviewed for eligibility based on a Certificate of Need (CON). The 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.

The process for CON submission and review is established by DHMH and Value Options. It is anticipated that this process will closely mirror the process currently used to submit and process CON documentation for youth seeking RTC placement. CCO providers are required to comply with the finalized process for 1915(i) youth. Based on RTC procedures for CON documentation, it is likely to include CCO coordination of CON documentation with and on behalf of the family, as well as submission of the completed packet to the local Core Service Agency and Value Options for eligibility determination. Protocols for financial eligibility determinations for 1915(i) youth will be established, and CCO will participate in this process at the discretion of DHMH or its designee.

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.

E. 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 Behavioral 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 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) Program 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.
17. Develop policies and procedures based on regulations, to include crisis response, reportable events, customized goods & services, program model, job descriptions, clinical supervision, etc.
18. If applicable, implement the transition plan outlined in the proposal submission to ensure that all youth enrolled with a prior provider are moved into services with the selected applicant.
19. Track and report on quality measures as required by DHMH/BHA and the CSA, which are subject to revision. For 1915(i) youth, the below data indicators are required:

| % of participants who had a team meeting at least every 45 days |
| % of participants whose plan of care was updated to include change in progress, services or other areas within five days of the team meeting |
| % of participants whose POC indicates that they were afforded choice in the selection of services and providers |
| Utilization review of services on POC in conjunction with provider authorization and claims data |
| % of providers who have submitted 1915(i) HCBS claims who are approved providers by Maryland Medicaid |
| % of providers who meet the initial and ongoing requirements established by DHMH/BHA |
| % of youth who disenrolled as a result of moving to a setting that is not authorized in this SPA |
| % of reportable events involving abuse, neglect, and/or exploitation reported that are resolved according to policy |

F. 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 Office on Mental Health/Core Service Agency of Harford County, Inc. 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. CLOSING DATE

The closing date for response to this RFP is February 5, 2014 @ 4:00 P.M.

VIII. DURATION OF OFFER

The duration of the award of Case Management status in Harford County shall be three years from July 1, 2015. The approval may be extended for up to two one year extensions.
IX. PROPOSAL SUBMISSION

All offerors must submit one copy electronically to JMiller@harfordmentalhealth.org and 5 hard copies to OMH/CSA, 125 N. Main Street, Rear, Bel Air, MD 21014.

X. PROPOSAL FORMAT & CONTENT

Proposal narratives submitted in response to this request shall not exceed 15 typed, single sided, single spaced pages and should address the criteria specified in II. Levels of Case Management, III. Wraparound Model, and IV. Offender Qualifications. Use a 12 point font. Budget pages DHMH Forms 432A thru 432H and attachments, such as letters of support, are not included in the 15 page maximum. It shall contain a one page executive summary.

At a minimum, each proposal shall include the following items in the stated order; all pages shall be numbered, and all listed components must be included. Proposals which do not include all components will be considered non-responsive and therefore not reviewed or considered.

1. Transmission Letter: Formal letter stating your intent to provide the services you are proposing and that you have the authority to do so. Provide name of organization, address, and all contact information, including primary contact person.

2. Approval of Governing Body: Letter which states that you have the approval and support of your governing body to submit such proposal.

3. Program Budget: Use DHMH Forms 432A thru 432H. The budget should specify costs including salaries and fringe, rent, supplies, mileage, etc. Submit a line item budget. The budget should be based on the provider’s estimated billing to the Maryland Public Mental Health System for the 1915i case management program and other sources of income. Personnel costs should be detailed on budget form 432D. Equipment costs should be detailed on 432F.

4. Proposed Program:

Provide a narrative describing your plan for implementation of the 1915i services in Harford County. Discuss any expertise and experience working with such populations in the Public Mental Health System you have had in the past and what you consider the primary issues for these consumers. Provide a detailed work plan for addressing requirements outlined in this RFP. Describe the plan for handling on-site and off-site emergencies and how clients can contact the program after hours. Fully explain how the proposed services will satisfy the the requirements of the RFP. Demonstrate a full understanding of the purpose and expectations and complexities of the program and how the objective may be accomplished.

