State Innovation Models:

Funding for Model Design and Model Testing Assistance

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
Center for Medicare & Medicaid Innovation

Cooperative Agreement

Initial Announcement

Funding Opportunity Number: CMS-1G1-12-001

CFDA: 93.624

Applicable Dates:

Electronic Cooperative Agreement Application Due Dates:

Model Design Applications:	Due September 17, 2012, by 5 p.m., Eastern Daylight Time (EDT)
Round One Model Testing Applications:	Due September 17, 2012, by 5 p.m., Eastern Daylight Time (EDT)

Anticipated Notice of Cooperative Agreement Award Dates:

Model Design Phase:	Award Date: November 15, 2012
Round One Model Testing:	Award Date: November 15, 2012

Anticipated Cooperative Agreement Period of Performance:

Model Design:	From award date through May 14, 2013.
Model Testing:	Ready-to-go States (Track 1) — Up to 6 months for implementation readiness and 36 months for testing after the date of award, through May 14, 2016. New Model States (Track 2) — Post waiver/plan review anticipated 6 months for CMS review, followed by up to 6 months for implementation readiness and 36 months for testing after the date of award, through November 14, 2016.

TABLE OF CONTENTS

OVERVIEW INFORMATION iv

I. FUNDING OPPORTUNITY DESCRIPTION 1

1. Purpose 1

2. Authority 2

3. Background 2

4. Program Requirements 3

5. Design Requirements 8

A. Model Design Proposal Requirements 8

B. Model Testing Proposal Requirements 10

6. Restriction on Awards 15

7. Alignment of Proposed Models 15

8. Technical Assistance 16

II. AWARD INFORMATION 16

1. Total Funding 16

2. Award Amount 16

3. Anticipated Award Date 17

4. Period of Performance 17

5. Number of Awards 18

6. Type of Award 18

7. Termination of Award 18

III. ELIGIBILITY INFORMATION 19

1. Eligible Applicants 19

2. Cost Sharing or Matching Requirements 21

3. Foreign and International Organizations 21
4. Faith-based Organizations 21
IV. APPLICATION AND SUBMISSION INFORMATION 21
1. Address to Request Application Materials 21
2. Content and Form of Application Submission 21
A. Letter of Intent to Apply 21
B. Application Materials 21
C. Format Requirements for Applications 25
D. Application Content and Structure 26
3. Submission Dates and Times 37
A. Letter of Intent to Apply 37
B. Cooperative Agreement Applications Due Dates 37
4. Intergovernmental Review 37
5. Funding Restrictions 37
V. APPLICATION REVIEW INFORMATION 38
1. Criteria 39
2. Review and Selection Process 45
3. Anticipated Announcement and Award Dates 47
VI. AWARD ADMINISTRATION INFORMATION 47
1. Award Notices 47
2. Administrative and National Policy Requirements 48
3. Reporting 51
A. Progress Reports 52
B. Project Monitoring 52
C. Evaluation 53
D. Evaluation Design and Data Collection 53

E. Monitoring and Rapid-Cycle Evaluation within States 55
F. Impact Evaluation 56
G. Federal Financial Report 57
H. Transparency Act Reporting Requirements 58
I. Audit Requirements 58
J. Payment Management Requirements 58
VII. AGENCY CONTACTS 59
1. Programmatic Contact Information 59
2. Administrative Questions 59
VIII. APPENDICES 60
Appendix 1: Innovation Center & Other Affordable Care Act Initiatives 60
Appendix 2: Guidance for Responding to SF 424A 63
Appendix 3: State Health Care Innovation Plan 71

OVERVIEW INFORMATION

Federal Agency Name: **United States Department** of Health and Human Services
Centers for Medicare & Medicaid Services
Center for Medicare & Medicaid Innovation

Funding Opportunity Title: ACA - State Innovation Models: Funding for Model Design or Model Testing Assistance

Announcement Type: Initial

Agency Funding Opportunity Number: CMS-**1G1-12-001**
Catalog of Federal Domestic Assistance (CFDA) Number: 93.624

Key Dates: Date of Issue: July 19, 2012

Application Due Date:

Model Design: Application Due Date: September 17, 2012, by 5 p.m. Eastern Daylight Time (EDT)

Model Testing: Round 1 Application Due Date: September 17, 2012, by 5 p.m. Eastern Daylight Time (EDT)

Anticipated Notice of Award:

Model Design: Award Date: November 15, 2012

Model Testing: Round 1 Award Date: November 15, 2012

Anticipated Period of Performance:

Model Design: From award date through May 14, 2013.

The period of performance and budget period is six months.

Model Testing: Ready-to-go States - Up to 6 months for implementation readiness and 36 months for testing after the date of award, through May 14, 2016.
New Model States — Post waiver/plan review anticipated 6 months for CMS review, followed by up to 6 months for implementation readiness and 36 months for testing after the date of award, through November 15, 2016.

Please note the period of performance for Ready-to-go Model Testing awards is 42 months and will be divided into four budget periods. The first budget period will be six months followed by three budget periods of 12 months each. Also note, the period of performance and budget period for States receiving pre-testing assistance awards is six months.

The period of performance for New Model Testing awards is 48 months and will be divided into five budget periods. The first budget period will be six months for waiver/plan review followed by six months for implementation and then by three budget periods of 12 months each. Also note, the period of performance and budget period for States receiving pre-testing assistance awards is six months.

State Innovation Models:

Funding for Model Design and Model Testing Assistance

I. FUNDING OPPORTUNITY DESCRIPTION

1. PURPOSE

The Center for Medicare and Medicaid Services (CMS) Innovation Center (CMS Innovation Center) is announcing the State Innovation Models (SIM) initiative. The purpose of the State Innovation Models[1] (SIM) initiative is to test whether new payment and service delivery models will produce superior results when implemented in the context of a state-sponsored State Health Care Innovation Plan. These plans must improve health, improve health care, and lower costs for a state's citizens through a sustainable model of multi-payer payment and delivery reform, and must be dedicated to delivering the right care at the right time in the right setting (see Appendix 3). The Innovation Center has created the SIM initiative for states that are prepared for or committed to planning, designing, testing, and supporting evaluation of new payment and service delivery models in the context of larger health system transformation.

The Innovation Center is interested in testing innovative payment and service delivery models that have the potential to lower costs for Medicare, Medicaid, and the Children's Health Insurance Program (CHIP), while maintaining or improving quality of care for program beneficiaries. These models should raise community health status and reduce long term health risks for beneficiaries of Medicare, Medicaid, and CHIP. This initiative is based on the premise that Governor-sponsored, multi-payer models that have broad stakeholder input and engagement, and are set in the context of broader state innovation, will achieve sustainable delivery system transformation that significantly improves health system performance. Because of the unique powers of state governments, Governors and their executive agencies, working together, with key public and private stakeholders and the Centers for Medicare & Medicaid Services can accelerate community-based health system improvements, with greater sustainability and effect, to produce better results for Medicare, Medicaid, and CHIP beneficiaries.

In this Funding Opportunity Announcement (FOA), the term "model" is defined in two different contexts:

[1] The term "state" includes U.S. Territories and the District of Columbia.

A. "Payment and service delivery models" refers to specific models, such as accountable care organizations, integrated care models, or medical/health homes that are supported by new payment methodologies that drive and reward better health, better care, and lower costs through improvement.

B. "State Innovation Models" refers to comprehensive approaches to transforming the health system of a state. These models will be described in a State Health Care Innovation Plan. State Health Care Innovation Plans will include new payment and service delivery models, but will also include a broad array of other strategies, including community-based interventions, to improve population health.

2. AUTHORITY

This opportunity for a cooperative agreement between states and CMS is being issued pursuant to Section 1115A of the Social Security Act, which provides the Innovation Center the authority to test innovative payment and service delivery models to reduce program expenditures for Medicare, Medicaid, and CHIP while maintaining or improving the quality of care for program beneficiaries. The Innovation Center's authority explicitly allows for collaboration with states to test and evaluate all-payer payment reform for medical care of residents of the state. [Social Security Act, Section 1115A(b)(2)(B)(xi)]. The Innovation Center will use this authority to provide states funding for the design, testing, and evaluation of innovative payment and service delivery models that integrate community resources with the state health system to drive broad health care system transformation.

3. BACKGROUND

The Innovation Center believes that states are key partners in developing and testing community-centered health systems and proving that they can deliver significantly improved cost, quality, and population health performance results for Medicare, Medicaid, and CHIP beneficiaries. States have policy and regulatory authorities, as well as ongoing relationships with private payers, health plans, and providers, that can help drive and accelerate performance of payment and service delivery models across the spectrum of public and private payers. The Innovation Center intends to provide states with funding to design and test models that use the full range of their policy authorities and their ability to convene a broad array of stakeholders, both private and public, to enhance and accelerate the development of innovative health system models that result in better health, better care and reduced costs through improvement. In this initiative, CMS is partnering with states to test the hypothesis that such important delivery system reforms can be accelerated and made more effective if CMS and states work together to test and evaluate new payment and delivery system models. These new models must be sustainable after the testing period and result in better health, better care, and lower cost through improvement for CMS beneficiaries. We expect that the involvement of other payers will result in similar benefits for non-CMS populations.

This initiative will provide financial, technical, and other support to states that are either prepared to test or are committed to designing and then testing new payment and service delivery models in the context of broader health system transformation. State models must be designed to reduce health care costs in Medicare, Medicaid, and CHIP, while maintaining strong protections for participating beneficiaries. States cannot use SIM funding to supplant funding levels for activities that are already provided by states or other payers, but they can use SIM funding to supplement existing efforts to enhance the broader transformation of the delivery system. While we expect States to pursue multi-payer reforms that will improve care across their health systems, Innovation Center funding must benefit Medicare, Medicaid, or CHIP beneficiaries.

4. PROGRAM REQUIREMENTS

The SIM initiative gives states the opportunity to join CMS as a partner in testing our hypothesis by developing and implementing a broad-based State Health Care Innovation Plan targeted on the objectives of better health, better care and reduced costs through improvement. Designing and testing a multi-payer health system transformation model requires a major commitment by the state, payers, stakeholders, and CMS. States will need to provide leadership as well as invest staff expertise and other resources to carry out the required multi-stakeholder design planning and testing work.

This FOA provides two different funding opportunities; a state can apply for a Model Design award or a Model Testing award, but not both.

Model Design awards will support states that need financial and technical support to engage stakeholders and create a State Health Care Innovation Plan. A State Health Care Innovation Plan must provide a broad vision of health system transformation and payment reform. The Plan shall describe the state's broad strategy for delivery system evolution into a higher quality, higher value health care delivery system where care is delivered according to a community-led integrated care strategy. The State Health Care Innovation Plan should describe a health system model design that includes the participation of multiple payers as part of a new payment and service delivery model. States receiving these awards must complete their Plan and Model Design and submit a Model Testing proposal for the second round Model Testing opportunity expected in the spring of 2013; however, Model Testing funding is not guaranteed.

Funding for Model Design will support the required work. We expect states to: 1) bring a broad range of stakeholders into the design process; 2) design multi-payer payment and service delivery models that include Medicare, Medicaid, CHIP, and other payers; 3) utilize the full range of their executive and legislative authority to facilitate and support new health care delivery models; and 4) design models that complement and coordinate with other initiatives

sponsored by the Department of Health and Human Services (HHS), including components such as CMS and the new Administration for Community Living.

Model Testing awards will provide funds for the state to implement the State Health Care Innovation Plan and to test and evaluate the proposed service delivery and payment models. CMS expects to offer two separate opportunities for states to apply for Model Testing Awards. This FOA presents the first of these FOA opportunities.

Testing new payment and service delivery models in the context of the broader State Health Care Innovation Plan is the central feature of the SIM initiative. Some states may find that new payment and service delivery models that are currently available through CMS, such as the Medicare Shared Savings Program or Innovation Center initiatives, are appropriate to achieve their goals. States may also seek to build upon the new flexibility that CMS, through State Medicaid Director letters and other mechanisms, has provided to states to utilize new payment and service delivery models for the Medicaid population In addition, states may seek to use existing authorities to provide managed care. Model testing proposals based on such established approaches will require less time for CMS to approve. However, we also recognize that in some limited instances, it may be appropriate for a state as part of its SIM proposal to request approval to pursue payment and service delivery models that differ from established CMS pathways. The approval process for such requests could take significantly more time. In light of this, CMS is offering two tracks for Model Testing:

Model Testing Track 1: Ready-to-go states — This track will be available for proposals that utilize current CMS program approaches (*e.g.*, Medicare Shared Savings ACOs and Medicaid State Plan Amendments) and/or utilize established Innovation Center models such as Bundled Payment for Care Improvement or Pioneer ACOs.

