

**U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
Center for Medicare and Medicaid Innovation**

Maternal Opioid Misuse Model

Notice of Funding Opportunity Type: New

Funding Opportunity Type: Cooperative Agreement

Notice of Funding Opportunity Number: CMS-2A2-20-001

CFDA: 93.687

Notice of Funding Opportunity Posting Date: February 8, 2019

Applicable Dates:

Letter of Intent to Apply Due Date: N/A

Electronic Application Due Date: May 6, 2019

3:00 PM Eastern U.S. Time

Anticipated Issuance Notice(s) of Award: November 6, 2019

Anticipated Period of Performance: 5 Years

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Executive Summary

The Maternal Opioid Misuse (MOM) model provides funding opportunities for selected state Medicaid agencies to test whether payments that support evidence-based, coordinated care delivery for pregnant and postpartum women with opioid use disorder (OUD) and their infants can reduce Medicaid and Children’s Health Insurance Program (CHIP) expenditures, and improve the quality of care for this population of Medicaid and CHIP beneficiaries.

Pregnancy, a time during which women may be more engaged in their own care due to more regular interactions with the healthcare system, provides a key opportunity for focused impact on health care outcomes for pregnant women and their infants within the context of the broader opioid crisis. The MOM model will test payment and care-delivery innovation to improve outcomes and reduce costs for pregnant and postpartum Medicaid beneficiaries with OUD and their infants.

The MOM model leverages Center for Medicare and Medicaid Innovation authorities and state flexibility to address the fragmented care that the model’s focus population currently receives. The Centers for Medicare & Medicaid Services (CMS) will provide support for model awardees to design and implement state-specific interventions through funding for infrastructure and capacity development and, potentially, 1) a one-year, transitional period of care delivery, and 2) achievement of quality milestones. During the model’s five-year performance period, responsibility for funding the care-delivery innovation will transition to each state, with the ultimate goal of sustaining successful payment and care-delivery strategies through incorporation into each state’s Medicaid programs.

Item	Description
HHS Awarding Agency	Centers for Medicare & Medicaid Services
CMS Awarding Center	Center for Medicare and Medicaid Innovation
Notice of Funding Opportunity Title	Maternal Opioid Misuse Model
Authorization	Section 1115A(b) of the Social Security Act (the Act) as added by Section 3021 of the Patient Protection and Affordable Care Act (P.L. 111-148)
Funding Opportunity Type	New
Funding Opportunity Number	CMS-2A2-20-001
Type of Award	Cooperative Agreement
Catalog of Federal Domestic Assistance	93.687
Letter of Intent to Apply Due Date (if applicable)	

Application Due Date & Time	May 6, 2019 3:00 PM Eastern U.S. Time
Anticipated Issuance Notice(s) of Award	November 6, 2019
Anticipated Period of Performance	January 1, 2020 – December 31, 2024
Anticipated Total Available Funding	\$64,560,000 pending availability of funds
Estimated Number of Awards	Up to Twelve (12)

A. Program Description

A1. Purpose

CMS, through its Center for Medicare and Medicaid Innovation (Innovation Center), seeks applications to the MOM model: a state-driven payment and service delivery model that aims to improve quality and reduce spending for pregnant and postpartum Medicaid and CHIP beneficiaries with OUD and their infants. The needs of this population are best served through coordinated and integrated physical and behavioral health care, including access to medication assisted treatment (MAT), and through appropriate linkages to community services. The MOM model will test whether funding states to develop and implement interventions that deliver evidence-based, coordinated care and referrals to community or other support services will improve beneficiary outcomes while reducing Medicaid expenditures. The model further addresses existing gaps by supporting state development of coverage and payment strategies that will sustain beneficiary access to high-quality, coordinated care during and after the model performance period.

CMS will award, through a competitive process, renewable one-year cooperative agreements to up to 12 successful applicants. The model will run for a five-year period. The parameters for the model are described in this Notice of Funding Opportunity announcement (NOFO).

A2. Authority

The authority for the MOM model is section 1115A of the Social Security Act (the Act). Section 1115A of the Act authorizes the Secretary of the Department of Health and Human Services to test innovative payment and service delivery models to reduce Medicare, Medicaid, or CHIP expenditures while preserving or enhancing the quality of care.

Waiver Authority

Under section 1115A(d)(1) of the Act, the Secretary of Health and Human Services may waive such requirements of Titles XI and XVIII and of sections 1902(a)(1), 1902(a)(13), and 1903(m)(2)(A)(iii), and 1934 (other than subsections (b)(1)(A) and (c)(5) of such section) as may be necessary solely for purposes of carrying out section 1115A with respect to testing models described in section 1115A(b). For this model and consistent with this standard, the Secretary may consider issuing waivers of certain fraud and abuse provisions in sections 1128A, 1128B, and 1877 of the SSA.

Waivers are not being issued in this document; waivers, if any, would be set forth in separately issued documentation. Thus, notwithstanding any other provision of this NOFO, all awardees, subawardees, and all other relevant individuals or entities must comply with all applicable laws and regulations, except as explicitly provided in any such separately documented waiver issued pursuant to section 1115A(d)(1) specifically for the MOM model. Any such waiver would apply solely to the MOM model and could differ in scope or design from waivers granted for other programs or models.

A3. Background

The Acting Secretary of the Department of Health and Human Services (HHS) declared on October 26, 2017 that the opioid crisis is a nationwide public health emergency..ⁱⁱ Opioid misuse has devastating consequences for individuals, families, caregivers, states, and communities. The impact of this crisis is significant for CMS beneficiaries, who have higher rates of opioid overdose deaths and opioid misuse-related healthcare utilization relative to the privately insured..^{iii,iv,v} Pregnant and postpartum Medicaid beneficiaries and their infants are at particular and growing risk of harm. Substance use is now a leading cause of maternal mortality; Medicaid is the primary payer for more than 75% of maternal hospital stays related to substance use disorders; and Medicaid pays for 80% of the \$1.5 billion annual cost of caring for infants exposed in utero to substances such as opioids..^{vi}

Despite the significant and costly burden of opioid misuse in pregnancy, numerous barriers remain to delivering well-coordinated, high-quality care that improves outcomes for pregnant and postpartum women with OUD. This lack of coordination is especially problematic for a population that faces numerous multifaceted challenges, including intense stigma, in accessing health care and non-clinical social supports. First, there is a critical lack of coordination and integration among providers caring for pregnant and postpartum women with OUD across practice settings. Second, while Medicaid affords states the flexibility to cover most needed services for pregnant and postpartum women with OUD, coverage varies widely across states and may impact access to evidence-based care..¹ Third, access to substance use disorder treatment for Medicaid beneficiaries is limited because providers do not universally accept Medicaid coverage or treat pregnant and postpartum women. Finally, there is a shortage of substance use treatment and maternity care providers for pregnant and postpartum women with OUD, particularly in rural areas, where the opioid crisis is magnified.

While there is an array of ongoing federal activity to address opioid misuse among different segments of the U.S. population, existing care fragmentation and coverage variation affecting pregnant and postpartum Medicaid beneficiaries represents a critical opportunity for a payment innovation that catalyzes care transformation for this group of women.

The Innovation Center has developed the MOM model in alignment with the Administration, HHS, and other CMS initiatives responding to the unfolding public health crisis. To optimize outcomes, pregnant and postpartum women with OUD need not only consistent prenatal care and treatment for OUD, including access to MAT – delivered by a multidisciplinary team of providers – but also prompt referral to community-based services such as housing, outreach services², and supported employment³. Under the

¹ For example, state policies may limit access to freestanding birth centers, which have been shown to improve birth outcomes for mothers and infants. See “Final Evaluation Report: Strong Start for Mothers and Newborns - Enhanced Prenatal Care Models,” Vols. 1-2 and Findings-At-A-Glance available at <https://innovation.cms.gov/initiatives/strong-start/>.

² “Outreach services” would include identifying and enrolling eligible beneficiaries in coverage and providing linkages to model services.

³ Defined at 42 C.F.R. 440.180(c)(2)(iii)(C) as “any combination of special supervisory services, training, transportation, and adaptive equipment that the State demonstrates are essential for persons to engage in paid employment and that are not normally required for nondisabled persons engaged in competitive employment.”

MOM model, awardees will develop and implement strategies that transform a fragmented system of care in order to improve health outcomes and reduce Medicaid expenditures associated with treating pregnant and postpartum women with OUD.

A3.1 Model Overview

State Medicaid agencies (referred to as “states”) will partner with one or more local or regional entities associated with clinical delivery sites (such entity referred to as a “care-delivery partner”) to design and implement an intervention that coordinates and delivers physical and behavioral healthcare services – along with appropriate coordination, beneficiary engagement, and referrals to community or other support services – for the model population. Applicants may propose to implement the model on a statewide basis or in a clearly-defined sub-state geography. In addition to a detailed description of its proposed intervention, each applicant must propose a Coverage and Payment Strategy that addresses how it will assume responsibility for funding care-delivery during the model performance period (as applicable) and that sets out a sustainable coverage plan that will allow members of the model population to access coordination, engagement, and referrals services after they are no longer enrolled in the model. States that use CHIP funding to provide health coverage to pregnant women may include pregnant CHIP beneficiaries in their proposed model population. This strategy should leverage available Medicaid and CHIP authorities as necessary, including State Plan Amendments (SPAs) and waivers. While the MOM model does not preclude collaboration between states considering whether to apply to the model: 1) each state must submit its own application; 2) each application will be evaluated individually based on the criteria set forth in the NOFO; and, 3) each awardee will be independently responsible for meeting all requirements set forth in its individualized cooperative agreement.

MOM model funds may not be used to supplant or duplicate existing resources that cover the costs of Medicaid-covered services or administrative expenses. Rather, model funds are intended to support the development and long-term sustainability of the model intervention. These strategies may include but are not limited to: developing needed Medicaid Special Terms and Conditions (STCs) or SPAs; increasing provider capacity in the geographic area; establishing data-reporting infrastructure; strengthening collaborative relationships among providers; developing telemedicine resources; designing an optimal state Coverage and Payment Strategy; and, continuing service-delivery transformation.

A3.2 Model Goals

The model seeks improved quality of care, reduced expenditures, and improved health outcomes for pregnant and postpartum Medicaid beneficiaries with OUD and their infants, as well as sustained care transformation across participating geographies. Over the life of the model, each state is expected to fully implement successful payment and care-delivery strategies to ensure sustainability, with the ultimate goal of incorporating them into their Medicaid programs using existing Medicaid authorities. The results of this model test will also support other states and communities in implementing evidence-based payment and care-delivery strategies to better serve this population.

A.4. Program Requirements

A.4.1 Medicaid and CHIP Authorities

CMS expects that awardees will use available Medicaid and CHIP authorities as necessary to support model implementation. Individual states may need to work with CMS to request new authorities. Each MOM model applicant should incorporate a description of the Medicaid and CHIP authorities that it proposes to use to implement the model (see A.4.6., Application Submission Requirements), including authorities currently in place as well as authorities the applicant would request if their application were successful. Information included in a MOM model application will be used solely for the purpose of application review and does not represent a formal request for a State Plan Amendment, waiver, or demonstration approval.

on the part of the state; nor a commitment to approval on the part of CMS. Rather, for successful applications, the identification of current and planned Medicaid authorities will help support state and federal planning efforts related to transitioning the financing of the care models from Innovation Center cooperative agreement-based funding to funding through the state Medicaid program, in compliance with applicable Medicaid statutory and regulatory requirements. During the Pre-Implementation Period of the model, each awardee will work with the Innovation Center and the Center for Medicaid and CHIP Services (CMCS) to refine and finalize the concepts detailed in its proposed implementation plan (see F.5.2., Table D, Operational Milestones).

A.4.2. Key Terms

The following key terms will be used throughout this NOFO (these and additional terms are defined in Appendix H., Glossary):

State Medicaid Agency: CMS will award funding to the state Medicaid agency, referred to throughout this NOFO as the “state,” “applicant,” or “awardee,” and including state Medicaid agencies for the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands. As an awardee, each state will be responsible for receipt and management of award funding in accordance with the model terms and conditions and applicable federal grant laws, and accountable for meeting all requirements set out in the Terms and Conditions of Award.

Care-Delivery Partner: Each state applicant must engage one or more care-delivery partners to develop the model application and, if the state is selected as an awardee, to implement the model. A care-delivery partner must be a health system or payer, such as a Medicaid managed care plan (MCP), that is associated with a clinical delivery site. Each state will be responsible for working with its care-delivery partner(s) to: identify, engage, and retain beneficiaries, participating providers, and clinical delivery sites in the model; design and implement an intervention that ensures that Medicaid-covered services and model services are delivered to beneficiaries in a coordinated fashion; and ensure participation by all model partners, including the awardee, care-delivery partner, clinical delivery site providers and staff, patients and other relevant individuals or entities, in model evaluation. Although a state can work with more than one local or regional care-delivery partner to serve multiple regions or counties, only one award will be issued per state.

Model Population: The MOM model population will consist of pregnant and postpartum Medicaid and CHIP beneficiaries with OUD who reside in the awardee state. A state may include pregnant women covered by CHIP in the model population. If an awardee proposes to implement the model on a sub-state basis, the state may propose to limit eligibility based on residence in the sub-state model service area, subject to applicable Medicaid and CHIP statutory and regulatory requirements. An individual will be eligible to receive model services if she is pregnant, has OUD, and is eligible for and enrolled in Medicaid. A beneficiary will be considered enrolled in the model when she has been screened for and diagnosed with OUD, has an established initial treatment plan for OUD, and has provided the necessary consent and authorization documents to allow for information-sharing among providers and plans.

Beneficiary Engagement: A beneficiary who is enrolled in the model and has received a physical or behavioral healthcare service, as defined in this NOFO, in a given calendar month, is considered engaged in the MOM model in that calendar month. A beneficiary who is enrolled in the model but has not received a physical or behavioral healthcare service, as defined in this NOFO, in a given calendar month is considered disengaged from the MOM model in that calendar month. An awardee’s eligibility to access Transition Funding, if available, varies based on a beneficiary’s engagement status (see B.2, Award Amount).

Model Intervention: Each awardee must design and implement a model intervention that delivers comprehensive physical and behavioral healthcare services in key categories of care to its model population and that provides coordination of services, beneficiary engagement, and referrals for necessary community or other support services. Additional information about required services is set out below in A.4.4., MOM Model Services and Care Structure. Each awardee must provide a plan for the provision of care by a multi-disciplinary team of healthcare professionals across a variety of settings, which may include co-located providers. The intervention may be implemented statewide or in a clearly defined sub-state geography and may build on but may not supplant or duplicate existing efforts.

Coverage and Payment Strategy: Each awardee must develop and implement a realistic, actionable, and sustainable Coverage and Payment Strategy. The Strategy must explain how the awardee will fund model services and establish coverage policies that ensure that members of the model population have access to such services, i.e., intake, assessment, creation of a treatment plan and coordination, engagement, and referral services. Each state has the flexibility to propose a Coverage and Payment Strategy tailored to the needs of its population and proposed service area, and the parameters of its State Plan, but is expected to consider State Plan Amendments and program waivers as necessary. The Coverage and Payment Strategy must be fully implemented by Year 3 of the model, but applicants will be expected to propose strategies that will sustain model interventions after the end of the model performance period.

Postpartum Period: Postpartum continuity of care is critical to success of the model, including maintaining both maternal and infant well-being as well as combatting the risk of relapse for women with OUD during the postpartum period. At a minimum, each awardee must ensure that members of its model population can access services throughout the postpartum period through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends, as required by 42 U.S.C. 1396(a)(e)(5). Each applicant must address care for its model population during the postpartum period in its Coverage and Payment Strategy. Each applicant also has the opportunity to earn additional points toward its overall application score based on the proposed scope of services in its strategies, duration of extended access to these services, and overall long-term sustainability of its postpartum plans.

A.4.3 Model Performance Periods and Associated Funding Structure

Each state and its care-delivery partner(s) will implement the model during three distinct model performance periods: the Pre-Implementation Period (Year 1); Transition Period (Year 2); and Full Implementation Periods (Years 3, 4, and 5).

Table A sets out a non-exhaustive list of potential state and care-delivery partner activities during each model performance period. (Note that each care-delivery partner will perform its duties pursuant to its independent agreement with the awardee.)

