U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services (CMS)

Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act: Section 1003
Demonstration Project to Increase Substance Use Provider Capacity

Notice of Funding Opportunity Type: New

Funding Opportunity Award Type: Cooperative Agreement

Notice of Funding Opportunity Number: FON

CFDA: 93.664

Notice of Funding Opportunity Posting Date: June 25, 2019

Applicable Dates

Letter of Intent to Apply Due Date: July 18, 2019

Electronic Application Due Date: August 9, 2019

Anticipated Issuance Notice(s) of Award: September 30, 2019

Anticipated Period of Performance: September 30, 2019 to March 29, 2021

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EXECUTIVE SUMMARY

The Centers for Medicare & Medicaid Services, in consultation with the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Agency for Healthcare Research and Quality (AHRQ), is conducting a 54-month demonstration project to increase the treatment capacity of providers participating under the Medicaid State plan (or a waiver of such plan) to provide substance use disorder (SUD) treatment and recovery services. The purpose of this notice of funding opportunity is to solicit applications for participation in the Demonstration Project to Increase Substance Use Provider Capacity under the Medicaid program.

Item	Description
HHS Awarding Agency	Centers for Medicare & Medicaid Services
CMS Awarding Center	Center for Medicaid and CHIP Services
Notice of Funding Opportunity Title	Demonstration Project to Increase Substance Use Provider Capacity
Authorization	Section 1903 of the Social Security Act (42 U.S.C. 1396b) as amended by section 1003 of the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act
Funding Opportunity Type	New
Funding Opportunity Number	CMS-2C2-19-001
Type of Award	Cooperative Agreement
Catalog of Federal Domestic Assistance	93.664
Letter of Intent to Apply Due Date (if applicable)	July 18, 2019
Application Due Date & Time	August 9, 2019
Anticipated Issuance Notice(s) of Award	September 30, 2019
Anticipated Period of Performance	September 30, 2019 to March 29, 2021
Anticipated Total Available Funding	$50 million
Estimated Number of Awards	At least ten (10)

A. PROGRAM DESCRIPTION

A1. Purpose

The purpose of this notice of funding opportunity is to solicit applications for participation in the Demonstration Project to Increase Substance Use Provider Capacity under the Medicaid program.

A2. Authority

Section 1003 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act amended section 1903 of the Social Security Act (42 U.S.C. 1396b) in 2018 to include a new subsection that requires the Secretary of the Department of Health and Human Services, in consultation with the Assistant Secretary for Mental Health and Substance Use (SAMHSA) and the Director of the Agency for Healthcare Research and Quality (AHRQ) as appropriate, to conduct a 54-month demonstration project to increase the treatment capacity of providers participating under the Medicaid State plan (or a waiver of such plan) to provide substance use disorder (SUD) treatment or recovery services.

SAMHSA and AHRQ will consult with CMS on three statutorily required reports to Congress: an initial report; an interim report; and a final report. In addition, AHRQ, in consultation with CMS, will submit to Congress a statutorily required summary of experiences of states awarded planning grants and of states conducting demonstration projects.

A3. Background

Impact of SUD

Substance use disorders (SUD) impact the lives of millions of Americans including individuals enrolled in the Medicaid program. They occur when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, and/or home. In 2017, approximately 19.7 million people aged 12 or older had an SUD related to their use of alcohol or illicit drugs in the past year. An estimated 2.1 million people had an opioid use disorder (OUD), which includes 1.7 million people with a prescription pain reliever use disorder and 0.7 million people with a heroin use disorder.[1]

Over the past decade, the United States has experienced significant increases in rates of opioid-related emergency department visits and hospitalizations,[2] neonatal abstinence syndrome (NAS),

[1] SAMHSA. (2018) Key Substance Use and Mental Health Indicators in the United States: Results from the 2017 National Survey on Drug Use and Health (HHS Publication No. SMA 17-5044, NSDUH Series H-52). Rockville, MD: Center for Behavioral Health Statistics and Quality, SAMHSA. Retrieved March 15, 2019 from https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2016/NSDUH-FFR1-2016.htm#summary

[2] HHS. (2018) Testimony from Brett P. Giroir & Kimberly Brandt on Tracking Opioid and Substance Use Disorders in Medicare Medicaid, and Human Services Programs before Committee on Finance. Retrieved March 19, 2019 from https://www.hhs.gov/about/agencies/asl/testimony/2018-04/tracking-opioid-and-substance-use-disorders-medicare-medicaid-hhs-programs.html

and pregnant women with OUD.[3] Most alarming are the continued increases in overdose deaths, especially the rapid increase since 2013 in deaths involving illicitly made fentanyl and other highly-potent synthetic opioids.[4] Medicaid beneficiaries have been disproportionately affected by the opioid epidemic, accounting for roughly half of all opioid-related overdose deaths in some states. The introduction of less expensive, more potent opioid alternatives, such as fentanyl, has also resulted in a higher risk of overdose for Medicaid beneficiaries.[5]

Treatment for SUD, including OUD, is mostly provided by specialty facilities that typically offer some combination of SUD services such as detoxification, pharmacotherapy, individual and/or group psychotherapy, and other psychosocial services in one or more settings (i.e. inpatient, residential, or outpatient).[6] However, according to one recent study, 40 percent of counties in the United States do not have an addiction treatment facility that provides outpatient care and accepts Medicaid. This lack of treatment capacity is most prevalent in rural counties in southern and mid-western states and in areas with a higher proportion of racial and ethnic minorities.[7]

Over the past decade, new trends and approaches have emerged in the SUD treatment field. Practitioners in generalist settings are beginning to screen for hazardous substance use patterns and potential disorders. Such screening now occurs in hospitals, emergency rooms, ambulatory clinics, and other medical and non-medical settings.[8] States are integrating recovery models into SUD treatment approaches that incorporate person-centered planning, peer support,[9] case management, and other home and community-based services and social supports that are used to address an individual's environment and provide emotional and practical support to maintain recovery.[10] Further, many states are implementing opioid prescribing guidelines and some states are making non-opioid pharmacologic and non-pharmacologic pain management therapies available within their Medicaid programs in order to prevent opioid use disorders while ensuring effective pain management for people with chronic pain.[11]

Recent SUD Initiatives

CMS has issued recent guidance and information on opportunities to design service delivery systems for individuals with SUD, including a new opportunity for demonstration projects approved under section 1115 of the Social Security Act (Act) to ensure that a continuum of care

[3] CDC. (2018) Haight SC, Ko JY, Tong VT, Bohm MK, Callaghan WM. Opioid Use Disorder Documented at Delivery Hospitalization — United States, 1999–2014. MMWR Morbidity and Mortality Weekly Report: 67:845–849. Retrieved on May 28, 2019 from http://dx.doi.org/10.15585/mmwr.mm6731a1
[4] See 2
[5] MACPAC. (2018) Access to Substance Abuse Treatment in Medicaid. Retrieved on May 28, 2019 from https://www.macpac.gov/wp-content/uploads/2018/06/Access-to-Substance-Use-Disorder-Treatment-in-Medicaid.pdf
[6] Cummings JR, Wen H, Ko M , et al, *Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the United States*, JAMA Psychiatry, 71(2): 190-196 (Feb 2014)
[7] Cummings JR, Wen H, Ko M, et al, Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the United States, JAMA Psychiatry, 71(2): 190-196 (Feb 2014)
[8] SAMHSA. (2006) Report to Congress: Addictions Treatment Workforce Development Retrieved on May 28, 2019 from https://www.samhsa.gov/sites/default/files/partnersforrecovery/docs/Report_to_Congress.pdf
[9] For more information on Medicaid coverage of peer supports see: SMDL #07-011
[10] SAMHSA. (2019) Recovery and Recovery Support. Retrieved on May 28, 2019 from https://www.samhsa.gov/find-help/recovery
[11]CMS. (2019) : Non-Opioid Pharmacologic and Non-Pharmacologic Chronic Pain Management" available at: https://www.medicaid.gov/federal-policy-guidance/downloads/cib022219.pdf

is available to individuals with SUD.[12,13] Some states that have received CMS approval for an SUD section 1115 demonstration under this initiative are using this demonstration as an opportunity to reexamine and significantly increase Medicaid reimbursement rates for SUD treatment providers, which may significantly increase the number of SUD providers participating in Medicaid and beneficiaries' access to treatment. For instance, during the first year of implementation for the Virginia demonstration, the number of outpatient practitioners billing for SUD services increased by 173 percent, the number of Medicaid beneficiaries accessing SUD services increased 57 percent, treatment rates for beneficiaries with SUD increased by 64 percent, and the number of beneficiaries who received medication assisted treatment (MAT) increased 34 percent. In addition, the number of emergency department visits related to SUD decreased by 14 percent, while the number of emergency department visits related to OUD decreased by 25 percent.[14] Additional information on the opportunity available to states under section 1115 demonstrations, as well as several other sections of the SUPPORT Act, is provided in Appendix I, "Crosswalk between § 1003 and Selected Medicaid Opportunities Addressing the Opioid Epidemic."

Need for Increased SUD Provider Capacity

Increasing Medicaid provider capacity is essential to expanding access to SUD treatment for Medicaid beneficiaries. The need for SUD providers with expertise and skills to provide SUD prevention, early detection, and whole-person treatment and recovery services is evident. In 2017, the Office of the Assistant Secretary for Planning and Evaluation (ASPE) published a final report that summarized financing and workforce policies that can be used by states to expand treatment access and capacity for OUD, focusing on MAT.[15] The report described five workforce barriers: 1) Not enough physicians with a U.S. Department of Justice Drug Enforcement Administration registration and a buprenorphine waiver; 2) Provider access in rural areas; 3) Lack of support for small, non-specialist physicians; 4) Lack of infrastructure to support treatment; and 5) Stigma and knowledge gaps among providers related to recognizing and treating SUD, including a belief among some providers that MAT is a replacement addiction treatment rather than a treatment.

While section 1003 of the SUPPORT Act focuses on increasing the treatment capacity of providers participating under the state Medicaid program to provide SUD treatment or recovery services, we recognize that Medicaid providers' willingness to treat individuals with SUD may also be a barrier to treatment. There are many providers who could provide treatment for SUD but may be unwilling to do so. The 2017 ASPE Report indicates that, although providers recognize the dangers of the opioid epidemic, many providers do not recognize OUD in their patient population, have significant misunderstanding about treating SUD, and may believe

[12]CMS. (2017), SMD #17-003 Strategies to Address the Opioid Epidemic. Retrieved on May 28, 2019 from https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf
[13] CMS. (2019) Medicaid Innovation Accelerator Program (IAP), Opioid Data Analytics Cohort Retrieved on May 28, 2019 from https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/program-areas/reducing-substance-use-disorders/index.html
[14] Virginia Department of Medical Assistance Services,VCU. (2018) Addiction and Recovery Treatment Services Evaluation Report. Retrieved on May 28, 2019 from https://hbp.vcu.edu/media/hbp/policybriefs/pdfs/ARTSone-yearreport_8.9.18_Final.pdf
[15] ASPE. (2017), State and Local Policy Levers for Increasing Treatment to Address the Opioid Epidemic Final Report. Retrieved on May 28, 2019 from https://aspe.hhs.gov/system/files/pdf/259511/SLlevers.pdf

MAT is a replacement addiction treatment rather than a treatment.[15]

In a recent report to Congress, SAMHSA highlighted a major challenge to expanding the SUD treatment capacity in any setting (that is, an SUD specialty facility or other health care setting)—the shortage of providers with sufficient experience, certification, and/or education to serve individuals with SUD.[16] This finding was further evidenced in a June 2018 HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) Issue Brief on *Substance Use Disorder Workforce* that identified workforce barriers to accessing SUD treatment services that also included a lack of institutional and clinician peer support, provider stigma, and inadequate or burdensome reimbursement.[17] In addition, there is geographic variability in the training, qualifications, and licensure of SUD treatment providers. States and localities have varying requirements with respect to clinical staffing in SUD treatment programs. SUD licenses and certificates tend to be state-specific. States may also have additional specific continuing education course requirements for credentialing and licensing.[18]

Key Terms

This Notice of Funding Opportunity (NOFO) uses many acronyms throughout. All acronyms are defined at first mention in the text and can be referenced in the Glossary (Appendix H).

Throughout this NOFO, "applicant" refers to the state applying for the funding opportunity, and "recipient" refers to the state selected to receive the cooperative agreement.

Section 1003 refers to "behavioral health treatment." In this NOFO, we use this term to refer to services or treatment to address substance use and mental health disorders. In addition, we consider the term "provider capacity" to include training, education, payment, and Medicaid providers' willingness to furnish services to address SUD including OUD.

A4. Program Requirements

Planning Phase

The funding opportunity described in this NOFO is for the planning grants required by section 1903(aa)(3) of the Act. Consistent with section 1903(aa)(3) of the Act, CMCS will award 18-month planning grants to at least 10 states for the purposes of preparing an application to participate in a 36-month demonstration project and for carrying out the activities set forth below. This 18-month period is referred to as the Planning Phase.

Initial Assessment

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[17] ASPE. (2018), Substance Use Disorder Workforce. Retrieved on May 28, 2019 from https://aspe.hhs.gov/basic-report/substance-use-disorder-workforce-issue-brief

[18] SAMHSA, Addiction Technology Transfer Center National Office. (2017) , National Workforce Report 2017, Strategies for Recruitment, Retention, and Development of the Substance Use Disorder Treatment and Recovery Services Workforce: A National Qualitative Report, Retrieved on June 24, 2019 from https://www.drugsandalcohol.ie/28384/1/ATTC_Network_Natl_Report2017.pdf

During the Planning Phase, grantees will conduct an initial assessment of the behavioral health treatment needs of the state to determine the extent to which providers are needed to address the SUD treatment and recovery needs of Medicaid beneficiaries (including the types of such providers, geographic area of need, and sources of state data). The assessment will include information on which to base efforts for improving the network of Medicaid-participating providers that provide SUD treatment and/or recovery services including the following:

- An estimate of the number and percentage of individuals enrolled in Medicaid who have SUD;
- Information on the capacity, qualifications, and willingness of Medicaid providers to provide SUD treatment and/or recovery services to Medicaid-eligible individuals;
- Information on the gap in Medicaid-covered SUD treatment and recovery services relative to the estimated number of individuals enrolled in Medicaid who have SUD; and
- Information on the level and amount of coordination between primary care, mental health care, and SUD treatment and recovery services for Medicaid beneficiaries

Development of State Infrastructure

Grantees will conduct activities that, taking into account the results of the state's needs assessment described above, support the development of state infrastructure. These activities can include recruiting prospective providers and providing training and technical assistance to providers. In addition, grantees will conduct activities to improve reimbursement, training, and education to expand Medicaid provider capacity to deliver SUD treatment and recovery services.

Grantees will also develop projections regarding the extent to which the state would increase the number and capacity of Medicaid providers offering SUD treatment or recovery services, as well as the willingness of Medicaid providers to offer SUD treatment or recovery services, during the demonstration project.

Post-Planning Phase

As required by section 1903(aa)(4) of the Act, CMCS will select not more than 5 states to participate in a demonstration and receive payment, as specified in section 1903(aa)(5) of the Act and described below, for 36 months following the 18-month Planning Phase. This 36-month period is referred to as the Post-Planning Phase. The funding opportunity described in this NOFO is not for the Post-Planning Phase. There will be a separate application for participation in the Post-Planning Phase.

The states selected to participate in the Post-Planning Phase will, for each quarter of the Post-Planning Phase, be paid an amount equal to 80 percent of the qualified sums expended during the quarter. Qualified sums are the amount expended by the state during the quarter that is attributable to SUD treatment or recovery services furnished by providers participating under the State plan (or a waiver of such plan), that exceeds one-quarter of the sums expended by the state during fiscal year 2018 that was attributable to SUD treatment or recovery services. Information on how CMCS will calculate payments to states during the Post-Planning Phase is provided in Appendix K.

The application for states to participate in the Post-Planning Phase is expected to include the following:

- A proposed process for carrying out an ongoing assessment of the state's behavioral health treatment needs, taking into account the results of the initial assessment;
- A review of reimbursement methodologies and other policies related to SUD treatment or recovery services under the State plan (or waiver of such plan) that may create barriers to increasing the number of providers delivering such services;
- An analysis of the prevalence of SUD among Medicaid-enrolled and eligible beneficiaries comparing state prevalence with the national average (as measured by per capita opioid drug overdoses and/or Medicaid substance use and opioid-related diagnoses);
- A plan that will result in long-term and sustainable provider networks under the Medicaid program that will offer a continuum of care for SUD. The plan shall include the following:
    - Specific activities to increase the number of providers (including providers that specialize in providing SUD treatment or recovery services, hospitals, health care systems, Federally Qualified Health Centers, and, as applicable, Certified Community Behavioral Health Clinics) that offer evidence-based SUD treatment. Evidence-based SUD treatment includes, but is not necessarily limited to: the use of FDA-approved pharmacotherapies for OUD (e.g., injectable naltrexone, buprenorphine products, methadone) or other SUD (including tobacco and alcohol use disorders, recovery, or support services), short-term medical withdrawal or detoxification services (which for OUD must include the provision of injectable naltrexone following completion of the medical withdrawal procedure), outpatient SUD services, and evidence-based peer recovery services;
    - Strategies that will incentivize providers to obtain the necessary training, education, and support to deliver SUD treatment or recovery services in the state;
    - Milestones and timeframes for implementing the activities set forth in the plan; and
    - Specific measurable targets for increasing the number and capacity of providers in the SUD treatment and recovery provider network under the State plan (or a waiver of such plan) or the willingness of such providers to provide SUD treatment or recovery services to Medicaid beneficiaries in the state.
- A proposed process for reporting the information required, including the following information to assess the effectiveness of the efforts of the state to expand the capacity of providers to deliver SUD treatment or recovery services during the period of the demonstration project:
    - The financial impact of the demonstration project on the state;
    - A description of all funding sources available to the state to provide SUD treatment or recovery services in the state;
    - A plan for how the state will sustain any increase in the capacity of providers to deliver SUD treatment or recovery services resulting from the demonstration project after the termination of the demonstration project; and
    - A description of how the State will coordinate the goals of the demonstration project with any waiver of such plan granted (or submitted by the state and pending) pursuant to section 1115 for the delivery of SUD services under the State plan, as applicable.

