CareFirst

CareFirst Commitment

CareFirst BlueCross BlueShield Request for Proposal Guidelines:
Improving Behavioral Health Outcomes through Increased Access to Services for Youth and Workforce Development for All Populations

Issue Date:

May 19, 2022

Submission Deadline:

June 13, 2022 by 11:59 a.m. EST

Improving Behavioral Health Outcomes through Increased Access to Services for Youth and Workforce Development for All Populations

This document describes the purpose of the CareFirst "Improving Behavioral Health Outcomes through Increased Access to Services for Youth and Workforce Development for All Populations" request for proposals (RFP), eligibility criteria, and the procedures to follow in submitting a proposal. Please review these guidelines carefully, provide all requested information and submit your proposal in the requested format. All proposals must be submitted using the online application here: https://www.GrantRequest.com/SID_843?SA=SNA&FID=35095.

Background

Mental Health Trends and Disparities

Behavioral health is a holistic term that encompasses the range of emotional, psychological, and social factors that affect a person's overall wellbeing.[1] As the United States has grappled with a global pandemic, the prevalence of mental health disorders has steadily increased, especially among LGBTQ young people and children of color.[2] Data also shows that rural children from small communities have higher rates of mental and behavioral disorders than their urban and suburban counterparts and are nearly twice as likely to commit suicide.[3,4] Other groups of children and youth who are increased risk for behavioral health disorders include youth from low-income households, youth involved in the child welfare and juvenile justice system, and youth who have disabilities[5]. The worsening trends in youth mental health are so concerning that the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, and the Children's Hospital Association declared a National Emergency in Children's Mental Health in 2021.[6]

Nationwide in 2019, 36.7% of youth experienced persistent feelings of sadness or hopelessness and nearly one in 10 attempted suicide.[7] Although White students were most likely to seriously consider attempting suicide, Black students were the most likely to attempt suicide and the most likely to be injured in a suicide attempt.[4] Disparities for LGBTQ youth are even more striking. 46.8% of LGB

[1] Behavioral Health Terms | CMS, accessed 4/12/22

[2] Panchal, Nirmita, Rabah Kamal, Cynthia Cox, Rachel Garfield, and Priya Chidambaram. "Mental health and substance use considerations among children during the COVID-19 pandemic." *San Francisco: Kaiser Family Foundation* (2021).

[3] Kelleher KJ, Gardner W. Out of sight, out of mind – behavioral and developmental care for rural children. The New England Journal of Medicine 2017; 376(14): 1301–1303. doi: 10.1056/NEJMp1700713

[4] Fontanella CA, Hiance-Steelesmith DL, Phillips GS, et al. Widening rural-urban disparities in youth suicides, United States, 1996–2010. JAMA Pediatrics 2015; 169(5): 466–473. doi: 10.1001/jamapediatrics.2014.3561

[5] https://youth.gov/youth-topics/prevalence-mental-health-disorders-among-youth#:~:text=Youth%20from%20low-income%20households%20are%20at%20increased%20risk,at%20or%20below%20the%20federal%20poverty%20level.%2011, Accessed 5/16/2022

[6] AAP-AACAP-CHA Declaration of a National Emergency in Child and Adolescent Mental Health, Accessed 4/13/22

[7] Centers for Disease Control and Prevention Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention Division of Adolescent and School Health. 2021. *Youth Risk Behavior Survey: Data Summary & Trends Report 2009-2019.*

youth seriously considered suicide, compared to 14.5% of heterosexual youth, and nearly one in four LGB youth attempted suicide in 2019.[4]

These national trends and disparities are mirrored in Maryland, Virginia, and the District of Columbia (DC) with some notable exceptions. Although youth mental health outcomes in Virginia and Maryland are close to or slightly better than national outcomes, the rate of suicide attempts in DC is nearly double the national average (14.9% in DC compared to 8.9% nationally). Depression and suicidality statistics in Virginia are consistent with national trends, but minority students in DC and Maryland report higher rates of depression and attempted suicide, in contrast to national trends where White students have higher depression rates than their peers. Furthermore, depression and suicidality rates in DC and Maryland were highest among youth who identified as multiracial. [8]

Access to Behavioral Health Services

The behavioral health crisis among youth has been exacerbated by limited access to services. Nationally, 60.3% of youth who experience a major depressive episode (MDE) do not receive mental health services. Although the situation is slightly better in Maryland, Virginia, and DC, over 40% youth who had experienced an MDE did not receive mental health services. Furthermore, only 25.0%, 34.5%, and 35.8% of youth with severe depression received consistent mental health treatment in Virginia, Maryland, and DC, respectively.[6]

