Capital for New or Expansion of Psychiatric Residential Treatment Facilities for Children and Adolescents
RFP#MH263029

Questions & Answers

Q1. Is there a cost estimate, budget or ballpark figure for the project listed?

A1. Section 4.3 states "up to $20 million in capital funding will be awarded through this RFP. If there are two or more new RTF applicants with passing scores, only two new RTF applicants will be awarded, in rank score order, according to section 4.4, consistent with the actual capital costs of up to $10 million in capital funds each. The expansion RTF awards will be for actual capital costs not to exceed $5 million each."

Q2. Is there an actual start date for the project?

A2. The anticipated contract start date is July 1, 2027.

Q3. Could I secure a copy of the plan holders list?

A3. OMH cannot provide a list of potential bidders on the project or individuals that have requested the bidding documents as documents are public with the Statewide Financial System. OMH does not know what organizations may submit applications for this RFP. Once awarded and approved by the Office of the State Comptroller, the list of awardees will be posted on the NYS Contract Reporter.

Q4. Will it be an occupied renovation?

A4. An occupied renovation is possible. A plan will need to submitted for continuity of care and recipient safety during the renovation, which will be subject to OMH review and approval.

Q5. Will temporary partitions be needed to section off the area for noise and dust control?

A5. They can be used if needed.

Q6. Title states for "new " program but section 2.4 says applicants must currently operate an OMH-licensed program or operate a residential program under another state. As we are a new Non-Profit organization who does not can you kindly assist in clarification?

A6. Section 2.4 states that "Eligible applicants must currently operate an OMH-licensed psychiatric inpatient, residential, or community-based service programs for children,

adolescents and/or transition age youth (ages 18-21) with diagnosed mental health conditions **OR** operate residential programs for children, adolescents, or transition age youth (ages 18-21) under another **State Authority**." If neither describes the programs you operate then you are not an eligible applicant.

Q7. In reference to the paragraph below, I wanted to seek confirmation that our organization is eligible to apply. We are currently a licensed voluntary foster care agency and serve youth in our residential program up to age 21:

A7. "Eligible applicants must currently operate an OMH-licensed psychiatric inpatient, residential, or community-based service programs for children, adolescents and/or transition age youth (ages 18-21) with diagnosed mental health conditions or operate residential programs for children, adolescents, or transition age youth (ages 18-21) under another State Authority." Therefore, a licensed agency serving youth in a residential program are *eligible* to apply.

Q8. We operate two Part 595 residences which are not serving youth exclusively. We do serve individuals 18 and over at these facilities. Are we eligible to apply to this RFP?

A8. "Eligible applicants must currently operate an OMH-licensed psychiatric inpatient, residential, or community-based service programs for children, adolescents and/or transition age youth (ages 18-21) with diagnosed mental health conditions or operate residential programs for children, adolescents, or transition age youth (ages 18-21) under another State Authority." Therefore, a licensed agency serving the transition age youth population is *eligible* to apply.

Q9. If proposing a new location, do you have to have a site identified for this application?

A9. No. "Once a bidder receives a conditional award through this RFP process, it must begin to actively search for and identify a viable project."

Q10. 6.2.b asks applicants to describe how proposed RTF beds will improve accessibility of services for RTF eligible youth statewide and regionally, and requests "available qualitative data". Does OMH have regional-level data available to applicants, such as C-SPOA referral volumes, wait times/wait lists for RTF placement, or bed capacity utilization by region, that could be shared to support this request?

A10. OMH is unable to provide data to prospective applicants. Additionally, youth are not placed in RTFs, they admit to RTFs temporarily for treatment.

Q11. Is there a page limit for the Proposal Narrative template, and do required attachments count against the limit?

A11. No there is no page limit.

Q12. Professional staff requirement of "a physician who has at least one year of post-medical degree experience in treating mentally ill children". Are there any waivers or exceptions for the inclusion of a PMHNP in the applicant's staffing plan/model?

