NJ Department of Human Services (DHS)
Division of Mental Health and Addiction Services (DMHAS)
Integrated Care Program
Request for Proposals (RFP)
Questions and Answers
June 23, 2026

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1.	Can you please clarify whether a CCBHC is considered a FQHC Look-Alike?	No, a Certified Community Behavioral Health Clinic (CCBHC) is not considered a FQHC Look-Alike. Please refer to RFP Section III Who Can Apply.	III. Who Can Apply?	5
2.	If an OTP is applying for funding, do we have to apply to become a FQHC Look-Alike with HRSA? A major barrier to becoming a FQHC Look-Alike is the required Governance Structure as outlined below. This could be a major hurdle for small non-profit organizations or larger organization with a corporate structure. 🏛️ Required Governance Structure (FQHC Look-Alike) 1. Board Size: 9–25 Members • Must have at least 9 and no more than 25 directors • Designed to ensure: o Enough diversity of expertise o Not so large that oversight becomes ineffective	Only FQHCs and FQHC Look-Alikes are eligible to apply for this funding.	I. Purpose and Intent III. Who Can Apply?	3 5

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	👉 Common pitfall:
	Boards that are too small (e.g., 5–7 members) → automatic non-compliance
	
	2. Patient-Majority Board (≥51%)
	• At least 51% of board members must be active patients
	• These patients must:
	  ○ Receive care from the organization
	  ○ Represent the population served
	This is the defining feature of FQHC governance.
	👉 Why it matters:
	• Ensures the organization is community-controlled
	• Prevents dominance by health systems, physicians, or investors
	👉 Common pitfalls:
	• "Token" patient members who are not truly engaged
	• Employees or affiliates counted as "patients" (often disallowed)
	• Patients not reflective of payer mix (e.g., mostly			

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	insured vs. Medicaid/uninsured)
	
	3. Board Reflects the Population Served
	• The board (especially patient members) must mirror key demographics, such as:
	  ○ Income levels
	  ○ Insurance status (Medicaid/uninsured)
	  ○ Race/ethnicity
	  ○ Language
	  ○ Special populations (e.g., homeless, elderly, migrant)
	👉 HRSA will compare:
	• Your patient profile data
	• Against your board composition
	If they don't align → finding during site visit
	
	4. Independent Governing Authority
	The board must have real legal authority, including:
	• Hiring/firing/evaluating the CEO
	• Approving:			

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	○ Budget ○ Strategic plan ○ Service scope • Oversight of: ○ Quality ○ Compliance ○ Financial performance 👉 Critical nuance (often missed): • The board cannot be controlled by a parent organization or hospital • Majority of decision-making must remain with the health center board Recent HRSA guidance even scrutinizes independence more aggressively [feldesman.com] 5. Limits on Conflicts of Interest • No more than 50% of non-patient board members can earn significant income from healthcare • Prevents: ○ Hospital dominance ○ Vendor influence ○ Financial conflicts			

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	⚠️ Why This Is So Scrutinized
	
	HRSA views governance as the "control point" for the entire model:
	• If the board is not compliant:
	  ○ The organization is not considered community-based
	  ○ Even strong clinical operations won't save the application
	
	During the Operational Site Visit (OSV), HRSA will:
	• Interview board members directly
	• Test if they understand:
	  ○ Finances
	  ○ Quality metrics
	  ○ Their authority
	
	✅ What "Good" Looks Like (Best Practice)
	
	A strong Look-Alike board:
	• ✔ 11–15 members (optimal size)
	• ✔ 6–8 are active patients
	• ✔ Patients reflect Medicaid/uninsured mix			

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	• ✔ Diverse skills among non-patients (finance, legal, community leaders) • ✔ Meets regularly with documented decisions • ✔ Demonstrates real oversight—not rubber-stamping			
3.	Prime applicant eligibility: New Brunswick Counseling Center (NBCC) is a New Jersey nonprofit licensed Opioid Treatment Program (OTP) and provides OTP/MOUD, SUD treatment, mental health treatment, case management, care coordination, and behavioral health screening/assessment. Please confirm whether the prime bidder itself must be a Federally Qualified Health Center (FQHC) or FQHC Look-Alike, or whether a licensed OTP/SUD/MH provider may apply as the prime applicant with an FQHC or FQHC Look-Alike as a formal partner.	The bidder must be an FQHC or FQHC Look-Alike. Please refer to RFP Section III Who Can Apply.	I. Purpose and Intent III. Who Can Apply?	3 5
4.	Partner/subrecipient role: If the prime bidder must be an FQHC or FQHC Look-Alike, may NBCC participate as a subcontractor/subrecipient or formal partner providing the OTP commitment, methadone coordination, SUD/MH treatment, MOUD care coordination, behavioral health clinician services, navigation, peer support, and related data/reporting support?	FQHC or FQHC Look-Alike must provide and/or dispense addiction medications, including but not limited to, oral and injectable buprenorphine, or oral and injectable naltrexone, and	I. Purpose and Intent III. Who Can Apply? IV. Contract Scope of Work	3 5 6-11

