Adult Critical Time Intervention Teams Q & A List

Q1. When will get the response to questions sent in?

A1. The Q&A is scheduled to be posted on the OMH website on or by 04/09/2024. The recording from the Bidders Conference will also be posted to the website.

Q2. What CTI RFP will be coming out next?

A2. OMH is working on the development of Specialty CTI Teams for the Mental Health/ Intellectual and Developmental Disability (IDD) population.

Q3. Will the slide deck be sent out?

A3. Slides from the Bidder's Conference have been uploaded to the OMH website.

Q4. Is this RFA in addition to the CTI RFA that was issued on 12/28/2023?

A4. Yes.

Q5. If someone already applied for this proposal in the initial round for one of the downstate teams, do we need to reapply? Will there be additional CTI Teams in the areas that were noted in the first RFP?

A5. OMH previously issued an RFP for Critical Time Intervention Teams (CTI Teams) in Long Island/ New York City on 12/28/2023. The 12/28/2023 RFP included 9 total awards, including 7 in New York City and 2 in Long Island. Proposals for that RFP were due on 02/15/2024. This RFP, issued 03/12/2024, includes 26 additional teams statewide, including 8 in New York City and 2 in Long Island. If you are interested in more than what you applied for with the December 2023 RFP, you can and should submit a proposal for this March 2024 RFP as well. We anticipate that award notifications for the December 2023 RFP should be issued prior to the 04/25/24 deadline for proposals for the March 2024 RFP.

Q6. Hi-How does this RFP relate, or not, to the CTI RFP issued on 12/28/23 that focused on NYC/LI? There is some overlap in geographic areas between 2 RFPs?

A6. See response to question 5.

Q7. Must an applicant serve all of the counties in the proposed region, or only the County where a hospital is identified?

A7. The CTI Team must partner with a hospital or hospitals in the identified county. This CTI Team may choose to additionally partner with hospitals located in the region and/or may support individuals returning to those counties from the hospital(s), depending on the capacity of the team and local needs.

Q8. In #11 re: Schenectady and Rensselaer - we have an established relationship with the hospital in Schenectady. We are happy to develop a relationship in Rensselaer as well. In covering both counties, are we precluded from working with the Hospital in Schenectady?

A8. The awardee for # 11 in the Capital Region must partner with a hospital in Rensselaer County. The awardee is not precluded from also partnering with a hospital in Schenectady County.

Q9. Section 4.3.1 of the RFP explains that, "CTI Team location and main service area should be based on the hospital(s) or hospital system(s) located in the noted county or counties you plan to serve." However, number 11 under Upstate/Rural Teams states, "11. One CTI Team Capital Region, Upstate Team, Hospital(s) in Rensselaer County a. Counties included in this award: Rensselaer, Schenectady" Must a CTI Team in Schenectady County partner with a hospital in Rensselaer County, or may a CTI Team in Schenectady County partner with a hospital in Schenectady County?

A9. Please refer to the response to Question 8.

Q10. Page 18 of the RFP, in part, states, "Agencies will choose a region based on the list below. CTI Team location and main service area should be based on the hospital(s) or hospital system(s) located in the noted county or counties you plan to serve. Then agencies will identify additional county(ies) from that region where the CTI Team may provide services, depending on capacity of the team and needs, either for individuals returning to those county(ies) from the hospital(s), or may work with additional hospitals in those county(ies). Agencies working with larger hospital systems that expand beyond the listed counties in the regions below, those counties may be served as well by the team." Will a proposal be more competitive if it proposes to serve multiple counties?

A10. There are no additional points based solely on additional counties served.

Q11. I heard from a colleague that the Adult CTI Team RFP is just for the rest of the state (not NYC), but on page 20 of the RFP, it lists that there will be eight CTI teams awarded in NYC. Can you please clarify whether or not there will be CTI teams awarded in NYC?

A11. This RFP includes eight (8) CTI Teams in New York City. Please see section 4.3.1 of the RFP for a breakdown of initial awards and allocations.

Q12. Are these 2 Kings County teams, 2 Bronx teams, 2 Manhattan teams and 1 Queens County team in addition to the 7 teams RFPd for New York City in December?