A12. Federal and state regulations specify that RTFs are physician directed programs and that a physician is required to be part of RTF recipient treatment team. While a PMHNP is able to provide services n the RTF they cannot replace physician specific staff service requirements. There are no waivers or exceptions to this.

Q13. Section 6.2.a asks applicants to identify whether the proposed RTF will serve the "general co-ed RTF eligible population" or a "specialized population,". Has OMH done any needs based assessment or existing referral data review around such specialized populations? Could OMH provide a list for consideration related to highest need specialized populations? (e.g., fire-setting, CSEC, I/DD co-occurring)

A13. There is a need for RTFs that offer specialized treatment and programming for those with primary mental health diagnoses and:

- co-occurring I/DD;
- co-occurring substance use disorders;
- with or at risk of juvenile justice involvement;
- fire-setting behavior; or
- problematic sexualized behavior.
- eating disorders

Q14. Please specify the amount of state aid per bed available for the Transitional Counselor positions.

A14. 1 FTE for Transition Coordinator assigned to every 6 RTF beds, as mentioned in Appendix B, page 39. The state salary model for Transition Coordinator is $85,768 Upstate and $89,029 Downstate. State Aid supports 25% of the salary for every 1 FTE Transition Coordinator. Service dollars are available at the rate of $1,363 per bed annually.\

Q15. For a newly established RTF, how is SSI revenue treated under the OMH/DOH fiscal model? Is the published Medicaid per diem intended to cover all operating costs, or is providers' retained SSI revenue expected to be an additional operating revenue source? If additional, what assumptions does OMH use regarding the proportion of residents receiving SSI and the expected amount of retained SSI revenue?

A15. Revenue, including SSI, does not factor into the RTF rate methodology. The published Medicaid per diem is intended to cover all RTF operating and capital costs.

Q16. For budget preparation purposes, would you explain what medical/psychiatric expenses to include under the per diem rate and what expenses are now carved out and billed separately through client Medicaid insurance?

A16. Medical and psychiatric expenses related to provision of RTF service should be included in the expenses used to build the per diem rate. As of July 1, 2026, the following services are carved out of the per diem rate:

- Hospital inpatient services
- Hospital non-psychiatric outpatient services as an alternative to hospitalization
- Hospital emergency department visits
- Durable medical equipment,
- Prosthetics and orthotics,
- Prescription and physician ordered non-prescription drugs and medical supplies
- Specialty physician and physician’s assistant nursing services
- Specialty services of Nurse Practitioners
- Dental services
- Eye and low vision services
- Audiology services

- Laboratory and radiology services
- Physical therapy services
- Urgent Care Center visits
- Family planning and reproductive health care services and supplies
- Neuropsychological testing/evaluation services
- Ambulance transportation services (emergency and non-emergency)

Q17. Is JCAHO accreditation still required?

A17. Accreditation by an approved Accrediting Organization (AO) is required. Approved Accrediting Organizations include The Joint Commission on Accreditation of Healthcare Organizations, and the Commission on Accreditation of Rehabilitation Facilities.

Q18. Do we meet the eligibility requirement if our existing residential program serves individuals ages 18 to 31, rather than being limited to transition-age youth ages 18 to 21?

A18. Yes.

Q19. If there are two buildings, with the same programming, on a single site does this count as a single project or is each building its own project?

A19. If the intent is for the two buildings on the single site to be licensed as one RTF then this would count as a single project.

Q20. If one building has four 4 bed units gathered around a central common program area, with adequate staffing ratios on each side, would the application be considered?

A20. Yes.

Q21. Given that several RTF's have closed over the past years, what is the assessed need that has prompted the current release of this RFP?

A21. "As a part of a historic investment to expand mental health services for children, adolescents and adults, the Office of Mental Health is seeking to increase RTF accessibility in areas of the State that in need of additional capacity by opening new RTF programs or beds in existing programs to serve children and adolescents based on regional and statewide need for RTF beds in Central, Hudson River, New York City and Long Island. Applicants from the OMH Regions Hudson River and New York City will be prioritized for award allocation as they have the greatest regional need."

