Flexible Assertive Community Treatment
Adult Teams
RFP#OMH110
Questions & Answers

Q1. Has there been a reimbursement rate decided for this program? What is the rate for the high intensity service and what is that rate for the less intensive service?

A1. There are three (3) Medicaid Reimbursement Rates for Flexible ACT (Adult ACT 100-capacity):

- a full rate (Rate Code 4508) for those individuals who receive the ACT (high intensity level) service, or at least six (6) contacts in a month (up to three (3) of these contacts may be with collaterals),
- a partial rate (Rate Code 4509) for those individuals who receive the ACT-Lite (less intensive level) service, or less than six (6) contacts but at least two (2) contacts per month, and
- an inpatient hospital rate (Rate Code 4511) for individuals in the hospital.

The proposed rates are posted on the OMH Medicaid Reimbursement website. These rates are subject to change and are pending CMS and DOB approval.

Q2. When will the approved ACT Downstate billing rates for Flexible ACT Teams be released?

A2. The proposed rates were posted on the OMH Medicaid Reimbursement website on 02/20/2024. These rates are subject to change and are pending CMS and DOB approval. OMH will update the Medicaid Reimbursement page when such approval is received.

Q3. What is the billing structure for individuals receiving ACT-Lite Services vs. individuals receiving regular ACT services?

A3. See A1.

Q4. Priority is also given to individuals with continuous high service needs that are not being met in more traditional site-based service settings. Individuals without active Medicaid should not be excluded from eligibility, what percentage of non-Medicaid clients would we be able/expected to support within the program?

A4. In addition to the billing rates, ACT Teams (including Flexible ACT Teams) receive funding from the state for non-Medicaid recipients in the form of net deficit funding and service dollars. There is no cap for non-Medicaid referrals, and no prescribed non-Medicaid to Medicaid client ratio. State aid funding amounts will continue to be evaluated and are subject to change during the contract period based on utilization and model assumptions. It is noted that this requirement

for Flexible ACT is not a change from the current eligibility criteria for ACT, as described on pg. 16 of the ACT Program Guidelines.

Q5. With respect to referrals, will there be a cap on the number of referrals given to any agency for individuals who do not have Medicaid and we would be unable to bill for?

A5. See A4.

Q6. Is the annual net deficit funding to be added on top of the one-time start up fund for the first year. In other words, for the first year, would we be budgeting for $239,002? Also, would this mean we are including current staff salaries into this amount in addition to the new staff to expand to a 100 slot to fit the model?

A6. The initial year of operation will include the net deficit funding per team as outlined in RFP section '5.4 Operating Funding' found below:

> Upstate $ 284,002 (includes $38,687 in service dollars)
> Downstate $ 357,488 (includes $38,687 in service dollars)

The above figures do not include one-time start-up funds of $75,000 to be issued in year 1.

Existing staff and any additional staff required to fulfill the updated staffing model requirements as outlined in RFP section 5.3 'Implementation' should be included in provider proposals.

Q7. What is the time frame for using the start-up funds?

A7. Start-up funds are expected to be used within the first contract year.

Q8. Do you know the billing rates for the ACT-Lite clients? Are billing rates the same?

A8. See A1.

Q9. Is there a difference in rate between high intensity and ACT lite?

A9. Yes; see A1.

Q10. Are ACT lite encounters billable? If so, since visits are 2-5 per month, would it be considered half billing?

A10. Yes, ACT Lite encounters are billable. See A1 for additional details.

Q11. What will the reimbursement rates be for the two levels....same as full and partial billing now?

A11. See A1.

Q12. Why is the flexible rate less than the regular ACT rate?

A12. The Flexible ACT rate is slightly lower than lower capacity ACT teams for various reasons. This includes assumptions and expectations for utilization at the varying levels of care (full, partial/lite, and IP) for Flexible ACT teams when compared to 'traditional' teams, and the effects of how the program staffing model was scaled.

Q13. Will the same billing rules apply for hospitalizations for ACT lite?

A13. Yes, existing ACT billing rules that apply to hospitalized individuals also apply for those receiving ACT Lite services by a Flexible ACT team.

Q14. If we see an ACT Lite client 6 times a month based on clinical need, will we get paid the full rate?

A14. The Flexible ACT team can use their clinical discretion to move individuals up and down in intensity level based on need, as often as needed. The team will need to have protocols for maintaining 60% of members billed at ACT (full) rate and 40% billed at ACT Lite (partial) rate. The team may bill the ACT (full) rate for individuals who receive ACT (high intensity) services.