Describe your organization’s experience in providing any similar services and the results those services have achieved. Demonstrate your organization’s capability to successfully manage and complete this agreement, including an outline of the overall concepts and methodologies to be employed. Key management individuals responsible for coordinating with the CSA should be
5. Staffing:

Clearly identify the proposed program team positions including any existing staff that will be assigned to the team. Describe the policy for initial and ongoing staff training, including cultural competency.

6. Collaborative Relationships

Describe the organization’s history of providing services in Harford County and established collaborative relationships. Describe the plan for marketing this program to referral sources and potential participants.

7. Timeline for Implementation:

Include a timeline showing when all major tasks associated with program start-up and implementation will be accomplished, including hiring and training of staff, obtaining office space, marketing, transitioning of current consumer (if any), supervision and evaluation.

8. Organizational Capacity

If incorporated, submit a roster of all members of the organization’s board of directors, including addresses and affiliations. Indicate consumer/family representation.

Attach an organizational chart illustrating the relationship of the proposed 1915i program to the other components of the agency.

Attach copies of most recent financial audit and current FY15 budget.

9. Letters of Reference:

Include at least two letters of reference/support.

10. Response to Case Vignette

Narrative response to case vignette Appendix A.

F. Technical Proposal Content

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.harfordmentalhealth.org
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 AAMCHA, which can be downloaded at www.harfordmentalhealth.org

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.

e. Fiscal Health of Applicant Organization

1. Applicants must submit the most recent year financial audit statements demonstrating fiscal viability to support this program.

2. Providers making application in response to this RFP should note that the local Core Service Agency is making no guarantee through this procurement on number of youth who will enroll or potential revenue for the selected provider. Providers should submit a statement regarding financial viability and the ability of the organization to fiscally support a program that will require ramp-up of referrals and revenue.
XI. PROPOSAL EVALUATION CRITERIA

A. Overview

B. Evaluation Method

i. Acceptable Offers (Attachment 1)

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%

Technical Scores

a. Budget Analysis Score

There is no price associated with this RFP. Funding will be through the Public Behavioral Health System 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.

b. Program Budget/Technical Proposal – Personnel Reconciliation

c. Revenue must be broken out by CPT code:

<table>
<thead>
<tr>
<th>Example</th>
<th>Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>90801</td>
<td>$ 40,000</td>
</tr>
<tr>
<td>90802</td>
<td>60,000</td>
</tr>
<tr>
<td>90791</td>
<td>20,000</td>
</tr>
<tr>
<td>T1016</td>
<td>250,000</td>
</tr>
<tr>
<td>In-kind</td>
<td>50,000</td>
</tr>
<tr>
<td>Total Budget</td>
<td>$420,000</td>
</tr>
</tbody>
</table>

XII. Agreement (MOU) Requirements

The selected Offeror will be required to enter into a Memorandum of Understanding with the Office on Mental Health/Core Service Agency of Harford County. The contents of this RFP and
the proposal of the successful Offeror will be incorporated by reference into the resulting agreement. The OMH/CSA shall enter into an agreement only with the selected Offeror and the selected Offeror will be required to comply with, and provide assurance of, certification as to certain Agreement requirements and provisions.

Contact Information:

For questions regarding this RFP please contact:

Jamie Miller, Deputy Director
410-803-8726
jmiller@harfordmentalhealth.org
APPENDIX A

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
MENTAL HEALTH CASE MANAGEMENT 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.
   If the selected applicant was not previously a TCM provider in this county, a detailed plan must be included to transition families enrolled in TCM with the former provider to the TCM/CCO provider selected through this RFP. A transition should be time sensitive and actively address prevention of gaps in service and client disenrollment. The selected applicant assumes responsibility for implementing the transition 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.
15. Use of technologies to improve quality and efficiency.

B. 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. Collecti