A12. Yes, see response to question 5 for additional details.

Q13. 5.4.4: Since the Finger Lakes coverage area is to service Monroe County and two other rural counties do we qualify for 7 staff for Monroe County and an additional 3 for a combination of both rural counties?

A13. As an Upstate Team, the Finger Lakes CTI Team serving a hospital or hospitals in Monroe County, the staffing will be comprised of 7 staff. This CTI Team may choose to additionally partner with hospitals located in Wayne and Livingston Counties and/or may support individuals returning to those counties from the hospital(s) in Monroe County, depending on the capacity of the team and local needs.

Q14. Given our service area is three counties, can we have a split position for an added assistant team leader if needed?

A14. Team staffing is based on the type of team (Downstate, Upstate, or Rural). OMH has established the budget for CTI Teams based on the minimum staffing patterns described in Section 5.4.4 of the RFP. As long as minimum staffing patterns are met, awardees are allowed to operate with staffing plans that exceed the minimum. Excess staffing costs must be funded by the provider if not within the operating funding outlined in Section 5.4. OMH will not increase funding to accommodate provider specific staffing.

Q15. Is there a required CTI training that should be budgeted for?

A15. OMH plans to provide CTI training, details forthcoming. Agencies may want to consider any additional training they may need to provide.

Q16. Is there a designated CTI training course that staff are expected to attend?

A16. Yes, there will be a CTI training staff will be expected to attend. OMH will provide further details on required training once teams are awarded.

Q17. What are the expected qualifications of Peer Specialists? Are they to be licensed/certified?

A17. OMH recommends that CTI Teams hire one (1) to two (2) Peer Specialists in the role of Care Manager. The minimum qualifications for a Care Manager will be specified in forthcoming guidance. At this time, OMH has not required that Peer Specialists employed as Care Managers in CTI be licensed or certified. OMH highly recommends that peer workers be certified or provisionally certified as an NY-CPS FPA-C, or YPA-C based on the population served by the CTI Team.

Q18: Can we hire OASAS peers (Certified Recovery Peer Advocate) on the CTI team?

A18: Yes, a CRPA may be hired into the role of Care Manager on the CTI Team. OMH recommends that if the agency is specifically seeking a qualified peer worker for this role, if a candidate does not have an OMH Peer Credential (New York Certified Peer Specialist, Credentialed Youth Peer Advocate, or Credentialed Family Peer Advocate) when they're interviewing, employers should message that they need to demonstrate they're qualified to pursue an OMH peer credential upon hiring and employers should support the employee in achieving Provisional or Full Certification or Credentialing within a reasonable amount of time

based on the requirements of the respective certification or credential. Employers should also ensure that the Peer Specialist/Advocate has the appropriate credential for the age cohort they're serving. Note that Certified Recovery Peer Advocates do not need to demonstrate lived experience when applying for their certification. This is a fundamental difference between the OASAS Peer Credential and the OMH Peer Certification and Credentials. We recommend that employers seek potential employees who hold both OASAS and OMH Peer Credentials. We recognize that the peer workforce is limited which is why we allow the hiring of CRPAS in mental health settings as long as they qualify for an OMH credential and pursue it upon hiring.

Q19. Given the value of the Peer role around enhanced engagement and recovery support skills, can we hire more than just 2 Peer Specialists?

A19. Yes.

Q20. Can we use the titles of Peer Specialists vs Care Manager for recruiting and role clarity?

A20. Peer Specialists recruited for this role should understand that the role they are filling is that of a care manager. The training and lived experience/expertise that Peer Specialists and Advocates bring to the table should be supported and encouraged to be used in fulfilling the tasks and duties of a CTI Care Manager.

Q21: We've heard OMH say that Peer Specialists and Advocates should have a clear scope of practice that is in line with the principles, values, and practices of Peer Specialists and Advocates. We are confused because OMH is saying in this RFP that Peer Specialists function as Care Managers? Please clarify.