States will also be required to consult with relevant stakeholders, including beneficiaries, families, and caregivers; Medicaid managed care plans; health care providers; Medicaid beneficiary advocates; Indian health care providers and tribal governments; and Medicare

providers for dually-eligible beneficiaries. States will be required to include a description of this consultation in their application. States will also be required to provide assurance that they will comply with SUPPORT Act section 1006(b).

A5. Overview of Competitive Award Process for Planning Grants

CMS invites applications for this solicitation from states that are seeking to increase the treatment capacity of Medicaid providers to furnish SUD treatment and recovery services through an approved State plan (or waiver of such plan). CMS will use a competitive award process to award 18-month planning grants to at least 10 states.

A synopsis of the award process and timeline is as follows:\

CMS publishes competitive solicitation for SUPPORT Act section 1003 planning grant: June 25, 2019
Applicant teleconferences with CMS occur: July 10, 2019 3:30pm to 4:30pm (ET); July 31, 2019 3:00pm to 4:00pm (ET)
State submits, as part of the application process, required Letter of Intent: July 18, 2019
States submit applications any time prior to due date: August 9, 2019
CMS awards planning grants: September 30, 2019

A6. Technical Assistance and Information for Prospective Applicants

Prior to the planning grant application deadline, CMS will host one or more teleconferences or webinars to provide details about the Demonstration Project to Increase Substance Use Provider Capacity under the Medicaid Program and to answer questions from states. Information about the forums will be posted on the following website:
https://www.medicaid.gov/medicaid/benefits/bhs/support-act-provider-capacity-demos/index.html

These will be held:
• July 10, 2019 3:30pm to 4:30pm (ET)
• July 31, 2019 3:00pm to 4:00pm (ET)

A third specific webinar is also scheduled for the 37 states with AI/AN populations, Indian health care providers, and AI/AN Medicaid beneficiaries.
• July 16, 2019 1:00pm to 2:00pm (ET)

Administrative questions about the Demonstration Project to Increase Substance Use Provider Capacity under the Medicaid Program may be directed to:
SubstanceUseProviderCapacity@cms.hhs.gov.

CMS expects to award one support contract for evaluation. Planning grantees will be required to work with the national evaluation contractor and participate in all evaluation activities including the collection of data and reporting of grant activities.

This includes completion of a semi-annual CMS web-based report detailing implementation progress, challenges, barriers, solutions, outputs and outcomes.

States may also choose to conduct their own independent evaluation to assist in the establishment of a formative learning process and/or to serve as the interface between the grant applicant and the CMS national evaluation contractor. The grant applicant and its evaluation contractor (if the grant applicant chooses to engage one) will be required to cooperate with CMS and the national evaluation contractor, including in the use of standard data sets such as T-MSIS.

The national evaluation will include an analysis of the impact, outcomes, and processes of the grant program, including identifying the elements that were critical to successful expansion of SUD treatment and recovery service capacity, as well as the barriers that impede states' success.

The evaluation will include both qualitative and quantitative methods to (1) assess whether the demonstration achieved its stated goals, (2) describe the strengths and limitations of the demonstration project, and (3) propose a plan for the sustainability of the project. The evaluation will also address the impact of the states' initiatives to expand the number, capacity, and willingness of providers to deliver SUD treatment and recovery services. In addition, the evaluation will assess the impact of the states' initiatives on the number of individuals enrolled in Medicaid who receive SUD treatment or recovery services under the demonstration and on the outcomes of Medicaid beneficiaries with SUD. The states' results will be assessed related to: (1) impact, benefits, barriers, and outcomes; (2) evidence of improved coordination and efficiencies in the SUD treatment and recovery system; (3) experiences of the beneficiaries and providers; and (4) SUD treatment and recovery services access and utilization.

B. FEDERAL AWARD INFORMATION

B1. Award Amount

CMS will award a maximum of $50 million total divided among at least 10 states for the purposes of the 18-month planning grant under the Demonstration Project to Increase Substance Use Provider Capacity. All state Medicaid agencies are eligible to compete for a planning grant. Grants will be awarded using a competitive process. We expect awards to range from between $2 million and $5 million per state.

B2. Anticipated Award Dates

State applications for participation in the Demonstration Project to Increase Substance Use Provider Capacity under the Medicaid Program will be due 45 days from the date of the NOFO posting. CMS expects to announce awardees within 52 days after the application deadline date.

B3. Period of Performance

The period of performance for the planning grants is 18 months. States have the flexibility to propose the scope and focus of their programs within this timeframes, as long as their approach includes the completion of the required activities by dates specified by CMS, where appropriate

(e.g., demonstration applications) and within the period of performance. CMS plans to award the planning grants by September 30, 2019.

B4. Number of Awards

CMS anticipates awarding at least 10 planning grant awards. The maximum planning grant award per state is contingent upon the scope of the activities proposed in the state's application and upon the total amount of funding available under this funding opportunity.

B5. Type of Award

The planning grant awards issued under this Notice of Funding Opportunity will be structured as cooperative agreements.[19] The Federal Grant and Cooperative Agreement Act of 1977, 31 U.S.C. 6301, defines the cooperative agreement as an alternative assistance instrument to be used in lieu of a grant whenever substantial Federal involvement with the award recipient during performance is anticipated. Therefore, statutes, regulations, policies, and the information contained in the HHS Grants Policy Statement that are applicable to grants also apply to cooperative agreements, unless the award itself states otherwise.

CMS may request an amendment of the applicant's proposals following award selection, including for the purposes of incorporating best practices or new national regulations and/or policies related to grants, coverage, payment, and delivery of services. CMS will monitor and evaluate recipients' activities performed under the cooperative agreement, including monitoring, measuring and evaluating achievement of states awarded planning grants through the Demonstration Project to Increase Substance Use Provider Capacity under the Medicaid Program. On at least a monthly basis, CMS anticipates informal communication with recipients.

Continued funding is dependent on satisfactory progress towards meeting the goals and performance expectations delineated in the grant's terms and conditions. CMS reserves the right to terminate the grant if it is determined to be in its best interests. At any point during the program if a state fails to meet the terms and conditions of award under this grant, CMS may suspend funding until the necessary benchmarks are met or terminate the award.

C. ELIGIBILITY INFORMATION

C1. Eligible Applicants

☒ State governments

Any State Medicaid Agency may apply. Only one application can be submitted for a given state. The term "State Medicaid Agency" means the single state agency for medical assistance provided under Title XIX of the Social Security Act (the Act). A Territory or Tribal organization, if interested, must come under the auspices of and work with the State Medicaid Agency in the implementation of this demonstration program. The State Medicaid Agency or designee must be the signatory and oversee implementation of the grant but may apply in

[19] https://blog.grants.gov/2016/07/19/what-is-a-cooperative-agreement/

conjunction with other co-applicant(s) including any other state agencies and/or Territory, Tribes, or Tribal organizations operating SUD treatment and recovery programs.

Only applications received by the specified deadline will be reviewed and scored. An application will not be funded if the application fails to meet any of the requirements as outlined in Section C. Eligibility Information and Section D. Application and Submission Information. Applicants are strongly encouraged to use the review criteria information provided in Section E. Application Review Information to help ensure that all of the criteria that will be used in evaluating the proposals are adequately addressed.

C2. Cost Sharing or Matching

Cost sharing/match is not required for the planning grant.

C3. Letter of Intent

☒ Mandatory

A non-binding letter of intent to apply must be submitted by the State Medicaid Agency to SubstanceUseProviderCapacity@cms.hhs.gov by July 18, 2019. A copy of the letter of intent should also be included with the final application. Entities that do not submit a letter of intent by this deadline will be ineligible to apply. CMS will provide confirmation of receipt of the letter of intent to each prospective applicant that submits such a letter.

C4. Ineligibility Criteria

CMS will consider the following criteria as potential reasons for applicant disqualification for award.

- **Incomplete application.** A non-exhaustive list of circumstances that constitute an incomplete application includes:
    - Failure to meet application requirements as described.
    - Omission of required application elements as described.

- **Insufficient supporting detail** provided in the application. CMS will not review applications that merely restate the text within the NOFO. Applicants must detail their approach to achieving program goals and milestones. Reviewers will note evidence of how effectively the applicant includes these elements in its application.

- **Inability or unwillingness to collect and share monitoring and evaluation data** with CMS or its contractors.

- **Program Integrity concerns.** CMS may deny selection to an otherwise qualified applicant on the basis of information found during a program integrity review regarding the organization, community partners, or any other relevant individuals or entities.

- **Disregard of maximum page limits** stipulated in the Notice of Funding Opportunity.

- **Late submission** of an application (see Section D)

- **Overlap with another model**: demonstration or program, including a CMMI model, which may result in duplication.

C5. Single Application Requirement

CMS intends to award one cooperative agreement per selected state. Applicants must be the State Medicaid Agency. An applicant must demonstrate through its application that it is partnering with the state agency responsible for enrolling Medicaid providers and furnishing Medicaid-covered SUD treatment or recovery services, public health, and other relevant state agencies. A state or the District of Columbia cannot receive more than one award over the duration of the Section 1003 Demonstration Project to Increase Substance Use Provider Capacity.

C6. Continued Eligibility

Award recipients must meet reporting and certification deadlines to be eligible throughout the initial 18-month planning budget period and to remain eligible for a non-competing continuation award for subsequent budget periods in multi-year projects. In addition, recipients would need to demonstrate strong performance during the previous funding cycle(s) before additional year funding is awarded or, in the case of awards where all funding is issued in the first year, to ensure continued access to funding. At any time in the award cycle, recipients could receive decreased funding or their award could be terminated if they fail to perform the requirements of the award.

C7. EIN, DUNS and SAM Regulations

To be able to submit an application at grants.gov, all applicants are required to have: a valid Employer Identification Number (EIN), otherwise known as a Taxpayer Identification Number (TIN); a Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number; and be registered in the System for Award Management (SAM) database (https://www.sam.gov/portal/public/SAM/). See Appendix B. Application and Submission Information for descriptions of EIN, DUNS, and SAM.

C8. Foreign and International Organizations

Foreign and international organizations are not eligible to apply.

C9. Faith-Based Organizations

Faith-based organizations are not eligible to apply. Only the single State Medicaid Agency in each state is qualified to address this solicitation.

C10. Other Eligibility Requirements

Not Applicable

D. APPLICATION AND SUBMISSION INFORMATION

D1. Address to Request Application Package

Application materials will be available at http://www.grants.gov. Please note that CMS requires applications for all announcements to be submitted electronically through Grants.gov. Applicants will be able to download a copy of the application packet, complete it offline, and then upload and submit the application via the Grants.gov website. Refer to Appendix B. Application and Submission Information for specific instructions on how to apply.

D2. Content and Form of Application Submission

a. Application Format

Applications determined to be ineligible, incomplete, and/or nonresponsive based on the initial screening may be eliminated from further review. However, in accordance with HHS Grants Policy, the CMS Office of Acquisition and Grants Management (OAGM) Grants Management Officer, in his/her sole discretion, may continue the review process for an ineligible application if it is in the best interests of the government to meet the objectives of the program. Each application must include all contents of the application package, in the order indicated, and conform to the following formatting specifications:

- The following page size must be used: 8.5” x 11” letter-size pages (one side only) with 1” margins (top, bottom, and sides). Other paper sizes will not be accepted. This is particularly important because it is often not possible to reproduce copies in a size other than 8.5” x 11”.
- All pages of the project and budget narratives and implementation plan must be paginated in a single sequence.
- Font size must be at least 12-point with an average of 14 characters per inch (CPI).
- The Project Narrative must be double-spaced. The page limit for the Project Narrative is 60 pages.
- The Budget Narrative may be single-spaced. The page limit for this document is 10 pages.
- The Business Assessment of Applicant Organization may be single spaced. The page limit for this document is 10 pages. The total page limit is 120 pages.
- Tables included within any portion of the application must have a font size of at least 12-point with a 14 CPI and may be single spaced. Tables are counted towards the applicable page limits.
- The project abstract is restricted to a one-page summary which may be single-spaced.
- The following required application documents are excluded from the page limitations described above: Standard Forms, Copy of Letter of Intent, Project Work Plan (including a timeline for proposed activities), and Memoranda of Understanding/Letters of Support with key state agencies and other partners (if applicable). Application Cover Letter/Cover Page (if applicable), Project Site Location Form, and Indirect Cost Rate Agreement. See text below

for other exclusions.

b. Standard forms

The following forms must be completed with an original signature and enclosed as part of the application:

- **Project Abstract Summary**

A one-page abstract should serve as a succinct description of the proposed project and must include the goals of the project, the total budget, and a description of how the funds will be used. The abstract is often distributed to provide information to the public and Congress, so write the abstract so that it is clear, accurate, concise, and without reference to other parts of the application. Personal identifying information should be excluded from the abstract. In the Grants Application Package that can be found at http://www.grants.gov/ (or alternatively http://www.GrantSolutions.gov/ for single-source applications), select the Project Abstract Summary and complete the form.

- **Application for SF-424: Official Application for Federal Assistance**

  Please note the following on SF-424:
  - On Item 15 "Descriptive Title of Applicant's Project," state the specific cooperative agreement opportunity for which you are applying (Section 1003 Demonstration Project to Increase Substance Use Provider Capacity).
  - Check "No" to item 19c, as Review by State Executive Order 12372 does not apply to this cooperative agreement funding opportunity.

- **SF-424A: Budget Information Non-Construction**

- **SF-424B: Assurances-Non-Construction Programs**

- **SF-LLL: Disclosure of Lobbying Activities.**

  All applicants must submit this document. Federal law prohibits the use of appropriated funds for publicity or propaganda purposes or for the preparation, distribution, or use of the information designed to support or defeat legislation pending before Congress or state legislatures. For more information, please see Current Provisions and Restrictions at this link: https://www.hhs.gov/grants/grants/grants-policies-regulations/lobbying-restrictions.html.) If your entity does not engage in lobbying with funds from any source, please insert "Non-Applicable" on the document and include the required Authorized Organizational Representative (AOR) name, contact information, and signature. Please note that the application kit available online on the Grants.gov website is utilized for many programs and therefore Grants.gov may designate this form as optional to allow for flexibility amongst programs. However, this form is required as part of your application package and must be submitted for your application to be considered eligible for review.

- **Project Site Location Form(s)**

  All applicants must submit this form. Please note that the application kit available online in Grants.gov is utilized for many programs and therefore Grants.gov may designate this form as optional to allow for flexibility amongst programs. This form is required as part of your application package and must be submitted for your application to be considered eligible for review.

c. Application Cover Letter or Cover Page

Cover letter or cover page not required.

d. Project Narrative (Maximum 60 pages)

The applicant must provide a Project Narrative that articulates in detail the proposed goals, measurable objectives, and milestones to be completed in accordance with the instructions and content requirements provided below and the specific criteria described in Section E1. Criteria. Please include the title "Project Narrative" at the beginning of the Project Narrative. The Project Narrative must include the following information:

1. Proposed activities to support the development of an initial assessment of the mental health and SUD treatment needs of the state to determine the extent to which providers are needed to address the SUD treatment and recovery needs of Medicaid beneficiaries, including: estimates of the number and percentage of individuals enrolled in Medicaid who have SUD; the capacity, qualifications, and willingness of Medicaid providers to provide SUD treatment and/or recovery services to Medicaid-eligible individuals; the gap in Medicaid-covered SUD treatment and recovery services; and the level and amount of coordination between primary care, mental health care, and SUD treatment and recovery providers. Applicants are encouraged to focus on the following Medicaid subpopulations in their assessments: pregnant women, postpartum women, infants (including those with neonatal abstinence syndrome), adolescents and young adults between the ages of 12 and 21, AI/ANs, people living in rural areas, and Medicare-Medicaid dual-eligibles. States may also focus on other subpopulations of specific interest to the state in their assessments.
2. Proposed activities that, taking into account the results of the assessment, would support the development of state infrastructure, including to recruit prospective providers and provide training and technical assistance to providers who deliver SUD treatment or recovery services to Medicaid beneficiaries.
3. Proposed activities to improve reimbursement, training, and education to expand Medicaid provider capacity to deliver SUD treatment and recovery services.
4. Proposed activities to develop projections regarding the extent to which the state would increase the number and capacity of Medicaid providers offering SUD treatment or recovery services, as well as the willingness of Medicaid providers to offer SUD treatment or recovery services, during the demonstration project; and
5. An analysis comparing the state's SUD prevalence with the national average, as measured by per capita opioid drug overdoses and the prevalence of substance use and opioid-related diagnoses among Medicaid enrollees. Applicants are encouraged to also provide information

on the prevalence of SUD among Medicaid subpopulations, including but not necessarily limited to, pregnant women, postpartum women, infants, adolescents and young adults between the ages of 12 and 21, AI/ANs, people living in rural areas, and Medicare-Medicaid dual-eligibles (or other subpopulations of specific interest to the state), as well as information on the prevalence of neonatal abstinence syndrome.

Applicants are encouraged to include information on current activities that relate to or will support the applicant's proposed activities, as well as help to inform CMS's review of the application. The projective narrative should also include information describing the following: staffing; state infrastructure; data sharing; reporting; and organizational structure.

e. Budget Narrative (Maximum 10 pages)

Applicants must supplement Form SF-424A with a Budget Narrative. The Budget Narrative must include a yearly breakdown of costs according to a 12-month period. See Section B. Federal Award Information for more information on the performance period. Applicants must include a clear description of the proposed set of activities that will be covered with grant funds. The Budget Narrative should provide a detailed cost breakdown for each line item outlined in the SF-424A by grant year, including a breakdown of costs for each activity/cost within the line item. The proportion of the requested funding designated for each activity should be clearly defined and should justify the applicant's readiness to receive funding. The budget must separate out funding that will be administered directly by the lead agency from funding that will be administered by sub-awardees. **For more specific information and instructions for completing the SF-424A and Budget Narrative, please refer to Appendix A. Guidance for Preparing a Budget Request and Narrative.**

f. Business Assessment of Applicant Organization (Maximum 10 pages)

As required by 45 CFR §75.205 for competitive grants and cooperative agreements, CMS will evaluate the risk posed by an applicant before they receive an award. This analysis of risk includes items such as financial stability, quality of management systems, and the ability to meet the management standards prescribed in 45 CFR Part 75.

