

CENTERS FOR MEDICARE & MEDICAID SERVICES

Maternal Opioid Misuse (MOM) Model Notice of Funding Opportunity (NOFO) and Application Webinar

**February 21, 2019
2:00 p.m. ET**

OPERATOR: This is Conference #: 3989207.

Operator: Hello, and welcome to today's Maternal Opioid Misuse Model Notice of Funding Opportunity and Application Review Webcast. My name is (Michelle), and I will be your event specialist today. Please note that all lines have been placed on mute to prevent any background noise and that today's webcast is being recorded.

During the presentation, we will have a question-and-answer session. You can ask text questions at any time by clicking on the green "Q&A" icon on the lower left-hand corner of your screen. Simply type your question in the open area and click "Send."

If you would like to view the presentation in the full-screen view, click the "Full Screen" button in the lower right-hand corner of your screen. Press the "Escape" key on your keyboard to return to your original view. For optimal viewing and participation, please disable your popup blockers.

And, finally, should you need technical assistance, as a best practice, we suggest you first refresh your browser. If that does not resolve the issue, please click on the Support option in the upper right-hand corner of your screen for online troubleshooting. It is now my pleasure to turn today's program over to Alice Thompson. Ma'am, the floor is yours.

J. Alice Thompson: Thank you. This is Alice Thompson from the CMS Innovation Center. I am the Maternal Opioid Misuse model lead. This afternoon, in the time that we have, we will provide a little background on the overall goals of the CMS Innovation Center, then some high-level – a high-level overview of the MOM model including program requirements.

And, then, I will turn it over to my colleague Geraldine Doetzer to go over the application requirements. And our grants management specialist will then – (Monica Anderson) will then provide an overview of the application and submission information as well as the federal award administration. Finally, as was said earlier, we will take a few questions and provide some resources that potential applicants could use to better understand the model and complete the application.

The CMS Innovation Center was created by the Affordable Care Act to allow CMS additional flexibilities to test innovative service delivery and payment models to increase the value of health care in the U.S. The high-level goals of all Innovation Center models are to reduce cost and improve quality to CMS programs, which include Medicare, Medicaid and the Children's Health Insurance Program or CHIP.

The Innovation Center models also align with broader CMS framework to shift from volume to value. Three scenarios represent success for all Innovation Center models based on the authorizing statute – first, improving quality while remaining cost-neutral; secondly, remaining quality-neutral but reducing cost; and, finally, the best result would be to improve quality and reduce cost.

So, in order to inform the development of the Maternal Opioid Misuse model, the Innovation Center engaged in extensive strategic conversations with external subject matter experts including – as well as the Center for Medicaid and CHIP services staff as well as other federal partners including the Substance Abuse and Mental Health Services Administration, SAMHSA; Health Resources and Service

Administration, HRSA; and the Centers for Disease Control and Prevention, CDC.

Key issues in delivering effective care for this population identified in these discussions include, first, a lack of access to care especially in rural areas. Another issue that was raised a number of times was fragmentation of care across settings. The current delivering system surrounding pregnant and postpartum women with opioid use disorder is characterized by a costly lack of coordination and integration.

Coverage barriers such as variation in covered services and how services are reimbursed even when services are covered can be significant contributors to this fragmentation. In addition, there is currently a limited number of providers that can prescribe medication-assisted treatment, and many that do either don't accept Medicaid or won't accept pregnant women due to a lack of education around treatment guidelines.

Finally, we heard a number of critical concerns related to stigma and the criminalization of substance use during pregnancy acting as significant barriers to women seeking care. The MOM model is specifically designed to address these challenges for pregnant and postpartum women with opioid use disorder.

MOM is a patient-centered service delivery model which aims to improve quality of care and reduce cost for pregnant and postpartum women with opioid use disorder and their infants, expand access to treatment, service delivery capacity and infrastructure based on state-specific needs, create a – and then create a sustainable coverage and payment strategy that would support ongoing coordination and integration of care.

Over the past few years, CMCS has been developing strategies for states to address these challenges through existing authorities such as opioid use disorder health homes state plan amendments and 1115 waivers. It was important that we ensure that any Innovation Center

model focused on Medicaid supports these authorities and complements these structures laid out by CMCS.

The next few slides provide an overview of the model as well as lay out key model requirements and guidelines including the establishment of partnerships between state Medicaid agencies and designated care delivery partners, the building of sustainable infrastructure and increased evidence base for OUD treatment capacity, supporting coordinated and integrated services for enrolled model population and developing a coverage and payment strategy for services to be covered by state Medicaid.

The Innovation Center has structured the Maternal Opioid Misuse model to ensure that the interventions can be tailored to the specific needs of communities hardest hit by the crisis. Key to this approach was the decision to direct the model to state Medicaid agencies.

Under the MOM model, the Innovation Center will issue up to 12 awards to state Medicaid agencies, which will then drive the implementation choices to meet their local needs such as whether to implement the model statewide or in a sub-state region. Each state applicant must engage one or more care delivery partners to develop the model application and, then, if selected (was awardee), to implement the model in conjunction with the care delivery partner.

