



Office of
Mental Health

Office of Addiction
Services and Supports

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Intensive Crisis Stabilization Center RFP Official Questions and Answers

ELIGIBILITY

1. We are an Article 28 facility with a behavioral health program. Our behavioral health program is currently applying for an Article 31 license. Do we qualify for the Intensive Crisis Stabilization Centers grant?

ANSWER: Eligible applicants must be not-for-profit agencies with 501(c) (3) incorporation *or* Public Benefit Corporations that have experience providing mental health and substance use services to persons with serious mental illness and/or substance use disorders.

Applicants shall include information needed to demonstrate that the provider is licensed, certified or otherwise authorized by OMH, OASAS *or* the NYS Department of Health (DOH); in compliance with the application certification requirements of the Offices; and in good standing at the time of certification approval. For more information on the certification application and approval process, please refer to the proposed regulations of Title 14 NYCRR Part 600 posted on the OASAS and OMH websites.

2. What does "otherwise authorized" by OMH, OASAS or NYS Health Dept. include?

ANSWER: The Offices can authorize programs in ways other than simply issuing an operating certificate. Contracted organizations provide funded services that are not subject to an operating certificate. Some providers have programs and services that are designated by the Offices. In order to be eligible for the RFP, your organization has to be certified, funded, or otherwise authorized by OMH, OASAS, or the NYS Department of Health.

3. The RFP states that eligible applicants are not-for-profit agencies with 501 (c) (3) incorporation that have experience providing mental health and substances abuse services to persons with serious mental illness. Our organization is a Public Benefit Organization created by New York State, it is not a 501 (c) (3), however it is also not a private, for-profit organization. Can you tell me if we would be eligible to apply for this solicitation?

ANSWER: You are eligible. Eligible applicants are not-for-profit agencies with 501(c)(3) incorporation or Public Benefit Corporations that have experience providing mental health and substance use services to persons with serious mental illness and/or substance use disorders.

4. As an OASAS only certified agency, are we ineligible for submitting an application for the Crisis Stabilization Centers RFP?

ANSWER: You are eligible. See response to question #1.

5. We wish to become a certified not-for-profit 820 residential treatment center for pregnant and postpartum women and are in the process of obtaining acceptance to become certified by the Department of Mental Health and OASAS. Would a 820 Residential Treatment Center be eligible to submit a proposal?

ANSWER: See response to question #1. Applicants must be currently certified, licensed or otherwise authorized.

6. Is (or will be) a Behavioral Health Urgent Care (BHUC) considered an Intensive Crisis Stabilization Center under Part 600?

ANSWER: See response to answer #1 regarding eligibility for this RFP. There are no crisis stabilization centers that are currently certified pursuant to Part 600 as that regulation has not yet been adopted by OMH and OASAS.

7. We are a nonprofit that provides housing and supportive health services for individuals living with mental health challenges. We are funded through both OMH and DOHMH to support transitional and permanent congregate residences along with hundreds of scatter site units.

We operate two Community Residence Single Room Occupancy provide services to formerly homeless men and women with a mental illness. They are licensed as the program subcategory "treatment program". We also operate six Supported Housing Programs which provide permanent housing to formerly homeless men and women with a mental illness and their families.

Are we eligible?

ANSWER: See response to question #1.

8. According to the RFP – Applicants shall include information needed to demonstrate that the provider is currently licensed, certified or otherwise authorized by OMH, OASAS or the NYS Department of Health; in compliance with the application certification requirements of the Offices; and in good standing at the time of certification approval.

We are not licensed, but are we certified or otherwise authorized by OMH?

ANSWER: See response to question #1. OMH and OASAS will review eligibility materials submitted with the proposal.

9. How is the possession of a valid operating certificate/license issued pursuant to either Article 31 or 32 of the Mental Hygiene Law or Article 28 of the Public Health Law related to operating an ICSC?

ANSWER: See response to question #1.

10. Can providers collaborate in submitting a proposal? If so, can providers be co-leads?

ANSWER: Yes, providers may collaborate on submitting a proposal, but there must be one provider or agency designated as the lead who will hold the Part 600 license and who will receive funding.

11. Can one provider be a lead with a subcontract to another provider?

ANSWER: See response to question #10.

12. Can multiple agencies join together and apply for this funding? If so, would there be 1 leading agency and then the others subrecipients?

ANSWER: See response to question #10.

13. Would all agencies, even subrecipients, need to meet the criteria of the eligible participants? For example, a peer agency that has licensed peers but not necessarily an OASAS license who may/may not have OASAS funding?

ANSWER: The lead agency or provider being licensed will need to meet the eligibility requirements described in the RFP and the response to question #1. The applicant's response to the RFP shall demonstrate in the proposal that services will be provided by qualified staff based on Proposed Part 600 Regulation.

14. Does Article 31 status or "for profit status" eliminate us from submitting for this RFP?

ANSWER: See response to question #1.

15. Is a licensed OMH provider who subcontracts with a licensed OASAS provider, eligible for this grant?

ANSWER: See answer to question #1 for more information on eligibility. See response to question #10 on provider collaboration.

16. Will new providers be considered? Or will only currently funded programs be considered. If new providers are being considered, what are the chances that they will be awarded? Just trying to

gage whether it is wise to apply if we would be a new provider. We offer many of these services and have for years but have not applied for this funding stream previously.

ANSWER: There are no preconceived awardees. The pool of applicants is open for all as long as you meet the eligibility requirements. See response to question #1.

17. Will you accept joint proposals as a partnership of more than one agency?

ANSWER: See response to question #10.

18. Does the person opening the program, does the owner, need to have some kind of license as in LMHC or any of that to apply?

ANSWER: To apply, the program needs to meet the eligibility criteria. See response to question #1.

19. Could LGUs in region join together and submit a regional proposal?

ANSWER: There is nothing that precludes this but there needs to be one identified provider that will hold the license. See responses to questions #1 and #10.

20. Regulations that govern the operation of a ICSC and thus the planning in the RFP, (Title 14 Part 600) states: “(d) The Governing Body shall comply with all requirements set forth in 10 NYCRR Part 405 as well as requirements established by appropriate local, State and Federal standard-setting bodies.” Part 405 are “hospital minimal standards” and covers 45 regulatory sections. Does this statement mean that the ICSC has to comply with the section related to Governing Body (Title 10 Part 405) only?

ANSWER: Part 600 was amended to reflect compliance with 405.2 only.

21. Must a proposal serve adults, children, and adolescents to be funded?

ANSWER: Yes.

22. Can a proposal that does not propose to serve each population (adults, children, adolescents) be funded?

ANSWER: A proposal that does not serve all populations will not meet eligibility criteria.

23. Is Behavioral Health Care Collaborative (BHCC) consisting of OMH and OASAS providers an eligible agency? Would this BHCC that does not have a 501(c)(3) determination letter from the IRS be an eligible agency if all of its members are 501(c)(3) entities?

ANSWER:

Per the answer to question #10, there must be one provider or agency designated as the lead who will hold the Part 600 license and who will receive funding. With respect to a BHCC or IPA the Offices would expect a member provider to submit the proposal consistent with the eligibility requirements listed in the response to question #1.