One major factor contributing to limited access to mental health services is a dearth of mental health providers. Eighteen of Maryland's 24 counties are full or partial health provider shortage areas (HPSAs) for mental health providers.[9] In DC, the Anacostia and Southeast Capital Beltway neighborhoods are defined as High Needs geographic HPSAs. Mental health provider shortages are especially pronounced for youth and adolescents given the relatively fewer providers serving these populations.[10]

There are also disparities in access to behavioral health services for low-income youth, LGBTQ youth and youth of color. Low household income significantly reduces the likelihood of adolescents receiving adequate mental health treatment, and although racial and ethnic minority youth are at higher risk for mental health disorders, they are less likely to receive mental health services.[11,12] While racial and ethnic disparities in mental health care access are not fully understood, studies have documented several barriers and facilitators to access. In two studies, adolescents avoided mental health services due to perceived barriers (e.g., not wanting parents to know, being afraid of

[8] Centers for Disease Control and Prevention. YRBSS Youth Online. Youth Online: High School YRBS - Home Page | DASH | CDC. Accessed 4/25/2022.

[9] https://data.hrsa.gov/topics/health-workforce/shortage-areas

[10] https://www.adolescenthealth.org/Advocacy/Advocacy-Activities/2019/Child-and-Adolescent-Mental-Health-Principles.aspx

[11] Carson N, Cook B, Alegría M. Social determinants of mental healthtreatment among Haitian, African American and white youth incommunity health centers.J Health Care Poor Underserved.(2010) 21(2 Suppl.):32

[12] Lu, Wenhua, Abigail Todhunter-Reid, Mary Louise Mitsdarffer, Miguel Muñoz-Laboy, Anderson Sungmin Yoon, and Lei Xu. "Barriers and facilitators for mental health service use among racial/ethnic minority adolescents: a systematic review of literature." Frontiers in Public Health 9 (2021): 184.

what the doctor would say)[13] and self-perceived stigma.[14] However, given that most adolescents and children do not seek services on their own behalf, most barriers and facilitators are related to adult gatekeepers such as parents and teachers. Some facilitators identified in the research include parent-youth agreement on perceived need for mental health services,[15] ethnic match between patient and provider,[16,17] and positive relationships with school health professionals. In contrast, negative social relationships in schools[18] and parent-perceived racial discrimination/prejudice[18] were barriers to treatment.

Evidence is also growing that mental health services available to LGBTQ youth are scarce and may offer inadequate and stigmatizing treatment, including "reparative" and "conversion" therapies.[19] In 2021, 48% of LGBTQ youth reported wanting mental health care but not receiving it.[7] Furthermore, Black and Latinx LGBTQ youth had the highest rates of unmet mental health care need.[7] Youth who have been exposed to conversion therapy are more than twice as likely to attempt suicide as those who have not, and 14% of youth between 18 and 24 years old report this exposure.[7] These negative experiences may contribute to mistrust of behavioral health services.

The current crisis in youth behavioral health and the stark disparities in behavioral health access for vulnerable youth require immediate attention through increased investments in targeted interventions.

Factors Influencing Behavioral Health Prevalence Disparities among Vulnerable Youth

Behavioral health disparities for LGBTQ youth and youth of color are driven by a complex network of factors at multiple levels. LGBTQ youth frequently experience stigma and discrimination that elevate stress and limit effective coping strategies.[20] In 2019, LGB and questioning students were twice as likely as heterosexual students to have been threatened or injured with a weapon at school and to have missed school in the past 30 days due to safety concerns.[4]

Stigma and discrimination are also realities for many LGBTQ youth within their homes and communities. In 2021, only one in three LGBTQ found their homes to be LGBTQ-affirming spaces and more than half of LGTBQ youth reported experiencing discrimination based on their sexual

[13] Kodjo CM, Auinger P. Predictors for emotionally distressed adolescents to receive mental health care. J Adolesc Health.(2004)35:368–73. doi: 10.1016/S1054-139X(04)00061-8

[14] Anyon Y, Whitaker K, Shields JP, Franks H. Help-seeking in the school context: understanding Chinese American Adolescents' Underutilization of School Health Services .J School Health.(2013)83:562–72. doi: 10.1111/josh.12066

[15] Williams CD, Lindsey M, Joe S. Parent–adolescent concordance on perceived need for mental health services and its impact on service use. Child Youth Serv Rev.(2011) 33:2253–60. doi: 10.1016/j.childyouth.2011.07.011

[16] McCabe KM. Factors that predict premature termination among Mexican-American children in outpatient psychotherapy. J Child Family Stud.(2002)11:347–59. doi: 10.1023/A:101687622438851.