Table A. Potential State and Care-Delivery Partner Activities by Model Period

	State	Care-Delivery Partners
Pre-Implementation Period (Year 1)	• Develop state Coverage and Payment Strategy • Develop related demonstration Special Terms and Conditions waiver or SPA submissions • Work with CMCS to ensure necessary authorities are or will be in place to operate model in implementation period	• Develop and prepare to operationalize care-delivery model • Strengthen provider collaborations • Increase providers' capacity in geographic area

	State	Care-Delivery Partners
	• Ensure provision of usable claims and encounter data as necessary to operate and evaluate model • Coordinate with care-delivery partners to support information-sharing, to the extent permitted by law • Report required data to the Innovation Center in accordance with award	• Develop any needed telemedicine resources • Establish data-reporting infrastructure • Develop information-sharing system and processes • Report required data to the Innovation Center in accordance with award
Transition Period (Year 2)	• Finalize a state Coverage and Payment Strategy • Secure approval for related demonstrations, waivers or SPAs • Coordinate with non-state partners to support information-sharing, to the extent permitted by law • Report required data to the Innovation Center in accordance with award	• Implement care-delivery model, funded by section 1115A • Report required data to the Innovation Center in accordance with award
Full Implementation Period (Years 3-5)	• Implement Coverage and Payment Strategy in Medicaid FFS, managed care, or other delivery system • Innovation Center Transition Funding terminates; the state takes on financial responsibility for these services • Report required data to the Innovation Center in accordance with award	• Implement care-delivery model, funded by state Medicaid and other sources identified in the Coverage and Payment Strategy • Operate information-sharing system • Report quality milestones • Report required data to the Innovation Center in accordance with award

These performance periods are associated with specific funding, described in more detail in Section B.2, Federal Award Information, Award Amount, Table B:

- Implementation Funding will be available annually during each year of the model to support infrastructure and capacity-building.
- Transition Funding will be available during the Transition Period only to support intake, assessment, and the creation of a treatment plan (once per pregnancy per beneficiary) and coordination, engagement, and referral activities (ongoing for up to 12 months) not otherwise covered by Medicaid. Model funds may not be used to supplant or duplicate existing funding sources. The state must assume these costs in alignment with its Coverage and Payment Strategy by Year 3.
- Milestone Funding will be available during the Full Implementation Period based on each awardee's demonstrated performance on pre-determined quality milestones.

Award amounts will vary based on the variations in healthcare costs in the awardee geography and the needs demonstrated by each applicant in its responses to this NOFO. For example, the amount of Transition Funding would take into account existing coverage of coordination, engagement, and referral activities in an applicant's State Plan. Figure 1 sets out MOM Model Periods and Associated Funding.

Figure 1. MOM Model Performance Periods and Associated 1115A Funding to States

Pre-Implementation Period <i>Year 1</i>	• Annual Implementation Funding
Transition Period <i>Year 2</i>	• Annual Implementation Funding • Transition Funding (Restricted and not guaranteed)
Full Implementation Period <i>Years 3, 4, and 5</i>	• Annual Implementation Funding • Milestone Funding (Restricted and not guaranteed)

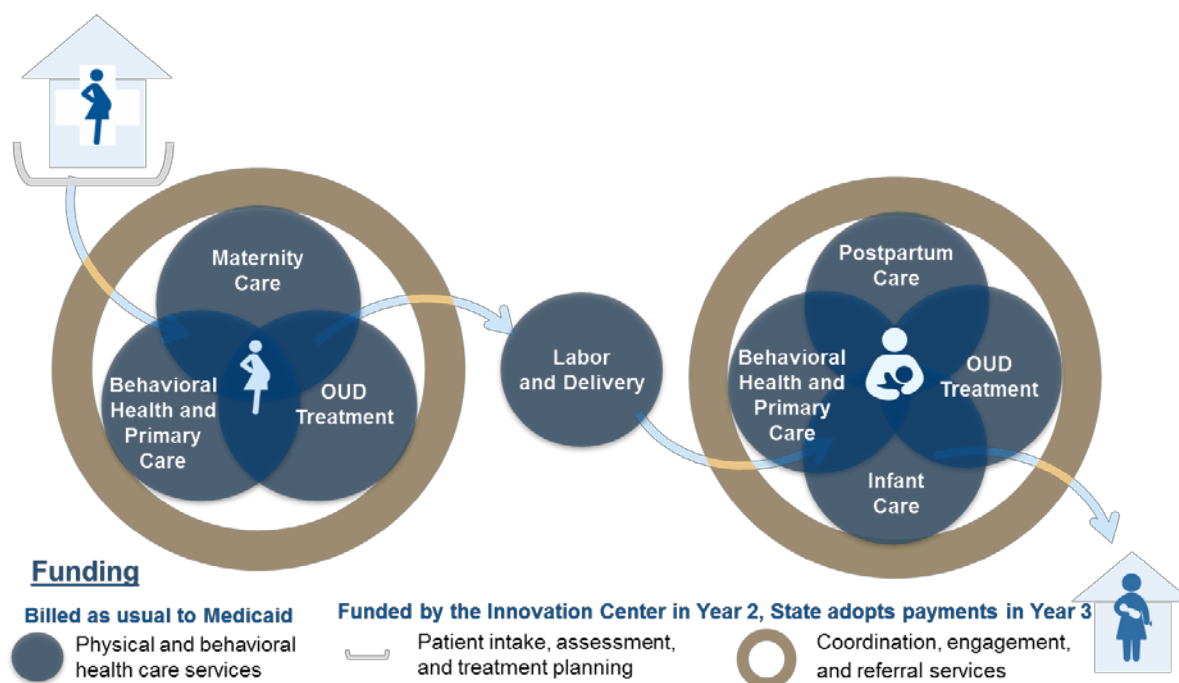
A.4.4 MOM Model Services and Care-Delivery Structure

An awardee's model population must have access to a combination of physical and behavioral healthcare services, billed as usual to Medicaid, in addition to intake, assessment, and creation of a treatment plan and coordination, engagement, and referral services (see Appendix H, Glossary). Coordination, engagement, and referrals not covered by Medicaid (but not the care itself) will be supported by model funding in the Transition Period (Year 2) only.

Each awardee must ensure that its model population has access to evidence-based OUD treatment consistent with current clinical guidelines. CMS recognizes that clinical guidelines may change during the course of the model. An awardee that wishes to change the services that it makes available to its model population in response to changes in clinical guidance must obtain prior written approval from CMS. Each awardee must fund payment for all coordination, engagement, and referral services based on their coverage and payment strategies during the Full Implementation Period (Years Three through Five). Model funds may not be used to cover the cost of any Medicaid-covered service at any time during the model.

Figure 2 illustrates the MOM model care-delivery structure. As the figure shows, the MOM model would encompass care from the prenatal through the postpartum period. Within this structure, covered clinical and behavioral healthcare services would be billed as usual to Medicaid, including well-woman care, OUD treatment, prenatal and postpartum care, labor and delivery, and infant care (including NICU stays). Figure 2 also highlights the patient intake, assessment, treatment planning, coordination, engagement, and referral services that would be paid for through MOM model Transition Funding in Year 2 of the model. In Years 3-5, all of the services included in the care-delivery model are expected to be covered through the state Medicaid program.

Figure 2. MOM Model Care-Delivery Structure



A.4.4.1 Physical and Behavioral Healthcare Services

Awardees will be responsible for ensuring that beneficiaries participating in the model can access a set of essential physical and behavioral healthcare services in each of the categories below. These services, would be billed as usual to Medicaid and include:

- Physical health care: MAT for OUD, maternity care, and relevant primary care services; and
- Behavioral health care: mental health and other appropriate addiction services beyond MAT.

A.4.4.2 Coordination, Engagement, and Referral Services

The model will also require awardees to coordinate care, engage beneficiaries, and provide referrals for community and other support services. These additional model components will complement the current set of Medicaid-covered services to meet the model population's comprehensive needs, including referrals for health-related social needs. Each state will have flexibility in defining the specific set of services that satisfy the following five components:

- Comprehensive care management;
- Care coordination;
- Health promotion;
- Individual and family support; and,
- Referral to community/support services (see Appendix H).

CMS will review the proposed set of services to ensure that each applicant will provide services in each of the five components. See Appendix G for an illustrative list of services for this population across categories (physical and behavioral health care, coordination, engagement, and referral services).

A.4.4.3 Recommended Optional Partners (Not Required)

Each state and its care-delivery partners may consider engaging and coordinating with entities other than

clinical delivery sites in order to promote model goals and address the comprehensive needs of the model's population. Such recommended partnerships could include the following entity types:

- Single State Agency for substance abuse services
- State and/or local public health agencies
- Child welfare agencies
- Justice system components, including problem-solving courts focused on family, substance use, and juvenile issues
- Civil legal aid organizations
- State or regional perinatal quality collaboratives
- Local government entities
- Area hospitals
- Local academic institutions and researchers
- Homeless and other temporary shelters
- Professional organizations
- National/local branches of advocacy organizations
- Home visiting programs
- Early intervention services
- Early care and education programs

A.4.5 Application Sections

Applicants for the MOM Model must submit a Model Implementation Plan, Model Impact Analysis, completed Model Budget Narrative, and Program Duplication Questionnaire. Model application sections are as follows:

- Model Context
 - A.4.6.1 Statement of the Problem and Gap Analysis*
 - A.4.6.2 Characteristics of the Proposed Model Service Area and Model Population*
- Model Implementation Plan
 - A.4.6.3 Intervention Design*
 - A.4.6.4 Coverage and Payment Strategy*
 - A.4.6.5 Sustainability Plan*
- A.4.6.6 Memorandum/a of Understanding
- Data-Sharing, Reporting, and Evaluation Plan
 - A.4.6.7 Data-Sharing Capacity and Plan*
 - A.4.6.8 Reporting Plan*
 - A.4.6.9 Evaluation Plan*
- Model Impact Analysis
 - A.4.6.10 Impact on Quality of Care*
 - A.4.6.11 Cost Savings Projection*
- A.4.6.12 Organizational Capacity of Applicant and Care-Delivery Partner
- A.4.6.13 Model Budget Narrative
- A.4.6.14 Program Duplication Assessment

A.4.6 Application Submission Requirements

MOM model applicants must address the following areas in their applications. CMS reserves the right to request that an applicant revise or otherwise modify its proposal and budget based on CMS recommendations.

Model Context

The applicant should use this section to describe the current state of care for pregnant and postpartum women with OUD within the proposed model service area.

A.4.6.1 Statement of the Problem and Gap Analysis

Applicants must provide a narrative that identifies the current process(es) for identifying and treating pregnant and postpartum women with OUD in the proposed model service area. The Statement of the Problem should include a Gap Analysis that identifies the gaps in providing, funding, and ensuring access to comprehensive physical and behavioral health care for this population; and, explain how participating in the model will address these gaps.

A.4.6.2 Characteristics of Proposed Model Service Area and Model Population

Applicants must clearly identify the geographic area(s) in which they propose to implement the model. Descriptions could include ZIP codes; identification of political subdivisions such as counties, parishes, or cities; census tracts; any other unit that will unambiguously specify the boundaries of the geographic focus area; or, whether the model service area will include all political subdivisions within the state. Any applicant that proposes to conduct the model test in one or more sub-state regions must include a justification for focusing on such particular sub-state region(s). An applicant that proposes to conduct the model test on a sub-state basis must indicate whether eligibility for model services will be limited to beneficiaries who reside in the sub-state region(s), to the extent permitted by Medicaid and CHIP requirements.

The applicant must provide information about the population of pregnant and postpartum women residing in the proposed model service area using the following data points:

1. Number and percentage of births in the proposed geographic service area(s) covered by Medicaid and CHIP, by age and ZIP code for years 2016-2018. Note that if an applicant does not have data for one or more years in this required range, it should provide an explanation and, if possible, a proxy in the form of the most recent year that is available.
2. Description of current healthcare provider and treatment capacity, including information about Medicaid beneficiary access to relevant providers and treatment facilities, within the proposed model service area for the types of care listed below. Applicants should use this section to identify the current capability of their provider networks, practices, and health systems to support coordinated care for the model population.
 - a.) Behavioral health care for pregnant and postpartum Medicaid beneficiaries with OUD; applicants should specifically describe availability of and access to MAT for Medicaid beneficiaries
 - b.) Maternity care providers (prenatal, peripartum, and postpartum care) for Medicaid beneficiaries
 - c.) Neonatal care for substance-exposed infants, including protocols for diagnosing and treating neonatal abstinence syndrome, for Medicaid beneficiaries

3. Description of opioid use among the model population within the proposed model service area, including the following data points for years 2016-2018:
 - a.) Number of opioid overdoses (fatal and non-fatal) among women ages 15-44
 - b.) Number of women enrolled in Medicaid between the ages of 15-44 who have been identified as having opioid use disorder (OUD)
 - c.) Numbers of emergency department visits and hospital inpatient admissions for pregnant Medicaid beneficiaries with and without substance use disorders
 - d.) Total number of treatment admissions for pregnant Medicaid beneficiaries to facilities that are licensed or certified by the State substance use agency to provide substance use disorder treatment
 - e.) Number of infants born with neonatal abstinence syndrome (NAS) in the proposed model service area
 - f.) Number of Neonatal Intensive Care Unit (NICU) admissions associated with NAS, and total number of NICU admissions
 - g.) Average length of stay (LOS) for infants admitted to the NICU with NAS or NOWS, and average NICU LOS for infants without NAS
 - h.) At the discretion of the applicant, no more than three additional data points relevant to the impact of the opioid crisis on the model population within the proposed geographic service area. Provision of any additional data provided in response to h.) Is optional and will count towards page limit for the Project Narrative.

If any of the data requested above are not available, the applicant should provide an explanation for why such data are not available and, if possible, a proxy for each missing data point. Note that each applicant must also provide a detailed plan for gathering and sharing critical data in the Model Implementation section below. Applicants should provide verifiable sources for all data points.

Model Implementation Plan

Applicants must submit information on their proposed Intervention Design and Coverage and Payment Strategy and a Sustainability Plan. Applicants must include all subsections of their implementation plan within their Project Narrative.

A.4.6.3 Intervention Design

Applicants must provide a detailed description of their proposed model intervention. This description must identify the following elements:

1. Expected number of beneficiaries to be (a) screened for eligibility to enroll in the model and (b) and enrolled in each year of the model.
2. A clear statement indicating whether the applicant proposes to impose a maximum number of beneficiaries the model would serve at a given time. If so, the applicant must provide an explanation for why it believes an enrollment maximum is necessary; how the enrollment maximum will be designed and implemented (including the existing Medicaid authority that would permit a beneficiary cap, the number of enrollees who would be permitted to enroll over a specified time period, and a waitlist policy); and, how the applicant proposes to ensure access to usual care for Medicaid beneficiaries who seek model services if enrollment is closed due to the cap.

3. Strategy for identifying and enrolling individuals eligible for model services. This strategy should identify and describe all proposed points of entry for potential model enrollees and a plan for notifying beneficiaries when they have been enrolled in the model.
4. Plan for screening beneficiaries enrolled in the model to identify health-related social needs. Applicants should identify a validated screening tool that the applicant will use to screen beneficiaries. This tool must screen beneficiaries, at minimum, for unmet needs across the following six domains: housing, food, transportation, utilities, interpersonal safety, and family and community support. The plan identified in response to this requirement should explain how the results of each screening will be integrated into the coordination, engagement, and referral activities detailed in the intervention design. (See Section F.5.2.2, Performance Milestones, for information about Milestone Funding separately associated with health-related social needs screening.)
5. Strategy for verifying beneficiary contacts during the course of the model, including a process for responding to CMS program audits of reported beneficiary contacts by the awardee and the care-delivery partner.
6. Description of the model's proposed timeline for postpartum coverage, including the length of time after delivery model enrollees will be eligible for (a) Medicaid coverage and (b) model services. The applicant should use this section to explain how it will ensure that all beneficiaries who participate in the model will continue to have access to critical physical and behavioral healthcare services following delivery, including beneficiaries who are no longer eligible for Medicaid or model services. (Note that applicants must set out their proposed Coverage and Payment strategy in A.4.6.6, including a postpartum plan that meets minimum statutory requirements. Applicants have the opportunity to earn additional points based on access to services, duration of coverage, and sustainability of postpartum plans.)
7. Plan for successfully implementing the proposed intervention within the context of laws, regulations, or policies (including policies of individual clinical delivery sites) that relate to substance use during pregnancy or as a parent. The applicant should also explain how it will inform beneficiaries of the implications of these policies and address beneficiary, provider, and other stakeholder concerns related to their enforcement.
8. Description of services that will be available to model enrollees. Each awardee must propose a set of services that address physical and behavioral health care and care-delivery activities including coordination, engagement, and referrals. Physical and behavioral healthcare services must include prenatal, peripartum, and postpartum services and comprehensive treatment for opioid use disorder, including access to MAT. Coordination, engagement, and referral activities must address each the following five components: (1) comprehensive care management, (2) care coordination, (3) health promotion, (4) individual and family support, and (5) linkages to community/support services. (Note that applicants will be required to set out their strategy for coverage and payment of these services in A.4.6.6).
9. Plan for retaining beneficiaries once enrolled in the model. Each applicant should address the role of relapse in treating OUD and define the set of activities that will constitute "substantial outreach" to beneficiaries who are disengaged from care. A beneficiary who is enrolled in the model but has not received a physical or behavioral healthcare service in a given calendar month is considered disengaged from the MOM model in that calendar month. (See A.4.2, Key Terms – Beneficiary Engagement).