Care delivery partners can be health systems, hospital systems or payers such as Medicare managed care plans. Care delivery partners will work with the state to establish relationships with clinical partners, build capacity at the service delivery level and implement the state's care delivery approach.

Again, the reason for designing the model this way was to ensure the Innovation Center was supporting and not supplanting efforts currently under way in the state. We believe this approach will allow state Medicaid programs with a variety of structures, including high

managed care penetration, to be well-positioned to implement the model.

By focusing on pregnant and postpartum women with opioid use disorder and their infants to address the issues described above, the Innovation Center has a number of key opportunities for impact. First, since opioid use in pregnancy increases the risk of poor maternal and neonatal outcomes including neonatal abstinence syndrome, by focusing on improving maternal care in the model, we can improve both outcomes for both mother and infant.

Secondly, CMS disproportionately shoulders the cost for opioid use disorder in this population. For example, Medicaid is the primary payer for maternal hospital stays related to substance use disorder, and Medicaid pays for the majority of costs associated with infants exposed in utero to substances such as opioids. So, MOM is well-positioned to see significant benefits by improving care for pregnant and postpartum women with opioid use disorder and their infants.

While the structure of the MOM model allows for a great deal of state flexibility, what our research and outreach tell us is that a high quality of care for pregnant and postpartum women with opioid use disorder should include a specific set of comprehensive service categories and have an integrated and coordinated care delivery structure.

So, ensuring this kind of care will be central to the model (test). To help guarantee the provision of effective care, the MOM model will require awardees to provide integrated physical and behavioral health care services such as medication-assisted treatment, maternity care, relevant primary care services and mental health services. In addition, wraparound services like coordination, engagement and referral to community and social supports are critical for the effective provision of clinical services.

Within these requirements, states will, however, have the flexibility to design the specific set of wraparound services that will satisfy the

following five components – comprehensive care management; care coordination; health promotion; individual and family support, which could potentially include parental education and peer counseling; and, finally, referral to community and social services.

In the next – in the next few slides, I will now talk about the model timeline and funding. First, the MOM model has a five-year performance period, which is designed to both support states in transitioning their provision of care to the comprehensive and integrated approach I just outlined as well as ensure that the transformation can be sustained.

To this end, the performance period of the model is broken down into three segments. The pre-implementation period is a one-year period when states and care delivery partners focus on developing and strengthening relationships with critical organizations and providers, building capacity, and designing coverage and payment strategies for sustainability.

In the transition period, which is year two of the model, awardees and their partners will continue to build capacity and finalize their coverage and payment strategies. In addition, care delivery partners will begin to provide care to pregnant and postpartum women with opioid use disorder.

During this one-year transition period, the Innovation Center will find coordination, engagement and referral services that are not currently covered by the state Medicaid program. The model includes this funding to expedite and accelerate the delivery of care.

And, finally, during the full implementation period in years three through five of the model, to foster sustainability, the state will be completely responsible for covering and paying for the comprehensive set of services for the model population and ensuring that the integrated and coordinated care structure is effectively sustained

through their coverage and payment strategy designed by the state and the improved by CMS.

The funding associated with the model aligns with these three periods and is designed to directly support states and localities in building the capacity to pay for and deliver these services; accelerate the delivery in coordination, engagement and referral services that are not currently covered; and incentivize sustainability of care transformation.

Specifically, MOM will provide three types of funding – implementation funding, transition funding and milestone funding. The implementation funding is available for all five years of the model and allows awardees to address structural barriers to care transformation including the development or adoption of telemedicine platforms, conducting provider education to help increase capacity and access, as well as building data sharing infrastructure, which is critical for the – to the integrated and coordinated care model.

Other key uses of these funds will be to support states in developing sustainable and effective coverage and payment strategies for the integrating coordinated model of care by leveraging Medicaid flexibilities like health homes, waivers and other state plan amendments. Transition funding provided in year two of the model will pay for wraparound coordination and engagement and referral services, allowing care delivery partners to start caring for women prior to the states finalizing their coverage and payment strategies.

During the full implementation period in years three through five of the model, CMS Innovation Center will offer the opportunity for states to receive milestone funding designated to sustain care transformation. Awardees will have the ability to unlock these milestone funding through the achievement of a limited number of quality metrics that are central to the model aim including utilization, quality of care and improved care coordination.

The total funding across all awardees will be up to \$64.6 million. However, the amount per awardee will vary based on proposed scope and awardee needs. So, this slide brings together all aspects of care envisioned under the model. As you can see, the MOM model is designed to support an integrated care delivery approach for the full set of services to be provided to pregnant Medicaid beneficiaries with OUD during the prenatal, peripartum – during labor and delivery – and postpartum period. In addition, maternal care is to be coordinated with the care being provided to the infant during the postpartum period.

Now, I will turn the presentation over to Geraldine Doetzer, who will provide some additional information on application requirements and the Notice of Funding Opportunity.