24. Would a 501(c)(3) entity that is not a BHCC and not an OMH or OASAS provider be an eligible agency if all of its members are licensed agencies?

ANSWER: See eligibility criteria in response to question

LICENSING

25. Will there be an ability in the future to establish a “satellite” off of an existing Crisis Stabilization program and if so, would any deficit funding that is currently received be potentially adjusted to reflect increased scale/operations through the satellite. For example, there is a need for Crisis Stabilization Model in in Eastern Suffolk given the geographical barriers and expansiveness of the County. Be establishing a satellite, one could leverage the established infrastructure and would be an overall savings for the system and meet the needs out East which various stakeholders are in support of.

ANSWER: At the present time, we are not envisioning “satellite” Crisis Stabilization Centers. Our current focus is on getting Centers established and operational. That is not to say we may not entertain the idea in the future but at the time, satellite CSCs are not an option.

26. When can it be expected that agencies will be able to apply for the Part 600 Intensive Crisis Stabilization Center licensure?

ANSWER: The licensure process can begin as soon as soon as the Proposed Part 600 Regulation is adopted and/or as soon as practicable thereafter.

27. If awards resulting from this RFP are made in October 2022, when is Part 600 licensure expected?

ANSWER: See response to question #26.

28. If an organization is licensed by both OASAS and OMH (separate licenses) is it considered to have a jointly issued operating certificate?

ANSWER: No, this program will be the first program that will be a jointly licensed by OMH and OASAS.

29. If an agency already has an IOS license, does it cover for this program as well?

ANSWER: No, it does not.

30. If an organization currently only serves children through preventive services, but serves adults and families through both Article 31 and 32, can children be added to the jointly issued operating certificate that the organization will apply for upon grant award?

ANSWER: The expectation is that all ages will be served by the ICSC. There are not age designations for crisis stabilization centers as there may be for other certified or licensed programs.

31. If an organization is currently an Article 31 and an Article 32 but does not yet have an operating certificate to serve children, can it apply for the grant and work on getting the operating certificate to serve children? The organization currently serves children under preventive services.

ANSWER: See responses to questions #1 and #30. ICSCs are a new program type, requiring certification pursuant to the proposed Part 600 Regulation.

32. Can an organization with a pending application for OASAS licensure apply?

ANSWER: See response to question #1.

33. On page 22 of the RFP, it states "ICSCs will be jointly licensed, monitored, and overseen by OMH and OASAS, in accordance with Title 14 NYCRR Part 600." However, the Regulation read as though a non-profit may be licensed as either or both OMH or OASAS. Please clarify.

ANSWER: The proposed Part 600 Regulation is jointly issued by OMH and OASAS.

34. Will OASAS and OMH provide joint Regulation, or will there be 2 sets of Regulation for this level of care?

ANSWER: See response to question #33.

POPULATION

35. Does OMH have any expectations regarding the number of individuals served by an ICSC?

ANSWER: There are no specific expectations, but the ICSC must meet the needs of the service area. Needs of service area may be determined or projected based on demographic data. Data analysis will help the Center to assess capacity over time.

36. Is there a specific client volume that operators are expected to aim for/meet?

ANSWER: See response to question #35.

37. Does OMH have any expectations regarding the outcomes of individuals served by ICSC?

ANSWER: Yes. Refer to section 5.4 of RFP.

38. Is it required to serve children and adults? Can a proposal only serve adults? Having children and adults in one facility (separately of course) could still pose logistical challenges and could be traumatic for children.

ANSWER: ICSCs must serve both children and adults. All spaces for children must be separated. Refer to the Proposed Part 600 regulation and Program Guidance for more information.

39. Do you need to serve all populations: children, adolescents?

ANSWER: Yes.

AWARD LOCATION/ CO-LOCATION

40. Given that there is one Crisis Stabilization Center that will be funded on Long Island through this RFP process, is it fair to say that Nassau County is more of a priority?

ANSWER: Review RFP language section 1.1. There will be one Center awarded on Long Island.

41. Are there any designated economic development areas in WNY and how many are considered for WNY?

ANSWER: Refer to section 1.1 of RFP which identifies which counties are in each of the economic development regions.

42. If the BHUC does not fall under Part 600, would it be considered a duplication of service to have a Part 600 Intensive Crisis Stabilization Center and a BHUC in a County?

ANSWER: This RFP is funding ICSCs as authorized pursuant to the standards established in Proposed Part 600. The Offices do not legally recognize “BHUC” as a licensed/certified program type.

43. If the ICSC will be co-located with other services (i.e., crisis residence) – can common areas like kitchens/living areas be shared (with adults and children remaining separate)?

ANSWER: Centers may be co-located with existing facilities and service providers, consistent with any applicable CMS and regulatory requirements. For example, Part 589 Crisis residences would be unable to share space with another program [Crisis Residence Program Guidance - 6/2/2021 \(ny.gov\)](https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/2016/docs/2016-09-14_shared_space_guide.pdf). More information would be needed to answer this question. Please review guidance the following guidance at https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/2016/docs/2016-09-14_shared_space_guide.pdf

44. Can you share staff between the ICSC and other programs that might be co-located within the same building?

ANSWER: Yes - provided program regulatory staffing requirements are otherwise met. See response to question #43.

45. Will you consider models that house both the ICSC with a respite unit in the same building?

ANSWER: See responses to questions #43 and #44. Proposals need to meet Proposed Part 600 regulatory requirements.

46. What if you have services in more than one economic development area?

ANSWER: There is an expectation that a Center can serve individuals not just across counties, but across Economic Development Regions (EDRs). For the purposes of this RFP and the funding distribution, OMH and OASAS will consider the applicable EDR to be the one where the Center is physically located.

47. Is the expectation that the centers will cover the entire region, or can it cover only a few of the counties within a region?

ANSWER: Your proposal should describe which counties would be served if awarded.

48. Will serving all counties within a given region make a respective proposal more competitive than not serving all counties within the region?

ANSWER: The Offices will award the strongest proposal per EDR. See response to questions #46 and #47.

49. Given the mix of counties that have complex individual needs across an identified economic development region, would you consider applications that have a hub and spoke model with multiple providers in a collaborative?

ANSWER: The application has to meet the standards of the Proposed Part 600 Regulation. We do not see an opportunity for a hub and spoke model based on the Regulation currently available. Development of the ICSC needs to be consistent with the proposed and ultimately adopted Regulation.

50. Can an ICSC be co-located with a SAMHSA CMHC?

ANSWER: See response to question #43.

51. Are patients in crisis allowed to access a center in a region other than their own?

ANSWER: Yes.

52. Will the locations of existing crisis stabilization centers within a region be taken into account when evaluating the proposed location of the new Intensive Crisis Stabilization center (so that the "coverage" within the region is maximized)?

ANSWER: There are currently no "existing" Crisis Stabilization Centers certified/licensed in NYS pursuant to Part 600. Therefore, for purposes of this RFP, all ICSCs will be new to a region.

