ATR RFA General Questions

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Will Altarum staff continue to serve as the technical assistance providers for ATR III?

A new contract for the ATR III cohort will be open for bid to all interested and eligible contractors in 2010. Altarum may or may not receive the next award. It has not yet been determined as the competitive process has not yet occurred.

What is the award amount?

It's $2 to $4 million per year. Over the course of the 4 year grant cycle, a total of $382 millio
n will be awarded.

When will the ATR awards be made?

SAMHSA will make the ATR awards no later than September 1, 2010, although the awards may be made sooner than this date. The amount of money granted is based on the targets proposed in the application and the targets SAMHSA is seeking to accomplish.

Are you looking to fund certain percentages of previously funded and new grantees?

SAMHSA does not have a target percentage or quota for funding new verses previously ATR funded grantees. The evaluation criteria were developed in a fashion to equalize the two types of applicants, but—ultimately—all applications will be combined into one list in order of scores.

I didn't receive any information about the RFA Preapplication Meetings. Can project directors get a copy of the grantee letters that come from your office?

The RFA Preapplication meetings were posted publicly on SAMHSA's ATR Web site (http://atr.samhsa.gov) and were distributed through SSA and tribal network distribution lists. The reason that current grantee project directors did not get the letters directly was to ensure that information about these opportunities was made available to the public in a fair and equal fashion. Therefore, eligible applications (SSAs and tribal networks) were made aware of the correspondence, and the postings were made on the public Web site.

When we applied in 2007, we never received a copy of the reviewers' comments. Is there a way for us to secure these comments now? If so, the person named as contact person is no longer employed. To whom should we provide contact information?

Reviewers comments were sent to the person designated as the project director on the application. If you were not listed as the project director, you would not have received it. You may want to check with the person who was listed as the project director, and see if they have the comments. If you are still unable to locate the comments, please contact us again, and we can search through the various databases to see if we still have them on file. Please send your request to Stanley Kusnetz at stanley.kusnetz@samhsa.hhs.gov.

Have any ATR States developed a way to collect data electronically, as an alternative to paper forms?

Yes. Several current grantees collect data electronically whether it is to meet the GPRA requirements or to allow providers to bill online for reimbursement of services rendered. Having computers with internet access is key, as is building an electronic voucher management system that is capable of permitting these functions online.

Would CSAT support an ATR application that focused services on participants who either will not accept their need for specialized treatment or do not require specialized treatment? That is, if we proposed to serve only persons who are in recovery, would our application be competitive?

As stated in the ATR RFA, SAMHSA is looking for applications that propose both clinical treatment and recovery support services (RSS). A competitive application is one which offers both. However, SAMHSA does not stipulate that ATR clients must receive both. It is both permissible and competitive to allow clients who only need RSS to access and receive only RSS.

If you experienced a need to decrease services in order to meet a client target number in the previous grant and would now like to provide a higher level of service to fewer people, will you be penalized for not serving as many clients as you did in the previous grant cycle?

An applicant or grantee will not be penalized for proposing or actually serving fewer clients in ATR III than they did in ATR I or II. Reviewers are scoring the applications based on whether you can deliver the outcomes that you are proposing in your application. SAMHSA project officers are looking for you to deliver what is agreed upon in the notice of award. As long as the need is justified and there is a focus on expansion and sustainability, your efforts will be acceptable.

Previous ATR requests for applications required an electronic health record (EHR), whereas ATR III requires an electronic voucher management system. Does CSAT envision that the electronic voucher management system would, for ATR States, be a platform for implementing EHR?

Correction: Previous ATR RFA's did not require EHRs; they required electronic voucher management systems. Since the broader healthcare changes are moving in the direction of EHRs, SAMHSA would encourage applicants to conceptualize the voucher management system as a platform for implementing EHRs.

There does not appear to be a dedicated evaluation section in the RFA. Does this mean that you do not expect to see subcontracts made to external evaluators?

SAMHSA is not requiring that you have an external evaluation conducted on your ATR grant. However, on page 13 of the RFA, you will find that SAMHSA does expect grantees to assess their performance using, at a minimum, the outcomes and process questions listed on page 13.

If your ATR model is family-focused, can you count the family members in your participant count along with the primary participant? If so, would you have to do a GPRA on family members?

No, only the primary client should be included in the target number to be served.

With respect to GPRA measures, is entry into service considered the "point of intake?"

Yes, entry into services (including ATR dollars spent on the client) is considered the "point of intake" with respect to the GPRA measures.

Please clarify whether GPRA records for single distinct client are counted for that client's entire ATR experience or whether a new GPRA record has to be established for each treatment episode that the client may have during the 4 years of the grant period.

Only one GPRA intake should be completed.

What is the maximum allowable IDC rate for the applicant organization?

SAMHSA does not have a maximum allowable Indirect Cost rate for applicant organizations. SAMHSA does specify that the applicant organization should not exceed 20% of the yearly budget for administrative costs (which includes indirect costs).