A21: That is correct. However, CTI is an evidence-based care management model and members of the team perform care management functions. Peer Specialists perform the exact same duties in line with the evidence-based model. Peer Specialist positions in CTI function as Care Managers while utilizing the principles, values, and practices of Peer Support as they perform the functions of Care Manager.

Q23. Can Peer Specialists be provided via contract with a third-party organization?

A23. Subcontracts for qualified staff may be considered. It is expected that if staff are subcontracted through another organization, they would be fully embedded in the CTI Team. If Peer Specialists are hired through a subcontract, the awardee should be very clear that these individuals are being hired to fill the *role* of care manager.

Q24. Are evidence-based peer support models such as the accredited Clubhouse acceptable alternatives to staff the CTI Team?

A24. CTI Teams must meet the minimum team staffing as specified in section 5.4.4 of the RFP.

Q25. 5.4: What is the role and responsibilities of the nurse [RN/LPN] position?

A25. The roles and responsibilities for each staff role will be described in forthcoming guidance. Nursing professionals, within scope of practice, can assist with navigating the medical

system, liaising with primary care and medical specialists, health education, and monitoring chronic health conditions.

Q26. Can you explain the role of the RN/LPN and mental health professionals on the CTI team?

A26. See above question regarding RN/LPN. For Mental Health professionals, they will resolve clinical issues that impact the individual's ability to meet recovery goals and support community tenure. They may provide therapeutic interventions for both mental health and substance use disorders. They may educate about mental health, treatment, and recovery, teaching skills for coping with specific symptoms and stress management, including development of a crisis management plan, developing a relapse prevention plan, including identification/recognition of early warning signs and rapid intervention strategies. All positions will be expected to carry a caseload as part of their role.

Q27. As a backup plan, is it okay to have a 0.5 FTE Nurse for the team?

A27. Downstate and Upstate CTI Team Staffing includes 1.0 FTE Registered Nurse/ Licensed Practical Nurse. These teams may staff the position in a way that best meets their needs, for example 0.5 FTE RN and 0.5 FTE LPN.

Q28. Which types of credentials fulfill the staff requirement of "mental health professionals"?

A28. Team Leader's will need to be a Licensed Professional of Healing Arts (LPHA) and Mental Health Professional is defined as an individual with a minimum of a Master's degree in the human services field. OMH will consider qualifications that include experience working with the identified populations as in forthcoming guidance.

Q29. Is this program model the same as the program model for the CTI Teams that were issued in December?

A29. The program model for downstate providers is the same. The December RFP did not include an Upstate or Upstate Rural model.

Q30. 6.6.I: Is the entire team expected to work through the lens of being recovery-oriented?

A30. Yes.

Q31. We want to help people with their community life goals and participating in meaningful activities in their community. For example, we want to help people with employment, educational, relationships, faith, leisure, volunteering, and other interests. Will OMH allow us to do that?

A31. Yes, OMH encourages supporting people in all aspects of their personal recovery journey. CTI Teams should facilitate community inclusion to ensure the people they serve have enduring ties to their community and support systems; this may include connection to rehabilitation programs to provide ongoing skill development and support for community inclusion and participation. OMH recognizes that recovery is multidimensional. This includes the four major dimensions of recovery including health, home, purpose, and community. For

examples of the four dimensions of recovery, please visit SAMHSA's website, https://www.samhsa.gov/find-help/recovery.

Q32. 5.3: Can the length of the Pre-CTI phase be person-centered/directed?

A32. The duration of Pre-CTI is flexible and will be determined by a number of factors including the timing of the referral by the hospital to the CTI Team. Pre-CTI begins as soon as possible upon referral, while the individual is still hospitalized, and ends upon discharge from the hospital, when Phase 1 begins.

Q33. How does OMH define recovery?

A33. SAMHSA's defines recovery as a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential. Hope is essential for recovery. Hope is the belief that mental health and substance use challenges and conditions can be overcome. A person's recovery is holistic and builds on people's strengths, talents, coping abilities resources, and inherent values. It addresses the whole person and their community. The process of recovery is highly personal and occurs via many pathways. It may include clinical treatment, medications, rehabilitation supports, faith-based approaches, peer support, family support, self-care, and other approaches. Recovery is characterized by continual growth and improvement in one's health and wellness and managing setbacks. Because setbacks are a natural part of life, resilience becomes a key component of recovery.