53. Given the logistics of NYC, is the expectation to award a center in the Bronx or Manhattan, one in Brooklyn or Queens and one Staten Island?

ANSWER: Review RFP section 1.1. There will be up to 3 awards within the NYC Economic Development Region.

54. Our service area crosses over a couple of different economic development zones. Is it better to submit for one economic development zone and serve any NY State resident who needs crisis intervention services (even though they come from different economic development zones), or should two applications be submitted? Is one approach viewed more favorably than the other?

ANSWER: See response to question #46. It's acceptable if your service area crosses an EDR designation. It is up to the provider how many proposals to submit – an application should be submitted for each proposed ICSC.

55. Do we have to have a location determined and/or secured before applying?

ANSWER: Without an identified location, the Offices would be unable to perform an adequate review of a proposal submitted pursuant to the requirements of this RFP.

56. In responding to question-prompt 6.2b, if a Provider/applicant has a pending Statewide Health Care Facility Transformation Program III grant application that could influence the site of the proposed stabilization center, would OASAS and OMH prefer the applicant to provide detailed information about BOTH the default plan (if our organization does NOT win that grant, leading to one type of co-location) AND the alternative grant-win plan (leading to a different locality and more enhanced co-location arrangement)?

Answer: In both of the above cases, if the proposed co-location will be with a Certified Community Behavioral Health Clinic (CCBHC) that the Provider/applicant's own organization administers, would you like the Provider/applicant to indicate that the TYPE of co-location being planned does NOT require a PARTNERSHIP with an outside organization. Please describe all possible scenarios.

Fiscal and Billing

57. Page 33 – it is stated "Note that administrative costs cannot be more than 15%." Is this referring to a cap on the indirect rate? Or is this saying that administrative functions in the PS line items cannot

amount to more than 15% of the total budget? My organization as a federal NICRA of 26%, so we're wondering if we would be allowed to use that for this application?

ANSWER: The indirect cost, administrative overhead, has been capped at 15%.

58. If a provider has multiple projects for this type of service currently underway, can they submit an application for more than one community and use the total funds between the multiple Intensive Crisis Stabilization Centers if awarded? Or would there need to be separate applications for each one, and if so, is that allowed?

ANSWER: There will be one award for each EDR. There is an expectation that the funds be expended in that region to establish one Center.

59. Can OMH describe the methodology for which annual expected Medicaid revenue was projected (Section 5.5)? Is there a projected number of individuals with services provided that form the Medicaid revenue assumption? Is there a percentage of program participants who are Medicaid eligible that formed the Medicaid revenue assumption?

ANSWER: OMH reviewed a payor mix for programs of similar modalities and target population to generate an estimated Medicaid enrollment rate then applied it to the total gross model program costs.

60. Is Medicaid billing expected to flow through the clinic?

ANSWER: No, Medicaid billing will be specific to services offered at a Crisis Stabilization Center. See Rates provided in #66.

61. What kinds of expenses are allowable start-up expenses?

ANSWER: Typically, start-up expenses can include but are not limited to: costs associated with the recruitment and training of staff, purchase computer equipment, office supplies, furniture as need for program, etc. No construction or renovation costs can be paid for with Start-up funding.

62. Is the \$1.4M of annual net deficit provided if the agency bills the full Medicaid revenue or is the \$1.4M of annual net deficit support provided only if the agency isn't able to bill the expected full Medicaid revenue?

ANSWER: All ICSCs must have the ability to bill – net deficit will be provided but billing is expected and will be evaluated based on state oversight processes.

63. Please explain how net deficit support will be provided.

ANSWER: If net deficit, or State Aid, support is provided, it will be through a contract with the grantee/provider.

64. How is the anticipated Medicaid revenue calculated? What is the number of uninsured individuals is a large percentage of those served?

ANSWER: OMH reviewed a payor mix for programs of similar modalities and target population to generate an estimated Medicaid enrollment rate then applied it to the total gross model program costs. State aid is provided for indigent care.

65. Given the regional approach to development of an Intensive Crisis service, will transportation services to/from be an allowable use for the deficit funding?

ANSWER: Any Transportation costs would have to be deemed reasonable and budgeted for in the program budget.

66. Is acquisition funding available? Is rent included in the budget?

ANSWER: Acquisition is not an eligible expense for the capital or operating funding available through this RFP. Rent should be included in the operating budget.

67. We are considering locating the program in an existing medical office space and leasing it for the 5-year term of the grant. Is this allowable, rather than purchasing a building? If a lease is allowed, can the lease be paid for using funds that would have been used for building purchase? If a lease is allowed, could the fit-up costs for the space be paid for using funds that would have been used to fit up a purchased building?

ANSWER: A long term lease is required to be in place at minimum 25 years with stipulations to be discussed at time of award.

CAPITAL FUNDS

68. If the ICSC will be co-located with other services, but the whole building will be renovated, can the capital be used for the whole building?

ANSWER: The capital funding can only be used to renovate the ICSC space.

69. If there is a current project underway to provide these ICSC services, can the capital money be used to pay on past expenses that were occurred before the contracting in October of 2022?

ANSWER: Capital funding cannot pay on expenditures made prior to the capital contracting date.

70. Is there a preference for this to be a stand-alone building or co-located with different levels of treatment (i.e., outpatient, crisis residence, etc.)?

ANSWER: The Offices have no preference.

71. If awards resulting from this RFP are made in October 2022, when will capital awards be made?

ANSWER: Applicants receiving an award through this RFP will have the opportunity to work with the Bureau of Housing Development and Support (the Bureau) to develop a scope of work and budget which the Bureau will use to support a funding request to the NYS Division of the Budget (DOB).

72. When is it anticipated that capital awards will be contracted?

ANSWER: Capital contracts will be submitted for execution once the Bureau receives DOB approval.

73. Will a separate application be required for a capital award? How will OMH determine the amount of capital awarded to each project?

ANSWER: Through the development of a scope of work and budget estimate.

74. If a provider has 12 months to complete its capital project (“Note these funds may not be used for acquisition and must be expended within 12 months of the award”), how will the ICSC be operational by January 2023?

ANSWER: As long as the awardee is moving forward to become operational, OMH and OASAS can be flexible based on when capital funds are awarded and distributed.

75. Is an applicant required to have site control to apply under this solicitation?

ANSWER: No.

76. Can an applicant be awarded under this solicitation if they do not have site control by the application due date?

ANSWER: Yes.

RATES

77. Is there any indication on what the proposed rates for this service will be?

ANSWER: See below for draft rates.



**Office of
Mental Health**

OMH DRAFT Crisis Stabilization Rates

Regional Rates*

Crisis Stabilization Centers		
Rate Code	Downstate (represents NYC, Nassau, Suffolk, Rockland, Westchester, Putman) All other counties are upstate.	Effective 4/1/2022*
4630	Intensive Crisis Stabilization Center - Brief (Upstate)	\$581.30
4630	Intensive Crisis Stabilization Center - Brief (Downstate)	\$666.48
4631	Intensive Crisis Stabilization Center - Full (Upstate)	\$1,162.59
4631	Intensive Crisis Stabilization Center - Full (Downstate)	\$1,332.95
4632	Supportive Crisis Stabilization Center - Brief (Upstate)	\$413.21
4632	Supportive Crisis Stabilization Center - Brief (Downstate)	\$484.43
4633	Supportive Crisis Stabilization Center - Full (Upstate)	\$826.43
4633	Supportive Crisis Stabilization Center - Full (Downstate)	\$968.85

*Crisis stabilization rates as displayed are reference rates pending Centers for Medicare and Medicaid Services and NYS Division of Budget approval.