Are there any changes to the VI file or VT file for upload?

No, at the time, there are no changes to either the VI or VT forms for upload.

Application Preparation and Submission

Will the deadline for the RFA be extended due to the inclement weather in D.C.?

SAMHSA staff were out of the office for almost one week, coordinating the annual grantee meeting. Immediately following the meeting, the Federal Government shut down for almost one week due to a treacherous snow storm. These two events created a backlog of questions to be answered on the RFA. Unfortunately, SAMHSA is unable to move the deadline any later, but SAMHSA is returning to the same level of responsiveness prior to these events.

The RFA says that applications may be submitted in either electronic or paper format. Can an organization submit its application in both formats?

Organizations are not encouraged to submit their applications using both formats, as it can create confusion if the office receives two applications from the same organization. SAMHSA encourages you to either submit your application in electronic format or in paper format.

If we submit our application through www.grants.gov, will we receive a confirmation number indicating that it was received?

Yes.

Is SAMHSA offering technical assistance (TA) to applicants to help them during the application process?

Yes. SAMHSA has offered two face-to-face, in-depth TA events, and two Webinars. SAMHSA is also providing a Question and Answer Web site, to which individuals can submit questions and receive answers publicly. Also, technical assistance can be provided on an individual basis by calling Roula K. Sweis, ATR Team Leader, at 240-276-1574.

Is SAMHSA offering scholarships to help pay for applicants' travel costs to attend the face-to-face preapplicant technical assistance meetings?

Unfortunately, SAMHSA is unable to offer interested applicants scholarships to attend the preapplication TA activities.

Are the onsite preapplication TA sessions open only to SSAs?

The SSA TA meetings are open to SSAs and anyone else designated by and/or affiliated with the SSA, such as grant writers, program staff, management staff, or administrative staff.

Can more than one person from the same State, tribe, or tribal organization attend the pre-application TA meetings?

Yes. Applicants may bring along or send as many individuals as they deem necessary to support their application efforts.

Is the signature of the Governor of the potential grantee State required on our application?

No, the signature of the Governor of the potential grantee is not required on the application submission.

Are you expecting lengthy applications?

There is a page limit for narrative sections and for some of the appendices. Please see pages 18-19 of the RFA for the page limitations. Grants.gov determines length by word limit (18,025 words for a new applicant's narrative; 20,600 words for a previously funded applicant). See page 60 of the RFA.

Are we held to a 12-point font requirement for tables, graphs, and charts?

If you're submitting the application electronically, then you are held to the 12-point Times New Roman font throughout. If you're submitting a hard copy, you are not held to that requirement for the tables and charts.

There is an announcement to use headings in your application. How many levels of headings do we need?

At a minimum, use headings for the main sections (i.e., Statement of Need, Proposed Approach to Meet Program Goals, etc.). You may want to use subheadings, just to be organized.

What is the difference between a letter of commitment and an MOU?

A letter of commitment is an organization's pledge to contribute in one way or another to the ATR initiative. A memorandum of understanding (MOU) is a much more formal form of commitment, or "contract," whereby two or more parties enter into the agreement with specified distinct roles, responsibilities, and accomplishments or targets. With an MOU, the two or more parties sign the document indicating their concurrence, thus making the document a contract verses a pledge of commitment, which is not as binding as an MOU.

Should letters of commitment be included in the application for all of the providers listed in the proposed provider directory?

If possible, the applicant should include as many letters of commitment as possible in order to demonstrate readiness to implement or expand the project.

Where is the MOU/tribal resolution supposed to be in the application?

The MOU or Tribal Resolutions should be included as Attachment 1 of your application. (See page 19 of the RFA.) Please note, that applicants may submit unsigned draft MOUs or Tribal Resolutions with the application if a signed MOU or Resolution is not available at the time of application. Upon award of the grant, the grantee would be asked to submit the signed MOU or Tribal Resolutions before the implementation deadline.

The timeline and action plan referred to in Section B of the evaluation criteria are also repeated in Section D. Does that mean that we have to enter it twice?

Section B of the evaluation criteria focuses more on the actual targets and the implementation plan. Section D focuses on the management aspects of the proposed project. Naturally, there will be some overlap between the items listed in the two sections, but the nature of these two sections is distinct. Because reviewers are only allowed to score each section based on the criteria listed in the RFA for that specific section, it will be in the best interest of the applicant to repeat information that may overlap between the two sections.

The page limit for Sections A-D for new applicants is 35 pages long. Is it more economical to use graphs and tables, and do we cite them?

Yes. Graphs, charts, and tables are a succinct way to communicate a lot of information in a clear fashion. Please include citations of your data sources.

How is cultural competence included in the application?

Cultural competence should be included in each section of your narrative and is framed as "the reduction or elimination of health disparities." Cultural competency is expected throughout the application and should be built into the processes you develop. Also, see page 17 of the RFA to reference SAMHSA's guidelines on cultural competence.

