Flexible Assertive Community Treatment
Adult Teams Round 2
RFP#OMH143
Questions & Answers

Q1. Could you please list the Counties that are associated with each region/area of the 12 Flexible Assertive Community Treatment (ACT) teams identified in the RFP?

A1. New York City Region counties: Bronx, Kings, New York, Queens and Richmond.

Hudson River Region counties: Albany, Columbia, Dutchess, Greene, Orange, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, Washington and Westchester.

Central New York Region counties: Broome, Cayuga, Chenango, Clinton, Cortland, Delaware, Essex, Fulton, Franklin, Hamilton, Herkimer, Jefferson, Madison, Montgomery, Lewis, Oneida, Onondaga, Oswego, Otsego and St. Lawrence.

Western New York Region counties: Allegany, Cattaraugus, Chautauqua, Chemung, Erie, Genesee, Livingston, Monroe, Niagara, Ontario, Orleans, Schuyler, Seneca, Steuben, Tioga, Tompkins, Wayne, Wyoming and Yates.

Long Island Region counties: Nassau and Suffolk.

Q2. For ACT Lite, is there an expectation that participants will complete the program within five years, similar to the traditional ACT model?

A2. Flexible ACT teams will follow the transition and discharge process in the ACT Program Guidelines (Section 5.5). Teams will develop a transition process to determine readiness for transition to a lower level of care from the Flexible ACT team. Flexible ACT teams are expected to engage in discharge planning conversations with all individuals. Because Flexible ACT is new to New York State, OMH will be monitoring Length of Stays for individuals served by Flexible ACT teams, from which any benchmarks for Flexible ACT can be explored.
Individuals who meet the following criteria should be considered for discharge: Receiving services voluntarily and request to be discharged from the Flexible ACT team; demonstrated stabilization and/or maintenance of symptoms; improved community integration and utilization of natural supports; demonstrated improvement of functional skills; connections to community services and linkage to care; effectively manages complex medication use; adequate support system (assessed by the team); work or daytime activities (assessed by the team); stable housing; stable financial situation; the individual accepts treatment and is able to ask for help; the individual is able to meet with the psychiatrist in the office rather than out in the community; and has established mental health services for treatment and care coordination outside of the ACT team to provide continued support the individual may need.

Q3. Is OMH approval required to transition a client between ACT Intensive and ACT Lite? If so, what is the process for securing that approval?

A3. OMH approval is not required. The Flexible ACT team will have the clinical discretion to determine when to move individuals between ACT (intensive) and ACT-Lite (less intensive) levels of service, based on each individual's needs and circumstances. The team must ensure the clinical justification and level of service is documented in the individual's record. OMH is not requiring a specific assessment tool or evidence-based tool be used but is required that there be input from the entire team when determinations are made.

Q4. Can you clarify the role of the Assistant Team Leader? Specifically, what is the expected balance between clinical and administrative responsibilities, how frequently are they expected to provide field-based services, and will they hold a specialist title within the team?

A4. A description of the Assistant Team Leader role can be found on page 7 of the Flexible ACT Program Guidance Addendum. The role of the Assistant TL is to assist the Team Leader in supervisory and administrative oversight of the team and provide direct services as a clinician. The ATL may provide supervision to ACT team staff but should not be solely responsible for the supervision of the team. 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.

Q5. In Section 5.3: "The Team will utilize clinical discretion to determine when to move individuals to ACT-Lite (less-intensive)" Is there a specific protocol that has been developed regarding clinical discretion? Is there a specific staff person/role that is empowered or designated to grant clinical discretion?

A5. See A3.

Q6. Would the state be open to reconsidering the exclusion criteria around time spent on moratorium in 2024? Many ACT providers experienced significant challenges with workforce resulting in moratorium, but if a team is now fully staffed and positioned to employ a flex Act model, would the agency not be eligible for this?

A6. Not at this time. We understand some ACT teams have experienced workforce challenges warranting the need for temporary moratorium. However, this procurement opportunity requires additional staff be hired - in addition to the full 68-size team - to serve as a Flexible ACT team, so for this reason, we are at this time making this opportunity available to teams without recent history of extended time on moratorium status, but we will keep an eye on the moratorium data moving forward.

Q7. Can all staff potentially see all intensity levels? If an ACT lite client is seen six or more times based on need, would billing for that client be at the act level for the month?

A7. Yes, any of the ACT staff can see any individuals whether they are receiving ACT (High Intensity) or ACT Lite services. In the event, you have an ACT-Lite individual that needs temporary increased support any given month and minimum contact requirements for the ACT (high intensity) level of service are met, the Full ACT rate may be billed for that month.

Q8. Can you share with us how many ACT teams would be eligible to apply for the opportunity?

A8. There are 63 eligible agencies throughout the state.

Q9. Q9. For Rest of State applicants, are we correct to assume that our service area can remain the same as our current 68 slot ACT team (within one county versus across the region)?

A9. Correct. The county or catchment that your team is currently licensed to serve, can remain the same as you expand into a 100 flexible team.

Q10. Can the team transition current ACT clients to ACT Lite, or must all ACT Lite referrals be new from SPOA?

A10. The team will transition individuals they currently serve into ACT Lite level of services, utilizing the clinical discretion of the team to identify individuals no longer needing an intensive level of support.

Q11. For ACT Lite, is there a requirement to see three different staff each month or is it ok to see 1-2? Is there a requirement to see a psychiatrist each month or is it ok to skip months based on need?

A11. There is flexibility on ACT Lite. The team will determine - based on the individual's needs - which staff and how many times a month they will be seen.

Q12. Can you share more about how the expected Medicaid revenue was calculated? Is there a formula that was assumed for visit mix for ACT and ACT Lite?

A12. The ACT models all contain region and team size specific model assumptions for Medicaid enrollment rate, the rate the billing threshold is met for enrollees, general occupancy, and the anticipated split between full and partial claims (partial includes step-down and inpatient). At the time of initial rate development for Flexible ACT rate assumes 64%, while downstate assumes 60% full claims, with the balance being partial. Note that all assumptions used in the methodology are subject to change based on real world utilization upon review of provider reported and claims data.

Q13. Can you explain what it means that a tie between applications would be decided on implementation?

A13. If two applications receive the same total score, the way OMH decides who gets the award is based on which applicant scored higher on the Implementation section of the RFP, which is the highest point value section.

Q14. Do you anticipate any more delays in agencies receiving their MHPD certificate?

A14. No. The timing for the EZPAR approval will be dependent on the readiness of the team; timelines may vary due to hiring, census, readiness of space, etc.