78. Are there calculated Medicaid rates for an ICSC program?

ANSWER: See response to question #77.

79. Do we have a draft rate and structure of the Medicaid funding yet?

ANSWER: See response to question #77.

80. What are the billing rates? Are there partial rates if someone access services for only a few hours?

ANSWER: See response to question #77.

81. What constitutes a Medicaid billable service?

ANSWER: Follows guidelines of the State Plan Amendment.

82. Are services billed fee-for-service or is there a day rate?

ANSWER: See response to question #77.

83. How are the rates established for this type of program?

ANSWER: Through the state-rate setting process.

84. How did OMH derive their Medicaid revenue assumption? Can you breakdown the payments or billing codes?

ANSWER: OMH reviewed a payor mix for programs of similar modalities and target population to generate an estimated Medicaid enrollment rate then applied it to the total gross model program costs.

85. Can you say more about the MD revenue expectation of \$2.57M per year? Where can i find the billable services/rates?

ANSWER: See response to question #84.

86. Will commercial insurance be required to pay for the crisis service?

ANSWER: As of 2021, New York State regulated commercial insurance policies are required to cover medically necessary outpatient services provided in licensed Crisis Stabilization Centers.

87. Do the commercial insurance requirements include self-funded plans?

ANSWER: Generally speaking, pursuant to 29 U.S.C. § 1144(a), ERISA plans are exempt from state laws regulating insurance. This includes the law referenced above in the response to question #86.

88. What about Medicare? Do we know if it will pay for these services?

ANSWER: Medicare does not cover these services. The Offices would strongly support Medicare coverage.

89. Can the ICSC provider bill Medicare, MCOs or private insurance for ICSC services?

ANSWER: See responses to questions #86-#88.

90. Is MCO authorization required for ICSC services?

ANSWER: No prior authorization will be required.

91. What if an individual presents with IDD related issues, what is the expectation; is there an ability to bill in such circumstances?

ANSWER: Billing is based on the amount of time an individual is being served by the ICSC. See response to question #77.

92. Are follow-up calls or contacts Medicaid billable? Please provide billing codes.

ANSWER: Follow-up calls are part of the per-diem rate at this time.

93. We are a CCBHC. If a client has already been seen at a CCBHC location (and the daily rate billed), are we able to also bill for services the same day as the Crisis Center?

ANSWER: Providers can bill for both services.

94. What about billing if a client is currently enrolled in PROS, ACT, and/or Health Home? Billing for those is based on the total monthly activity and not same day services.

ANSWER: Individuals enrolled in PROS, ACT, and/or Health Homes can be served at an ICSC, and their services billed for accordingly. CSC services will be billed using the guidelines of the State Plan Amendment. See draft billing rates above, question #77.

95. If the draft/final Part 600 (or other guidance) is silent on the matter, is a Care Coordinator reimbursable through the specified funding streams that OASAS/OMH lays out in the RFP, including the Medicaid funding stream?

ANSWER: Billing is based on the amount of time an individual is being served by the ICSC. See response to question #77 and Proposed Part 600 Regulation.

SERVICES

96. What's the definition of mild to moderate detox?

ANSWER: See definitions of mild to moderate detox in Program Guidance.

97. For moderate detox, is there an expectation that physical exams and lab studies would be performed?

ANSWER: Refer to Program Guidance.

98. Are there any evidence-based practices that's available for adults and children's programs to assist in planning for treatment and staffing ratio?

ANSWER: A variety of organizations have published best practices and/or recommendations for Crisis Stabilization Center operations that may be consulted. The Crisis Stabilization Center Program Guidance document will also be a tool to reference when submitting your proposal.

99. Is there a length of stay requirement?

ANSWER: Individuals may receive services at an ICSC for up to 24 hours.

100. What are the repercussions to have a patient on site for over 24 hours if we are still working to mitigate the crisis i.e., managing mild withdrawal or still looking for connection to housing?

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

101. Can Pediatric services be located/operated separately from adult (separate buildings)?

ANSWER: No.

102. Are transitional peer support services allowable to support follow-up after discharge from the ICSC?

ANSWER: Yes. Refer to Program Guidance.

103. Are parents required to stay on site at the ICSC the entire time?

ANSWER: Refer to Program Guidance.

104. If a parent or guardian leaves a child at the ICSC, must CPS be contacted?

ANSWER: Centers should develop policies and procedures to address the care of minors.

105. Incident Reporting: the RFP and Regulation say reporting must be done through NIMRS, but is there also a requirement to report directly to OASAS for certain incidents? If so, where can we find that information?

ANSWER: More information will be coming regarding Incident Reporting and management. A single process will be established subject to OMH/OASAS joint oversight.

106. Is there a definition of “acute” mental health and/or substance use? To what extent is the ICSC expected to serve an individual experiencing “acute” mental health and/or substance use before hospitalization (in-patient crisis, etc.) is considered the appropriate level of care?

ANSWER: Assessment of the recipient upon presentation will help determine if the ICSC is the appropriate level of care.

107. In addition to open access and walk-in services, would the state allow a telehealth triage as a permissible service to address the expansiveness of the geographical region, reduce disparities, ease access to care, and enable more effective coordination?

ANSWER: No, ICSCs are meant to provide in-person crisis services. Crisis Stabilization Telehealth Guidance is still under development.

108. Are we able to provide any services virtually? (Especially with the context of having to provide services to the region and imagining that a location in the city would be a barrier to care for those living in rural locations).

ANSWER: Crisis Stabilization Telehealth Guidance is still under development.

109. Do all of the required services have to be provided in the same location?

ANSWER: Yes.

110. Can some of the required services be provided through a partnership or contract with another provider?

ANSWER: All required services must be provided on-site. ICSCs may contract with other providers and agencies to offer those services on-site.

111. Are we able to provide mobile services in order to expand the reach beyond the four walls of the center?

ANSWER: ICSCs do not include a mobile component.

112. To what extent does the comprehensive assessment required by the ICSC model mirror the comprehensive assessment required by the CCBHC model, in order to assure appropriate reimbursement and to minimize undue duplication of assessment for consumers who may use both services? (The related underlying question is: can qualified staff of an ICSC awardee organizations that are also designated CCBHCs conduct a single comprehensive assessment during a consumer's 23-hour stay at the Crisis Center that will also be valid for the consumer's potential subsequent enrollment in CCBHC services – or, instead, based on potential variations in the requirements of such comprehensive assessments, will the CCBHC be required to conduct an entirely new multi-page comprehensive assessment with the client when they are subsequently admitted to the CCBHC (in order to meet CCBHC rules and regs)? The response to this question will help plan for the clarity of workflow, efficiency and the most consumer-centered process possible.