For job descriptions, do you just want the four key staff or everyone?

Please include job descriptions just for the four key staff. Also, please include the role of the SSA or Tribal Authority as they are considered a key staff as well.

Application Review Process

Who votes on the scoring for applications?

The reviewers who are chosen to sit on the review committee are the only ones who vote on the application scores.

Do program staff meet with the review triads, the small group assigned to respective applications?

No. To avoid bias, SAMHSA-CSAT program staff are not involved in the review process, aside from strictly observing the proceedings. Prior to the review process, program staff meet with the reviewers as a group during the orientation process.

Are members of the National Advisory Council required to disclose conflicts?

Yes, and they do. This policy is very strict.

Is the application scored on individual sections, or is the score based on the whole?

The application is scored on individual sections and the priority score is the sum of the means of the section scores.

Are applications compared to each other?

No. Reviewers are not allowed to compare applications to another. Each application is reviewed in relation to the evaluation criteria not in relation to other applications.

If we propose a higher number of clients, will we get a higher score?

No, the review criteria are not set up that way. Points will not be added or deducted based on the number you are proposing. Propose what you think you can do. Don't try to make a super-ambitious grant application because you will be held accountable to it. Do your budget for what you can do. If you know you don't have the capacity, we might come back and negotiate with you to correct it, but it is not scored or part of the evaluation process.

Do we get fewer points if our memorandum of understanding (MOU) is unsigned?

No, if you can submit at least a copy of the MOU—even if it's an unsigned draft—that would suffice during the application process. If you become a grantee, you need to submit your signed MOU prior to the implementation deadline.

Grantee Requirements

There are eligibility determinations for clinical treatment and recovery support, clients, new clinical treatment, and recovery support service providers. Are these eligibility requirements considered elements of the program that may change over time in response to changing program needs?

As with all funded grant programs, SAMHSA expects awarded grantees to fulfill the elements of the proposal that was approved and funded. However, if issues arise during the period of performance that may require changes to eligibility determinations in order to keep the project viable, SAMHSA will work flexibly with you in order to continue accomplishing the goals and objectives of the program and keep your project viable and relevant for the people who need the services.

In section 2.2, "Performance Assessment," of the RFA, it notes that grantees will be required to report on the progress achieved, barriers, etc., and that this

performance assessment report will be submitted at least annually. Does the SSA designate the responsible team member to complete this task, or can it be done by a team? Is a report template provided?

All reports submitted to SAMHSA-CSAT must come from the SSA. A team may complete the report, but the report must be reviewed and submitted by the SSA. SAMHSA-CSAT will provide the reporting templates for monthly, quarterly, or annual reports.

Current grantees are required to demonstrate in their applications that they will expand their ATR activities with this next grant cycle. What constitutes an expansion?

An expansion is when the jurisdiction adds to its existing project a new target population (e.g., adolescents or veterans), a new geographic region (e.g., a city, district, county, or region), and/or new services that address critical gaps.

How is "in kind" level of effort going to be documented?

Descriptions of in-kind efforts must be provided in the application. Additionally, each year the grantee must complete a continuation application, which requires the documentation of in-kind level of effort. In-kind effort will be documented through monthly or quarterly reports submitted to the project officers as well as during annual ATR grantee meetings.

Are we going to be expected to participate in cross-site evaluations?

No. If cross-site evaluations are going to occur, you will get as much advanced notice as possible. It's unnecessary to budget for it at this time.

Suppose supplies and travel are related to the specific voucher training. Should that expense be listed under supplies and travel or some other category?

If they are supplies, put them in the supply category. They can be identified in that category as "supplies and training."

Previously Funded Grantees

If you’re a previously funded applicant, but you skipped a cohort, what’s the timeframe for implementation?

The timeframe for implementation is 3 months after the award date, per the RFA.

Will a previous ATR grantee's application be more likely to be approved for funding if they can name the VMS contractor that they have selected?

No. The RFA states that the applicant must be able to demonstrate that the VMS will be implemented by the stated deadline and must include the components and capabilities listed in the RFA. These items are a measure of readiness. An applicant will not be more likely to be approved if they can name the contractor.

The RFA states that the VMS component must be in place and functioning within 3 months of the award. Will not having a VMS contractor in place at the time that the application is submitted be a primary reason for not receiving an award?

No. The RFA does not mandate that the contractor must be in place at the time of the application. The RFA states that the applicant must be fully implemented by 3 months after the award date. Please see page 29 of the RFA for the components which comprise SAMHSA’s definition of implementation.

What level of accountability needs to be implemented to ensure that ATR II funding and ATR III funding do not overlap?

If an ATR II grantee is awarded the ATR III grant, the two funding streams and projects must be considered two separate programs. This means that the grantee must ensure that supplantation does not occur, that two sets of reports are submitted to SAMHSA, and the dollars should not be mingled. This will require vigilant oversight and may also require two project directors since the mandatory level of effort for project directors is at least 75%.