Q15. Flexible ACT consists of two (2) levels of service: ACT service (high intensity) and ACT-Lite, a less intensive level of ACT for those who no longer need intensive support but continue to benefit from the ACT core principles of service. Please define the service criteria and reimbursement rates for high intensity and low intensity.

A15. Flexible ACT providers will provide two (2) levels of service based on individualized need. Individuals will be able to move up and down in intensity level based on need as often as needed.

- ACT (high intensity) service – as outlined per existing ACT Program Guidelines. The number of contacts provided shall be six (6) or more contacts per month. Rate Code: use the applicable Upstate/Downstate Adult ACT 100-capacity rate (Rate Code 4508).
- ACT-Lite (less intensive) service - a less intensive level of ACT for individuals who no longer need ACT level of intensive support but are not yet ready to transition off ACT and benefit from the core principles of the ACT model. The number of contacts provided shall be between two (2) and five (5) contacts per month. Rate Code: Use the applicable Upstate/Downstate Adult ACT Partial 100 (Rate Code 4509).

See A1 for additional information on the reimbursement rates.

Q16. How should providers make sure that their Flexible ACT Teams maintain the ratio of serving 60% of individuals at the ACT level and 40% at the ACT-Lite level?

A16. Flexible ACT teams must have protocols for maintaining a ratio of 60% ACT and 40% ACT-Lite, including an internal tracking system for monitoring the number of individuals served at each level of service and for reviewing changes to individual needs on an ongoing basis.

Q17. What are the qualifications needed for the Assistant Team Leader and the Mental Health Specialists to be hired?

A17. The Assistant Team Leader should have the same qualifications as required for the Team Leader, as described on pg. 27 of the ACT Program Guidelines (11/2023). The Mental Health Specialist (Clinical) must minimally meet the qualifications of a Professional Staff with a Master's degree (see pgs. 5-6 of the ACT Program Guidelines). The Mental Health Specialist (Wellness) must minimally meet the qualifications of a paraprofessional staff as described on pg. 5 of the ACT Program Guidelines.

Q18. What are the qualifications needed for the Assistant Team Leader and the Mental Health Specialists to be hired?

A18. See A17.

Q19. Do people need to be at the ACT-Lite service level before they can be discharged, or can some be discharged from regular ACT level without transitioning to ACT-Lite?

A19. Individuals receiving the ACT level of service on a Flexible ACT Team may be discharged from the program without transitioning to ACT Lite first.

Q20. What qualifies an ACT team staff member as a paraprofessional Mental Health Specialist? Can they be a Case Manager, or do they need to provide counseling services?

A20. See A17.

Q21. Can someone be admitted to a Flexible ACT team at the ACT-Lite level? Or is the ACT -Lite level intended for people to step down to after receiving ACT services?

A21. At this time, we are requiring that all new admissions to a Flexible ACT team start at the ACT (high intensity) level of service.

Q22. Our City contracted traditional ACT teams all have 2 Substance Use Specialists (SUS). Will this change?

A22. The NYC Flexible ACT teams will be required to have the 12 – 12.5 FTE (depending on psychiatric coverage) listed in the RFP, in addition to the 1 FTE DOHMH funded SUS position.

The second SUS is specific to NYC teams and is based on DOHMH funding. This additional SUS does not count as part of the core required staff per New York State guidelines, and therefore will remain as additional component to the Flexible ACT team.

OMH has not included this position in guidance for general ACT teams or any specialty teams, including Flexible ACT. Teams will not lose that funding as long as it is still available from DOHMH.

Q23. Will the Assistant Teal Leader carry another specialist title? And I assume this position will be a licensed clinician?

A23. See A17 regarding qualifications for the Assistant Team Leader. The Assistant Team Leader will not carry another specialist role; the responsibilities of the Assistant TL will be dependent on the needs of the team.

Q24. Can you say more about the mental health specialist that is more clinical than a Wellness Specialist.

A24. The Mental Health Specialist (MHS) role can be used as needed based on individuals served. Teams may have a need for staff to provide wellness-related interventions, or having someone fulfill a clinical role that can provide psychotherapy or other EBPs within scope of practice. However, there is flexibility for how teams can utilize these two roles.

Over time, as we learn more how teams are utilizing these positions, OMH may provide more specific guidance related to roles, responsibilities, and best practices.

