Critical Time Transition Program for Children, Youth and Families
January 2025
RFP#OMH136
Questions & Answers

Q1. Regarding capital funding for a TRS site, must the applicant be the owner of the building, or is a long-term lease acceptable? If a long-term lease is acceptable, are there minimum lease terms? And what documentation is required, if any, at time of application submission?

A1. Ownership is preferred. Exceptions for the leasing of property may be considered, however, it is important to note that the funding model does not include additional monies for rent. On the contrary, however, capital is allotted for the purchasing of the property. Specific lease proposals will need to be reviewed. In general, however, a lease must be for a long enough term to cover the length of the DASNY bonds (25 years) and OMH program assurances (40 years). In addition, there must be default language that allows for uninterrupted use of the property for an approved mental health use.

Q2. As an Article 28 acute care hospital are we eligible to apply? We have housed many children in the past few years for months at a time. Does that meet the standard for qualify as providing inpatient care?

A2. Applicants for this RFP must provide all services and must meet all eligibility criteria detailed on page 5 of the RFP. Experience providing inpatient care is not a criterion for applicants.

Q3. As an Article 28 acute care hospital facility if we have underutilized space in the hospital setting that already incorporates some of the required specifications (i.e.; dedicated patient rooms with dedicated bathrooms and security measures to prevent elopement) would we be able to utilize this space or is the TCS required to be located in a residential setting?

A3. The Transitional Residential Setting (TRS) cannot be housed within a hospital. Please see page 24 of the RFP, including the expectation that the TRS is a home-like setting.

Q4. It appears that the requirement for placement in the TRS is to have a discharge setting identified prior to admission. Many of the children boarding in ED's require residential placement services. Are we required to secure a space in a residential setting before moving children into this program? Those processes are often delayed and take months at times to secure.

A4. At least one discharge setting needs to be identified prior to admission to both components of CTTP (CTI and TRS); the discharge setting does not need to be guaranteed, and it is recognized that the discharge setting may change during the 6-9 month course of treatment in CTTP.

Q5. Page 1 last paragraph suggests "some children/youth, and families /caregivers enrolled in the CTTP may also benefit from a stay in or participate in services in the TRS. Does this mean we would have to allow family members to stay with the children if they desired?

A5. No; families would receive the clinical services available from TRS staff but would not reside in the TRS.

Q6. Is it the responsibility of the Provider to train the staff on the CTI model of care? If so, can start- up funds as well as a portion of the budget, be allocated for staff training and ongoing consultation support?

A6. Training on the CTI model of care will be a joint effort between OMH and the CTTP provider; training is included in the start-up funding provided.

Q7. Does the Provider need a vehicle with a wheelchair lift? If so, can this expense be allocated under the capital budget of this program, and not within the start-up costs?

A7. A vehicle with a wheelchair lift is not a required piece of equipment, but an applicant may choose to include this in their application; a vehicle with a wheelchair lift is an allowable expense for start-up funding.

Q8. Can the TRS be located on the same campus as an existing Residential Treatment program?

A8. Yes.

Q9. Can there be co-mingling of OCFS and OMH youth in the TRS?

A9. The TRS will be provided solely to admitted recipients of CTTP; all recipients of CTTP are recipients of an OMH service.

Q10. The program hours of operation are listed as 24/7…The staffing model proposed is 1 FTE for most positions…How do we staff a position 24/7 with one person? Is the Provider able to share staff across their existing similar programs located on the same campus (Residential Treatment and Enhanced Respite programs, BH Clinic and CFTSS, etc.) due to the 24/7 operating hours?

- **In addition to the required staffing for the CTI team of 1 RN, can RNs be shared with another program, to achieve 24/7 coverage?**
- **The Provider has an Expressive Therapist employed in our Behavioral Health clinic…can the Provider utilize this staff within the CTTP?**

A10. Please see page 23 of the RFP: "The CTTP's support and interventions will include: access to 24/7 crisis support." This crisis support can be provided by CTTP staff and/or partnered crisis programs serving the CTTP catchment area, and not all CTTP staff are required to be on site 24/7.The onsite 24/7 staffing in the TRS is detailed on page 26 of the RFP: "The required direct staffing must include both direct care staff and senior direct care staff, with

adequate staffing for direct care counselors to stay in ratio of no less than 3 staff to every 8 youth on unit during awake hours and no less than 1 staff to every 4 youth overnight (with at least 1 staff awake). The budget should additionally include allowance for 1:1 supervision for youth who require it and allowance for a relief factor as needed". 24/7 RN coverage is not required. The Recreation/Expressive Therapist is a 1.0 FTE position, and allocating this staff to another program area would not be allowed. The recruitment and retention of staff that meet the staffing requirements of CTTP is determined by the CTTP provider.