It is critical that CTI team members believe in the ability of program participants to recover. The Recovery Self-Assessment (RSA) by Yale School of Medicine's Program for Recovery and Community Health is a helpful tool for identifying strengths and areas of improvement in recovery-oriented care. For more information, please visit SAMHSA's website, https://www.samhsa.gov/find-help/recovery.

Q34. How is the CTI program different than Health Homes Plus for SMI and would enrollment in both programs be considered duplication of services for Medicaid billing?

A34. CTI is an evidence-based approach that is a time-limited, phase-based care management service. CTI promotes community integration, self-advocacy, and access to ongoing support by helping individuals develop and utilize strong ties to their professional and non-professional support systems during and after transition periods. CTI includes assertive outreach and engagement with individuals in higher-level of care settings as well as in the community with a focus on addressing key social care needs at the individual level. CTI places emphasis on helping individuals build skills and strengthen linkages to ongoing sources of support that will remain in place after the time-limited CTI intervention ends. Receiving both CTI and HH+ would be considered a duplication of services, however, this will be discussed further during implementation.

Q35. Can OASAS SUD clinic (Part 822) licensed providers apply for this RFP to serve people with co-occurring mental health and substance misuse disorders?

A35. CTI teams will be expected to serve all eligible populations as listed in the RFP Section 1.2 (please note specifically 1.2.2). Eligible applicants are:

- Not-for-profit agencies with 501(c) (3) incorporation, including county run, that have experience providing persistent outreach, case management and/or behavioral health services to persons with mental illness.
- General hospitals designated pursuant to Section 9.39 of NYS mental hygiene law which are operated by state or local governments or voluntary agencies.
- Community-based Behavioral Health Independent Practice Associations (BH IPA) which developed from the NYS Behavioral Health Care Collaborative (BHCC) project.

Q36. Can a member be enrolled in CTI and Health Home?

A36. Please see answer A34. Receiving both CTI and HH would be considered a duplication of services, however, this will be discussed further during implementation.

Q37. To the Care Coordination question.... there should be a time for overlap of services, right? Since CTI is time limited, we would want a warm handoff to Care Coordination to ensure ongoing support in the community, should that be needed.

A37. Please see answer A34.

Q38. Are there any exclusions with populations served? HH enrolled or Peer Bridger?

A38. Individuals currently receiving care coordination from another program type would need to be reviewed to determine duplication of services. Please also see answer A34.

Q39. Do individuals with any mental health diagnosis qualify for these CTI services assuming they meet the other requirements (ex. hospital discharge, co-occurring conditions, etc.)? Or is this intended only for individuals with SMI?

A39. Please see Section 1.2 of the RFP, specifically section 1.2.2, SMI is not a requirement, but they must meet the eligibility requirements as listed.

Q40. Section 1.2: For “individuals who are 16/17 young adults,” what is the specific intake criteria? Because the current system has a gap in services for this need, we are interested in any suggestions on how to avoid becoming the first community resource for agencies for this population, to be able to focus mainly on serving adults.

A40. CTI Teams without the expertise or capacity to serve IDD population or young adults will not be required to do so.

Q41. Is there consideration for individuals who are identified by hospital staff as being close to a crisis but do not require hospitalization for referral to the CTI team? The question about working with someone who is not hospitalized was something that was asked of us by a hospital. They were thinking of someone who may be minimally connected to an outpatient clinic. Their idea was to avoid a possible hospitalization by connecting the person to a CTI team.

A41. CTI promotes community integration, self-advocacy, and access to ongoing support by helping individuals develop and utilize strong ties to their professional and non-professional support systems during and after transition periods. CTI teams are not considered crisis

services but may provide the support needed for someone leaving the hospital or an ER to follow through with community/outpatient services.

Q42. Can applicants highlight a specialization for a team in this RFA? For instance, individuals with substance use disorders.

A42. CTI teams will be expected to serve all eligible populations as listed in the RFP Section 1.2 (please note specifically 1.2.2).

