Request for Proposals:

Mental Health Targeted Case Management Services for Adults

Release Date: February 17, 2026

Due Date: April 3, 2026

CALVERT COUNTY
HEALTH
DEPARTMENT

Calvert County Local Behavioral Health Authority (LBHA)
P.O. Box 980
PRINCE FREDERICK, MD 20678
443-295-8584

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Mental Health Targeted Case Management for Adults

I. BACKGROUND

Calvert County Local Behavioral Health Authority (LBHA) is responsible for planning, managing, and monitoring the Public Behavioral Health System in Calvert County. The LBHA envisions a county where people live and thrive in communities that promote and support behavioral health and wellness.

The LBHA is committed to enhancing the behavioral health and wellness of individuals, families, and communities through:

- The promotion of behavioral health and wellness, prevention, early intervention, treatment, and recovery;
- The creation and leadership of an integrated network of providers that promotes universal access to comprehensive, data-driven services; and
- Advocacy and leadership of behavioral health-related efforts to align resources, programs and policy.

Targeted Case Management (TCM) services play an integral role in assisting individuals to navigate complex public systems. Specifically, these services assist individuals with identifying and enrolling in needed behavioral health care, obtaining benefits and entitlements, and assuring needed supports are in place to help people thrive in the community. TCM services are provided in the home or community in order to assist individuals in gaining access to the full range of mental health services, as well as to any additional needed medical, social, financial assistance or benefits, counseling, educational, housing and other supportive services. TCM services assist individuals, based on an assessment of needs, to link to services, advocate on behalf of the individual, and empower the individual to secure needed services. TCM services are time limited as individuals are effectively linked to needed resources and services. The purpose of this Request for Proposal (RFP) is to select mental health targeted case management providers to serve in Calvert County in accordance with COMAR 10.09.45, the State regulation which requires Local Behavioral Health Authority (LBHA's) to procure mental health targeted case management services in their respective jurisdictions at least once every five years. In order to comply with this mandate, the LBHA, as the LBHA for Calvert County, is issuing this RFP to secure qualified adult mental health case management providers to deliver comprehensive targeted case management services for eligible adults who reside in Calvert County. The providers authorized to serve adults in Calvert County via this RFP process will be required to provide both levels of care outlined in the Scope of Service. Only those providers selected through this RFP process will be permitted to provide mental health targeted case management services for adults in Calvert County.

A. Priority Areas to be Served

It is envisioned that four (4) different primary areas of priority will be served. The priority areas

to be served under this proposal include the following:

1. Persons who are in a psychiatric crisis, are at risk of hospitalization, and/or chronically disengaged from the behavioral health service system. A subset of interest for this group are:

    - Veterans of Iraq or Afghanistan, as well as veterans of other wars,
    - Persons with a co-occurring substance use disorder, and/or
    - Chronically homeless due to their psychiatric illness.
    - A secondary subset interest group includes those who excessively use high-cost services such as inpatient and Emergency Departments, particularly those with co-occurring substance use disorder or health issue, as well as high-cost users of emergency medical services.

    The primary source of referrals in this area will be the Crisis Response System, Emergency Departments of Hospitals, Calvert County Fire and Rescue Emergency Medical Services, and homeless shelters. Procurement of financial entitlements, particularly Medical Assistance is to be emphasized for these groups.

2. Persons who are incarcerated due to their psychiatric illness and there is a likelihood of continued or repeated incarceration that can be reduced with adequate and appropriate psychiatric and support services.

    The primary source of referrals for this area will be the local Detention Centers, State Prisons, and forensically involved individuals at state hospitals.

3. Persons with Continuum of Care vouchers need targeted case management services to maintain their housing. Providers selected will work in collaboration with any other community partner or support agency that provides services to the individuals living in the Continuum of Care program.

4. Adult persons with serious and persistent mental illness (SPMI), especially those transitioning from State or acute psychiatric hospitals, particularly those with histories of inconsistent use of outpatient services or inconsistent hospital follow-up with outpatient services.