10. Explanation for how services identified above, including Medicaid-covered services and model services, will be coordinated in order to deliver care to beneficiaries participating in the model. (Note that applicants will be required to set out their data-sharing strategy in A.4.6.8).
11. The full legal name, all DBAs, address, Tax Identification Number (TIN), and National Provider Identification (NPI) number (if applicable) of each care-delivery partner. For each care-delivery partner, the state must verify its compliance with any applicable Medicaid Program Integrity requirements at 42 C.F.R. Part 455.
12. Description of each care-delivery partner's capacity to engage clinical delivery sites, including a strategy for engaging these sites and/or an identification of sites that have been engaged at the time of application.
13. Strategy for identifying and recruiting sufficient providers to participate in the model, including physical and behavioral health care providers and care coordinators. This strategy should be aligned with the proposed set of services also required in this section; for example, if a state proposes to make buprenorphine available as one treatment option for all enrollees, it should present evidence that the model will recruit a sufficient number of potential certified prescribers.
14. Description of the nature of the financial relationships (including any downstream relationships) that the applicant foresees pursuing in an effort to achieve the goals of the MOM model. Examples of financial relationships could include, but are not limited to, relationships with care-delivery partners, participating healthcare providers and facilities, community partners, and any other entity with whom the applicant proposes establishing a financial relationship.
15. Plan for selecting and monitoring participating providers to serve beneficiaries enrolled in the model. This plan must set out the standards that each awardee and its care-delivery partner(s) will use to select and maintain a qualified pool of participating providers. Past or future referrals may not serve as the basis for selecting or retaining participating providers.
16. Plan, including a detailed timeline, for engaging Medicaid Managed Care Programs (MCPs) in the proposed model service area (if applicable). Regardless of the care-delivery partner, awardees will be expected to work with MCPs (as applicable) during the model Pre-Implementation Period to support the implementation of the payment model and ensure that existing MCP care coordination and case management efforts are aligned with the MOM model.
17. Any other information about the proposed implementation design that the applicant believes should be considered.

A.4.6.4 Coverage and Payment Strategy

Each Applicant must detail its proposed Coverage and Payment Strategy for the intervention set out at A.4.6.6. Additionally, the applicant should use this section to present its plan to sustain the intervention implemented through the model in the Medicaid program following the end of the model performance period.

Applicants should describe in detail their strategy for ensuring that model enrollees can access all services identified in the model design and implementation plan above. This strategy should address how the state will determine that prospective model enrollees are eligible for Medicaid; coverage of physical and behavioral healthcare services and care coordination; and funding to support delivery of these services to model enrollees. State-specific factors could influence a state's strategy, including: existing demonstrations and SPAs; extent of managed-care penetration in the state; broader OUD/SUD efforts; coverage of pregnant women through CHIP; and, the potential for non-model financial incentives provided by the federal government for the uptake of certain flexibilities (e.g., enhanced match for health homes).

Examples of the questions that an applicant should address in its Coverage and Payment strategy include:

- Which Medicaid benefit categories does the state expect to use for submitting a Medicaid State Plan Amendment (OAGM) or SPAs by the Transition Period (Year 2) to cover any new Medicaid services, if necessary?
- How does the state anticipate meeting federal Medicaid State Plan requirements of statewideness, comparability, and freedom of choice of provider for these services, or requesting authority to waive those requirements? If the model is focused on sub-state regions rather than the entire state, strategies might require an Innovation Center or Medicaid waiver for statewideness prior to receipt of Innovation Center funding in the Transition Period.
- How will the state comply with Early and Periodic Screening, Diagnostic, and Treatment rules that require that all children under 21 (not limited to beneficiaries enrolled in the model) receive medically necessary 1905(a) State Plan services?
- What is the proposed length of time for providing services to postpartum model enrollees? Does the state propose to extend care to the model population beyond the current eligibility period in the state's existing plan? If so, what is the coverage and payment strategy for supporting this approach?
- Does the applicant propose to include any patient engagement incentives? If so, what incentives are proposed, how would they be funded and monitored by the awardee, and how would beneficiaries qualify for and access incentives?

Coverage Strategy: With respect to coverage, the strategy description must identify any changes to the Medicaid program that the applicant proposes to implement in order to carry out the model; any partners external to the state Medicaid agency who will be involved in executing these changes (including other state agencies); and, a timeline for developing, negotiating, and finalizing these changes. Specifically, the applicant should provide a detailed timeline for developing and implementing any applicable SPAs, waivers and demonstrations, changes to MCP contracts, changes to provider rates, and state regulatory and legislative changes necessary to enable a coverage and/or payment strategy necessary to fulfill the MOM model requirements.

1115A Funding: With respect to Innovation Center funding, the applicant must propose an annual budget that distinguishes between a) Implementation Funding; and b) Transition Funding. If the applicant is requesting Implementation Funding, it must specify, for each of the five years of the model, the level of funding requested and how the funding will support the model intervention set out in A.4.6.4. If the applicant is requesting Transition Funding for the Transition Period of the model, it must specify, for Year 2 only, the level of funding requested and how the funding will support the model implementation plan set out in A.4.6.4. Table A in A.4.3., Model Performance Periods and Associated Funding Structure, includes a non-exhaustive list of examples of potential annual Implementation Funding activities.

Medicaid Funding: The applicant should identify how the state will use Medicaid funding in both a) the Transition Period; and b) the Full Implementation Period. During the Transition Period, awardees may access funding to support care-delivery activities that are not already funded through Medicaid or another source, including intake, assessment, and creation of a treatment plan; and coordination, engagement, and referral activities. Model funding is not available to cover the cost of physical or behavioral healthcare services themselves. The applicant should provide a detailed explanation that sets out how the state will integrate these care-delivery activities into the Medicaid program during the Full Implementation Period (Years 3, 4, and 5).

Other Funding Sources: If applicable, the strategy should also identify non-CMS funding sources and describe how the applicant will integrate other sources of funding into the model. Note that applicants will

be required to address how any existing programs or funding overlap with the proposed model test in its responses to Appendix F., Program Duplication Assessment Questionnaire.

A.4.6.5 Sustainability Plan

Applicants should present their strategy for sustaining services, including physical and behavioral health care as well as model services, to the model population after the model performance period ends. Specifically, applicants should address how they will sustain funding and services to pregnant and postpartum women with OUD, including non-Medicaid funding if identified in the Coverage and Payment section above.

A.4.6.6 Memorandum of Understanding with Care-Delivery Partner(s)

To be eligible to participate in the MOM model, a state Medicaid agency must submit an application that demonstrates that it has partnered with at least one care-delivery partner. If selected, the applicant must commit to collaborating with the identified care-delivery partner(s) to implement the model. The applicant should provide a copy of a Memorandum of Understanding (MOU) between the state Medicaid agency and each of its care-delivery partners. Each MOU should identify the full legal name, all DBAs, address, TIN, and organizational NPI (if applicable) of the care-delivery partner, and confirm that the care-delivery partner is in compliance with Medicaid Program Integrity rules at 42 C.F.R. Part 455. The MOU must include a detailed explanation of the role for the state Medicaid agency and care-delivery partner during Year 1 of the model, including performance deliverables; any transfer of funds, including a timeline for payments; data-sharing plan between the entities; and reporting requirements between the entities. The MOU must also provide a plan for converting the MOU to an enforceable contract as soon as one of the parties begins performance under the arrangement. The MOU should be signed by the state Medicaid director and an individual with the legal authority to bind the care-delivery partner.

Data-Sharing, Reporting, and Evaluation

Applicants should use this section to provide a detailed data-sharing plan that demonstrates their capacity to gather, maintain, and share data in order to facilitate provision of coordinated care to the model population. Additionally, applicants must provide a plan for completing ongoing reporting requirements set out below. As noted in F.5.3, Evaluation, awardees are solely responsible for any Institutional Review Board (IRB) procedures and approvals or any other permissions from their organizations or states that may be needed to submit these data.

A.4.6.7 Data-Sharing Capacity and Plan

T-MSIS Status: Applicants should identify their T-MSIS data submission status. If the applicant is not submitting production data monthly to T-MSIS and/or their catch-up data files are not current, then a timeline for achieving timely, monthly production data submission should be provided.

Linking Claims for Mother-Infant Dyads: Applicants must clearly indicate whether they can link maternal claims to infant claims as of the date of application. If the applicant cannot link claims for mother-infant dyads at the time of application, the applicant must set out a plan for achieving this capacity by the beginning of the Transition Period (Year 2).

Other Funding Sources: Applicants must explain how they will meet all data-sharing and data-reporting requirements for services covered by non-Medicaid funding, as applicable. The applicant must explain how it will ensure that providers treating model enrollees, care-delivery partner(s), and CMS have access to all required information through an alternative mechanism outside of the typical claims pathways.

Qualitative Data: Applicants must indicate their willingness and ability to share program documents, training materials, and any other program related materials (e.g., patient education materials) with the CMS evaluation contractor and to assist in arranging other data gathering activities.

Data-Sharing Plan: Applicants should provide a data-sharing plan that demonstrates their ability to facilitate the exchange of data, including protected health information if applicable, among the following entities:

1. State Medicaid agency
2. Care-delivery partner(s)
3. Participating clinical delivery sites
4. Individual providers
5. State vital statistics systems
6. CMS, including CMS contractors
7. Community service organizations, to the extent that these organizations receive, maintain, or share PHI
8. Any other entities, systems, or individuals that the applicant believes will have access to data related to model activities, including but not limited to beneficiary-specific data

The data-sharing plan should demonstrate an understanding of state and federal privacy laws and ensure compliance with these standards, including HIPAA privacy regulations and 42 C.F.R. Part 2. The plan should clearly identify when and how written patient consent and authorization forms will be obtained, where required.

For each proposed care-delivery partner, the applicant should provide a brief narrative identifying the partner's relevant experience gathering, storing, protecting, and sharing Medicaid data, including protected health information and information governed by 42 C.F.R. Part 2, if applicable.

A.4.6.8 Reporting Plan

Applicants should provide a plan for gathering and timely reporting data to CMS, including quarterly and Annual Progress Reporting (refer to Section F.5.2.1) and data related to performance milestones (refer to Section F.5.2.2).

A.4.6.9 Evaluation Plan

Applicants should use this section to describe their strategy for ensuring participation in the Innovation Center's mandatory model evaluation by all model partners and participants, including the awardee, care-delivery partner, clinical delivery site providers and staff, patients and any other individuals or entities. Specifically, the awardee should demonstrate its capacity to participate in patient- and program-level data provision and qualitative evaluation tasks, which may include arranging site visits, observations, interviews and focus groups with providers and patients as well as program staff; screening patients for health-related social needs; submitting patient medical information through a system that complies with privacy standards including HIPAA and 42 C.F.R. Part 2; gathering required consent; and other activities as needed. All applicants must be able to provide personal identifiers that will allow all participants to be identified in Medicaid claims. All applicants should 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.

Model Impact Analysis

Applicants should use this section to a) identify how their proposed interventions will impact quality of care, including specific goals for quality improvement and the strategies that would be implemented to achieve them; and b) estimate the potential impact of the model on Medicaid and, if applicable, CHIP spending.

A.4.6.10 Impact on Quality of Care

Applicants should provide an explanation for how the model could impact quality of care, including specific goals for quality improvement and the strategies that would be implemented to achieve them. Specifically, applicants should identify how they will maximize the effect of their proposed intervention on the quality milestones set out in F.5.2, Monitoring, and identify any additional quality improvement strategies they propose.

A.4.6.11 Cost Savings Projection

Applications should provide a financial model that illustrates anticipated Medicaid and/or CHIP spending for the model population and compares a projection, including the intervention to a projection in the absence of the intervention, over the same period. The cost savings projection should include:

1. The total monthly cost of Medicaid-covered services for pregnant and postpartum women with OUD and their infants, through 60 days postpartum, in the proposed model service area;
2. The total monthly cost of Medicaid-covered services for women without OUD and their infants, through 60 days postpartum in the proposed model service area;
3. Size of the model's population of focus in the proposed model service area, including an estimated minimum number of women needed to achieve cost neutrality; and,
4. The estimate of potential savings of the proposed model intervention on Medicaid and/or CHIP spending, including the financial models explaining the logic driving the forecasted impact on Medicaid and/or CHIP spending for the model population with and without the proposed model intervention.

Specifically, the applicant should demonstrate how it expects to achieve cost neutrality or cost savings to the federal government with regard to the Innovation Center investment.

A.4.6.12 Organizational Capacity of State Medicaid Agency and Care-Delivery Partner(s)

Applicants should use this section to demonstrate their capacity, together with the care-delivery partner(s), to organize and manage the model. The application should address each of the following:

1. Describe the past, current, and projected future involvement of the state Medicaid agency and proposed care-delivery partner(s) in federally-funded programs aimed at improving health outcomes for pregnant women with substance use disorders and/or substance-exposed infants. (Note: the applicant may provide clear cross-references to information provided elsewhere in the application in order to avoid unnecessary repetition.)
2. Identify the individual or individuals who will have management authority over the model at the state Medicaid agency and each care-delivery partner, and provide a resume or curriculum vitae for each identified manager.
3. Describe management controls and coordination mechanisms that will be utilized to ensure the timely and successful execution of this project.
4. Identify the individual who will be the project manager and primary liaison to CMS for the model, and provide a resume or curriculum vitae for that person.

5. Provide an organizational chart for the state Medicaid agency and each care-delivery partner that identifies lines of authority.
6. Provide job descriptions for the roles at both the state Medicaid agency and the care-delivery partner(s) related to the model. These descriptions should estimate the percentage of full-time equivalent employment the role will comprise.
7. Describe the state Medicaid agency's experience with the following tasks:
 - a. Designing and implementing performance-based payment initiatives
 - b. Designing and implementing alternative payment models
 - c. Managing cooperative agreement funds in accordance with federal grant regulations and HHS grants policy
8. Describe each care-delivery partner's experience with the following tasks:
 - a. Coordinating and integrating patient care across multiple care-delivery sites
 - b. Engaging and maintaining provider participation in innovative care models
 - c. Establishing, modifying as needed, and maintaining agreements between care team members across multiple care-delivery sites
 - d. Conducting outreach to patients in the community
 - e. Developing partnerships with non-clinical community partners

A.4.6.13 Model Budget Narrative

Detailed justifications must be provided for each activity, supply, or personnel proposed to be funded under this award along with full computations for budget estimates. Applicants must also clearly link each activity to the goals of this NOFO and be consistent with MOM model requirements. Overhead and administrative costs must be reasonable and are only reimbursable in accordance with grant policy. Administrative costs included in the Budget Narrative, and which are funded by the Innovation Center, cannot also be claimed as administrative expenses for the awardee's administration of its Medicaid State Plan under Section 1903(a)(7) of the Social Security Act. For more information on completing the budget narrative, please refer to Appendix A: Guidance for Preparing a Budget Request and Narrative. Applicants should submit the Budget Narrative Attachment Form in the Grants Application Package at <http://www.grants.gov>; select the Budget Narrative Attachment Form and "Add Mandatory Budget Narrative." Completion of the Standard form, SF 424A, is also required.

The MOM model provides three distinct funding opportunities for awardees:

- Implementation Funding will be available annually during each year of the model to support infrastructure and capacity-building.
- Transition Funding will be available only during the Transition Period and only to support intake, assessment, and creation of a treatment plan (payment available once per pregnancy per beneficiary) and coordination, engagement, and referral activities (payment available on a monthly basis for up to 12 months for each beneficiary who receives these services) not otherwise covered by Medicaid. Model funds may not be used to supplant or duplicate existing funding sources. The state must take over these costs in alignment with its Coverage and Payment Strategy by Year 3 of the model. Transition Funding is restricted and not guaranteed.
- Milestone Funding will be available during the Full Implementation Period based on an awardee's demonstrated performance on pre-determined quality milestones. Milestone Funding is restricted and not guaranteed.