ANSWER: Assessments utilized by an ICSC with a service recipient must meet the requirements identified in the Proposed Part 600 Regulation and Program Guidance.

STAFFING

113. Please clarify the definition of “on duty” and “available at all times”.

ANSWER: Per Part 600 revised rule, on-duty is defined as:
Proposed Part 600.4(a)(18): On duty, for purposes of this Part, shall include the individual being physically present or on-call and available which includes the ability to come on-site as needed.

114. Title 14 NYCRR Part 600 does not define “on duty”. Please provide the definition of “on duty” as it relates to ISCS staffing.

ANSWER: The definition of on-duty has been included in the revised rule, Part 600.4. See response to question #113.

115. On duty requires the provider to “come to the site if needed.” What circumstances would trigger the necessity of an on-site appearance by the on-duty provider?

ANSWER: The provider must respond on-site as clinically indicated.

116. May on duty staff be available solely through telehealth?

ANSWER: No.

117. Given the disperse nature of the NYS Economic Development Regions, will telehealth be a permanently allowable and billable service for the ICSCs?

ANSWER: Telehealth is not a service; it is a service delivery modality. Telehealth will be permanently allowable and billable. Crisis Stabilization Telehealth Guidance is still under development.

118. Does a telehealth on-call arrangement with CASACs, Licensed Mental Health Professionals, Registered Nurses, Psychiatric Nurse Practitioners and Psychiatrists meet the requirement to offer walk-in services 24/7, 365-days per year so long as the center is open and staffed 24/7, 365 days per year?

ANSWER: Preference is for services to be available in-person. Staffing plans may include on-call arrangements. Applicants should describe any such arrangements which would be utilized to meet the staffing requirements in their proposal.

119. Psych. NPP, CASAC, & Cert. Peers & RNs are very high demand across healthcare right now... any flexibility on that "on-call & available" - could they consult via phone/telehealth?

ANSWER: See response to question #113 for the definition of on-duty. Crisis Stabilization Telehealth Guidance is still under development. Refer to Proposed Part 600 Regulation and Guidance.

120. There is mention of 24/7 prescriber coverage – does that mean they have to be on-site 24/7 or can there be a 24/7 on call/telehealth system?

ANSWER: Part 600.11(f) prescribing professionals shall be on-duty or on-call at all times. Prescriber coverage may be provided via telehealth provided other New York State and federal laws, rules and regulations allow for the patient to be examined and the required medication prescribed via telehealth.

121. The RFP states ‘At least one Psychiatrist or Psychiatric Nurse Practitioner, a Credentialed Alcoholism and Substance Abuse Counselor, and a Certified or Credentialed Peer Specialist on-duty and available.’ Does the Psychiatrist have to be on site all the time? Or on call?

ANSWER: See proposed Part 600 revised rule and response to question #113 for the definition of “on-duty” per Part 600.

122. Can the prescriber be available on call instead of on site to meet the 24-hour requirement?

ANSWER: See response to #120.

123. Does the prescriber have to be physically present the whole time (24/7) or can they be “on duty” as in – available via telehealth and/or to come in as the need arises?

ANSWER: See response to #120.

124. Page 5 of the RFP states that services must be provided by staff...” including but not limited to Peer Specialist and Advocates, Credentialed Alcoholism and Substance Abuse Counselors (CASACs), Licensed Mental Health Professionals, Psychiatric Nurse Practitioners and Psychiatrists.” Please confirm that only a Psychiatric Nurse Practitioner or a Psychiatrist is required for the staffing pattern?

ANSWER: The crisis stabilization center shall have at least one Psychiatrist or Psychiatric Nurse Practitioner.

125. Neither the RFP nor Part 600 provide a definition of “Medical Director”. Is there a definition for “Medical Director”? Is this expected to be a full-time position?

ANSWER: See Proposed Part 600.11 Regulation and Program Guidance.

126. “Centers must ensure services are delivered in a comfortable and welcoming environment by staff from various disciplines, including but not limited to, Peer Specialists and Advocates, Credentialed Alcoholism and Substance Abuse Counselors (CASACs), Licensed Mental Health Professionals, Psychiatric Nurse Practitioners and Psychiatrists.” “Staffing numbers will be based on the needs of operating a 24/7 facility and will reflect demographic data obtained on the service area.” Are each of these positions required for the staffing plan? Are each of these positions required 24/7, 365 days per year, or is on-call and/or telehealth staffing permitted?

ANSWER: Yes, each of the positions listed are required for the staffing plan. Refer to Proposed Part 600 Regulation.

127. Does OMH have a proposed staffing ratio for an ICSC?

ANSWER: Staffing ratio is to be determined by the ICSC based on service area data.

128. Is there a minimum staff to client ratio?

ANSWER: See response to question #127.

129. Is there any requirement for including addiction medicine providers in the staffing matrix? I see psychiatry, but I do not see addiction medicine.

ANSWER: Refer to Proposed Part 600 Regulation.

130. The bidders' conference stated that there "must be staff 24/7 who has training in child and adolescent development and behavioral health." Please describe the level of training which is required (i.e., a bachelor's degree in adolescent development/behavioral health, etc.)?

ANSWER: Refer to Program Guidance.

131. Question-prompts 6.1b and 6.1f (Equity section) use the term "organizational positioning" in regard to requests for applicants to describe characteristics associated with individuals tasked with reducing disparities in client access and outcomes. In this context, what is OMH's/OASAS's definition of "organizational positioning" and how might such definition differ from the individual's title, job role, education, and relevant experience?

ANSWER: Organization positioning refers to the level that the individual(s) responsible for leading the organization's activities related to reducing disparities in client access and outcomes is. Ideally, the individual(s) should be positioned in a role that is management level and able to drive progressive change across the organization. The definition should not differ from the individual's title, job role, education or relevant experience.

132. Question-prompt 6.1.ha asks about current staffing levels of "administrative staff members" who are from or have experience working with the most prevalent cultural groups of...service users. In this context, does OMH/OASAS refer chiefly to executive-level upper management level administrative personnel (i.e. those individuals who oversee the "supervisors" referenced in this same question-prompt) or chiefly to clerical, task-oriented administrative support staff who work in non-client-facing support roles such as finance, bookkeeping, scheduling and "administrative assistant"-type roles? (Please explicitly define "administrative staff" members in the context of this question-prompt)

ANSWER: “Administrative staff members” refers to clerical staff across the entire organization, as opposed to just upper management level administrative personnel. There should be focused attention and efforts on recruiting and retaining staff who are from or have experience working with the most prevalent cultural groups of the service users being served at all levels across the organization.

133. For the last part of question-prompt 6.1ha, can OMH/OASAS please clarify a typo / confusing conclusion to the prompt, here it says, “& efforts to retain diverse employees use of best practice approaches to mitigate biases in interview/hiring processes.” Should the word “including” be added between “employees” and “use” ... or is OMH/OASAS asking applicants to focus its response to the last portion of this complex question-prompt differently?