Geraldine Doetzer: Thank you, Alice. And thanks to everyone who is joining us on the phone today. During the next segment of the presentation, we will provide an overview of the application requirements that are described in detail in Section A of the Notice of Funding Opportunity announcement.

These requirements, which are laid out on the slide on your screen, are designed to provide each applicant with the opportunity to provide CMMI with the information we need to understand your community, its needs and how your state proposes to use MOM model funding to improve quality of care and reduce Medicaid cost associated with treating the model population.

As you can see on the slide on your screen, there are a number of required MOM model-specific materials, a project abstract, a multi-faceted project narrative – and we will go into each of the subcategories there – a model budget narrative and a program duplication questionnaire.

The first item that is required is simply a project abstract. This is a one-page summary of your proposed project. It should include at a high level the goals of your project, the total budget and the description

of how your funds will be used if you are awarded a MOM Model Cooperative Agreement.

The next slide identifies the first piece of what we refer to as the project narrative, the model context. In response to the model context requirement, you should provide a statement of the problem that you are attempting to solve and a gap analysis.

This should identify the current processes your state uses for identifying and treating pregnant and postpartum women with OUD. This should identify gaps in ensuring access to care for this population, and explain how participating in the MOM model specifically would address these gaps.

Additionally, we require certain data points associated with the model service area and population. You will have to define your proposed model service area, which may be statewide or a clearly defined sub-state region, and respond to requested data or provide a proxy for the model population residing in the proposed model service area.

The next piece of the project narrative is the model implementation plan. This is, in many ways, the heart of the project narrative where you will provide your intervention design including the elements on the screen – how many beneficiaries you expect to enroll in the transition and full implementation periods of the model, how you would identify, enroll and screen patients; how you would describe services that will be available to enrolled beneficiaries; and your timeline for postpartum coverage.

In addition to describing your intervention design, you should provide a coverage and payment strategy. That means identifying any Medicaid SPAs or waivers that you would need state plan amendments or waivers, outlining your financing strategy for postpartum coverage and outlining any proposed beneficiary engagement incentives that you believe are necessary for the model.

Finally, we require a sustainability plan. A crucial part of the MOM model is testing whether funding these new types of interventions through CMMI funding can be sustained in a state Medicaid plan or, otherwise, through the MOM model but also after the MOM model period is over. So, the sustainability plan should provide your state plan for sustaining the interventions after the five-year performance period ends.

The next element of the project narrative is the Memorandum of Understanding with your care delivery partner or partners. This agreement should include an explanation of the roles of the state Medicaid agency and care delivery partners during the first year of the model including a payment timeline if there is to be a sub-awarding or other payment to the care delivery partner, the data sharing plans – how the two partners will share data – and reporting requirements and responsibilities.

Next, we require applicants to set forth their data sharing capacity and plan. You should identify your T-MSIS status and provide a plan to achieve monthly T-MSIS data reporting if that is not already in place at the time of application. You should confirm your ability to link maternal and infant claims data and outline a data sharing plan to support delivering the coordinated and integrated care to model beneficiaries that is crucial to the success of the model.

Additionally, in your reporting plan, you should explain how you will meet the quarterly and annual progress reporting requirements as well as data submission requirements associated with performance milestones and, finally, confirming your evaluation plan that partners will participate in all aspects of the Innovation Center's model evaluation.

The next part of the model narrative is the model impact analysis, which has two distinct sections. The first is the impact on quality of care. So, each applicant must outline how the proposed intervention

will reach quality milestones. And the second piece is a cost savings projection.

In the cost savings projection, applicants should provide a financial model – a financial model for the model population including what the current Medicaid and CHIP cost for the population are today or at the time you apply, the project cost in the absence of a proposed model intervention and the project cost if the model is implemented.

Finally, in the project narrative, we ask you to set forth the information that would allow us to understand the organizational capacity of the state Medicaid program in a way that demonstrates the capacity of you, the applicant, together with care delivery partners to organize and manage all aspects of the model intervention, including the coverage and payment strategy.

We in this NOFO ask for information about the structure of the state Medicaid program, leadership that is responsible for model operation and evidence that the state Medicaid agency and the care delivery partner have experience implementing programs or initiatives that are similar to the MOM model.

After the budget – or after the model narrative – program narrative, we ask for a model budget narrative. This requires applicants to outline in detail the use of each model funding source. That includes implementation funding, transition funding and milestone funding, including specific activities proposed by the state Medicaid agency and the care delivery partner for the entire model performance period broken down, again, by those three types of funding.

Finally, this NOFO requires the completion and submission of a program duplication assessment questionnaire. This form is listed under Appendix F in the NOFO. And it asks each applicant to provide CMS with the information that we need to assess whether there is a risk of any programmatic or funding duplication between the MOM model should an applicant be awarded and other current programs

including federal, state or local programs that would serve the model population in the proposed model service area.

We recognize that there is a great deal of interest and activity in treating opioid use disorder at this time. And we want to make sure that states are participating in MOM while keeping in mind opportunities that they may already be taking part of or planning to take part of from other funding sources.