Applicants should use this section to describe in detail how they will use Implementation Funding and Transition Funding to implement the model. Detailed justifications must be provided for each activity, supply, or personnel proposed to be funded under this award along with full computations for budget estimates. Applicants must also clearly link each activity to the goals of this NOFO and be consistent with

MOM model requirements. In addition to the detailed justifications for use of Implementation Funding and Transition Funding, each applicant should provide a plan for how Milestone Funding, if unrestricted, would be used to support the goals of the MOM model. Federal funds cannot be used as the source of a state non-federal share to draw down federal funds. Overhead and administrative costs must be reasonable and are only reimbursable in accordance with grant policy; administrative costs funded through a MOM model award cannot also be claimed as administrative expenses for the awardee's administration of its Medicaid State Plan. For more information on completing the budget narrative, please refer to Appendix A, Guidance for Preparing a Budget Request and Narrative. Below is an illustrative list of activities that may be paid for using model funds (assuming other federal, state, or local programs do not already fund such activities). This list is intended to guide each applicant in its development of a Budget Narrative, but does not constitute an exhaustive list of all possible expenses. CMS will work with each awardee to determine whether other proposed expenses are allowable.

- **Implementation Funding**

- Build or adapt Medicaid Health Information Technology (HIT) and data infrastructure to support data collection, data linkages, and information-sharing
- Support the use of performance measures (see F.5.2.2, Table E, Performance Milestones) and monitoring measures, such as maternal depression and tobacco screening
- Provide administrative support to develop and implement their state coverage and payment strategies and related Medicaid waivers or State Plan Amendments
- Expand state Medicaid staff capacity and technical expertise to implement the MOM model, and to satisfy model monitoring and evaluation requirements
- Support participation in the model awardee learning system
- Develop and execute care-delivery models that are person-centered
- Establish and maintain agreements with required care team members
- Create or adapt and implement telemedicine resources to address the needs of the model population
- Build or adapt HIT and data-sharing capacity among providers at the care-delivery level
- Expand staff capacity and expertise at care-delivery sites to support the integrated and coordinated care delivery
- Conduct outreach to model population in the community
- Develop partnerships with community partners and nonprofits to support comprehensive care for pregnant women with OUD
- Participate in CMS evaluation activities, including data collection and reporting
- Participate in annual independent audit of staff time and effort accounting
- Provide patient engagement incentives, as permitted by existing law

- **Transition Funding**

- Patient intake, assessment, and creation of a treatment plan
- Ongoing coordination, engagement, and referral activities, including:
 - Comprehensive care management
 - Health promotion
 - Individual and family support
 - Referral to community/support services

- **Milestone Funding**

- Milestone Funding is available during the Full Implementation Period (Years 3, 4, and 5), but is restricted and not guaranteed. (Refer to Section F.5.2.2, Performance Milestones). Each awardee

should describe how it would use Milestone Funding, if unrestricted, to meet the goals and objectives of the MOM model.

A.4.6.14 Program Duplication Assessment

We will consider an applicant's understanding of program duplication risks as well as the thoroughness of their plan to avoid program duplication during our review of their application, including the applicant's proposed Budget.

The U.S. Government Accountability Office (GAO) defines program duplication as two or more agencies or programs engaged in the same activities or providing the same services to the same beneficiaries. ([2017 Annual Report: Additional Opportunities to Reduce Fragmentation, Overlap, and Duplication and Achieve Other Financial Benefits](#)). Consistent with the federal government's aim to avoid program duplication, we also prohibit the use of model funding to supplant funding for services or administrative expenses already provided by federal, state, or local agencies, programs, or CMS Innovation Center models. Applicants are encouraged to propose the use of model funding to extend and strengthen the impact of past and current programs and activities, but awardees must not use model funding to supplant or duplicate past, current, or projected future funding.

Applicants must submit as part of the application a Program Duplication Assessment Questionnaire (Appendix F). This assessment must provide CMS with sufficient information to prevent program and funding duplication related to the MOM model, including whether:

- Other programs that are funded by Medicaid, Title V agencies, or other federal, state or local programs will provide direct care coordination or case management services to the model population; and
- Some or the entire model focus population may also participate in a separate program, model, demonstration, or alternative payment model that would be similar to the MOM model.

It will be the awardee's responsibility to provide information that will allow CMS to determine the extent of potential program duplication. If an awardee engages in program duplication, the awardee must report the program duplication to CMS and must eliminate the program duplication. CMS provides this duplication background and the assessment questionnaire to assist applicants in understanding program duplication risks. Failure to complete the program duplication questionnaire or evidence that the applicant is at serious risk of program duplication may disqualify the applicant.

If the applicant is unclear about whether it would be permissible to use MOM model funding for a specific activity, ask the following questions, at a minimum:

1. Is this expense fully paid for by another federal, state, or local program or grant (e.g., SAMHSA, HRSA, NIH, or a CMS Innovation Center model)?
2. Is this service already provided through a separate program, model, demonstration, or alternative payment model to a member of the model's focus population of pregnant Medicaid beneficiaries with OUD?
3. Will I submit a claim to Medicaid or another entity (Medicaid Managed Care Plan, Medicaid Managed Care Organization, Medicare, Medicare Advantage Plan, etc.) to reimburse for this expense in its entirety?

If you answer yes to any of these three questions, then you would not be allowed to use model funding to

pay for this expense. The applicant's budget should reflect the extent to which current funding may partially cover projected expenses under the MOM model. The amount of a MOM model award will account for the availability of other funds to cover projected expenses under the MOM model.

Hypothetical scenarios with program duplication implications are included below to provide further clarity. These hypothetical scenarios are examples only. They are not an exhaustive description of all potential areas of program duplication.

Scenario 1: Staff Overlap and Program Duplication

The awardee uses Medicaid administrative funding *and* model funding to pay for the salary of a state Medicaid agency staff person assigned to develop a new Coverage and Payment Strategy for the model. The staff person has other duties unrelated to the model. In this example, the awardee must ensure the staff person is properly accounting for his or her time and effort for separate tasks: strategy development (model activity) and other duties (non-model activity). The awardee must take care to avoid using model funding for non-model duties. The awardee may not use MOM model funds to cover the portion of the staff person's time spent fulfilling other duties as an employee of a state Medicaid agency; nor may the awardee receive Medicaid reimbursement for the portion of time the staff member is working on model activities and is being reimbursed through model funds.

Scenario 2: Health Information Technology Enhancements

The state Medicaid agency proposes to use MOM model Implementation Funding to enhance its health information technology capacity to deliver behavioral telehealth services to Medicaid enrollees. No other federal, state, or local agency or program funds these enhancements. The awardee may use MOM model funds to fund the infrastructure and policy capacity development that would enable delivery of behavioral telehealth services to the model population. The awardee may not, however, use MOM model funds to cover the cost of behavioral telehealth services that are furnished to Medicaid beneficiaries.

Scenario 3: Transition Funding During Transition Period (Year 2)

A state Medicaid Agency with a Medicaid Health Home Program covers ongoing care coordination for beneficiaries enrolled in the Health Home Program. A beneficiary with a diagnosis of substance use disorder is only eligible to enroll in the Health Home Program if she has another chronic condition, which does not include pregnancy. The awardee may use MOM model funds to cover the care coordination costs for Medicaid beneficiaries enrolled in the model who do not have access to these services through existing Medicaid coverage, such as a pregnant beneficiary with OUD but no other chronic conditions. The awardee may not use MOM model funds to supplant or duplicate existing funding for these services, including federal, state, local, or independent program funding.

Scenario 4: Intake and Coordination Funding During Full Implementation Period (Years 3-5)

A state submitting an application for MOM model funding already provides targeted case management (TCM) or a Medicaid Health Home to at-risk pregnant women in certain parts of the state, but proposes to extend model services to pregnant women with OUD statewide. The state must identify the current TCM or Health Home benefit as an area of potential program duplication, because it will be able to leverage existing infrastructure and expertise to extend these services to model enrollees. The state should account for these efficiencies in its Budget request.

A.5 Technical Assistance and Information for Prospective Applicants

Prior to the application deadline, CMS will host multiple forums to provide details about this model and to answer questions from potential applicants. Information about the forums will be posted on the Innovation Center website at <https://innovation.cms.gov>.

CMS expects to award three support contracts: one for evaluation, one for program implementation, and one for a learning system.

The evaluation contractor will collect and analyze data necessary to evaluate each award. The overarching goal of the evaluation is to determine if the interventions implemented by awardees (1) produces savings to Medicaid and (2) improves health outcomes of pregnant women with OUD and their infants. To the extent possible, CMS will identify factors that are driving the identified impact and any savings, and use qualitative and quantitative data to inform our findings.

The implementation contractor will support program operations including: providing technical assistance to awardees; facilitating reporting requirements; managing program data; assisting in the monitoring of program implementation, including potential for payment duplication and general model compliance; as well as supporting programmatic operations. During the model performance period, CMS may request modification to an awardee's implementation plan or associated documents (e.g., assessments of program duplication and standard operating procedures) to ensure continued program integrity and to streamline program operations with contractor functions. CMS will provide details to awardees for contractor-related work after awards are made.

The learning system contractor will create and facilitate peer-to-peer exchange for awardees. The system developed by this contractor will allow awardees and their care-delivery partners to share their experiences and learning, track their progress, adopt promising practices, and rapidly adopt new ways of achieving improvements in care quality and cost reduction.

The implementation, valuation and learning system contractors coordinate site visits and interviews to observe program implementation, facilitating continuous quality improvement, and evaluating the qualitative impacts of the program.

B. Federal Award Information

B1. Total Funding

CMS intends to award cooperative agreements of up to \$64.56 million, pending availability of funds, to a maximum of 12 awardees to cover a total model funding period of five years. Cooperative agreements will be awarded with consideration to: (1) overall cost effectiveness of implementation proposal, (2) overall quality of the proposal and the ability to meet project goals, and (3) availability of non-model funding. The amount of funding for each cooperative agreement award will depend on the individual awardee's need as demonstrated in its responses to this NOFO.

B2. Award Amount

The model performance period is divided into three periods: Pre-Implementation (Year 1); Transition (Year 2); and Full Implementation (Years 3, 4, and 5). Award amounts will vary based on the needs demonstrated by applicants in response to this NOFO for each phase of the award, including the scope and content of the proposed intervention design, availability of other funding, and variations in healthcare costs in the awardee geography.

Funding During the Pre-Implementation Period: The total funding available during the Pre-Implementation Period (Year 1) will be up to \$750,000 of Pre-Implementation Funding per awardee.

Funding During the Transition Period: The total funding available during the Transition Period (Year 2) is up to \$18.4 million across up to 12 awardees. Funding during the Transition Period will consist of a combination of Implementation Funding and Transition Funding. The total Implementation Funding available during the Transition Period is up to \$9,000,000 across up to 12 awardees with a maximum Implementation Funding award of up to \$750,000 per awardee. The total Transition Funding available is up to \$9,360,000 across up to 12 awardees.

Transition Funding is restricted and not guaranteed. Transition Funding will be unrestricted on a quarterly basis, i.e., made available to each awardee that conducts the following activities, as demonstrated in quarterly reports to CMS:

- Complete intake, assessment, and creation of a treatment plan, which can be funded only one time per pregnancy per beneficiary;
- Provide care-delivery activities (coordination, engagement, and referral) to enrolled beneficiaries, which can be funded for up to 12 months per beneficiary during the course of the Transition Period; and
- Conduct substantial outreach to enrolled beneficiaries who are disengaged from care; i.e., beneficiaries who have not received a physical or behavioral healthcare service in a given calendar month. Substantial outreach can be funded for up to two consecutive months per beneficiary. Substantial outreach will be funded at a lower amount per beneficiary than actual provision of coordination, engagement, and referrals.

Each awardee must describe how it defines “care-delivery activities” and “substantial outreach” in its responses to A.4.6.3, Intervention Design. In the Budget Narrative, each applicant should justify its Transition Funding request by providing the following information:

- Per-beneficiary payment rate for intake, assessment, and creation of a treatment plan
- Per-beneficiary per-month payment rate for providing care-delivery activities to enrolled beneficiaries
- Per-beneficiary per-month payment rate for providing substantial outreach to disengaged beneficiaries
- Number of beneficiaries the applicant anticipates serving during the Transition Year
- Total Transition Funding award amount requested

Funding During the Full Implementation Period: The total funding available during the Full Implementation Period will be up to \$37.2 million across up to 12 awardees. Funding during the Full Implementation Period (Years 3, 4, and 5) will be made up of a combination of Implementation Funding and Milestone Funding. During the Full Implementation Period (Years 3, 4, and 5), the annual available amount will include \$600,000 (for Year 3 only) and \$500,000 (for each of Years Four and Five) in Implementation Funding; plus an additional potential \$1,500,000 of Milestone Funding (for Years 3, 4, and 5, collectively). Milestone Funding will be restricted and will be awarded only if the awardee demonstrates satisfactory performance on quality measures (refer to Section F., Reporting).

Table B. Cooperative Agreement Funding Amounts by Award Period

	Implementation Funding: Infrastructure/ Operations support	Transition Funding: Care-Delivery Activities	Milestone Funding
Year 1 (Pre-Implementation)	\$750,000	N/A	N/A

	Implementation Funding: Infrastructure/ Operations support	Transition Funding: Care-Delivery Activities	Milestone Funding
Year 2 (Transition)	\$750,000	\$9,360,000 – Maximum across up to 12 awardees	N/A
Year 3 (Full Implementation)	\$600,000	N/A	\$1,500,000
Year 4 (Full Implementation)	\$500,000	N/A	
Year 5 (Full Implementation)	\$500,000	N/A	
Total	\$3,100,000 maximum per awardee	\$9.36 million maximum across all awardees	\$1,500,000 maximum per awardee across Years 3, 4,

B3. Anticipated Award Date

11/06/2019

B4. Period of Performance

The project and budget period for each cooperative agreement awarded will be five years from the date of award. The estimated project period is January 1, 2020 – December 31, 2024. The grant period will consist of five 1-year budget periods.

Year one 12-month project and budget period: January 1, 2020 to December 31, 2020.

Year two 12-month project and budget period: January 1, 2021 to December 31, 2021.

Year three 12-month project and budget period: January 1, 2022 to December 31, 2022.

Year four 12-month project and budget period: January 1, 2023 to December 31, 2023.

Year five 12-month project and budget period: January 1, 2024 to December 31, 2024.

B5. Number of Awards

Maximum number of awards: 12

B6. Type of Award

These awards will be structured as cooperative agreements. 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 awardee 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 around the coordination of clinical and community services and

resources. CMS will monitor and evaluate awardee activities performed under the cooperative agreement, including monitoring, measuring and evaluating achievement of model goals. CMS anticipates informal weekly communication with each awardee.

Continued disbursement of MOM model funding over the performance period of the award is conditional on the awardee meeting specified progress milestones and the availability of funds. These milestones will be further detailed in the terms and conditions of the cooperative agreement.

C. Eligibility Information

C1. Eligible Applicants (select all that apply)

- ☐ City or township governments
- ☐ County governments
- ☐ Faith-based organizations
- ☐ For profit organizations other than small businesses
- ☐ Foreign and international organizations
- ☐ Independent school districts
- ☐ Individuals
- ☐ Native American tribal organizations (other than federally recognized tribal governments)
- ☐ Nonprofits having a 501(c) (3) status with the IRS, other than institutions of higher education
- ☐ Private institutions of higher education
- ☐ Public and State controlled institutions of higher education
- ☐ Public housing authorities/Indian housing authorities
- ☐ Small businesses
- ☐ Special district governments
- ☒ State governments
- ☐ Unrestricted
- ☐ Other

C2. Cost Sharing or Matching

Cost sharing or matching is not required. Awardees may contribute funds or resources of their own.

C3. Letter of Intent

- ☐ Mandatory
- ☐ Optional
- ☒ N/A

Letters of Intent will not be collected or considered for this funding opportunity.