Q43. Can hospitals work with more than one program?

A43. Yes, hospitals can work with more than one CTI Team. There should be policies and procedures put in place to ensure hospital personnel and both teams understand where referrals should be sent and to ensure access and collaboration with all teams.

Q44. What is the anticipated ramp up for enrollment? How many admissions per week/month is expected?

A44. OMH has not yet determined what the ramp up for enrollment will be, as this is a new model in NYS. We will work closely with providers to determine what the ramp up will look like as they build their staff. CTI Teams will not be required to hire all staff immediately; staffing can ramp up as referrals/enrollments increase.

Q45. Will the OMH be assisting agencies to become embedded into EDs/inpatient units if needed? This question is based on the fact that there is a long history of barriers for any CBOs to become embedded into hospital systems.

A45. Effective partnership between the hospital and the CTI Team is critical to the success this model. As such, OMH has required a letter of support from the hospital, which includes a description from the hospital of how they will ensure access for CTI team staff to engage with individuals served while they are inpatient. OMH will work with awardees and hospitals throughout the implementation of CTI to learn and promote best practices. However, it will be the responsibility of the CTI Team agency to build and maintain the relationships with the hospitals.

Q46. 5.4.5: Does a 24/7 referral/warm line suffice? Can this 24/7 after hours service be all telephonic?

A46. CTI Teams will have a process to ensure that hospitals can connect with them 24/7. Upon receiving a referral, the CTI Team must begin efforts toward connection with the individual within 24 hours, including on weekends. The hospital should be able to reach the CTI Team 24/7 in relation to new referrals or communication regarding and individual being served by the CTI Team.

Q47. 6.3.d: Can the 24-hour face-to-face requirement be per business day?

A47. Please refer to the response to Question 46.

Q48. For example, if we receive a referral from an E.D. on Saturday, would connecting with the person face-to-face within one business day be sufficient?

A48. Please refer to the response to Question 46.

Q49. 4.3.1: For the Finger Lakes Team that also includes Wayne and Livingston counties, can those counties be around 10% of our total annual caseload (given Monroe County has such high need)?

A49. Agencies will choose a region based on the list included in section 4.3.1 of the RFP. CTI Team location and main service area should be based on the hospital(s) or hospital system(s) located in the noted county or counties you plan to serve. Then agencies will identify additional county(ies) from that region where the CTI Team may provide services, depending on capacity of the team and needs, either for individuals returning to those county(ies) from the hospital(s), or may work with additional hospitals in those county(ies). Agencies working with larger hospital systems that expand beyond the listed counties in the regions below, those counties may be served as well by the team.

CTI Teams will work with the partnered hospital(s) to prioritize referrals based on need. For the purposes of the RFP, the applicant may assume a given caseload in outer counties; however, as the team is implemented those % are likely to vary based on local capacity and need.

Q50. Will there be an MCO authorization process?

A50. To be determined.

Q51. Are there any allocated wraparound dollars for emergency housing, engagement purposes, emergency needs, etc.?

A51. CTI Teams will include an annual allocation of Service Dollars. Appropriate uses of service dollar funds are outlined in Service Dollar Guidance, which can be found here: https://omh.ny.gov/omhweb/guidance/service-dollar-guidance.pdf

Q52. The service dollar amount is in addition to the net deficit funding amount?

A52. Yes.

Q53. Should the 5-year budget reflect the full annual deficit funding amount for each year, or should we incorporate Medicaid billing revenue in Years 2-5?

A53. As a definitive start date for Medicaid billing cannot be provided, it is recommended for providers to choose a date on or after 10/1/24 for the effective start date of Medicaid billing, the date used is at each provider's discretion.

Q54. Are the proposed Medicaid rates available?

A54. No. We will work closely with awarded teams to provide proper notice when the rates are available; additionally, there will be a required notification to MCOs.

Q55. What will the Medicaid rate structure/billing/reimbursement look like post PAR approval?