An applicant must review, answer, and submit the business assessment questions outlined in Appendix D. Business Assessment of Applicant Organization.

D3. Unique Entity Identifier and System for Award Management (SAM)

Unless the applicant is an individual or Federal awarding agency that is excepted from those requirements under 2 CFR 25.110(b) or (c), or has an exception approved by the Federal awarding agency under 2 CFR 25.110(d)), each applicant is required to:

i. Be registered in SAM before submitting its application;
ii. Provide a valid unique entity identifier in its application; and
iii. Continue to maintain an active SAM registration with current information at all times during which it has an active Federal award or an application or plan under consideration by a Federal awarding agency.

The Federal awarding agency may not make a Federal award to an applicant until the applicant has complied with all applicable unique entity identifier and SAM requirements and, if an applicant has not fully complied with the requirements by the time the Federal awarding agency is ready to make a Federal award, the Federal awarding agency may determine that the applicant is not qualified to receive a Federal award and use that determination as a basis for making a Federal award to another applicant.

D4. Submission Dates and Times

All applications must be submitted electronically and be received through http://grants.gov (as well as single source and non-competing continuations submitted to GrantSolutions) by the date and time set forth below. Applications submitted after 3:00 pm, Eastern Time, of the date set forth below will not be reviewed or considered for award.

We strongly recommend that you do not wait until the application deadline date to begin the application process through grants.gov. We encourage applicants to submit **well before** the closing date, so that if difficulties are encountered, an applicant will have time to solicit help.

Date August 9, 2019. 3:00 PM Eastern U.S. Time

D5. Intergovernmental Review

Applications for these awards are not subject to review by states under Executive Order 12372, "Intergovernmental Review of Federal Programs" (45 CFR 100). Please check box "C" on item 19 of the SF 424 (Application for Federal Assistance) as Review by State Executive Order 12372, does not apply to these cooperative agreements.

D6. Cost Restrictions

Indirect Costs

If requesting indirect costs, the applicant must submit a copy of the approved Indirect Cost Rate Agreement used in calculating the budget. The provisions of 2 CFR Part 225 (previously OMB Circular A-87) govern reimbursement of indirect costs under this solicitation.

Note: If an organization intends to establish an indirect cost rate, they may request in this application an amount equaling one-half of the amount of indirect costs up to a maximum of ten (10) percent of direct salaries and wages (exclusive of fringe benefits).

Prohibited Uses of Award Funds

No funds under this award may be used for any of the activities/costs outlined below unless an exception is specifically authorized by statute:

- To match any other Federal funds.
- To provide services, equipment, or supports that are the legal responsibility of another party

under Federal, State, or Tribal law (e.g., vocational rehabilitation or education services) or under any civil rights laws. Such legal responsibilities include, but are not limited to, modifications of a workplace or other reasonable accommodations that are a specific obligation of the employer or other party.

- To provide goods or services not allocable to the approved project.
- To supplant existing State, local, Tribal or private funding of infrastructure or services, such as staff salaries, etc.
- To be used by local entities to satisfy state matching requirements.
- To pay for construction.
- To pay for capital expenditures for improvements to land, buildings, or equipment which materially increase their value or useful life as a direct cost, except with the prior written approval of the Federal awarding agency.
- To pay for the cost of independent research and development, including their proportionate share of indirect costs (unallowable in accordance with 45 CFR 75.476).
- To use as profit to any award recipient even if the award recipient is a commercial organization (unallowable in accordance with 45 CFR 75.216(b)), except for grants awarded under the Small Business Innovative Research (SBIR) and Small Business Technology Transfer Research (STTR) programs (15 U.S.C. 638). Profit is any amount in excess of allowable direct and indirect costs.
- To expend funds related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or executive order proposed or pending before the Congress or any state government, state legislature, or local legislature or legislative body. (See Current Provisions and Restrictions at this link: https://www.hhs.gov/grants/grants/grants-policies-regulations/lobbying-restrictions.html.)
- To duplicate or supplant existing federal or state funding as part of any other CMS or HHS initiatives, grants, or other federal resources.
    - To pay healthcare providers for SUD treatment or care delivery.

Reimbursement of Pre-Award Costs

☒No

CMS will not reimburse awardees for pre-award costs.

D7. Mandatory Disclosure

Submission is required for all applicants, in writing, to the awarding agency and to the HHS Office of Inspector General (OIG), all information related to violations of federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the federal award. Disclosures must be sent in writing to:

U.S. Department of Health and Human Services
Centers for Medicare and Medicaid Services
Office of Acquisition and Grants Management

Attn: Director, Division of Grants Management
7500 Security Blvd, Mail Stop B3-30-03
Baltimore, MD 21244-1850

AND

U.S. Department of Health and Human Services
Office of Inspector General
ATTN: Mandatory Grant Disclosures, Intake Coordinator
330 Independence Avenue, SW, Cohen Building, Room 5527
Washington, DC 20201
URL: https://oig.hhs.gov/fraud/report-fraud/index.asp
(Include "Mandatory Grant Disclosures" in subject line)
Fax: (202) 205-0604 (Include "Mandatory Grant Disclosures" in subject line) or
Email: MandatoryGranteeDisclosures@oig.hhs.gov

Materials should also be scanned and emailed to the Grants Management Specialist assigned to this NOFO.

E. APPLICATION REVIEW INFORMATION

Please refer to Appendix E for specific information about the Review and Selection Process.

E1. Criteria

Applicants must submit applications in the required format, no later than the deadline date and time. If an applicant does not submit all of the required documents and does not address each of the topics described in Section D2. Content and Form of Application Submission (with cross reference to this section and other applicable sections and appendices), the applicant risks not being eligible and/or awarded. Applications are reviewed in accordance with criteria outlined below.

- Awards may be adjusted to a lower amount if the applicant fails to meet grant requirements (refer to Section F. Federal Award Administration Information).
- The application itself is not a legally binding contract and does not require any applicant or CMS to enter into an agreement.
- CMS will select recipients at CMS's sole discretion. Such selection will not be subject to administrative or judicial review.
- CMS must consider geographic diversity among grant recipients.
- CMS will give preference to applicants that:
    - Have a prevalence of SUD (in particular OUD) that is comparable to or higher than the national average prevalence, as measured by aggregate per capita drug overdoses.
    - Condition grant funding on specific, measurable outcomes.

Project Narrative (Maximum 40 points)

This section describes the evaluation criteria for the planning grant application. The following criteria will be used to evaluate applications received in response to this NOFO.

Assessment of the Mental Health and SUD Treatment Needs of the State to Determine the Extent to Which Providers are Needed

Applicants must describe the state's process for carrying out an initial assessment of the mental health and SUD treatment needs of the state to determine the extent to which providers are needed to address the SUD treatment and recovery needs of Medicaid beneficiaries, including:

- Activities to estimate the number and percentage of individuals enrolled in Medicaid who have SUD, including OUD;
- Activities to assess the capacity, qualifications, and willingness of Medicaid-enrolled providers to provide SUD treatment and/or recovery services, including all forms of MAT approved by the FDA consistent with the SUPPORT Act section 1006(b), across a continuum of settings to Medicaid-eligible individuals;
- Activities to assess the gap in Medicaid-covered SUD treatment and recovery services, including in the number and capacity of participating providers and in the type, range, and intensity of services, relative to the prevalence of SUD (and in particular OUD) in the Medicaid population. In assessing the gap for Medicaid, applicants should compare the gap in SUD treatment and recovery services for the Medicaid population to the gap for the entire state population. This information may also include an assessment of the socio-demographic or geographic (e.g., rural/urban/suburban) distribution of SUD in the state, as well as potential gaps created by certified clinicians not prescribing MAT or providing MAT at levels lower than they are approved to provide; and
- Activities to assess the level and amount of coordination between primary care, mental health, and SUD treatment and recovery providers and the capacity of those providers to support coordinated care for Medicaid-eligible individuals with SUD, particularly OUD.

Applicants must describe the state's plan for collecting, reporting, and analyzing the data and information needed for the assessment. In the assessment of gaps in Medicaid-covered SUD treatment and recovery services, applicants should identify barriers to SUD treatment and recovery services and plans for overcoming them. Examples of such barriers include, but are not limited to:

- Provider Capacity: lack of providers trained in MAT, lack of waivered providers, lack of behavioral health services, provider type limitations, limitations on use of tele-health to provide SUD, scope of practice laws that prohibit nurse practitioners from being authorized to prescribe buprenorphine, and lack of technical support/practice facilitation to help primary care providers integrate SUD services;
- Provider Willingness: providers qualified to provide SUD treatment but unwilling to do so, unwillingness to serve Medicaid beneficiaries, lack of provider recognition of OUD in their patient populations, provider misunderstanding about MAT and/or treating SUD, and professional stigma about SUD and SUD treatment;
- Financial: beneficiary cost sharing, limits on the types of diagnosis codes primary care

providers may receive reimbursement for, low provider reimbursement, and burdensome provider reimbursement requirements or process;
- Access: transportation, geographic barriers, facility licensing and certification laws that limit where SUD providers can be located, and a lack of providers in specific geographic areas, particularly areas with a high prevalence of SUD; and
- Care Provision: enrollment caps, prior authorization requirements, lack of care coordination between SUD providers or other providers (e.g., primary care, mental health), cultural barriers to care, limits on treatment duration, and "first fail" or step therapy criteria.

Applicants must describe how input on the development of the assessment will be solicited from consumers, family members, providers, and other stakeholders, including AI/ANs, and how they will be kept informed of the activities, changes, and processes related to the project.

Proposed Activities to Develop State Infrastructure

Applicants must describe the state's plan for carrying out the following activities:
- Proposed activities that, taking into account the results of the assessment, would support the development of state infrastructure, including to recruit prospective providers and provide training and technical assistance to providers who deliver SUD treatment or recovery services to Medicaid beneficiaries;
- Proposed activities to improve reimbursement, training, and education to expand Medicaid provider capacity to deliver SUD treatment and recovery services; and
- Proposed activities to develop projections regarding the extent to which the state would increase the number and capacity of Medicaid providers offering SUD treatment or recovery services, as well as the willingness of Medicaid providers to offer SUD treatment or recovery services, during the demonstration project.

Activities to improve reimbursement should (at a minimum) include:
- Development of an inventory of current Medicaid payment methodologies and rates, prior authorization requirements, other administrative barriers to provider reimbursement, and limits on the amount, duration, and scope of SUD services, as well as an assessment of the potential impact of these factors on provider capacity; and
- An assessment of potential reimbursement methodologies to expand Medicaid provider capacity to deliver SUD treatment and recovery services.

In their descriptions of proposed activities, applicants should provide information on the extent to which any proposed activities are focused on specific Medicaid subpopulations, including pregnant women, postpartum women, infants (including those with neonatal abstinence syndrome), adolescents and young adults between the ages of 12 and 21, and AI/ANs. Applicants should also describe the extent to which any proposed activities are focused on the following types of providers:
- Providers authorized to dispense drugs approved by the Food and Drug Administration for individuals with SUD who need withdrawal management or maintenance treatment for such disorder;
- Providers who have in effect a registration or waiver under section 303(g) of the Controlled Substances Act for purposes of dispensing narcotic drugs to individuals for maintenance

treatment or detoxification treatment and are in compliance with any regulation promulgated by the Assistant Secretary for Mental Health and Substance Use for purposes of carrying out the requirements of section 303(g); and

- Providers qualified to address the needs of specific populations described in section 1003, including pregnant women, postpartum women, infants (including those with neonatal abstinence syndrome), adolescents and young adults between the ages of 12 and 21, and AI/ANs.

Analysis of the Prevalence of SUD

Applicants must include, in the Project Narrative, an analysis of the prevalence of SUD, comparing state prevalence with the national average, as measured by per capita opioid drug overdoses and the prevalence of substance use and opioid-related diagnoses among Medicaid enrollees. Applicants are encouraged to also provide information on the prevalence of SUD among Medicaid subpopulations, including but not necessarily limited to, pregnant women, postpartum women, infants, adolescents and young adults between the ages of 12 and 21, AI/ANs, people living in rural areas, and Medicare-Medicaid dual-eligibles (or other subpopulations of specific interest to the state), as well as information on the prevalence of neonatal abstinence syndrome. Applicants must include information on the data and information sources used for the analysis.

Staffing (maximum 15 points)

Applicants must describe how the project will be staffed, including the number of staff, their skills and credentials, and how they will be recruited, retained, and deployed. Applicants must include brief job descriptions for the Project Director and other positions paid under the cooperative agreement and a statement of the percentage of time that each person will be working on this project and the percentage of time that is spent on duties outside of the cooperative agreement activities. CMS expects the Project Director to devote 100 percent of his or her time to cooperative agreement activities. Applicants should describe how the Project Director will develop and provide on the job training and will foster a team culture in order to promote collegiality and collective achievement.

Budget (maximum 20 points)

Applicants must provide a budget with appropriate budget line items and a narrative that describes the funding needed to accomplish the goals of the grant. For the budget recorded on form SF-424A, the applicant must provide a breakdown of the aggregate numbers detailing their allocation to each major set of activities. The proposed budget for the program should distinguish the proportion of grant funding designated for each grant activity. The budget must separate out funding that is administered directly by the lead agency from funding that will be subcontracted to other partners.

State Infrastructure, Data Sharing, Reporting (maximum 15 points)

Applicants must describe the state's capacity to collect data to inform the evaluation of the demonstration program including (but not necessarily limited to) provider utilization and

payment data, beneficiary claims and encounter data, patient records, chart-based/registry data, and patient experience data.

T-MSIS Status: Applicants must identify their T-MSIS data submission status. If the applicant is not submitting T-MSIS production data monthly to CMS and/or their catch-up data files are not current, then a timeline for achieving timely, monthly production data submission and/or a plan for submitting the data as outlined. States selected for this grant opportunity will be expected to be current with their T-MSIS data submissions and addressing T-MSIS data quality issues.

Qualitative Data: Applicants must indicate their willingness and ability to share program documents, training materials, and any other program-related materials (e.g., provider enrollment materials) with CMS for purposes of monitoring and evaluating the project in accordance with 42 CFR 403.1110 and to assist in arranging other data gathering activities.

Reporting Plan: Applicants must provide a plan for gathering and timely reporting data to CMS, including Quarterly and Annual Progress Reporting and data related to milestones. CMS expects to use this information in developing its three statutorily required reports: an initial report; an interim report; and a final report. In addition, AHRQ may use this information in developing its statutorily required report to Congress on the experiences of states awarded planning grants and of states conducting demonstration projects.

Evaluation Participation: Applicants must use this section to describe their strategy for ensuring participation in the project's evaluation by all partners and participants, including the awardee, affiliated departments and agencies, providers, and any other individuals or entities. Specifically, the applicant must demonstrate its capacity to participate in beneficiary- and program-level data provision and qualitative evaluation tasks, which may include: arranging site visits, observations, interviews and focus groups with state program staff and affiliates, providers, and beneficiaries; screening beneficiaries for health-related social needs; ensuring that any transmission of beneficiary/patient-identifiable medical information utilizes a system that complies with privacy and security standards in the HIPAA regulations at 45 C.F.R. parts 160 and 164, as well as SAMHSA's SUD data regulations at 42 C.F.R. Part 2; gathering any required beneficiary/patient consents or authorizations; and other activities as needed. If T-MSIS data is not research quality or if the applicant is including commercial payers, the applicant (if selected) is responsible for directly providing utilization and cost data to CMS and its contractor(s) in sufficient detail to fully evaluate the project's impact. All applicants must be able to provide CMS with personal identifiers that will allow all participating providers and beneficiaries receiving services through the project to be identified in Medicaid claims and encounter data.

Though independent evaluation is not a requirement of the project, if the applicant chooses to conduct an independent evaluation using grant funds, the applicant should describe their evaluation plan, indicate their ability to gain Institutional Review Board (IRB) approval (if needed), and/or describe any other necessary permissions for evaluation activities, data collection, and data sharing and submission. IRB approval is the sole responsibility of applicants and their partners.

Organizational Structure (Maximum 10 points)

Applicants must provide a summary of how the applying agency (State Medicaid Agency) will conduct the work proposed under the project. This section must include an organizational structure detailing the staff to be assigned to oversee the project and conduct project activities, as well as a summary of how the applying agency will work in close collaboration with other key state partners.

1. Describe the past, current, and projected future involvement of the state in federally-funded programs aimed at improving access and outcomes for individuals with SUD.
2. Describe how the applying agency will work in close collaboration with other relevant key state partners, including but not limited to: public health agency, Indian health care providers, single state agency responsible for SUD services, social services agency, criminal justice, department of education, and home and community-based services and supports.
3. Identify the individual or individuals who will have oversight authority over the project at the state, and provide a resume or curriculum vitae for each identified leader.
4. Describe management controls and coordination mechanisms that will be utilized to ensure the timely and successful execution of this project.
5. If different from the individual in #3 above, identify the individual who will be the project manager and primary liaison to CMS for the project, and provide a resume or curriculum vitae for the identified staff person.
6. Provide an organizational chart for the applicant agency that identifies lines of authority over the proposed cooperative agreement activities.
7. Provide job descriptions for the roles of key state staff operating the project. These descriptions should estimate the percentage of full-time equivalent employment the role will comprise.
8. Describe the applying state agency's experience with managing cooperative agreement funds in accordance with federal grant regulations and HHS grants policy. The applicant is required to have an individual trained in federal grants management assigned to the award; if no individual exists within the agency, the applicant is required to assign such an individual who will attend federal grants management training within the first 3 months of the award period. Funding for this position and any such federal grants management training is an allowable use of award funds.
9. Describe who will be the primary contact in the state agency for Tribal Consultation requirements.