Q	Bidder Question	DMHAS Answer	RFP Section	Pg. #
		naloxone. Methadone can be coordinated through an OTP. FQHC or FQHC Look-Alike must provide medications, the behavioral health screening and assessment, care coordination, and brief intervention. The FQHC or FQHC Look-Alike must hire and maintain the services of staff responsible for data collection and submit all data reporting as required by DMHAS and SAMHSA.		
5.	FQHC/Look-Alike documentation: What documentation should be attached to demonstrate that the prime bidder is an FQHC or FQHC Look-Alike from the New Jersey Department of Health? Is HRSA Look-Alike designation documentation sufficient, or is a specific NJ DOH document required?	Please refer to RFP Section III Who Can Apply. As per Section VII. of the RFP, the Bidder's proposal will include a description of the Bidder's current New Jersey Department of Health license, and designation as an FQHC or FQHC look-alike. The Bidder's DOH license and Bidder's HRSA	III. Who Can Apply VII. Required Proposal Content/Bidder's Organization, History and Experience (10 points) XI. Post Award Required Documentation	5 13 24

Q	Bidder Question	DMHAS Answer	RFP Section	Pg. #
		designation will be required post award.		
6.	Licensed OTP commitment: is the OTP license sufficient, or should the bidder still submit a separate OTP commitment letter? If the FQHC prime partners with NBCC as a licensed OTP, what specific elements should the OTP commitment letter include?	Please see response to Question #4.		
7.	340B enrollment: The RFP states the successful bidder(s) must be enrolled in the 340B Drug Pricing Program. Must 340B enrollment be held by the prime FQHC/FQHC Look-Alike, or can the requirement be satisfied through an affiliated/partner entity? What form of 340B attestation or documentation is acceptable?	The eligible applicant must be an FQHC or FQHC Look-Alike. As per Section VII. of the RFP, the Bidder's proposal will include an attestation that they are enrolled in a 340B drug pricing program.	III. Who Can Apply IV. Contract Scope of Work VII. Required Proposal Content/Project Description	5 6-11 14
8.	One proposal vs. each location: May one legal entity submit one proposal covering multiple program locations/counties, or must each physical site/location be submitted as a separate proposal? Is there a maximum of one application or one award per agency? If separate site applications are allowed, may the same licensed OTP/SUD/MH provider serve as the OTP partner on more than one FQHC-prime application?	Each eligible site must submit an application. There is no maximum number of awards by agency. An OTP can provide services to more than one site of an FQHC. Please see response to Question #4.		
9.	Program location and co-location: The Facilities section states that the program location must include a site	Please see response to Question #4.		

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	where FQHC/Look-Alike services are also delivered. May behavioral health/OTP services be provided at NBCC licensed OTP/SUD/MH sites through warm handoffs and coordinated care while FQHC primary care is delivered at the FQHC site, or must all ICP services be delivered at the same physical location?			
10.	FQHC services at NBCC site: If FQHC staff provide primary care services on scheduled days at an NBCC OTP/SUD/MH site, may that arrangement satisfy the requirement that the ICP include a site where FQHC/Look-Alike services are delivered, assuming the arrangement complies with licensing, scope, documentation, and billing requirements?	All services must be delivered at an FQHC or FQHC Look-Alike designated site. If there is an affiliation between an FQHC or FQHC Look-Alike and an OTP to provide methadone the methadone may be administered at the OTP site.	III. Who Can Apply IV. Contract Scope of Work	5 6-11
11.	Does the FQHC have to provide Medications for Opioid Use Disorder and Medications for Alcohol Use Disorder directly or can in be through a collaborative partner using the co-location model? (pg. 5)	Please response to Question #4.		
12.	Can the OTP requirement be satisfied through a formal partnership with an independent OTP while the FQHC separately partners with a behavioral health provider for specialty SUD services? (pg.6)	Please see response to Question #4. FQHC and FQHC Look-Alike should detail how the behavioral health staff will be	IV. Contract Scope of Work VII. Required Proposal Content/Staffing	6-11 16