Model Testing Track 2: New Models — This track will be available for proposals that require:

a. New Medicare payment and service delivery models or significant modification of existing models (such as changes to shared saving methodologies or payment calculations);
b. Medicaid waivers; or
c. New waivers under section 1115A(d)(1) authority to support new payment and service delivery models.

While CMS will try to respond expeditiously to all requests for new models, we expect that Track 2 will take more time to implement since there will need to be a waiver and/or model review phase prior to CMS making a final commitment to fund the cooperative agreement. Funding will therefore flow faster to Track 1 awardees. Track 2 awardees will receive a limited initial funding amount while requests for new payment models and/or Medicaid waivers are reviewed. This limited funding will be available only for activities consistent with the purposes of this Funding Opportunity Announcement, even if the awardee's request for a Medicaid waiver

or new Medicare payment model is not ultimately approved. Please note that if a state's request can be accomplished through existing Medicaid state plan authorities other than Medicaid waiver authority, no waiver will be granted. The balance of their award will be available through non-competing continuation awards only after their Medicaid waiver and/or new Medicare payment model requests have been fully analyzed and approved or when it has been determined that the state's request can be accomplished through authorities other than Medicaid waiver authority. If the necessary waivers or new payment models are not approved, CMS may terminate the cooperative agreement.

If a State Health Care Innovation Plan is judged not be fully developed, the state may qualify for pre-testing assistance to expand its proposal and will be eligible to compete for Model Testing awards in the second round. Pre-testing assistance awards will be available only to states that submit a testing proposal in the first round that is not funded. Pre-testing assistance awards shall be used by states to fund the additional work necessary to address areas of their model designs and/or Model Testing strategy that need improvement. Pre-testing assistance awards will be counted toward the limit of 25 state Model Design awards.

States are eligible to apply only for one funding award opportunity offered in this FOA. States are not required to apply for a Model Design award in order to submit a Model Testing proposal. States can submit a complete application for either Model Design or Model Testing, but not both. There are separate application procedures and requirements for each type of funding opportunity. As noted above, states that submit a qualified application for Model Testing may receive a full Model Testing award or may be eligible for pre-testing assistance (if it is determined that such assistance would allow the state to improve its proposal for re-submission in round two of Model Testing in Spring of 2013).

Model Design Cooperative Agreements

CMS will fund up to 25 states for Model Design awards. This solicitation is the only one planned for Model Design assistance. States that apply for but do not receive a Model Design cooperative agreement may still submit a proposal for the second round of Model Testing. The funding amounts of cooperative agreements for Model Design will be based on a variety of factors, including the proposed model plan and budget requirements submitted by the state. The proposed budget will be evaluated based on the following elements: the scope of the proposed plan and size of the target Medicaid, CHIP, and Medicare populations; the complexity of the Model Design proposed by the state; the activities necessary to complete the required plan; and the reasonableness of expenditures in the budget plan. States may submit only one proposal for Model Design funding. The Governor's Office (or the Mayor's Office of the District of Columbia) must be the applicant for Model Design funding.

State Model Design applications must meet the requirements specified in this FOA. Applications must be submitted through Grants.gov by September 17, 2012, 5:00 p.m. EDT.

States that receive Model Design funding must produce and deliver a State Health Care Innovation Plan that includes their proposed multi-payer payment and service delivery models. These states must also submit a proposal for the planned second round of Model Testing awards in the spring of 2013. This second round of Model Testing will be competitive and there is no guarantee that all applicants will be funded.

Cooperative agreements may be terminated for failure to perform under the requirements of the agreement. All deliverables from Model Design work must be submitted on or before May 14, 2013, 5:00 PM EDT. No additional funds will be allocated by CMS after that time or upon termination of the agreement, whichever occurs first.

Model Testing Cooperative Agreements

CMS expects to offer two rounds of cooperative agreement awards through the SIM initiative for testing models that are based on a State Health Care Innovation Plan. Up to five states may be awarded Model Testing cooperative agreements in the first round. CMS expects to issue a second FOA for Model Testing awards in the spring of 2013. As mentioned above, a state does not need to apply for a Model Design award in order to apply for a Model Testing award. All applications must be submitted by the Governor's Office (or the Mayor's Office of the District of Columbia).

States that apply for Model Testing funding in Round 1 but do not receive a Model Testing award may qualify for pre-testing assistance to help them improve their State Health Care Innovation Plans. As an example, a state proposal might not be selected for a Model Testing award because it needed to improve its multi-payer elements or cost analysis data. Nevertheless, CMS may offer that state pre-testing assistance because with further development and assistance, the state will be able to submit a viable Model Testing proposal for the second round of awards in the spring of 2013. The eligibility standards, deliverables, and other requirements for pre-testing assistance awards must meet the general requirements for Model Testing and will be on the same six month schedule for completion of development work as Model Design awards. Any pre-testing assistance awards provided to unsuccessful applicants for Model Testing awards will be counted toward the limit of 25 state Model Design cooperative agreements and will be given preference over Model Design awards for funding under this FOA. Note that the future FOA solicitation for the second round of Model Testing will not include a pre-testing assistance award option and that states receiving pre-testing awards will not receive preference in the future FOA.

Model Testing applications must be submitted through grants.gov on or before September 17, 2012 at 5 p.m., Eastern Daylight Time. Any Model Testing proposal received after 5 p.m. EDT on September 17, 2012, will not be eligible for first round Model Testing funding.

Once the Model Testing period begins, the model will run for three consecutive years. However, should the model fail to meet its performance milestones, including savings targets, CMS may modify or terminate that agreement prior to the completion of the three-year testing period. The Model Testing cooperative agreement with the state will delineate all testing and evaluation support requirements for the model. A state can receive only one Model Testing award. States that submit a proposal in round one and are not selected for a Model Testing cooperative agreement may submit a proposal in round two, whether or not they have received a pre-testing assistance award. States may also submit a Model Testing proposal without having received a Model Design cooperative agreement.

State Health Care Innovation Plans must be included with the Model Testing proposal and will be evaluated based on the state's commitment to and rationale for system transformation. Model Testing proposals will be evaluated based on their potential to produce better care, better health, and lower cost through improvement for Medicare, Medicaid, and CHIP beneficiaries. State Health Care Innovation Plans are encouraged to include care models and interventions that aim to reduce health disparities and address the social, economic, and behavioral determinants of health, including mental health and substance use disorders. In addition, State Health Care Innovation Plans should document how the state will use its full executive and legislative authority to support the proposed health system transformation and multi-payer Model Design. Additional weight will be given to Model Testing proposals that integrate community health and community prevention activities in their multi-payer models.

The performance period for all Model Testing cooperative agreements includes implementation and model testing periods. States will have six months to complete their implementation work to start their Model Test. Model Testing Track 1 states, using existing CMS models, are expected to start model testing within 6 months of receiving the award. Model Testing Track 2 states, requiring waivers, will require analysis and review by CMS, anticipated to take six months, and if approved will then start the six month implementation period. Each state's capacity and readiness to implement its proposed model within the six month period after award, including the ability to reach agreement with CMS on any needed Medicare payment and service delivery models or modifications, Medicaid waivers, and/or State Plan amendments, will be considered by the approving official in selecting awardees. Please note that if a state's request can be accomplished through authorities other than Medicaid waiver authority, no waiver will be granted. Examples of implementation activities include contracting, outreach, data and performance monitoring system configuration, and provider training.

The Model Testing period is three years. The scope of CMS' investment for Model Testing will be for those aspects of the states' model designs that have the potential to produce better care, better health, and lower cost through sustainable improvement for Medicare, Medicaid, and CHIP beneficiaries. States are also expected to collaborate with participating private payers to evaluate the impact of their model design on similar private payer performance goals. Proposals

will be required to show net federal savings potential for each program over the project period. The proposals' federal savings estimates will be reviewed for their reasonableness by the CMS Office of the Actuary and these reviews will be taken into account in the selection process.

5. DESIGN REQUIREMENTS

A. Model Design Proposal Requirements

Applicants for Model Design cooperative agreements must include the standard forms and comply with the following requirements:

i. The Governor's Office (or Mayor's Office of the District of Columbia) must submit the request for the Model Design funds.

ii. The application must identify the proposed stakeholders that will actively participate in the Model Design process and present a clear and pragmatic strategy for engaging them in the Model Design process and maintaining their commitment to developing a State Health Care Innovation Plan. States are expected to work with a broad group of stakeholders in their Model Design process, including, where applicable:

a) State and local health agencies, tribal governments, legislative leaders, state health IT coordinators, local government representatives, and community service and support organizations;
b) Health care providers, including medical, behavioral health, developmental disability, substance abuse, public university hospital/academic medical centers and physician groups, health centers, Area Agencies on Aging, and long-term services and support providers (institutional and home- and community-based);
c) Consumers, health care advocates, employers, and community leaders;
d) Public and private payers, including self-insured employers as well as public and private health plans;
e) Social service organizations, faith-based organizations, representatives for health education, and community health organizations; and
f) Others, including funders and resources such as foundations, academic experts, External Quality Review Organizations, hospital engagement networks, policy institutes, and health associations.

iii. The applicant must describe its Model Design process and, at a minimum, must present an approach that is organized to continually improve cost, quality, and population health outcomes for Medicaid, and CHIP beneficiaries. In addition, the Model Design must present plans to coordinate and build upon any CMS existing waivers and other HHS and CMS health care reform initiatives taking place within the state, such as the Medicare-

Medicaid Financial Alignment Initiative for states. Note that states cannot receive SIM funding for activities already funded through other CMS programs and initiatives.

iv. As part of the development of their State Health Care Innovation Plans and designs for new payment and service delivery models, states must consider levers and strategies that can be applied to influence the structure and performance of the health care system, such as:

a) Creating multi-payer (including Medicare, Medicaid, CHIP, and state employee health benefit programs) strategies to move away from payment based on volume and toward payment based on outcomes;

b) Developing innovative approaches to improve the effectiveness, efficiency and appropriate mix of the health care work force through policies regarding training, professional licensure, and expanding scope of practice statutes, including strategies to enhance primary care capacity, and to better integrate community health care manpower needs with graduate medical education, training of allied health professionals, and training of direct service workers;

c) Aligning state regulatory authorities, such as certificate of need programs (if applicable), to reinforce accountable care and delivery system transformation or develop alternative approaches to certificate of need programs, such as community-based approaches that could include voluntary participation by all providers and payers;

d) Restructuring Medicaid supplemental payment programs to align the incentives with the goals of the state's payment and delivery system reform Model;

e) Creating opportunities to align regulations and requirements for health insurers with the broader goals of multi-payer delivery system and payment reform;

f) Creating mechanisms to develop community awareness of and engagement in state efforts to achieve better health, better care, and lower cost through improvement for all segments of the population by:

- developing effective reporting mechanisms for these outcomes;
- developing community-based initiatives to improve these outcomes;
- developing potential approaches to ensure accountability for community-based outcomes by key stakeholders, including providers, governmental agencies, health plans, and others;
- coordinating efforts to align with the state's Healthy People 2020 plan, the National Prevention Strategy, the National Quality Strategy, and the state's health IT plan; and

- coordinating state efforts with non-profit hospitals' community benefits/community building plans;

g) Coordinating State-based Affordable Insurance Exchange activities with broader health system transformation efforts;

h) Integrating the financing and delivery of public health services and community prevention strategies with health system redesign models;

i) Leveraging community stabilization development initiatives in low income communities and encouraging community investment to improve community health. For example, the Federal Reserve Bank's Healthy Communities Initiative was designed to enable cross-sector approaches to revitalizing low-income communities and neighborhoods and improving community health;

j) Integrating early childhood and adolescent health prevention strategies with the primary and secondary educational system to improve student health, increase early intervention, and align delivery system performance with improved child health status;

k) Creating models that integrate behavioral health, substance abuse, children's dental health, and long term services and support as part of multi-payer delivery system model and payment strategies;

l) Creating or expanding models such as the Administration on Community Living's Aging and Disability Resource Centers and CMS' Money Follows the Person Program and Balancing Incentives Payment Program to strengthen long-term services and support systems in a manner that promotes better health, reduces institutionalization, and helps older adults and people with disabilities maintain independence and maximize self-determination;

m) Using other policy levers that can support delivery system transformation (part of the expectation for states participating in the SIM initiative is that they will assess and consider the application of policy authorities available to them to create a successful and sustainable health system transformation); and

n) Leveraging health IT, electronic health records (EHRs), and health information exchange technologies, including interoperable technologies, to improve health and coordination of care across service providers and targeted beneficiaries.