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 specify a proposed model service area;
 - Failure to meet application requirements, including failure to fully respond to requests for data;

- Omission of a Memorandum of Understanding for each care-delivery partner relationship, signed by the director of the state Medicaid agency and leadership of the care-delivery partner(s)
- Omission of a Coverage and Payment Strategy
- Omission of a data-sharing plan;
- Omission of a Budget Narrative;
- Omission of a completed Program Duplication Questionnaire
- **Overlap with another model, demonstration, or program**, including an Innovation Center model, which may result in duplicate payments for similar services or other waste of federal funds. A program overlap may include an overlap in service area, participating organizations or providers, or beneficiaries.
- **Proposed Care-Delivery Partner is an Integrated Care for Kids (InCK) Model Applicant.** An entity that has applied to the InCK model as a Lead Organization may not also participate in the MOM model application as a Care-Delivery Partner. A Lead Organization under the InCK Model (or a proposed Lead Organization if the application is still under review) may, however, apply to participate in the MOM model as a Care-Delivery Partner if the state was the InCK model applicant.
 - **Insufficient supporting detail** provided in the application. CMS will not review applications that merely restate the text within the NOFO. Applicants should detail their approach to achieving program goals and milestones. Reviewers will note evidence of how effectively the applicant includes these elements in their application.
 - **Lack of current participation in the Transformed Medicaid Statistical Information System (T-MSIS) by the start date of the model.** States must demonstrate that they are actively participating in T-MSIS at the time of application and that their data is current in the system; or have a plan that will ensure active participation with current data by the start of the Transition Period of the model (Year 2).
 - **Inability to link maternal-infant claims data.** Applicants must demonstrate that they can currently link maternal and neonatal Medicaid claims for mother-infant dyads or will be able to do so by the start of the Transition Phase (Year 2) of the model.
 - **Inability or unwillingness to collect and share monitoring and evaluation data** with CMS or its contractors.
 - **Inability or unwillingness to ensure the participation of all model partners in qualitative evaluation activities and providing patient-level data.** These activities may include, but are not limited to, arranging site visits, observations, interviews and focus groups with providers and patients as well as program staff, screening patients for health-related social needs, submitting patient medical information through a system that complies with privacy laws including HIPAA and 42 C.F.R. Part 2, gathering any required consent, and other activities as needed.
 - **Inability or unwillingness to comply with federal privacy laws** governing protected health information, including substance use disorder treatment records.
 - **Insufficient detail in Coverage and Payment Strategy related to Medicaid and CHIP authorities.** Applicants must describe how they intend to use Medicaid and CHIP authorities to implement the MOM model. CMS expects these proposals will require additional refinement and discussion with the Center for Medicaid and CHIP Services prior to model award and during the model Pre-Implementation and Transition Periods. CMS may deny the selection to an otherwise qualified applicant due to insufficient detail in submitted proposals.
 - **Program integrity concerns.** CMS may deny selection to an otherwise qualified applicant on the basis of information found during a program integrity review regarding a state Medicaid agency, a care-delivery partner(s), clinical delivery sites, individual providers, community partners, or any other relevant individuals or entities.

- **Late submission** of an application (refer to Section D.4)

C5. Single Application Requirement

CMS intends to award only one cooperative agreement per each state that applies to participate in the MOM model. Applicants must be state Medicaid agencies. A state Medicaid agency applicant must demonstrate through its application that it has partnered with at least one care-delivery partner. Applicants may partner with more than one care-delivery partner as described in this NOFO.

C6. Continued Eligibility Requirements

Each awardee must meet reporting and certification deadlines (as outlined in Section F., Reporting) to be eligible for funding throughout the initial 12-month budget period and to remain eligible for a non-competing continuation award for subsequent budget periods that last for multiple years projects. In addition, an awardee will need to demonstrate that it has met the programmatic goals and objectives of the award during the previous project and budget period, as confirmed by the Project Officer Recommendation, before additional year funding is awarded. (Similarly, an awardee will need to demonstrate that it has met model performance milestones during the previous budget period before Milestone Funding is awarded.) At any time in the award cycle, an awardee could receive decreased funding or its grant could be terminated if the awardee fails to perform award requirements.

C7. EIN, DUNS, and SAM Regulations

Applicants must provide 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/>) to be able to submit an application at <http://www.grants.gov>. See Appendix B, Application and Submission Information, for descriptions of EIN, DUNS, and SAM.

D. Application and Submission Information

D1. Address to Request Application Package (select one)

Application materials will be available at <http://www.grants.gov>. Please note that HHS 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 and include the components listed below. The page limit for the Project Narrative with the exception of the Memorandum(s) of Understanding is 60 pages.

Required components of the Project Narrative are:

- The "Model Context" section, which includes the "Statement of the Problem & Gap Analysis" and "Characteristics of Proposed Model Service Area and Model Population."
- The "Model Implementation Plan" section, which includes the "Intervention Design," "Coverage and Payment Strategy," "Sustainability Plan," and "Memorandum/a of Understanding." "Memorandum/a of Understanding" are not counted towards the 60-page Project Narrative limit. The "Memorandum/a of Understanding" between the applicant and Care-Delivery Partner(s) may be single-spaced. The page limit for each "Memorandum of Understanding" is 5 pages.
- The "Data Sharing, Reporting, and Evaluation" section, which includes the "Data-Sharing Capacity and Plan," "Reporting Plan," and "Evaluation Plan."
- The "Model Impact Analysis" section, which includes the "Impact on Quality of Care" and "Cost Savings Projection."
- The "Organizational Capacity of Applicant and Care-Delivery Partner" section.
- 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.
- 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, Application Cover Letter/Cover Page (if applicable), Project Site Location Form and Indirect Cost Rate Agreement. See text box below for other exclusions.
- The responses to the Program Duplication Questionnaire must be provided in a standalone document in an appendix and may be single-spaced. The page limit is 10 pages.
- The total number of appendices per application may be no more than 5, to include the Model Budget Narrative and Program Duplication Questionnaire; the page limits for each of the appendices are stated above. Other optional standalone appendices (3 maximum), if submitted, may be single-spaced and each page limit is 5 pages.

a. 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 please 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 www.GrantSolutions.gov for single-source applications), select the Project Abstract Summary and complete the form.

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

Note: On SF 424 “Application for Federal Assistance”:

- On Item 15 “Descriptive Title of Applicant’s Project”, state the specific cooperative agreement opportunity for which you are applying.
- 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. If your entity does not engage in lobbying, 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. 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.

b. Application Cover Letter or Cover Page

c. Project Narrative

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 in A.4., Program Requirements and the specific criteria described in E.1., Application Review Criteria. Please include the title “Project Narrative” at the beginning of the Project Narrative.

d. Budget Narrative

Applicants must supplement Form SF-424A with a Budget Narrative. The Budget Narrative must include a yearly breakdown of costs according to the budget 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 expenses 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.

e. Business Assessment of Applicant Organization (maximum 10 pages)

An applicant must review, answer, and submit the business assessment questions outlined in Appendix D.

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://www.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.

5/06/2019

3:00 PM Eastern U.S. Time

Late applications: Any application that is received after the due date and time shall be deemed a “late application” and shall not be reviewed.

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 applicant is requesting indirect costs, they are required to use current negotiated indirect cost rate. Any non-Federal entity that has never received a negotiated indirect cost rate, except for those non-Federal entities described in Appendix VII to 2 CFR Part 200 (Uniform Guidance) —States and Local Government and Indian Tribe Indirect Cost Proposals may elect to charge a de minimis rate of 10% of modified total direct costs (MTDC) which may be used indefinitely. As described in section 200.403 Factors affecting

allowability of costs, costs must be consistently charged as either indirect or direct costs, but may not be double charged or inconsistently charged as both. If chosen, this methodology once elected must be used consistently for all Federal awards until such time as a non-Federal entity chooses to negotiate for a rate, which the non-Federal entity may apply to do at any time.

The provisions of 2 CFR Part 200, Direct and Indirect (F &A) Costs sections 200.412 to 200.415 and Special Considerations for States, Local Governments and Indian Tribes, sections 200.416 to 200.417 govern reimbursement of indirect costs under this solicitation

If the recipient fails to provide a proposal, indirect costs paid in anticipation of establishment of a rate shall be disallowed. See the Health and Human Services Grants Policy Statement at <http://www.hhs.gov/asfr/ogapa/aboutog/hhsgps107.pdf> for more information.

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 federal 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.

Reimbursement of Pre-Award Costs

☐ Yes

☒ No

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.

E.1. Application Review Criteria

This section fully describes the evaluation criteria for this cooperative agreement. In preparing applications, applicants should review the requirements detailed in Section A.4, Program Requirements. Applicants must submit applications in the required format, no later than the deadline date. 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 Information, the applicant may be disqualified from consideration for award. Technical review panelists will assess and score applicants’ responses in accordance with the criteria below, using a scale of 200 total points.

Note to applicants:

- CMS will consider the geographic diversity of all applications when making final award determinations.
- Awards may be adjusted to a lower amount if the applicant fails to meet performance milestones (refer to Section F.5, Reporting).
- The application itself is not a legally binding contract and does not require any applicant or CMS to enter into a cooperative agreement.
- CMS will select awardees at CMS's sole discretion. Such selection will not be subject to administrative or judicial review, per Section 1115A (d) (2) of the Act.

Table C. Required Application Sections and Point Values	
PROJECT ABSTRACT	0 Points
PROJECT NARRATIVE	
Model Context	20 Points
- Statement of the Problem and Gap Analysis - Characteristics of Proposed Model Service Area and Model Population	
Model Implementation Plan	55 Points
- Intervention Design - Coverage and Payment Strategy - Sustainability Plan	
Memorandum of Understanding with Care-Delivery Partner	10 Points
Data-Sharing, Reporting, and Evaluation	25 Points
- Data-Sharing Capacity and Plan - Reporting Plan - Evaluation Plan	
Model Impact Analysis	35 Points
- Impact on Quality of Care - Cost Savings Projection	
Organizational Capacity of State Medicaid Program	20 Points
ADDITIONAL REQUIRED DOCUMENTATION	
Model Budget Narrative	25 Points
Program Duplication Questionnaire	10 Points
TOTAL	200 Points
<i>Additional Preference for Postpartum Continuity of Care</i>	<i>Up to 5 Points</i>

PROJECT ABSTRACT (Required for all applicants)

Applicants should submit a one-page, single-spaced abstract to serve as a succinct description of the proposed project. The abstract should include the proposed model service area, 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 successful applicants should 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.

Applicants should upload the abstract in the Grants Application Package which can be found at <http://www.grants.gov>; select the "Project Abstract Summary," and complete the form.

PROJECT NARRATIVE

The review criteria for the Project Narrative are described below. All elements of the Project Narrative are required and will be used to assess an applicant's ability to design and implement a model intervention that aims to improve health outcomes for pregnant and postpartum Medicaid beneficiaries with OUD residing in the proposed model service area and produce cost savings to Medicaid. Incomplete, unclear, and confusing proposals will receive point deductions. Project Narratives with significant content deficiencies may receive a score of zero. Proposals that merely restate the content of the Notice of Funding Opportunity, without responding to the Program Requirements and Application Review Criteria, will receive a score of zero. Each component of the Project Narrative will be weighted as indicated below. The Project Narrative must be double-spaced and should not exceed 60 pages in length. This page limit does not include the Memorandum/a of Understanding.

Model Context

20 Points

Statement of the Problem and Gap Analysis

Applicants must provide a narrative that identifies the current process(es) for identifying and treating pregnant and postpartum women with OUD in the proposed model service area. The Statement of the Problem should include a Gap Analysis that identifies the gaps in providing, funding, and ensuring access to comprehensive physical and behavioral health care for this population; and, explain how participating in the model will address these gaps. Applicants should respond to the requirements set out in A.4.6.1 and demonstrate a comprehensive awareness of the current status of the model population in the proposed model service area, including existing gaps in care delivery.

Characteristics of Proposed Model Service Area and Model Population

Applicants must specifically identify a model service area and provide the required data elements set out at A.4.6.2. If data are not available, the applicant should provide an explanation for any missing data and, if possible, a proxy for each missing data point.

Model Implementation Plan

55 Points

Intervention Design

The applicant should use this section to provide a detailed description of its proposed model intervention. Applicants must respond completely to each of the requirements set out in A.4.6.3. The Intervention Design section should respond to the circumstances set out in the Statement of the Problem section, and present a clear plan for using MOM model funds to close identified gaps. Applicants should set out a clear strategy for identifying, enrolling, and retaining beneficiaries, participating providers, and clinical delivery sites in the model; plan for screening beneficiaries for health-related social needs; standards for selecting and retaining participating providers; identify and describe the physical and behavioral healthcare services and intake, care coordination, and referral services that will be provided to beneficiaries enrolled in the model; and explain how the applicant and care-delivery partner(s) will work together (and, if applicable, with Managed Care Plans in the proposed model service area) to ensure that Medicaid-covered services and model services are delivered to beneficiaries in a coordinated fashion. Additionally, applicants must identify any potential legal and policy barriers that might impact their ability to successfully implement the model in their proposed service area, and explain how they propose to address these barriers. Finally, applicants must describe the nature of the financial relationships (including any downstream relationships) that the applicant foresees pursuing in an effort to achieve the goals of the MOM model.

Coverage and Payment Strategy

In this section, applicants should provide a detailed strategy that ensures that eligible Medicaid

beneficiaries can access all services identified in the model design and implementation plan above. Applicants must respond to each of the requirements set out in A.4.6.4, Coverage and Payment Strategy. This strategy should incorporate two key elements: coverage of services through the Medicaid program and funding for services for the model population. Applicants should propose innovative coverage and payment strategies that are tailored to the needs of their proposed model population as set out in the Statement of the Problem section.

Coverage: Applicants should present a coverage strategy that addresses the gaps set forth in the Statement of the Problem section, including any changes to the Medicaid program that the applicant plans to implement in order to carry out the model. Applicants should provide a detailed and feasible timeline for developing and implementing any applicable State Plan Amendments, waivers and demonstrations, changes to Managed Care Plan contracts, changes to provider rates, and state regulatory and legislative changes necessary to ensure that the model population will have access to model services. The coverage plan should also set out the applicant's proposal for ensuring that women will continue to have access to critical services during the postpartum period. The model postpartum period must, at minimum, fulfill the requirements set out at 42 U.S.C. 1396a (l) (1) (A). See "Postpartum Continuity of Care" below for an additional opportunity to earn points based on scope of services, duration of access to services, and sustainability of the postpartum care plan.

Payment: The applicant must set forth a plan for paying for the proposed model implementation plan in each of the five years of the model. Applicants should distinguish between funding sources (Innovation Center funding, including Implementation Funding and Care-Delivery Funding; Medicaid funding; and other, non-CMS funding sources) and between model periods (Pre-Implementation, Transition, and Full Implementation Periods.) The applicant should provide a detailed explanation that sets out how the state will take over care-delivery payments during the Full Implementation Period (Years 3, 4, and 5).

Sustainability Plan

Applicants should use this section to present their strategy for sustaining services, including physical and behavioral healthcare services, and model services, to the model population after the model performance period ends. Applicants must respond to each of the requirements set out at A.4.6.5. The sustainability strategy must account for both coverage of services and funding to support care.

Postpartum Continuity of Care

5 points

All applicants must provide in their Coverage and Payment Strategy a plan that sets out how the applicant proposes to ensure that women will continue to have access to care through the end of the month in which the 60-day period beginning on the last day of her pregnancy ends, as required by law.⁴ (See Coverage, above). In order to encourage states to provide postpartum and parenting women with continued access to critical services, this criterion establishes up to a 5-point priority available to applicants whose postpartum coverage plans would provide a broad scope of physical and behavioral healthcare services to women after delivery and extend the duration of access to these services beyond the minimum length of time required by law for pregnant Medicaid beneficiaries. Applicants who clearly identify a sustainable plan for achieving these goals may be considered for this 5-point preference.

Memorandum of Understanding with Care-Delivery Partner(s)

10 Points

The applicant should provide a copy of a Memorandum of Understanding (MOU) between the state Medicaid agency and each of its care-delivery partners, signed by the state Medicaid director and an

⁴ 42 U.S.C. 1396a(l)(1)(A)

individual with the legal authority to bind the care-delivery partner. The MOU should demonstrate the strong partnership between the state and the care-delivery partner by responding completely to the requirements set out in A.4.6.6. Each MOU should set forth the performance deliverables and any transfer of funds between the two entities during Year 1 of the model, including a timeline for payments. Each MOU should also demonstrate that both entities understand the data-sharing and reporting requirements of the model. Each MOU should include an actionable plan for converting the MOU to an enforceable contract as soon as one of the parties begins performance under the arrangement.

