UPDATE 9/8/22:
Revised Budget Template – please be advised that there are formatting issues in the budget template (Appendix B) provided on the Grants Gateway platform. The template that is available to applicants in the Gateway cannot be used.

The revised budget template can be found on the OMH and OASAS websites where the RFP is posted, refer to links provided in the response to question #73. The revised template is the **only** template that can be used and uploaded into the Grants Gateway in response to Question 6.7a.

Supportive Crisis Stabilization Center RFP
Official Questions and Answers

ELIGIBILITY

1. The RFP states that applicants must have experience providing Mental Health and Substance Use Disorder services, but it also states that they can be either OASAS or OMH licensed. Could you please clarify if it's expected that applicants currently provide both MH/SUD services or can they provide one or the at the time of application as long as they include both in the SCSC?

   ANSWER: The applicant must be licensed, certified, or otherwise authorized by OMH, OASAS, or NYS DOH. The applicant does not need to currently be licensed by both OMH and OASAS in order to submit a proposal. The provider must demonstrate their experience, ability, and understanding of how to provide services for both mental health and substance use crises in their proposals.

2. If a county/area was awarded the ICSC grant, could they also be eligible for a SCSC grant?

   ANSWER: Yes.

3. What does "otherwise authorized by OMH, OASAS, or DOH" mean exactly?

   ANSWER: There are certain services that have OMH/OASAS approval that do not require license or certification. These services may or may not be funded but they are authorized. Provider organizations should know the services they offer with OMH/OASAS authority (example: CORE services, housing programs, certain HCBS services, etc.).

4. Is it necessary for a provider to have both OMH and OASAS certifications in order to apply? Or can they have only OMH or only OASAS?

ANSWER: You do not need to have both OMH and OASAS certifications in order to apply. See eligibility requirements outlined in section 2.5 of the RFP.

5. Did you say that we must have both OMH and OASAS certifications?

   ANSWER: No. See response to question #4.

6. Can one organization submit multiple applications in different economic development regions?

   ANSWER: Yes. A separate proposal would need to be submitted for each economic development region**.**

7. The RFP states that applicants must be "licensed, certified or otherwise authorized by OMH/OASAS/DOH." As a consultant, I am working with a group that consists of psychiatrists and mental health professionals, that expressed interest in this program, but they are not operating as an organization with a certification or license per se (they are all licensed professionals, but they are practicing individually). Is there a way to present them to the appropriate agency so they can obtain an authorization to become a qualified bidder?

   ANSWER: Please see response to question #1. If the providers do not currently meet the eligibility criteria, they would have to do so by the proposal due date on 10/5/22.

LICENSING

8. Can an OMH licensed applicant collaborate with an OASAS licensed partnering organization to meet the requirement that awardees must become dually licensed, or must the applicant obtain an OASAS licenses once awarded? If so, what is the timeline expected for applicants to obtain the dual license?

   ANSWER: The license under Part 600 is one (1) license jointly issued by OMH and OASAS. There is not a requirement for dual licensure. Applicants should apply for licensure as soon as possible once awarded. A single license will be issued under the joint authority of OMH and OASAS. An OMH licensed and an OASAS licensed agency could apply together, but it is not required. See question #12 for information on collaborative proposals.

9. Could you provide further information regarding centers that may be operating at this time, that might apply for certification. What might this look like, additionally, if a program applied for the RFP and was not awarded, could the program then apply for certification?

   ANSWER: The Offices will be releasing guidance about the certification process. If your program contains the components of the SCSC, you can apply for the SCSC certification if you don't receive the RFP.

10. Is there a vision/plan to collaborate with existing urgent/crisis centers? Will these centers be able to apply for this dual license at some point in the future?

    ANSWER: Yes, the vision is for CSCs to collaborate with local providers in order to provide linkages to care and community referrals. The provider must determine what the need is in the service area and how they are going to work with the community around the development of this program and a streamlined referral system. See response to question #9.

11. When are SCSCs supposed to launch? May 2023?

    ANSWER: May 2023 is the timeframe included in the RFP. If there are currently agencies with operational components of an SCSC that apply for licensure outside of this RFP process, then they may be licensed before May 2023.