ANSWER: Yes, the word “including” should be added between employees and use.

134. Can you speak to your specific expectations regarding the DEI section of the RFP, particularly around "stakeholder input"?

ANSWER: “Stakeholder input” means input from a diverse cross section of service users, community members and other entities with knowledge about the mental health crisis service system. The Offices cannot provide specific information about how to answer the questions. We are looking for the strongest proposals possible.

ENVIRONMENT

135. Are there any required room types for the ICSC? For example, are sleeping/rest quarters required?

ANSWER: Refer to Program Guidance Premises section for more information on layout and environment.

136. The length of stay “24 hours” seems very unrealistic. In other states, the length of stay is 7-10 days which seems much more manageable. Can this be changed? That’s not enough time for someone to sleep, let alone get billing information and referrals started.

ANSWER: Length of stay is up to 24 hours as this is an outpatient service, not residential. Refer to Program Guidance.

137. Are there any minimum square foot requirements for the ICSC? What does OMH foresee to be the average square footage of an ICSC?

ANSWER: There is no average square footage. Space will need to be large enough to provide all services in a safe, comfortable environment. Refer to Program Guidance Premises Section.

138. Will the ICSC design require beds or chairs?

ANSWER: There are no specific requirements that address beds or chairs. Recipient comfort and physical layout should be taken into consideration. Refer to Program Guidance.

139. Do we have a maximum/minimum "bed" count requirement?

ANSWER: See response to question #138.

140. Services can be provided for up to 24 hours, doesn't that require beds?

ANSWER: See response to question #138.

141. Can you clarify how individuals would be served through crisis stabilization if there are no beds?

ANSWER: See response to question #138. For further reference, the Offices recommend looking at how Crisis Stabilization Center programs are designed across the country.

142. I know the RFP gives some info about layout/facility (separate entrance for Law enforcement). I am wondering if there is any additional guidance or best practice recommendation regarding layout, total square footage, etc.

ANSWER: Proposed Part 600 Regulation and Program Guidance do not include recommendations for total square footage. Size of location and layout should reflect needs of the service area. Refer to Program Guidance premises section and question #141.

143. Regarding 'observation' and space-allocation criteria for mild-to-moderate detoxification services, what are the minimum requirements regarding the arrangement, separation, and/or amount of physical space allocated to this function?

ANSWER: See response to question #142.

144. Can there be one shared entrance for children and adults? (Separate waiting and treatment areas)?

ANSWER: Yes.

145. Is an ICSC required to have security on site?

ANSWER: No, there are no security requirements. An ICSC may choose to have security available on-site.

146. Based on the most current draft of Part 600 (or other guidance), does OASAS/OMH advise that the ICSC needs to provide separate spaces for men and women (i.e., people who self-identify as male and people who self-identify as female) for mid-to-moderate detoxification services? Or is a single such space across gender-identification acceptable?

ANSWER: No, we do not require separate spaces based on gender or gender identity.

PARTNERSHIPS

147. Are letters of support, linkage agreements, or MOUs required to be submitted to demonstrate “partnerships with other agencies within the crisis response system, including but not limited to mobile crisis providers, crisis residences, Supportive Crisis Stabilization Centers, law enforcement, EMS, and other community treatment and support services?

ANSWER: Letters of support are not required but may be submitted as part of the RFP proposal and will be required as part of the certification process. The Offices strongly encourage providers to consult with LGUs prior to proposal submission. See Proposed Part 600 Regulation and Program Guidance for more information on linkage agreements and MOUs.

148. Will there be an expectation of close collaboration with law enforcement so as to facilitate jail as well as ER Diversion?

ANSWER: Yes.

149. Are letters of support and/or commitment required in this application? If not, are they allowed?

ANSWER: Not required but allowed. See response to question #147.

150. Are collaborative partnerships encouraged in this model?

ANSWER: Yes.

151. Given that there may be more than 100 entities interested in applying to this RFP (based on attendee list), how do you envision all of us collaborating with the LGU/OMH/OASAS field offices in the development of our proposals? Have you identified and can share preferred contacts at each of these public entities for discussion?

ANSWER: Collaborative resources include consulting with the OMH field offices and OASAS regional offices. Contact information to the OMH field offices and OASAS regional offices and regional coverage are available on the OMH and OASAS websites. If you were to reach out to either the OMH Field office or OASAS regional office, we trust that they would cooperate within their own counterparts, so you do not need to reach out to both. Additional collaborative resources are available through the Conference of Local Mental Hygiene Directors (CLMHD).

OMH Field Offices:

<https://omh.ny.gov/omhweb/aboutomh/fieldoffices.html>

OASAS Regional Offices:

<https://oasas.ny.gov/providers/regional-offices>

Conference of Local Mental Hygiene Directors:

http://www.clmhd.org/contact_local_mental_hygiene_departments/

152. Will the relevant government agencies provide help in finding linkages/placements for clients following their 24-hour ICSC stay? It can be very difficult to make those kinds of linkages so quickly, especially if working with both the adult and pediatric networks of aftercare services, which are completely separate.

ANSWER: Demonstration of linkages and partnerships should be included in the proposal, refer to Section 5.3 of the RFP (page 23). Additionally, See Proposed Part 600 Regulation and Program Guidance.

153. Are there any community needs assessments that we can review to understand the unique needs of each region?

ANSWER: Examples of community needs assessment include local services plans through CLMHD. Other community assessments may be available through the OMH field offices and OASAS regional offices, the Departments of Health and LGUs.

154. Would OMH & OASAS like to see (uploaded via the Grantee Document Folder) any Letters of Commitment or Memoranda of Agreement/Understanding... or would you prefer that such agreements be mentioned / briefly referenced in the relevant narrative responses? (Is there a preference for Letters of Commitment vs. MOUs/MOAs for any specific types of partners that are enumerated in the RFP?)

ANSWER: Applicants need to put together the strongest application they can that will demonstrate their ability to develop and operate an ICSC. The Offices encourage proposals to include anything along those lines (MOUs/MOAs, Letters of Commitment) that can help further the goal of successfully operating an ICSC. Additionally, see response to question #147.

155. Under which section in the "Technical Evaluation" will letters of support contribute to the scoring? How many letters of support are required to obtain full points?

ANSWER: Letters of support will not contribute to scoring. The submission of these letters should be considered voluntary and there is no consideration of points to be given.

156. What would constitute an appropriate relationship with a contracted OASAS provider?

ANSWER: See Proposed Part 600.9 Regulation.

GRANTS GATEWAY

157. The OMH Procurement Opportunities website for this RFP indicated the due date as 4/21/2022, but the RFP and the Grants Gateway indicate it is 5/19/2022. Please confirm which is correct.

ANSWER – The due date of the proposals for the RFP is 6/09/2022 at 3:00 PM.

158. A question related to the Grants Gateway: Are Program Specific Question responses limited to 4,000 characters or are attachments with narrative longer than 4,000 characters permitted?

ANSWER: Please refer to the instructions given in the “Instructions/Introductory Text” box in the Program Specific Questions section.