B. COMAR

Providers selected through this procurement will commit to provide mental health targeted case management services to eligible adults in Calvert County in accordance with COMAR 10.09.45, and will be reimbursed through the Administrative Services Organization (ASO) in accordance with the tiered structure for mental health targeted case management under COMAR 10.09.45. Throughout this document, COMAR will be cited as the primary reference for regulations pertaining to mental health targeted case management. The selected applicants will be required to maintain compliance with current and future COMAR regulations, including new policies released by the Maryland Behavioral Health Administration (BHA) for mental health targeted case management.

II. GOALS

The major goals of Targeted Case Management are:

A. Linking

1. Assisting consumers to access entitlements and needed medical, behavioral 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 ensure the consumer has applied for, has access to, and is receiving the necessary services to meet the participant's needs, such as behavioral health and medical services, resource procurement, transportation, state benefits, and or crisis intervention.

Providers must ensure that all of their targeted case management staff will be SOAR (SSI/SSDI Outreach Access to Recovery) trained, and will initiate SOAR applications when appropriate. SOAR provides expedited SSI/SSDI for individuals with behavioral health disorders who are homeless or at risk of homelessness.

B. Monitoring and Follow-up

1. Activities and contacts are necessary and must be conducted to ensure the Care Plan for each participating consumer is implemented and adequately addresses the participant's needs. They may include the participants family members, providers, or other entities or individuals and shall be conducted as frequently as necessary. At least one assessment must be conducted every six months, or more frequently as needed, 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, necessary adjustments are made 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.
3. Conduct follow-up activity after the service referral has been made, 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.
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

1. Empower the participant 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 to carry out these decisions.

III. BIDDER QUALIFICATIONS

Applicants must meet either all the criteria below or (A, C-F) or (B-F) to be considered eligible to become a mental health targeted case management provider through this RFP.

A. Applicants must be approved or licensed as a community mental health provider under COMAR 10.21.19 (Mobile Treatment Services), 10.21.20 (Outpatient Mental Health Center, or 10.21.21 (Psychiatric Rehabilitation Program) for at least three years, **or** have three years of experience as a mental health targeted case management provider.
B. Be enrolled as a targeted case management provider in the public behavioral health system, or be eligible for approval as a mental health targeted case management service provider per conditions for participation as set forth in COMAR 10.09.36.03, 10.09.45, and any additional applicable Medical Assistance provisions.
C. Be eligible for approval by the Maryland Medicaid System as a TCM provider.
D. Have at least 3 years of experience providing behavioral health services to high-risk populations and adults with serious mental illness and substance use disorders.
E. Applicants should have knowledge of Calvert County's public behavioral health system and the target population outlined in this RFP.
F. Applicants should have a strong commitment to provide culturally competent, high quality services to eligible consumers within diverse communities in Calvert County.

IV. SCOPE OF WORK

A. Overview

Calvert County LBHA is seeking a provider, or multiple providers, that are 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 Calvert County LBHA, and
4. Statements made in the reply to this Request for Proposal (RFP).

The Calvert County LBHA will oversee and monitor compliance with all contract conditions. The offeror shall ensure the LBHA 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 ensure procedural requirements and contract deliverables are met.

The major outcome for this population may be measured by reducing the use of inpatient and other institutional-based care, obtaining and maintaining entitlements, reducing re0incarceration rates, 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.

a. Target Group
A recipient is eligible for mental health targeted 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:

a) Adults, who have a serious and persistent mental health diagnoses, according to a current Diagnostic and Statistical Manual of the American Psychiatric Association that is recognized by the Secretary, and who are:
- at risk of, or need continued community treatment to prevent inpatient psychiatric treatment;
- at risk of, or need continued community treatment to prevent being homeless;
- at risk of incarceration or will be released from a detention center or prison;
- Transitioning from a recent hospitalization from an acute psychiatric illness and are at risk for reoccurrence; or
- Shown to repeatedly utilize emergency medical services, emergency department services, and/or crisis services for psychiatric illness.

b) The LBHA also requests that providers give priority to individuals who may be particularly vulnerable to or at risk of adverse outcomes without these services in place. Giving these consumers priority, means using your best clinical judgment to identify and quickly admit individuals who may be considered one of the “priority” populations. Providers should make special efforts to reach out to and enroll these populations. These populations include, but are not limited to individuals who:
- Are not linked to behavioral health services;
- Are lacking basic support such as shelter, food, and income;
- Living under the Continuum of Care program and need targeted case management to maintain their housing;
- Are transitioning from one level of care to another;
- Do not have insurance;
- Are being released from an inpatient psychiatric unit, state psychiatric hospital, residential crisis service, or emergency department.