12. Can a group of organizations work together in a collaboration to submit one (1) application?

    ANSWER: Yes, but there must be one (1) designated awardee who will hold the license and receive the funding. The awardee will be the agency who submits the application and applies for the license. Partnerships and collaboration efforts must be described in the proposal.

OPERATIONAL FUNDS, RATES & BILLING

13. If the provider has a youth that cannot be placed within the 24 hours permitted by this program design and cannot safely discharge them within the 24 hours, does payment for services stop at 24 hours even if services/care does not (or cannot safely)? In other words, can a Supportive CSC bill for a per diem rate and then a subsequent half day or per diem?

    ANSWER: Crisis Stabilization Centers, whether Supportive or Intensive, only have the authority to serve an individual for up to 23 hours and 59 minutes because they are outpatient programs. Services that exceed 24 hours require the program be either an inpatient or residential facility. Therefore, it is important for CSCs to have processes and linkages in place through community partnerships to provide streamlined referrals to local providers and higher levels of care. The Center should continuously assess if the SCSC is the appropriate service and level of care for that recipient. Reimbursement is not available for recipients that remain admitted to a CSC for more than the allowable 23 hours and 59 minutes.

14. To follow up on the question "can it be two consecutive days". Given that the guidance states that the services are available for individuals up to 24 hours, would the center be able to bill beyond that first 24-hour period?

    ANSWER: Per Proposed Part 600 Regulation, individuals are only able to be served for up to 23 hours and 59 minutes. Individuals who require services beyond 24 hours should be transferred to the appropriate level of care.

15. Since services are voluntary, are there minimum services which must be provided to qualify for billing of the half-day or per diem rates, such as triage, screening, and assessment?

    ANSWER: Services provided to an individual must be consistent with Part 600 Regulation and Program Guidance in order to bill.

16. Are Medicaid managed care providers required to pay for this service without pre-authorization? Are there any reasons they can deny payment for the service because they claim it is not medically necessary for a Medicaid beneficiary? Do Medicaid beneficiaries who seek CSC services need to meet any pre-admission criteria to be eligible, such as referred by EMS, a behavioral health provider or law enforcement?

    ANSWER: No prior authorization will be required. That being said, the services provided need to be well documented. The Offices will be providing specific benefit and billing guidance and working with the managed care plans around how they implement this benefit. This will be provided to the managed care companies in writing and posted on the OMH and OASAS websites for more information.

17. How was the $1.9M Medicaid billing estimate calculated? What this the volume of clients used to come up with this number and the mix of half-day and per diem payments?

    ANSWER: The reimbursement methodology is composed of a provider cost modeling consistent with NYS Financial Reporting and the Bureau of Labor, Statistics, Wage data. When we create the provided cost model, we include staffing assumptions and staff wages, employee related expenses, program related expenses, provider overhead, and program billable units. We do not have specifics on that mix of those per-diem rates and volume.

18. Can you provide any more specific projected client numbers you can share - particularly is there an expected projection in terms of individuals billed per-diem vs hourly?

    ANSWER: The rate development model used available information from existing programs to estimate the quantity of daily brief and full visits. The RFP asks the provider to estimate projected client volume based on needs of the service area and how you intend to meet that volume.

19. What is the maximum number of clients to be served daily?

    ANSWER: There is not a daily maximum service capacity. The RFP asks the provider to estimate projected client volume based on needs of the service area and how you intend to meet that volume.

20. If Medicaid reimbursement is not what is projected, are there additional funding opportunities- historically 24/7 programs in our area have had low utilization rates?

    ANSWER: The provider will need to determine, based on need in the service area, if this is a viable program for your community. There are no additional funding opportunities from the Offices beyond those outlined in the RFP expected at this time. As of 2021, New York State

regulated commercial insurance policies are required to cover medically necessary outpatient services provided in licensed Crisis Stabilization Centers. There are other program models that are not 24/7 that may better suite this community, but this is something the provider will need to determine in their planning and proposal development. The Offices recommend collecting data and working with your LGUs to determine if an SCSC in your area will be viable.

21. Is $1.25 million startup same as “capital funding “?

    ANSWER: No. Start-up funding and capital funding are separate.

