THE CENTER
at Sierra Health Foundation

MAT access points project

Low-Barrier Opioid Treatment at Syringe Service Programs
Funding Opportunity
Questions and Answers

ELIGIBILITY – WHO CAN APPLY?

Q: If we're a mobile site, do we need to offer prescriptions on-site to be eligible or just through linkage to care?

A: You are eligible. Although your proposal would be significantly stronger if you are able to offer those kinds of clinical services (including directly prescribing to people) rather than through referral, which is something that occurs frequently already.

COLLABORATION – WHAT IS PERMITTED?

Q: Can an NTP partner with an existing SSP apply?

A: Yes. However, the lead applicant in any application must be the SSP. If you are an NTP and are looking for SSPs to partner with, we encourage you to collaborate. We fully expect that there will be partnerships between NTPs and SSPs. Here are links to the CDHP's **Directory of SSPs** and **Map of counties with SSPs.**

Q: May SSP applicants partner with any type of nonprofit to accomplish project goals? For instance, could an SSP partner with another nonprofit to provide care coordination services?

A: It is permissible to partner with another organization to accomplish project goals as long as the lead organization is currently authorized to operate a SSP. If the other organization or its employees would need to be compensated for this collaborative work, you would need to specify that in your proposed budget.

Q: If a partnership of two SSPs apply, but they are from the same jurisdiction/region, can that application be for $700,000?

A: Yes. If there are multiple distinct SSP's involved, even from the same region, the budget can be increased in this way.

Q: Will collaborative SSP applications receive priority over single SSP applications?

A: No, collaborative SSP applications will not take priority over single SSP applications.

USE OF FUNDS – WHAT IS ALLOWABLE?

Q: May grant funds be used to rent space for program activities?

A: Yes, if renting a space furthers your programmatic goals, funds may be used in this way. Please note that rent should be cost shared with other programs if applicable.

Q: Can this opportunity fund a needle exchange program that we do not have staff for but have been using existing staff for only 4 hours per week? This could increase capacity and bring more clients into our MAT services.

A: This funding is not generally oriented toward funding syringe access or closely associated harm reduction services – it is squarely about opioid treatment access. However, we will not screen out proposals that include wraparound services and activities such as outreach that gets people information and engagement around their treatment options. Activities that focus on outreach and engagement fit well, activities that focus on funding for things that we have previously funded in other areas most likely do not.

Q: May grant funds be used for medical supplies that are not obtainable through either the CDPH Harm Reduction Supplies Clearinghouse or the DHCS Naloxone Distribution Project?

A: Yes, as long as they further programmatic goals and do not fall within the Standard Funding Restrictions included in the RFA.

Q: May grant funds be used to purchase electronic equipment (cell phones, laptops, tablet computers) and internet service for mobile capability and street-based services?

A: Yes, if such an expense serves to further your programmatic goals, you would specify this expense in your budget. Please note that equipment may only be purchased for service providers and not for use by clients.

Q: Can we pay clients stipends with this funding for participation in "patient advisory groups and leadership opportunities to gain feedback on the design of services?" In other words, can we pay clients for their meaningful involvement?

A: Yes, that is permissible and encouraged. That is categorically different than contingency management or paying people for involvement in treatment.

Q: The RFA states that patient services that can be billed to Medi-Cal cannot be covered by this funding. However, providers can be salaried through the grant as long as the organization is not contracted and/or billing Medi-Cal, correct?

A: Correct – if services and costs can be billed to Medi-Cal, an organization must first utilize Medi-Cal and other insurance funds (for example Buprenorphine is reimbursed via Medi-Cal and should not be charged under this contract). Only services and activities that are not covered by Medi-Cal or other insurance funds may be billed to this contract. A provider may be salaried through this contract, as long as the services are non Medi-Cal. If a provider is serving both Medi-Cal and non Medi-Cal patients, the organization must ensure the provider's salary is sufficiently cost-shared.

Q: Can you clarify allowable expenses for clinicians? For instance, if MAT services are rendered outside of a clinic, they are typically not reimbursable by Medi-Cal. Would grant funds cover such costs?

A: Yes, if you are not able to reimburse those through Medi-Cal, Medi-Care, or other insurance, you are eligible to bill this grant.

Q: What if you do not have the capacity to do medical billing to provide medical services but want to hire a nurse?

A: If an organization does not have the capacity to do medical billing, they may still use these funds to hire a nurse to provide services.

Q: If we are providing services that are technically billable through Medi-Cal, but we do not have the infrastructure to do Medi-Cal billing, can we use these funds to provide said services? Or must we create the infrastructure to bill Medi-Cal for all services for which they will provide reimbursement and only use these funds for services that are not billable through Medi-Cal?

A: If a service can be billed to Medi-Cal it should be billed to Medi-Cal. However, if an organization does not have the infrastructure or set-up to bill to Medi-Cal, these funds may be used to cover those services.

Q: Are we allowed to use this funding to supplant existing staff funding?

A: Generally, we are looking to use these funds to expand capacity for SSPs to deliver new opioid treatment services and are not looking to duplicate current capacity. Please keep in mind that there are restrictions around these federal funds and they are not supposed to supplant other funding. If the role of a current staff member is expanding, you are expanding services, which would qualify as a permissible use of funds. If you have an outreach worker that is being funded through this and you are taking the whole salary and using that somewhere else and you are using this funding for that salary, just be mindful of those restrictions because the aim of this is to expand services and opportunities for clients of the SSP.