159. In submitting responses via Grants Gateway, when an applicant chooses to upload a specific response (vs filling in the textbox), is the applicant allowed to include tables or graphs (which wouldn't format easily in a textbox) AND/OR may the applicant periodically exceed the 4,000-character textbox limit in such uploaded responses where SLIGHTLY more explanation is needed to concisely but thoroughly answer all parts of a more multi-part question?

ANSWER: An applicant can choose to respond within the 4,000-character textbox or upload a response, but the caveat is that the answer must be succinct and specific to the question. Responses should answer the question without going off into tangents. In the days of paper RFP submissions, number of pages were typically limited to around 20. Moving into the Gateway, we are no longer allowed to limit responses, other than through the 4,000-character box, because we found it to be restrictive. The most important thing is to make sure your answer is succinct. Make sure you also put “see attached” in the text box if you do choose to use an attachment. If you do not put something in the text box, you will get an error message. You may attach charts, tables, or graphs when applicable to answering a question.

160. This is a nuanced, not a duplicate question, aimed at facilitating the least complicated reviewing experience by the reviewers. If a Provider/applicant chooses to use the 4,000-character textbox responses for about 2/3 of the question-prompts BUT will use the Upload option for the remaining 1/3 of question-prompts (which request [a] lengthier, more detailed response[s] than can fit within the 4,000 characters), will the reviewers' experience be made easiest (for them) if the Provider/applicant simply types “See attached” in the relevant 1/3 of textboxes, where the uploads accompany. OR, will the reviewers' experience be made even easier (more flowing), if the Provider/applicant elects to simply UPLOAD EVERY response, regardless of brevity or length (e.g., for consistency of how the REVIEWERS see and access the responses)? In this latter scenario, the Provider/applicant will simply type “See attached” for ALL responses. We are aiming to get an understanding of how complicating/distracting it feels to reviewers when the response pattern alternates between textbox responses and “See attached” responses (vs. all textbox responses or ALL uploaded responses).

ANSWER: There is no opportunity to provide both a response within the 4,000-character text box and provide an upload. This is an either/or option. An applicant can choose to respond within the text box OR respond through providing an upload. If choosing to upload, applicants must type “See Attached” in the response box. An applicant cannot respond using both formats.

It is up to the applicant to determine how they will respond – either through the 4,000-character limit text box or with an upload. The scoring process is not affected by which method an applicant chooses to utilize.

NOTE: if an applicant chooses to provide an upload and not respond in the 4,000 character limit text box, the response must be succinct and specific ONLY to the question being posed. The response must be explicit to the question. If using an upload, applicants are cautioned to ensure that reviewers are not searching for response to the question due to the fact that an upload may provide a more expanded response. As part of the score, applicants can take into account any part of the upload that is not responsive to the exact question being posed.

161. In looking at the Grants Gateway, in sections 6.11-6.4b of the “Program Specific Questions” there is a limit of 4,000 characters per answer. Is that the max space we should use to answer those questions? Alternately, we see there is also the option of uploading an attachment with each answer; is that where we should be answering the questions, instead? (And if so, what is the character/page limit for those docs?)

Any insights into how detailed/succinct you want us to answer the questions would be very helpful - as we could respond to these questions in one page or 10 pages, depending on how much detail you'd like.

ANSWER: See Response to question #160.

162. Are applicants free to use the Grantee Document Folder to upload supporting information that the applicant feels would strongly convey capacity of the applicant to succeed in launching and sustaining the Crisis Stabilization Center (assuming such supportive information is not requested/submitted elsewhere in the application)?

ANSWER: There are 2 spots on the upload properties page where you can provide additional documentation that is not specifically asked for in another question. You may have to scan several documents altogether because there are only 2 document placeholders altogether. It is suggested to include a cover page to explain what the documents are if you choose to upload several documents altogether.

163. For required Attestations Numbers 4 and 5, unlike Attestations 1 through 3, Grants Gateway does not provide a “Yes/No” pull-down menu but instead requests a response in up to 4,000 characters. Does OMH/OASAS request that providers/applicants simply type in “Yes” if they agree with this attestation?

ANSWER: For all of the Attestation questions, the applicant should type “Yes” in the response box if they agree with the Attestation and “No” if the applicant does not agree.

164. For question prompt 6.7b, which has a Grants Gateway character limit of only 250 (compared to 4,000 for most other prompts), does OMH/OASAS prefer providers/applicants to simply type “See

Attached” and to then address all parts of this question (including “Describe how your agency manages its operating budget”) within the uploaded Appendix B1?

ANSWER: as indicated in the Instructions/Introductory Text box, the response to this question requires the upload of the Budget Narrative (Appendix B1). The construct within the Gateway requires the upload but does not require a response in the 250 character limit text box.

165. Does the Excel spreadsheet template provided in the Pre-Submission Uploads (Appendix B) exclude any/all planned expenditures for the separate Capital Project Funds (up to \$1 million) that are referenced in Section 6.4.1 and 6.4g question-prompts of Grants Gateway? OR [how/where does OMH/OASAS wish providers/applicants to include expenses pertaining to such capital project within Appendix B (the 5-year Budget referred to in 6.7a)?

Are providers/applicants correct in understanding that “up to \$1 million” set aside for Capital Project Funds are entirely separate (and excluded from) the “start-up funds totaling \$1.67M” that are referenced in question-prompt 6.7a?

With regard to Grants Gateway question prompt 6.4g, does OMH/OASAS wish providers/applicants to use this response as the only response (i.e. the only form/field/attachment) within the entire application whereby applicants are expected to address the proposed costs pertaining to the separate Capital Project funds? Is there any separate budget form beyond the budget narrative and timeline response requested in prompt 6.4g that applicants should prepare and upload to address the proposed Capital Project expenditures?

ANSWER: The excel template is for start-up funding only. Once an applicant receives an award through this RFP, they will have an opportunity to work with the Bureau of Housing Development and Support to access capital funds, of up to \$1 million if needed, to modify program space to meet the requirements of Title 14 NYCRR Part 600. The only response regarding capital funds expected is for Question 6.4 g.

166. The Bidders’ Conference stated that letters of support were permitted. Where should letters of support be uploaded in Grants Gateway?

ANSWER: There is a Placeholder spot on the Pre-Submission uploads page that allows for applicants to provide any additional documentation that is not a required component of the RFP.

167. What documents are acceptable to upload into the “placeholder” sections under the Pre-Submission Uploads? Can you provide some examples of what you might be looking for?

ANSWER: There is no prescribed, expected, suggested document(s) for these placeholders. As stated in the Gateway – “In the event applicant wants to provide supporting documentation not otherwise required by the RFP”

WEBSITE

168. When providers/applicants are answering Question-prompts in Grants Gateway associated with sections 6.3 (Description of Program) and 6.4 (Implementation), and with the related RFP instructions on page 29 and page 30 that say “Responses should be consistent with the Crisis Stabilization Program Guidance but should not be a reiteration of the Guidance. Responses should describe how your agency would meet these areas following the Crisis Stabilization Program Guidance”, **what is the most direct way for providers/applicants to assure that they are accessing the complete and most updated documents available that comprises what is referred to by the OMH/OASAS as the “Crisis Stabilization Program Guidance”?**

ANSWER: Refer to OMH and OASAS links in section 1.1 of the RFP.