Q25. Can an agency that covers more than one county create a flexible team that is shared across both counties?

A25. If the existing 68-capacity ACT team would provide services to the existing service area currently covered/licensed by that team.

Q26. If the team already has a part time psychiatrist, will hiring a full-time psych NP be able to meet the staffing requirement?

A26. Yes. You will want to make sure it falls within budget but there are a number of scenarios that can be utilized here.

Q27. Is there a municipality providing flexible ACT that OMH has used as a model for this RFP?

A27. Flexible ACT is a model that exists in other states and countries. OMH worked with individuals from Oklahoma, Ontario (Canada), and the Netherlands to learn how they implemented the Flexible ACT model in those areas. The NYS model of Flexible ACT takes into account local differences, including regulatory and funding rules specific to our state.

Q28. We already have Peer Specialist on our teams, if we are transitioning to Flexible ACT and a peer specialist is required, does it mean we need to have 2 peer specialists? What are the flexibility in titles/credentials depending on the current staffing composition of the team?

A28. If the team already has 1 FTE Peer Specialist (PS), they do not need a second Peer Specialist. However, the Team may choose to hire a second PS. OMH heard in focus groups that some teams felt that this would be a great addition to a Flexible ACT model, but it is not required by OMH at this time. To the second part of the question, in terms of credentials, the 60% professional is one requirement that teams need to keep in consideration as they develop the Flexible ACT Team.

Q29. The staffing on the PP didn't show two Substance Use Specialists so wanted clarity on that. We have 3 traditional ACT teams that are DOHMH contracted.

A29. That is correct. See A22 for additional information.

Q30. If a team already has 1FTE NPP would the team need to hire an additional NPP for .5 and an additional 3 FTE's?

A30. Yes, there should be increased practitioner time (either psychiatrist or NPP). This is an area that can be further reviewed with OMH.

Q31. Staffing requirement of 1FTE Psychiatrist or 1.5 FTE NPP? Why is there an additional .5FTE of NPP time required?

A31. OMH provided funding based on a 1FTE psychiatrist. If a team is hiring 1FTE NPP, the team will have additional funding to support additional NPP time. NPPs are not credentialed the

same as a psychiatrist, so OMH supports NPPs having additional time to support this transition from a 68-capacity team size to 100-capacity team size.

Q32. Did you consider adding another program assistant, at least a part time person to manage this additional volume and office activity?

A32. At this time, the Flexible ACT model does not support having additional program assistant time.

Q33. Does the Team Leader have to be a licensed professional? or can they just be professional staff?

A33. The qualifications for the ACT Team Leader are described on pg. 27 of the ACT Program Guidelines (11/2023).

Q34. The staffing for the 100-person Flexible team does not seem to be more than on the traditional ACT teams that are contracted with the DOHMH. Except for the addition of a .5FTE LPN and a .5FTE NPP. Is this accurate? So, the City contracted teams would have one additional staff member.

A34. Every 68-capacity ACT team expanding to a 100-capacity Flexible ACT teams will adhere to the following staffing requirements:

- **Existing** ACT Team Staffing requirements, the 68-capacity ACT teams are required to have 9 total staff: 1 FTE Team Leader; 1 FTE Registered Nurse; 0.36 FTE LPN / RN 1 FTE; Vocational Specialist; 1 FTE Substance Use Specialist; 1 FTE Family Specialist; 1 FTE Peer Specialist (required for Flexible ACT); 1 FTE Program Assistant; 0.68 FTE Psychiatrist / 1 FTE NPP
- **Added** staffing for Flexible Team, the 100-capacity ACT teams are required to have 12-12.5 total staff: 1 FTE Assistant Team Leader; 0.64 FTE LPN / RN; 1 FTE Mental Health Specialist; 1 FTE Mental Health Specialist; 0.32 FTE Psychiatrist / 0.5 FTE NPP

Please note, some New York City (DOHMH) contracted teams have an additional 1 FTE Substance Use Specialist position.

Q35. If someone is moved to an ACT-Lite spot on the team, would they be able to begin seeing a treatment provider in an Article 31 to support a more successful transition?

A35. No.

Q36. The total staffing doesn't seem to be more except for the addition of the .5FTE LPN (on top of the current .5LPN) and the addition of the .5NPP (in addition to the 1.0FTE NPP).

A36. See A34.

Q37. How will referrals work?