Q: Can you explain your definition of indirect costs?

A: Indirect is limited to 10% of the total award (as part of the 20% for "other costs"). Recipients must treat administrative costs consistently and may not charge for direct administrative costs typically considered indirect in nature. Examples of indirect costs include: administrative and clerical salaries, rent, accounting fees, utilities, etc. While salaries of administrative and clerical staff should normally be treated as indirect costs, direct charging of these costs may be appropriate only if all of the following conditions are met (see points 1-4 below). If administrative and clerical salaries are charged under direct costs, no more than 5% of the total award may be used for those direct administrative costs. We ask that you provide a thorough description and cost breakdown in your budget narrative/justification.

1. Administrative or clerical services are integral to a project or activity;
2. Individuals involved can be specifically identified with the project or activity;
3. Such costs are explicitly included in the budget or have prior written approval of the federal awarding agency; and
4. The costs are not also recovered as indirect costs

Programs seeking to charge indirect costs should follow the guidance specified within **DHCS Behavioral Health Information Notice 20-020**.

Q: Can indirect costs be 10% of the total budget, or only 10% of the 20% "other costs?"

A: Indirect Costs can be no more than 10% of the total budget but will fall under the 20% “other costs” category. This means that you can use a maximum of 50% of the “other costs” funds toward indirect costs.

Q: Can you please outline what is meant by unallowable use of funds towards "…non-evidence-based treatment approaches, such as short-term methadone or buprenorphine use ("detox" with initial treatment less than one year)."

A: Treatment providers are expected to collaborate with their patients to meet their patients' self-directed, individual needs. So long as providers offer long-term MAT services and the program is designed to support and encourage retention in care, intermittent or short-term utilization of opioid treatment by individual patients is allowable. In contrast, a project specifically designed to provide short-term detoxification services using buprenorphine or methadone is not allowable under this funding opportunity. Detoxification services are allowable, however, as part of a patient's transition from opioid agonist use to extended-release naltrexone.

OTHER QUESTIONS

Q: Can you explain contingency management and incentives?

A: We encourage you to review the RFA regarding what we will not fund under this opportunity. It outlines specifically the allowances for contingency management and amounts.

Q: There is a red asterisk next to the Letters of Commitment attachment on the online application. Does this mean that agencies that are not submitting collaborative applications must still submit a letter of commitment from their own agency?

A: If you're a single entity that is applying and have the capacity to do all aspects of this program "in-house," we ask for a letter from your executive team or director stating that they are aware and accepting of this proposal. If you need to work with partners in collaboration to deliver any part of these services and they are receiving funding under this grant, then those are the letters of commitment you would include.

Q: Should we provide annual figures for unique individuals served?

A: Yes, please provide annual figures for the number of unique individuals served by the SSP. When you enter this figure in the "Individuals to be Served" section of the "Project Information" tab, please note that this projection is an annual figure.

Q: Can you clarify the restrictions around "permitting" a patient to use marijuana for the purpose of treating substance use and mental disorders?

A: Although marijuana use is legal in California, because these are federal funds, marijuana may not be used in the treatment of substance use and mental health disorders. This means that under federal guidelines, if a provider is being funded through these dollars they may not prescribe or provide marijuana as a treatment option. Permitting in this case would be

specifically related to how these funds are used and if they specifically fund services or providers (billed to these funds) that prescribe marijuana use as treatment.

Q: Can you provide additional information about SAMHSA Government Performance and Results Act (GPRA)?

A: *DHCS has reached out to SAMHSA requesting that GPRA data collection not be a requirement of this funding. However, because we have not yet received a response, we are requesting that you include GPRA data collection in your proposed budget and funding allocations if applicable. If GPRA turns out not to be required, we will allow funded organizations to reallocate that portion of funds to other programmatic line items. Below is general GPRA information for your review and reference.*

As with other federal funding, awarded organizations using contract funds to cover individual direct patient services will be responsible for complying with SAMHSA Government Performance and Results Act (GPRA) reporting requirements and provide client outcome data. Any client directly supported through this funding opportunity will need to have GPRA forms completed at intake, six months, and upon discharge. Individual direct patient services are defined as specific fee-for-service charges tied to an individual uninsured or underinsured patient, such as the cost of an office visit or a medication.

Organizations using this funding for any of the following will be required to collect GPRA data:

- Organizations who use the MAT Access Points Project dollars for direct services
- If the funding is used to cover staff salaries for staff providing direct patient services (for example a nurse or counselor)
- If the funding is used to cover MAT medications for un/underinsured patients
- If the funding is used to cover clinical counseling and therapy sessions (not MI), if seen by a certified/licensed medical professional

Examples of activities that do not require GPRA reporting include the following:

- Gift cards, patient incentives, contingency management, travel vouchers
- Supplies, harm reduction supplies
- Lab fees (for un/underinsured patients)
- Substance Use Navigators, Care Coordinators that provide education, referrals and outreach (unless they are providing direct MAT medical services)

Organizations funded under this opportunity that will be required to submit GPRA data will receive technical assistance and training on the submission of GPRA data. Aurrera Health will partner with organizations funded and will provide technical assistance webinars, forms, and support on the collection and submission of all GPRA data (GPRA data will be submitted directly to Aurrera Health).

Q: Could you please clarify whether a Medical Assistant that takes vitals, schedules appointments, and supports the provider, but does not provide direct medical services would be considered "staff providing direct patient services"?

A: No, such a Medical Assistant would not be considered "staff providing direct MAT services."