Additionally, there is an opportunity to earn up to five points towards the total NOFO score through presentation of a sustainable postpartum coverage plan to address the period beyond 60 days after birth. Again, this provides a priority on application scoring.

But, applicants are not required to extent postpartum Medicaid eligibility. Rather, they should propose a strategy for continuing to meet enrolled beneficiaries' physical and behavioral health needs after the immediate postpartum period that is required by law under Medicaid.

This application scoring rubrics set out – and it is included as Table C in the NOFO. It sets out for each one of the elements that we just reviewed the point value. And, so, you can sort of see for each piece of the project narrative as well as the additional required documentation how much each one is valued out of the overall (or) 200 points.

And this – each application needs to meet certain formatting guidelines. This is detailed in the – in the NOFO itself. But, it's incredibly important. And failure to meet the application formatting requirement could result in ineligibility to participate.

Finally, this sets forth an application timeline. The NOFO was released on February 8 and the application period is currently open. Applications are due on May 6 at 3:00 p.m. I am about to turn the presentation over to our grants management specialist, who will emphasize the importance of these deadlines – the 3:00 p.m. Eastern

Time deadline is one that I know she will emphasize – and encourage applicants not to wait until noon of the day that the application is due to submit materials through Grants.gov.

Finally, we anticipate that notices of awards will be issued in fall of 2019. And, now, I will turn the application submission information segment of the presentation to Monica Anderson.

Monica Anderson: Thank you, Geraldine. And thank you to everyone who has taken the time to attend today's information session. Next, we will be discussing the application and submission requirements, identifying the resources available to help you submit an application successfully through the Grants.gov system, as well as share a brief overview of the grants management process for federal awards and how they are implemented here at CMS.

When you go to – first, you will need to register with Grants.gov. Search through the – for the CFDA number 93.687, and you will see the NOFO listed there. You will be able to click on the link to set up – to pull up – I'm sorry – the application itself.

The application, as Geraldine mentioned, is May 6 at 3:00 p.m. Any applications that are received after 3:00 p.m. will not necessarily be accepted. We set that deadline and strongly encourage you to submit your application prior to the May 6 deadline.

It is very common for it to take longer to upload your application the later that you wait because there are more individuals and more applicants attempting to upload their applications at that time. So, even if you started at 12 noon, your application could take up to 3 o'clock to upload. And if it uploads after 3 o'clock and one second, it will not be eligible. It will meet the eligibility – ineligibility requirement. There are additional specific details and instructions listed in the NOFO that is on Grants.gov.

All applicants must also register with the System for Award Management. I strongly encourage you to do this now. If you intend –

if you determine that your state Medicaid agency will be applying or your state will be applying for this award, ensure that you are registered with the SAM databased in order to submit an application.

You must also have a valid employer identification as well as a Dun & Bradstreet number. Most states have this. But, you have to be very specific to the agency that you are applying for this specific award.

Lastly, the other requirement that you want to look at now is your authorized organizational representative who will be the person officially submitting the application on behalf of your state agency. That person must – it is required that they register with Grants.gov and have a user name and password in that system. I encourage you the minute you know who that person will be that one of the first tasks that is done either on their behalf or by them is that they register in Grants.gov and make sure that your agency is registered in SAM.

All applications will be submitted through Grants.gov. Please familiarize yourself with this vehicle. There are videos on Grants.gov. If you go to the homepage, there is a menu at the top, and there are videos that will familiarize yourself if you are not currently familiar with that system on Grants.gov.

I also encourage you to watch those videos if you have not been on Grants.gov in a while because it has been updated in the last year. What will be submitted through Grants.gov are listed here on the screen. These are forms that are typically required for all federal award application.

We strongly encourage you, again, not to wait until the due date. I will – you will hear me say that several times. Many applicants have been deemed ineligible simply because they waited and their application was not uploaded into that system. We do not control that system. But, it is inherently important that you make sure that your application is uploaded by the deadline date at 3:00 p.m.

Now, we will review, as I said the grants management system and the federal – how we administer federal awards here at CMS. This slide provides you with an overview of the HHS grants management process. We are currently in the announcement phase, which is number two.

We spent about a year almost planning – a year or so planning. The announcement phase started on February 8 when the NOFO was posted and will go through May 6 when the applications are due. We will start on May 7 with the application evaluation phase. The negotiation phase will go through the summer and early fall. And we will issue the awards in late fall of 2019.

Then, once those awards are issued, we will begin the post-award monitoring with those recipients who accept the application. And then, after the five years of implementation of this award, we will begin the close-out phase. That's a brief overview of the process.

What is a grant or cooperative agreement? You can see here – it's the definition. A grant and/or cooperative agreement are defined as the transfer of money, property, services or anything of value to a recipient in order to accomplish a public purpose. That is the difference between a grant and a contract.