Q	Bidder Question	DMHAS Answer	RFP Section	Pg. #
		incorporated into current FQHC staffing. FQHC or FQHC Look-Alike should detail how the behavioral health services will be incorporated into the FQHC or FQHC Look-Alike work flow.		
13.	If we already have a BH program on-site but not specializing in SUD services, can we still apply? (pg. 3)	Yes.	IV. Contract Scope of Work	6-11
14.	What does it mean to deliver behavioral and physical health "collaboratively?" (pg. 7)	Bidder will define in their proposal how their agency will provide collaborative BH and PC services.	IV. Contract Scope of Work	7
15.	If specialty behavioral health services are provided by a collaborative partner via telehealth facilitated at our FQHC location (when appropriate), does their site need to be listed as a location where the ICP is held?	Please see response to Question #4. Telehealth services will be considered in the Bidder's proposal. Telehealth services must be consistent with state and federal law as applicable. The proposal should include details about how BH services will be delivered and specify the role of telehealth in the services provided.	IV. Contract Scope of Work	6-11

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16.	Budget range and award size: DMHAS anticipates several awards from a combined annual pool of $900,000. Is there an expected or recommended annual award range per provider or per site? Are one-time start-up costs included in the same annual request, and should applicants prioritize one-time costs only where essential to structural capacity?	No recommended award size. Budgets should accurately reflect the scope of responsibilities in order to accomplish the goals of this project. Start-up funding is not available. The contract negotiation meeting can be used to determine specific funding questions. Please see P4.10 of the Department of Human Services Contract Policy and Information Manual for the procedures and policies that govern the need/justification for, and authorization of, an Initial Advance Payment (that is, a payment made during a Contract term, but before expenses are incurred or services are provided).	I. Purpose and Intent VII. Required Proposal Content	3 17-19
17.	Allowable non-billable services: Because the RFP identifies this funding as payer of last resort and prohibits supplanting, please confirm whether funds may support non-	Yes. These funds can be used to fund services for the uninsured and for services that are not	IV. Contract Scope of Work/Other	6-11

Q	Bidder Question	DMHAS Answer	RFP Section	Pg. #
	billable or otherwise unreimbursed activities such as behavioral health clinician time for brief intervention, patient navigation, peer navigation, care coordination, warm handoffs, outreach for missed appointments, SUPRT/GPRA data collection, quality improvement, and linkage to specialty care.	billable through other sources.		
18	Medical supplies and infectious disease activities: May funds support HCV point-of-care testing workflows, wound care/SSTI supplies related to injection drug use and xylazine, naloxone distribution support, nicotine replacement therapy linkage, transportation or childcare assistance for access, and SAMHSA-authorized follow-up incentives where these costs are not otherwise reimbursable?	Please refer to the RFP for full disclosure of the funding source. This initiative is funded by SAMHSA SOR and is subject to SAMHSA's Dear Colleague letter.[1] The applicable contract scope of work shall be limited to allowable services and supplies in accordance with RFP and shall not include the provision of safer use supplies. Please see two attestations attached to this Q&A. (1) Allowable and Unallowable "HARM REDUCTION"	I. Purpose and Intent IV. Contract Scope of Work VII. Required Proposal Content/Budget	3 6-8 17-19

[1] April 24, 2026 (updated guidance)
April 24, 2026 (OUD medications - length of time for treatment)
May 4, 2026 (non-pharmaceutical interventions & deprescribing)

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		Services and Supplies Attestation; (2) (2) MOUD Attestation The successful Bidder(s) will be required to sign both attestations post award. Bidders should detail the supplies that will be required for this initiative.		
19.	Board composition: NBCC currently has four board members and is a New Jersey nonprofit. Does DMHAS require any minimum board size beyond New Jersey nonprofit law for a non-FQHC OTP/SUD/MH partner or subcontractor? If the prime applicant is an FQHC/FQHC Look-Alike with a HRSA-compliant governing board, will NBCC board composition be reviewed only under standard DMHAS contracting/fiscal viability requirements?	Applicants' Board composition will be reviewed as part of the proposal using existing regulations/statutes.	III. Who Can Apply VII. Required Proposal Content/Staffing VII. Required Proposal Content / Attachments/Appendices	6 13 19-20
20.	Audit and interim financials: For Required Attachments #8-#10, will DMHAS accept issued 2023 audited financial statements and draft 2024 financial statements if the 2024 final audit is still in process? If not, what interim financial statements should	As per the RFP, the Bidder's proposal must include Audited financial statements and Single Audits (A133), prepared for the two (2) most recent fiscal years; 10.	VII. Required Proposal Content	20