A55. The figures provided in RFP section '5.4 Operational Funding', under "the ongoing annual Medicaid" are indicative of the State modeled annual (and monthly) Medicaid revenue of a mature CTI program. Average annual mature CTI program caseloads are outlined in the RFP by team type/region. Eligible services, duration and quantity of service, reimbursement amounts, rate/modifier/procedure codes, and billing frequency details are being developed for this service.

Q56. Are the Medicaid rates available for when the Medicaid reimbursement is expected?

A56. Please refer to the response for question 54.

Q57. Is there an anticipated timeline for transition to Medicaid billing?

A57. A definitive start date for Medicaid billing cannot be provided as it is dependent upon CMS review and approval.

Q58. What is the unit of service that will be used for billing Medicaid and how many units of service did they use for the projected Medicaid revenue (for each type of team)? What is the anticipated Medicaid rate per unit of service? Do you have an idea when the State Plan Amendment will be submitted?

A58. Please refer to the responses for questions 54, 55, and 57.

Q59. If Medicaid rates are not yet calculated, how does OMH know that Medicaid billables will financially support the proposed program? We are concerned about the financial stability of the program with regard to the transition from state aid to Medicaid billing.

A59. Please refer to the response for question 55.

Q60. 5.4: What are the specific details of the SPA Medicaid reimbursement mechanism? How was this calculated? Is it based on a face-to-face billable rate?

A60. Please refer to the responses for questions 54, 55, and 57.

Q61. Could you please provide the assumptions that informed the expected annual Medicaid revenue per team to include rate and utilization?

A61. On the topic of the Medicaid rate, please refer to the response for question 55. The estimated program cost is multiplied by a Medicaid enrollment rate that determines the Medicaid revenue as provided in the RFP. This rate is derived from programs of similar modality and/or service population.

Q62. We would like to know how we will be expected to bill for these services after the first year. Will it be a single amount/billing code per month or fee for service?

A62. Please refer to the responses for questions 54, 55, and 57.

Q63. What will make a person billable?

A63. Specific billing requirements are still being reviewed and will not be final until approval of the State Plan. OMH notes that services are billable, not people.

Q64. Will there be a minimum amount of visits or some other criteria when these teams transition to Medicaid billing.

A64. Please refer to the responses for questions 55.

Q65. Is a Letter of Support from each county's LGU which is being proposed to be served required?

A65. It is not required to submit a letter of support from the LGU(s). Due to limitations in SFS we are unable to edit the RFP to allow submissions of letters of support.

Q66. May a Letter of Support from each county's LGU which is being proposed to be served be included with the proposal?

A66. Please refer to the response to Question 65.

Q67. Page 3 of the RFP, in part, states, "Notification of intent to apply should be made to the Local Governmental Unit (county director of community services) for each county to be served under the program application. Is proof of notification to each county's LGU which is being proposed to be served required to be included with the proposal?

A67. Please refer to the response to Question 65.

Q68. If we submit an application for the Monroe Region, do we need to also obtain a letter of support from the other two rural counties, or will the Monroe County LGU be sufficient?

A68. Please see the response to Question 65. Additionally, if you plan to work with the other two counties, the LGUs there should also be notified.

Q69. For the proposal/application, section 6.4 – Implementation, item a. requires the applicant to provide a letter of support from the hospital in the primary County. If the hospital has been unresponsive/unwilling to provide such letter, how should an applicant proceed with responding to 6.4 (a) and will the absence of that letter impact points earned in this section?

A69. At least one letter of support from a hospital in the identified county must be submitted with the RFP proposal including the hospital answers to the three (3) questions listed in Section 6.4.a, and signatures from the hospital executive leadership. If you are identifying additional hospitals in your proposal, there should be a letter of support from each identified hospital. The absence of a letter of support will impact scoring.

Q70. Can we submit, without point reduction in our application scoring, if the local hospital is unwilling to provide us with the letter of support?

A70. Please refer to response to question 69.

Q71. The RFP requires a letter of support from a "hospital executive." What does OMH consider a "hospital executive?" Is a hospital CEO/President required to meet threshold?