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 Behavioral Health Administration facility, according to the provisions of Health General Article, Title 12, Annotated Code of Maryland; or
b) An individual in a Behavioral Health Administration facility or a Behavioral Health Administration funded inpatient psychiatric hospital who requires community services. This excludes individuals eligible for Developmental Disabilities Administration's residential services.

b. Levels of Service

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

d) Level I – General: For a minimum of one and a maximum of two units of service per month, minimum of 30 minutes face-to-face monthly. Does not include the assessment 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 targeted case management services to maintain community-based treatment and services.

e) Level II – Intensive: For a minimum of two and a maximum of five units of service per month. Does not include the assessment 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 targeted case management services to maintain community-based treatment and services.

c. Definition of Services:

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

a) Comprehensive Assessment and Periodic Reassessment

Assessment, or reassessment, involves the participant's stated needs and review of information concerning a participant's behavioral 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. 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.

b) 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, 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. 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:

- 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;
- The development and periodic updating of the written individualized Care Plan based on the participant's needs, progress, and stated goals;
- Transitional Care Planning that involves contact with the participant 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 to another type of community service; and,
- Discharge planning from mental health targeted case management services, when appropriate, or when goals for case management have been achieved.

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

c) Referral and Related Activities
Community support specialist associates, under the direction of community support specialists, shall assure that the participant 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:
Community support development by contacting, with the participant's consent, members of the participant's support network, including, family, friends, and neighbors, as appropriate, to mobilize assistance for the participant.

- Crisis intervention by referral of the participant to services on an emergency basis when immediate intervention is necessary.

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

d) 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.
The mental health targeted case management provider must ensure that:
- Services are being furnished in accordance with the participant's Care Plan.
- Services in the Care Plan are adequate.
- If the needs of the participant change, and if applicable, necessary adjustments are made to the Care Plan including referrals for services.

The mental health targeted case management provider must also:
Engage in ongoing interaction with the participant, and, with the participant's consent, the participant's family and friends as appropriate, and service providers.
- 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.
- Revise the Care Plan to reflect changing needs identified from the service monitoring.

Targeted 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.

e) The mental health targeted case management provider must engage in advocacy efforts, including:
- Empowering the participant to secure needed services;
- Taking any necessary actions to secure services on the participant's behalf; and,
- Encouraging and facilitating the participant's informed decision making and choices leading to accomplishment of the participant's goals.

d. Requirements
General requirements for participation in the public behavioral health system as a mental health targeted case management provider are that a targeted 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.
Providers that offer TCM to individuals participating in the Continuum of Care program will work in collaboration with any other community partner or support agency that provides services to the individuals.
Specific requirements for participation in the public behavioral health system as a mental health case management program include all of the following:

a) 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 severe and persistent mental illness.
b) 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 targeted case management services, an initial Care Plan shall be completed within 10 days after completion of the initial assessment.
c) Refrain from providing other services for participants which would be viewed by the Department as a conflict of interest.
d) Be knowledgeable of the eligibility requirements and application procedures of federal, State, and local government assistance programs which are applicable to participants.
e) Maintain information on current resources for mental health, medical, social, financial assistance, vocational, educational, housing, and other support services.
f) Safeguard the confidentiality of the participant's records in accordance with State and federal laws and regulations governing confidentiality.
g) Comply with the Department's fiscal reporting requirements and submit reports in the manner specified by the Department.
h) Comply with the requirements for the delivery of mental health services outlined by the Department.
i) 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 and/or reassessment, which involves the 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.