22. What types of expenses are considered allowable start-up expenses?

    ANSWER: Start-up expenses can include but are not limited to: costs associated with the recruitment and training of staff, staff salaries, purchase of computer equipment, phone systems, office supplies, furniture as needed for program, medical storage, utilities, insurance, etc. Start-up funds can be used for service delivery while building revenue through Medicaid and Commercial billing. No construction or renovation costs can be paid for with Start-up funding.

23. What are allowable categories of start-up costs?

    ANSWER: See response to question #22.

24. For upstate region- is the $1.25M for start up the full extent of the deficit support for the first year? I see that $768K is available for each year but probably not in addition to the $1.25 M start up for year one?

    ANSWER: The State aid as outlined in the RFP is in addition to the start-up funding.

25. If an agency or group of agencies successfully uses this process and money to open a SCSC, and once open, we add on the elements of an ICSC within the program, can we bill for ICSC-level services down the road?

    ANSWER: If licensed as an SCSC, the applicant would need to apply for the ICSC license in order to bill as an ICSC. This procurement is specific to the development of SCSCs.

26. Given that Centers that do not get funding through this RFP can still apply for licensure through OMH/OASAS, do we need ICSC licensure to bill Medicaid or other insurers for ICSC services?

    ANSWER: Yes, you would need ICSC licensure to bill for the ICSC rates. Same goes for SCSCs.

27. Is there a maximum budget amount that an applicant can submit, or is an applicant expected to project revenue based on Medicaid/3rd party billing rates/deficit funding?

    ANSWER: There is no maximum budget; however, your total expenses after revenue, reflected on row 69 of the budget template, should equal the net deficit plus start-up dollar

amounts from section 5.5, page 25 of the RFP. Since start-up can be spent over the course of the first two years, your year one (1) and two (2) total expenses after revenue (row 69) will include start-up and net deficit. Your year three (3), four (4), and five (5) total expenses after revenue (row 69) should equal the net deficit amounts only.

28. How many hours are considered a brief rate?

    ANSWER: The brief rate is for service provision up to three hours.

29. Does OMH/OASAS plan to issue separate/higher rates for children?

    ANSWER: No. The current rates are inclusive of service provision without regard to recipient age.

30. Section 5.5 states “providers will be funded through a combination of sources, including but not limited to net deficit, Medicaid and other third-party payors”. Can OMH/OASAS identify the types of third-party payors anticipated as a funding source? Is there an anticipated volume for the third-party payors or may an applicant project the volume as part of their application and budget?

    ANSWER: OMH reviewed payor mix for programs of similar modality and target population to generate an estimated Medicaid enrollment rate, then applied to the total gross model program costs. Other payors may include out-of-pocket payment, private insurers, or other payors otherwise not considered.

31. Is there any annual budget cap/maximum?

    ANSWER: See response to question #27.

32. Should start-up costs be separated and/or notated as such in the Operating Budget and/or in the Budget Narrative?

    ANSWER: Start-up expenses should be included in the budget narrative and operating budget. They do not need to be lined out separately in the operating budget.

33. Is $900k for documented debt reduction? (i.e., must we prove deficit dollar amount?)

    ANSWER: We do not require applicants to prove deficit.

LOCATION & CO-LOCATION

34. Do we need to show proof of site/location for award?

    ANSWER: Yes, please refer to Section 6.2 of the RFP.

35. Is OMH/OASAS seeking for the Supportive Crisis Stabilization Centers to be located geographically within a certain proximity to the recently awarded Intensive Crisis Stabilization Centers?

    ANSWER: We are looking for SCSCs to be located where there is both identified need and connections to other services in the community. The services provided by an ICSC include the services provided at a SCSC, therefore having both services in close proximity may be a duplication of services unless there is a need for both Centers in the community, which should be described in your proposal.

36. Does OMH/OASAS have any expectations around the geographical and/or programmatic synergy with the region's ICSC? That is, does OMH/OASAS expect both centers to be in the same geographic area? Does OMH/OASAS expect the centers to be in different geographic areas to promote more geographic coverage?

    ANSWER: The Offices expect that the providers demonstrate need in their service area, taking other local services and programs, including ICSCs into consideration. See response to question #35.

37. Do you intend on awarding these in similar locations that were awarded the Intensive Stabilization Centers?

    ANSWER: See response to questions #35 and #36.

38. Will geography be taken into account if an ICSC is located in one part of the region, will the reviewers seek geographical diversity for the SCSC?