The MOU(s) should be single-spaced. Each MOU should not exceed five pages in length. The MOU(s) do not count toward the 60-page Project Narrative limit.

Data-Sharing, Reporting, and Evaluation

25 Points

Data-Sharing Capacity and Plan

Applicants should use this section to present a detailed data-sharing plan that demonstrates their capacity to gather, maintain, and share data in order to facilitate provision of coordinated care to the model population. Applicants must respond to each of the requirements set out in A.4.6.7, Data-Sharing Capacity and Plan. Applicants should provide plans that demonstrate an understanding and commitment to patient privacy and can demonstrate experience gathering, storing, protecting, and sharing Medicaid data, including information governed by 42 C.F.R. Part 2 and other protected health information.

Reporting Plan

Applicants should use this section to present a Reporting Plan that demonstrates their capacity to provide timely and complete data to CMS to fulfill Quarterly and Annual Reporting requirements and Performance Milestones (refer to Section F.5.2, Monitoring). Applicants must respond to each of the requirements set out in A.4.6.8, Reporting Plan.

Evaluation Plan

Applicants should use this section to provide a strategy for ensuring participation in the mandatory model evaluation by all model partners and participants, including the awardee, care-delivery partner, clinical delivery site providers and staff, patients, and any other individuals or entities. Applicants must respond to each of the requirements set out in A.4.6.9., Evaluation Plan.

Model Impact Analysis

35 Points

Impact on Quality of Care

Applicants should use this section to identify how they will maximize the effect of their proposed intervention on the quality milestones set out in F.5.2, Monitoring and identify any additional quality improvement strategies they propose. Applicants must respond to each of the requirements set out at A.4.2.10, Impact on Quality of Care.

Cost Savings Projection

Applicants should use this section to provide a financial model that illustrates anticipated Medicaid and/or CHIP spending for the model population, comparing a projection including the intervention to a projection in the absence of the intervention, over the same period. Applicants must respond to each of the requirements set out at A.4.6.11, Cost Savings Projection.

Organizational Capacity of State Medicaid Agency and Care-Delivery Partner(s)

20 Points

Applicants should use this section to demonstrate their capacity, together with the care-delivery partner(s), to organize and manage the model. The application must address each of the requirements set out at A.4.6.12, Organizational Capacity. Applicants should identify the relevant organizational structure including leadership within each partner entity responsible for managing the model and provide evidence that the state Medicaid agency and the Care-Deliver Partner(s) have significant experience designing and implementing comparable projects, including past and current projects aimed at improving the health outcomes and cost savings associated with treating women and infants affected by opioid use disorder.

ADDITIONAL REQUIRED DOCUMENTATION

Model Budget Narrative

25 Points

In the Budget Narrative, applicants should provide a reasonable justification and rationale for the proposed model budget for the Pre-Implementation, Transition, and Full Implementation Periods. Applicants must respond to each of the requirements set out at A.4.6.13, Budget Narrative. Specifically, applicants should provide a budget with sufficient detail that would allow CMS to understand how the applicants would meet their objectives given their budget, and to assess the reasonableness of the proposed budget. Applicants should clearly identify apportionment of funds between the state and the care-delivery partner(s) and provide line items for all activities related to model implementation. Finally, applicants should identify what current or potential future funding streams could apply to these activities, and identify gaps toward which they could apply model funding.

Program Duplication Questionnaire

10 Points

Applicants must submit a completed Program Duplication Questionnaire (Appendix F). Responses to the Questionnaire should explain how the applicant will use MOM model funds to deliver and coordinate physical and behavioral health care to the model population in the proposed service area without duplicating existing funding or program efforts. The responses to the Questionnaire should clearly and completely identify potentially duplicative initiatives and provide a strategy for avoiding duplication of programs and funding. The applicant should demonstrate how it proposes to build upon current programs and initiatives, if applicable; while avoiding duplication with Medicaid, Title V, and any other federal, state, or local funding.

E2. Review and Selection Process (select one)

- ☐ Anticipated Federal Review
- ☒ Anticipated Mix of Federal and Non-Federal Review

E3. Federal Awardee Performance Integrity Information System (FAPIS)

- 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 FAPIS) (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

If successful, Applicant will receive a Notice of Award (NoA) signed and dated by the HHS 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 Applicant prior to issuance of the NoA is not an authorization to begin performance of a project.

If unsuccessful, 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

A. National/Public Policy Requirements

By signing the application, the authorized organizational official certifies that the organization will comply with the public policies referenced in this section. Once a grant is awarded, the Recipient is responsible for establishing and maintaining the necessary processes to monitor its compliance and that of its employees and, as appropriate, subrecipients and contractors under the cooperative agreement with these requirements. 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 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. <https://www.minorityhealth.hhs.gov/>
4. <http://www.hhs.gov/ocr/civilrights/understanding/section1557/index.html>
5. [HHSAR352.270-1](https://www.hhs.gov/ocr/civilrights/understanding/disability/index.html)
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 J to this NOFO.

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

B. 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 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 5.412 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 <http://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 regulations at 45 CFR Part 75 supersede 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.

CMS may impose additional conditions, as described in 45 CFR § 75.207, on any awardee that fails to comply with Federal statutes, regulations, or the terms and conditions of a Federal award. In addition, CMS may take one or more of the actions set forth at § 75.371, as appropriate in the circumstances, in the event that CMS determines that noncompliance cannot be remedied by imposing additional conditions.

The award may be terminated in whole or in part as set forth in 45 CFR § 75.372. As explained therein, CMS may terminate the award for an awardee's noncompliance with the terms and conditions of the award.

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 section 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 performance of the activities. Under each Cooperative Agreement, CMS' 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 & 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 Indian Health Service, the Internal Revenue Service, the Department of Homeland Security, the Administration for Children and Families, and the Social Security Administration.

Project Officers and Monitoring – CMS will assign specific Project Officers to each Cooperative Agreement award to support and monitor recipients throughout the period of performance. CMS's Grants Management Officers, Grants Management Specialists, Project Officers, and implementation contractor will monitor, on a regular basis, progress of each recipient. This monitoring may be by phone, document review, on-site visit, other meeting and by other appropriate means, such as reviewing program progress reports and Federal Financial Reports (FFR or SF-425). This monitoring will be to determine 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. Recipients will be required to engage in the following activities:

- Reporting – comply with all reporting requirements outlined in the terms and conditions of the Cooperative Agreement to facilitate the timely release of funds.
- Program Evaluation – cooperate with CMS-directed program evaluations.
- Technical Assistance – participate in technical assistance activities, as may be requested by CMS. The Project Officer determines the need for and form of technical assistance.
- Program Standards – comply with all applicable program requirements, as detailed in regulations, guidance, and the cooperative agreement terms and conditions provided with the NoA.

F.5. Reporting

Each awardee is required to submit the following:

F.5.1. Financial Reports

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-annually or annually, 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 sub-recipient's five most highly compensated executives as outlined in Appendix A to 2 CFR Part 170 (available online at <https://www.fsrc.gov/>).

Audit Requirements

Awardees must comply with audit requirements outlined in HHS regulation 45 CFR Part 75 (implementing 2 CFR Part 200). See Subpart F – Audit Requirements, <https://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). Awardees 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 awardees 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 pmssupport@psc.gov or call (877) 614-5533 for assistance.

F.5.2. Monitoring

CMS will monitor the performance of each award recipient pursuant to the Terms and Conditions of Award.

Each awardee will be required to comply fully with CMS's and any CMS contractor's efforts to monitor the MOM model. CMS will primarily monitor awards through data collection and reporting to the Innovation Center and the Office of Acquisition and Grants Management (OAGM). CMS's goal is to monitor and measure model activities in a manner that optimizes its usefulness for both awardees and the Innovation Center. The Innovation Center will closely track model progress through project officers and an implementation contractor. A key monitoring activity is the provision of feedback to awardees to facilitate compliance with the Terms and Conditions of the cooperative agreement.

Each awardee will be required to participate in model monitoring activities that include but are not limited

to:

- Submission of quarterly and annual progress reports
- Regular communications with a CMS project officer
- Regular learning system event attendance and participation
- Submission of other standalone documents as specified in Tables C and D, below

F 5.2.1. Quarterly and Annual Progress Reporting

Each awardee will be required to submit quarterly progress reports (QPRs) and annual progress reports (APRs). CMS will provide awardees with guidance and a template for QPR and APR submissions. These reports will include narrative updates on model activities as well as information on operational and performance milestones in accordance with the MOM model cooperative agreement. The Innovation Center will use the quarterly and annual reports to track progress on model goals, identify technical assistance needs, and inform learning activities for all awardees. The operations and performance milestones will support Innovation Center efforts to confirm that each awardee is able to meet program requirements and deliver high quality care to beneficiaries. The Innovation Center will also share these findings with awardees individually on an ongoing basis for quality improvement purposes. Awardees must maintain records of all source data used to calculate program milestone measures and make such data available to the Innovation Center for periodic audits. CMS will consider awardees for corrective action, funding restrictions, or termination if they do not meet the model reporting requirements outlined in their cooperative agreement Notice of Award and Terms and Conditions.

A list of specific operational milestones that each awardee must report to CMS is included in Table D, below. CMS reserves the right to revise these operational milestones as needed during model performance periods.

Table D. MOM Model Operational Milestones	
Operational Milestone	Description
Learning system attendance and participation	See detailed description of learning system activities in Section F 5.3.
Medicaid or CHIP SPA/waiver timeline	Each awardees must meet with CMCS immediately upon award to begin the process of State Plan Amendment (SPA) or waiver approval necessary to implement their proposed coverage and payment strategies. Each awardee must submit a timeline for SPA/waiver approval agreed upon by the state and CMCS, as an appendix to their QPR submission in model Year 1, Quarter 1. Every quarter thereafter, each awardee must update the timeline and their progress toward SPA/waiver approval in subsequent QPRs until obtaining final CMCS approval. Each awardee must inform their project officers of changes as they occur during regular communications. Each awardee must obtain any SPA or waiver approvals from CMCS that are necessary for model

Table D. MOM Model Operational Milestones	
	implementation by the time of their non-competitive continuation application submissions in model Year 2, Quarter 3.
Documentation of managed care plan participation (if applicable)	If applicable, each awardee must submit documentation confirming managed care plans' agreement to participate in MOM model as an appendix to the QPR submitted by the end of model Year 1, Quarter 2 and provide updates annually thereafter. Each awardee must inform their project officers of changes as they occur during regular communications.
Updated implementation plan	Each awardee must submit a revised copy of their Implementation Plan as a standalone document by the end of model Year 1, Quarter 2. Each awardee must revise their Implementation Plan annually thereafter, and submit to CMS as a standalone document at the time of Annual Progress Reports. Each awardee must inform their project officers of changes as they occur during regular communications.
Provider participation standards	Each awardee must submit a written policy detailing their standards for selecting participating providers by the end of Year 1, Quarter 2. This policy should build on the provider participation plan set out in the updated Implementation Plan. The policy should clearly identify the criteria that the awardee and its care-delivery partners will use to select and monitor participating providers. Past or future referrals may not serve as the basis for selecting or retaining participating providers.
Updated Sustainability Plan	Each awardee must submit a revised copy of its Sustainability Plan as a standalone document by the end of model Year 1, Quarter 3. Each awardee must revise their Implementation Plan annually thereafter, and submit to CMS as a standalone document at the time of Annual Progress Reports. Each awardee must inform their project officers of changes as they occur during regular communications. Beginning with the Year 4 Annual Progress Report, each awardee must update the Sustainability Plan to address how they will continue to serve the model population after the end of the performance period and how they could scale

Table D. MOM Model Operational Milestones	
	the model to serve Medicaid beneficiaries in the future (for example, expanding implementation from a sub-state region to a statewide scope and identifying additional populations that could benefit from a similar coordinated approach).
Updated Program Duplication Assessment	Each awardee must submit a revised copy of its Program Duplication Assessment as a standalone document by the end of model Year 1, Quarter 3. Each awardee must revise its Program Duplication Assessment annually thereafter, and submit to CMS as a standalone document at the time Annual Progress Reports are submitted.
Contractual agreement between state and care-delivery partner	The state must submit its signed contractual agreement(s) with its care-delivery partner(s) by the end of model Year 1, Quarter 3, at the time of non-competitive continuation application submission for model Year 2. Each awardee must submit any updated or new contractual agreement(s) with its care-delivery partner(s) annually thereafter (including a tracked changes version) if substantive changes have been made. The terms and conditions of the contract must be made available to CMS upon request.
Beneficiary data	Starting in Year 2, each awardee must provide CMS with the following information on a quarterly basis: - Aggregate count of beneficiaries enrolled in the model during the reporting quarter, separated by the count of beneficiaries who were newly enrolled for that quarter (i.e., for whom the one-time intake, assessment, and creation of a treatment plan payment was requested), and the count of beneficiaries who were enrolled in a prior quarter (i.e., who are continuing in care). - Total number of beneficiaries for which care-delivery payment was requested for the quarter, separated by the number of beneficiaries who received physical and/or behavioral healthcare services along with coordination, engagement, and referral services and the number of disengaged beneficiaries who did not receive physical and/or behavioral healthcare services, but for whom substantial outreach attempts were made by the care-delivery partner.

Table D. MOM Model Operational Milestones

	• Average duration of participation in months per beneficiary during the quarter. • Engagement status of beneficiaries for the three months in the reporting quarter. • Other beneficiary data in response to monitoring measures, to be specified in the Terms and Conditions of the cooperative agreement. Monitoring measures will be designed to capture important data about beneficiaries (e.g., regarding screening for depression or tobacco use). Monitoring measures are not associated with Milestone Funding and are separate from evaluation requirements (see Section F. 5.3, Evaluation). Note: Beneficiary data are de-identified and will be used by the Innovation Center Model team for program monitoring. The aggregate counts will be used by the Innovation Center both for monitoring and to determine an awardee's eligibility to receive Transition Funding.
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F.5.2.2. Performance Milestones

Awardees must report aggregated data on their MOM-model enrolled beneficiaries for performance milestones. The requirements under consideration in these domains are listed in Table E below.

During the course of the Full Implementation Period, up to \$1,500,000 in Milestone Funding per awardee is restricted and will be unrestricted in whole or in part, based on awardee performance on select milestones. This means that each awardee will have the opportunity to access up to \$1,500,000 in funding across the entire Full Implementation Period (Years 3, 4, and 5). The actual, unrestricted funding amount to which an individual awardee has access may be less than \$1,500,000 and will be determined based on the awardee's reporting or performance on measures in the most recent budget year for which data have been analyzed. Benchmarks for the measures linked to funding will be determined using the baseline data submitted by awardees beginning during the Transition Period (Year 2); benchmarking may continue beyond Year 2 for certain measures.

There will be a delay between awardee performance on a measure and the availability of funding linked to that measure. This delay is intended to provide the necessary time for data to be transmitted to the Innovation Center or its relevant contractor and analyzed to determine eligibility for payment.

Table E. Performance Milestones Under Consideration

Performance Milestone	Source	Description ⁵
Gains in Patient Activation Scores	10- or 13-item survey, administered twice, at least 3 months apart	The Patient Activation Measure (PAM) is a patient-reported outcome measure of the level of “activation” or engagement in treatment, which has been directly associated with improved outcomes for a variety of acute and chronic conditions. The outcome of interest is the patient’s knowledge, skills and confidence for managing his or her health and health care. Milestone funding for this measure would be determined based on an awardee’s progress from an initial benchmark calculated by the Innovation Center or its contractor.
Health-Related Social Needs Screening	Validated screening tool proposed by applicant and approved by CMS	Beneficiaries in this model will be unlikely to thrive, even with excellent clinical care and access to MAT, unless they are connected to non-clinical supports for food, housing, legal aid, parenting classes and other community resources. A first step is to survey their needs in this area through a validated tool that screens patient social needs. Applicants should propose a validated tool to screen beneficiaries, at minimum, for unmet needs across the following six domains: housing, food, transportation, utilities, interpersonal safety, and family and community support. ⁶ Awardees will have the opportunity to earn Milestone funding based on the number or percentage of beneficiaries enrolled in the model that complete a screening. Milestone funding for this measure would be

⁵ Note: CMS may require awardees to submit similar or overlapping identifiable data in some or all of these domains as part of the model evaluation.