B. Model Testing Proposal Requirements

State models must describe a pathway with specific milestones to move the preponderance of care in the state from models that reward service volume to clinical and financial models that

reward better health, better care, and lower cost through improvement. States seeking Model Testing awards must describe a State Health Care Innovation Plan that meets the requirements for the Model Design awards specified in this FOA. The plan should describe how broad-based accountability for outcomes, including total cost of care for Medicare, Medicaid, and CHIP beneficiaries, is created. Cooperative agreements for the Model Testing period include the six month implementation phase and the three-year testing phase. During the six month implementation phase, states need to finalize their testing plans and ensure that their systems are ready to go.

State Model Testing applications must include the State Health Care Innovation Plan and the required standard forms. **Applications must propose the implementation and testing of a State Health Care Innovation Plan, encompassing the payment and services delivery models included within the Plan, that meets the requirements for models based on a State Health Care Innovation Plan as specified in the Model Design section above.** In addition, Model Testing proposals must address the following requirements:

i. The Governor's Office (or Mayor's Office of the District of Columbia) must submit the request for the Model Testing.

ii. The proposal must demonstrate how Model Testing funds will be used to produce better health, better care, and lower cost through improvement for Medicare (which may involve new or modified payment models), Medicaid, and CHIP beneficiaries. Specifically the proposal must include specific new payment and service delivery models that will support these outcomes. Listed below are some examples of the types of payment and service delivery models that states could propose, in the context of their State Health Care Innovation Plan:

- ***Accountable Care*:** Accountable care arrangements or/integrated care models bring together groups of clinicians, other providers, and at times other community entities that accept clinical and financial responsibility for a defined population. Accountable care arrangements can be structured as "virtual" integrated delivery systems, so that even outside a capitated risk contract or salaried group practice, clinicians and other providers are incentivized to provide high quality care, without focusing on generating billable transactions.

- ***Medical or Health Homes*:** In medical home or health home arrangements, practitioners create processes and provide services that are not ordinarily provided by primary care practices, often because they are not reimbursed under fee-for-service systems. These processes and services could include the use of expanded access through extended office hours, telephone or e-mail communications with

beneficiaries, and employment of a multi-disciplinary care coordination team to assist beneficiaries in self-management of their conditions.

- ***Bundled Payments/ Payments for Episodes of Care*:** This model would need to be proposed in conjunction with other efforts to coordinate care and improve quality of services. In a fee-for-service system, providers are usually paid for each discrete transaction they generate. This approach rewards volume over value—making no distinction among providers in terms of their quality of care—and does not create an incentive for longitudinal efficiency. Alternative approaches would pay providers based on performance and their ability to achieve satisfactory outcomes for beneficiaries in the most efficient manner. Under these models, the state would work with other payers to establish aligned "bundled" or episode payments for the majority of services, using value-based purchasing approaches intended to reward the delivery of care that results in better health, better care, and lower cost through improvement. States should note that not all providers are reimbursed on a fee for service basis. States should be cognizant of these alternative payment systems when designing new payment and service delivery models.

iii. CMS, through the Medicare Shared Savings Program and through a variety of Innovation Center initiatives, has already established many new payment approaches that could support State Health Care Innovation Plans. In addition, CMS, through State Medicaid Director letters and other mechanisms, has similarly provided latitude for states to utilize new payment and service delivery models for Medicaid beneficiaries. States planning to coordinate their plans with these existing models should be eligible for Track 1 and will receive preference in the selection process.

We also recognize that in some limited instances, it may be appropriate for a state as part of its SIM proposal to request approval to pursue payment and service delivery approaches that differ from established CMS pathways. The approval process for such requests could take significantly more time than would be required for CMS engagement using established approaches. States may request Medicare alignment with their proposed payment and service delivery models. CMS will separately evaluate such proposals in accordance with the statutory requirements for Medicare under title XVIII of the Social Security Act, as well as the Innovation Center's authority to test new payment and service delivery models under Section 1115A of the Act, but approval of new models is not guaranteed. CMS will not compel

providers in any Model Testing state to participate in new payment and service delivery models, nor will CMS cede Medicare payment authority to the state.[2] These Track 2 state proposals will need to meet requirements for a new or modified Medicare payment and service delivery model, go through the separate model approval process, propose a viable approach for improving care, and be determined through a separate review by the CMS Office of the Actuary to be expected to generate cost savings to Medicare.

The application must also note whether Medicaid waivers or State Plan amendments would be requested as part of the proposal, and must include the documentation and timeline for such requests. The proposal must describe the extent to which the plan could be implemented if such waiver requests were not granted. If a state is negotiating with CMS for a Medicaid/CHIP waiver or has received authority for a waiver, the state should describe the impact of the waiver on the state's planning, design, and model testing. Note that all waiver requests associated with this model proposal would be reviewed through a separate process (which will be subject to state and federal public notice and comment periods) concurrent with the grant review process, and approval of waivers is not guaranteed.

Track 2 states selected for award that are requesting new or modified Medicare payment models and/or Medicaid waivers will undergo a waiver review period before the implementation period can start. In the event a Medicare payment model or Medicaid waiver is not approved, and it has not been determined that the State's request can be accomplished through authorities other than Medicaid waiver authority, the state would not move to the implementation phase or to Model Testing, and the cooperative agreement may be terminated or modified to terminate funding associated with the denied request. If the new Medicare payment model or Medicaid waiver is approved, the state would enter the implementation phase.

iv. The following are areas that are out of scope and will not be considered under the State Innovation Models initiative:

a. Medicare or Medicaid eligibility changes;
b. Coverage or benefits reductions in Medicare or Medicaid or any changes that would have the effect of rationing care;
c. Increases in premiums or cost sharing;

[2] An exception to this rule will apply in states currently operating under a Medicare waiver authorized under Section 1814(b)(3) of the Social Security Act.

d. Increases in net federal spending under the Medicare, Medicaid or CHIP programs;
e. Medicare payments directly to states, including shared savings;
f. Medicaid FMAP formula changes;
g. Changes to the EHR incentive program for eligible professionals and eligible hospitals;
h. Changes in State Financial Alignment Models;
i. Reductions in Medicare beneficiary choice of provider or health plan or Medicaid choice of provider or health plan beyond those allowed today; or changes to maintenance of effort requirements; and
j. Changes to CMS sanctions, penalties, or official denial of participation currently in effect.

v. The application must also describe what other policy, regulatory, or legislative-based activities or authorities the state is utilizing to support the goals of the model. States' model proposals need to deliver broad-based accountability for high value outcomes and include multi-payer alignment. Payment and service delivery models are just one component of a state strategy that utilizes a broad array of tools and resources to transform health system performance.

vi. The proposal should also demonstrate how as a result of the proposed new payment and service delivery models, as well as the use of the other state levers, the preponderance of providers, including publicly supported health care providers will transition to a value-based clinical and business model.

vii. State model proposals must describe the evidence base for their approaches and explain how the model would improve health and reduce total cost of care, as well as reduce health disparities and address the social, economic, and behavioral determinants of health, including mental health and substance use disorders; or lay the foundation for building delivery system capacity to achieve these outcomes in the future. A description of how these approaches will improve the quality of care, the experience of care, and reduce health care expenditures for Medicare, Medicaid, and CHIP beneficiaries must also be included; for Track 2 states a description of how these goals would be achieved even without a new Medicare model or Medicaid waiver. This description should include coordinating efforts to align with the state's Healthy People 2020 plan, the National Prevention Strategy, and the National Quality Strategy. States may propose phasing in the model. The proposals' savings estimates will be reviewed for their reasonableness by the CMS Office of the Actuary and these reviews will be taken into account in the selection process.

viii. State proposals should describe how the State Health Care Innovation Plan integrates community health and prevention into its multi-payer delivery system and payment models.

ix. The application must describe how the model will coordinate with and build upon other CMS, HHS, and Federal initiatives taking place within the state; without duplicating funding requests.[3] For example, if a state is participating in the State Financial Alignment Models, the state should describe how the financial alignment complements the state's Model. States should note that federal funding cannot be claimed for duplicative activities, or to supplant federal or state funding.

x. The application must specify procedures for performance monitoring, data collection, and model progress tracking and reporting. Awardees must agree to cooperate with and facilitate the role of the Innovation Center and its evaluation contractor. However, the state is not expected to provide work space for federal participants. Awardees are expected to participate actively in the learning activities that the Innovation Center will establish as part of the initiative.

xi. The application must describe how current CMS beneficiary protections, such as access, quality, and due process protections, will be maintained and must specifically describe how Medicare, Medicaid, and CHIP beneficiaries will benefit from the proposed model.

xii. The application must describe how the effects of the model can be measured with reference to a comparison or control group using some element of random assignment, a scientifically controlled design, or a rigorous quasi-experimental design.

6. RESTRICTION ON AWARDS

CMS will not fund proposals that duplicate models for populations that are already being funded and tested as part of CMS and/or HHS initiatives. For example, if the state receives a Strong Start for Mothers and Newborns cooperative agreement, SIM funding will only be used in a coordinated manner and not to supplant funding for Strong Start for Mothers and Newborns. SIM funding may not supplant existing federal or state funding. States may propose the use of SIM testing funds to support additional costs associated with or created by testing a SIM model.

7. ALIGNMENT OF PROPOSED MODELS

The Innovation Center anticipates that different states may propose similar models. The Innovation Center may choose to work with awardees that have proposed similar models to

[3] See Appendix 1 for Innovation Center and other CMS and HHS initiatives.

identify shared needs and model elements to coordinate and maximize SIM testing and implementation funding. States are encouraged to leverage as much of existing or to-be-developed CMS business processes, systems, model design/methodologies, and infrastructure as possible in order to appropriately maximize design or testing resources.

8. TECHNICAL ASSISTANCE

CMS will host Open Door Forums or webinars to provide further details about the SIM initiative and answer questions from potential state applicants. Information about the Open Door Forums will be available on the Innovation Center web site at http://innovations.cms.gov.

The Innovation Center is prepared to offer technical assistance to awardees of Model Design and Model Testing cooperative agreements. This technical assistance is in addition to funds provided under the award. The Innovation Center anticipates contracting with an entity or entities to provide limited technical assistance to state awardees.

CMS recognizes that some states may be interested in receiving Medicare data to inform the development of their multi-payer models and evaluate the results of implementation. CMS will review such requests to determine if it is possible to meet awardees' data requests. States' proposals should identify and justify requests for CMS data requests. Existing data access rules for providing Medicare or other CMS data will be applied.

II. AWARD INFORMATION

1. TOTAL FUNDING

CMS may award a total of up to $50 million for up to twenty five (25) states for Model Design cooperative agreements. Any pre-testing assistance awards provided to unsuccessful applicants for Model Testing awards will be counted toward this limit of 25 Model Design cooperative agreements. CMS may award a total of up to **$**225 million in funding for up to five state-sponsored Model Testing cooperative agreements, awarded in this first round. All states, the District of Columbia, and U.S. Territories may submit applications for Model Design and Model Testing funding in round one through this FOA.

2. AWARD AMOUNT

Model Design: State Model Design awards will be based on the budget submitted by the state to support its work to produce a State Health Care Innovation Plan and Model Design proposal. The range for Model Design cooperative agreement awards is $1 million to $3 million**.** State budget proposals will be reviewed to determine the appropriateness of itemized budget expenditure estimates and the total requested amount. CMS reserves the right to request modifications to the Model Design budget and expenditure plan. Consideration will be given to

the size of the Medicaid, CHIP, and Medicare population in the state as well as the overall efficiency and sustainability of the proposal.