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	be submitted to avoid disqualification for fiscal viability review?	All interim financial statements prepared since the end of the bidder's most recent fiscal year. If interim financial statements have not already been prepared, provide interim financial statements (balance sheet, income statement and cash flows) for the current fiscal year through the most recent quarter ended prior to submission of the bid.		
21.	SUPRT reporting: The RFP states that effective October 1, 2025 SAMHSA replaced the GPRA reporting tool with SUPRT-A and SUPRT-C. Should bidders describe staffing, workflow, and budgeted follow-up incentives using SUPRT-A/SUPRT-C terminology, and are there target follow-up completion expectations that should be addressed in the proposal?	The successful bidder(s) must comply with the DMHAS' program evaluation by responding to all data requests from DMHAS and its third-party evaluator, thus enabling DMHAS to meet all federal data reporting requirements, including but not limited to the GPRA data collection.	IV. Contract Scope of Work	10
22.	What are the authorized SAMHSA incentives that could be provided with this grant? (pg. 10)	Incentives may be allowed for data collection and will be	IV. Contract Scope of Work	10

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		discussed during contract negotiation.		
23.	Attachment page limits: Do OTP licenses, 340B attestations, FQHC/OTP commitment letters, FQHC partnership MOUs, and additional narrative-requested attachments count toward the 50-page limit for Required Attachments #1-#7 and Appendices #1-#9? Please confirm that audited and interim financial statements are excluded from the 50-page limit as stated in the RFP.	VII. Required Proposal Content / Attachment / Appendices pages 19-20 provides a list of required attachments and appendices. As per the RFP, the enumerated items are bound by a 50-page limit. However, the audited and interim financial statements, and the description of all pending and in-process audits identifying the requestor, the firm's name and telephone number, and the type and scope of the audit are excluded from the 50-page limit as stated in the RFP. As per the RFP, the following items are required with the Bidder's proposal and do not count toward the 10-page narrative limit and do not count toward the 50-page	VII. Required Proposal Content/ Project Description VII. Required Proposal Content/ Attachment / Appendices VIII. Submission of Proposal Requirements	14-16 19 – 20 20-21

Q	Bidder Question	DMHAS Answer	RFP Section	Pg. #
		attachment/appendix page limit: 1. a copy of a document which will memorialize an OTP's commitment to coordinate with and to receive and serve facilitated referrals and coordinate care when appropriate. 2. If applicable, the provider license as an OTP. 3. an attestation that your agency is enrolled in the 340B Drug Pricing Program.		
24.	Are the proposal attachment forms, linked on page 20 of the Integrated Care Program RFP, up to date for use by applicants? I noticed that the Disclosure of Investment Activities in Iran Form and the Disclosure of Investigations and Other Actions Involving Bidder Form are dated to December 2021, so I just wanted to verify that these are the most current versions of these forms.	These are the most current forms.	VII. Required Proposal Content / Attachment/Appendices	19-20

ALLOWABLE AND UNALLOWABLE "HARM REDUCTION" SERVICES AND SUPPLIES ATTESTATION

I, _____, authorized representative for _____ (hereinafter "PA"), hereby affirm and attest that PA has received and reviewed the April 24, 2026, Dear Colleague Letter from the Substance Abuse and Mental Health Services Administration ("SAMHSA") regarding "Harm Reduction" services and supplies[1] and further affirms and attests that, with respect to the use of SAMHSA funding and consistent with current practices, the PA:

1. **CAN** use SAMHSA funds, either directly, indirectly or through subsequent reimbursement of grantees, to support or purchase in accordance with Department of Human Services Contract Policy and terms of contract, any of the following:

a. Life-Saving Overdose Prevention and Response Services
- Opioid overdose reversal supplies, including the purchase and distribution of opioid overdose reversal medications (OORMs) such as naloxone and nalmefene
- Medication lock boxes and medication disposal kits
- Overdose reversal education and training services
- Distribution mechanisms (e.g., bags or metal boxes/containers) for OORMs

b. Infectious Disease Prevention Services
- Wound care supplies
- FDA-approved home testing kits for viral hepatitis (i.e., HBV and HCV) and HIV
- Sharps disposal kits
- Navigation services to ensure linkage to HIV and viral hepatitis prevention, testing, treatment, and care services — including antiretroviral therapy for HCV and HIV, preexposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), prevention of mother to child transmission, and partner services
- Referral to hepatitis A and hepatitis B vaccinations (to reduce risk of viral hepatitis infection)
- Provision of education on HIV and viral hepatitis prevention, testing, and referral to treatment and care services, including for PrEP
- Education and activities to reduce risk of sexually transmitted infectious diseases, including distributing condoms

c. Other Supplies and Services
- Nicotine cessation therapies

2. **CANNOT** and **SHALL NOT** use SAMHSA funds, either directly, indirectly, or through subsequent reimbursement of grantees or others, to support, purchase or distribute any of the following:

- Syringes or needles used to inject illicit drugs
- Pipes or other supplies for safer smoking kits
- Fentanyl test strips or any other substance test kits, including xylazine and medetomidine test strips, intended for use by people using drugs
- "overdose hotlines" that have a primary function of facilitating illicit drugs use by providing people using drugs a virtual or telephonic companion while they are using drugs
- sterile water, saline, or ascorbic acid (vitamin c) used to facilitate drug use
- any other drug paraphernalia or supplies that promote or facilitate drug use not listed as acceptable above

[1] The New Jersey Department of Human Services' issuance of this Attestation does not waive or relinquish any legal rights or defenses available to it in the event of any adverse action, including but not limited to an action brought under 31 U.S.C. § 3729, nor does it waive arguments concerning the imposition of legally invalid, vague, retroactive, or unclear conditions or regarding the legal validity applicability of any Executive Order.

I affirm and attest that the foregoing statements made by me are true. I understand that if PA fails to comply with any of the above, DMHAS reserves any rights reserved to it under the terms of the agreement between the parties, including but not limited to recoupment of funding.

Dated: _____ Signed: _____

ATTESTATION OF COMPLIANCE WITH UPDATED SAMHSA GUIDANCE DATED APRIL 24, 2026, FOR MEDICATIONS FOR OPIOID USE DISORDER (MOUD)

I, _____, authorized representative for_____ (hereinafter "PA"), hereby affirm and attest that the PA has reviewed and received a copy of the April 24, 2026 Dear Colleague Letter from the Substance Abuse and Mental Health Services Administration ("SAMHSA") that outlines "core clinical tenets and provides new language that will be included in updated terms and conditions for current grantees and new FY2026 funding announcements for all relevant treatment services and training and technical assistance funding announcements."[1]

The PA further affirms and attests that, with respect to the use of SAMHSA funding and consistent with current practices, the PA:

1. **SHALL** employ a holistic care integration model using evidence-based practices to address the complex psychosocial needs of individuals with MOUD;

2. **SHALL** use the following SAMHSA approved medications (hereafter medication) when administering MAT, as clinically appropriate and as clinically indicated:

   (a) Methadone
   (b) buprenorphine
   (c) Naltrexone

3. **SHALL** organize and require clinical and behavioral staff to be trained in the following subjects:

   (a) Clinically appropriate use of SAMHSA approved medications
   (b) Options for safe tapering and discontinuation of medication when indicated
   (c) Strategies for shared-decision making to ensure that patients understand the risks and benefits of treatment initiation, continuation and termination.
   (d) Provision of tools to support the development of individualized comprehensive treatment plans with patients that include consideration of medication treatment duration, tapering and discontinuation as clinically indicated based upon individual circumstances, recovery and preferences.

4. **SHALL** require clinicians to engage patients in an assessment of treatment and recovery goals **at a minimum on an annual basis** to evaluate the continued use of medication, although the PA also understands that "research has shown that arbitrary maximum time limits or abrupt discontinuation of treatment can result in poor outcomes for patients."[2]

5. **SHALL** ensure patients are fully informed of the risks and benefits of MOUD initiation, continuation and termination.

[1] The New Jersey Department of Human Services' issuance of this Attestation does not waive or relinquish any legal rights or defenses available to it in the event of any adverse action, including but not limited to an action brought under 31 U.S.C. § 3729, nor does it waive arguments concerning the imposition of legally invalid, vague, retroactive, or unclear conditions or regarding the legal validity applicability of any Executive Order.
[2] See April 24, 2026 Dear Colleague letter from SAMHSA.

6. **SHALL** require that, should the patient and clinician choose to discontinue medication, the process must be gradual and individualized and accompanied by intensified support and monitoring to prevent relapses.

7. **SHALL** require that, should the patient and clinician choose to continue medication, any such determination must be made on an individual basis, taking into consideration progress toward treatment goals, stability in treatment, recovery capital and patient preference.

8. **SHALL** utilize FDA-approved MAT medication to, where clinically indicated and appropriate, help parents at risk of losing children to foster care.

9. **SHALL NOT** administer FDA-approved MAT medications utilizing a medication-only model without other clinical and recovery support services.

I affirm and attest that the foregoing statements made by me are true. I understand that if PA fails to comply with any of the above, DMHAS reserves any rights reserved to it under the terms of the agreement between the parties, including but not limited to recoupment of funding.

Dated: _____ Signed:_____

[OR]

I affirm and attest that PA does not provide MAT or MOUD.

Dated: _____ Signed:_____