Is it true the award for previously funded grantees will be solely based on the average expenditure per clients served in ATR II?

This is not true. Previously funded ATR grantees' awards will be based on the scored evaluation criteria listed in sections A through E of the RFA (pages 23-33) and Attachments 1-6.

What is meant by the term "expansion?" Does it mean choose one of the following: territory, population, or service array? Or, does it mean to choose two of the categories?

Expansion is defined as one or more of the above. However, given the emphasis on expansion and enhancement for previously funded ATR grantees, these applicants are encouraged to expand their projects through more than just one method.

The RFA indicates that for current grantees, their past ATR performance will be evaluated in their application based on program data. What reporting period will SAMHSA review for past performance?

For current ATR grantees, SAMHSA will review performance data from Years 1 and 2 of ATR II. For previously-funded ATR grantees that received a grant in the first cohort and not the second cohort, all 3 years of performance will be evaluated.

The RFA indicates that current grantees who are applying for ATR III will receive their performance data, which will be reviewed with their application. When will current grantees receive their data from SAMHSA?

They will receive their data no later than January 19, 2010.

According to the RFA, any grantee that meets the necessary criteria when CSAT conducts data reviews at the end of Year 2 and Year 3 may receive a supplemental award of up to 5 percent of the yearly requested amount. Those grantees that meet the necessary criteria for Years 1 and 2 at the end of Year 2 will receive the supplemental award in Year 3 of the grant. Those grantees who meet the necessary criteria for Year 1 through Year 3 will receive the supplemental award in Year 4 of the grant. Grantees who meet the necessary criteria may be eligible to receive supplemental awards in both Year 3 and Year 4. If a grantee falls short on Year 1's client numbers and expenditures, is there any way to get an incentive award in Year 3 or 4?

Yes, they may be eligible to receive an incentive award if the grantee falls short in Year 1 but makes up for the difference in clients served and the GPRA follow-up rate and achieves the targets (125% of client target and 80% GPRA follow-up rate) by the end of Year 2.

Project Implementation

Do I have to have my voucher management system implemented by March 10?

No. By March 10, you need to have your plan for implementing it. If you're a new grantee, you have four months after receiving the award to implement your project. If you're a previously funded grantee, you have three months.

The award date could be anywhere between July and September. Is implementation expected 3 months from then?

If you are a new grantee, yes. The implementation period begins on the date of your award.

If we were a member of the ATR I Cohort, skipped the second Cohort, and want to resume serving the same population in Cohort 3 that we targeted in Cohort I, can we?

From the program perspective, you'll be asked why you are going after the same population—why you are doing it again, and what you are going to do differently.

For our implementation, do we include Year 1?

You should include all 4 years, including the steps to shut down. Think about the end at the beginning. Use the ATR Implementation Toolkit as a map for implementing your program. The toolkit walks readers through the three phases of managing an ATR grant: startup, full operations, and closing out the grant.

Single State Authority and Staffing

Who qualifies as a Single State Authority?

The Single State Authority is the head of that component of State Government designated by the Governor as responsible for the planning and development of the substance use disorder treatment system.

You stated that the SSA refers to "single substance abuse authority." My understanding is that it actually refers to "single State authority" and that ATR may be implemented by different branches of the State. Am I correct?

There are many administrative models for implementing the grant, and SAMHSA encourages the SSA to partner with various units, departments, or entities in order to implement the grant. However, the SSA will always be considered the grantee and is ultimately held accountable by SAMHSA for the performance of the grant.

Is it correct that we need a centralized staff with just four key staff members?

Yes, we hold five key staff members accountable (including the SSA), but—of course—if you are proposing a program in a wide catchment area, you may need many more than 5 staff. SAMHSA considers the core, centralized staff to be the five key staff positions listed in the RFA.

Is it possible to divide the percentage of time required for the project director among two individuals? Or, must the minimum 75 percent be dedicated to one staff member?

In the past, SAMHSA has permitted more than one person to be the project director but this situation is not ideal for accountability purposes. If there is a compelling justification for having this arrangement, SAMHSA encouraged the applicant/grantee to designate one of the persons as the lead project director with a higher level of effort than the second person.

Can one person serve as 50 percent of the time as IT coordinator and 50 percent of the time as fiscal coordinator?

Yes, this would be acceptable. The person would need to have the credentials and qualifications to do both jobs and would need to be approved by SAMHSA.

If you have a Web-based system, it basically supplants the need for an IT person. How low of a percentage is acceptable?

The only requirement we have for staffing level of effort is for the SSA/highest tribal official and the project director. There is no required level of effort for the other three positions, including the IT person. We defer to the applicant to determine the level of effort that is appropriate for your project. A low percentage may be acceptable as long as you can demonstrate that you manage your program effectively with that arrangement.

The RFA states that the SSA official must commit to—at a minimum—a 10 percent level of effort, but another source says 5 percent. What is the minimum required?