Model Testing: Up to five Model Testing cooperative agreements will be awarded under the State Innovation Models initiative in this first round of awards. Each state's budget plan will be reviewed to determine appropriateness of the amount requested based on the model's complexity, size of the target population, spectrum of state policy activity, level of multi-payer and other stakeholder engagement, the return on investment, and the strength of the evidence base or logic model in supporting the expected impact of the Plan. The proposals' savings estimates will be reviewed for their reasonableness by the CMS Office of the Actuary. These reviews will be taken into account in the selection process. CMS expects the total for each Model Testing award to range from **$20 to 60** million per state for the implementation and testing period. This amount would include any state cost of testing the model and meeting state and federal evaluation requirements as specified in Section VI.3 below. The Innovation Center is responsible for the evaluation of each Model Test. States must also develop their own model evaluation process, under the guidance of the Innovation Center. The state evaluations should focus on the impact on all populations, not just those enrolled in CMS programs. In general, we expect that Model Testing awards will cover only costs not normally part of a state's operational cost, data collection cost, or administrative cost.

States applying for Model Testing awards may receive pre-testing assistance ranging from **$1-3** million if they do not qualify for a full Model Testing award, but meet enough of the Testing award requirements to merit further consideration. The eligibility standards, deliverables and other requirements for pre-testing assistance awards are based on the review of the state's Model Testing application.

3. ANTICIPATED AWARD DATE

CMS expects to announce which states are being awarded cooperative agreements for Model Design on or around November 15, 2012. Two rounds of awards for Model Testing cooperative agreements are anticipated; CMS expects to announce which states are being awarded cooperative agreements for the first round of Model Testing on or around November 15, 2012.

4. PERIOD OF PERFORMANCE

Initial funding of Model Design, Model Testing, and pre-testing assistance awards is contingent upon the state's acceptance of the award's terms and conditions and, in the case of Model Testing awards, CMS approval of an operational plan submitted by the state.

States receiving Model Design awards and pre-testing assistance awards have six months from the funding award date to complete their State Health Care Innovation Plans and Model Designs. The period of performance and budget period for Model Design and Model Pre-Testing assistance awards will be six months, anticipated to be until May 14, 2013. The 42 month

performance period will be divided into four budget periods, with an initial budget period of six months followed by three budget periods of 12 months each. Following the initial six month budget period, non-competing continuation awards will be granted for each additional year of the cooperative agreement contingent upon availability of funding, state performance, and demonstrated progress towards the goals and objectives of this FOA. The anticipated test completion date for states receiving Track One Model Testing awards is May 14, 2016. The anticipated test completion date for states receiving Track Two Model Testing awards is November 14, 2016. The specific period of performance for each state model will be included in the cooperative agreement and be executed upon the approval and signing of each cooperative agreement.

Track 2 states receiving Model Testing awards involving new Medicaid waivers, new Medicare payment models and/or waivers under section 1115A(d)(1) authority will receive some initial limited funding during an anticipated six month waiver review period for state pre-implementation work. During this time their request(s) will be reviewed by federal officials and will be subject to otherwise applicable state and federal public notice, comment, and consultation periods. If the waiver and/or payment model is approved, the state will receive additional funding during a six month implementation period to complete their implementation activities and then three years of funding to test their model. The 48 month performance period will be divided into five budget periods, with an initial budget period anticipated to be six months for waiver review followed by six months for implementation activities, followed by three budget periods of 12 months each. Following the initial six month waiver review period (if the waiver and/or payment model is approved), non-competing continuation awards will be granted for each additional period of the cooperative agreement contingent upon availability of funding, state performance, and demonstrated progress towards the goals and objectives of this FOA and the terms of the agreed upon waiver. The specific period of performance for each state model will be included in the cooperative agreement and be executed upon the approval and signing of each cooperative agreement.

5. NUMBER OF AWARDS

Up to 25 states will receive Model Design cooperative agreements. Any pre-testing assistance awards will be counted toward this limit. Up to five Model Testing awards will be awarded in round one.

6. TYPE OF AWARD

Awards are for cooperative agreements.

7. TERMINATION OF AWARD

Continued funding is dependent on satisfactory performance against goals and performance expectations delineated in the cooperative agreement's terms and conditions and, if applicable, approved operational plans. CMS reserves the right to terminate the cooperative agreement if it is determined to be in its best interests. Projects will be funded subject to meeting terms and

conditions of the award, and subject to Section 1115A(b)(3)(B) of the Social Security Act, which requires the Secretary to terminate or modify the design and implementation of a model unless it is determined after testing has begun that it is expected to improve quality of care without increasing Medicare, Medicaid and CHIP spending, reduce Medicare, Medicaid and CHIP spending without reducing quality of care, or improve quality of care and reduce spending for Medicare, Medicaid, and CHIP beneficiaries.

Track 2 states selected for award that are requesting new or significantly modified Medicare payment models and/or Medicaid waivers will undergo a waiver review process before the implementation period can start. In the event a Medicare payment model or Medicaid Waiver is not approved, the cooperative agreement may be terminated or modified

CMS also may terminate or modify an agreement based upon CMS review of the state's progress, including a review of whether or how well quality and savings targets are met. In such cases CMS staff will make a recommendation to the CMS Administrator based on the best interests of CMS including consideration of the Innovation Center's mission to test and evaluate new payment and service delivery models. A decision to modify the agreement could extend the time a state is given to implement a model.

III. ELIGIBILITY INFORMATION

1. ELIGIBLE APPLICANTS

CMS invites the 50 state Governor's Offices, United States Territories' Governors' Offices (American Samoa, Guam, Northern Mariana Islands, Puerto Rico, and the Virgin islands), and the Mayor's Office of the District of Columbia to apply. Only one application from a Governor per state is permitted for Model Design requests, and one application for each round of Model Testing awards (assuming the state applied and was not selected for funding under the first round of Model Testing awards). A state cannot receive multiple Model Design, pre-testing assistance, or Model Testing awards. Each application must include a letter from the Governor (or the Mayor, if from the District of Columbia) officially endorsing the application for a Model Design award or for a Model Testing award.

Eligibility Threshold Criteria:

- Application deadline: Applications not received by the application deadline through www.grants.gov will not be reviewed.
- Application requirements: Applications will be considered for funding only if the application meets the requirements outlined in Section III, Eligibility Information and Section IV, Application and Submission Information.

- Page limit: Model Design applications shall not be more than 35 pages in length. The page limit for a Model Testing application is 65 pages and must be limited to the page maximums, sequence of sections, and section content specified in Section IV.2 Content and Form of Application Submission, parts C & D.
    - In addition, applications should include letters of support and participation from major stakeholders. These letters of support will not be included in the page limits for applications.
    - The cover page, standard forms, and financial analysis are also not included in these page limits.

States are strongly encouraged to review the criteria information provided in Section V, Application Review Information, to help ensure that the proposal adequately addresses all the criteria that will be used in evaluating applications and determining appropriate funding levels for each award.

Employer Identification Number: All applicants must have a valid Employer Identification Number (EIN) assigned by the Internal Revenue Service.

Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS number): All applicants must have a Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number in order to apply. The DUNS number is a nine-digit identification number that uniquely identifies business entities. Obtaining a DUNS number is free. To obtain a DUNS number, access the following website: www.dunandbradstreet.com or call 1-866-705-5711. See Section IV, Application and Submission Information, for more information on obtaining a DUNS number.

Central Contractor Registration (CCR) Requirement: All awardees must provide DUNS and EIN numbers in order to be able to register in the Central Contractor Registration (CCR) database at www.ccr.gov. Applicants must successfully register with CCR prior to submitting an application or registering in the Federal Funding Accountability and Transparency Act Subaward Reporting System (FSRS) as a prime awardee user. See Section IV, Application and Submission Information, for more guidance on CCR registration. Prime awardees must maintain a current registration with the CCR database, and **may make subawards only to entities that have DUNS numbers**. Organizations must report executive compensation as part of the registration profile at www.ccr.gov by the end of the month following the month in which this award is made, and annually thereafter (based on the reporting requirements of the Federal Funding Accountability and Transparency Act (FFATA) of 2006 (Pub. L. 109-282), as amended by section 6202 of Public Law 110-252 and implemented by 2 CFR Part 170)). See Section VI, Award Administration Information, for more information on FFATA.

2. COST SHARING OR MATCHING REQUIREMENTS

Cost sharing is not required.

3. FOREIGN AND INTERNATIONAL ORGANIZATIONS

Foreign and international organizations are not eligible to apply.

4. FAITH-BASED ORGANIZATIONS

Faith–based organizations are not eligible to apply.

IV. APPLICATION AND SUBMISSION INFORMATION

1. ADDRESS TO REQUEST APPLICATION MATERIALS

This Funding Opportunity Announcement serves as the application package for this cooperative agreement and contains all the instructions to enable a potential applicant to apply. The application should be written primarily as a narrative with the standard forms required by the Federal government for all cooperative agreements. A separate and complete application must be submitted for each type of submission and for each round of submission.

2. CONTENT AND FORM OF APPLICATION SUBMISSION

A. Letter of Intent to Apply

No letter of intent is required.

B. Application Materials

Application materials will be available for download at http://www.grants.gov. Please note that HHS requires applications for all announcements to be submitted electronically through http://www.grants.gov. For assistance with Grants.gov, contact support@grants.gov or call 1-800-518-4726. The Funding Opportunity Announcement can also be viewed on the Innovation Center website at http://innovations.cms.gov.

Specific instructions for applications submitted via http://www.grants.gov:

- You can access the electronic application for this project at http://www.grants.gov. You must search the downloadable application page by the CFDA number shown on the cover page of this announcement.
- At the http://www.grants.gov website, you will find information about submitting an application electronically through the site, including the hours of operation. HHS strongly recommends that you do not wait until the application due date to begin the

application process through http://www.grants.gov, because of the time needed to complete the required registration steps.

- All applicants under this announcement must have an Employer Identification Number (EIN) to apply. **Please note, the time needed to complete the EIN registration process can be substantial, and applicants should therefore begin the process of obtaining an EIN immediately upon posting of this FOA to ensure the EIN is received in advance of application deadlines.**
- All applicants, as well as sub-recipients, must have a Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number at the time of application in order to be considered for a grant or cooperative agreement. A DUNS number is required whether an applicant is submitting a paper application (only applicable if a waiver is granted) or using the Government-wide electronic portal, www.grants.gov. The DUNS number is a nine-digit identification number that uniquely identifies business entities. Obtaining a DUNS number is easy and free. To obtain a DUNS number, access the following website: www.dunandbradstreet.com or call 1-866-705-5711. This number should be entered in the block with the applicant's name and address on the cover page of the application (Item 8c on the Form SF 424, Application for Federal Assistance). The name and address in the application should be exactly as given for the DUNS number. **Applicants should obtain this DUNS number as soon as possible after the announcement is posted to ensure all registration steps are completed in time.**
- The applicant must also register in the Central Contractor Registration (CCR) database in order to be able to submit the application. Applicants are encouraged to register early, and must have their DUNS and EIN numbers in order to do so. Information about CCR is available at http://www.ccr.gov. The Central Contractor Registration process is a separate process from submitting an application. **You should allow a minimum of 5 business days to complete CCR registration; however, in some cases, the registration process can take approximately two weeks or longer to be completed. Therefore, applicants should begin the CCR registration process as soon as possible after the announcement is posted to ensure that it does not impair your ability to meet required submission deadlines.**
- Authorized Organizational Representative: The Authorized Organizational Representative (AOR) who will officially submit an application on behalf of the organization must register with Grants.gov for a username and password. AORs must complete a profile with Grants.gov using their organization's DUNS Number to obtain their username and password, at http://grants.gov/applicants/get_registered.jsp. AORs must wait one business day after registration in CCR before entering their profiles in Grants.gov. **Applicants should complete this process as soon as possible after**

successful registration in CCR to ensure this step is completed in time to apply before application deadlines.