Q11. The Expressive Therapist is a licensed position….does the Provider have any staffing latitude to put the recreation piece of the Expressive Therapist position with the .5 FTE Educational/Vocational Specialist and make that position 1 FTE, responsible for the Educational/Vocational duties as well as the recreational activities within the TRS?

A11. The Recreation/Expressive Therapist may be a professional or paraprofessional, and a Licensed Creative Arts Therapist is preferred. Please see page 26 of the RFP; the Recreation/Expressive Therapist is a 1.0 FTE position.

Q12. Is the Provider able to contract out with an agency specializing in Youth and Family Peer Advocacy services instead of employing a Family Peer Advocate directly?

A12. Yes. Please note that regardless of direct employment or contracting out, the total Peer Advocate staffing should total 2.0 FTE and be comprised of 1 Youth Peer Advocate and 1 Family Peer Advocate – a per diem staffing model would not be acceptable. Peer advocates are expected to be an integrated part of the CTTP team, working full-time with the CTTP, and receive all training for CTTP operation.

Q13. There is no Intake Coordinator listed as part of the staffing model – are the Case Managers expected to be the liaison between the hospital and the CTTP?

A12. CTI staff (Care Managers, Program Director and Educational/Vocational specialist) are expected to have access to the hospital and liaison with hospital staff.

Q14. When does the 120 day length of stay start? When the youth enters the CTI program or when the youth enters the TRS component of the program? Does 120 days cover both the CTI portion and the TRS portion?

- **If the youth enters into the CTI program, but does not enter into the TRS until after 120 days, does the CTI portion get extended? What happens to the youth once the 120 day length of stay is surpassed? Is there an expectation of after care?**

A14. The 120-day expectation is for the TRS only and is measured by the number of bed days in the TRS. Please see page 20 of the RFP for the expected six (6) to nine (9) month enrollment in CTTP. It is the responsibility of the CTTP to provide comprehensive discharge planning for recipients. [Regarding the question related to aftercare: due to lack of specificity, OMH cannot provide a response to this question].

Q15. The RFP eludes to a youth's guardian/community support being present at the time of admission into the CTTP…does the Provider not have to accept any youth that does not have a legal guardian identified? If we do have to accept a youth without a legal guardian, is the responsibility of finding that youth a guardian, ours?

A15. It is expected that CTTP providers accept youth into CTTP that meet the eligibility requirements listed on page 3 of the RFP. There is not a requirement that a youth have a legal guardian. The care planning meetings described on page 22 of the RFP include required entities such as LDSS/ACS and are designed to address and resolve dispositional issues for the enrolled youth.

Q16. On page 3 of the RFP, it states "For youth with other payors meeting eligibility criteria, it is expected that the CTTP seek Home and Community-Based Waiver services and Family of One Medicaid"….do we as an Agency have to become the Home and Community-Based waiver program or can we refer to an agency that already has this established?

A16. Home and Community Based Waiver Services (HCBS) can be provided by any designated HCBS provider.

Q17. On page 26 of the RFP it states "All eligible CTTP Team members are expected to obtain and maintain Transport for Evaluation (958) certification"…Are you expecting the Provider's CTTP case managers to obtain and be trained in the 958 transport certification? Are we able to use our current Psychiatric Nurse Practitioners to support this piece of the program?

A17. Page 26 of the RFP states "All eligible CTTP Team members are expected to obtain and maintain Transport for Evaluation (9.58) certification, as applicable". It is possible for CTI Case Managers to be 9.58 certified if they meet eligibility requirements. Roles and responsibilities of all staff in the staffing plan is a component of the RFP application, as is a balanced budget that includes personnel costs.

Q18. We are in the process of transitioning to a new EHR (this process won't be complete for another 2 years)…would NYS be willing to wait on the HL7 FHIR standard link being established until we are on the new EHR system? Can we allocate money in the budget for this purpose?