The grant is – or cooperative agreement is specifically for a public purpose through the support or stimulation that has been authorized by a federal statute or appropriation. Grants and cooperative agreements are used when the principal purpose, as I said, is to provide assistance for public good or benefit. So, this model, the Maternal Opioid Misuse model, is a cooperative agreement.

These are in – now, we will discuss the application process itself. There are some specific steps that you would want to go through. I have mentioned the registration process. But, this slide lists them specifically – obtaining your Dun & Bradstreet number, registering with CCR – that is registering on the System for Award Management, the

SAM system – getting a user name and password for AOR, getting their authorization to submit and, then, tracking your AOR status to ensure that they are registered in Grants.gov.

Then you want to learn Grants.gov. One of the videos that I mentioned earlier is Grants 101. That is a terrific overview of the grants process and how you can apply through the Grants.gov system.

And this slide just provides the visual for those of us who are visual learners of where you would go in Grants.gov to look for Grants 101 and the summary presentations and videos of those – videos that I recommend that you review prior to submitting your application.

Now, we have the Notice of Funding Opportunity. If you have not done so and you're interested in this opportunity, I suggest that you download that NOFO and read it. Then tomorrow when you wake up, you can read it again and, then, on Monday, you can read it again. It is very, very important that you read it carefully and follow the instructions that are listed in the NOFO.

Registration is key. And I'm repeating myself, I know. But, that's just how important these are, that these are the four areas that you must have a registration for. You must be registered in SAM, therefore receiving your CCR registration. You must have an EIN number and a Dun & Bradstreet number.

You also should start early with registering your AOR, as I mentioned before and, then, reviewing the questions that you must ask yourself and within your organization to ensure that you are not disqualified. "Are we an eligible entity?" For this particular model, it must be a state government. No exception.

"Did we stay within the page limit?" You cannot go over 60 pages. I know that your information is very, very important. But, if you submit 61 pages, you could be deemed ineligible for this opportunity.

“Did we use the appropriate font size, (facing), page sizes?” We are looking 8.5 by 11, not 11 by 17. “And did we include all of the required forms?” That – we are not going to come back to you and ask you to submit a form that you’ve missed. It is incumbent upon you to make sure that you meet all of the requirements that are listed in the NOFO in order to be deemed a qualified applicant.

Now, there are different roles and responsibilities for those of us that will be working on this model. I am the grants management specialist who is assigned to the Maternal Opioid Misuse model. I will serve as the specialist for all of these awards.

There will also be a grants management officer. I will work with you day to day, month to month, year to year on the awards. The grants management officer is someone you will probably never interact with. However, they are the person that officially obligates the award to your state.

Then, there is your project officer, who – you’ve met Alice today – and your program authorizing official, who is also a CMS employee, a federal employee who authorizes MOM models to be implemented through CMMI and CMS. Those are the four federal staff that you will – that will be working on this particular project. But, as I’ve stated, your grants management specialist and your project officer are the people who will work with you on a daily basis.

The non-federal employees that are key personnel for any – for this (type) of award are your authorized organizational representative and your principal investigator and/or project director. That role could be filled by one or more persons. But, those roles are very, very important.

And let me be clear. The authorized organizational representative would be one person. And, then, the principal investigator and/or the project director may be filled by one or more person for your state agency.

Once your applications are submitted to Grants.gov, that will end your portion of the application phase, and there will be some things that will be done behind the scenes. CMS works directly with the Grant Center of Excellence and specifically with Grant Solutions, where all of the applications that are submitted through Grants.gov will be downloaded. And that is how we manage the official grants file. And they are all now managed in an electronic format.

Through Grant Solutions, we will issue the Notice of Award, we will communicate official grant notes either from the program or grant staff or both. We will also – you are also eligible to apply for amendment through that system. And those amendments could be the – in the form of budget reallocation, carryovers, no cost extensions at the end of the project period, as well as your closeout amendment at the end of the award.

All of your semi-annual federal financial reporting systems are done through Grant Solutions. So, you will submit your official federal financial report through Grant Solutions and, ultimately, your final federal financial report along with other required documents for your closeout.

At this time, the MOM team will answer questions submitted through the green “Q&A” chat box. And I am going to turn this portion of the session back over to Alice as well as my other colleagues. We do have several questions that have come in. And would you like for me to read the first one? I don’t know.

J. Alice Thompson: Yes. So, I think that a couple of them, just to get some of the housekeeping questions out of the way, are about whether these slides will be available. This is being recorded and will be put up on the MOM – Maternal Opioid Misuse website under the CMS Innovation Center website. And, so, you will be able to relive this experience in the future if you want to go back and see any information that you may have missed. So, they will be available. So, anyone who asked that question, the answer is yes.

So, the next question is that “The RFP indicates there will be three national support contracts – evaluation, implementation assistance and learning. Will these contracts be issued prior to or after” – sorry – “after award?” So, we are still working out the exact timing of when these contracts will begin. Typically, I can – I can speak to what CMMI models typically have in relation to these contracts.

The implementation and the learning system contracts typically align with the model performance period. The evaluation contract may vary slightly in order to allow the evaluation contractor to fully evaluate the entire performance period of the model. And, so, that is typically how things work at the Innovation Center.