- When an AOR registers with Grants.gov to submit applications on behalf of an organization, that organization's E-Biz point-of-contact will receive an e-mail notification. The e-mail address provided in the profile will be the e-mail used to send the notification from Grants.gov to the E-Biz POC with the AOR copied on the correspondence.

- The E-Biz POC must then login to Grants.gov (using the organization's DUNS number for the username and the special password called "M-PIN") and approve the AOR, thereby providing permission to submit applications.

- **Any files uploaded or attached to the Grants.Gov application must be PDF file format and must contain a valid file format extension in the filename. Even though Grants.gov allows applicants to attach any file format as part of their application, CMS restricts this practice and only accepts PDF file formats. Any file submitted as part of the Grants.gov application that is not in a PDF file format, or contains password protection, will not be accepted for processing and will be excluded from the application during the review process. In addition, the use of compressed file formats such as ZIP, RAR, or Adobe Portfolio will not be accepted. The application must be submitted in a file format that can easily be copied and read by reviewers. It is recommended that scanned copies not be submitted through Grants.gov unless the applicant confirms the clarity of the documents. Pages cannot be reduced in size, resulting in multiple pages on a single sheet, to avoid exceeding the page limitation. All documents that do not conform to the above constraints will be excluded from the application materials during the review process.**

- After you electronically submit your application, you will receive an automatic email from http://www.grants.gov that contains a Grants.gov tracking number. **Please be aware that this notice does not guarantee that the application will be accepted by Grants.gov. Rather, this email is only an acknowledgement of receipt of the application by Grants.gov.** All applications must be validated by Grants.gov before they will be accepted. Please note, applicants may incur a time delay before they receive acknowledgement that the application has been validated and accepted by the Grants.gov system. In some cases, the validation process could take up to 48 hours. If for some reason the application is not accepted, then the applicant will receive a subsequent notice from Grants.gov indicating that the application submission has been rejected. **Applicants should not wait until the application deadline to apply because notification by Grants.gov that the application is incomplete may not be received until close to or after the application deadline, eliminating the opportunity to correct errors and resubmit the application. Applications submitted after the deadline because the original submission failed validation and is therefore rejected by Grants.gov, as a result of errors on the part of the applicant, will not be accepted**

by CMS and/or granted a waiver. For this reason, CMS recommends that applicants apply in advance of the application due date and time.

- After HHS retrieves your application package from Grants.gov, a return receipt will be e-mailed to the applicant contact. This will be in addition to the validation number provided by Grants.gov.

- Each year organizations and entities registered to apply for Federal grants and cooperative agreements through http://www.grants.gov will need to renew their registration with the Central Contractor Registration (CCR). You can register with the CCR online; registration will take about 30 minutes to complete (http://www.ccr.gov). **Failure to renew CCR registration prior to application submission will prevent an applicant from successfully applying.**

Applications cannot be accepted through any email address. Full applications can only be accepted through http://www.grants.gov. Full applications cannot be received via paper mail, courier, or delivery service, unless a waiver is granted per the instructions below.

All applications for the awards must be submitted electronically and be received through http://www.grants.gov by the deadlines listed below:

All applications will receive an automatic time stamp upon submission and state applicants will receive an e-mail reply acknowledging the application's receipt.

The applicant must seek a waiver **at least** ten days prior to the application deadline if the applicant wishes to submit a paper application. Applicants that receive a waiver to submit paper application documents must follow the rules and timelines that are noted below.

In order to be considered for a waiver application, an applicant **must** have adhered to the timelines for obtaining a DUNS number, registering with the Central Contractor Registration (CCR), registering as an Authorized Organizational Representative (AOR), obtaining an Employer Identification Number (EIN), and completing Grants.gov registration, and must have requested timely assistance with technical problems. Applicants who do not adhere to timelines and/or do not demonstrate timely action with regards to these steps will not be considered for waivers based on the inability to receive this information in advance of application deadlines.

Please be aware of the following:

1) Search for the application package in Grants.gov by entering the CFDA number. This number is shown on the cover page of this announcement.

2) Paper applications are not the preferred method for submitting applications. However, if you experience technical challenges while submitting your application electronically,

please contact Grants.gov Support directly at: www.grants.gov/customersupport or (800) 518-4726. Customer Support is available to address questions 24 hours a day, 7 days a week (except on Federal holidays).

3) Upon contacting Grants.gov, obtain a tracking number as proof of contact. The tracking number is helpful if there are technical issues that cannot be resolved and a waiver from the agency must be obtained.

4) If it is determined that a waiver is needed from the requirement to submit your proposal electronically, you must submit a request in writing (e-mails are acceptable) to Michelle.Feagins@cms.hhs.gov with a clear justification for the need to deviate from our standard electronic submission process.

5) If the waiver is approved, the application should be sent directly to the Division of Grants Management and received by the application due date.

To be considered timely, applications must be received by the published deadline date. However, a general extension of a published application deadline that affects all state applicants or only those in a defined geographical area may be authorized by circumstances that affect the public at large, such as natural disasters (e.g., floods or hurricanes) or disruptions of electronic (e.g., application receipt services) or other services, such as a prolonged blackout.

Grants.gov complies with Section 508 of the Rehabilitation Act of 1973. If an individual uses assistive technology and is unable to access any material on the site, including forms contained with an application package, he or she can e-mail the Grants.gov contact center at support@grants.gov for help, or call 1-800-518-4726.

C. Format Requirements for Applications

Each application must include all contents described below, in the order indicated, and in conformance with the following specifications:

- Use 8.5” x 11” letter-size pages (one side only) with 1” margins (top, bottom, and sides). Other paper sizes will not be accepted. This is particularly important because it is often not possible to reproduce copies in a size other than 8.5” x 11”.

- All pages of the project narrative must be paginated in a single sequence.

- Font size must be 12-point with an average character density no greater than 14 characters per inch.

- The narrative portions of the application must be double-spaced.

- The project abstract is restricted to a one-page summary, which can be single-spaced.

Applications and attached proposals must not be more than 35 pages in length for Model Design awards, and no more than 65 pages for Model Testing awards. For Model Design this total includes the letter of endorsement, project abstract, project narrative, project plan and timeline, and the budget narrative and expenditure plan. For Model Testing, this total includes the letter of endorsement, project abstract, project narrative, project plan and timeline, budget narrative and expenditure plan, and the plan for performance reporting, continuous improvement, and evaluation support. The maximum page limit includes all supporting materials, including documentation related to financial projections, profiles of participating organizations, relevant letters of endorsement, etc. In addition, states should submit letters of support from other payers and stakeholders. The standard forms, financial analysis, and letters of support from other payers and stakeholders are NOT included in the page limits.

D. Application Content and Structure

Standard Forms

The following standard forms must be completed with an electronic signature and enclosed as part of the proposal:

a. SF 424: Official Application for Federal Assistance (see note below)

b. SF 424A: Budget Information Non-Construction

c. SF 424B: Assurances-Non-Construction Programs

d. SF LLL: Disclosure of Lobbying Activities

e. Project Site Location Forms(s)

f. Project Abstract Summary

Note: On SF 424 "Application for Federal Assistance":

a. On Item 15 "Descriptive Title of Applicant's Project", state the specific cooperative agreement opportunity for which you are applying: State Innovation Models.

b. Check "No" to item 19c, as Review by State Executive Order 12372 does not apply to this cooperative agreement funding opportunity.

Governor's Letter of Endorsement

A letter from the Governor (or Mayor, if from the District of Columbia) endorsing the project and identifying the title of the project, the principal contact person and the major partners, departments, and organizations collaborating on the project. The letter should be addressed to:

Michelle Feagins
Grants Management Officer
Office of Acquisition and Grants Management
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Room 733H-02
Washington, DC 20201

Project Abstract

A one-page abstract must succinctly describe the proposed project and should include the goals of the project, the total budget, the number of projected participants, projected total cost of care savings, and a description of how the funds will be used. The abstract is often distributed to provide information to the public and Congress, so please write the abstract so that it is clear, accurate, concise, and without reference to other parts of the application. Personal identifying information should be excluded from the abstract.

Model Design Proposal

The application narrative in Model Design applications must address how the applicant will carry out the design work required. Chart 1 below lists in tabular form the application package requirements and includes a brief description of the type of information that is required to be addressed within each section.

Model Testing Proposal

The application narrative for Model Testing applications must address the elements outlined in Chart 2 below, which include, but are not limited to, the following: model design, geographic areas and/or communities, the likelihood of success and potential risks, a financial analysis of the target population including demonstrated total cost savings and return on investment, the current status of patients' experience of care, the current population health status, other targeted improvements, other payers, all processes necessary for implementation and testing, and staffing resources and roles.

CHART 1: Application Package, Model Design Proposals

APPLICATION PACKAGE, MODEL DESIGN PROPOSALS		Maximum Pages
I.	Governor's Letter of Endorsement	2 pages
II.	Project Abstract	1 page

III. Project Narrative **A. State Health Care Innovation Plan Design Strategy** Describe the state's strategy for completing the work necessary to develop and deliver a Model Design (see required planning elements under Section. I, Funding Opportunity Description, 5. Model Design Proposal Requirements). Describe the payment and service delivery models and state policy levers and strategies included in the Model Design. Describe existing waiver ,Affordable Care Act implementation, other state health initiatives, coordinating efforts to align with the state's Healthy People 2020 plan and the National Prevention Strategy and the National Quality Strategy, and other Affordable Care Act activities within the state and describe how they will be integrated or support the State Health Care Innovation Plan. **B. Stakeholders** Provide a specific list of stakeholders and the roles they will play in the design process. **C. Public and Private Payer Participation** Provide a list and description of other payers and health plans that will be involved in the Model Design and financial or in-kind resources they will provide. **D. Project Organization** Provide a project organization chart and describe the roles of various key staff that will be involved in the Model Design. **E. Provider Engagement** Describe the state's plan to engage providers in delivery system transformation planning . Demonstrate the level of current participation by providers in transforming their care model and the reasons to believe they will supportive of the state's efforts.	24 pages
IV. Project Plan and Timeline Provide a project plan and timeline for completing the Model Design deliverables	3 pages

V. Budget Narrative and Itemized Expenditure Plan (note also need to complete SF-424A) A. Personnel costs (itemized) B. Fringe benefit costs C. Itemized description of contractors and/or vendor services and costs D. Travel and training costs E. Other costs (itemized) F. Indirect or overhead costs not itemized above (up to 10% of direct costs) G. Total funding requested H. Total other revenue or in-kind support; identify the sources of other funding. I. Equipment J. Attestation that Innovation Center funds will not supplant funding from other sources	5 pages
MAXIMUM NUMBER OF PAGES FOR MODEL DESIGN APPLICATIONS	35 pages
VI. Financial Analysis [CMS will provide a template for this section on its website]: A. Describe the populations being addressed and their respective total medical and other services costs as per member per month and population total B. Described anticipated cost savings resulting from specified interventions, including the types of costs that will be affected by the model and the anticipated level of improvement by target population C. Describe expected total cost savings and return on investment for the overall state model and basis for expected savings (previous studies, experience, etc.).	Defer to template.
VII. Letters of support and participation from major stakeholders	As much as needed.
VIII. Standard Forms	As much as needed.