A37. The referral process has not changed, and referrals will still go through the local government unit's Single Point of Access (SPOA). Eligibility for Flexible ACT is the same as eligibility for ACT, as described on pgs. 16-18 of the ACT Program Guidelines.

Q38. Will the LGU have to approve the step down. Will an evidence-based tools be used?

A38. Flexible ACT Teams will have discretion to determine when to transition someone to ACT Lite and discharge from ACT. OMH is not requiring specific assessment tool or evidence-based tool for step down to ACT Lite level of service; Teams will have flexibility when moving individuals up and down based on each individual's needs and circumstances. OMH will require that there be input from the entire team when determinations are made. However, at this time and until further guidance is provided, individuals on AOT may not be served at an ACT-lite level of care.

Q39. Does case manager count as mental health specialist?

A39. There are no case manager roles on an ACT team. All team members assist in case management work, but staff have specialty roles as a focus of their work on the team. Team composition is based on education and experience.

Q40. Can we have a 70/30 split so we don't lose 8 full/traditional billable slots?

A40. No. The way the rate was developed was based on the 60/40 split. You're not technically losing 8 slots, but increasing by 32 half billing slots.

Q41. Can you confirm that one of the Mental Health Specialist positions can be paraprofessional?

A41. Yes, they can.

Q42. Would 1 FTE NPP and .4 Psychiatrist satisfy the staffing requirement?

A42. Yes, See A34.

Q43. Can individuals currently on another ACT Team transfer to an ACT team that offers "ACT Lite" services if they're ready to step down in care?

A43. Yes, individuals currently on an ACT team, who would benefit from the low-intensity step-down level, can be transferred from another ACT team to the Flexible ACT team. OMH will provide further guidance related to such transfers.

Q44. Is the movement between ACT and ACT Lite at the discretion of the team? Are there guidelines around how many times/how often individuals can move back and forth? Is there a separate enrollment/disenrollment process for ACT Lite and back to ACT, or is it fluid?

A44. The team will utilize clinical discretion to determine when to move individuals between ACT and ACT-Lite. Individuals will be able to move up and down in intensity level based on need as often as needed. There is not a separate enrollment / disenrollment process for individuals moving between the two levels.

Q45. Are there designated staff for the ACT Lite consumers (1MH Specialist, 1Peer, LPN and additional psychiatry time)?

A45. Individuals who receive ACT Lite level of care will work regularly with one (1) dedicated staff and the Psychiatrist/NPP. The individual may work with others on the team as needed; for example, the RN or other staff member in cases where the specialty role of other staff is related to their goals.

Q46. How soon are the Flexible ACT Teams expected to reach the 100-capacity after receiving the award?

A46. The team is expanding from 68-capacity to 100-capacity, this is about 4-8 months, based on the 4-6 admissions allowed per month. We are expecting that time frames will vary based on the team and needs of the team.

Q47. How soon are the Flexible ACT Teams expected to reach the 100-capacity, given that no more than 4-6 people may be added to the team per month?

A47. See A46.

Q48. Are you able to hire staff as numbers increase maintaining the 10 to 1 ratio?

A48. Yes. As the capacity of the team grows the staffing grows. New staff do not need to be hired all at once and should ramp up along with the capacity.

Q49. Do applicants need to provide proof of notifying their LGU? If so, how should it be included in the application?

A49. No, however, applicants must notify the LGU(s) of their intent to apply.

Q50. Where can we find the M/WBE Policy Statement form we need to provide in our application?

A50. The M/WBE statement is not required to be submitted with the application but will be requested if awarded a contract.

Q51. This RFP is not for a new team but for the transition of an existing "traditional" ACT team?

A51. That is correct. This RFP is for existing NYS OMH-licensed Adult 68-capacity teams that will transition to a Flexible ACT Team.

Q52. When entering the proposal narrative into the SFS will we be able to upload some sections, or will we be required to keep within the maximum character limit on all sections?

A52. You can upload attachments in response to questions. The 2,000-character limit is limiting and we're working with SFS staff but in meantime can upload attachments.

Q53. Will you be emailing these PowerPoint slides to participants of this webinar?

A53. The Webex recording is posted on the OMH website here: https://omh.ny.gov/omhweb/rfp/2024/flexible-act/index.html

Q54. What's the eligibility for teams to apply?

A54. Eligibility is only for existing NYS OMH licensed Adult 68-capacity ACT teams that are not specialty teams (e.g., Shelter ACT, Forensic).