“How long will post – how long postpartum are women eligible for the MOM model?” So, the eligibility for participants in the MOM model will be aligned with whatever the eligibility for these women – whatever it is within the state that is the awardee.

So, one of the things that we have tried to work on and tried to focus on in terms of the postpartum period is to try to find ways to ensure that applicants and awardees have thought through continued access for this population beyond the 60 days postpartum required by federal statute.

However, as Geraldine mentioned, this does not include changing an eligibility for Medicaid for this population. We are really talking about access. And, so, we are asking in the application for interested states to lay out how they will continue access for this population and not, in any way, requiring eligibility for Medicaid to continue.

We understand that in different states there will be different Medicaid factors that will play into this, things like Medicaid expansion, the percent of poverty line that make people eligible for Medicaid under different non-pregnant categories – so, parents and things like that. And, so, those will all be in place. And, then, we are asking how the applicant can continue to give access to MOM participants.

“Could a community-based organization serve as a model partner?”
Currently, the way that the model is designed is that it must be a health system, a hospital system or a payer. Having said that, that is for the distinct role of the care delivery partner.

We do expect and I think that we mentioned in the NOFO that there are other entities that we expect will be partners in this model. And they can be broad and things like child welfare agencies, community organizations, local government entities, civil legal organizations, local academic institutions – a wide variety of potential partners for this model because we know that the needs of this population are complex and involve a lot of different segments of community.

Having said that, only those that I outlined can be official care delivery partners. But, both the state Medicare and the care delivery partner can reach out to these other types of organizations.

“Is the state supposed to be the applicant and awardee?” The short is yes. The state Medicaid agency is the applicant and will be the awardee for the model.

“How will CMMI expect states to account for duplication in funding used for populations of interest such as the InCK funds used for mothers with opioid use disorder?” This is a great question. I will point you first to a fact sheet that is on both the MOM and the InCK websites that talks a little bit about the overlap of specifically these two models.

However, we understand that there will be duplication for other types of programs that may be aren't CMMI models that may address the needs of this population. I think that we have, hopefully, laid out the overlap section and the overlap questionnaire in a way that will allow potential awardees and applicants to let us know what already have going on and how the MOM funding could supplement and support those activities.

We really don't think that if you have something else going on in this space, you would not immediately be ineligible to participate in the MOM model. But, we would want to know exactly how the federal funds associated with the MOM model would be used sort of in conjunction with those other funds but not as a duplication of funding for those same activities.

"One slide indicates that states will pick up the cost in years three through five. Is that correct? All cost or just treatment cost with implementation cost covered by the state?" So, this is a little bit complicated. But, in years three through five of the model, states will be – state Medicaid agencies will be required to cover the physical health care, the behavioral health care and the wraparound services that we outlined in the model care delivery approach.

During that time, there are still two types of CMMI funding available to states. There is implementation funding provided in all five years of the model, which includes years three to five of the model.

Additionally, in years three through five, there is this milestone funding, which if a state reaches certain benchmarks and measures that we are working on, they will receive additional sort of quality or performance measure funding that will, hopefully, help to continue to support capacity building and infrastructure that will be required for the sustainability of this care transformation. So, yes, the services will be covered by state Medicaid. But, additional CMMI funds will be coming in as well.

Next question. "With regard to the care delivery partner, it's defined as a health system or payer. Can it be a single hospital within a health system?"

Geraldine Doetzer: So, I think it's difficult for us to provide an individualized assessment without knowing more about the implementation design. I think at times we know that a hospital can really serve as hub for a

community and can provide more than just those traditional inpatient services.

I think that the goal is to identify a systemic kind of care delivery partner that is associated with one or more clinical delivery site. So, I would say most likely a single hospital would be a clinical delivery site but not necessarily a care delivery partner, which the aim is to identify, again, a system or a payer associated partner.

J. Alice Thompson: “With regard to the business assessment on page 74 through 78 of the Notice of Funding Opportunity, to who are these questions aimed, the state agency or the partner organization?”

Monica Thompson: Well, the short answer to that is it’s the state agency. The business assessment is the questionnaire that is designed for the recipient of the federal award. So, that business – we are assessing whether or not that is an entity that the federal government wants to do business with. So, that questionnaire should be answered in relationship to the state agency that is applying. For this model, it would be your state Medicaid agency.

J. Alice Thompson: Next question. “With regard to the duplication assessment, if Medicaid currently does not pay for a program, would that count as duplicated if we wanted to fund that program with the MOM model?”
I’m not ...

Geraldine Doetzer: So ...

J. Alice Thompson: Yes.

Geraldine Doetzer: ... without knowing all of the background for this question, I would recommend that the questioner and everyone who is dialed in take a close look at Appendix F, which is our detailed program duplication assessment questionnaire that asks a lot of specific questions and gives more context to what CMMI is looking for in terms of duplication.