CHART 2: Application Package, Model Testing Applications

MODEL TESTING APPLICATIONS	Maximum Pages
I. Governor's Letter of Endorsement for the State Health Care Innovation Plan	2 pages

II.	**Project Abstract**	1 page
III.	**State Health Care Innovation Plan**	As much as needed
IV.	**Project Narrative** **A. Description of the State Health Care Innovation Plan Testing Strategy** 1. Models purpose 2. Scope of the Models, include possible phase-in schedule(what are all the program components or services, participating payers engaged in the model test) 3. Description of the delivery system or payment model(s) that will be tested 4. Describe value propositions and the performance and improvement objectives to be achieved 5. Evidence basis for testing the model(s) 6. Theory of action that supports the model design and the impact that is expected on cost, quality, and population health. 7. Identify other federal initiatives operating in the state and how the model will coordinate or integrate with them, such as: Medicare Share Savings Program ACOs, Pioneer ACOs, Bundled Payment for Care Improvement initiative, Aging and Disability Resource Centers, Medicaid health homes, , the Money Follows the Person Demonstration Program, etc. 8. Plan for sustainability of the new payment and service delivery model(s) after testing phase. 9. Describe the potential to replicate the service delivery model in other states. 10. Describe the, geographic areas, or communities that will be the focus of model testing (how will the program be gradually rolled out to the state population.) 11. Describe the likelihood of success and the potential risk factors that must be addressed to increase the probability of success, such as stake holder engagement, and required state legislative action. 12. Describe current clinical quality and beneficiary experience outcomes and the specific improvement targets 13. Describe current population health status by target population and the target outcomes that are expected from the model 14. Identify other Medicare payment models and Medicaid waiver authorities, , including anticipated section 1115 demonstration requests, and a description of those requests Expected use of Medicaid State plan authorities, including any Medicaid State Plan amendments that would be needed 15. Describe the extent to which the proposal could be implemented if the requested new or significantly modified Medicare payment models,	43 pages total for Section IV (continued on next page)

modifications under section 1115A(d)(1) authority, or Medicaid section 1115 demonstration requests are not approved including how the proposal would benefit Medicare, Medicaid and CHIP beneficiaries in the absence of such approvals..

16. Describe any other targeted improvements not presented above
17. Project processes and operational planning – Identify necessary Model Testing processes to support the implementation and testing of the model:

    a. Data collection and reporting
    b. Provider payment systems
    c. Model enrollment or assignment processes
    d. Contracting and administrative processes
    e. Continuous improvement analysis and performance optimization process
    f. Other processes needed to complete delivery system reform
    g. Project Management and governance structure
    h. Describe model staffing resources and roles

B. Describe the expected transformation of the major provider entities within the state, the rationale for their transformation and include evidence that these groups have committed to making the specified changes.

This should include a listing of the major health care entities controlled by the state or local governments and plans for ensuring their transformation into entities capable of being accountable for population health outcomes and total cost of care consistent with the broader expectations for the delivery system models.

C. Describe the roles of other payers and stakeholders participating in the model

D. Describe linkage of Models to state's State Health Care Innovation Plan.

1. Identify other state reform initiatives and/or the use of other policy and/or regulatory authorities and levers of state government which will be central to the effort such as Certificate of Need (CON), licensing changes, school-based services, public health – including coordinating efforts to align with the state's Healthy People 2020 plan and the National Prevention Strategy and National Quality Strategy;
2. Describe the level of integrated community health and prevention and long-term service and supports in the state's multi-payer model.

E. Multi-Stakeholder Commitment – Describe state's plan to actively engage and obtain commitment from community stakeholders, such as: relevant public agencies such as public health, long-term services and support, behavioral health, mental health, substance abuse, developmental disabilities, and local health (city, county, or state-level), consumer organizations, and/or

community based organizations.	
V. Budget Narrative and Operational Expenditure Plan (note also need to complete SF-424A) A. Provide a three-year model testing budget and expenditure plan, (provide a budget for each year, including the 6 month implementation period). Provide a summary budget and expenditure that summarizes all Model Testing expenditures, and provides the following budget and expenditure plan detail: A. Personnel cost (Itemized) B. Fringe benefit cost C. Contract and vendor services cost (itemize by type) D. Equipment cost E. Travel, training, hotel cost (note - states must budget for attending SIM workshops and conferences) F. Supplies and miscellaneous G. System and/or data collection cost H. State evaluator costs I. Other (Itemized) J. Indirect or overhead charge to the project. Indirect charges, in compliance with 2 CFR Part 225 (previously OMB Circular A-87). For this Cooperative Agreement the indirect charge level is capped at 10 percent. If requesting indirect costs in the budget, a copy of the indirect cost rate is required. K. Other grants, revenues or in-kind services or resources that will be applied to the implementation and testing of the model, including support from other parties. L. Expected or needed funding from other Federal sources. M. Attestation that Innovation Center funding will not supplant any other funding sources N. Budget to collect data (including Medicaid/CHIP claims and cost data) and perform continuous quality improvement (monitoring and rapid cycle evaluation	10 pages total for Section V (continued on next page)
VI. Project Plan for Performance Reporting, Continuous Improvement, and Evaluation Support, including the following: A. Anticipated data needs; B. Description of data collection and performance reporting processes; C. Plans for coordinating data collection efforts with Innovation Center evaluation contractors;	5 pages

D. Methodology for state continuous improvement, in collaboration with Innovation Center evaluators; and E. Processes for continuous learning, adoption of best practices, and other performance improvement based on performance assessment and continuous improvement.	
VII. Project Plan and Timeline with milestones.	4 pages
MAXIMUM NUMBER OF PAGES FOR MODEL TESTING APPLICATIONS	**65 pages**
VIII. Financial Analysis [CMS will provide a template for this section on its website] A. Describe the populations being addressed and their respective total medical costs as per member per month and population total including expected or needed funding from other sources. B. Describe anticipated cost savings resulting from specified interventions, including the types of costs that will be affected by the model and the anticipated level of improvement by target population and basis for expected savings (previous studies, experience, etc.) C. Describe expected total federal cost savings and return on investment during the project period for the overall state model. Note the CMS Office of the Actuary will review and assess the reasonableness of achieving the cost savings in these documents and this review will be considered in the selection process.	Defer to template.
IX. Standard Forms	As much as needed.
X. Letters of support from participating major stakeholders	As much as needed.

Budget Narrative and Expenditure Plan (see Appendix 2 for more details)

All state applicants must submit a Form SF-424A and a Budget Narrative. For this cooperative agreement the application must include a budget for each year of the Model Testing period. Project proposals should include leveraging other funding resources, including private payers, foundations, ACA supported demonstrations and models, other federal funding resources, and other Innovation Center opportunities (as allowed by law). The expected or needed amount of funding from other sources should be included in the budget. Overhead and administrative costs must be reasonable, with a strong focus on operational implementation of the model. Budget and Expenditure Plans should include the cost of data collection, performance monitoring, and project expenditure reporting. Note: states cannot use funding from this initiative to supplant

other funding sources. States need to show how their models will be sustainable after the testing period is complete.

In addition, state applicants must supplement Budget Form SF-424A with a Budget Narrative. The Budget Narrative must include a yearly breakdown of costs for the entire project period. Specifically the Budget Narrative should provide a detailed cost breakdown for each line item outlined in the SF 424A by year, including a breakdown of costs for each activity/cost within the line item. The proportion of cooperative agreement funding designated for each activity should be clearly outlined. The Budget Narrative should reflect the organization's readiness to receive funding, and provide complete explanations and justifications for the proposed cooperative agreement activities. The budget must separate out funding that will be administered directly by the awardee from any funding that will be subcontracted.

All applicants must submit an SF-424A. To fill out the budget information requested on form SF-424A, review the general instructions provided for the SF 424A and follow the instructions outlined below.

Section A – Budget Summary

- *Grant Program Function or Activity* (column a) = Enter "State Innovation Models" in row 1.

- *New or Revised Budget, Federal* (column e) = Enter the Total Federal Budget Requested for the project period in rows 1 and 5.

- *New or Revised Budget, Non-Federal* (column f) = Enter Total Amount of any Non-Federal Funds Contributed (if applicable) in rows 1 and 5.

- *New or Revised Budget, Total* (column g) = Enter Total Budget Proposed in rows 1 and 5, reflecting the sum of the amount for the Federal and Non-Federal Totals.

Section B – Budget Categories

Enter the total costs requested for each Object Class Category (Section B, number 6) for each year of the project period.

- Column (1) = Enter the heading for this column as Year 1. Enter Year 1 costs for each line item (rows a-h), including the sum of the total direct charges (a-h) in row i. Indirect charges should be reflected in row j. The total for direct and indirect charges for all year 1 line items should be entered in column 1, row k (sum of row i and j).

- Column (2) = Enter the heading for this column as Year 2 (as applicable). Enter Year 2 costs for each line item (rows a-h), including the sum of the total direct charges (a-h) in row i. Indirect charges should be reflected in row j. The total for direct and indirect charges for all year 2 line items should be entered in column 2, row k (sum of row i and j).

- Column (3) = Enter the heading for this column as Year 3 (as applicable). Enter Year 3 costs for each line item (rows a-h), including the sum of the total direct charges (a-h) in row i. Indirect charges should be reflected in row j. The total for all year 3 line items should be entered in column 3, row k (sum of row i and j).

- Column (4) = Enter the heading for this column as Year 4 (as applicable). Enter Year 4 costs for each line item (rows a-h), including the sum of the total direct charges (a-h) in row i. Indirect charges should be reflected in row j. The total for all year 4 line items should be entered in column 3, row k (sum of row i and j).

- Column 5 = Enter total costs for all years of the project period for each line item (rows a-h), direct total costs (row i), and indirect costs (row j). The total costs for all line items for the project period should be entered in row k (sum of row i and j). The total in column 5, row k should match the total provided in Section A – Budget Summary, New or Revised Budget, column g, row 5.

Illustrative List of Allowable Model Design Costs

Allowable costs associated with state Model Design work could include:

- State staff costs to engage in model design
- Staff participation and travel to relevant learning collaboratives and workshops and other relevant learning and diffusion opportunities
- Investments in State data collection and analysis capacity and cost and utilization pattern analysis
- Consumer and provider engagement and focus group costs
- Actuarial modeling
- Performance measure development and evidence-based improvement research
- Business process analysis and requirement system analysis
- Policy, legal, and regulatory research to address legislative and legal frameworks for models
- Planning and convening for creating a statewide all–payer data-base

- Planning work relating to public health programs including the state's Healthy People 2020 plan, and meeting goals for the National Quality Strategy and/or National Prevention Strategy
- Model Design costs, including:

    - Model scope development
    - Theory of action development
    - Target population research
    - Setting performance targets
    - Financial analysis and analysis of health care trend impacts
    - Budget planning
    - Travel to SIM workshop and conferences

Illustrative List of Allowable Model Testing Costs

Allowable costs associated with state Model Testing work could include:

- Technical resources necessary to implement new models
- Model performance data collection, analysis, reporting cost
- Data center costs, and system information processing associated with the model testing
- Provider costs for data collection
- Coordination with Innovation Center rapid cycle evaluation, and costs for collecting and preparing data for Innovation Center evaluator and/or state evaluator
- Staff resources associated with model management and project management, including travel to SIM workshops and conferences
- Simulation and modeling cost
- Provider and beneficiary data management system cost
- Health information exchange cost associated with the model
- Infrastructure costs to build or expand telemedicine system
- Model beneficiary assignment or reconciliation cost
- Web and internet collaborative learning and communication cost
- Project management and reporting cost
- Business operation associated with the model
- Model contract management and administration
- Building a statewide all–payer database
- Impact model evaluation data collection, reporting, beneficiary and provider survey data, and other costs associated with final model evaluation
- In addition, on a limited, case-by-case, basis CMS may consider funding provider payments for performance-based shared savings.

- Other activities necessary to implement the overall State Health Care Innovation Plan that will further the testing of payment and service delivery models and improve outcomes for Medicare, Medicaid and CHIP beneficiaries.

States should consider the most efficient use of funds within the range of award amounts when developing a proposal.

3. SUBMISSION DATES AND TIMES

A. Letter of Intent to Apply

None Required.

B. Cooperative Agreement Applications Due Dates

Model Design Application Due Date

September 17, 2012 by 5 p.m. Eastern Daylight Time

Model Testing Application Due Dates

First Round Due Date:

September 17, 2012 by 5 p.m. Eastern Daylight Time

4. INTERGOVERNMENTAL REVIEW

Applications for these cooperative agreements are not subject to review by states under Executive Order 12372, "Intergovernmental Review of Federal Programs" (45 CFR 100). Please check box "C" on item 19 of the SF 424 (Application for Federal Assistance) as Review by State Executive Order 12372, does not apply to these cooperative agreements.

5. FUNDING RESTRICTIONS

Indirect Costs

If requesting indirect costs, an Indirect Cost Rate Agreement will be required. For this Cooperative Agreement funding opportunity indirect costs are limited to 10%.