E2. Review and Selection Process

Please refer to Appendix E. Review and Selection Process for more information on the review and selection process.

☒ Anticipated Mix of Federal and Non-Federal Review

Applications submitted by states for the Demonstration Project to Increase Substance Use Provider Capacity will be reviewed and scored by an expert review panel based on the criteria described in this NOFO.

E3. Federal Awardee Performance Integrity Information System (FAPIIS)

i. CMS, prior to making a Federal award with a total amount of Federal share greater than the simplified acquisition threshold, is required to review and consider any information about the applicant that is in the designated integrity and performance system accessible through the System for Award Management (SAM, currently FAPIIS) (see 41 U.S.C. 2313).
ii. An applicant, at its option, may review information in the designated integrity and performance systems accessible through SAM and comment on any information about itself that the HHS awarding agency previously entered and is currently in the designated integrity and performance system accessible through SAM.
iii. CMS will consider any comments by the applicant, in addition to the other information in the designated integrity and performance system, in making a judgment about the applicant's integrity, business ethics, and record of performance under Federal awards when completing the review of risk posed by applicant as described in section 75.205.

F. FEDERAL AWARD ADMINISTRATION INFORMATION

F1. Federal Award Notices

CMS may redistribute cooperative agreement funds based upon the number and quality of applications received for each cooperative agreement opportunity. CMS will not fund activities that are duplicative of efforts funded through its grant programs or other federal resources.

If successful, applicant will receive a Notice of Award (NoA) signed and dated by the HHS/CMS Grants Management Officer. The NoA is the document authorizing the cooperative agreement award and will be issued to the applicant as listed on the SF-424 and available to the applicant organization through the online grants management system used by CMS and awardee organizations. Any communication between HHS and the applicant prior to issuance of the NoA is not an authorization to begin performance of a project.

If unsuccessful, the applicant will be notified by letter, sent electronically or through the U.S. Postal Service to the address as listed on its SF-424, within 30 days of the award date.

F2. Administrative and National Policy Requirements

National/Public Policy Requirements

By signing the application, the authorized organizational official certifies that the organization will comply with applicable public policies. Once a cooperative agreement is awarded, the recipient is responsible for establishing and maintaining the necessary processes to monitor its compliance with these requirements and that of its employees and, as appropriate, subrecipients and contractors under the cooperative agreement. Recipient should consult the applicable Appropriations Law, Exhibit 3 of the HHS Grants Policy Statement, titled Public Policy Requirements, located in Section II, pages 3-6, as well as the terms and conditions of the award for information on potentially applicable public policy requirements.

Non-Discrimination

All awardees receiving awards under this cooperative agreement project must comply with all applicable Federal statutes relating to nondiscrimination, including but not limited to:

a. Title VI of the Civil Rights Act of 1964;

b. Section 504 of the Rehabilitation Act of 1973;

c. The Age Discrimination Act of 1975; and

d. Title II, Subtitle A of the Americans with Disabilities Act of 1990.

Accessibility Provisions

Award recipients, as recipients of federal financial assistance (FFA) from Health and Human Services (HHS), must administer their programs in compliance with federal civil rights laws. This means that award recipients must ensure equal access to their programs without regard to a person's race, color, national origin, disability, age, and, in some circumstances, sex and religion. It is HHS' duty to ensure access to quality, culturally competent care, including long-term services and supports, for vulnerable populations.

HHS provides guidance to award recipients on meeting their legal obligation to take reasonable steps to provide meaningful access to their programs by persons with limited English proficiency. In addition, award recipients will have specific legal obligations for serving qualified individuals with disabilities by providing information in alternate formats.

Several sources of guidance are provided below:

1. http://www.hhs.gov/civil-rights/for-providers/index.html
2. http://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/index.html
3. http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53
4. http://www.hhs.gov/ocr/civilrights/understanding/section1557/index.html
5. HHSAR 352.270-1
6. http://www.hhs.gov/ocr/civilrights/understanding/disability/index.html

Award recipients will be required to review and comply with the Accessibility Requirements outlined in Appendix F of this NOFO.

Please contact the HHS Office for Civil Rights for more information about obligations and prohibitions under federal civil rights laws at http://www.hhs.gov/ocr/office/about-us/index.html or call 1-800-368-1019 or TDD 1-800-537-7697.

Administrative Requirements

- All equipment, staff, and other budgeted resources and expenses must be used exclusively for the projects identified in the applicant's original grant application, or agreed upon subsequently with HHS, and may not be used for any prohibited uses.
- Consumers and other stakeholders must have meaningful input into the planning, implementation, and evaluation of the project.

- This award is subject to 45 CFR Part 75, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS awards [available at http://www.ecfr.gov/cgi-bin/text-idx?node=pt45.1.75], which implements 2 CFR Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards ("Uniform Guidance") effective December 26, 2014. See below for more information.

Uniform Administrative Requirements, Cost Principles, and Audit Requirements

Applicant and recipients should take particular note of the following information found in 45 CFR Part 75:

Uniform Administrative Requirements

In accordance with 45 CFR section 75.112, all award recipients receiving federal funding from CMS must establish and comply with the conflict of interest policy requirements outlined by CMS (available for applicant upon request).

In accordance with 45 CFR section 75.113, Mandatory Disclosures, the non-Federal entity or applicant for a Federal award must disclose, in a timely manner, in writing to the HHS awarding agency or pass-through entity all violations of Federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the Federal award. Non-Federal entities that have received a Federal award including the term and condition outlined in Appendix XII to 45 CFR Part 75 are required to report certain civil, criminal, or administrative proceedings to SAM. Failure to make the required disclosures can result in the imposition of any of the remedies described in section 75.371, including suspension or debarment. (See also 2 CFR Parts 180 and 376, and 31 U.S.C. 3321.) For specific information on reporting such disclosures to CMS and HHS, please see Section F3. Terms and Conditions of this NOFO.

Cost Principles

CMS grant and cooperative agreement awards provide for reimbursement of actual, allowable costs incurred and are subject to the Federal cost principles. The cost principles establish standards for the allowability of costs, provide detailed guidance on the cost accounting treatment of costs as direct or indirect, and set forth allowability and allocability principles for selected items of cost. Applicability of a particular set of cost principles depends on the type of organization. Award recipients must comply with the cost principles set forth in HHS regulations at 45 CFR Part 75, Subpart E with the following exceptions: (1) hospitals must follow Appendix IX to part 75 and commercial (for-profit) organizations are subject to the cost principles located at 48 CFR subpart 31.2. As provided in the cost principles in 48 CFR subpart 31.2, allowable travel costs may not exceed those established by the Federal Travel Regulation (FTR).

There is no universal rule for classifying certain costs as either direct or indirect (also known as Facilities & Administration (F&A) costs) under every accounting system. A cost may be direct with respect to some specific service or function, but indirect with respect to the Federal award or other final cost objective. Therefore, it is essential that each item of cost incurred for the same purpose is treated consistently in like circumstances either as a direct or F&A cost in order to avoid double-charging of federal awards. Guidelines for determining direct and F&A costs charged to federal awards are provided in 45 CFR sections 75.412 to 75.419. Requirements for development and submission of indirect (F&A) cost rate proposals and cost allocation plans are

contained in Appendices III-VII and Appendix IX to Part 75.

Indirect Costs

HHS will reimburse indirect costs to recipients under an award if: (1) allowable under the governing statute, regulations, or HHS grants policy; (2) the recipient requests indirect costs; and (3) the recipient has a federally approved indirect cost rate agreement covering the grant supported activities and period of performance or the non-federal entity has never received an indirect cost rate and elects to charge a de minimis rate of 10% of Modified Total Direct Costs (MTDC).

If the applicant entity has a current negotiated indirect cost rate agreement (NICRA) and is requesting indirect costs, a copy of the current NICRA must be submitted with the application. Any non-Federal entity that has never received a negotiated indirect cost rate, except for those non-Federal entities described in Appendix VII(D)(1)(b) to 45 CFR part 75, may elect to charge a de minimis rate of 10% of MTDC which may be used indefinitely.

Commercial (For-Profit) Organizations: Indirect Costs are allowable under awards to for-profit organizations. The for-profit recipient must have a federally-approved indirect cost rate agreement covering the grant supported activities and period of performance. Indirect cost rates for for-profit entities are negotiated by DFAS in the Office of Acquisition Management and Policy, National Institutes of Health (if the preponderance of their federal awards are from HHS), available at http://oamp.od.nih.gov/dfas/indirect-cost-branch/, or other federal agency with cognizance for indirect cost rate negotiation. If there is no federally-approved indirect cost rate for the specific period of performance and the for-profit recipient has never received an indirect cost rate, then the non-federal entity may elect to charge a de minimis rate of 10% of MTDC.

Cost Allocation

In accordance with 45 CFR section 75.416 and Appendix V to Part 75 – State/Local Government-wide Central Service Cost Allocation Plans, each state/local government will submit a plan to the HHS Cost Allocation Services for each year in which it claims central service costs under Federal awards. Guidelines and illustrations of central service cost allocation plans are provided in a brochure published by the HHS entitled "A Guide for State, Local and Indian Tribal Governments: Cost Principles and Procedures for Developing Cost Allocation Plans and Indirect Cost Rates for Agreements with the Federal Government." A copy of this brochure may be obtained from the HHS Cost Allocation Services at https://rates.psc.gov/. A current, approved cost allocation plan must be provided to CMS if central service costs are claimed.

Public Assistance Cost Allocation Plans

Appendix VI to Part 75 – Public Assistance Cost Allocation Plans provides that state public assistance agencies will develop, document, and implement, and the Federal Government will review, negotiate, and approve, public assistance cost allocation plans in accordance with Subpart E of 45 CFR part 95. The plan will include all programs administered by the state public assistance agency. Where a letter of approval or disapproval is transmitted to a state public assistance agency in accordance with Subpart E, the letter will apply to all Federal agencies and programs. This Appendix (except for the requirement for certification) summarizes the

provisions of Subpart E of 45 CFR part 95.

Audit Requirements

The audit requirements in 45 CFR Part 75, Subpart F apply to each award recipient fiscal year that begins on or after December 26, 2014. A non-Federal entity that expends $750,000 or more during the non-Federal entity's fiscal year in Federal awards must have a single or program-specific audit conducted for that year in accordance with the provisions of Subpart F, Audit Requirements.

Commercial Organizations (including for-profit hospitals) have two options regarding audits, as outlined in 45 CFR section 75.501 (see also 45 CFR section 75.216).

F3. Terms and Conditions

This announcement is subject to the Department of Health and Human Services Grants Policy Statement (HHS GPS) at https://www.hhs.gov/sites/default/files/grants/grants/policies-regulations/hhsgps107.pdf. The general terms and conditions in the HHS GPS will apply as indicated unless there are statutory, regulatory, or award-specific requirements to the contrary. Standard and program specific terms of award will accompany the NoA.

Potential applicants should be aware that special requirements could apply to cooperative agreement awards based on the particular circumstances of the effort to be supported and/or deficiencies identified in the application by the HHS review panel. The recently released HHS regulation (45 CFR Part 75) supersedes information on administrative requirements, cost principles, and audit requirements for grants and cooperative agreements included in the current HHS Grants Policy Statement where differences are identified. Awardees must also agree to respond to requests that are necessary for the evaluation of national efforts and provide data on key elements of their own cooperative agreement activities.

HHS may terminate any CMS award for material noncompliance. Material noncompliance includes, but is not limited to: violation of the terms and conditions of the award; failure to perform award activities in a satisfactory manner; improper management or use of award funds; or fraud, waste, abuse, mismanagement, or criminal activity.

In the event a recipient or one of its subrecipients enters into proceedings relating to bankruptcy, whether voluntary or involuntary, the recipient agrees to provide written notice of the bankruptcy to CMS. This written notice shall be furnished within five (5) days of the initiation of the proceedings relating to bankruptcy filing and sent to the CMS Grants Management Specialist and Project Officer. This notice shall include the date on which the bankruptcy petition was filed, the identity of the court in which the bankruptcy petition was filed, a copy of any and all of the legal pleadings, and a listing of Government grant and cooperative agreement numbers and grant offices for all Government grants and cooperative agreements against which final payment has not been made.

Intellectual Property

Recipients under this solicitation must comply with the provisions of 45 CFR § 75.322,

Intangible property and copyrights. The non-Federal entity may copyright any work that is subject to copyright and was developed, or for which ownership was acquired, under a Federal award. The Federal awarding agency reserves a royalty-free, nonexclusive, and irrevocable right to reproduce, publish, or otherwise use the work for Federal purposes and to authorize others to do so. The non-Federal entity is subject to applicable regulations governing patents and inventions, including government-wide regulations issued by the Department of Commerce at 37 CFR part 401.

The Federal Government has the right to:

(1) Obtain, reproduce, publish, or otherwise use the data produced under a Federal award; and

(2) Authorize others to receive, reproduce, publish, or otherwise use such data for Federal purposes.

F4. Cooperative Agreement Terms and Conditions of Award

The administrative and funding instrument used for this program will be a Cooperative Agreement, an assistance mechanism in which substantial CMS programmatic involvement with the recipient is anticipated during the period of performance. Under each Cooperative Agreement, CMS's purpose is to support and stimulate the recipient's activities by involvement in, and otherwise working jointly with, the award recipient in a partnership role. To facilitate appropriate involvement during the period of this Cooperative Agreement, CMS and the recipient will be in contact at least once a month and more frequently when appropriate.

Cooperative Agreement Roles and Responsibilities are as follows:

Centers for Medicare and Medicaid Services

CMS will have substantial involvement in program awards, as outlined below:

- Technical Assistance – CMS will host opportunities for training and/or networking, including conference calls and other vehicles.

- Collaboration – To facilitate compliance with the terms of the Cooperative Agreement and to support recipients more effectively, CMS will actively coordinate with other relevant Federal Agencies including but not limited to the Substance Abuse and Mental Health Services Administration, the Agency for Healthcare Research and Quality, the Health Resources and Services Administration, the Centers for Disease Control and Prevention, and the Office of the National Coordinator for Health Information Technology.

- Program Evaluation – CMS will periodically evaluate recipient efforts to assess progress toward work plan targets and milestones and work with award recipients to implement lessons learned. Some evaluation activities may include: participation in surveys; interviews; site visits; and other activities that CMS determines necessary to conduct a comprehensive evaluation.

- Oversight and Monitoring – CMS will assign specific Project Officers and Grants Management Specialists to each Cooperative Agreement award to support and monitor

recipients throughout the project period. CMS Grants Management Officers, Grants Management Specialists, and Project Officers will monitor, on a regular basis, the progress of each recipient. This monitoring may be by phone, document review, on-site visit, or other appropriate means, such as reviewing program progress reports and Federal Financial Reports (FFR or SF-425). This monitoring will serve to assess compliance with programmatic and financial requirements.

Recipients

Recipients and assigned points of contact retain the primary responsibility and dominant role for planning, directing, and executing the proposed project as outlined in the terms and conditions of the Cooperative Agreement and with substantial CMS involvement. Recipients shall engage in the following activities:

- Reporting – Comply with all reporting requirements outlined in this funding opportunity and the terms and conditions of the Cooperative Agreement to ensure the timely release of funds.
- Program Evaluation – Cooperate with CMS-directed national program evaluations.
- Technical Assistance – Participate in technical assistance venues as appropriate.
- Program Standards – Comply with all applicable current and program requirements and standards, as detailed in regulations, guidance, and the cooperative agreement terms and conditions provided with the NoA.

F5. Reporting

All recipients are required to submit the following:

Progress Reports
Recipients will be required to submit quarterly progress reports (QPR) and annual progress reports (APR). CMS will provide recipients with guidance and/or a template for QPR and APR submissions. These reports will include narrative updates on grant activities as well as information on work plan targets and in accordance with the program terms and conditions. CMS will use the quarterly and annual reports to track progress on grant goals, identify technical assistance needs, and inform learning system activities for all recipients. CMS will consider recipients for corrective action, funding restrictions, or termination if they do not meet the requirements outlined in their terms and conditions.

Quarterly Cash Transaction Financial Reporting
Recipient must report, on a quarterly basis, cash transaction data via the Payment Management System (PMS) using the Federal Financial Report (SF-425 or FFR) form. The FFR combines the information that grant recipients previously provided using two forms: the Federal Cash Transactions Report (PSC-272) and the Financial Status Report (SF-269). Cash transactions data is reflected through completion of lines 10a-10c on the FFR. Recipient must include information on indirect costs if approved as part of grant award. The quarterly FFR is due within (30) days after the end of each quarter.

Semi-Annual, Annual, and Final Expenditure Reporting
Recipient must also report on Federal expenditures, Recipient Share (if applicable), and Program Income (if applicable and/or allowable) at least annually. Frequency of expenditure reporting, whether semi-annual or annual, is stipulated in the Program Terms and Conditions of award. This information is reflected through completion of lines 10d through 10o of the FFR. Recipient must include information on indirect costs if approved as part of grant award.

Additional information on financial reporting will be provided in the terms and conditions of award.

Federal Funding Accountability and Transparency Act Reporting Requirements
New awards issued under this NOFO are subject to the reporting requirements of the Federal Funding Accountability and Transparency Act of 2006 (Pub. L. 109– 282), as amended by section 6202 of Public Law 110–252 and implemented by 2 CFR Part 170. Grant and cooperative agreement recipients must report information for each first-tier sub-award of $25,000 or more in Federal funds and executive total compensation for the recipient's and subrecipient's five most highly compensated executives as outlined in Appendix A to 2 CFR Part 170 (available online at https://www.fsrs.gov/.

Audit Requirements
Grantees must comply with audit requirements outlined in HHS regulation 45 CFR Part 75 (implementing 2 CFR Part 200). See Subpart F – Audit Requirements. http://www.ecfr.gov/cgi-bin/text-idx?node=pt45.1.75#sp45.1.75.f.

Payment Management System Reporting Requirements
Once an award is made, the funds are posted in recipient accounts established in the Payment Management System (PMS). Grantees may then access their funds by using the PMS funds request process. Recipients must submit a quarterly SF-425 via PMS. The report identifies cash transactions against the authorized funds for the award. Failure to submit the report may result in the inability to access funds.