Q22. Can we include initial outfitting into the capital budget?

A22. Start up funds are available via this RFP. Start-up funding will be based on the most current rate at the time of opening, which is $10,197 per bed at this time. All reasonable costs to develop RTF beds should be included in the Start-up budget.

Q23. How is the ongoing operational rate developed? In looking at the current rates, there is a lot of variability among the providers.

A23. Variability exists due to variance in the costs of service provision between providers. Medicaid rates for Psychiatric Residential Treatment Facilities for Children and Youth ("PRTFs") are established prospectively, based upon actual costs and patient days as reported on cost reports for the fiscal year two years prior to the rate year. The PRTF fiscal year and rate year are for the twelve months July 1 through June 30. Alternate Cost Reports will be utilized to align with appealed rate periods until such time that the appealed information would be fully reflected in the facilities annual cost report. Effective on or after July 1, 2025, actual patient days are subject to a maximum utilization of 96 percent and a minimum utilization of 82 percent.

In determining the allowability of costs, the OMH reviews the categories of cost, described below, with consideration given to the special needs of the patient population to be served by the PRTF. The categories of costs include:

- Clinical/Direct Care (C/DC). This category of costs includes salaries and fringe benefits for clinical and direct care staff.

- Administration, Maintenance and Supports (AMS). This category of costs includes the costs associated with administration, maintenance and child support.

Purchased Health Services (PHS). This category of costs includes clinical services such as MD on call and response, purchased on a contractual basis and not subject to the clinical standard if the services are not uniformly provided by all PRTFs and thus not considered by the Commissioner in the establishment of the approved staffing levels.

Allowable per diem operating costs in the category of C/DC are limited to the lesser of the reported costs or the amount derived from the number of clinical staff approved by the Commissioner multiplied by a standard salary and fringe benefit amount.

Allowable per diem operating costs in the category of AMS are limited to the lesser of the reported costs or a standard amount.

The standard amounts for the C/DC and AMS categories are computed as follows. For PRTFs located in the New York City metropolitan statistical area and Nassau and Suffolk counties the standard is: the sum of 50 percent of the provider costs, 25 percent of the average per diem cost for all PRTFs in this geographic area and 25 percent of the average per diem cost for all PRTFs in the state; increased by seven and one half percent. For PRTFs located outside the New York City metropolitan statistical area and Nassau and Suffolk counties the standard is: the sum of 50 percent of the provider costs, 25 percent of the average per diem cost for all PRTFs located outside the New York City metropolitan statistical area and Nassau and Suffolk Counties and 25 percent of the average per diem cost for all PRTFs in the state; increased by seven and one half percent.

For facilities with inadequate cost experience, provider costs will be based on alternative cost reports or satisfactory cost projections, trended to the statewide base period.

Q24. Which accreditation organizations are acceptable? Only JCOH? or others?

A24. See response to Question 17.

Q25. Please advise on the cost reporting mechanism.

A25. If awarded, applicants will be instructed on cost reporting mechanism for the capital project during contract execution process.

Q26. Will startup funding include the cost of hiring and onboarding staff?

A26. Yes, this RFP includes start-up funding.

Q27. Is there a total bed cap for RTF?

A27. "For all OMH regions: Existing RTF programs may propose to expand bed capacity by a minimum of 2 beds for a maximum of 40 beds per licensed facility with no more than 8 beds in each facility's living units. For the Hudson River, Long Island and Central New York regions: New RTF programs may propose a minimum of 8 and a maximum of 24 beds per site with no more than 8 beds in a unit. For the New York City region: New RTF programs must propose a minimum of 14 and a maximum of 24 beds per site with no more than 8 beds in a unit."

Q28. Are nurse practitioners able to provide medication management or health services? Or is only a licensed physician (MD) acceptable?

A28. A PMHNP may provide medication management and health services but cannot replace requirements of the physician in federal PRTF and state RTF regulations. RTFs are a physician directed program. A physician is required as part of RTF recipient treatment team. A physician is required to supervise any staff including PMHNP.