169. Throughout the RFP, when the term “Crisis Stabilization Center Program Guidance” is used, and when guidance instruction “See Section 1 of this document for a link to the draft guidance” appears, are providers/applicants correctly understanding that the most updated “draft guidance” is the document currently titled at the top “A new Part 600 is added to Title of the NYCRR to read as follows,” and which is accessible (at the time of this Q&A exchange” at this named link: https://omh.ny.gov/omhweb/policy_and_Regulation/proposed/omh600.pdf

ANSWER: Proposed Part 600 Regulation has been updated and is posted on the OMH and OASAS websites. Draft Program Guidance is in the process of being finalized for publication and will be posted on the OMH and OASAS websites when complete. See response to question #168.

170. As of the publishing of the Q&A for the Intensive Crisis Stabilization Centers (ICSC) funding opportunity, anticipated on or about 4/28/22, can OMH/OASAS please clarify the most updated status of the following statement (and regulatory guidance) indicated on pages 5-6 of the RFP: “The Offices anticipate Title 14 NYCRR Part 600 will be re-posted for public comment by February 2022. The reposted Crisis Stabilization Program Guidance will be released at a later date and will be available using the links below:

Title 14 NYCRR Part 600:

https://omh.ny.gov/omhweb/policy_and_regulations/

<https://oasas.ny.gov/legal>

Crisis Stabilization Program Guidance:

<https://omh.ny.gov/omhweb/bho/crisis-intervention.html>

<https://oasas.ny.gov/legal>

ANSWER: See response to question #169.

171. Can OMH/OASAS please clarify if there are any more granular, specific URLs, web links or sub-web pages/sub-directories that are incorporated more deeply within each/any of the landing-page links named in the RFP on page 6 that link more directly into the most updated Crisis Stabilization Program Guidance available?

ANSWER: Draft Program Guidance was not available at the time of the Bidder's Conference but will be made available as soon as possible.

SUPPORTIVE CSCs

172. Will the State also be releasing an RFP for the Supportive Crisis Stabilization Centers? If so, when is it anticipated this request to be released?

ANSWER: This RFP is only for the development of Intensive Crisis Stabilization Centers. At the moment, there is no RFP for the development of Supportive Crisis Stabilization Centers. An RFP for Supportive CSCs is anticipated to be released Summer 2022

173. Is the RFP application out now only for ICSC's? If so, when do you expect the RFP to be released for the SCSC's?

ANSWER: See response to question #172.

GENERAL

174. What type of zoning designation does OMH foresee an ICSC being classified as? Our municipality does not have a specific zoning designation for this type of program.

ANSWER: The Offices are unable to advise. OMH and OASAS do not determine zoning designations and recommend the applicant reach out to their municipality for assistance.

175. When is construction expected to begin?

ANSWER: ICSCs are expected to be operational by January 2023.

176. What is the project budget or firm value?

ANSWER: The award amount is determined by provider submitting the proposal. Per Section 5.5 of the RFP, start-up funds will be allocated up to \$1.67 million and may be spent over two years. State Aid is \$1.2 Million. Ongoing net deficit funding and capital funding will be made available to applicants awarded pursuant to this RFP.

177. Are union bids required?

ANSWER: Unrelated to this RFP.

178. Performance Measures are also grantee-defined and should reflect some measurable benchmark(s) in order to demonstrate adequate progress within 18 months of the award date, as required by the RFP (Pg. 11). What benchmarks are specifically expected to be accomplished within 18 months of award?

ANSWER: Please Refer to reporting, quality improvement and utilization review section of the RFP.

179. Will there be a recording and slides from the Bidders Conference be shared?

ANSWER: Yes, slides and recording are available using the following link:
<https://omh.ny.gov/omhweb/rfp/2022/icsc/index.html>

180. Will the Bidders Conference slides be available to print?

ANSWER: See response to question #179.

181. Does OASAS see these centers as a replacement for open access centers, and or will those continue to be allowed to operate?

ANSWER: No, crisis stabilization centers are not a replacement for Open Access Centers.

182. Will you provide a list of existing respite programs to work with?

ANSWER: This is an opportunity to reach out to your local Director of Community Services to begin discussions on what resources already exist within your given region. Additionally, see response to question #151.

183. Are we able to get access to any assessment reports or input from the public that was used to develop the RFP?

ANSWER: There are no public facing documents that were used to develop the RFP. See response to question #151.

184. Do you anticipate future opportunities for the development of additional ICSC's if one per economic development region proves to be insufficient to meet the region's need?

ANSWER: The Offices will evaluate this first phase of development before considering future opportunities.

185. What data sets did NYS use in developing the utilization assumptions that led to the funded budget? Can providers look at that data in developing responses to the RFP?

ANSWER: See response to question #84. The data used for utilization is not public.

186. Is the program required to provide meals?

ANSWER: The ICSCs are not required to provide meals but are allowed. Refer to Proposed Part 600 Regulation and Program Guidance.

187. What are the key differences between the ICSCs proposed in the RFP and the Comprehensive Psychiatric Emergency Services Program (CPEP)?

ANSWER: ICSCs are jointly licensed by OMH and OASAS and offer voluntary services for all New Yorkers for up to 24 hours. ICSCs have specific staffing and programmatic requirements licensed under Proposed Part 600 Regulation.

Comprehensive Psychiatric Emergency Programs (CPEPs) are licensed by OMH, offering emergency services that are embedded within hospitals that have inpatient programs. CPEPs offer both voluntary and involuntary services. CPEPs have specific staffing and programmatic requirements under Part 590.

188. For the Grants Gateway Work Plan Overview form, what start date and end date does OMH/OASAS prefer to see indicated for this Intensive Crisis Stabilization Center project?

ANSWER: See section 2.13 of RFP – “The Work Plan Period should reflect the anticipated contract period. Contracts will be approved for a five-year term”. The anticipated award contract date is 10/1/22.

189. Page 25 of the RFP states: “EHR is expected to have an HL7 FHIR/CCDA/CSV or similar web service for seamless direct integration of data.” Can we have more information on what is expected: what system are we integrating with? What is the timeframe for data to begin to be submitted? Where would the CSV data drop be if we do not create a direct HL7 connection?

ANSWER: The Interoperable solution/system envisions to minimize the data collection burden. During the implementation phase, we expect to meet with providers to develop the best solution for data submission and we will be working with providers to develop a plan for monthly reporting, expected once programs are up and running.

190. When are proposals due?

ANSWER: June 9, 2022. The RFP timeline was updated in February 2022. The RFP publication does not reflect these changes, but you will find the updated timeline as an announcement on both the OMH and OASAS websites below. The updated timeline is also reflected in the Grants Gateway.

OMH Website

<https://omh.ny.gov/omhweb/rfp/2022/icsc/index.html>

OASAS Website

<https://oasas.ny.gov/funding/intensive-crisis-stabilization-centers>