The minimum is 5 percent. The RFA states that the Level of Effort for the SSA should be between 5-10%.

Can the SSA delegate authority on the grant to another entity?

No. The SSA may partner with other entities to help manage and implement the project, but the ultimate authority on the grant rests with the SSA, and the SSA is accountable for the program.

Will the SSA be expected to attend or be invited to the grantee meetings?

The SSA is expected to be there, but is not required. We want the SSAs at the table. Based on lessons learned we have found that those grantees who do not have SSA involvement often struggle with the system's changes and performance targets expected throughout the grant.

Will five key staff members be budgeted for attendance at the grantee meetings?

Five key staff members, including the SSA, should be budgeted. The four key staff is mandatory. Note that there is typically one grantee meeting, which includes all grantees, each year.

What can and can not be contracted out (e.g., assessments, providers, vouchers, voucher management system, screening)?

You can not establish contracts with entities for assessments or service delivery. The administration of the VMS can be contracted out. In some cases, screening requires administrative costs (i.e., Web site or call-in line). If this is the case, then you can count such activities as administrative costs which may or may not require a contract. If you have clinical staff conducting in-depth, thorough screenings in person, then this is considered a service and can not be contracted.

Tribes, Tribal Leaders and Tribal Organizations

Is there a place on the application where the reviewers check whether they are a tribal organization?

Yes, the application will have that information. It's already clear to us when we get them, but there is an ID section where you can put it. If you are concerned, put that as the first line in your application. There is a sample MOU in the back of the RFA that you can use as reference.

The RFA states that the SSAs, tribes, and tribal organizations should propose innovative strategies for their ATR projects to accomplish specific program objectives, including "Provide all substance abuse assessment, clinical treatment, and recovery support services funded through the ATR grant." Can these funds be used for only recovery services if treatment is made available through another funding source, such as a block grant?

SAMHSA has stated in the RFA that it is seeking to fund applicants who propose a combination of both clinical treatment and recovery support services. In order to score competitively, applicants are encouraged to propose both clinical and recovery support services. Please note that SAMHSA defers to the applicant in terms of what percentage or ration of each type of services is proposed and also defers to the applicant in terms of whether clients may receive recovery support services independent from clinical treatment.

The RFA states that federally recognized tribes, tribal leaders, and tribal organizations are eligible to apply for ATR. For the purposes of applying for the ATR grant opportunity, what is the definition of a tribal organization?

A tribal organization is a recognized governing body of any Indian tribe, any legally established organization of Indians that is controlled, sanctioned, or chartered by such a governing body or that is democratically elected by the adult members of the Indian community to be served by such an organization, and that includes the maximum participation of Indians in all phases of its activities (PL 93-638 as amended, 25 U.S.C. 450 b).

We have nine tribes in Oregon. If other States apply to take care of these tribes, how do we add that to our application?

It is permissible to list the same population in multiple applications. However, please work with the tribes in order to establish an arrangement and garner permission for the proposal. If, ultimately, the same population is targeted by more than one grant, then you will need to demonstrate to SAMHSA that you are not duplicating efforts.

Who is the high official and who is in charge? Is it correct that the high official is the chief, but the person in charge is the executive director?

Based on discussion and analysis, SAMHSA has concluded that the tribal equivalent to an SSA would be the executive director. SAMHSA would accept the signature and ultimately sign-off on the application to come from the executive director.

Typically, we have a number of partners but our primary partners are the 12 tribes of Michigan. The way we've worked with them in the past, they have a resolution and the vote on it, and we put that in our application. Would we be well-served to do an MOU? Reviewers may not know that a resolution is better than an MOU in Native cultures.

Both the MOU and the Tribal Resolution will have the same weight. This will be communicated and re-emphasized with the review committee prior to the reviews and scoring of the applications.

ATR III Vouchers

Can ATR III vouchers cover a client's co-pays?

Yes.

Can an ATR III client's GPRA survey be considered a service for which a voucher can be issued?

No, it is not considered a service and therefore can not be vouchered. However, you may want to bundle the GPRA survey with other services, such as care coordination or recovery check-ups, in an effort to maintain a high level of client engagement and determination of the client's need for more or less services at the time of the GPRA interview.

Do we need a written statement from the client in order to transfer a voucher from one provider to another?

SAMHSA does not require written documentation of these types of transfers. However, for management and accountability purposes, the grantee may chose to have such paperwork.

Of all vouchers issued, is there a certain percentage of vouchers that must be redeemed in order to comply with ATR III?

SAMHSA does not have a target ratio of vouchers issued compared to vouchers redeemed. However, based on lessons learned from the past two cohorts, successful grantees tend to have a very small gap between the amount of dollars issued and the amount of dollars redeemed, and there are a number of ways to ensure a small gap. Please reference the ATR Implementation Toolkit or call Roula K. Sweis, ATR Team Leader, at 240-276-1574 for additional information.

Are individuals who are going to a substance use disorder facility for treatment (either outpatient or inpatient) eligible to receive an ATR voucher to help pay for the cost of their respective treatments?