The PMS funds request process enables grantees to request funds using a Personal Computer with an Internet connection. The funds are then delivered to the recipient via Electronic Funds Transfer (EFT). If you are a new grant recipient, please go to PMS Access Procedures to find information to register in PMS. If you need further help with that process, please contact the One-DHHS Help Desk via email at pms support@psc.gov or call (877) 614-5533 for assistance.

G. AGENCY CONTACTS

G1. Programmatic Questions

Programmatic questions about the Demonstration Project to Increase Substance Use Provider Capacity may be directed to an e-mail address accessed by multiple staff. This ensures that someone from CMS will respond even if others are unexpectedly absent during critical periods. This e-mail address is SubstanceUseProviderCapacity@cms.hhs.gov. In addition, programmatic inquiries may be directed to:

Melanie M. Brown

Centers for Medicare & Medicaid Services
Disabled and Elderly Health Programs Group
7500 Security Boulevard
Mail Stop: S2-13-20
Baltimore, MD 21244-1850
melanie.brown@cms.hhs.gov

G2. Administrative Questions

Grant and solicitation administrative questions concerning this grant opportunity may be directed to the following mailbox: SubstanceUseProviderCapacity@cms.hhs.gov. Questions submitted telephonically will not be honored.

Grants Management Contact:

Frederick F. Filberg
Centers for Medicare & Medicaid Services
Office of Acquisition and Grants Management
7500 Security Boulevard,
Mail Stop: B3-30-03
Baltimore, MD 21244

Appendix A. Guidance for Preparing a Budget Request and Narrative

Applicants should request funding only for activities that will be funded by this specific Notice of Funding Opportunity. All applicants must submit the Standard Form SF-424A as well as a Budget Narrative. The Budget Narrative should provide detailed cost itemizations and narrative supporting justification for the costs outlined in SF-424A. Both the Standard Form SF-424A and the Budget Narrative must include a yearly breakdown of costs for the entire project period.

Please review the directions below to ensure both documents are accurately completed and consistent with application requirements.

This appendix provides additional detailed instructions and examples of how the information in the budget narrative should be presented. Detailed explanations must be provided for each activity as well as full computations. Applicants must also clearly link each activity to the goals and requirements of this Funding Opportunity announcement. Funding to support activities that do not include sufficient justification (to include full descriptions and computations) may be omitted from the final budget approved.

This guidance is offered for the preparation of a budget request. Following this guidance will facilitate the review and approval of a requested budget by ensuring that the required or needed information is provided. Applicants should be careful to request funding only for activities that will be funded by this specific Funding Opportunity. Any other grant/cooperative agreement funding provided by HHS, including previously or currently awarded cooperative agreements, should not be supplanted by funds issued through this opportunity.

Applicants must request funding only for activities not already funded/supported by a previous or current award. Awards should support separate activities and new federal funding should not be supplanted by prior federal funding. In the budget request, applicants should distinguish between activities that will be funded under this Cooperative Agreement application and activities funded with other sources. Applicants should request funding only for activities which will be funded by this specific Funding Opportunity.

All applicants must submit the Standard Form SF-424A as well as a Budget Narrative. The Budget Narrative should provide detailed cost itemizations and narrative supporting justification for the costs outlined in SF-424A. Both the Standard Form SF-424A and the Budget Narrative must include a yearly breakdown of costs for the entire period of performance. Please review the directions below to ensure both documents are accurately completed and consistent with application requirements:

Standard Form SF-424A

All applicants must submit an SF-424A. To fill out the budget information requested on form SF-424A, review the general instructions provided for form SF 424A and comply with the instructions outlined below.

Note: The directions in the NOFO may differ from those provided by Grants.gov. Please follow

the instructions included in this NOFO as outlined below when completing the SF-424A.

Note: The total requested on the SF-424 (Application for Federal Assistance) should be reflective of the overall total requested on the SF-424A (Budget Information – Non-Construction) for the entire project period.

Section A – Budget Summary

Grant Program Function or Activity (column a) = Enter "Section 1003 Demonstration Project to Increase Substance Use Provider Capacity" in row 1.
New or Revised Budget, Federal (column e) = Enter the Total Federal Budget Requested for the project period in rows 1 and 5.
New or Revised Budget, Non-Federal (column f) = Enter Total Amount of any Non-Federal Funds Contributed (if applicable) in rows 1 and 5.
New or Revised Budget, Total (column g) = Enter Total Budget Proposed in rows 1 and 5, reflecting the sum of the amount for the Federal and Non-Federal Totals.

Section B – Budget Categories

Enter the total costs requested for each Object Class Category (Section B, number 6) for each year of the project period. Notice of Funding Opportunities with a 5-year project period will need to also utilize a second SF-424A form.

- Column (1) = Enter Year 1 costs for each line item (rows a-h), including the sum of the total direct charges (a-h) in row i. Indirect charges should be reflected in row j. The total for direct and indirect charges for all year 1 line items should be entered in column 1, row k (sum of row i and j).

- Column (2) = (If applicable) Enter Year 2 estimated costs for each line item (rows a-h), including the sum of the total direct charges (a-h) in row i. Indirect charges should be reflected in row j. The total for direct and indirect charges for all year 2 line items should be entered in column 2, row k (sum of row i and j).

- Column (3) = (If applicable) Enter Year 3 estimated costs for each line item (rows a-h), including the sum of the total direct charges (a-h) in row i. Indirect charges should be reflected in row j. The total for direct and indirect charges for all year 3 line items should be entered in column 3, row k (sum of row i and j).

- Column (4) = (If applicable) Enter Year 4 estimated costs for each line item (rows a-h), including the sum of the total direct charges (a-h) in row i. Indirect charges should be reflected in row j. The total for direct and indirect charges for all year 4 items should be entered in column 4, row k (sum of row i and j).

- Column (5) = Enter total costs for the project period for each line item (rows a-h), direct total costs (row i), and indirect costs (row j). The total costs for all line items should be entered in row k (sum of row i and j).

- The total in column 5, row k should match the total provided in Section A – Budget Summary, New or Revised Budget, column g, row 5.

- If the NOFO is for a 5-year project period, please complete a second SF-424A form and upload it as an attachment to the application (this specific attachment will not be counted towards the page limit). Year 5 information should be included in column 1 of Section B. Then enter the total for years 1-4 (per the first SF-424A form) in column 2 of Section B. The second SF-424A form will compute columns 1 and 2, reflecting total costs for the entire project period. This total should be consistent with the total Federal costs requested on the SF-424, Application for Federal Assistance. A blank SF-424A form can be found at Grants.gov: http://www.grants.gov/web/grants/forms/sf-424-individual- family.html #sortby=1.

Budget Narrative – Sample Narrative and Instructions

Applicants must complete a Budget Narrative and upload it to the Budget Narrative Attachment Form in the application kit. Applicants must request funding only for activities not already funded/supported by a previous award. Awards should support separate activities and new federal funding should not be supplanted by prior federal funding. In the budget request, applicant should distinguish between activities that will be funded under this application and activities funded with other sources. Other funding sources include other HHS grant programs, and other federal funding sources as applicable.

A sample Budget Narrative is included below.

A. (Personnel) Salaries and Wages

For each requested position, provide the following information: title of position; name of staff member occupying the position, if available; annual salary; percentage of time budgeted for this program; total months of salary budgeted; and total salary requested. Also, provide a justification and describe the scope of responsibility for each position, relating it to the accomplishment of program objectives. These individuals must be employees of the applicant organization.

Sample Budget

*Personnel Total $*_____

*Grant $*_____

*Funding Other than Grant Sources of Funding $*_____

Sources of Funding _____

Position Title	Name (if known)	Annual	Time	Months	Amount Requested
Project Coordinator	Susan Taylor	$45,000	100%	12 months	$45,000
Finance Administrator	John Johnson	$28,500	50%	12 months	$14,250
Outreach Supervisor	Vacant	$27,000	100%	12 months	$27,000
Total:					$86,250

Sample Justification
The format may vary, but the description of responsibilities should be directly related to specific program objectives.

Job Description: Project Coordinator - (Name)
This position directs the overall operation of the project; responsible for overseeing the implementation of project activities, coordination with other agencies, development of materials, provisions of in-service and training, conducting meetings; designs and directs the gathering, tabulating and interpreting of required data; responsible for overall program evaluation and for staff performance evaluation; and is the responsible authority for ensuring necessary reports/documentation are submitted to HHS. This position relates to all program objectives.

B. Fringe Benefits
Fringe benefits are usually applicable to direct salaries and wages. Provide information on the rate of fringe benefits used and the basis for their calculation. If a fringe benefit rate is not used, itemize how the fringe benefit amount is computed. This information must be provided for each position (unless the rates for all positions are identical).

Sample Budget

*Fringe Benefits Total $*_____

*Grant $*_____

*Funding Other than Grant Sources of Funding $*_____

Sources of Funding _____

Fringe Benefit	Rate	Salary Requested	Amount Requested
FICA	7.65%	$45,000	$3443
Worker's Compensation	2.5%	$14,250	$356

Fringe Benefit	Rate	Salary Requested	Amount Requested
Insurance	Flat rate - $2,000 (100% FTE for 12 months)	$2,000	$2,000
Retirement	5%	$27,000	$1,350
Total:			$7,149

C. Travel

Dollars requested in the travel category should be for **staff travel only**. Travel for consultants should be shown in the consultant category. Allowable travel for other participants, advisory committees, review panel, etc. should be itemized in the same way specified below and placed in the **"Other"** category. Travel incurred through a contract should be shown in the contractual category.

Provide a narrative describing the travel staff members will perform. This narrative must include a justification which explains why this travel is necessary and how it will enable the applicant to complete program requirements included in the Notice of Funding Opportunity. List where travel will be undertaken, number of trips planned, who will be making the trip, and approximate dates. If mileage is to be paid, provide the number of miles and the cost per mile. The mileage rate cannot exceed the rate set by the General Services Administration (GSA). If travel is by air, provide the estimated cost of airfare. The lowest available commercial airfares for coach or equivalent accommodations must be used. If per diem/lodging is to be paid, indicate the number of days and amount of daily per diem as well as the number of nights and estimated cost of lodging. Costs for per diem/lodging cannot exceed the rates set by GSA. Include the cost of ground transportation when applicable. Please refer to the GSA website by using the following link http://www.gsa.gov/portal/content/104877.

Sample Budget

*Travel Total $*_____

*Grant $*_____

*Funding Other than Grant Sources of Funding $*_____

Sources of Funding _____

Purpose of Travel	Location	Item	Rate	Cost
Site Visits	Neighboring areas of XXX	Mileage	$0.545 x 49 miles (use mileage rate in effect at time of mileage incurrence) x 25 trips	$668
Training (ABC)	Chicago, IL	Airfare	$200/flight x 2 persons	$400
		Luggage Fees	$50/flight x 2 persons	$100
		Hotel	$140/night x 2 persons x 3 nights	$840
		Per Diem (meals)	$49/day x 2 persons x 4 days	$392
		Transportation (to and from airport)	$50/shuttle x 2 persons x 2 shuttles	$200
		Transportation (to and from hotel)	$25/shuttle x 2 persons x 2 shuttles	$100
Total:				$2,700

Sample Justification
The Project Coordinator and the Outreach Supervisor will travel to (location) to attend a conference on the following topic XXXX. This conference is only held once a year in Chicago, IL. Attending this conference is directly linked to project goals/objectives and is a necessity because XXXX. The information and tools we will gather from attending this conference will help us to accomplish project objectives by XXXX. A sample itinerary can be provided upon request. The Project Coordinator will also make an estimated 25 trips to birth center sites to monitor program implementation (# of birth centers, # of trips per site). We are still in the process of identifying all birth center sites, but have identified an average mileage total for each site. This travel is necessary to ensure birth center sites are consistently and systematically collecting birth center data and submitting by deadlines provided. On-site monitoring will enable us to immediately address concerns. This travel also furthers our efforts to accomplish specific project goals for the following reasons

D. Equipment

Equipment is tangible nonexpendable personal property, including exempt property, charged directly to the award having a useful life of more than one year and an acquisition cost of $5,000 or more per unit. However, consistent with recipient policy, lower limits may be established. Technology items such as computers that do not meet the $5,000 per unit threshold or an alternative lower limit set by recipient policy that may therefore be classified as supplies must

still be individually tagged and recorded in an equipment/technology database. This database should include any information necessary to properly identify and locate the item. For example: serial # and physical location of equipment (e.g., laptops, tablets).

Provide justification for the use of each item and relate it to specific program objectives. Maintenance or rental fees for equipment should be shown in the "Other" category. All IT equipment should be uniquely identified. Show the unit cost of each item, number needed, and total amount.

Sample Budget

*Equipment Total $*_____

*Grant $*_____

*Funding Other than Grant Sources of Funding $*_____

Sources of Funding _____

Item(s)	**Rate**	**Cost**
All-in-one Printer, Copier, and Scanner (large scale)	1 @ $5,800	$5,800
X-Ray Machine	1 @ $8,000	$8,000
Total:		$13,800

Sample Justification

Provide complete justification for all requested equipment, including a description of how it will be used in the program. For equipment and tools which are shared amongst programs, please cost allocate as appropriate. Applicant should provide a list of hardware, software and IT equipment which will be required to complete this effort. Additionally, they should provide a list of non-IT equipment which will be required to complete this effort.

E. Supplies

Supplies include all tangible personal property with an acquisition cost of less than $5,000 per unit or an alternative lower limit set by recipient policy. Individually list each item requested. Show the unit cost of each item, number needed, and total amount. Provide justification for each item and relate it to specific program objectives. If appropriate, general office supplies may be shown by an estimated amount per month times the number of months in the budget category.

Sample Budget

*Supplies Total $*_____

Grant $_____

Funding Other than Grant Sources of Funding $_____

Sources of Funding _____

Item(s)	**Rate**	**Cost**
Laptop Computer	2 @ $1,000	$2,000
Printer	1 @ $200	$200
General office supplies	12 months x $24/mo x 10 staff	$2,880
Educational pamphlets	3,000 copies @ $1 each	$3,000
Educational videos	10 copies @ $150 each	$1,500
Total:		$9,580

Sample Justification
General office supplies will be used by staff members to carry out daily activities of the program. The project coordinator will be a new position and will require a laptop computer and printer to complete required activities under this notice of funding opportunity. The price of the laptop computer and printer is consistent with those purchased for other employees of the organization and is based upon a recently acquired invoice (which can be provided upon request). The pricing of the selected computer is necessary because it includes the following tools XXXX (e.g., firewall). The education pamphlets and videos will be purchased from XXX and used to illustrate and promote safe and healthy activities. Usage of these pamphlets and videos will enable us to address components one and two of our draft proposal. Word Processing Software will be used to document program activities, process progress reports, etc.

F. Consultant/Subrecipient/Contractual Costs

All consultant/subrecipient/contractual costs should include complete descriptions and cost breakdowns – for each consultant, subrecipient, or contract. The following information, outlined below, should be provided for each consultant, sub-award (subrecipient), or contract.

REQUIRED REPORTING INFORMATION FOR CONSULTANT HIRING

This category is appropriate when hiring an individual who gives professional advice or provides services (e.g., training, expert consultant) for a fee and who is not an employee of the grantee organization. Submit the following required information for consultants:

1. Name of Consultant: Identify the name of the consultant and describe his or her qualifications.
2. Organizational Affiliation: Identify the organizational affiliation of the consultant, if applicable.
3. Nature of Services to Be Rendered: Describe in outcome terms the consultation to be provided including the specific tasks to be completed and specific deliverables. A copy of the actual consultant agreement should not be sent to HHS.
4. Relevance of Service to the Project: Describe how the consultant services relate to the accomplishment of specific program objectives.
5. Number of Days of Consultation: Specify the total number of days of consultation.
6. Expected Rate of Compensation: Specify the rate of compensation for the consultant (e.g., rate per hour, rate per day). Include a budget showing other costs such as travel, per diem, and supplies.
7. Justification of expected compensation rates: Provide a justification for the rate, including examples of typical market rates for this service in your area.
8. Method of Accountability: Describe how the progress and performance of the consultant will be monitored. Identify who is responsible for supervising the consultant agreement.

If the above information is unknown for any consultant at the time the application is submitted, the information may be submitted at a later date as a revision to the budget. In the Budget Narrative, a summary should be provided of the proposed consultants, the work to be completed, and amounts for each. Recipient must not incur costs for consultant activities until the aforementioned information is provided for each consultant and CMS approval obtained.

REQUIRED REPORTING INFORMATION FOR SUBRECIPIENT APPROVAL
The costs of project activities to be undertaken by a third-party subrecipient should be included in this category. Please see 45 CFR Part 75.351, *Subrecipient and contractor determinations*.

Applicants must submit information on the: (a) Statement of Work; (b) Period of Performance; and (c) Itemized Budget and Justification. If this information is unknown at the time the application is submitted, the information may be submitted at a later date as a revision to the budget. In the Budget Narrative, a summary should be provided of the proposed sub-awards (subrecipients), the work to be completed, and amounts for each. Recipient must not incur costs for subrecipient activities until the aforementioned information is provided for each subrecipient and CMS approval obtained.

REQUIRED REPORTING INFORMATION FOR CONTRACT APPROVAL
All recipients must submit to HHS the following required information for establishing a third-party contract to perform project activities.

1. Name of Contractor: Who is the contractor? Identify the name of the proposed contractor and indicate whether the contract is with an institution or organization.
2. Method of Selection: How was the contractor selected? State whether the contract is sole source or competitive bid. If an organization is the sole source for the contract, include an explanation as to why this institution is the only one able to perform contract

services.

3. Period of Performance: How long is the contract period? Specify the beginning and ending dates of the contract.
4. Scope of Work: What will the contractor do? Describe in outcome terms, the specific services/tasks to be performed by the contractor as related to the accomplishment of program objectives. Deliverables should be clearly defined.
5. Method of Accountability: How will the contractor be monitored? Describe how the progress and performance of the contractor will be monitored during and on close of the contract period. Identify who will be responsible for supervising the contract.
6. Itemized Budget and Justification: Provide an itemized budget with appropriate justification. If applicable, include any indirect cost paid under the contract and the indirect cost rate used.

