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

ELIGIBILITY – WHO CAN APPLY?

Q: If we are 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.

Q: Does having an out of state fiscal sponsor affect your eligibility?

A: Organizations are eligible to apply if you are operating your services in California, regardless of the location of fiscal sponsorship or if your organization is incorporated elsewhere.

PARTNERSHIPS – 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: Will reporting provided by the grantee on previous grants be a consideration when approving grantees for this funding opportunity?

A: No. We will not look at other project reporting data to determine funding decisions for this opportunity. The review committee will look at your proposal and scope of services in terms of activities and objectives.

Q: The 2020 RFA allowed two SSPs to apply together. Is this still allowable?

A: For organizations that would like to submit a collaborative application for a larger funding amount, please reach out directly via email. These requests will be addressed on an individual basis.

Q: Are organizations allowed to use funds for contingency management?

A: Contingency management is not an allowable expense under this funding opportunity. There is a separate contingency management program being rolled out by DHCS through CalAIM which will support that work.

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?
**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 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 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.

Q: Can funds be used to purchase malpractice insurance for medical professionals? And/or how have orgs dealt with obtaining malpractice insurance for bringing medical professionals on site?

A: If this is the type of insurance tied directly to the medical professional being brought on, then it can include as a direct cost like a benefit. If this is some other type of insurance that the program has in order to cover program interests, then it would be an indirect/administrative cost. In either case, if the medical professional is providing services beyond the scope of this project, cost sharing should be implemented.

OTHER QUESTIONS

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: *We are requesting that you include GPRA data collection in your proposed budget and funding allocations if applicable. 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, 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 funded organizations 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). Additionally, if a participant declines to complete the GPRA data form no GPRA data collection is required for that individual.

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.”

Q: *If I am at an FQHC that has Physician Led SSP, and has an in-office MAT program, is it appropriate to apply for these funds if I am trying to expand MAT more broadly with less barriers, with more employment of people from the community being served?*
A: This is from building new or expanding services. As long as you are proposing something that is truly built on work that exists in your clinic and pays attention to the values and strategies outlined in the RFA.

December 5, 2022