A71. Titles of hospital executives will vary between hospitals and health systems. OMH is asking for a letter of support from somebody the hospital considers to be executive staff in their

leadership or organizational chart. Typically, these individuals will have considered C-Suite executives (e.g., Chief Executive Officer, Chief Financial Officer, Chief Medical Officer, Chief Operating Officer, Chief of Psychiatry, or Vice President of Behavioral Health).

Q72. With the new SFS system, responses to the RFP questions can be provided by either typing into the text box for each question or uploading an attachment. Our question is, is there a word or character count limit to the attachment.

A72. There is no word limit to the attachment, however we encourage clear and concise response that answer the question being asked.

Q73. In the SFS portal, textboxes for responses to the Proposal Narrative questions (RFP sections 6.1-6.6, pp29-35) are each limited to 2,000 characters, AND each textbox offers a link indicating “Add Comments or Attachments.” Question: For longer (multi-component) OMH question-prompts (like 6.3c, 6.6d, 6.6h and others), are applicants allowed to type "Please see attached" in the textbox and then upload a complete but concise response to all parts of the OMH question, which could exceed 2,000 characters.

A73. Yes, in order to circumvent the character limit in SFS we are recommending the use of attachments.

Q74. The RFP does not mention a Work Plan. Is OMH expecting applicants to supply a Work Plan in the SFS portal, or is a Work Plan not required for this application? Just to ask a follow-up to Jeremy's helpful response about the fact that SFS does offer the capability to submit a work plan: SO, then even though the RFP itself does NOT instruct applicants to submit a work plan OMH IS instructing applicants through this bidder's conference (and maybe the published Q&A) to definitely submit a work plan as a required part of this application? Is that a correct understanding? Please do confirm about the work plan. This is not always required for OMH programs, including most recently several ACT RFPs and the stabilization centers (with OASAS).

A74. OMH is requiring applicants to fill out work plans in SFS.

Q75. How would OMH like applicants to calculate and/or fill in the "Your Unit Bid Price" that appears in the SFS portal? Would OMH be looking for just a single aggregate numerical figure in that spot which reflects the total one-year (or 5-year?) dollar amount being requested directly from OMH? Is it a correct understanding that the only ITEMIZATION of budget line items will occur in Appendix B and Appendix B-1, uploaded in association with prompts 6.7a and 6.7b respectively?

A75. Please submit the 5-year amount.

Q76. Section 6.7 Financial Assessment states, "Any travel costs included in the Budget must conform to New York State rates for travel reimbursement." What is the current NYS mileage reimbursement rate that will conform to "NYS rates for travel reimbursement?"

A76. Up-to-date allowable mileage reimbursement rates are posted on the Office of the State Comptroller website here.

Q77. Are subcontractors allowable? For instance, if there are two counties listed in a region, can a lead agency provide CTI services in one county and subcontract with another agency to provide CTI services in the other county? If subcontractors are allowable, what would the

Medicaid billing process look like for each agency? Are there processes in place that would allow for two separate agencies to share Medicaid billing and reimbursement under the same contract? Where might we find additional guidance around this?

A77. The CTI Team will be awarded to a single Sponsor Agency. Any subcontractor engaged by the Sponsor Agency will be the responsibility of the Sponsor Agency, including arrangements for payment to the subcontractor and oversight of the subcontractor. The Sponsor Agency will be responsible for becoming licensed to provide CTI and for Medicaid claiming associated with billable CTI services.

Q78. Does this grant allow for partnerships between multiple agencies (subrecipients)? Could two agencies come together to serve the different counties, if there are multiple? Could an agency be the recipient and then the other agency be a grant subrecipient?

A78. Please refer to response for question 77.

Q79. How does this process look like for IPAs?

A79. Behavioral Health Independent Practice Associations (BH IPAs) are eligible to apply for this RFP and will be scored using the same measures as any other eligible applicant. IPAs will be responsible for adhering to the same program requirements as any other awardee. Please refer to the response to question 77 for additional information regarding subcontractors.

Q80. Could you share some details on how this process looks like for IPAs?

A80. Please refer to the response to question 79.

Q81. Can we use the same letter of support from a hospital that we received for the first CTI RFP?

A81. Yes, as long as the relationship will remain active. Please indicate in your proposal that the letter of support is still current.