If the above information is unknown for any contractor at the time the application is submitted, the information may be submitted at a later date as a revision to the budget. Copies of the actual contracts should not be sent to HHS, unless specifically requested. In the Budget Narrative, a summary should be provided of the proposed contracts, the work to be completed, and amounts for each. Recipient must not incur costs for contractual activities until the aforementioned information is provided for each contract and CMS approval obtained.

G. Construction (not applicable)

H. Other

This category contains items not included in the previous budget categories. Individually list each item requested and provide appropriate justification related to the program objectives.

Sample Budget

*Other Total $*_____

*Grant $*_____

*Funding Other than Grant Sources of Funding $*_____

Sources of Funding _____

Item(s)	**Rate**	**Cost**
Telephone	$45 per month x 3 employees x 12 months	$1,620
Postage	$250 per quarter x 4 quarters	$1,000
Printing	$0.50 x 3,000 copies	$1,500

Item(s)	Rate	Cost
Equipment Rental *specify item	$1,000 per day for 3 days	$3,000
Internet Provider Service	$20 per month x 3 employees x 12 months	$720
Word Processing Software (specify type)	1 @ $400	$400
Total:		$8,240

Some items are self-explanatory (telephone, postage, rent) unless the unit rate or total amount requested is excessive. If the item is not self-explanatory and/or the rate is excessive, include additional justification. For printing costs, identify the types and number of copies of documents to be printed (e.g., procedure manuals, annual reports, materials for media campaign).

Sample Justification

We are requesting costs to accommodate telephone and internet costs for the 3 new hires that will be working on this project in the new space designated. We are also requesting printing and postage costs to support producing fliers to disseminate in the community and brochures to educate participants enrolled in the program. The word processing software will be used to help us track data and compile reports. To track and compile the data, we will need to rent____. Without this equipment, we will not be able to produce this information in an accurate and timely manner.

A. Total Direct Costs **$_____**

Show total direct costs by listing totals of each category.

B. **Indirect Costs** **$_____**

To claim indirect costs, the applicant organization must have a current approved indirect cost rate agreement established with the Cognizant Federal agency unless the organization has never established one (see 45 CFR §75.414 for more information). If a rate has been issued, a copy of the most recent indirect cost rate agreement must be provided with the application.

Sample Budget

The rate is____% and is computed on the following direct cost base of $_____.

Personnel $_____

Fringe $_____

*Travel $*_____

*Supplies $*_____

*Other$*_____

Total $x _____*% = Total Indirect Costs*

If the applicant organization has never received an indirect cost rate, except for those non-Federal entities described in Appendix VII(D)(1)(b) to 45 CFR part 75, the applicant may elect to charge a de minimis rate of 10% of modified total direct costs (MTDC). If the applicant has never received an indirect cost rate and wants to exceed the de minimis rate, then costs normally identified as indirect costs (overhead costs) can be budgeted and identified as direct costs. These costs should be outlined in the "other" costs category and fully described and itemized as other direct costs.

Appendix B. Application and Submission Information

This NOFO contains all the instructions to enable a potential applicant to apply. The application should be written primarily as a narrative with the addition of standard forms required by the Federal government for all grants and cooperative agreements.

EIN, DUNS, AND SAM REQUIREMENTS (ALL APPLICATIONS)

Employer Identification Number

All applicants under this announcement must have an Employer Identification Number (EIN), otherwise known as a Taxpayer Identification Number (TIN), to apply. **Please note that applicants should begin the process of obtaining an EIN/TIN as soon as possible after the announcement is posted to ensure this information is received in advance of application deadlines.**

Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS Number)

All applicants must have a Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number. The DUNS number is a nine-digit number that uniquely identifies business entities. To obtain a DUNS number, access the following website: www.dunandbradstreet.com or call 1-866-705-5711. This number should be entered in block 8c (on Form SF-424, Application for Federal Assistance). The organization name and address entered in block 8a and 8e should be exactly as given for the DUNS number.

Applicants should obtain this DUNS number as soon as possible after the announcement is posted to ensure all registration steps are completed in time.

System for Award Management (SAM)

The applicant must also register in the System for Award Management (SAM) database in order to be able to submit the application. Applicants are encouraged to register early and must have their DUNS and EIN/TIN numbers in order to do so. Information about SAM is available at https://www.sam.gov/portal/public/SAM/. The SAM registration process is a separate process from submitting an application.

Applicants should begin the SAM registration process as soon as possible after the announcement is posted to ensure that it does not impair your ability to meet required submission deadlines.

SAM registration process is a separate process from submitting an application. Applicants are encouraged to register early, and must provide their DUNS and EIN/TIN numbers in order to do so. **Applicants should begin the SAM registration process as soon as possible after the announcement is posted to ensure that it does not impair your ability to meet required submission deadlines.**

Each year organizations and entities registered to apply for Federal grants through Grants.gov (or GrantSolutions as applicable) must renew their registration with SAM. **Failure to renew SAM registration prior to application submission will prevent an applicant from successfully applying via Grants.gov (or GrantSolutions as applicable). Similarly, failure to maintain an active SAM registration during the application review process can prevent HHS from issuing your agency an award.**

Applicants must also successfully register with SAM prior to registering in the Federal Funding Accountability and Transparency Act Subaward Reporting System (FSRS) as a prime awardee user. Please also refer to Section F5. Reporting (Federal Funding Accountability and Transparency Act Reporting Requirements) of this Funding Opportunity for more information. Primary awardees must maintain a current registration with the SAM database and **may make subawards only to entities that have DUNS numbers.**

Organizations must report executive compensation as part of the registration profile at https://www.sam.gov/portal/public/SAM/ by the end of the month following the month in which this award is made and annually thereafter (based on the reporting requirements of the Federal Funding Accountability and Transparency Act (FFATA) of 2006 (Pub. L. 109-282), as amended by Section 6202 of Public Law 110-252 and implemented by 2 CFR Part 170). The Grants Management Specialist assigned to monitor the sub-award and executive compensation reporting requirements is Iris Grady, who can be reached at DivisionOfGrantsManagement@cms.hhs.gov

APPLICATION MATERIALS AND INSTRUCTIONS TO APPLY VIA GRANTS.GOV (COMPETITIVE APPLICATIONS)

Application materials will be available for download at http://www.grants.gov. Please note that HHS requires applications for all announcements to be submitted electronically through http://www.grants.gov. For assistance with http://www.grants.gov, contact Support@Grants.gov or 1- 800-518-4726. At http://www.grants.gov, applicants will be able to download a copy of the application packet, complete it off-line, and then upload and submit the application via the Grants.gov website.

Specific instructions for applications submitted via http://www.grants.gov**:**

- You can access the electronic application for this project at http://www.grants.gov. You must search the downloadable application page by the CFDA number.
- At the http://www.grants.gov website, you will find information about submitting an application electronically through the site, including the hours of operation. HHS strongly recommends that you do not wait until the application due date to begin the application process through http://www.grants.gov because of the time needed to complete the required registration steps.
- **Applications not submitted by the due date and time are considered late and will not be reviewed.**
- Authorized Organizational Representative: The Authorized Organizational Representative (AOR) who will officially submit an application on behalf of the organization must register with Grants.gov for a username and password. AORs must complete a profile with Grants.gov using their organization's DUNS Number to obtain their username and password

at http://grants.gov/applicants/get_registered.jsp. AORs must wait one business day after successful registration in SAM before entering their profiles in Grants.gov. **Applicants should complete this process as soon as possible after successful registration in SAM to ensure this step is completed in time to apply before application deadlines. Applications that are not submitted by the due date and time as a result of AOR issues will not be reviewed.**

- When an AOR registers with Grants.gov to submit applications on behalf of an organization, that organization's E-Biz POC will receive an email notification. The email address provided in the profile will be the email used to send the notification from Grants.gov to the E-Biz POC with the AOR copied on the correspondence.
- The E-Biz POC must then login to Grants.gov (using the organization's DUNS number for the username and the special password called "M-PIN") and approve the AOR, thereby providing permission to submit applications.
- **Any files uploaded or attached to the Grants.gov application must be PDF file format and must contain a valid file format extension in the filename.** Even though Grants.gov allows applicants to attach any file formats as part of their application, CMS restricts this practice and only accepts PDF file formats. Any file submitted as part of the Grants.gov application that is not in a PDF file format, or contains password protection, will not be accepted for processing and will be excluded from the application during the review process. In addition, the use of compressed file formats such as ZIP, RAR, or Adobe Portfolio will not be accepted. The application must be submitted in a file format that can easily be copied and read by reviewers. It is recommended that scanned copies not be submitted through Grants.gov unless the applicant confirms the clarity of the documents. Pages cannot be reduced in size, resulting in multiple pages on a single sheet, to avoid exceeding the page limitation**.**
- **All documents that do not conform to the above specifications will be excluded from the application materials during the review process.** Please also refer to Section D2. Content and Form of Application Submission.
- After you electronically submit your application, you will receive an acknowledgement from http://www.grants.gov that contains a Grants.gov tracking number. HHS will retrieve your application package from Grants.gov. **Please note that applicants may incur a time delay before they receive acknowledgement that the application has been accepted by the Grants.gov system.**
- **Applicants should not wait until the application deadline to apply because notification by Grants.gov that the application is incomplete may not be received until close to or after the application deadline, eliminating the opportunity to correct errors and resubmit the application. Applications submitted after the deadline, as a result of errors on the part of the applicant, will not be reviewed.**
- After HHS retrieves your application package from Grants.gov, a return receipt will be emailed to the applicant contact. This will be in addition to the validation number provided by Grants.gov.

Applications cannot be accepted through any email address. Full applications can only be accepted through http://www.grants.gov. Full applications cannot be received via paper mail, courier, or delivery service.

All grant applications must be submitted electronically and be received through http://www.grants.gov by 3:00 p.m. Eastern Standard or Daylight Time (Baltimore, MD) for the applicable deadline date. Please refer to the Executive Summary for submission date.

- All applications will receive an automatic time stamp upon submission and applicants will receive an email reply acknowledging the application's receipt.

Please be aware of the following:

- Search for the application package in Grants.gov by entering the CFDA number. This number is shown on the cover page of this announcement.
- If you experience technical challenges while submitting your application electronically, please contact Grants.gov Support directly at: https://www.grants.gov/web/grants/support.html or (800) 518-4726. Customer Support is available to address questions 24 hours a day, 7 days a week (except on Federal holidays).
- Upon contacting Grants.gov, obtain a tracking number as proof of contact. The tracking number is helpful if there are technical issues that cannot be resolved.

To be considered timely, applications must be received by the published deadline date. However, a general extension of a published application deadline that affects all state applicants or only those in a defined geographical area may be authorized by circumstances that affect the public at large, such as natural disasters (e.g., floods, hurricanes) or disruptions of electronic (e.g., application receipt services) or other services, such as a prolonged blackout. This statement does not apply to an individual entity having Internet service problems. In order for there to be any consideration, there must be an effect on the public at large.

Grants.gov complies with section 508 of the Rehabilitation Act of 1973. If an individual uses assistive technology and is unable to access any material on the site, including forms contained with an application package, they can e-mail the Grants.gov contact center at support@grants.gov for help or call 1-800-518-4726.

Appendix C. Application Check List - Required Contents

A complete proposal consists of the materials organized in the sequence below. Please ensure that the project and budget narratives are page-numbered and the below forms are completed with an electronic signature and enclosed as part of the proposal. **Everything listed below must be submitted through http://www.grants.gov and formatting requirements must be followed.**

For specific requirements and instructions on application package, forms, formatting, please see:

Section D. Application and Submission Information & Appendix B. Application and Submission Information
Section E. Application Review Information
Appendix A. Guidance for Preparing a Budget Request and Narrative

Standard Forms

- ☐ SF 424: Application for Federal Assistance
- ☐ SF-424A: Budget Information
- ☐ SF-424B: Assurances-Non-Construction Programs
- ☐ SF-LLL: Disclosure of Lobbying Activities
- ☐ Project Abstract Summary
- ☐ Project Site Location

Form Narrative Documents

- ☐ Copy of Letter of Intent
- ☐ Project Narrative
- ☐ Project Work Plan
- ☐ Budget Narrative
- ☐ Supporting Documents: PDF of second SF 424A (see Section D2. Content and Form of Application Submission)
- ☐ Supporting Documents: Program Duplication Assessment
- ☐ Supporting Documents: Memoranda of Understanding (MOUs) with Key State Agencies and Other Partners
- ☐ Business Assessment of Applicant Organization

Appendix D. Business Assessment of Applicant Organization

As required by 45 C.F.R. §75.205 for competitive grants and cooperative agreements, CMS will evaluate the risk posed by applicants before they receive an award. This analysis of risk includes items such as financial stability, quality of management systems, and the ability to meet the management standards prescribed in 45 C.F.R. Part 75.

An applicant must review and answer the business assessment questions outlined below. There are ten (10) topic areas labeled A-J, with a varying number of questions within each topic area. Applicant MUST provide an answer to each question. Moreover, the applicant should refrain from solely answering "yes" or "no" to each question or solely providing web site address(es) – i.e., a brief, substantive answer should be given for almost all questions (referring to sections of official agency policy is acceptable). If the answer to any question is non-applicable, please provide an explanation. Please note, if CMS cannot complete its review without contacting the applicant for additional clarification, the applicant may not be selected for award.

A. General Information
   1. Does the organization have a Board of Directors with specific functions and responsibilities (by-laws)?
   2. Are minutes of the Board of Directors' meetings maintained?
   3. Is there an organizational chart or similar document establishing clear lines of responsibility and authority?
   4. Are duties for key employees of the organization defined?
   5. Does the organization have grants or cost-reimbursement contracts with other U.S. Department of Health and Human Services components or other Federal agencies?
   6. Have any aspects of the organization's activities been audited recently by a Government agency or independent public accountant?
   7. Has the organization obtained fidelity bond coverage for responsible officials and employees of the organization?
   8. Has the organization obtained fidelity bond insurance in amounts required by statute or organization policy?

B. Accounting System
   1. Is there a chart of accounts?
   2. Is a double-entry accounting system used?
   3. Does the organization maintain the basic books of account as applicable?
      a. General ledger
      b. Operating ledger
      c. Project (Job) cost ledger
      d. Cash receipts journal
      e. Cash disbursement journal
      f. Payroll journal
      g. Income (sales) journal
      h. Purchase journal
      i. General journal
   4. Does the accounting system adequately identify receipt and disbursement for each grant

(or contract)?

5. Does the accounting system provide for the recording of expenditures for each program by required budget cost categories?
6. Does the accounting system provide for recording the non-Federal share and in-kind contributions (if applicable for a grant program)?
7. Does the organization prepare financial statements at least annually? If not, how often?
8. Have the financial statements been audited within the past 2 years by an independent public accountant?
9. Does the organization have a bookkeeper or accountant? If no, who is in charge of the accounting section?
10. Is there an accounting instruction manual?

C. Budgetary Controls

1. Does the organization use an operating budget to control project funds?
2. Are persons in the organization who approve budget amendments authorized to do so by the Agency of Directors or top management?
3. Are there budgetary controls in effect to preclude incurring obligations in excess of:
   a. Total funds available for an award?
   b. Total funds available for a budget cost category?
4. Are cash requirements and/or drawdowns limited to immediate need?

D. Personnel

1. Are personnel policies established in writing or in the process of preparation which detail at a minimum:
   a. Duties and responsibilities of each employee's position?
   b. Qualifications for each position?
   c. Salary ranges associated with each job?
   d. Promotion Plan?
   e. Equal Employment Opportunity?
   f. Annual performance appraisals?
   g. Types and levels of fringe benefits paid to professionals, nonprofessionals, officers, or governing Agency members?
2. Is employee compensation reasonable and comparable to that paid for similar work in the competitive labor market?
   a. Are salary comparability surveys conducted? How often?
   b. Are salaries of personnel assigned to Government projects about the same as before assignment? Identify reasons for significant increases.
   c. Does the organization maintain a payroll distribution system which meets the required standards as contained in the applicable cost principles for that organization?
   d. Does the organization maintain daily attendance records for hourly employees? Does this show actual time employees sign in and out?
   e. Does the payroll distribution system account for the total effort (100%) for which the employee is compensated by the organization?
   f. Who signs and certifies work performed in items 5, 6, and 7 above?
   g. Where duties require employees to spend considerable time away from their offices, are reports prepared for their supervisors disclosing their outside activities?

E. Payroll
   1. Does preparation of the payroll require more than one employee?
   2. Are the duties of those individuals preparing the payroll related?
   3. Are the names of employees hired reported in writing by the personnel office to the payroll department?
   4. Are the names of employees terminated reported in writing by the personnel office to the payroll department?
   5. Is the payroll verified at regular intervals against the personnel records?
   6. Are all salaries and wage rates authorized and approved in writing by a designated official or supervisor?
   7. Are vacation and sick leave payments similarly authorized and approved?
   8. Is there verification against payments for vacation, sick leave, etc., in excess of amounts approved and/or authorized?
   9. Is the payroll double-checked as to:
      a. Hours?
      b. Rates?
      c. Deductions?
      d. Extensions, etc.?
   10. Are signed authorizations on file for all deductions being made from employees' salaries and wages?
   11. Is the payroll signed prior to payment by the employee preparing the payroll? The employee checking the payroll?
   12. Are salary payrolls approved by an authorized official prior to payment?
   13. Are employees paid by check or direct deposit? If no, how are they paid?
   14. If paid by check, are the checks pre-numbered?
   15. Are checks drawn and signed by employees who do not:
      a. Prepare the payroll?
      b. Have custody of cash funds?
      c. Maintain accounting records?
   16. Are payroll checks distributed to employees by someone other than the supervisor?
   17. Is there a payroll bank account? If no, will one be opened if recipient is selected for award?
   18. Is the payroll bank account reconciled by someone other than payroll staff or personnel who sign and distribute the pay checks?