    ANSWER: See response to questions #35 and #36.

39. Do you intend on awarding these in similar locations that were awarded the intensive stabilization centers?

    ANSWER: See response to questions #35 and #36.

40. How does OMH/OASAS expect the ICSC and the SCSC to collaborate and/or co-exist if they are located within the same community? Can there be sharing of staff if they are in the same geographic area?

    ANSWER: See response to questions #35 and #36. There is nothing that precludes providers from sharing staff among agencies, as long as the Centers are in compliance with Part 600 Regulation.

41. Does OMH/OASAS have a preference for geographic location for the SCSC in relationship to the location of the ICSC award? Would OASAS/OMH prefer the SCSC located in the same community as the ICSC to pool resources with the ICSC or in another community within the region to spread out availability?

    ANSWER: No, the Offices do not have a preference. See response to questions #35 and #36.

42. Do applicants need to have a formal arrangement (lease agreement, purchase, etc.) for the proposed facility at the time of submitting the application or is there room to determine some of those details post award?

    ANSWER: There is room to determine those details post award, but part of the RFP proposal asks to describe the population you are servicing. Therefore, you will need to think about the location of these programs and need to be able to move quickly toward making it a viable location in order to have it opened in a reasonable amount of time. We are looking for clear descriptions of where the SCSC will be located.

43. The RFP asks some specific questions about the site (e.g., parking, access, etc.). Will it be appropriate for us to describe our intended location if we do not have official plans?

    ANSWER: Yes.

44. Where specifically site control, as part of the submitted application, addressed in the RFP?

    ANSWER: We are not requiring site control for purposes of the submission of the response.

45. Can you locate the SCSC with a OCFS residential if separate treatment areas?

    ANSWER: The Offices recommend reviewing the OCFS certification requirements. The provider should describe the design, layout, and benefits of this collocation in their proposal. Additionally, see response to question #47.

46. Does the model offer the opportunity for smaller satellite centers outside of the main center for initial triage and transportation to better serve the coverage area? If so, would these sites be billable, and would there be an opportunity for a reduced staffing plan at these sites?

    ANSWER: No, at the present time we are not exploring satellite CSCs. We are looking to establish main site CSCs that offer the full array of services as outlined in the Part 600 Regulation.

47. Is it acceptable to provide 589 services on the same campus if approved by OMH?

    ANSWER: Yes, but they have to be separate and distinct programs. If collocated with the SCSC, the provider should describe the benefits of the collocation in their proposal.

SERVICES

48. Page 6 of the RFP, section 1.2 Eligible Population states “SCSCs are designed to serve all New Yorkers experiencing a mental health and/or substance use crisis in their service area regardless of age, ability to pay, or location of residence. This includes children, adolescents, adults, and families.” Does this mean the main applicant must not have an age

limit or can the main applicant only serve a certain age group and have partnerships with organizations that serve patients outside their age catchment?

For example – we are an adolescent clinic only serving patients 10-26 years of age, however, we have established partnerships with organizations providing services outside these age ranges. Would we still qualify?

ANSWER: The SCSC must serve all recipients, regardless of age. All centers must serve children, adolescents, and families on-site. Only serving a specific age range would not be allowable per Part 600 Regulation. Per response to question #13, "It is important for CSCs to have processes and linkages in place through community partnerships to provide streamlined referrals to local providers and higher levels of care".

49. If based on our partnerships and referral sources we do not expect to see adolescents/youth - would we be able to make partnerships to serve youth through referrals?

    ANSWER: SCSCs must serve adults, children, and families. If they came to the Center, the Center must provide age-appropriate services at the SCSC on-site.

50. Psych/Medical contractors/referrals must be available 24/7?

    ANSWER: Partnerships must be established within the community to ensure referrals are available to all recipients for either next level of care or maintenance services following a crisis.

51. Can an SCSC-hosting agency refer to itself for the referral services, such as psychiatric evaluation?

    ANSWER: Yes.

52. Is animal-assisted therapy a permitted service allowable in the SCSC based on regulation and code for this type of facility?

    ANSWER: Part 600 regulation does not address animal assisted therapies. The Offices suggest investigating if the location will allow animals if dependent on building code, etc.

53. Can a person be admitted to an ICSC and SCSC in two consecutive days? Can a person be discharged and re-admitted the following day?