[17] Mukolo A, Heflinger CA. Rurality and African American perspectiveson children's mental health services.J Emot Behav Disord.(2011) 19:83–97. doi: 10.1177/1063426609344604

[18] Yeh M, McCabe K, Hough RL, Lau A, Fakhry F, Garland A. Why botherwithbeliefs? Examining relationships between race/ethnicity, parental beliefs aboutcauses of child problems, and mental health service use.J Consult Clin Psychol.(2005) 73:800. doi: 10.1037/0022-006X.73.5.800

[19] Mongelli, Francesca, Penelope Georgakopoulos, and Michele T. Pato. "Challenges and opportunities to meet the mental health needs of underserved and disenfranchised populations in the United States." *Focus* 18, no. 1 (2020): 16-24.

[20] Russell, S. T., & Fish, J. N. (2020). Mental health in lesbian, gay, bisexual, and transgender (LGBT) youth. Annual Review of Clinical Psychology, 12(1), 465–487. https://doi.org/10.1146/annurev-clinpsy-021815- 093153

orientation or gender identify within the past year.[21] These experiences are directly correlated to behavioral health outcomes. For example, LGBTQ youth who reported access to affirming spaces reported lower rates of attempting suicide than those who did not.[7]

Although there is limited data on prevalence of racial and ethnic discrimination for youth of color, studies have shown that between 50 and 75% of Black, Hispanic, and Asian adults report discriminatory treatment.[22] Ethnic and racial discrimination among youth of color is correlated to poor behavioral health outcomes such as depression and lower self-esteem.[23] Youth of color are also exposed to more violence at school than their White counterparts. In 2019, 11.5% of Black students and 10.9% of Hispanic students did not go to school due to safety concerns at least once in the past 30 days compared to 6.7% of white students.[4] Furthermore, school policies and norms may have a negative effect on the mental health of minority students. Safe and nurturing school settings can be a protective factor for youth mental health, but students' perceptions of their school environment vary by race/ethnicity. Specifically, Black youth are more likely to report negative experiences in school compared to their White counterparts.[24] One factor accounting for these negative experiences is harsher school disciplinary action based for youth of color.[25]

LGBTQ youth of color are especially vulnerable due to the intersectionality of their race and ethnicity with their sexual and/or gender identity. In 2021, 75% of youth reported sexual orientation and/or gender identify, and more than half of LGBTQ youth of reported discrimination based on their race or ethnicity in the past year. The experience of intersecting vulnerabilities and discrimination is extremely difficult for LGBTQ youth of color and has dire consequences. Thirty-six percent of youth who experienced three types of discrimination attempted suicide in the past year, compared to only 13% of youth who experienced only one type.[7]

The data on youth mental health underlines both the urgency of the current crisis and provides direction on promising approaches to address it. Research has revealed several key factors contributing to disparate behavioral health outcomes for LGBTQ youth and youth of color, such as discrimination and stigma. These root causes of poorer behavioral health are then exacerbated by limited access to behavior health services for youth of color and LGBTQ youth.

Purpose

CareFirst will invest up to $4.8 million over three years to invest in programs that will work to improve behavioral health outcomes through:

[21] The Trevor Project. (2021). 2021 National Survey on LGBTQ Youth Mental Health. West Hollywood, California: The Trevor Project.
[22] Lee, Randy T et al. "On the prevalence of racial discrimination in the United States." PloS one vol. 14,1 e0210698. 10 Jan. 2019, doi:10.1371/journal.pone.0210698
[23] Umaña-Taylor AJ (2016). A post-racial society in which ethnic-racial discrimination still exists and has significant consequences for youths' adjustments. Current Directions in Psychological Science, 25, 111–118. doi:10.1177/0963721415627858
[24] Bottiani JH, Bradshaw CP, Mendelson T. Inequality in Black and white high school students' perceptions of school support: an Examination of race in context. J Youth Adolesc 2016;45(6):1176–91.
[25] Owens J, McLanahan SS. Unpacking the drivers of racial disparities in school suspension and expulsion. Social Forces 2020;98(4):1548–77.