The provisions of 2 CFR Part 225 (previously OMB Circular A-87) govern reimbursement of indirect costs under this solicitation. A copy of these cost principles is available online at: http://www.whitehouse.gov/sites/default/files/omb/fedreg/2005/083105_a87.pdf

Direct Services

Cooperative Agreement funds may not be used to provide individuals with services that are already funded through Medicare, Medicaid, and/or CHIP

Reimbursement of Pre-Award Costs

No cooperative agreement funds awarded under this solicitation may be used to reimburse pre-award costs.

Prohibited Uses of Cooperative Agreement Funds

- To match any other Federal funds.
- To provide services, equipment, or support that are the legal responsibility of another party under Federal or state law (e.g., vocational rehabilitation, criminal justice, or foster care) or under any civil rights laws. Such legal responsibilities include, but are not limited to, modifications of a workplace or other reasonable accommodations that are a specific obligation of the employer or other party.
- To supplant existing Federal state, local, or private funding of infrastructure or services.
- To be used by local entities to satisfy state matching requirements.
- To pay for the use of specific components, devices, equipment, or personnel that are not integrated into the entire service delivery and payment model proposal.
- To lobby or advocate for changes in Federal and/or state law.

V. APPLICATION REVIEW INFORMATION

In order to receive a cooperative agreement for either Model Design or for Model Testing, states must submit an application in the required format, no later than the established deadline date and time. Applications that do not meet all the technical requirements will not be reviewed.

If an applicant fails to submit all of the required documents or does not address each of the topics described below, the applicant risks not being awarded a cooperative agreement.

As indicated in Section IV, Application and Submission Information, all state applicants for Model Design awards must submit the following:

1) Standard forms
2) Letter of Endorsement from Governor
3) Project abstract

4) Model design strategy
5) Description of stakeholder engagement
6) Evidence of public and private payer participation
7) Project organization information
8) Provider Engagement
9) Project plan and timeline
10) Budget narrative and itemized expenditure plan
11) Financial Analysis demonstrating net savings
12) Letters of support and participation from major stakeholders

All state applicants for Model Testing awards must submit the following:

1) Standard forms
2) Letter of Endorsement from Governor
3) Project abstract
4) State Health Care Innovation Plan
5) Description of the model testing strategy
6) Description of expected engagement and transformation of major provider entities within the state
7) Description of roles of other payers and stakeholders participating in the model
8) Description of linkage of Models to state's State Health Care Innovation Plan
9) Description of multi-stakeholder engagement and commitment
10) Budget Narrative and expenditure plan
11) Financial Analysis demonstrating net savings
12) Plan for performance reporting, continuous improvement, and evaluation support
13) Model Testing project plan and timeline with milestones
14) Letters of support and participation from major stakeholders including key provider groups, and payers committing to transforming their clinical and business models in support of the Model objectives.

1. CRITERIA

Model Design Awards: States that submit Model Design applications will be reviewed and scored based on the quality of their proposals. The review criteria for Model Design applications are based on a total of 100 points allocated across the following areas:

Model Design Strategy (30 points)

States must present their commitment and rationale for comprehensive health care transformation planning, their approach to Model Design, including payment and service delivery models, and their plans for the following activities: engaging stakeholders,

obtaining multi-payer participation, employing state policy levers, coordinating efforts to align with the state's Healthy People 2020 plan, the National Prevention Strategy and National Quality Strategy, and working with other experts and resources. States must explain the unique features of their design efforts and how their plan supports sustainable and accelerated improvements in cost, quality and population health, including for Medicaid and CHIP beneficiaries.

Plan for Provider Engagement (15 Points)

States must demonstrate their strategy to engage the major providers of healthcare in the state in a discussion of delivery system transformation. This should include a plan to ensure that state controlled entities such as university medical schools and public hospitals will commit to delivery system transformation to deliver improvements in cost, quality and population health.

Evidence of Payer, Consumer and other Stakeholder Engagement (15 points)

The state must describe the stakeholder participation in the model design process. States are expected to identify a broad group of stakeholders and create a mechanism for their effective participation in planning of the State Health Care Innovation Plan and document the development of a multi-payer Model Design.

Organizational Capacity, Project Plan and Timeline (10 points)

The state must demonstrate the organizational capacity and expertise to successfully complete the Model Design process. The project plan and timeline should be well described. The staff or consultants proposed to lead the planning effort should have the skills and experience needed to ensure smooth and effective implementation.

Model Design Budget and Financial Analysis (30 points)

The proposed budget is carefully developed and consistent with the Model Design requirements. Overhead and administrative costs are reasonable (limited to 10% of direct costs), with funding focused on supporting the Model Design effort. States should indicate other resources that will aid in completing the Comprehensive Health Care Transformation Plan and Model Design including the use of other Federal funding sources. The proposal should document how the overall Financial Analysis, including population and intervention specific savings will be developed.

Model Testing Awards: States that submit Model Testing applications will be reviewed and scored based on the quality of their proposals. The Model Testing proposals receiving the highest scores, and meeting other criteria specified under the Review and Section Process section

of this FOA, will be offered cooperative agreements to implement and test multi-payer payment and/or service delivery models. States with lower scores signifying that additional implementation work is needed, may be offered pre-testing assistance awards. Part of the review process will include an analysis of the readiness of the state to implement a model within six months after approval of a cooperative agreement award. Applications will be scored with a total of 100 points possible. The following criteria will be used to evaluate applications received in response to this solicitation:

Model Testing Strategy (25 points)

The Model proposed is aligned with the goals of the state's State Health Care Innovation Plan to allow CMS to test whether pursuing new payment and service delivery models in the context of a broad, State Health Care Innovation Plan delivers better outcomes. The Model Testing strategy should clearly describes the payment and service delivery system models being tested and be well-designed, well-justified, specific, measurable, and meet the intended goals of the SIM initiative to reduce costs, improve quality, improve population health, and integrate well with other CMS and Innovation Center initiatives. The strategy also includes creating through the Innovation Plan a context that is supportive of delivery system transformation. The proposal should also identify potential risk factors that must be addressed to increase the probability of success.

- Most significantly the project offers a high potential for success in producing better health, better care and lower costs through improvement for Medicare, Medicaid/CHIP, dual eligible beneficiaries and other broad segments of the state's population (including in the absence of any requested waivers or new models, as described below).

- The proposal clearly states how current beneficiary protections such as quality, access, and due process will be maintained, or improved.

- The proposal presents a strong value proposition indicating it is operationally feasible and cost-effective, and includes a sound actuarial model for the targeted utilization and cost reductions. Note that the CMS Office of the Actuary will review savings estimates to determine if they are reasonable, and its review will be considered in the selection process.

- The proposal shows that the state is broadly using its unique policy and regulatory authorities to create a context that will accelerate delivery system transformation, address health care workforce gaps, and develop innovative approaches to leveraging community health resources including long-term services and support.

- The proposal presents the evidence basis for testing the model(s) and the theory of action that supports the Model Design and the impact that is expected on cost, quality, and population health.

- The proposal shows high potential for replicating its delivery system and/or payment models, if proven successful, in other states.

- The proposal shows a high level of integrated community health and prevention in a multi-payer model, including coordinating efforts to align with the state's Healthy People 2020 plan and the National Prevention Strategy and National Quality Strategy.

- The proposal utilizes, when possible, and otherwise complements other CMS initiatives and programs and, where applicable, coordinates efforts between specific initiatives and the state's Model Testing proposal.

- The proposal includes documentation requesting needed waivers or amendments to the Medicaid State plan, if necessary. The proposal provides the required information on how the proposal could be implemented if such Medicaid waiver requests or new or significantly modified Medicare payment models are not granted and indicates whether the state would like to pursue the proposal without the requested waivers or models.

- The proposal describes the target populations, geographic areas, or communities that will be the focus of service delivery and payment model testing, the current quality and beneficiary experience outcomes including current health population status, and the specific improvement targets expected from the models. The proposal demonstrates the ability to impact care delivery for a preponderance of the population over the three years of the initiative.

- The proposal details a plan for sustainability after the testing period.

Evidence and Scope of Provider Engagement (15 Points)

The Model demonstrates that the major providers of health care in the state are actively involved in delivery system transformation such that the preponderance of care for the state's population will be transformed. This includes a commitment from the array of institutions receiving state funds for medical education such as hospitals and universities. These commitments include specific plans for changes to the clinical and business models of these organizations. Similarly, the proposal demonstrates the engagement of

other major delivery providers (aging, disability, mental health safety-net, health centers and other provider communities) to transformation.

Participation of Other Payers (15 points)

- The proposal demonstrates financial and participation commitment from the state and community stakeholders (e.g., employers and other payers) to participate in the proposed care delivery or payment models and the overall Innovation Plan.

- The proposal incorporates the participation of other payers in providing joint funding for the payment or care delivery model or for existing payment pilots or multi-payer initiatives (e.g., medical/health homes, quality reporting initiatives).

- The proposal demonstrates an alignment among all payers of payment methodologies and delivery system definitions.

Organizational Capacity, Project Plan and Timeline (5 points)

- Ability to meet the six month implementation requirement supporting testing and evaluation of the model. Provides a clearly defined project plan and timeline with milestones. If a state proposes to implement a model in phases, it must demonstrate the ability, with a defined phase-in schedule, to complete the full implementation process within the three year period.

- Strong, experienced leadership and management team in place to implement, coordinate, and work with other payers and engage stakeholders and to operationalize the model.

- The operational plan is well-described (including systems and infrastructure necessary) and shows evidence of effectively supporting the project. The operational plan includes a detailed implementation plan.

- Dedicated project coordinator and point of contact with well-defined project management structure to ensure accountability. Demonstrated plans for project accountability, including plans to report on project operations, cooperate with the government monitoring plans, and provide information needed to evaluate the project results.

- Evidence of the ability to collect data and support evaluation efforts, including data collection, provider payment system, and beneficiary assignment.

- Governance structures and functions in place, with clear decision-making processes.

Multi-Stakeholder Commitment (5 points)

- Active engagement and commitment from Medicaid/CHIP officials, other relevant public agencies such as public health, behavioral health, including mental health and substance abuse developmental disabilities, aging, and local health (city, county, or state-level).

- Demonstrated involvement and support and commitment by consumer organizations, physicians, hospitals, health plans, specialty providers, health centers, employers, community-based organizations, safety-net providers, foundations, Area Agencies on Aging, developmental disability providers, pharmacies, laboratories, and other key stakeholders essential to enabling state-wide health system transformation.

Model Testing Operational Budget Financial Analysis and Model Sustainability (25 points)

Applications should propose budget and expenditure plans to demonstrate a careful stewardship of Federal resources while being sufficient to carry out the work required for Model Testing. States may include itemized lists of specific support activities they are requesting from CMS. For example, the provision of whatever Medicare, Medicaid and/or CHIP data files that can reasonably be made available, the analysis of aspects of model performance that are outside of the purview of the state, or the provision of information about CMS quality, cost, or population health measures. In preparing budgets applicants need to acknowledge in writing that CMS will not make facilities, equipment, or IT system resources available beyond the scope specified in the cooperative agreement, as determined through prior agreement with CMS. Proposals dependent on CMS involvement may receive lower evaluation scores.

- Project proposal includes leveraging other funding resources, including private payers, foundations, Affordable Care Act demonstrations, other federal funding resources, and other CMS opportunities (in each case, to the extent permitted by law). Proposal indicates the amount of expected or needed funding from other Federal sources.

- Indirect costs are reasonable (limited to 10% of direct costs), with a strong focus on operational implementation of the model.

- Budget and Expenditure Plan includes appropriate funding for performance monitoring, data collection, and model progress tracking and reporting. While awardees are expected to cooperate with, and facilitate the role of, the Innovation Center and its evaluation contractor, it is not necessary to budget for these Federal activities beyond allowance for state staff time for interactions and data reporting. For example, the state is not expected to provide work space for federal participants.

- Proposals should also note the resources aside from Federal monies that will be used to support the broader multi-dimensional aspects of the Model. For example, public health department, school system, licensing and inspection, certificate of need resources, etc., that will be aligned with the broader initiative.

- The Financial Analysis should include the total cost of care for the populations addressed, anticipated savings for specific populations and/or interventions/models tested. The plan is expected to demonstrate a positive net savings for CMS programs (over the test period), i.e., a significant positive return on investment. Note: the financial analyses will be reviewed by the CMS Office of the Actuary and this review will be considered by in the selection process.