⁶ Awardees will not be required to use a specific tool. The CMS Accountable Health Communities Health-Related Social Needs Screening Tool includes all domains required in this NOFO. A link to the tool is available at <https://innovation.cms.gov/Files/worksheets/ahcm-screeningtool.pdf> for reference only.

		determined based on an awardee's progress from an initial benchmark calculated by the Innovation Center or its contractor. Note: Each awardee will be required to conduct health-related social needs screening (see A.4.6.3, Intervention Design). Milestone funding may be separately available based on performance, as described in this section.
Postpartum Follow-Up	Awardee-reported data, subject to audit	Awardees will report de-identified patient data on model enrollees who attend postpartum follow-up with maternity care provider and receive family planning counseling. Milestone funding for this measure would be determined based on an awardee's progress from an initial benchmark calculated by the Innovation Center or its contractor.
Initiation and Engagement in OUD Treatment	Awardee-reported data, subject to audit	Awardees will report de-identified patient data, including diagnosis, dates of treatment initiation and follow-up engagement visits, and dates of model exit or loss to follow-up. Milestone funding for this measure would be determined based on an awardee's progress from initial benchmarks calculated by the Innovation Center or its contractor.
Continuity of Pharmacotherapy at Delivery	Awardee-reported data, subject to audit	Awardees will report de-identified patient data, including date of pharmacotherapy initiation, date of delivery, and pharmacotherapy status at delivery. Milestone funding for this measure would be determined based on an awardee's progress from initial benchmarks calculated by the Innovation Center or its contractor.

F.5.3. Evaluation

CMS will conduct a formal and concurrent evaluation of each awardee's performance to assess model impact. The primary goal of the evaluation will be to assess the effects of coordinated, evidence-based maternity care and substance use treatment on health and health-related outcomes for pregnant and postpartum Medicaid beneficiaries with OUD and their infants, and the extent to which the model is associated with reduced expenditures. Sources will be reviewed in comparison with one another (e.g. encounter data with medical records) to ensure reliability of data.

The evaluation will focus on measures of health and well-being among women and their infants as well as tracking referrals, adherence to treatment, and appropriate resource utilization and follow-up. To the extent possible, given sample size and available data, CMS will investigate whether the intervention reduces emergency department use and hospitalizations for women in the prenatal and postpartum periods, neonatal intensive care stays for infants, and emergency department use and hospitalizations for infants during their first year.

CMS will also track other cost, quality, and health outcomes, including co-occurring substance use and mental health disorders, individual beneficiary breastfeeding practices and hospital and birth center breastfeeding protocols, and out-of-home placements for infants. This evaluation is expected to span the model's performance period, beginning during the Pre-Implementation Period and extending through the end of model performance (Year 5). The evaluation contractor will develop a system for the submission and receipt of all required data. Awardees are solely responsible for any Institutional Review Board (IRB) procedures and approvals or any other permissions from beneficiaries, their organizations, or states that may be needed to submit these data.

The Innovation Center will evaluate each awardee using the most rigorous evaluation design feasible, applying appropriate quantitative and qualitative methods to examine program outcomes and the

processes that lead to successes or challenges. CMS will require Awardees to provide the evaluation contractor data including, but not limited to:

- **Claims and encounter data.** The evaluation requires that awardees provide timely and accurate Medicaid claims to the Transformed Medicaid Statistical Information System (T-MSIS). Prior to model start, each state applicant should be current on their submissions. Beginning the second quarter of the first award year, and every quarter thereafter for the duration of the model performance period, awardees must submit all Medicaid and CHIP (if applicable) claims and encounter data with unique, traceable identifiers for the individual beneficiaries attributed to the MOM model for at least one month within the previous 12 months. If CMS/Innovation Center does not receive all necessary claims and encounter data for enrolled beneficiaries through T-MSIS, the awardee is responsible for obtaining and submitting the required claims and encounters through an alternative mechanism approved by the Innovation Center.
- **Authorization from beneficiaries for themselves and for their infants to access/transmit individual-level, identified vital records data.** Awardees are required to develop beneficiary consent forms that comply with all federal, state and local laws governing the access and transmission of patient data, including (but not limited to) substance use treatment claims, laboratory test results and other treatment data.
- **Awardee and site-level health and utilization data needed for the evaluation, but not captured by claims and encounters.** This may include prenatal and postpartum care for the enrolled women and any care for their infants. Required data may include, but are not limited to: referrals, patient follow-up on recommended services, interactions with related agencies such as social services, postpartum care for women not typically covered through Medicaid, or other data deemed necessary.
- **Qualitative data.** Beginning the second quarter of the first award year, and every quarter thereafter for the duration of the model performance period, Awardees and their program partners will assist the model evaluation contractor with the acquisition of qualitative data. Data collection activities that may require awardee cooperation/participation include: arranging and granting interviews; assisting in recruiting for focus groups and individual interviews with model-associated staff and beneficiaries; allowing observations of any model-funded activities; providing program documents such as patient education and staff training materials; surveys of staff and/or beneficiaries, including screening patients for health-related social needs; and, any other necessary activities.
- **Medicaid and CHIP identifiers.** CMS must have access to claims and encounter data with identifiers sufficient to longitudinally track all Medicaid and CHIP beneficiaries in the intervention, including both women and infants. Identifiers must be sufficient to link infants to their mothers. Awardees must provide the Innovation Center with Medicaid (and CHIP if applicable) identifiers for all attributed women and infants to facilitate claims matching. On an annual basis, the Awardee will provide the Innovation Center with a retrospective list of attributed beneficiaries to confirm beneficiaries' Medicaid or CHIP coverage status throughout the previous year for both the Awardee's model population and any in-state comparators.

F.5.4. Learning System Participation

A. Learning System Strategy

A Learning System is a structured approach to sharing, integrating, and actively applying quality improvement concepts, tactics, and lessons learned to accelerate implementation and improve the success

of the Model aims. The Innovation Center will design, implement, and manage a learning system, and tailor it to the needs of MOM model awardees and their care-delivery partner(s). The primary learning system functions by: identifying and packaging new knowledge and practice; leveraging data and participant input to guide change/improvement; and, building learning communities and networks to share and spread new knowledge and practice.

The MOM model learning system can serve two roles: 1) during the application period, the learning system may be designed to provide support to Applicants as they prepare to apply for this Model; and, 2) after model Participants have been announced, the learning system will support Participants in maintaining or improving the quality of care for their Medicaid beneficiaries while lowering costs.

i. Learning System Activities for Applicants

CMS may provide support to Applicants as they prepare to address the complex healthcare needs of pregnant and postpartum Medicaid beneficiaries with OUD as described in the Notice of Funding Opportunity (NOFO). Applicant Learning System activities may include learning sessions geared specifically towards Applicants, such as increasing understanding of the Model aims, plans, and conditions for participation through informational webinars and/or open door forums, as well as other activities as needed to support Applicants. These activities will provide an opportunity to introduce key concepts to Applicants; engage individuals from across the Applicant organization; and initiate action planning by Applicants and their proposed care-delivery partner(s). Applicants are encouraged, but not required, to participate in these application-related Learning System activities.

ii. Learning System Activities for Participants

Participants will be required, under the terms and conditions with CMS, to actively participate in Learning System activities throughout all periods of the Model implementation process (Pre-Implementation, Transition, and Full Implementation Periods) as a condition of participation. As outlined in this NOFO, state Medicaid Agencies will focus on developing and finalizing the coverage and payment strategies using existing Medicaid and CHIP authorities as necessary, while care-delivery partner(s) will be the direct care providers whose primary responsibilities include: establishing relationships with clinical partners, building capacity at the service-delivery level to support care-delivery transformation, and implementing the MOM model integrated care-delivery approach.

Overall, the types of learning system activities participants can expect will vary, but the Learning System will facilitate peer learning and information-sharing around how to best achieve quick and effective performance improvement. The Learning System will allow participants to share their experiences, track their progress, glean promising practices from their peers, and rapidly adopt new ways of achieving improvements in care quality and cost reduction.

CMS encourages care-delivery partner(s) and their clinical partners to join a robust learning network to ensure rapid diffusion of best practices across awardees and partners. Learning system activities will provide awardees with MOM model learning support and activities to include didactic presentations and interactive discussions, both live and asynchronous, and may include peer-to-peer learning, virtual site visits, face-to-face visits, teleconferences, webinars, training exchanges, report-outs, affinity groups, integrated learning events, case studies, vignettes, training videos, and TBD in-person meetings at a CMS designated location in the Baltimore/District of Columbia area. Peer-to-peer learning among awardees is a key activity because state-to-state knowledge transfer about model implementation in unique state environments is crucial to successful future model adoption by other states.

Each participant will be required to:

1. Participate in targeted learning on Driver Diagrams, and during the Pre-Implementation Period (Year 1), develop and submit to CMS, or its contractors, an individualized participant Driver Diagram (after submission to CMS, the awardee Driver Diagram should be maintained and updated by the awardee throughout the life of the grant as a framework to guide and align the intervention design and implementation activities and shared with CMS upon request);
2. Upon request, answer surveys, participate in interviews or engage in other activities to assist CMS and its contractors in identifying their learning needs;
3. Participate in the identification and dissemination of practices that are showing positive outcomes, through sharing lessons learned with other Model participants (e.g. presenting on webinars);
4. Participate in at least one virtual MOM model learning activity every quarter during the 5-year model period, beginning Year 1;
5. Share with CMS, its contractors, and if relevant, other model participants, information on state and federal programs that complement MOM model interventions in the communities they serve;
6. Develop, track, and report to CMS on quality improvement efforts, activities, and program measures, at regular intervals; and
7. Participate in in-person events during some years of the model (TBD). These in-person events will be held in the Baltimore/District of Columbia area and will be geared towards participant learning, collaboration, and dissemination of MOM model promising practices and other participant needs.

G. CMS Contacts

G1. Programmatic and Administrative/Budget Questions

For programmatic and administrative questions about this funding opportunity, please contact:

MOMmodel@cms.hhs.gov

Appendix A. Guidance for Preparing a Budget Request and Narrative

Applicants should request funding only for activities which 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.

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 “Maternal Opioid Misuse Model” 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.

(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 _____

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 \$ _____

Fringe Benefit	Rate	Salary Requested	Amount Requested

Federal Insurance Contributions Act (FICA)A	7.65%	\$45,000	\$3443
Worker's Compensation	2.5%	\$14,250	\$356
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 _____

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, etc.).

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 _____

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 includes 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 _____

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, etc.). 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, etc.) for a fee and who is not an employee of the awardee 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 _____

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
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.

I. Total Direct Costs **\$_____**

Show total direct costs by listing totals of each category.

J. 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, 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.dnb.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 F5.C. (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 <https://www.grants.gov/web/grants/register.html>. 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, 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:

- 1) Search for the application package in Grants.gov by entering the CFDA number. This number is shown on the cover page of this announcement.
- 2) 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).
- 3) 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 or 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-Off List Required Contents

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 www.grantsolutions.gov, and formatting requirements followed.**

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

Section D: Application and Submission

Section E: Application Review Information

Appendix A: Sample Budget and Narrative Justifications

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

- ☐ Project Narrative
- ☐ Budget Narrative
- ☐ Business Assessment of Applicant Organization

Appendix D. Business Assessment of Applicant Organization

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?
3. Are salary comparability surveys conducted? How often?
4. Are salaries of personnel assigned to Government projects about the same as before assignment? Identify reasons for significant increases.
5. Does the organization maintain a payroll distribution system which meets the required standards as contained in the applicable cost principles for that organization?
6. Does the organization maintain daily attendance records for hourly employees? Does this show actual time employees sign in and out?
7. Does the payroll distribution system account for the total effort (100%) for which the employee is compensated by the organization?
8. Who signs and certifies work performed in items 5, 6, and 7 above?

9. 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.?
2. 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?
- 12. 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, and 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/GMO, in her 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 Review criteria described in Section E1., Application Review 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; 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. 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.
- v. HHS reserves the right to conduct pre-award Negotiations with potential awardees.

Appendix F. Program Duplication Assessment Questionnaire

State: _____

Individual Contact: (Name/Email): _____

Are you aware of your responsibility to avoid program duplication?

Yes _____

No _____

If you are awarded MOM model funding, will you ensure award funds are not used to duplicate or supplant current federal, state or local funding; or be used for the non-federal share of Medicaid payments?

Yes _____

No _____

Please provide an explanation for how your Budget Narrative accounts for existing programs or resources that can be leveraged for the MOM model.

Please summarize your standard operating procedures and best practices for avoiding program duplication. If available, please attach as an appendix to the application your standard operating procedure for preventing program duplication.

Do you expect to be involved in any alternative payment and/or delivery reform programs or demonstrations during the model implementation phase (calendar years 2019-2024)?

Yes _____

No _____

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

Please provide a list and description of all alternative payment and/or delivery reform programs or demonstrations that you are currently involved in or plan to be involved in during the model (calendar years 2019-2024). For each program identified, please provide the following information:

1. Name of the program;
2. Description of the program objectives and allowed expenses;
3. Payer(s) of the program services;
4. Amount of funding on an annual basis;
5. Expected start and end dates of the program (if applicable);
6. Authority for the alternative payment model (if applicable);
7. Whether beneficiaries who you propose to include in the MOM model population are eligible for

- services under the program;
8. What percentage of proposed MOM model enrollees would participate in both programs (if applicable); and
 9. An explanation for how payment under the MOM model would not result in duplicative services or funding for your proposed MOM model population.

Do you expect to be involved in any programs or demonstrations during the model (calendar years 2019-2024) that are aimed at (1) addressing opioid use disorder among women of reproductive age, (2) addressing opioid use disorder among pregnant or postpartum women, or (3) reducing neonatal abstinence syndrome?

Yes _____

No _____

If you answered "Yes" to Question 7, please complete Question 8. If you answered "No," please skip Question 8 and move to Question 9.

Please provide a list and description of all programs with the following aims in which you are currently involved or plan to be involved during the model (calendar years 2019-2024): (1) addressing opioid use disorder among women of reproductive age; (2) addressing opioid use disorder among pregnant or postpartum women; (3) reducing neonatal abstinence syndrome). For each program identified, please provide the following information:

1. Name of the program;
2. Description of the program objectives and allowed expenses;
3. Payer(s) of the program services;
4. Amount of funding on an annual basis;
5. Expected start and end dates of the program (if applicable);
6. Authority for the alternative payment model (if applicable);
7. Whether beneficiaries who you propose to include in the MOM model population are eligible for services under the program;
8. What percentage of proposed MOM model enrollees would participate in both programs (if applicable); and
9. An explanation for how payment under the MOM model would not result in duplicative services or funding for your proposed MOM model population.

Provide information regarding any potentially duplicative services for each of the key MOM model elements below. You may use Table F or provide a narrative response for each element:

1. Substance use disorder intake, assessment, and creation of a treatment plan;
2. Comprehensive care management;
3. Care coordination;
4. Health promotion;
5. Individual and family support; and,
6. Referral to community/support services

For each element, provide

- a. A description of existing services;
- b. Current funding sources;
- c. How the MOM model will address service gaps; and
- d. Your strategy for avoiding duplication of programs and funding

Table F. Program Duplication Mitigation Strategies				
	Description of existing services	Current funding source	How MOM model funding will address service gaps	Strategy for avoiding duplication of services and funding
SUD intake, assessment, and creation of a treatment plan				
Comprehensive care management				
Care coordination				
Health promotion				
Individual & family support				
Referral to community & other support services				

Appendix G. Illustrative Medicaid Services for Pregnant and Postpartum Women and Their Infants

The table below represents an illustrative list of the types of services that an awardee could include to serve pregnant and postpartum women with OUD and their infants across categories of physical health care, behavioral health care, as well as coordination, engagement, and referral.