    ANSWER: An ICSC contains the services of a SCSC. This question seems to address the potential for a lack of discharge options. It is expected that CSCs have planned for and identified linkages for individuals across the treatment continuum. There is no prohibition for individuals receiving services at a CSC on consecutive days, but these circumstances should be examined based on access to services outside of the CSC. CSCs are not intended for longer term treatment.

54. May a SCSC provider discharge a client to an ICSC if clinically indicated?

ANSWER: See response to question #53.

55. Can individuals be readmitted to the program, or will that be part of pre-admission criteria?

    ANSWER: For readmission on subsequent days, see response to question #13. An individual may be seen in a SCSC multiple times during an individual crisis episode or across multiple crisis episodes, if there is demonstrated client need.

56. How do you foresee these centers distinguishing themselves from the Intensive Crisis Centers and how will they coordinate services with one another? Along with Short Term Crisis Respite?

    ANSWER: For the first part of the question, see response to question # 45. The SCSC model is part of an ICSC model. Part of the SCSC planning should include how the SCSC will coordinate with local services, including short term crisis respites. It would be up to the provider submitting their proposal to determine if a protocol or MOU would be in place with programs, including short-term crisis respites, for referrals.

57. To create more geographic coverage particularly for rural areas, is it allowable for an applicant to propose a telehealth kiosk in a rural area of its region to remotely connect with the SCSC?

    ANSWER: See Program Guidance for more information on how to apply for telehealth coverage. In addition to Program Guidance, CSC Telehealth Regulation and CSC Telehealth Guidance are currently being developed.

58. When a child needs to remain in the center for a period of time (hours or even overnight), is a parent required to be with them? What if the school or another agency drops off a child and the parent cannot be contacted? Can the Center hold the child until a parent can be reached and arrives?

    ANSWER: Yes, a parent or guardian is required to remain with the child at the SCSC where clinically appropriate. If a school or program brings the child to the SCSC to receive services, the staff member(s) should remain with the child until a parent or guardian is present. A school or another agency should not drop off a child without prior parent or guardian verbal or written consent. Refer to Program Guidance for more information.

STAFFING

59. Among the required staffing positions, can you please clarify which must be available 24/7, which can be on-call or available via telehealth, and which can be available on a referral basis?

ANSWER: Refer to Part 600 Regulation and Program Guidance for staffing requirements and telehealth guidance. CSC services are intended to offer in-person services; therefore, telehealth coverage may be utilized to supplement or improve but not replace in-person staff. CSC Telehealth Regulation and CSC Telehealth Guidance are currently being developed.

60. How many hours per day must the psychiatrist or psych NP be on site? Can they be available be telehealth or must they be on site during those hours?

    ANSWER: See response to question #59.

61. If operating in a rural area or area where psychiatrists/PNPs are difficult to hire, would it be acceptable to have a contracted services that can provide 24-7-365 telehealth capabilities? Or must they be onsite?

    ANSWER: The SCSC must have at least one Psychiatrist and/or Psychiatric Nurse Practitioner on-duty and available 24/7 per Part 600 Regulation. A Psychiatrist and/or Psychiatric Nurse Practitioner must either be on-site or on-call with the availability to come on-site as needed. Refer to Part 600 Regulation and Program Guidance.

62. Can you clarify if a CASAC must be on call or on site 24 hours?

    ANSWER: A CASAC must be on-duty and available at all times. See Part 600 Regulation for the definition of “on-duty”.

63. May a phase-in staffing plan be proposed and be in compliance with the regulation?

    ANSWER: The staffing outlined in Part 600 Regulation and statute are required for certification.

64. If the SCSC is in the same vicinity of the ICSC, can the SCSC leverage staff from the ICSC? For example, can a region’s SCSC and ICSC share a Medical Director and/or Program Director?

    ANSWER: There is nothing that precludes providers from sharing staff among agencies, as long as the Centers are in compliance with Part 600 Regulation.

ENVIRONMENT

65. What are the space requirements? How much space do we need? Any other criteria for space?

    ANSWER: Refer to the Program Guidance. The Offices were not specific on space requirements because we acknowledge the space size will vary based on projected volume for the given region.

66. What is minimum square footage for program?

    ANSWER: There is no minimum square footage. Please refer to Program Guidance.

67. The SCSC'S are similar to the living room model but servicing adults, children, adolescents, and families providing person centered trauma informed care. Can you tell me more about expectations for providing services in this type of setting for adults and children?

    ANSWER: Refer to the Program Guidance for more information on the service provision and environment in order to serve individuals across the lifespan.

PARTNERSHIPS

68. How can EMS be a source of referral? I understand that ambulances must bring patients to an ED or CPEP.

    ANSWER: Ambulances can get a waiver from DOH to transport recipients.

69. Do partnering entities (contracted or referred) have to provide 24/7 services?

    ANSWER: No.

GRANTS GATEWAY & SCORING

70. What is the policy for reviewers recusing themselves from reviewing an application if they have previously worked at a named applicant's agency?

    ANSWER: There is no official policy to address this. Reviewers are asked not to allow their familiarity with any particular applicant (whether it be through prior employment or state employ working knowledge of the applicant) to be considered. Scores are to be based solely on the question posed and how/what the applicant provides as response. There are numerous reviewers assigned to each application.

GENERAL

71. What is the citation for Part 600 regs?

    ANSWER:
    https://omh.ny.gov/omhweb/policy_and_regulations/proposed/omh600revised.pdf
72. Will the deadline be changed to reflect that the due date, 10/5, is the Jewish Holiday of Yom Kippur?

    ANSWER: Yes, the proposal date has been updated to 10/6/22.

73. When will webinar recording be publicly available?

    ANSWER: The Bidders Conference PowerPoint slide deck and webinar recording are currently available on the OMH and OASAS websites where the RFP documents are accessible. See here:

    https://omh.ny.gov/omhweb/rfp/2022/scsc/

    https://oasas.ny.gov/rfp/supportive-crisis-stabilization-centers

74. Will you be sending this slide deck out to us?

    ANSWER: See response to the question above.

75. What role will OMH and OASAS play in communicating the availability of these centers in the community? What role will OMH and OASAS play in educating crisis services and behavioral health providers in the communities where crisis stabilization centers are located about their existence and purpose? What role will NYC DOHMH play?

    ANSWER: On a local and regional basis, we are looking for the applicants to tell us how you are going to partner in the community to make local providers and services aware of the CSC. It is important for providers to tell us how you will make sure your community is aware of the services and the service availability.

76. Will agencies operating Crisis Stabilization Centers (CSC) have the main responsibility for developing referral relationships and educating the provider/consumer communities about this option for crisis care?

    ANSWER: Yes, the agencies operating CSCs will have those responsibilities. That is why it is important to identify partnerships in the development of a SCSC, to ensure there are clear pathways for referrals to and from the Center. Additionally, see response to question #75.

77. When and where can we find a list of the "recently awarded" Intensive Crisis Stabilization Centers?

    ANSWER: The ICSCs awardees have been released in the governor's public announcement. See here: https://www.governor.ny.gov/news/governor-hochul-announces-75-million-awards-develop-new-intensive-crisis-stabilization-centers

78. Can you please discuss what 'learning collaboratives' or 'learning communities' are currently in place?

    ANSWER: OMH and OASAS are in the process of developing learning collaboratives. Awardees will be notified of learning collaborative opportunities when they become available.

79. Award will be made approx. 11/22, with a contract start of 5/23. But capital funds can be used within 12 months of contract execution. Can you please explain that timeline?

    ANSWER: If you receive capital funds, there will be some flexibility in the operational timeline, but our expectation is that you move forward in an efficient way to use the capital funds and open your program as soon as possible.

80. Why are the answers to questions being posted so late?

    ANSWER: After the Bidders Conference, there is a deadline to submit additional questions to the procurement officer by 8/16/22. This timeframe allows attendees to ask additional questions and for others who may have not been able to attend the Bidders Conference to ask their questions. The Official Q&A is posted on 9/13 to allow the Offices time to answer all the questions that have been submitted up until 8/16/22, condense all the questions into one document, and then publish those questions on both of the OMH and OASAS websites.

81. SCSCs must contract with RH column, or are referrals only acceptable?

    ANSWER: Unable to respond because question is unclear.

82. Can a provider cite maximum number served?

    ANSWER: The Offices are not identifying a maximum number served.