A18. Please see page 35 of the RFP: "Applicants who don't have EHRs that support FHIR® standard can also describe how they will securely submit data files to OMH Platform using a secure file transfer method (MFT Process, SFTP, etc.)". A&OH funding can be used toward EHR.

Q19. Pg. 16 of the RFP notes To support the provision of care for specialized populations, an additional 3 points will be added to the applications of those eligible applicants who currently have programs serving children/youth that are licensed or certified by both OMH and OPWDD; that is, if an eligible applicant has at least one program serving children/youth that is licensed by OMH and at least one program serving children/youth that is certified by OPWDD. This is different than the and/or detailed in the chart. Please clarify if an applicant must have BOTH OMH and OPWDD program or if it is in fact only one of these licenses.

A19. There was an error on the Bidders Conference slide deck. Eligible applicants may have programs licensed or certified by either OMH or OPWDD. To support the provision of care for specialized populations, an additional 3 points will be added to the applicants who currently have programs serving children/youth that are licensed or certified by both OMH and OPWDD.

Q20. Does the property purchase option have a total cap amount or it based on a per client formula? similar to the STTR program.

A20. There is not a cap amount; however, the cost per bed amount must be reasonable as it will need to be approved by the NYS Division of Budget. Purchase price must also be supported by a real estate appraisal and construction costs are required to ultimately be supported by a competitively bid through an invited bid process.

Q21. Can the TRS be located on the same campus as a residential treatment center?

A21. A State Aid Grant Lien will be on the TRS, and it is advised that the portion of land for the TRS be subdivided from the larger campus. Programmatically, it would not be a concern for a TRS and Residential Treatment Center to be located on the same campus.

Q22. Can you clarify how education services will provided to youth and what role will the CTTP provider play/be responsible for?

A22. Education services will be coordinated with youth's home school district, as led by the Educational/Vocational Specialist, and it is not expected that a teacher be on-site at the TRS.

Q23. What is the anticipated timeframe for initiation of services after award? Would CTI services commence right away or only when the TRS is in place, which can take significant time.

A23. CTI services would be expected to start up prior to the development of the TRS. The funding available prior to the opening of the TRS will cover staff allocated to the TRS to begin working with families and CTI funding, to be distributed upon contract execution and prior to the opening of the TRS.

Q24. If a purchase option is exercised, what happens to the property. does it get it get a deed restriction on its usage. Or only a SAGL.

A24. There would not be a deed restriction, but there would be a Program Assurances Agreement completed. This document essentially states that OMH is committed to assisting with the purchase/development of the property and that the program commits to using the property to provide mental health services for forty (40) years. There would also be a State Aid Grant Lien and a NYS Dormitory Authority Mortgage for the property.

Q25. I asked this question via email but asking here as well: Must the applicant own the building where the TRS is being proposed or is demonstration of site control acceptable? If site control is acceptable, are there specific terms (i.e., min number of years) or documentation required at application?

A25. Ownership is preferred. Exceptions for the leasing of property may be considered, however, it is important to note that the funding model does not include additional monies for rent. On the contrary, capital is allotted for the purchasing of the property. Specific lease proposals will need to be reviewed. In general, however, a lease must be for a long enough term to cover the length of the DASNY bonds (25 years) and OMH program assurances (40 years). In addition, there must be default language that allows for uninterrupted use of the property for an approved mental health use.

Q26. Will youth be eligible to receive CTTP services and other Medicaid services (i.e. CFTSS, HCBS, etc.) or would this be considered a duplication?

A26. Prior to the State Plan Amendment (SPA) approval, it is possible for an CTTP recipient to be co-enrolled in other Medicaid-reimbursed case management programs such as CFTSS and HCBS, if the program determines that there is not a duplication of services. Final allowable co-enrollment and associated reimbursement limitations will be shared in program and/or billing guidance to be issued prior to the start of Medicaid reimbursement.

Q27. Given the stepwise addition of program components and staff, should the proposed budget still cover a fully operational CTI/TRS program?

A27. The budget should cover all CTTP components.

Q28. Is budget 1 year or for full 5 year contract?

A28. The budget template is for a 5-year budget; year 1 funding would include an extra $100,000 for start-up costs.

Q29. Are there regulations regarding having OCFS kids and OMH kids (for example, if the TRS is on the same campus)?

A29. There are no current regulations for this program at this time.

Q30. Might kids in foster care qualify for this program?

A30. Yes.