F. Consultants
   1. Are there written policies or consistently followed procedures regarding the use of consultants which detail at a minimum:
      a. Circumstances under which consultants may be used?
      b. Consideration of in-house capabilities to accomplish services before contracting for them?
      c. Requirement for solicitation or bids from several contract sources to establish reasonableness of cost and quality of services to be provided?
      d. Consulting rates, per diem, etc.?
      e. Are consultants required to sign consulting agreements outlining services to be

rendered, duration of engagement, reporting requirements, and pay rates?

G. Property Management
   1. Are records maintained which provide a description of the items purchased, the acquisition cost, and the location?
   2. Are detailed property and equipment records periodically balanced to the general ledger?
   3. Are detailed property and equipment records periodically checked by physical inventory?
   4. Are there written procedures governing the disposition of property and equipment?
   5. Are periodic reports prepared showing obsolete equipment, equipment needing repair, or equipment no longer useful to the organization?
   6. Does the organization have adequate insurance to protect the Federal interest in equipment and real property?

H. Purchases
   1. Does the organization have written purchasing procedures? If not, briefly describe how purchasing activities are handled.
   2. Does the purchasing policy/procedure consider such matters as quality, cost, delivery, competition, source selection, etc.?
   3. Has the responsibility for purchasing been assigned to one department, section, or individual within the organization? If not, explain.
   4. Is the purchasing function separate from accounting and receiving?
   5. Are competitive bids obtained for items such as rentals or service agreements over certain amounts?
   6. Are purchase orders required for purchasing all equipment and services?
   7. Is control maintained over items or dollar amounts requiring the contracting or grants management officer's advance approval? Describe controlling factors.
   8. Is the accounting department notified promptly of purchased goods returned to vendors?
   9. Is there an adequate system for the recording and checking of partial deliveries and checking deliveries against purchase orders?
   10. When only a partial order is received, is the project account credited for the undelivered portion of the purchase order?
   11. Are the vendor invoices checked for:
      a. Prices and credit terms?
      b. Extensions?
      c. Errors and omissions?
      d. Freight charges and disallowances?
      e. Are vouchers, supporting documents, expenses, or other distributions reviewed and cleared by designated staff before payment is authorized?

I. Travel
   1. Does the organization have formal travel policies or consistently followed procedures which, at a minimum, state that:
      a. Travel charges are reimbursed based on actual costs incurred or by use of per diem and/or mileage rates?
      b. Receipts for lodging and meals are required when reimbursement is based on actual cost incurred?

c. Per Diem rates include reasonable dollar limitations? Subsistence and lodging rates are comparable to current Federal per diem and mileage rates?
d. Commercial transportation costs are incurred at coach fares unless adequately justified? Travel requests are approved prior to actual travel?
e. Travel expense reports show purpose of trip?

J. Internal Controls
1. Is there a separation of responsibility in the receipt, payment, and recording of cash?
   a. For example: Are the duties of the record keeper or bookkeeper separated from any cash functions such as the receipt or payment of cash?
   b. Or, is the signing of checks limited to those designated officials whose duties exclude posting and/or recording cash received, approving vouchers for payment, and payroll preparation?
2. Are all checks approved by an authorized official before they are signed?
3. Are all accounting entries supported by appropriate documentation (e.g., purchase orders, vouchers, vendor payments)?
4. Does the organization have an internal auditor or internal audit staff?
5. Is there a petty cash fund where responsibility is: vested in one individual; limited to a reasonable amount; restricted as to purchase; and counted, verified, and balanced by an independent employee at time of reimbursement?
6. Are all checks pre-numbered and accounted for when general purpose bank account is reconciled?
7. If a mechanical or facsimile signature is used for cash disbursements, is the signature plate, die, key, electronic card, etc., under strict control?
8. Are bank accounts reconciled by persons not handling cash in the organization? Are all employees who handle funds required to be bonded against loss by reason of fraud or dishonesty?

Appendix E. Review and Selection Process

The review and selection process will include the following:

i. Applications will be screened to determine eligibility for further review using the criteria detailed in Section C. Eligibility Information and Section D. Application and Submission Information (with cross-reference to Appendix B) of this NOFO. Applications that are received late or fail to meet the eligibility requirements as detailed in this NOFO or do not include the required forms will not be reviewed. However, the CMS OAGM Grants Management Officer, in its sole discretion, may continue the review process for an ineligible application if it is in the best interest of the government to meet the objectives of the program.

ii. Procedures for assessing the technical merit of grant applications have been instituted to provide for an objective review of applications and to assist the applicant in understanding the standards against which each application will be judged. The application requirements described in Section D. Application and Submission Requirements and the review criteria described in Section E1. Criteria will be used. Applications will be evaluated by an objective review committee. The objective review committee may include Federal and/or non-Federal reviewers. Applicants should pay strict attention to addressing all these criteria, as they are the basis upon which the reviewers will evaluate their applications.

iii. The results of the objective review of the applications by qualified experts will be used to advise the CMS approving official. Final award decisions will be made by a CMS approving official. In making these decisions, the CMS approving official will take into consideration: recommendations of the review panel;; the readiness of the applicant to conduct the work required; the scope of overall projected impact on the aims and overall quality of the proposal; reviews for programmatic and grants management compliance; the reasonableness of the estimated cost to the government and anticipated results; and the likelihood that the proposed project will result in the benefits expected.

iv. CMS will also consider other factors, including: CMS may give strong preference to state applicants that have a prevalence of SUD that is comparable to or higher than the national average (as measured by per capita opioid drug overdoses and/or Medicare and Medicaid OUD diagnoses).

v. As noted in 45 CFR Part 75, CMS will do a review of risks posed by applicants prior to award. In evaluating risks posed by applicants, CMS will consider the below factors as part of the risk assessment (applicant should review the factors in their entirety at section 75.205)

   a. Financial stability;
   b. Quality of management systems and ability to meet the management standards prescribed;
   c. History of performance (including, for prior recipients of Federal awards: timeliness of compliance with applicable reporting requirements, conformance to the terms and conditions of previous federal awards, extent to which previously awarded amounts will be expended prior to future awards);
   d. Reports and findings from audits performed under Subpart F of 45 CFR Part 75; and
   e. Applicant's ability to effectively implement statutory, regulatory, and other requirements

imposed on non-federal entities.

vi. HHS reserves the right to conduct pre-award Negotiations with potential awardees.

Appendix F. 504 Compliance

CMS and its grantees are responsible for complying with federal laws regarding accessibility as noted in Section F2. Administration and National Policy Requirements.

The grantee may receive a request from a beneficiary or member of the public for materials in accessible formats. All successful applicants under this announcement must comply with the following reporting and review activities regarding accessible format requests:

Accessibility Requirements:

1. Public Notification: If you have a public facing website, you shall post a message no later than **30** business days after award that notifies your customers of their right to receive an accessible format. Sample language may be found at: https://www.hhs.gov/civil-rights/for-providers/clearance-medicare-providers/technical-assistance/example-notice-nondiscrimination/index.html.

2. Processing Requests Made by Individuals with Disabilities:

    a. Documents:
        i. When receiving a request for information in an alternate format (e.g., Braille, large print) from a beneficiary or member of the public, you must:
            1. Consider/evaluate the request according to civil rights laws.
            2. Acknowledge receipt of the request and explain your process within **2** business days.
            3. Establish a mechanism to provide the request.
        ii. If you are unable to fulfill an accessible format request, CMS may work with you in an effort to provide the accessible format. You shall refer the request to CMS within **3** business days if unable to provide the request. You shall submit the request, using encrypted e-mail (to safeguard any personally identifiable information), to the AltFormatRequest@cms.hhs.gov mailbox with the following information:
            1. The e-mail title shall read "Grantee (Organization) Alternate Format Document Request."
            2. The body of the e-mail shall include:
                a. Requester's name, phone number, e-mail, and mailing address.
                b. The type of accessible format requested, e.g., audio recording on compact disc (CD), written document in Braille, written document in large print, document in a format that is read by qualified readers.
                c. Contact information for the person submitting the e-mail – Organization (Grantee), name, phone number, and e-mail.
            3. The document that needs to be put into an accessible format shall be attached to the e-mail.

            CMS may respond to the request and provide the information directly to the requester.
        iii. The Grantee shall maintain record of all alternate format requests received including the requestor's name, contact information, date of request, document requested, format requested, date of acknowledgment, date request provided, and date referred to

CMS if applicable. Forward quarterly records to the AltFormatRequest@cms.hhs.gov mailbox.

b. Services
   i. When receiving request for an accessibility service (e.g., sign language interpreter) from a beneficiary or member of the public, you must:
      1. Consider/evaluate the request according to civil rights laws.
      2. Acknowledge receipt of the request and explain your process within **2** business days.
      3. Establish a mechanism to provide the request.
   ii. If you are unable to fulfill an accessible service request, CMS may work with you in an effort to provide the accessible service. You shall refer the request to CMS within **3** business days if unable to provide the service. You shall submit the request, using encrypted e-mail (to safeguard any personally identifiable information) to the AltFormatRequest@cms.hhs.gov mailbox with the following information:
      1. The e-mail title shall read "Grantee (Organization) Accessible Service Request."
      2. The body of the e-mail shall include:
         a. Requester's name, phone number, e-mail, and mailing address.
         b. The type of service requested (e.g., sign language interpreter and the type of sign language needed).
         c. The date, time, address and duration of the needed service.
         d. A description of the venue for which the service is needed (e.g., public education seminar, one-on-one interview).
         e. Contact information for the person submitting the e-mail – Organization (Grantee), name, phone number and e-mail.
      3. Any applicable documents shall be attached to the e-mail.

      CMS will respond to the request and respond directly to the requester.
   iii. The Grantee shall maintain record of all accessible service requests received including the requestor's name, contact information, date of request, service requested, date of acknowledgment, date service provided, and date referred to CMS if applicable. Forward quarterly records to the AltFormatRequest@cms.hhs.gov mailbox.

3. Processing Requests Made by Individuals with Limited English Proficiency (LEP):

   a. Documents:
      i. When receiving a request for information in a language other than English from a beneficiary or member of the public, you must:
         1. Consider/evaluate the request according to civil rights laws.
         2. Acknowledge receipt of the request and explain your process within **2** business days.
         3. Establish a mechanism to provide the request as applicable.
      ii. If you are unable to fulfill an alternate language format request, CMS may work with you in an effort to provide the alternate language format as funding and resources allow. You shall refer the request to CMS within **3** business days if unable to provide the request. You shall submit the request, using encrypted e-mail (to safeguard any personally identifiable information), to the

AltFormatRequest@cms.hhs.gov mailbox with the following information:

1. The e-mail title shall read "Grantee (Organization) Alternate Language Document Request."
2. The body of the e-mail shall include:
   a. Requester's name, phone number, e-mail, and mailing address.
   b. The language requested.
   c. Contact information for the person submitting the e-mail – Organization (Grantee), name, phone number and e-mail.
3. The document that needs to be translated shall be attached to the e-mail.

CMS may respond to the request and provide the information directly to the requester.

iii. The Grantee shall maintain record of all alternate language requests received including the requestor's name, contact information, date of request, document requested, language requested, date of acknowledgment, date request provided, and date referred to CMS if applicable. Forward quarterly records to the AltFormatRequest@cms.hhs.gov mailbox.

b. Services

i. When receiving request for an alternate language service (e.g., oral language interpreter) from a beneficiary or member of the public, you must:
   1. Consider/evaluate the request according to civil rights laws.
   2. Acknowledge receipt of the request and explain your process within **2** business days.
   3. Establish a mechanism to provide the request as applicable.

ii. If you are unable to fulfill an alternate language service request, CMS may work with you in an effort to provide the alternate language service as funding and resources allow. You shall refer the request to CMS within **3** business days if unable to provide the service. You shall submit the request, using encrypted e-mail (to safeguard any personally identifiable information), to the AltFormatRequest@cms.hhs.gov mailbox with the following information:
   1. The e-mail title shall read "Grantee (Organization) Accessible Service Request."
   2. The body of the e-mail shall include:
      a. Requester's name, phone number, e-mail, and mailing address.
      b. The language requested.
      c. The date, time, address and duration of the needed service.
      d. A description of the venue for which the service is needed (e.g., public education seminar, one-on-one interview).
      e. Contact information for the person submitting the e-mail – Organization (Grantee), name, phone number and e-mail.
   3. Any applicable documents shall be attached to the e-mail.

   CMS will respond to the request and respond directly to the requester.

iii. The Grantee shall maintain record of all alternate language service requests received including the requestor's name, contact information, date of request, language requested, service requested, date of acknowledgment, date service provided, and date referred to CMS if applicable. Forward quarterly records to the

AltFormatRequest@cms.hhs.gov mailbox.

Please contact the CMS Office of Equal Opportunity and Civil Rights for more information about accessibility reporting obligations at AltFormatRequest@cms.hhs.gov.

Appendix G. Program Duplication Assessment

Purpose: The purpose of this Program Duplication Assessment is for applicants to identify other alternative payment and/or delivery reform programs and funding sources at the local, state, and federal levels that are relevant to the state's proposed work under the section 1003 project and address how they will ensure that CMS funding for section 1003 will not duplicate those services and/or funding already available. Applicants will also identify how they will monitor potential program and funding duplication, including mitigation strategies if duplication is identified. Selected applicants (recipients) will be required to complete an updated Assessment no less than annually, providing updates to such programs and funding sources (or an attestation of no changes, if applicable). Failure to complete the Program Duplication Assessment, or evidence that the applicant is at serious risk of program duplication (as determined by CMS), may disqualify the applicant. CMS, in its sole discretion, will determine whether the information provided by the applicant and/or recipient constitutes duplication.

State: _____ Individual Contact: (Name/Email):_____

1. Is the state aware of its responsibility to avoid program duplication?

   Yes ____
   No ____

2. If the state is awarded section 1003 funding, will it ensure award funds are not used to duplicate or supplant current federal, state, or local funding, or be used for Medicaid administrative match or the non-federal share of Medicaid payments?

   Yes ____
   No ____

3. Please provide an explanation for how the state's budget takes into account existing state and federal programs or resources that can be leveraged for the section 1003 demonstration project.

4. Please summarize the state's standard operating procedures and best practices for avoiding program duplication, demonstrating that the state agency administering the project has the internal budget and grants management staffing and capacity required to maintain and track separate budgets to monitor for and avoid duplication over the course of the project period. If available, please attach as an appendix to this assessment the state's standard operating procedure for preventing program duplication.

5. Does the state expect to be involved in any alternative payment and/or delivery reform programs or demonstrations during the project period (September 2019 through March 2021), including but not limited to: Comprehensive Primary Care Plus Model, Accountable Health Communities Model, State Innovation Model, Maternal Opioid Misuse Model, Integrated Care for Kids Model, existing Medicaid demonstrations and programs (that may potentially overlap or complement section 1003 activities), etc.?

Yes ____
No ____

If the state answered "Yes" to Question 5, please complete Question 6. If the state answered "No" to Question 5, please skip Question 6 and move to Question 7.

6. Please provide a list and description of all alternative payment and/or delivery reform programs or demonstrations at the local, state, and federal level that the state is currently involved in or plans to be involved in during the grant demonstration project period that may be relevant to the state's application (e.g., overlapping activities, beneficiaries, and/or participating providers). For each program identified, please provide the following information:

    i. Name of the program;
    ii. Description of the program objectives and allowed expenses;
    iii. Payer(s) of the program services;
    iv. Amount of funding on an annual basis;
    v. Expected start and end dates of the program (if applicable);
    vi. Authority for the alternative payment model (if applicable); and
    vii. An explanation for how payment under section 1003 would not result in duplicative services or funding.

7. Does the state expect to be involved in any programs or demonstrations during the project period that are aimed at (1) addressing SUD or OUD among Medicare, Medicaid, and/or dual-eligible beneficiaries, (2) addressing MAT for individuals with OUD, and/or (3) intensive care management for SUD or OUD?

    Yes ____
    No ____

If the state answered "Yes" to Question 7, please complete Question 8. If the state answered "No," please skip Question 8.

8. Please provide a list and description of all programs with the following aims in which the state is currently involved or plans to be involved during the project period: (1) addressing SUD OUD among Medicare, Medicaid, and/or dual-eligible beneficiaries, (2) addressing MAT for individuals with OUD, and/or (3) intensive care management for SUD or OUD. For each program identified, please provide the following information:

    i. Name of the program;
    ii. Description of the program objectives and allowed expenses;
    iii. Payer(s) of the program services;
    iv. Amount of funding on an annual basis;
    v. Expected start and end dates of the program (if applicable).

Appendix H. Glossary

Beneficiary: An individual or participant who is eligible for and enrolled in the Medicaid program in the state in which he or she resides.

Case management and targeted case management services: Case management services means services furnished to assist individuals eligible under the State plan who reside in a community setting or are transitioning to a community setting from a medical institution in gaining access to needed medical, social, educational, and other services. Targeted case management services means case management services furnished without regard to requirements of statewide provision of services or comparability. Examples of groups that states may target for case management include adults with mental health conditions and SUD, pregnant women who meet risk criteria, and such other groups as a state might identify. (42 CFR 441.18 and 440.169)

Cultural and linguistic competence: Culturally and linguistically appropriate services are respectful of and responsive to the health beliefs, practices and needs of diverse consumers (Office of Minority Health [2014]).

Family: Families are important participants in treatment planning, treatment, and recovery. Families come in different forms and, to the extent possible, providers should respect the individual's view of who constitutes their family. Families can be organized in a wide variety of configurations regardless of social or economic status. Families can include biological parents and their partners, adoptive parents and their partners, foster parents and their partners, grandparents and their partners, siblings and their partners, care givers, friends, and others as defined by the consumer. Medicaid services to non-Medicaid enrolled individuals are not coverable. Under the rehabilitative services benefit, however, some services like family therapy can be covered when the beneficiary is present, the service is for the direct benefit of the beneficiary, in accordance with the beneficiary's needs and treatment goals identified in the beneficiary's treatment plan, and for the purpose of assisting in the beneficiary's recovery.