Q29. For expansion, if a site is already licensed to provide RTF services for 24+ clients can it still apply for expansion?

A29. "For all OMH regions: Existing RTF programs may propose to expand bed capacity by a minimum of 2 beds for a maximum of 40 beds per licensed facility with no more than 8 beds in each facility's living units."

Q30. Are regional PACCs still involved with the RTF admissions process?

A30. In 2021, regional PACCs were replaced by a new entity called OMH RTF Authorization Teams. The OMH RTF Authorization teams are comprised of an OMH Psychiatrist and a licensed social worker. The Teams have the same responsibility of receiving all applications to access RTFs and determining whether the application meets eligibility and medical necessity criteria. RTFs receive applications for admission that have been found eligible by an RTF Authorization Team. The RTFs have their own established admission criteria and may make admissions decisions once a youth is found eligible by the Central Office Authorization Team. As mentioned in Appendix A, page 35, "each RTF maintains their own OMH approved written admission, continued stay and discharge criteria. The admission criteria must, at a minimum, provide that the youth is eligible to access RTF services as determined by an OMH RTF Authorization Team."

Q31. Are there any specific education, certification/licensure requirements for rehabilitative specialist?

A31. “A rehabilitation counselor who has a master's degree in rehabilitation counselling from a program approved by the New York State Education Department, current certification by the Commission on Rehabilitation Counselor Certification and three years of post-certification experience in treating mentally ill children” as mentioned in Appendix B, page 38.

Q32. How long would a budget-based rate last? Using a cost-based rate based on year 1 CFR expenses may reflect only partial operating expenses needed.

A32. For facilities with inadequate cost experience, provider costs will be based on alternative cost reports or satisfactory cost projections, trended to the statewide base period. This basis of rate computation will remain in place until such time as the program has adequate cost experience, that being a certified cost report for the fiscal year two years prior to the rate date.

Q33. Are RTFs still carved out of managed care?

A33. Yes.

Q34. If there are no regional PACCS, what is the coordination with the local SPOAs?

A34. See response to A30. Applications for accessing RTFs must be submitted to the young person’s C-SPOA of origin. C-SPOA then sends the application to the OMH RTF Authorization Teams for an eligibility determination. C-SPOAs are notified of all OMH eligibility determinations and if the applicant is eligible the CSPOA is notified of which RTFs the eligible application is submitted for consideration of admission. C-SPOAs are often involved in the RTF pre-admission process, throughout admission and discharge planning.

Q35. Is there a time frame to get someone admitted?

A35. Once an RTF eligible application has been submitted to an RTF for consideration for admission, the RTF is expected to admit the youth as soon as possible given the RTF’s pre-admission process, youth/family readiness, bed availability and the number of other youth accepted waiting for admission to the RTF for each open bed will inform an applicant’s admission date and length of wait for admission.

Q36. Does the site need to go through Padavan if it is over 14 beds?

A36. No, Padavan is not a requirement if the proposed RTF will exceed a 14 bed capacity.

Q38. Is OMH providing a Budget Template for this proposal, or should applicants create their own?

A38. There is no budget required to submitted to apply for this RFP.

Q39. For an existing RTF with more than 40 licensed beds, does the 40-bed limit apply even if a portion of the beds are specialized to serve a different population?

A39. Yes, the 40 bed limit applies. "For all OMH regions: Existing RTF programs may propose to expand bed capacity by a minimum of 2 beds for a maximum of 40 beds per licensed facility with no more than 8 beds in each facility's living units."

Q40. If an expansion project results in improved resident space but maintains the total licensed bed count, would it remain eligible for funding?

A40. No, that would not be considered as eligible to apply for this RFP.

Q41. Does OMH consider renovation and reconfiguration of an existing RTF (e.g., converting double-occupancy rooms to single-occupancy rooms, improving bathrooms, or enhancing therapeutic living space) to be an eligible expansion project if it improves the quality of care but does not increase licensed bed capacity?

A41. No, that would not be considered as eligible to apply for this RFP.

Q42. Would OMH consider a project that converts existing double-occupancy bedrooms to single-occupancy bedrooms as an eligible expansion or capital improvement, recognizing that the project is intended to improve privacy, safety, and the therapeutic environment rather than increase bed capacity?

A42. No, that would not be considered as eligible to apply for this RFP.

Q43. May capital funds be used to renovate or expand a single building or cottage within a multi-building RTF campus, or must the project encompass the entire licensed program?

A43. If the project is for RTF bed expansion or a new RTF and the project would require renovation to a single building for RTF recipients on the proposed campus this would be allowed. If the project is for the renovation a single building for RTF recipients on an existing RTF campus without expanding beds this would not be allowed.

Q44. Are projects that improve resident privacy, safety, accessibility, and the therapeutic environment considered eligible capital improvements under the expansion component of the RFP?

A44. No, that would not be considered as eligible to apply for this RFP.

Q45. Are there any restrictions on completing renovations in phases while an existing RTF remains operational?

A45. Existing RTFs will need to submit a plan for continuity of care and recipient safety during renovation which will be subject to OMH review and approval.

Q46. Can you use grant funds for renovations to existing school building in order to adapt for RTF?

A46. Yes.

Q47. Can staffing be shared between RTF and existing RTC (29-I) via allocations?

A47. The same individuals may be allocated to work with an RTF and an RTC as long as:

1) the proposed program plan and staffing plan meets the guidelines set forth in Appendices A & B, pages 33–40 and staff training requirements in 14 NYCRR 584, 524 and 526.
2) The individual is trained to work effectively in the RTF as a sub-acute inpatient program for youth with primary psychiatric needs and require 24/7 care at the direction of a Physician.

Q48. Can RTF youth be integrated in same school, recreational & other spaces with other agency programs (RTC, Community-Based Services, Public programs, etc.)?

A48. RTFs must have discrete and identifiable staff, program and space. Although the RTF may share some staff via allocations and other than living unit space with other programs, each RTF must be separately identifiable from other programs which a particular agency may operate. While youth are admitted and not in a school program the Agency must ensure the RTF recipients are programmed on their own to meet their -sub-acute inpatient psychiatric needs. While the Agency may use shared spaces like a cafeteria on a campus or a recreational space, the RTF recipients must by scheduled to use the cafeteria on their own with no comingling with other program recipients. While attending school it is permitted for the RTF recipients to be integrated with the other populations served by the school program.

Q49. What is RTF agency's responsibility for any Department of Social Services placed youth?

A49. RTFs are not placement settings. A youth may be in DSS custody and determined eligible to admit to RTF for treatment. The RTF would work with the DSS on active discharge planning like they would any other custodian.

Q50. Since only 25% of professional staff need to meet listed requirements (Appendix B), is it agency discretion that determines which ones?

A50. Yes.

Q51. Can your Permanency/Family Connections Specialist also provide support to other agency programs (RTC)?

A51. See response to Question 47. This position is expected to support all RTF recipients, regardless of custody status, in achieving both physical (a discharge resource) and emotional permanency. Family search and engagement, and the fostering of family connections involve clinical expertise that goes beyond the standard treatment of mental health disorders. Through the Family Finding (or analogous) process, intensive tactics are to be used to find and cultivate lifelong supports for youth who may have few or no family connections. The Family Finding (or analogous) process can also create or re-establish bonds that will help youth learn more about their families. Through appropriate use of Family Finding (or analogous,) there are significant benefits to families and young people, a sense of belonging, and the future path to permanency and lifelong resiliency. The Permanency/Family Connections Specialist is distinct from a Family Peer Advocate position. This is intended to add a layer of expertise that is not

consistently present across the RTF system. This position's aim will be to promote more timely and successful discharge planning experiences for youth.

Q52. What are the requirements for post-discharge services?