4) A Care Plan, updated at a minimum of every six 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 targeted 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 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 and their credentials;
   d. Nature, content, and number of 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.
6) Monthly summary notes, which reflect progress made towards the participant's stated goals.
7) Have formal written policies and procedures, approved by the Department, which specifically address the provision of mental health targeted case management services to participants in accordance with these requirements.
8) Be available to participants and, as appropriate, the participant's families 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 behavioral health treatment and evaluation services in order to prevent the participant from accessing a higher level of care.
9) Participants may decline targeted case management services. This will be documented in the participant's targeted case management record.
10) 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.

e. Required Staff

The mental health targeted 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 targeted 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 experience providing mental health support; or
   b. Bachelor's degree in a field other than mental health and two years of experience in providing mental health support;
   c. Is employed by the mental health targeted case management provider to provide targeted 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
   b. Is employed by the mental health targeted case management provider to assist Community Support Specialists in the provision of mental health targeted case management services to participants; and
   c. Works under the supervision of a Community Support Specialist who delegates specific tasks to the Associate.

C. Preauthorization

All covered services under this chapter shall be preauthorized and comply with the requirements of COMAR 10.67.08.

D. Payment Procedures

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

E. Program Reporting and Outcomes

Calvert County LBHA is dedicated to enhancing outcomes reporting system wide in order to evaluate the quality of public behavioral health services in Calvert County. Clients that enroll in mental health targeted case management services are expected to improve over time, and programs should be able to demonstrate that clients are being linked to the appropriate services and moved through an appropriate step-down process based upon an assessed level of need.

The selected applicants will be expected to report client-level data to LBHA and its partners during the entirety of the approved service term. LBHA will require at least monthly program reporting on key indicators that are assessed throughout the client's tenure with mental health targeted case management. LBHA will collaborate with the selected providers to develop outcomes and associated data reporting mechanisms that all mental health targeted case managers will use. Data points may be both qualitative and quantitative in nature including, but not limited to:

- Demographic information
- Linkage to and engagement in needed behavioral health and somatic health care
- Linkage to entitlements and other needed resources
- Housing status
- Hospital admissions
- Engagement in meaningful activities (e.g. work, education, volunteerism, etc.)

As a systems partner, the selected providers are required to develop and implement practices and procedures to support the system outcomes outlined above.

V. PROCUREMENT PROCESS

Issuing Office

Calvert County Health Department
Local Behavioral Health Authority (LBHA)
P.O. Box 980
Prince Frederick, MD 20678
443-295-8584 ext. 101

Issuing Officer

Andrea McDonald-Fingland, LCSW-C
Director, LBHA

VI. PRE-BID CONFERENCE

A pre-bid conference will be held virtually on Monday, Monday March 23, 2026, at 11:00 a.m. All interested parties should register with Andrea McDonald-Fingland, at andrea.mcdonald-fingland@maryland.gov by **Friday, March 20, 2026 at 4:30pm**.

VII. PROPOSAL SUBMISSION AND CLOSING DATE

The deadline for submission of proposals is 5:00 pm Eastern Daylight-Saving Time, Friday, April 3, 2026 at Calvert County Local Behavioral Health Authority. Please submit an **electronic copy to andrea.mcdonald-fingland@maryland.gov.**

VIII. DURATION OF OFFER

The offeror agrees to be bound by its technical and price proposals for a period of 60 days from the proposal closing date during which time Calvert County Local Behavioral Health Authority (LBHA) may request clarification or corrections for the purpose of evaluation. Amendments or clarifications requested by the LBHA 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. Calvert County LBHA 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 submitted. It is planned that the selection of the contractor will be announced no later than **Friday, May 8, 2026**. The project will commence on July 1, 2026.

B. Cost of Proposal Preparation

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

C. Selection 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 the LBHA, after review by representatives from the Local Behavioral Health Advisory Council and other stakeholders.

IX. PROPOSAL SUBMISSION

A. Form of Proposal

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

1. *Mental Health Case Management for Adults – Offeror Qualifications*

   Offerors' name and date of proposal
   Please note there is a 5 page limit for this section of the proposal

2. *Mental Health Case Management for Adults – Technical Proposal*

   Offerors' name and date of proposal
   Please note there is a 10 page limit for this section of the proposal

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 the Calvert County LBHA 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, the LBHA 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.