Peer Supports or Peer Recovery Services: Peer support services are an evidence-based model of care which consists of a qualified peer support provider who assists individuals with their recovery from mental illness and SUD. CMS recognizes that the experiences of peer support providers, as consumers of mental health and SUD services, can be an important component in a state's delivery of effective treatment. States may choose to deliver peer support services through several Medicaid funding authorities. The following current authorities have been used by States to date: section 1905(a)(13) rehabilitative services; section 1915(b); and section 1915(c).

(See State Medicaid Directors Letter, SMDL #07-011, https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD081507A.pdf

Person-centered planning: Person-centered planning is a process directed by the person with service needs which identifies recovery goals, objectives, and strategies. Person-centered care is aligned with the requirements of section 2402(a) of the Affordable Care Act: Standards for Person-Centered Planning and Self-Direction in Home and Community-Based Services

Programs (Department of Health & Human Services [June 6, 2014]).

Practitioner or Provider under the Medicaid Program: Any individual (practitioner) or entity (provider) engaged in the delivery of health care services and who is legally authorized to do so by the state in which the individual or entity delivers the services. Provider means either of the following: (1) For the fee-for-service program, any individual or entity furnishing Medicaid services under an agreement with the Medicaid agency; (2) For the managed care program, any individual or entity that is engaged in the delivery of health care services and is legally authorized to do so by the State in which it delivers the services. (42 CFR § 400.203). Medicaid-covered health care services include services furnished to address SUD.

Recovery: Recovery is defined as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." The guiding principles of recovery are: hope; person-driven; many pathways; holistic; peer support; relational; culture; addresses trauma; strengths/responsibility; and respect. (Substance Abuse and Mental Health Services Administration [2012]).

Appendix I. Crosswalk between § 1003 and Selected Medicaid Opportunities Addressing the Opioid Epidemic

	1115(a) SUD Demonstration	§ 1003 of the SUPPORT Act	§ 1006(a) of the SUPPORT Act	§ 1006(b) of the SUPPORT Act
Overview	Federal financial participation in SUD treatment in Institutions for Mental Disease (IMDs) to encourage development of a comprehensive approach to treating SUD. This includes improved transitions from residential and inpatient IMD facilities to community-based settings. States are expected to take steps to ensure good quality of care in residential treatment settings (RTC) and implement processes to limit access to settings for those who truly need RTC care. Must be budget neutral.	Demonstration to increase capacity for SUD treatment and/or recovery services in Medicaid. At least 10 Medicaid agencies will receive planning grants. From among planning grantees, up to 5 states will be selected for a demonstration in which they can receive enhanced federal reimbursement for SUD services.	2-quarter extension of enhanced Federal Medical Assistance Percentage (FMAP) for Health Homes for individuals with SUD.	Requirement for state Medicaid plans to provide coverage for MAT.

	1115(a) SUD Demonstration	§ 1003 of the SUPPORT Act	§ 1006(a) of the SUPPORT Act	§ 1006(b) of the SUPPORT Act
Key characteristics	No resources to improve care delivery effectiveness Designed to address gaps in care by including federal reimbursement for services provided in residential settings and incentivize other SUD system reforms including implementation of provider qualifications to ensure quality of care in those settings	Focuses on treatment capacity broadly, not necessarily MAT Focuses on treatment capacity for Medicaid providers only Enhanced federal financial participation for increases in SUD services' expenditures as compared to 2018	No up-front resources to support development and implementation of a health home, e.g., infrastructure needed to meet data collection requirements, provider level care delivery transformation	Does not require elimination of prior authorization Does not provide resources/ incentives to eliminate other coverage barriers to accessing MAT
Scope	No limit; 21 states as of Jan 2019	At least 10 states for 18-month planning grants; up to 5 states will be selected for 36-month demonstration	Any state that applies for an SUD health home after 10/1/2018	National, with provider shortage exclusion for opt-out with Secretary approval
Funding	N/A	$50 million for planning grants; 80% federal reimbursement for spending on SUD treatment and recovery services above 2018 level for up to 5 demonstration states; $5 million to CMS for implementation	Enhanced 90/10 FMAP for up to 10 quarters for health home services. (Note: Indian Health Care Improvement Act 100% FMAP for AI/AN Medicaid services.)	None specified in statute

	1115(a) SUD Demonstration	§ 1003 of the SUPPORT Act	§ 1006(a) of the SUPPORT Act	§ 1006(b) of the SUPPORT Act
Effective Dates	Beginning November 2017	2019-2025	Beginning October 2018	October 2020 – September 2025
Quality Incentives	None specified	None specified in statute	None specified	None specified in statute
Treatment services	Medicaid-coverable services provided to individuals residing in residential treatment facilities that are not ordinarily matchable because these facilities qualify as IMDs	Medicaid-covered SUD treatment and recovery services, including (but not limited to) MAT, short-term detoxification, outpatient SUD treatment, and rehabilitative services including peer supports	Comprehensive care management, care coordination, health promotion, comprehensive transitional care/follow-up, patient and family support, and referral to community and social support services	All drugs approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262) to treat OUD Related counseling and behavioral therapy
Eligible providers	Medicaid providers	Medicaid providers that furnish SUD treatment or recovery services, hospitals, health care systems, FQHCs, and certified community behavioral health clinics. Not restricted to but includes a focus on Medicaid	Medicaid providers	Medicaid providers, including OTPs that meet federal certification and treatment standards

	1115(a) SUD Demonstration	§ 1003 of the SUPPORT Act	§ 1006(a) of the SUPPORT Act	§ 1006(b) of the SUPPORT Act
		providers qualified to address the needs of: individuals with neonatal abstinence syndrome; pregnant and post-partum women; infants; adolescents and young adults ages 12-21; or AI/ANs		
Beneficiaries	Varies by state. Can be as broad as all Medicaid beneficiaries in the state or limited to certain geographic regions and/or limited to certain age ranges, with all of these limitations requiring waiver of some core Medicaid State plan requirements, such as statewideness and comparability, which section 1115 authority allows.	Gives preference to states with a higher than national average prevalence of SUD, as measured by aggregate per capita drug overdoses. Requires selection of States in a manner that ensures geographic diversity.	Medicaid beneficiaries diagnosed with either: (1) two chronic conditions; (2) one chronic condition and at risk for a second; or (3) a serious mental illness.	All Medicaid beneficiaries who are determined to need MAT.

Appendix J. Relevant Medicaid Benefit Categories

Some relevant mandatory State plan benefit categories under which mental health and SUD services can be furnished, as specified in section 1905(a) of the Act, are described below[20]:

- Inpatient Hospital Services. The inpatient hospital service mandatory benefit is defined in section 1905(a)(1) of the Act and described in regulations at 42 CFR §440.10. Inpatient hospital services, as defined in 42 CFR §440.10, are those services that are ordinarily furnished in a hospital for the care and treatment of inpatients; are furnished under the direction of a physician or dentist; and are furnished in an institution that is maintained primarily for the care and treatment of patients with disorders other than mental diseases, is licensed or formally approved as a hospital by an officially designed authority for State standard-setting, meets the requirements for participation in Medicare as a hospital, and has a utilization review plan in effect unless a waiver has been granted.
- *Outpatient Hospital Services.* The outpatient hospital services mandatory benefit is defined at section 1905(a)(2)(A) of the Act and described in regulations at 42 CFR §440.20(a). "Outpatient hospital services" means preventive, diagnostic, therapeutic, rehabilitative, or palliative services that: are furnished to outpatients; are furnished by or under the direction of a physician or dentist; and are furnished by an institution that is licensed or formally approved as a hospital by the state and meets the requirements for participating in Medicare as a hospital.
- *Federally Qualified Health Center Services (FQHC).* FQHC services are defined in section 1905(a)(2)(C), section 1905(l)(2), and section 1861(aa)(3) of the Act. This mandatory benefit includes services provided by certain core providers including physicians, nurse practitioners and physician assistants (subject to any state law prohibition on furnishing primary health care), nurse midwives, clinical psychologists, clinical social workers, and visiting nurses in areas with a shortage of home health agencies. FQHC services also include other ambulatory care services otherwise included in the Medicaid State plan.
- *Rural Health Clinic Services (RHC).* The RHC services are defined in section 1905(a)(2) (B), section 1905(l)(1), and section 1861(aa) of the Act and in regulations at 42 CFR §440.20(b) and (c). RHC services are provided by a rural health clinic certified in accordance with 42 CFR Part 491 and include services provided by certain core providers including physicians, nurse practitioners and physician assistants (subject to any state law prohibition on furnishing primary health care), nurse midwives, clinical psychologists, clinical social workers, and visiting nurses in areas with a shortage of home health agencies. RHC services also include other ambulatory care services otherwise included in the Medicaid State plan.
- *Physicians' Services.* The physician services mandatory benefit defined in section 1905(a)(5) of the Act and in regulations at 42 CFR §440.50. Physicians' services are furnished within the scope of practice of medicine or osteopathy as defined by State law whether furnished by or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy. Physicians' services can be furnished in the office, the recipient's

[20] CMCS Informational Bulletin Medicaid Strategies for Non-Opioid Pharmacologic and NonPharmacologic Chronic Pain Management, February 22, 2019 https://www.medicaid.gov/federal-policy-guidance/downloads/cib022219.pdf

home, a hospital, a skilled nursing facility, or elsewhere.

- *Nurse Practitioner Services*. The nurse practitioner services mandatory benefit is defined in section 1905(a)(21) of the Act and in regulations at 42 CFR §440.166. Nurse practitioner services mean services that are furnished by a registered professional nurse who meets a State's advanced education and clinical practice requirements, if any, beyond the 2 to 4 years of basic nursing education required of all registered nurses. The requirements for Certified Pediatric and Family nurse practitioners are also described in 42 CFR §440.166.

Optional 1905 (a) Benefits

- *Rehabilitative Services.* Rehabilitative services are an optional benefit as specified in section 1905(a)(13) of the Act. Medicaid regulations at 42 CFR §440.130(d) broadly define rehabilitative services as "any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice under State law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level" except as otherwise provided in the regulations. Examples of services that states could cover under the rehabilitative services benefit include MAT, cognitive behavioral therapy, and peer support services.

- *Physical and Occupational Therapy Services.* States have several options for providing coverage for physical therapy and occupational therapy. Both are optional Medicaid State plan benefits as specified in section 1905(a)(11) of the Act. Both or either can be covered: as a therapy benefit as specified under section 1905(a)(11) of the Act; as a rehabilitative services benefit, as described above and defined in section 1905(a)(13) of the Act; or through the home health benefit specified in section 1905(a)(7) of the Act. Regardless of the mechanism for coverage, the practitioners of physical therapy or occupational therapy must meet the qualifications set forth in 42 CFR 440.110.

- *Other Licensed Practitioner Services (OLP).* Section 1905(a)(6) of the Act provides states flexibility in covering services provided by licensed practitioners as defined by state law. As set forth in 42 C.F.R. § 440.60(a), other licensed practitioner services are "any medical or remedial care or services, other than physicians' services, provided by licensed practitioners within the scope of practice as defined under State law."

- *Preventive Services.* Section 1905(a)(13) of the Act authorizes preventive services which are defined in 42 C.F.R. § 440.130(c) as "services recommended by a physician or other licensed practitioner of the healing arts acting within the scope of authorized practice under State law to:
    i. Prevent disease, disability, and other health conditions or their progression;
    ii. Prolong life; and
    iii. Promote physical and mental health and efficiency."

  Preventive services must "involve direct patient care and be for the purpose of diagnosing, treating, or preventing (or minimizing the adverse effects of) illness, injury, or other impairments to an individual's physical or mental health."[21]

[21] State Medicaid Manual, Section 4385(b)

Regardless of the specific authority chosen, states must meet certain requirements in their State plan benefits. Services under a Medicaid-covered benefit generally must be provided in the same amount, duration, and scope to all enrollees in the same eligibility group. Medicaid beneficiaries must also be permitted to choose a health care provider or practitioner from any qualified provider or practitioner who undertakes to provide the services, and services provided under the State plan must be available statewide to all eligible individuals. However, states may request waivers as described below to allow exceptions to these requirements.

Section 1945 Health Home Benefit

Through the Medicaid Health Home optional State plan benefit, states can establish Health Homes to coordinate care for people with Medicaid who have chronic conditions as set forth in Section 1945 of the Act. Since individuals with chronic conditions may experience chronic pain, the Medicaid Health Home benefit provides states with another strategy to help address chronic pain management among those individuals. Specifically, Health Home providers integrate and coordinate all primary care, acute care, mental health and SUD services, and long-term services and supports to treat the whole-person to promote wellness. The Health Home works with beneficiaries to educate them about their condition(s) and to support the individual in developing the knowledge and activities that support lifestyle changes, focusing on the goals of maintaining and protecting wellness.[22]

Home and Community Based Services 1915(c) Waivers

States have the option to apply for home and community-based services waivers (HCBS Waivers) to enable beneficiaries who would otherwise need an institutional level of care to receive long-term care services and supports in their home or community, rather than in an institutional setting. HCBS waivers allows states to waive certain Medicaid requirements (statewideness, comparability of services, and/or income and resource rules applicable in the community) enabling them to target populations by age or diagnosis.

Section 1915(i) State Plan Amendment

Like the Section 1915(c) waiver, the 1915(i) State Plan Amendment (SPA) allows states to provide HCBS not already available under the State plan targeted to individuals who meet state defined needs-based criteria. Section 1915(i) also enables states to establish additional needs-based criteria for specific services, establish a new eligibility group for people to receive HCBS for a limited period of time, and define the services included in the benefit, as set forth in 42 C.F.R. § 441.700.

States could use the 1915(i) SPA to offer services that are not already available under the State plan to specific target populations by age, disability, diagnosis, and/or Medicaid eligibility group.

Section 1115 Demonstrations

[22] Additional information on the Health Home benefit, including descriptions of how states are utilizing this option is available at https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home- information-resource-center/index.html.

States may utilize section 1115 demonstration authority to test non-opioid pain management strategies. Section 1115 demonstrations are intended to give states the flexibility to pilot new approaches that are likely to assist in promoting the objectives of the Medicaid program. As referenced above, CMS recently issued guidance on a section 1115 demonstration opportunity including flexibilities to help states improve access to and quality of SUD treatment. Through this section 1115 initiative, states have an opportunity to receive federal financial participation (FFP) for the full continuum of services to treat addiction to opioids or other substances, including services provided to Medicaid enrollees residing in residential treatment facilities that are not ordinarily eligible for federal Medicaid reimbursement due to the exclusion in the Medicaid statute of services provided to patients in IMDs. Participating states are expected to take steps to improve access to community-based outpatient and intensive outpatient treatment as well as MAT. In addition, states are expected to take certain actions to improve quality of care.

Managed Care Strategies

States may provide non-pharmacologic treatment options in either a fee-for-service or managed care delivery system. When states use a risk-based managed care delivery system, a managed care plan may voluntarily choose to provide additional benefits that are not covered under the State plan but the cost and utilization of such additional benefits may not be used in developing capitation rates for the managed care plan.

A managed care plan may also provide alternative services in lieu of pain management services covered under the State plan so long as the state and the managed care plan meet the requirements for in lieu of services outlined in 42 CFR 438.3(e)(2). Services provided in lieu of services covered under the State plan may be taken into account when developing rates for the managed care plan if the regulation requirements are met, including the requirement that the state determine that the alternative is a medically appropriate and cost effective substitute for the covered service.

Appendix K. Demonstration Project to Increase Substance Use Provider Capacity – Questions and Answers

1. *Is it necessary for a state to apply twice to participate in this demonstration project – first in pursuit of a planning grant and again to become a demonstration?*

Yes. The demonstration project includes two components: planning grants and demonstrations. All states are eligible to compete for a planning grant. CMS anticipates awarding at least 10 planning grants. From among the planning grantees, up to 5 states will be selected to implement demonstrations. Selections will be based on the criteria in Section E1. Criteria. CMS will provide notification to the planning grantees regarding when the applications for Phase II should be submitted.

2. *What technical assistance (TA) will be available to states receiving planning grants?*

TA to grantees will include regular grantee teleconferences, webinars, and in-person meetings with subject matter experts. These gatherings will be venues for problem-solving and sharing promising strategies.

3. *How will states selected to implement demonstrations be reimbursed for SUD treatment or recovery services?*

Section 1903(aa)(5) addresses payment under the demonstration. Per section 1903(aa)(5)(B), a "qualified sum" for a State for a quarter is the amount equal to "the amount (if any) by which the sums expended by the State during such quarter attributable to SUD treatment or recovery services furnished by providers participating under the State plan (or a waiver of such plan) exceeds ¼ of such sums expended by the State during fiscal year 2018 attributable to SUD treatment or recovery services." Per section 1903(aa)(5)(A), for each quarter in the demonstration (not the 18-month planning grant period), each state receives an amount equal to 80 percent of the qualified sums expended during such quarter.

CMS will implement this payment provision as follows:

a) Define, for each state, what expenses are considered SUD treatment and recovery services.
b) Determine the state expenses for those SUD treatment and recovery services for fiscal year 2018 ("FY 2018 expenses").
c) Calculate .25 of the FY 2018 expenses.
d) For each quarter in the 36-month demonstration, determine whether the state spent at least .25 of the FY 2018 expenses on SUD treatment and recovery services. If yes, subtract .25 of FY 2018 expenses from the amount spent in the demonstration quarter. That difference is the qualified sum.
e) Pay the state 80% of the qualified sum.

4. *Do services have to include MAT to be counted as SUD treatment and recovery services?*

SUD treatment or recovery services covered under the State plan or a waiver of such plan may be counted. This includes MAT (if applicable) but is not limited to MAT.

APPENDIX L. Notice of Intent to Apply for Demonstration Project to Increase Substance Use Provider Capacity

NOTE: Completed forms must be submitted by email.

If intending to apply, please complete and return by July 18, 2019 to SubstanceUseProviderCapacity@cms.hhs.gov.

Name of State:

Applicant Agency/Organization:

Contact Name and Title:

Address:

Phone:

Fax:

E-mail address: