

Maternal Opioid Misuse (MOM) Model

Frequently Asked Questions from Notice of Funding Opportunity (NOFO) Webinars

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Applicant Eligibility

Is the state required to be the applicant for this funding opportunity?

Yes. Only state Medicaid agencies are eligible to apply for the MOM model; however, Medicaid agencies must demonstrate at the time of application that they will engage at least one care-delivery partner that will work with the agency throughout the model performance period to implement the MOM model's coordinated and integrated care-delivery approach. Providers are expected to participate in the model through clinical delivery sites under the direction of a care-delivery partner. State Medicaid agencies participating in the model will be responsible for management of the award funding as well as accountable for meeting all model requirements, according to the Terms and Conditions of the Cooperative Agreement and applicable federal grant laws.

What types of entities are eligible to partner with MOM model applicants as care-delivery partners?

Designated care-delivery partners must be a health system or payer that is associated with at least one clinical delivery site. This includes Medicaid managed care plans, hospital systems, and other entities that can complete the following activities in collaboration with the applying state Medicaid agency: identify, engage and retain beneficiaries, providers and care-delivery sites in the model; design and implement an intervention to ensure that model services are delivered to beneficiaries in an integrated and coordinated way; and, participate in the model's evaluation. Applicants may propose partnerships with any entity that meets the requirements set forth in the NOFO, and the Innovation Center encourages states to engage partners that will meet the unique needs of their proposed model populations.

Could a community-based organization (i.e., not a hospital or payer) serve as a model partner?

All designated care-delivery partners must be a health system, a hospital system or a payer. However, there are other opportunities for entities to be involved in the model, since coordinated and integrated care for pregnant and postpartum with opioid use disorder (OUD) is complex and can involve many different segments of the community. Examples of other partner entities include but are not limited to child welfare agencies, community organizations, local government entities, civil legal organizations, and local academic institutions. While these entities cannot be selected as the designated care-delivery partner, the awarded state Medicaid agency and designated care-delivery partner can engage these other types of organizations to support their model intervention.

Can a state Medicaid agency designate more than one care-delivery partner?

Yes, an applying state can work with more than one care-delivery partner to serve multiple regions or other sub-divisions within the state, but only one award will be issued per state.

If MOM model applicants engage more than one care-delivery partner, does each care-delivery partner have to use the same intervention approach? Or can each care-delivery partner implement different strategies in keeping with the model?

The MOM model offers flexibility to states to partner with one or more entities, and to design an intervention - within the model requirements - that is appropriate for the intended region(s) and population(s). An applicant's intervention may be multi-faceted, and as such, could utilize one or more care-delivery partner(s) with different roles or strategies. All such plans would be subject to Centers for Medicare & Medicaid (CMS) pre-approval.

Do the Memorandums of Understanding between the state Medicaid agency and designated care-delivery partner(s) have to be fully executed by the application deadline?

As part of the application package, each state Medicaid agency must submit a Memorandum of Understanding (MOU) between the state and each of its proposed care-delivery partners. At the time of application submission, the MOU(s) should be signed by the state Medicaid director and an individual with the legal authority to bind the care-delivery partner to the terms in the agreement, including the requirements in section A.4.6.6 of the NOFO, Memorandum(s) of Understanding with the Care-Delivery Partner(s). The MOU should be effective and enforceable when the first requirements that are described in that agreement occur at the start of model performance period. 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.

Can a state Medicaid agency use a fiscal fiduciary to apply and administer its grants through Grants.gov for this model?

No.

Can a for-profit business be a subcontractor to a state Medicaid agency applicant?

There are no known federal regulations that would prevent a for-profit business from serving as a contractor or subcontractor to a state Medicaid agency under this model. Applicants will have to review any relevant state regulations to ensure that they are in compliance with those regulations.

Model Service Area

Should applicants provide information in response to Section A.4.6.2, Characteristics of Proposed Model Service Area and Model Population, focused on the entire state or just the proposed model service area?

Each of the data points required under Section A.4.6.2, Characteristics of Proposed Model Service Area and Model Population, include a specific description of what should be included in the application. For example, question 3 on p. 16 specifies that the applicant should provide “Description of opioid use among the model population **within the proposed model service area**, including the following data points for years 2016-2018” (emphasis added). Each applicant should review each question in this section carefully to ensure that its application is responsive to each specific requirement.

Given the flexibility to define the model service area for this funding opportunity, CMS recognizes that an applicant may not have data that completely aligns with the granularity of data required in the text of the NOFO. If any of the data requested in Section A.4.6.2, Characteristics of Proposed Model Service Area and Model Population, are not available or cannot be provided in the required format (for example, if the applicant’s state does not collect or store the data in the format required in the NOFO or the required format would take up an unreasonable amount of the applicant’s page limit), the applicant must provide an explanation for why such data are not available and, if possible, a proxy for each missing data point. This includes the data request for the number and percentage of births by age and ZIP code.

Section A.4.6.2, Characteristics of Proposed Model Service Area and Model Population, of the NOFO lists required data points that each applicant must submit. The NOFO mentions OUD in a few places in this section, but then mentions substance use disorders in other data points. Does the Innovation Center want all of the data to focus specifically on OUD?

For each element of question 3 under section A.4.6.2, Characteristics of Proposed Model Service Area and Model Population, the NOFO provides specific details on what information should be included in the application and the desired level of granularity. If a question is directly asking for information about OUD or opioid overdoses, an application should include information at that level of granularity. If it is asking more broadly for information about substance use disorders (SUDs) or conditions related to SUDs, an application should include information at that broader level of detail. See also the response to the previous question.

Model Funding and Cost Savings

Is the state Medicaid agency responsible for all model intervention costs in Years 3-5? Or just the treatment costs, with implementation costs covered by the Innovation Center?

During the Full Implementation period (Years 3-5), state Medicaid agencies that are MOM model awardees will be required to cover the physical health care, the behavioral health care, and the wraparound model services that are outlined in the model Implementation Plan. By Year 3, a state must have fully implemented the Coverage and Payment Strategy proposed in its application and refined during the Pre-Implementation and Transition Periods. If a state requires a change to its Medicaid program in order to cover the costs of model services or any physical or behavioral health services, these changes (e.g., a state plan amendment (SPA), 1115(a) demonstration or other waiver, etc.) must be fully approved and implemented by the start of Year 3. During the Full Implementation Period (Years 3-5) the Innovation Center will continue to provide annual Implementation Funding. Additionally, each awardee will have the opportunity to earn Milestone Funding based on its demonstrated performance on specific Performance Milestones. Implementation Funding awarded to participating state Medicaid agencies can be used to build institutional and organizational capacity (e.g., strengthen provider collaborations, build infrastructure to support data collection, linkages, and sharing) to address key challenges in the provision of coordinated and integrated care. Each state awardee will determine the use of Implementation Funding among its care-delivery partner(s). Additional examples are on page 26 of the NOFO. Milestone Funding is restricted and will be released only if the awardee demonstrates satisfactory performance on selected performance measures.

How will the Innovation Center expect states to account for duplication in funding used for populations of interest?

Applicants must submit a Program Duplication Assessment Questionnaire (Appendix F) as part of their application package. 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. This questionnaire is a tool to help applicants to understand their program duplication risks. If an applicant is at serious risk of program duplication or fails to submit the questionnaire, CMS may disqualify the applicant from participating in the MOM model. Therefore, applicants should consider current programs that are funded by Medicaid, Title V agencies, and other federal, state, or local programs that provide care coordination or case management services to some or the entire MOM model population.

An applicant should also include any funding opportunities matching the criteria set out in Appendix F for which it has also applied, even if the funding has not yet been awarded. CMS recognizes that state Medicaid agencies are combatting the opioid epidemic using a variety of funding sources, and a state that identifies potential duplication in its response to the MOM NOFO will not be automatically ineligible for MOM model funding but will be responsible for eliminating the duplication. The goal of this questionnaire is to allow potential awardees to alert CMS to any related programs that the state Medicaid agency and care-delivery partners are already participating in, and determine how current or future 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 MOM model expenses.

For more information or possible scenarios of duplication, please refer to section A.4.6.14, Program Duplication Assessment, of the NOFO.

Regarding the duplication assessment, if Medicaid currently does not pay for a program or service, would that count as duplicated if an applicant wanted to fund that program with the MOM model?

There are limited activities that MOM model funding is designed to support. In general if Medicaid is already providing a service, then MOM model funding could not be used to provide that same service since it would be duplicative. However, MOM model funds may not be appropriate to support a service simply because it is not already covered by Medicaid. Applicants should approach the Program Duplication Questionnaire with two questions in mind, both of which are relevant to the determination of program duplication risk. First: is the service that you are seeking to support with MOM model funding aligned with the goals of the MOM model, and acceptable based on the information in the NOFO that details what each funding stream is designed to cover? Second: are there other federal, state or local funds that are already paying for that same service?

Does an applicant need to provide an Indirect Cost Rate Agreement for this application?

To claim indirect costs, the applicant organization must have a current negotiated indirect cost rate agreement (NICRA) covering the grant supported activities and period of performance established with the Department of Health and Human Services unless the organization has never established one (see 45 CFR §75.414 for more information). If a rate has been issued previously to the applicant, a copy of the most recent negotiated indirect cost rate agreement must be provided with the application requesting indirect costs. Any non-federal entity that has never received a NICRA, 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 modified total direct costs, which may be used indefinitely. Recipients must include information on indirect costs, if approved, as part of grant award financial reporting.

Should indirect costs be included in the proposed budget, and are they part of the grant award?

Indirect costs are a budget category of the application's Budget Narrative and may be included at the discretion of the entity applying for the award when developing its proposed budget. Indirect costs, however, must be included in the total budget request by the applicant and will be included within the MOM model overall award amount. Please see the response to the previous question for more details.

Are the indirect costs capped?

No.

Do the cost savings for the MOM model have to come exclusively from federal Medicaid expenditures? What about savings from state agencies, such as child welfare?

Yes, the savings that applicants must outline in their Cost Savings Projection should reflect savings or cost neutrality to the federal Medicaid program via the Innovation Center's investment. This is directly linked to the Innovation Center's three statutory criteria defining model success: improved quality of care and cost neutrality, no changes in quality of care and achieving cost savings, and (the ideal scenario) improved quality of care and achieving cost savings. However, it is possible that awardee participation in the MOM model may reduce costs to their related state agencies.

Can you clarify the "Coverage and Payment Strategy" application requirement? Does this mean each applicant must design an alternative payment model (APM)? What are the expectations?

Applicants do not need to design an APM for their Coverage and Payment Strategy, although a state may take that approach. Each state has the flexibility to propose a Coverage and Payment Strategy tailored to the needs of its population and proposed service area(s), and the parameters of its Medicaid State Plan, but is expected to consider SPAs and program waivers as necessary. The coverage and payment strategy must explain how the applicant 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 through its state Medicaid program by Year 3 of the model. During the model's Pre-Implementation and Transition Periods, awardees will be required to update and finalize the coverage and payment strategy proposed in their model application. On page 19 of the NOFO, there are examples of questions that an applicant can answer in its coverage and payment strategy that provide additional detail on what should be included in the application as far as coverage and funding.

Would it be an advantage or disadvantage for model applicants to highlight participation in currently funded CMS projects that are coming to an end, such as a State Innovation Model project focused on integrating behavioral health and primary care?

Applicants are required to complete the Program Duplication Assessment Questionnaire (Appendix F) in order to identify current participation in programs that present a potential risk of duplication. Additionally, each applicant has the opportunity to highlight participation in currently funded, relevant CMS projects in response to the requirements detailed in Section A.4.6.12 of the NOFO, Organizational Capacity of Applicant and Care-Delivery Partner to demonstrate its capacity and that of its proposed care-delivery partner(s) to implement the MOM model successfully. There is no preference to being a past or current State Innovation Model awardee or other CMS project awardee aside from the experience that the state Medicaid agency and/or care-delivery partner can demonstrate in its responses to the NOFO. MOM model awardees cannot use MOM model funds to supplant or duplicate existing funding sources for projects serving the model population.

Have the MOM model performance milestones been finalized and, if so, when will their operational definitions, corollary indicators and metrics, and associated reporting tools become accessible to interested stakeholders?

Applicants should reference Section F.5.2.2, Performance Milestones, on pages 54-55 of the NOFO for the available information on the model's performance milestones. Additional information on the milestones, including operational definitions and metrics, will be available to model awardees in the Terms and Conditions of their Cooperative Agreement. Applicants will be assessed based on their

responses to the NOFO only, and will not be evaluated based on information that is not available in the NOFO.

Model Services and Beneficiary Eligibility

How long are postpartum women eligible for the MOM model?

Model eligibility is aligned with Medicaid eligibility, so it will depend on each awarded state's Medicaid plan. 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.

Can CMS share a range, or at least lower limit/minimum expectation for the number of enrolled women and their infants?

CMS does not have a required range or minimum on expected beneficiary enrollment for MOM model awardees. Each applicant must propose in its Intervention Design the 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 (Section A.4.6.3.1(a) and (b)) based on the needs of the model population within the proposed model service area, scope of the Implementation Plan, and goals and capacity of the applicant. With respect to the Cost Savings Projection required in Section A.4.6.11 of the NOFO, CMS recognizes that there are multiple factors that will influence the potential for cost savings in a particular state, including the current cost of care for pregnant and postpartum women and their infants enrolled in Medicaid and CHIP, as well as the geographic differences in cost and coverage, as well as the scope of the proposed MOM model.

With the rapidly changing SUD landscape, is MOM model funding available to treat pregnant women with other SUDs (e.g., methamphetamines etc.)?

OD is one of the key eligibility criteria for women to participate in the model. However, the model does not prohibit awardees from addressing the entire scope of the woman's needs in terms of their SUD(s). Medication assisted treatment is not the only form of OD treatment or SUD treatment that is allowable under the model. Therefore, there is some flexibility for treating eligible beneficiaries who have polysubstance use disorder that includes OD.

Application Process

Is a Letter of Intent required? If so, what is the deadline for submission?

No, a Letter of Intent is not required for this funding opportunity. See NOFO Section C3 Letter of Intent.

Would you please confirm that the Authorized Organization Representative (AOR) can be an organization designated by the Medicaid state agency?

An AOR must be a person, and is the individual(s) named by the applicant/recipient organization as authorized to act for the applicant/recipient and to assume the obligations imposed by the federal laws, regulations, requirements, and conditions that apply to grant applications or awards. The AOR is the individual(s) responsible for signing and submitting the application for funding.

Can any representative beside the AOR review Grants 101?

Yes. Anyone who would be involved in the application process, specifically in submitting the application through Grants.gov or working on the project itself or the application itself, should review Grants 101. The AOR is the individual(s), named by the applicant/recipient organization, who is authorized to act for the applicant/recipient and to assume the obligations imposed by the federal laws, regulations, requirements, and conditions that apply to grant applications or awards. The AOR is the individual who must sign and submit the application for funding.

Should Appendix D be completed by the state Medicaid agency, the care-delivery partner, or both entities?

Appendix D, the Business Assessment of Applicant Organization, should be completed by the **state Medicaid agency**.

Section A.4.6.12 of the NOFO states that resumes and organizational charts for the state Medicaid agency and all designated care-delivery partners are required. Do the resumes and organizational charts count toward the 60-page page limit for the Project Narrative?

Resumes and organizational charts **do** count toward the 60-page page limit for the Project Narrative. Only resumes from individuals who will have management authority over the model at the state Medicaid agency and each care-delivery partner, plus the state Medicaid individual who will be the project manager and primary liaison to CMS for the model, are required. The resumes submitted can be shortened to ensure that applicants stay within the page limit, and the organizational charts can be targeted toward individuals who will be involved with overseeing and implementing the model. In addition, section D.2 in the NOFO identifies the opportunity to add optional standalone appendixes, which could be used to provide additional information related to the application. Other optional standalone appendixes (three maximum), if submitted, may be single-spaced, and are limited to five pages each.

One of the slides discussing the registration process listed the acronym "CCR"- what does this stand for?

CCR stands for "Central Contractor Registration." When an organization registers in the System for Award Management (SAM), its AOR will receive a CCR number, which has to be validated and active for an applicant to become a MOM model awardee. If the CCR is not active for a state applicant in the SAM system, CMS cannot issue a federal award to the applicant. Organizations must renew their CCRs annually.

Awardee Support

The NOFO indicates that there will be three support contracts--evaluation, implementation assistance, and learning. Will these contracts be issued prior to or after awards to states?

The Innovation Center typically issues implementation and learning system contracts to align roughly with the model performance period, so for the MOM model the contracts should start on or about January 1, 2020. The timeline of the evaluation contract may vary to allow the evaluation contractor to fully evaluate the entire model performance period, which ends on December 31, 2025.

What expectation can applicants have regarding CMS' involvement? How intensively will CMS be working with states?

MOM model awards are structured as renewable one-year Cooperative Agreements. Cooperative Agreements are alternative assistance instruments to be used in lieu of a grant whenever substantial federal involvement with the awardee during performance is anticipated. It is the Innovation Center's intent to have model project officers as well as the Center for Medicaid and CHIP Services (CMCS) and the CMS Office of Grants Management work closely with awardees. The Office of Grants Management will assist with using Grant Solutions as well as the actual procedural aspects of the grant. The Innovation Center's project officers will work on policy issues and help to navigate implementation of the model. CMCS will also assist with implementing the coverage and payment strategy and navigating potential challenges in Medicaid as they relate to federal approval of SPAs and waivers relevant to the model.

How will potential SPA processes and the MOM model award schedule be aligned and implemented?

State Medicaid agencies will have two years to completely implement the Coverage and Payment Strategy by the start of the Full Implementation Period (Year 3). However, if a state requires changes to its Medicaid program in order to cover proposed physical and behavioral health services for its proposed model population, those changes must be in place by the Transition Year (Year 2) of the model, because MOM model funds are not available to support services other than the model services. (Model services are defined in Appendix G., Glossary, and comprise 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 3-5)). CMCS experts will be available to states participating in the model, to ensure that they are able to design the most appropriate coverage and payment strategy, and that the strategy can be approved in alignment with the model performance period. Table B in the NOFO also sets out a number of operational milestones, including the requirement that awardees must meet with CMCS immediately upon award to begin the process of SPA and waiver planning and approval.

Will there be support for working with CMS on SPAs related to the MOM model?

Yes, awardees will receive implementation funding during all five years of the model, and one of its intended uses is to help support the development of coverage and payment strategies for the model population. CMCS was involved with the MOM model development process, and will be an integral partner to awardees through the process of getting either adjustments or approval of the different coverage and payment strategies needed for the model through SPAs or waivers. An awardee's Innovation Center Project Officer will determine the need for and form of any technical assistance.

What happens if CMS does not approve activities proposed in the Project Narrative as submitted by an applicant, but the applicant is still selected to become a MOM model awardee?

If there is an element of an awardee's application or Implementation Plan that is ultimately not approved by CMS, there would be an assessment with the model project officer and CMS Office of Grants Management to determine whether that particular awardee can still meet the program requirements going forward. If it determines that the program requirements cannot be met, then it is possible the award could be terminated. As the MOM model award is a Cooperative Agreement rather than a grant, both CMCS and the Innovation Center will work closely with awardees to address any issues that arise during the model's period of performance with the goal of enabling the awardee to continue to participate.

Please note that the Project Narrative submitted as part of the response to the NOFO does not constitute a formal application for a SPA, Medicaid waiver, or other change to the approved Medicaid state plan. Materials submitted as part of the application package for MOM will be evaluated only to determine whether an applicant will be selected as a MOM award recipient. While the Project Narrative should form the basis for a state's implementation of the model if it is selected as a MOM award recipient, the application is simply the applicant's strategy for what changes may be needed for the state Medicaid agency to take over coverage of the model population in the proposed model service area and funding for all MOM model services by Year 3 of the model. CMCS is aware that some awardees will potentially be pursuing SPAs or waivers for their state Medicaid programs, and will continue to govern the approval process for any submitted SPAs or waivers related to the MOM model.

Section F.5.2.1 of the NOFO, Quarterly and Annual Progress Reporting, states CMS will provide a template for quarterly progress reports and annual progress report submissions. Should these templates be included in an applicant's reporting plan?

These reports are not required from applicants. Report templates for quarterly and annual progress reports will be detailed in the Special Terms and Conditions for each awardee that executes a Cooperative Agreement with the Innovation Center. At that point, and as the first quarterly progress report and annual progress report are due, each awardee will work with a project officer to ensure that they have the correct, most current template.

How should awardees include the 'unique, traceable identifiers' in the Medicaid and CHIP claims and encounter data for beneficiaries attributed to the MOM model as required by the Innovation Center's evaluation contractor?

The "unique, traceable identifiers" are unique, unchanging beneficiary identifiers that will permit the Innovation Center's evaluation contractor to identify each MOM model enrollee and her infant(s), and to access each enrollee's:

- Eligibility & enrollment data;
- Claims/encounter record data;
- Medicaid Numbers and CHIP Numbers, if applicable. (This is the identifier printed on each beneficiary's Medicaid (or CHIP) card.)

It is also necessary for the state to enable data users to link each mother's "unique, traceable identifier" to that of her infant(s).

These "unique, traceable identifiers" need to be capable of tying all data for each participant together across the entire time period covered by the model. This may already be accomplished by the "MSIS-IDENTIFICATION-NUM" that is currently part of the T-MSIS data. However, if it is possible that the state has assigned multiple MSIS-IDENTIFICATION-NUMs to some of its beneficiaries over time, then the state would also need to supply a crosswalk that ties all of each person's MSIS-IDENTIFICATION-NUMs together. The state's options for passing this additional data to T-MSIS (should it be necessary to do so) could be worked out with CMCS's Data & Systems Group if the state is selected for participation in the MOM model.