A52. The Transition Coordinator program provides services to youth post-discharge from the RTF for up to 6 months. The Transition Coordinator aftercare services include continuity of care coordination, consultation, advocacy and support to reinforce successful community integration, service linkage and address challenges that may arise during the transition. One full-time Transition Coordinator is to be assigned for every 6 RTF beds. Their caseload also includes up to 3 youth in post discharge status, as mentioned in Appendix B, page 39.

Q53. What are the qualifications and job responsibilities for the Family Peer Advocate? Any requirements in terms of hours worked?

A53. Each RTF determines the job responsibilities and policies & procedures for their Family Peer Advocate.

Q54. Without an initial year CFR cost report how will the first year RTF rate be determined for a PRTF?

A54. See A32 - For facilities with inadequate cost experience, provider costs will be based on alternative cost reports or satisfactory cost projections, trended to the statewide base period. This basis of rate computation will remain in place until such time as the program has adequate cost experience, that being a certified cost report for the fiscal year two years prior to the rate date.

Q55. If an agency ran an RTF program in the past, but exited years ago, can their original Operating Certificate # and Medicaid ID# be reactivated?

A55. No. A new operating certificate and Medicaid ID # will be required.

Q56. What guidance exists for what services will be paid though the RTF rate, MMC, FFS or some other mechanism?

A56. All services expected to be provided as part of the Residential Treatment Facility program will be paid through the RTF per diem, which is paid solely through Medicaid fee-for-service billing. Please refer to A16 for a list of services which are carved out of the RTF per diem rate.

Q57. What documentation is required to support full reimbursement?

A57. Support for RTF rate setting will initially include an OMH-approved staffing plan as well as fiscal and staffing information submitted in a format which mirrors the Consolidated Fiscal Report (CFR) schedules CFR-1, CFR-4 and CFR-4a. Once the RTF has been in operation long enough to have submitted two years of CFRs, the standard RTF rate setting process will utilize the OMH-approved staffing plan and the CFR from two years prior to the rate year.

Q58. For a VFCA, can youth transition out of foster care into RTF and vice versa?

A58. The custody status of a youth has no impact on eligibility for the RTF level of care. Every applicant is evaluated for RTF eligibility and medical necessity. It is possible for a youth in foster

care to be found eligible for RTF, receive RTF treatment and then be referred and found appropriate for QRTP.

Q59. What incidents must be reported and to whom?

A59. RTF providers are subject to requirements in 14 NYCRR 524. These regulations, as well as additional guidance and training, is available on OMH's Clinical Risk Management webpage. RTFs report restraint use through the NIMRS restraint and seclusion module. Additionally, RTFs are required to report any serious occurrences to the state-designated Protection and Advocacy system, which is currently Disability Rights New York.

Q60. Once the PACC approves a youth for this level, does the agency still get to screen, or do we have to admit if we have the opening?

A60. See response to question 30.

Q61. Can required spaces such as therapy rooms, recreation spaces, etc. that are shared by the RTF and school program be built with capital funds? How is the cost of these shared spaces determined?

A61. OMH will evaluate individual project scopes after award to finalize scope and determine if any cost-sharing for renovations of shared space is required.

Q62. Can the psychiatric evaluation and or services be virtual?

A62. No. Any staff and services required by RTF regulation must be delivered in person. Telehealth may may supplement in-person service delivery with Telehealth Services to preserve or enhance access to care. These services may include but are not limited to the following:

- Screening for admission with an applicant as well as their caregiver(s) and collaterals.
- Family therapy and engagement with supports.
- A specialized service beyond the program's standard array (e.g., access to a contracted clinical specialist for assessment and/or consultation).
- Services to the youth and their caregiver while not onsite, such as while on therapeutic leave.
- Ad hoc medication treatment by an attending prescriber to a youth as long as nursing staff are on-site during the delivery of services. Medication treatment to youth in RTF cannot be solely through Telehealth Services.

Q63. In Appendix B, pg. 37, two different professional staff members must be employed full time (2 FTE each). Does that mean 2 FTE in total or 4 FTE?

A63. 2 FTE in total.