There are limited activities that MOM model funding is designed to support. So, although in general if Medicaid is already providing a service the MOM model funding could not be used to provide that same service – that would be duplicative – it is not necessarily a guarantee that if Medicaid does not pay for a service or program, MOM model funds would be appropriate for that program. So, it's really a two-part sort of assessment.

One is the service that you are seeking to support with MOM model funding kind of acceptable under the goals of the MOM model, acceptable based on the information in the NOFO that details what each funding stream is designed to cover? And, then, in addition to that and separately, are there other federal, state or local funds that are already paying for that same service? And that's the duplication question.

So, it is a complicated sort of assessment. I would say that Appendix F is going to provide your best guide. And to recap, just because Medicaid does not pay for a current service does not necessarily mean that it would be appropriate for MOM model funding. So, we look at both what you are trying to cover – does it meet the requirements for implementation, transition or milestone funding? And, then, if you think that it does, the duplication question is sort of the next step of the analysis.

J. Alice Thompson: “How is the cadence with potential SPA process and grant schedule going to be implemented?” So, the way that the model is designed, states will have two years to get the coverage and payment strategy in place to begin paying for the entire set of services by year three of the model.

We have been working very closely with CMCS to ensure that they are involved in the – they were involved in the development of this model, and they will continue to work closely with us to ensure that states participating in the model will have their expertise available to them to be able to design the most appropriate coverage and payment strategy

as well as ensure that the timing of approval of those will be aligned with the model performance period.

Geraldine Doetzer: In addition to that, Table B in the NOFO sets out a number of operational milestones. One of them is relevant to this question. Each awardee – so, an applicant that is successful – we encourage them and say that they must meet with the Center for Medicaid and CHIP Services immediately upon award to begin the process of state plan amendment and waiver planning and approval because those (spots) and waivers are sort of aligned with but separate from the MOM model grant cycle.

And, so, I think that the person who is asking the question is very aware that those timelines may not naturally align. And, so, the applicant who becomes an awardee and their project officer will have to work very closely with CMCS to ensure that those pieces come together to make the model effective.

J. Alice Thompson: “Can any representative besides the AOR review Grants 101?”

Monica Anderson: Yes. So, that I’m clear, anyone who is interesting in applying and would be involved in the application process, specifically in submitting it through Grants.gov or working on the project itself or the application itself, should review Grants 101.

The AOR is the person who will officially submit the application on behalf of your state Medicaid agency and must be an officer who can speak on behalf of the state Medicaid agency. So, they are the only person that must register. But, anyone can review any of the videos and training materials available on Grants.gov.

J. Alice Thompson: (So, I think you’re) ...

Monica Anderson: Yes.

Monica Anderson: The next question is “Would you please confirm that the AOR can be an organization designated by the Medicaid state agency?” So, I

may not have been clear on what the AOR is. The AOR stands for authorized organizational representative. That is a person and not an entity. It is an official person that can speak for your – for the applicant.

And the applicant in this instance would be your state Medicaid agency. So, in many cases, your AOR is going to be your Medicaid director. It maybe your COO for the – for the state Medicaid agency. It may be your general counsel. It is whoever can speak on behalf of the agency, who has signing authority for the state Medicaid agency.

The next question is “If a state Medicaid agency uses a fiscal fiduciary to apply and administer its grants through Grants.gov, is that – is this OK?” The – let me be clear. The reason why an EIN and Dun & Bradstreet number are required is because the state Medicaid agency is the entity that is applying and the state Medicaid agency is the entity who will be the recipient of this federal fund.

Now, if you implement that through a fiscal fiduciary, as long as they are acting on behalf of and the AOR who is registered in Grants.gov is an official of your state Medicaid agency, then that would be appropriate. In many cases, it's also your CFO – your chief finance officer could be your AOR. But, it cannot be a contractor or someone who cannot officially speak on behalf of your state.

Emily Hall: So, the question on “Can you push the link to us” – we actually have several links queued up. So, if you can be more specific on what you want. We have the application. We have a link to the MOM model website. If you can just put that in the chat box, I am happy to push whatever link that you're asking for.

J. Alice Thompson: If there is a date other than May 6 listed, that is a typo. And we will go in and make that correction because the due date for this model is May 6, 2019. Any other date – we appreciate you letting us know of that error, and we will go in and correct it immediately.

“With the rapidly-changing SUD landscape, is the funding open to extend to pregnant women with other substances of abuse such as meth?” I think that we understood in designing this model that there are a number of – that many of these women will have polysubstance use disorder and have a number of different issues with a variety of different substances.

The model does not prohibit addressing the entire scope of the woman’s needs in terms of their substance use disorder. I will say that the model was designed specifically to focus on opioid use disorder. So, that is a qualifying element to participate in the model for beneficiaries.

Having said that, medication-assisted treatment is not the only form of OUD treatment or SUD treatment that is allowable under the model. And, so, there is some flexibility for treating these women who have polysubstance use disorder which includes opioid use disorder.