Individuals who already have a source of funding for their treatment may not be eligible for ATR funds to cover such services. This is because of SAMHSA's requirement that supplantation not occur. However, if a person in treatment needs additional services or additional treatment for which there is no other source of funding, you may use ATR to pay for them. They may also receive ATR recovery support services while in treatment, again, if there is no other source of funding to pay for them.

If an individual is eligible for an ATR voucher, how does the individual apply for one?

There are many types of programmatic models for issuing vouchers, but—at the core— the steps are same. 1) The client is assessed; 2) the needed services and/or level of care are determined; 3) the findings from the assessment feed into the development of a voucher; 4) the voucher is issued to the client; 5) the client is presented with a list of choices from which to receive services; 6) the client makes the choice; 7) the appointment is set up; and 8) the client ideally shows up for the services. Most important throughout this entire process are the intake staff, the assessment staff, and the care coordinators who communicate to the client how ATR works and what steps need to occur before they receive their voucher.

Does a voucher allow the individual to select the treatment facility/provider of his or her choice, or are only certain providers allowed to receive payment from the ATR voucher?

The ATR project must ensure a genuine choice of providers for each service that the client is determined to need. The grantee is required to establish a network of providers that become the ATR network. The client must choose from within the ATR network. However, if the grantee builds a flexible system, they may allow open enrollment of providers throughout the duration of the grant, thus allowing new providers to join the network in response to client's requests.

Can an organization contracted to screen clients and issue and track vouchers also be reimbursed with vouchers for treatment services provided?

First, the ATR grant does not allow grantees to establish monetary contract with screeners and voucher issuers. However, if you are proposing to have your intake entities also deliver other services, this is permissible. However, you must demonstrate that the client received a genuine choice of providers from which he/she can receive services. This can be done by asking the client to sign a form indicating that they have received a choice of providers. Also, as the management entity, the grantee will be expected to monitor this potential conflict of interest and to respond with corrective action if the entity is found to continually refer clients to itself.

Is contact information available for vendors who designed successful voucher management systems for ATR I and ATR II States?

Yes. On SAMHSA's ATR Web site, we have descriptions of all of the current ATR grantees at http://atr.samhsa.gov. Also, below, you may click on the various links to be routed to the Web sites of the current ATR II grantees:

Missouri: http://www.dmh.mo.gov/ada/ATR/ATRII.htm
Hawaii: http://hawaii.gov/health/substance-abuse/ATR/index.html
Washington: http://www.dshs.wa.gov/dasa/default.shtml
Oklahoma: http://www.odmhsas.org/ATR.htm
Wisconsin: http://www.county.milwaukee.gov/SAILAODA8063.htm
Alaska:
http://www.southcentralfoundation.com/index.ak?CFID=598051&CFTOKEN=47681667
Arizona: http://gocyf.az.gov/SAP/GRT_AR.asp
California: http://www.californiacares4youth.com/
California Rural Indian Health Board: http://www.crihb.org/aair/
Cherokee Nation, Oklahoma: http://atr.cherokee.org/Home/tabid/583/Default.aspx
Connecticut: http://www.ct.gov/dmhas/cwp/view.asp?a=2901&q=335020
Colorado: http://www.atrcolorado.org/Home/welcome.aspx
Iowa: http://www.idph.state.ia.us/atr/
Louisiana: http://www.dhh.louisiana.gov/offices/?ID=154
Montana-Wyoming Rocky Mountain Tribal Leaders Council: http://www.tribalrecovery.com/
New Mexico:
http://www.atrnm.com/content.asp?CustComKey=158663&CategoryKey=450854&pn=Page&DomName=atrnm.com
Rhode Island: http://www.mhrh.ri.gov/SA/accessRecovery.php
Tennessee: http://state.tn.us/mental/A&D/ATR_main.html
Ohio: http://www.odadas.ohio.gov/public/ContentPage.aspx?ContentID=0678c221-d103-4258-8b38-1031467fa8d5
Texas: http://www.dshs.state.tx.us/sa/atr.shtm

Client Assessments

Does the term assessment in the application mean a biopsychosocial assessment or a screening?

Think of the logical process flow: Figure out what your client needs and how to get that through the voucher. The screening comes first (i.e., is this person eligible?). You set up your eligibility criteria, and the person fits in that criteria. The next step is to do the full assessment. In a number of jurisdictions, they do several assessments. That's the stage when you're figuring out what the individual needs. Then, once that's figured out, the voucher is developed and issued. Screenings determines eligibility. Assessments involve the biopsychosocial aspect. See page 72 of the RFA for the definitions of terms.

Is each State required to fund assessments (not screenings)?

Each State is not required to use ATR funds for assessments if another source of funding for assessments is already in place.

Are all clients required to receive a clinical assessment when participating in ATR III?

All ATR clients are expected to receive a full assessment, which includes clinical treatment and recovery support services.