X. PROPOSAL FORMAT and 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

Each Offeror’s submission must be provided in electronic format, bear the Offeror’s name, the date of proposals and “MH TCM for Adults – Offeror Qualifications” in the title. Inside this document shall be the Offeror's Qualification submission. Any supporting documentation that cannot be included within the document should be included as attachments. There is a 5 page limit for this section of the proposal.

C. Qualification Content

Response to each qualification required.

D. Technical Proposal Format

Each Offeror’s submission must be provided in electronic format, bear the Offeror’s name, the date of proposals and “MH TCM Adults – Technical Proposal” in the title. Inside this document shall be the Offeror's Technical Proposal submission. There is a 10 page limit for this section of the proposal. Any supporting documentation that cannot be included within the document should be included as attachments.

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 Behavioral Health Authority 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 Behavioral Health Authority should be identified. The Offeror must meet periodically with respective Local Behavioral Health Authority 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 Behavioral Health Administration (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 the LBHA to contact any reference provided.). SSI/SSDI Outreach, Access and Recovery (SOAR) certification is required for all staff employed through this program. Proof of certification or a plan for ensuring this requirement is met should be included. Additionally, Offerors may submit formal letters of support to further substantiate their specific experience and technical qualifications.

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 of 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. Staffing patterns must follow all guidelines set forth in COMAR 10.09.45.05.

F. Financial Overview

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 Local Behavioral Health Authority must have demonstrated success by meeting deliverables in current contracts. Use of, and ability to bill and collect "Medicare, Medicaid, and third-party payments" should be documented.

XI. PROPOSAL EVALUATION CRITERIA

A. **Overview**

An RFP Selection Committee, comprised of LBHA stakeholders, shall review any submitted proposals for compliance with essential qualifications and technical requirements as expressed in this RFP. The proposals and scores of the top contenders will be reviewed by LBHA staff for final determination of award(s). In the event that there are multiple successful bidders of equal ranking, the RFP Selection Committee would make the selection based on their review of the results.

B. **Evaluation Method**

1. Acceptable Offers

Each member of the RFP Selection Committee will complete a technical evaluation. All offerors who receive an average rating of 80% or more of total points possible on the technical proposal evaluation will be eligible for consideration. Technical factors will be weighted as follows:

a. Qualifications of Offeror and Proposed Staff 20%

b. Philosophy and Approach to Service Delivery 20%

c. Quality and Outcomes 20%

d. Implementation and Operations Strategy 40%

2. Unacceptable Offers

Those for whom the RFP Selection Committee evaluates with an average technical rating of less than 80% of the total possible points will not be considered further.

3. Technical Scores

Technical scores will be calculated based on the attached rating sheet.

C. **Price Score**

There is no price associated with this RFP. Funding will be through the Maryland Public Behavioral Health System (MPBHS) Fee for Service (FFS) billings.

D. RFP Postponement/Cancellation

Calvert County Local Behavioral Health Authority reserves the right to postpone, modify or cancel this RFP, in whole or part.

XII. CONTRACT REQUIREMENTS

The selected offeror will be required to enter into a contractual agreement with the Calvert County LBHA. A sample contract packet is available at the Calvert County LBHA 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 Calvert County LBHA will enter into a contract only with the selected offeror(s) and the selected offeror(s) will be required to comply with, and provide assurance of, certification as to certain contract requirements and provisions.

Attachment 1

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 statements for the last two years.

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
   a. Patient centered care
   b. Recovery oriented
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.
7. Strength of Disaster Plan.

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.
10. Satisfaction surveys.

Attachment 2

Case Management Proposal Timeline – Calvert LBHA

STEPS TO COMPLETION	**COMPLETION DATE**
Advertise/E-mail	Monday, March 2, 2026
Register for Pre-Bid Conference RSVP to: Andrea McDonald-Fingland	Friday, March 20, 2026 by 4:30pm
Pre-Bid Conference:	Monday, March 23, 2026 11:00 am
Proposal Submission Deadline: Email to: Andrea McDonald-Fingland, LCSW-C	Friday, April 3, 2026 at 5:00 pm
Contract Award Announcement	Friday, May 8, 2026
Work to Begin	Thursday, July 1, 2026