1. Addressing behavioral health disparities for at-risk youth (e.g., rural youth, low-income youth, youth of color and LGBTQ youth) through innovative and evidence-based and promising programs that:
    a. Address root causes leading to higher prevalence of mental health and substance use disorders among at-risk youth
    b. Reduce barriers to access to behavioral health services for at-risk youth
2. Workforce development to increase availability of behavioral health providers; including, but not limited to physicians, Licensed Clinical Social Workers (LCSW), therapists, peer support specialists, Licensed Clinical Professional Counselors (LCPC), psychologists, psychiatrists, care coordinators, educators, and other support staff.

The below section provides examples of the types of interventions CareFirst seeks to support in each priority area:

- **Addressing behavioral health disparities for at-risk youth (e.g., rural youth, low-income youth, youth of color and LGBTQ youth)**
    - Address **root causes** leading to higher prevalence of mental health and substance use disorders among at-risk youth through initiatives to identify and address root causes (e.g., bullying, discrimination, trauma) of behavioral health disparities such as depression, suicide, substance use disorders, for youth age up to age 24.
        - Evidence-based or promising strategies may include, but are not limited to initiatives that:
            - Provide programming to reduce discrimination and provide affirming spaces for LGBTQ youth in schools and communities (e.g., gender and sexuality alliances, training for teachers and staff, etc.)
            - Provide programming to reduce racial and ethnic discrimination in schools and communities
            - Promote healthy coping strategies for youth (e.g., mindfulness, arts, sports and exercise, etc.)
            - Community/caregiver interventions to educate and combat stigma of mental health and/or gender/sexual identification
            - Promote mental health literacy and resilience among adolescents and their parents
    - Reduce barriers to **access** to behavioral health services for at-risk youth (e.g., rural youth, low-income, youth of color and LGBTQ youth) by offering additional or new access to culturally responsive and trauma-informed behavioral health services and/or support services (e.g., peer support or other non-traditional evidence-based or promising support services).
        - Evidence-based or promising strategies may include, but are not limited to initiatives that:
            - Provide access to culturally responsive and trauma-informed behavioral health services outside of traditional settings to increase access (e.g., schools, community centers, etc.)
            - Reduce stigma around behavioral health services among youth, families, and their communities

- Improve screening and referral pathways for behavioral health services
- Increase access to peer-to-peer support interventions
- Provision of non-billable behavioral health services to underinsured and/or uninsured youth
- Mental health distress identification training (including a referral process) for school staff and community members that work closely with youth
- Adding a behavioral health service line in healthcare settings serving at-risk youth (e.g., pediatric clinics, endocrinology centers, etc.)

Workforce development to increase availability of behavioral health providers

- Increase access to behavioral health providers and provide training and resources to increase culturally responsive and trauma-informed behavioral health care and support.
  - Evidence-based or promising strategies may include, but are not limited to initiatives that:
    - Promote recruitment and retention of providers (e.g., wellness programs to address staff burnout, novel recruitment strategies)
    - Provide incentives to health professionals to practice in geographical areas with limited access to mental health care or in HPSA designated facilities (e.g., Federally Qualified Health Centers, justice facilities, etc.)
    - Provide training to improve the capacity of existing behavioral health professionals to provide high-quality behavioral health care
    - Provide continuing education or career development to behavioral health providers

Target Population

For initiatives addressing behavioral health disparities for at-risk youth (e.g., rural youth, low-income, youth of color and LGBTQ youth), the target population is at-risk youth (e.g., rural youth, low-income, youth of color and LGBTQ youth) (up to age 24). The target population may also include youth experiencing multiple vulnerabilities, including but is limited to youth in rural areas, youth experiencing homelessness or who are involved in the child welfare or juvenile justice system, youth in immigrant households, or youth in low-income households.[26]

For workforce development initiatives, we encourage workforce development initiatives that serve all populations in areas designated as "Mental Health" Health Provider Shortage Areas (HPSAs) as defined by the Health Resources & Services Administration. Information regarding mental health HPSAs can be found here. We also encourage workforce development initiatives that address workforce shortages in organizations providing services to underserved populations.

[26] https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf

Eligibility criteria

CareFirst will accept proposals with durations of up to three years with a budget between $100,000 and $200,000 per year.[27] The start date for all proposals will be August 1, 2022. Eligible applicants include qualified 501(c)3 or 501(c)6 non-profit organizations in Maryland, Washington, DC, Northern Virginia (located north and east of route 123, including portions of Fairfax, Alexandria, and Arlington Counties), and Charleston, West Virginia. CareFirst supports partnerships including, but not limited to, nonprofits, public (governmental) health entities, and/or other community-based organizations.