“Do the savings have to explicitly come from Medicaid? What about savings from other state agencies such as Child Welfare?” Yes, the savings has to come from state – from the – from Medicaid. What we are talking about – and I think it is outlined in more detail in the NOFO – is savings to Medicaid and, specifically, to the federal portion of Medicaid.

So, as some of you may know or may not know, CMMI models, as I mentioned at the beginning, in general have to be cost-neutral because we are trying to either reduce cost or maintain cost and improve quality. And, so, we do need to do our due diligence around assessing each applicant based on their ability to potentially save money for the federal portion of Medicaid.

“Can a for-profit business be a subcontractor of the state agency applicant?” That is an excellent question. And a for-profit entity – there are no federal regulations that prevent a for-profit entity from being a contractor or subcontractor of a federal award recipient. You

would have to look at the state regulations to ensure that you are in compliance with those regulations. However, there are no federal regulations that would prevent that from being – from that being applied.

Next question. “Can a Medicaid agency submit two system or payer partners?” If you mean care delivery partners, then yes. We understood when designing this model that there are requirements for state Medicaid around things like managed care plans where there has to be multiple managed care plans in a certain geography.

And we wanted to allow states to be able to bring in multiple partners, not just two necessarily, maybe more, that align with the current structure of the state Medicaid relationship with these potential care delivery partners. So, yes, you can have two or more.

“What is the – what expectation can applicants have regarding CMS’ involvement? How intensive will CMS be working with states?” So, these are cooperative agreements. And, so, it is our intent to have CMMI in particular as well as CMCS and our Office of Grants Management to work close with awardees.

I think that we would work on multiple fronts. Obviously, our Office of Grants Management would help with things like Grant Solutions as well as some of the actual procedural aspect. The project officer at CMMI will work on policy issues as well as helping to navigate implementation of the actual model. And then, again, working with your project officer, CMCS will help with the coverage and payment strategy and navigating potential challenges in Medicaid as it – as it relates to sort of the federal approval of those sorts of (spots) or waivers or anything relevant.

“Does the MOU have to be fully executed by the application date?” So, I would recommend that everyone take a look at the MOU requirement in Section A4 of the NOFO for detail requirements here. In terms of whether it has to be fully executed, without wanting to

interpret exactly what the questioner means by that, the MOU has to lay out the relationship between the parties including financial and legal relationships, the reporting requirements on each side and how they plan to share data and have to be sort of signed by decision makers in both the state Medicaid agency and the care delivery partner entity.

In terms of the effective date, the MOU should be effective and enforceable when the first requirements that are described in that agreement sort of come to – come to play or become effective. So, if the MOU is signed, it's sort of promising that those parties will work together when the – if the application is awarded. So, it does not necessarily mean that the parties are bound at the time that the application is submitted. But, it would have to be effective as soon as those requirements need to be in place.

And, then, the last question. “Is a letter of intent required? If so, what is the deadline for submission?” And the answer is, no, there is no letter of intent required.

Great. So, as we mentioned previously, there are some resources that potential applicants can use and draw from to help better understand the model, reach out and ask additional questions. On this slide, you will see the model itself as an e-mail address which you can send questions related to either the model design or the application.

There is MOM model website where we post everything that comes out related to the MOM model. That is where the fact sheet is for the model, the (INC) and MOM fact sheet that talks a little bit about the overlap of the two models. That is where this webinar will be available as well as the webinar we previously did on announcement is already available.

There are also some Grants.gov resources listed here including a phone number and customer support website. There are also a number of grant policies that are probably useful. If you do have any

questions regarding sort of how – what (Monica) went over in terms of how grants are handled – and these sort of outline some key aspects that could be looked at by potential applicants.

Monica Anderson: Absolutely. And if you have any questions regarding the grants policy, please submit your question through our e-mail, which is MOMmodel@cms.hhs.gov. Again, that is on your screen now, and it's MOMmodel@cms.hhs.gov. You can also reach those resources and that contact information from the MOM Model website, which the link is listed here.

And then, of course, if you have any questions regarding submitting, downloading, reviewing, starting your application in Grants.gov, their toll-free number is listed here at 1-800-518-4726. And you can also visit their customer support at Grants.gov through the link listed here or when you go to their website – when you go to the Grants.gov website, it is listed in the top right-hand corner.

So, these are our policies. All federal awards are regulated through the Uniform Administrative Requirements Guidance, which was updated in 2016. HHS specifically implements 45 CFR Subpart 75 of the Uniform Guidance. I would recommend that you pull that off of the Internet and bookmark that on your – on your system because that – all federal awards, including the MOM award, will be – from application through closeout are regulated by that specific policy for HHS.

J. Alice Thompson: Great. Thank you so much. As I mentioned before, the slides and related materials will be posted on the MOM Model website. And we will send out an e-mail to those on the Listserv letting them know when those materials are available. Thank you so much for attending today and look forward to further communication. Have a great day.

Monica Anderson: Thanks.

Operator: Thanks to all our participants for joining us today. We hope you found this webcast presentation informative. This concludes our webcast, and you may now disconnect. Have a good day.

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