Physical Health Care	Behavioral Health Care
<i>Substance Use Disorder</i>	Individual counseling
SUD screening/assessment*	Group counseling
Brief SUD intervention	Peer support
Lab testing	Behavioral health diagnostic screenings (e.g., SUD, depression)
Intensive outpatient treatment	Mental health services (e.g., group/individual counseling, medication)*
Partial hospitalization	Maternal depression screening*
Medication assisted treatment*	Maternal depression diagnostic and treatment services *
Non-pharmacological alternatives to pain management	Coordination, Engagement, and Referral Services
Residential treatment for adults in non-IMDs	Case management
Residential treatment for adults in IMDs	MH/SUD care coordination
Services in home visits	Outreach services
<i>Maternity Care</i>	Supported employment
Prenatal care, labor and delivery, and postpartum care	Intimate partner violence screening, counseling & interventions
Prenatal vitamins	Trauma counseling
Ultrasound	Family counseling
Preventive screenings (e.g., STIs, cervical cancer, HIV, and Hepatitis C)	Social service referrals
Tobacco cessation services	Social service benefits (employment, legal, and room & board)
Group prenatal visits	Transportation to medical appointments
Access to freestanding birth center-based care	
Doula services	
Reproductive counseling	
Contraceptive coverage (including LARC)	
Breastfeeding support	
<i>Infant Care</i>	
NAS withdrawal protocols	
“In-Room” NAS interventions	
Eat, sleep, and console NAS treatment model	
Outpatient NAS Treatment	
EPSDT, including routine pediatric visits	

* In-person and/or telehealth

Appendix H. Glossary

Term	Definition
Beneficiary engagement	A beneficiary who is enrolled in the model and has received a physical or behavioral healthcare service as defined in this NOFO in a given calendar month is considered engaged in the MOM model. A beneficiary who is enrolled in the model but has not received a physical or behavioral healthcare service in a given calendar month is considered disengaged from the MOM model. An awardee's eligibility to access Transition Funding, if available, varies based on a beneficiary's engagement status (see B.2, Award Amount).
Buprenorphine	A medication under several brand names used in MAT to help people reduce or quit their use of heroin or other opioids. Unlike methadone treatment, which must be performed in a highly structured clinic, buprenorphine may be prescribed or dispensed in physician offices, significantly increasing treatment access. Buprenorphine is a partial opioid agonist. As such, it may produce effects such as euphoria or respiratory depression.
Care coordination	The deliberate organization of patient care activities among two or more providers involved in a patient's care to facilitate the integrated and appropriate delivery of healthcare services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information and consultation among providers responsible for different aspects of care.
Care-delivery partner	A care-delivery partner must be a health system or payer, such as a Medicaid managed care plan (MCP) that is associated with a clinical delivery site. Each applicant must engage one or more care-delivery partners to develop the model application and, if the state is selected as an awardee, to implement the model. Each state will be responsible for working with its care-delivery partner(s) to: identify, engage, and retain beneficiaries, participating providers, and clinical delivery sites in the model; design and implement an intervention that ensures that Medicaid-covered services and model services are delivered to beneficiaries in a coordinated fashion; and ensure participation by all model partners, including clinical delivery site providers and staff, patients and any other individuals or entities, in model evaluation.
Case management services	Services furnished to assist individuals eligible under the Medicaid State plan who reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, educational, and other services. See 42 C.F.R. 440.169.
Community/Support Services	These services provide patients with a wide array of supports to help overcome barriers, increase self-management skills, and achieve overall health. Some examples include: primary care providers and specialists; wellness programs; specialized support groups (i.e. cancer or diabetes support groups); recovery support services such as support groups, recovery coaches, 12-step groups; housing, including recovery housing; social integration opportunities including Recovery Centers; and benefit attainment assistance.
Coverage and Payment Strategy	Each awardee must develop and implement a realistic, actionable, and sustainable Coverage and Payment Strategy. The Strategy must explain how the awardee will fund model services and establish coverage policies that ensure that members of

Term	Definition
	the model population have access to such services, i.e., intake, assessment, and creation of a treatment plan, coordination, engagement, and referral services. Each state has the flexibility to propose a Coverage and Payment Strategy tailored to the needs of its population, its proposed service area, and the parameters of its State Plan, but is expected to consider State Plan Amendments and program waivers as necessary. The Coverage and Payment Strategy must be fully implemented by Year 3 of the model, but applicants will be expected to propose strategies that will sustain model interventions after the end of the model performance period.
Fentanyl	Fentanyl is a Schedule II synthetic opioid pain reliever that is 50-100 times more potent than heroin and morphine. Pharmaceutical fentanyl is approved for treating severe pain, such as advanced cancer pain, and is prescribed in the form of transdermal patches or lozenges. Most recent cases of fentanyl-related harm, overdose, and death in the U.S. are linked to illegally made fentanyl that is sold through illegal drug markets for its heroin-like effect. It is often mixed with heroin and/or cocaine as a combination product—with or without the user's knowledge—to increase its euphoric effects.
Full Implementation Period	Years 3, 4, and 5 of the MOM model. During this period, the state is responsible for funding all care-delivery payments while the Innovation Center will begin to unrestrict Milestone Funding based on achieving specified quality targets.
Health Home	The Affordable Care Act of 2010, Section 2703 (1945 of the Social Security Act), created an optional Medicaid State Plan benefit for states to establish Health Homes to coordinate care for people with Medicaid who have chronic conditions. CMS expects states' Health Home providers to operate under a "whole-person" philosophy. Health Home providers will integrate and coordinate all primary, acute, behavioral health care, and long-term services and supports to treat the whole person.
Health Information Technology	Information technology applied to health and healthcare. It supports health information management across computerized systems and the secure exchange of health information among consumers, providers, payers, and quality monitors.
Health Promotion	As defined by the World Health Association (WHO), the process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behavior, toward a wide range of social and environmental interventions.
Heroin	A highly potent illegal synthetic opioid that can produce severe consequences, such as overdose and death. Heroin is typically injected into a vein but can also be smoked, snorted, or inhaled. Onset of effects is usually rapid and lasts for a few hours.
Individual and Family Services	These services promote recovery supporting participation in treatment, reducing barriers to access to care, and supporting age and gender appropriate adult role functioning. These services may include, but are not limited to: Providing assistance in accessing needed self-help and peer support services; advocacy for individuals and families; assisting individuals to identify and develop social support networks; assistance with medication and treatment management and adherence; identifying resources that will help individuals and their families reduce barriers to promote the highest level of health and success; connection to peer advocacy groups, wellness centers, and psycho-educational programs; and individual and family support (where appropriate).

Term	Definition
Innovation Center	The Innovation Center was established by section 1115A of the Social Security Act (as added by section 3021 of the Affordable Care Act). Congress created the Innovation Center for the purpose of testing “innovative payment and service delivery models to reduce program expenditures ...while preserving or enhancing the quality of care” for those individuals who receive Medicare, Medicaid, or Children’s Health Insurance Program (CHIP) benefits.
Medicaid waiver	Waivers allow states to test new methods for offering healthcare services in the Medicaid program. Medicaid program waiver authorities include Section 1115 Research & Demonstration Projects, Section 1915(b) Freedom of Choice (Managed Care) Waivers and Section 1915(c) Home and Community-Based Services Waivers.
Medication assisted treatment	Medication Assisted Treatment (MAT) is the use of medications in combination with counseling and behavioral therapies to treat substance use disorders and prevent opioid overdose. Common MAT therapies for pregnant women include methadone and buprenorphine. MAT is primarily used for the treatment of addiction to opioids such as heroin and prescription pain relievers. Medications used in MAT are approved by the Food and Drug Administration (FDA), and MAT programs are clinically driven and tailored to meet each patient’s needs.
Methadone	A medication used in MAT to help people reduce or quit their use of heroin or other opioids. The duration of methadone maintenance ranges from a few months to a lifetime. By law, methadone can only be dispensed through an opioid treatment program certified by SAMHSA. Methadone is an opioid agonist. Taken daily, it eliminates physical withdrawal symptoms.
Milestone Funding	Awardees may access this category of funding if they demonstrate achievement based on pre-determined quality milestones during the Full Implementation Period of the model (Years 3-5). Milestones would be captured by specific process and outcome measures, indicating progress toward key quality improvements, funded by CMS Innovation Center Section 1115A funds. Achieving milestones would be optional and represents an additional funding opportunity for awardees.
Model awardee	A state (represented by its Medicaid agency) that has been awarded funding through a cooperative agreement with the Innovation Center to test the MOM model.
Model enrollee	A beneficiary who is a member of the Model Population (see below) and has been screened, established an initial treatment plan, and consented to the disclosure of protected health information to allow for information-sharing among providers and plans.
Model intervention	Each awardee must design and implement a model intervention that delivers comprehensive physical and behavioral healthcare services in key categories of care to its model population and that provides coordination of services, beneficiary engagement, and referrals for necessary community or other support services. Each awardee must provide a plan for the provision of care by a multi-disciplinary team of healthcare professionals across a variety of settings, which may include co-located providers. The intervention may be implemented statewide or in a clearly defined sub-state geography and may build on but may not supplant or duplicate existing efforts.
Model population	The MOM model population will consist of pregnant and postpartum Medicaid and CHIP beneficiaries with OUD who reside in the relevant awardee state. A state may

Term	Definition
	include pregnant women covered by CHIP in the model population. If an awardee proposes to implement the model on a sub-state basis, the state may propose to limit eligibility based on residence in the sub-state model service area, subject to applicable Medicaid and CHIP statutory and regulatory requirements. An individual will be eligible to receive model services if she is pregnant, has OUD, and is eligible for and enrolled in Medicaid.
Model services	Intake, assessment, creation of a treatment plan, coordination, engagement, and referral activities that may be supported during the Transition Period (Year 2) by Transition Funding, and funded by awardees during the Full Implementation Period (Years 3, 4, and 5).
Mother-Infant Dyad	The mother-infant pair or relating to the relationship between a mother and infant. In the MOM model, awardees must be able to link claims and cost data for the mother-infant dyad.
Neonatal	Of, relating to, or affecting the newborn and especially the infant during the first month after birth.
Neonatal Abstinence Syndrome	Neonatal Abstinence Syndrome (NAS) is a constellation of symptoms in newborn infants exposed to any of a variety of substances in utero, including opioids. Experts consider NAS to be an expected and treatable result of women's prenatal opioid or other substance use, although long term ramifications for the infants are still unknown. NAS is not characterized as an addiction or substance use disorder; rather, it is a medical condition. NAS may also be referred to as Neonatal Opioid Withdrawal Syndrome (NOWS).
Opioid	A class of drugs chemically similar to alkaloids found in opium poppies. Historically, they have been used as painkillers, but they also have great potential for misuse. Repeated use of opioids greatly increases the risk of developing an opioid use disorder. A number of opioids are prescribed by doctors to relieve pain. These include: hydrocodone, oxycodone, morphine, and codeine. Illegal opioids include heroin, synthetic fentanyl, etc. and others.
Opioid Use Disorder (OUD)	The Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-V) outlines various substance use disorders (SUDs), including OUD, that occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities. A diagnosis of SUD is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria. OUD is defined as two or more of the following within 12 months: using larger amounts of opioids, or over a longer period than intended; persistent desire to cut down or unsuccessful efforts to control opioid use; great deal of time spent obtaining, using, or recovering from use; craving, or a strong desire or urge to use opioids; failure to fulfill obligations at work, school, or home due to recurrent opioid use; continued use despite recurrent or persistent social or interpersonal problems caused or exacerbated by opioid use; giving up or reducing social, occupational, or recreational activities due to opioid use; recurrent opioid use in physically hazardous situations; continued opioid use despite physical or psychological problems caused or exacerbated by its use; tolerance; and, withdrawal syndrome.
Patient-centered	Defined by the Institute of Medicine as providing care that is respectful of, and responsive to, individual patient preferences, needs and values, and ensuring that

Term	Definition
	patient values guide all clinical decisions.
Peripartum	Referring to the period shortly before, during, and immediately after giving birth.
Pharmacotherapy	Pharmacotherapy is therapy using pharmaceutical drugs.
Physical and Behavioral Healthcare Services	MOM model awardees will be responsible for ensuring that beneficiaries participating in the model can access a set of essential “physical and behavioral health services,” which would be billed to Medicaid as usual, and would include the following: • Physical healthcare services: MAT for OUD, maternity care, and relevant primary care services; and • Behavioral healthcare services: mental health and other appropriate addiction services beyond MAT.
Postpartum Period	Postpartum continuity of care is critical to success of the model, including maintaining both maternal and infant well-being as well as combatting the risk of relapse for women with OUD during the postpartum period. At a minimum, each awardee must ensure that members of its model population can access services throughout the postpartum period through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends, as required by 42 U.S.C. 1396(a)(e)(5). Each applicant must address care for its model population during the postpartum period in its Coverage and Payment Strategy. Each applicant also has the opportunity to earn additional points toward its overall application score based on the proposed scope of services in its strategies, duration of extended access to these services, and overall long-term sustainability of its postpartum plans.
Pre-Implementation Period	Year 1 of the MOM model. During this year, the awardee will receive Section 1115A funding to build capacity for implementing key model activities. These capacity-building activities include but are not limited to establishing a data-reporting infrastructure and any needed information system/sharing processes, ensuring necessary Medicaid and CHIP authorities are in place to operate successfully during model implementation, and increasing provider capacity and collaboration. Beneficiaries are not enrolled in the model and do not receive MOM model services during the Pre-Implementation Period.
Prenatal	Before birth; during or relating to pregnancy.
State Medicaid Agency	CMS will award funding to the state Medicaid agency, referred to throughout this NOFO as the “state,” “applicant,” or “awardee.” As an awardee, each state will be responsible for receipt and management of award funding in accordance with the model terms and conditions and applicable federal grant laws and accountable for meeting all requirements set out in the Terms and Conditions of Award.
Support services	These services promote recovery by supporting participation in treatment, reducing barriers to access to care, and supporting age and gender appropriate adult role functioning. Patient support services provide quality care that allows clients to maintain independence and improve the quality of their lives. This support may involve families, communities, professionals and any other entity

Term	Definition
	identified by the patient as integral to their recovery process. Individual support services including family services where appropriate, are provided by the care coordinator and other members of the health team to reduce barriers to individuals' care coordination, increase skills, engagement and improve health outcomes.
Transition Period	Year 2 of the MOM model. During this period, the Innovation Center will provide funding, based on an awardee's need, to support the cost of care-delivery payments. The state and care-delivery partner will work together during this year to serve model enrollees. The state will finalize a Coverage and Payment Strategy for the Full Implementation Period of the model (Years 3-5) and develop related waiver/SPA submissions while the care-delivery partner enacts the model's key components and submits necessary data to the Innovation Center.
Transformed Medicaid Statistical Information System (T-MSIS)	The Transformed Medicaid Statistical Information System (T-MSIS) is a critical data and systems component of the CMS Medicaid and CHIP Business Information Solution. To participate in the model, states must demonstrate that they are actively participating in T-MSIS at the time of application and that their data is current in the system; or have a plan that will ensure active participation with current data by the start of the Transition Period (Year 2).

Appendix I. References

- ⁱ HHS. Memo. <https://www.hhs.gov/sites/default/files/opioid%20PHE%20Declaration-no-sig.pdf>.
- ⁱⁱ HHS. 'About the epidemic.' January 20, 2017, accessed January 10, 2018 at <https://www.hhs.gov/opioids/about-the-epidemic/>.
- ⁱⁱⁱ Data from the Centers for Disease Control WONDER database: Multiple Cause of Death Mortality File. Available at: <https://wonder.cdc.gov/>. ICD-10 codes for prescription opioid mortality included: T40.2 (Other opioids); T40.4 (Other synthetic narcotics); and T40.6 (Other and unspecified narcotics).
- ^{iv} AHRQ, "Hospital Inpatient Utilization Related to Opioid Overdose Among Adults, 1993-2012," Aug. 2014, <https://www.hcup-us.ahrq.gov/reports/statbriefs/sb177-Hospitalizations-for-Opioid-Overuse.jsp>.
- ^v Yokell, M. et al., "Presentation of Prescription and Nonprescription Opioid Overdoses to US Emergency Departments," Table 1, JAMA Internal Medicine, Dec. 2014, <http://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1918924>.
- ^{vi} Patrick, et al., "Increasing incidence and geographic distribution of neonatal abstinence syndrome: United States 2009 to 2012," J.Perinatol (Aug 2015), <https://www.ncbi.nlm.nih.gov/pubmed/25927272>.

Appendix J. 504 Compliance

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

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.medicare.gov/about-us/accessibility-nondiscrimination-notice>. Your notice shall be crafted applicable to your program.
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, etc.) 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, etc.
 - c. Contact information for the person submitting the e-mail– Organization (Grantee), name, phone number and e-mail.
 - d. The document that needs to be put into an accessible format shall be attached to the e-mail.
 - e. 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, etc.)
 - e. Contact information for the person submitting the e-mail – Organization (Grantee), name, phone number and e-mail.
 - f. Any applicable documents shall be attached to the e-mail.
 - g. 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.
 - d. The document that needs to be translated shall be attached to the e-mail.
 - e. 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, etc.)
 - e. Contact information for the person submitting the e-mail– Organization (Grantee), name, phone number and e-mail.
 - f. Any applicable documents shall be attached to the e-mail.
 - g. 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.