Eligible applicants include organizations serving Black, Indigenous, People of Color (BIPOC), disconnected youth, persons experiencing homelessness, populations with limited English proficiency (LEP), structurally disinvested communities, justice-involved individuals, LGBTQ populations, low-income communities, rural communities, and other marginalized communities.

Proposal Content and Preferences

The ideal proposal will present evidence-based and/or innovative programs that will address root causes of youth behavioral health disparities and/or increase access to behavioral health services for youth on a sustainable basis. It will provide a detailed plan for developing, implementing, and evaluating the program. Proposals are required to:

- Describe the grant project, target population, expected reach (number of direct and indirect beneficiaries), and project staffing
- Provide a sustainability plan beyond the grant period, particularly if any portion is proposed to support staffing
- Provide a logic model and monitoring and evaluation plan using the CareFirst templates included in the application platform
- Include a budget and budget justification for project needs

Evaluation Criteria

The following section describes CareFirst's criteria for evaluating the applications. A portion of funds may be used for the evaluation process, not to exceed 10% of the overall budget. The overall proposal and work plan will be evaluated on the following criteria:

1. Organizational Background, Commitment, and Financial Viability
    a. The grantee will:
        i. be committed to improving behavioral health and access to quality care for the targeted population,
        ii. demonstrate how its proposed project will contribute to this goal,
        iii. demonstrate sound financial standing,
        iv. have sufficient financial management systems,
        v. demonstrate capacity to manage grant funds,
        vi. submit periodic progress and expenditure reports, and deliverables committed to under the grant,

[27] Maximum and Minimum Grant Amounts are as follows:
1-year grant: $100,000 to $200,000
2-year grant: $200,000 to $400,000
3-year grant: $300,000 to $600,000

vii. provide clearly defined data elements, such as the examples outlined below, so that project accomplishments can be monitored, compared, and compiled, and
viii. provide a final written report describing quantitatively how the project has affected the target population served and the community overall.

b. As a condition of receiving grant funds, the grantee may be asked to:
   i. attend grantee convenings,
   ii. participate in site visits,
   iii. participate in interviews with evaluators, or
   iv. deliver progress reports and accomplishments to CareFirst, its staff and advisers, and other grantees.

2. Community Need
   a. The proposal should demonstrate an understanding of the community it seeks to serve. It should clearly define the geographic location and target population to be served.
   b. The number of direct and indirect beneficiaries must be reliably quantified, and the needs of this population documented through quantitative data, such as demographics, rates of insurance coverage, service utilization statistics, and health risk factors.
   c. Baseline statistics related to project goals for the targeted population must be clearly stated and supported.
3. Program Development and Project Description
   a. Proposals should describe and illustrate with a logic model how the program or project will address root causes of youth behavioral health disparities and/or increase access to behavioral health services for youth in Maryland, the District of Columbia, Northern Virginia, and/or Charleston, West Virginia.
   b. Strategies to achieve program outcomes for the population of interest should be evidence-based. Proposals should describe the rationale and evidence for program effectiveness.
   c. Program or project implementation including but not limited to recruitment, enrollment, service provision, and follow-up should be outlined in detail.
   d. If applicable, proposals should describe how program partners will support activities and goals in detail.
4. Data collection and Evaluation (see Section: Potential Indicators for Measuring Impact)
   a. Proposals should have a clear definition of success illustrated by goals and objectives with measurable targets.
   b. Proposals should describe how data for the project or program will be collected and how that data will be used to monitor program implementation and course correct as necessary AND evaluate the effectiveness of the program.
   c. Monitoring and evaluation plans should align with the logic model for the program and the program description.
   d. The grantee should have a demonstrated ability to measure progress and objectives through quantitative measures, such as the number, demographics, characteristics, and service utilization of the targeted population, both at baseline and as the project proceeds.

e. The grantee must be able to comply with the evaluation and monitoring requirements inherent in this grant program.

5. Participation of Stakeholders and Partners
    a. Proposals should include a list of key partners and relevant stakeholders.
    b. Any project partners should be meaningfully engaged in the planning and implementation of the project.
    c. Proposals must provide letters of support for all project partner organizations or agencies as attachments. Letters of support should clearly delineate partner/collaborator's contribution to the project.
6. Sustainability
    a. Proposals should demonstrate the benefits to the specific population and the larger community and identify likely revenue sources to sustain the program beyond the term of the grant.
    b. Evidence of past accomplishments will help demonstrate the grantee's capacity to successfully maintain the program.
    c. Strong preference will be given to proposals that demonstrate community support for their programs or services by the magnitude of funds an organization generates internally and/or through community matching support.

Indicators for Measuring Impact

Below, we provide a list of suggested indicators for measuring effects of services. All proposals will be required to submit targets for the indicators in the first line of the table below. Applicants should provide targets for those indicators appropriate to their proposal, as well as any additional indicators as necessary to effectively monitor and evaluate their proposal. Preferred are programs that evaluate impact, which can be used to leverage new funding streams for program replication, and/or sustainability.

Required and Suggested Indicators	
All Proposals	
Required	• Number of unique beneficiaries to be served over the life of the grant (direct beneficiaries) • Number of indirect beneficiaries to be served over the life of the grant • Beneficiary demographics: age, race/ethnicity, insurance status (commercially insured, publicly insured through Medicare or Medicaid, or uninsured)
Addressing Behavioral Health Disparities for Youth of Color and LGBTQ youth	
Use as appropriate	• Hours and instances of school-based programming to increase social support (e.g., gay-straight alliance meetings, taskforce meetings, discussion sessions, etc., does not include school-based behavioral health services such as counseling) • Hours and instances of community-based programming (e.g., outreach and education, drop-in hours, support groups, etc.) • Number of individuals trained, including type of training (e.g., anti-racism, mental distress identification, LGBTQ-affirming care, therapeutic methods) and individuals' roles (e.g., school staff, community member, peer support, staff at community-based organization, etc.) • Number of instances of discrimination in schools and/or community for LGBTQ youth and/or youth of color

	• Number of instances of bullying in schools and/or community for LGBTQ youth and/or youth of color • Number of LGTBQ youth reporting access to affirming spaces • Number of LGBTQ reporting that school is an affirming space (including use of correct pronouns) • Participant scores on validated mental health screening measures (e.g., PROMIS, PHQ-9) • Participant scores on validated mental health stigma measures • Number of youth reporting increased social support • Number of youth screened for behavioral health needs • Number of youth referred to behavioral health services • Number of youth beginning or resuming behavioral health treatment and type of treatment (e.g., therapy, substance use treatment, counseling, etc.) • Hours of behavioral health services provided in community or school-based locations • Hours of behavioral health services provided to underinsured or uninsured youth
Workforce Development	
	• Number and type of new behavioral health providers hired (e.g., LCSW, support staff, etc.), with demographics • Retention rate of behavioral health providers • Self-reported job satisfaction of behavioral health providers • Hours and type of employee support programming provided to behavioral health providers (e.g., wellness programs, employee incentives, etc.) • Instances of career development and/or educational opportunities provided to behavioral health providers • Number and type of behavioral health services provided to youth (up to age 24) • Number of individuals trained, including type of training (e.g., therapeutic methods, LGBTQ-affirming care, etc.) and individuals' roles (e.g., LCSW psychiatrist, LCPC, etc.) • Behavioral health provider demographics: age, race/ethnicity, gender identity • Number of individuals receiving new or better employment in behavioral services sector • Number of individuals receiving behavioral health certification or licensing

Proposal Format and Scope

The grant proposal must be completed and submitted using the dedicated online RFP application by **June 13, 2022, at 11:59 PM.** In addition to describing how your proposed project would satisfy the requirements as set forth in this document, the on-line application will prompt you to include other components in your proposal to assist CareFirst to better understand your organization and your proposal. For full consideration, applicants must submit all required documentation.

Before submitting:

- Please review the frequently asked questions (FAQs).

- Please attend a webinar on Wednesday, May 25, 2022 at 10:30 AM where CareFirst will review the RFP guidelines and answer questions. An informational webinar will be held on Wednesday May 25, 2022 at 10:30 a.m. To participate, please visit https://carefirst.zoom.us/j/93070047527?pwd=TjM0Y0tLTi9yZGMrUzdaVXhmeE5Ydz09
  (Meeting ID: 930 7004 7527; Passcode: 933655)
  Dial by your location
  +1 301 715 8592 US (Washington DC)
  +1 267 831 0333 US (Philadelphia)
  888 475 4499 US Toll-free
  Meeting ID: 930 7004 7527
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Contact Information

Please direct questions to community@carefirst.com