Do we need a clinical assessment if we are doing a recovery assessment?

This depends on how the program is set up. If it's set up to offer recovery support services only, then your assessment would reflect that. If a client has had a clinical assessment already, then you just need a copy of that assessment. SAMHSA encourages you to avoid putting clients through multiple assessments. However, if only conducting a recovery assessment, it is imperative that you somehow still gauge the need for clinical treatment, just in case the client is in need of acute care.

If the assessment shows only clinical services are needed, is choice required?

Yes.

Are we required to ensure genuine choice among entities in the provision of initial assessments? Or are we required to ensure choice only after the assessment has been done?

If you are using ATR funds for the assessment, than you must ensure a choice of assessors. If you are using funds other than ATR's to conduct the assessment, than choice is not required.

Can a client receive a lower level of care than the assessment indicates is needed, as in the case when the assessment indicates that residential care is needed, but the client wants only recovery support services?

This is a decision that needs to be made among the client, the clinician, and the treatment director on the grant. From a therapeutic standpoint, it is more important to ensure that the client is engaged somehow (through recovery support services) verses losing the client completely because they were not ready for a residential option. In many cases like these, SAMHSA has found that the recovery support services can serve as a precursor to more intensive treatment if the client is not immediately ready for the intensive treatment at the time of the assessment. Flexibility in the vouchering process, ensuring multiple pathways to recovery, and establishing a partnership among the client, the clinician, and the treatment director will be keys to making these judgments.

I understand that you cannot contract out assessment. But can you use a single source of voucherable assessment so that agencies cannot self-refer? Or, are you implying that this must be done in house?

Grantees that offer voucher assessments must ensure that the client receives a choice from where to receive the assessment. It is permissible to restrict your assessment entities to deliver only assessments in order to avoid a conflict of interest.

In our project, clients choose the central intake site where they want their comprehensive screening and assessment to take place. The assessment is not vouchered but provided as an in-kind service by four providers under contract. Is this arrangement acceptable?

Yes.

Do you need to be able to provide the full range of things that an individual is assessed as needing?

Sometimes, an assessment is so thorough that you may not have all the resources or services to address all the needs exhibited. SAMHSA encourages applicants/grantees to use ATR as well as other sources of funding to address those needs. However, in the past, we have seen large gaps between dollars obligated in vouchers compared to dollars redeemed through vouchers. Therefore, it may be wise for you to establish a system that prioritizes services on the vouchers starting with immediate or short-term needs. Then, through care coordination and regular

communication with the client, you may update the voucher to offer services that the client needs, based on where they are in the terms of progressing through their treatment/recovery plan. This is both good for the client and reflects good financial management practices.

Is there anything about assessment tools that is done remotely rather than face-to-face?

Yes, there are some assessment tools that can be done remotely rather than face-to-face. Please refer to the Appendix J in the RFA and also please note that applicants/grantees are not limited to the assessment tools listed in the RFA.

There aren't any recovery support services assessment tools in the appendix. What should we use?

You can use the comprehensive assessments in the appendix, or you can use an ASAM tool, electronic software that operates like an assessment tool. Please contact Roula K. Sweis, ATR Team Leader, at 240-276-1574 for a copy of the RSS assessment tool that was developed in partnership between SAMHSA and ASAM.

Idaho uses the GAIN assessment for all clients. Can we use the GAIN with the added GPRA questions to collect the GPRA data?

You may use the GAIN tool and the GPRA tool, but it is prohibited to modify the GPRA data collection tool. The GPRA data must be collected in the manner and order presented in the tool.

Care Coordination

Are the care coordinators being paid for in vouchers?

Yes.

Is each client required to have a care coordinator?

Yes. Clients have a choice among care coordinators (i.e., recovery coaches). To participate in ATR, however, it is required that they have one.

What is the difference between the "care coordinator" position, described in the ATR application, and a role of a "peer recovery specialist?" Can they be combined into the same position?

A peer recovery specialist may require a different set of skills than care coordination, so it may be challenging to expect the same people to conduct both functions. The care coordinator's role is to support the client through navigating the ATR service system (i.e., modifying the voucher when necessary, engaging the client when appointments are missed, etc.)

Are there standards/caseloads for care coordinators?

SAMHSA defers to the grantees to determine standards and caseloads for care coordinators.

Care coordination is a vouchered service, but we want it to be part of the administrative infrastructure. Since the care coordinator is so important, could we make it a requirement for them to be held accountable in an administrative way?

You may not reimburse care coordination through administrative funds; however, you may enter into signed agreements with care coordination providers and hold them accountable to those agreements. The grantee should hold all providers accountable to their agreements. You may make a special agreement for care coordinators that clearly lay out the expectations you have of them and also details consequences if those expectations are not honored according to the agreement. Because the service is vouchered, this may give care coordinators an added incentive for quality improvement and drive competition to better serve clients in a healthy way.

Other Client Services

What will this grant provide services or vouchers for? Will it include, for example, sober living or transitional housing?

Yes, this grant can pay for sober living and transitional housing. See Appendix I for a full list of service options that may be reimbursed through vouchers.

Can ATR be used for people who screen positive for substance use but are not yet addicted?

Yes.

Do clients have to receive clinical treatment before they can access tangible recovery support services, such as gasoline, food, or bus passes?

SAMHSA does not have a policy for this scenario and defers to the grantee to determine exactly how clients access services and resources. However, because the grantee is expected to conduct vigilant monitoring and prevention of fraud, waste, and abuse, it is in the best interest of the grantee to establish a treatment or recovery plan with the essential monitoring mechanisms to (1) ensure fidelity to the ATR mission—to serve individuals with substance use issues and (2) ensure that fraud or abuse does not occur.

What options do we have for documenting a client's choice of a different provider other than their first choice?

You may use your electronic voucher management system to document these types of changes, or you may include a form or paperwork that can become part of the client's case file.

In some geographical locations, recovery support services are provided primarily through one recovery center. While there is a "choice" of services, there may be only one provider. Is the expectation that other recovery support service providers would be recruited? What if this is not feasible?

It is the expectation that a client receive a choice of at least two providers per service that they need. If you are unable to provider at least two genuine choices, then you are discouraged to target that region.

Can any treatment provider partner with an approved ATR grantee?

This decision is for the grantee to decide. SAMHSA defers to the grantee to decide who is eligible to enroll in the provider network.

Does there need to be a faith-based option for every choice of service? What if there is no existing faith-based transportation provider, for example?

You may not be able to find faith-based options all the time. The client should be able to choose among two or more providers, at least one of which the client has no religious objection. The key is to try to avoid only having two faith-based options or only two secular options for each service. Clients must have enough options, including faith-based and secular, to be able to make an informed choice.

What is the best way to provider service choices for rural and frontier communities?

SAMHSA encourages you to focus on areas in which you can provide two genuine choices. If there are two choices, one close by and one 200 miles away, that's not a genuine choice. There must be at least two genuine choices. You can also focus on infrastructure so that you can build infrastructure using another source of funding. And—once the choices are available—then expand to serve a rural or frontier area. Another option is to provide mobile services, if possible, with the service providers traveling to the clients verses asking the clients to travel to the providers.

Can clients refuse to do GPRA and still get services?

Yes.

One of the biggest problems we have is time for treatment. If we build a system that says we'll get you a referral within 2-3 weeks—rather than waiting months—is that supplantation? Without ATR, it'd be 3-6 months. What we want to do is tell a client that, as part of ATR, you will meet this performance requirement, and you can get in within 2-3 weeks.

SAMHSA encourages you to serve clients that may be on a long waiting list but if you do this, please modify your agreement or paperwork with the provider to ensure that supplantation is clearly not occurring. SAMHSA encourages you to eliminate wait lists, if at all possible.

We're not supposed to supplant services, but if we have a recovery support provider, can we enroll that center as a provider in our network?

You can enroll that center in your network, but you must ensure that you are not using ATR to pay for the same services or amount of services being funded by another source of funding. You can also add services to that recovery center and fund the additional services through ATR.

How do you deal with a spiritual group that's not a formal organization?

That determination to enroll the group as a provider and the determination of standards for the group is done by the grantee. For example, in a ceremonial dance, the leader of the dance may be the "service provider," who is enrolled in the network.

Is the essence of this to give people options for spiritual and cultural bases?

Yes. Through ATR, SAMHSA is seeking to promote additional choices and strengthen the operationalization that there are many pathways to recovery.

For urban communities, it takes a while for travel. Does travel to and from services count?

Yes, they "count" with respect to a grantee's ability to use ATR to reimburse or pay for transportation to and from services.

Is it acceptable to offer services in some areas and not others?

It's acceptable to offer services in some areas and not others. You should target areas where there is a justifiable need, readiness to implement/expand, and the ability to offer genuine choices of providers for each service.

If someone comes in with a substance use disorder, and we refer them to a provider, how do we know what they're doing with that provider? How do we track them?

Firstly, the client must choose the provider from which they will receive services. There should be no direct referrals occurring in the project. Secondly, after the client is assessed, a voucher for their services should be issued that will be tracked through the voucher management system. Each client receives one unique client number in the voucher management system. Through the tracking of the vouchers, you will be able to track where the client is and what services they are receiving. Secondly, care coordination is a mandatory element of care for each client. Clients should receive a choice of care coordinators upon entry into the service system. This care coordinator will also track the progress of the client in relation to the treatment or recovery plan that is established for the client.

The RFA indicates that returning veterans and their families should be considered for inclusion in a project. Does this refer to just those veterans who are returning or have returned from duty in Iraq and Afghanistan or all veterans who have been deployed overseas?

The priority is on returning veterans coming back from Iraq and Afghanistan and their families. However, the RFA is flexible enough for you propose to serve any veterans based on your local needs.