Performance Reporting and Continuous Improvement and Evaluation Support (10 points)

The proposal explains the state's method for continuous improvement and performance improvement and describes how the state will work with the Innovation Center evaluator.

- Well-designed data collection, performance reporting plan that provides for identifying and acquiring necessary data to evaluate the state's model.

- Coordination between the Innovation Center evaluation contractor and the state is clearly explained.

- The proposal demonstrates a commitment to continuous learning and the adoption of best practices, and articulates how these processes will be employed.

- Proposals that require data, CMS specific expertise, or analytical resources from CMS should anticipate and specify this need.

2. REVIEW AND SELECTION PROCESS

There will be separate review processes for Model Design and Model Testing. CMS will work closely with the applicant to determine the appropriate funding amount. The review process will include the following:

- Applications will be screened for completeness and adherence to eligibility requirements for the category states' have applied for: Model Design or Model Testing. Applications received late or that fail to meet the eligibility requirements detailed in this solicitation or do not include the required forms will not be reviewed.

- An objective review panel will assess each application to determine the merits of the proposal and the extent to which the proposed model furthers the purposes of the SIM. In addition to the review panel, CMS will provide an assessment of the state's readiness to conduct the work required, based on the application submitted by the state. In cases where CMS determines that the applicant does not appear ready to conduct Model Testing work, CMS may use this information as part of the award approval process. For Model Testing applicants, this review process may result in an award for pre-testing assistance. All applications for Model Testing funding will be considered at the same time, regardless of whether they would be considered Track 1 or Track 2. They will be reviewed by the objective review panel

- For Model Testing applications, the CMS Office of the Actuary will provide an assessment of the reasonableness of the state's savings estimates. CMS reserves the right to request that state applicants revise or otherwise modify their proposals and budget.

Concurrently, a working group consisting of staff from CMS, HHS, and OMB will review whether proposals will require a new or modified Medicare payment/delivery model and/or Medicaid waivers or state plan amendments thereby differentiating Track 1 and Track 2 proposals. Track 2 proposals will then be evaluated to determine the feasibility of these requests, including the any related regulatory issues raised by the requests. Track 2 states selected for award, that are requesting new Medicaid waivers will need to submit a separate request for Medicaid 1115 demonstration waiver, and all waiver will undergo a full separate federal review. All otherwise applicable state and federal public notice, comment, and consultation periods will apply and may influence the time period for review. Track 2 awardees will receive a limited, initial funding amount while requests for new payment models and/or Medicaid waivers are reviewed. This limited funding will be available only for activities consistent with the purposes of this Funding Opportunity Announcement even if the awardee's request for a Medicaid waiver or new Medicare payment model is not ultimately approved.

- Implementation funds to states who have received Model Testing awards and are requesting waivers will not be made available until the waiver is approved and understanding exists between the state and federal government on the programmatic detail of any requested waiver, demonstration, or payment model, or a denial of the waiver request. <u>If Medicare participation or Medicaid waiver, demonstration, or payment model is denied,</u> and it has been determined that the State's request cannot be accomplished through existing authorities, <u>the cooperative agreement may be terminated.</u>

- The results of the objective review of Model Testing applications by qualified experts will be used to advise the approving CMS official who will make the final award decisions. In making these decisions, the CMS approving official will take into consideration: recommendations of the review panel; the geographical diversity of awardees; the readiness of the state to conduct the work required for Model Testing proposal; the range of service delivery and payment models proposed; the scope of impact across different state population segments; reviews for programmatic grants management and other compliance; the results of the feasibility review of any Medicaid waiver or new/modified Medicare payment models the State has requested (if any) and the viability of the model (including its ability to improve quality and reduce spending for Medicare, Medicaid and/or CHIP) without any such waiver or new or Significantly modified Medicare payment model; the reasonableness of the estimated cost to the government and anticipated results; the net Federal savings potential over the project period as reviewed and verified by OACT; the likelihood that the proposed Model will result in the benefits expected, including a positive return on investment. If OACT assesses the state's potential for savings and determines that a state's model is not likely to achieve significant savings, the CMS approving official has the right to revise the funding order recommended by the panel.

- Successful state applicants will receive one cooperative agreement award issued under this announcement for the appropriate funding category: Model Design, Model Testing, or pre-testing assistance. CMS reserves the right to approve or deny any or all proposals for funding. Note that Section 1115A of the Social Security Act specifies that there is no administrative or judicial review of the selection of organizations, sites, or participants to test models.

3. ANTICIPATED ANNOUNCEMENT AND AWARD DATES

Opportunity Announcement: July 19, 2012

Awards: Anticipated date of awards for Model Design or Model Pre-Testing assistance is November 15, 2012. Anticipated date of First round awards for Model Testing is November 15, 2012. All cooperative agreement awards (Model Design, Model Pre-Testing assistance, Model Testing) will have an initial budget period of six months.

VI. AWARD ADMINISTRATION INFORMATION

1. AWARD NOTICES

Successful applicants will receive a Notice of Award (NoA) signed and dated by the CMS Grants Management Officer. The NoA is the document authorizing the cooperative agreement award

and will be sent through electronic mail to the applicant organization as listed on the SF424. Any communication between CMS and applicants prior to issuance of the NoA is not an authorization to begin performance of a project.

Unsuccessful applicants are notified within 30 days of the final funding decision for each cooperative agreement and will receive a disapproval letter via the U.S. Postal Service and/or electronic mail.

Federal Funding Accountability and Transparency Act (FFATA) Subaward Reporting Requirement: New awards issued under this funding opportunity announcement are subject to the reporting requirements of the Federal Funding Accountability and Transparency Act of 2006 (Pub. L. 109–282), as amended by section 6202 of Public Law 110–252 and implemented by 2 CFR Part 170. Grant and cooperative agreement recipients must report information for each first-tier sub-award of $25,000 or more in Federal funds and executive total compensation for the recipient's and sub-recipient's five most highly compensated executives as outlined in Appendix A to 2 CFR Part 170 (available online at www.fsrs.gov).

2. ADMINISTRATIVE AND NATIONAL POLICY REQUIREMENTS

The following standard requirements apply to applications and awards under this FOA:

- Specific cost principles and administrative requirements, as outlined in 2 CFR Part 225 and 45 CFR Part 92, apply to cooperative agreements awarded under this announcement.
- All awardees under this project must comply with all applicable Federal statutes relating to nondiscrimination including, but not limited to:
    - Title VI of the Civil Rights Act of 1964,
    - Section 504 of the Rehabilitation Act of 1973,
    - The Age Discrimination Act of 1975, and
    - Title II Subtitle A of the Americans with Disabilities Act of 1990.

All equipment, staff, other budgeted resources, and expenses must be used exclusively for the project identified in the state's original cooperative agreement application or agreed upon subsequently with HHS, and may not be used for any prohibited purposes.

Terms and Conditions

Cooperative agreements issued under this FOA are subject to the *Health and Human Services Grants Policy Statement (HHS GPS)* at http://www.hhs.gov/grantsnet/adminis/gpd/. Standard terms and special terms of award will accompany the Notice of Award. Potential awardees should be aware that special requirements could apply to awards based on the particular

circumstances of the effort to be supported and/or deficiencies identified in the application by the HHS review panel. The General Terms and Conditions that are outlined in Section II of the HHS GPS will apply as indicated unless there are statutory, regulatory, or award-specific requirements to the contrary (as specified in the Notice of Award).

Cooperative Agreement Terms and Conditions of Award

The following categories of special terms of award are in addition to, and not in lieu of, otherwise applicable OMB administrative guidelines, OMB cost principles at 2 CFR Part 225, HHS grant administration regulations at 45 CFR Part 92 (Part 92 is applicable when state and local Governments are eligible to apply), and other HHS and PHS grant administration policies. CMS reserves the right to include any of the terms outlined below in the cooperative agreement with an appropriate level of specific details:

- Reporting (financial, quality, progress)
- Learning and Diffusion (training)
- Stakeholders (public notice, tribal consultation)
- Beneficiaries (access, enrollment, change in rights)
- Providers (approval of training)
- Payers (rate setting, marketing)
- Project Monitoring (contract review, audits)
- Data Collection (data integrity, use of data)
- Evaluation (rapid cycle and impact)
- Termination
- Funding
- Financial Arrangements
- Operations (information technology, claims, personal health information)
- Program Integrity

The administrative and funding instrument used for this program will be a cooperative agreement, an assistance mechanism in which substantial CMS programmatic involvement with the State is anticipated during the performance of the activities. Under each cooperative agreement, CMS' purpose is to support and stimulate the state's activities by involvement in and

otherwise working jointly with the award state in a partnership role. To facilitate appropriate involvement during the period of this cooperative agreement, CMS and the state will be in contact monthly and more frequently when appropriate.

Cooperative Agreement Roles and Responsibilities are as follows:

Centers for Medicare and Medicaid Services

CMS will have substantial involvement in program awards, as outlined below:

- Technical Assistance: CMS will provide technical assistance throughout the period of the cooperative agreement.
- Collaboration: To facilitate compliance with the terms of the cooperative agreement and to more effectively support states, CMS will actively coordinate with certain critical stakeholders, such as:

    - State-designated entities and
    - Other relevant federal agencies including but not limited to the Administration for Community Living, the Substance Abuse and Mental Health Services Administration, the Health Resources and Services Administration, the U.S. Office of Personnel Management, the Indian Health Service, the Internal Revenue Service, the Department of Homeland Security, the Administration for Children and Families, the Department of Veterans Affairs, and the Social Security Administration.

- Program Evaluation: CMS will work with states to implement lessons learned to enable other states to undertake health care transformation plans.
- Progress against the Model Design and Model Testing Work Plans: CMS will evaluate grant performance and progress against the grantee's Work Plan and will allow access to funding in alignment with state progress.
- Project Officers and Monitoring: CMS will assign specific Project Officers to each Cooperative Agreement award to support and monitor States throughout the period of performance. HHS Grants Management Officers and Project Officers will monitor, on a regular basis, progress of each State. This monitoring may be by phone, document review, on-site visit, other meeting and by other appropriate means, such as reviewing program progress reports and Federal Financial Reports (SF425). This monitoring will be to determine compliance with programmatic and financial requirements.
- Conference and Training Opportunities: CMS will host opportunities for training and/or networking, including conference calls and other vehicles.

States

States and assigned points of contact retain the primary responsibility and dominant role for planning, directing and executing the proposed project as outlined in the terms and conditions of the Cooperative Agreement and with substantial CMS involvement. States' responsibilities include:

- Fulfilling requirements: comply with all current and future requirements for Model Design and/or Model Testing.
- Collaboration: collaborate with the critical stakeholders listed in this funding opportunity and the HHS team, including the assigned Project Officer. States are also required to collaborate with their state Medicaid Directors, state Insurance Commissioners, and other key state stakeholders such as state developmental disabilities directors, aging directors, HIT coordinators, mental health directors, substance abuse directors, etc.
- Reporting: comply with all reporting requirements outlined in this funding opportunity and the terms and conditions of the cooperative agreement to ensure the timely release of funds.
- Program Evaluation: cooperate with Innovation Center directed evaluations.

3. REPORTING

The Innovation Center will take an active and substantial role in the evaluation and monitoring of SIM Design and Model Testing awards, and pre-testing assistance awards. The activities funded under the cooperative agreement and their resulting State responsibilities will be part of performance tracking, measuring, and evaluation responsibilities of CMS and the Innovation Center. In the case of Model Design awards, CMS will examine how the states used the funds. We will examine whether the planning and design support resulted in the multiple payers in the state coming together to develop a plan to transform the delivery system. To the extent that a delivery system reform plan was developed, we will examine the extent to which the plan was implemented, whether health care spending in those states changed over time, and what was the impact on health care quality.

Performance assessment, monitoring, and evaluation for Model Testing awards will focus on

- Impact on quality of care, patient experience, and health status
- Impact on health care costs
- Implementation and testing performance, including:

    - Meeting proposed design and planning or implementation and testing milestones.
    - Demonstrating readiness to carry out design and planning work or implementation activities required to test the proposed model.

- Producing timely and accurate reports showing clear progress on design and planning activities or providing the required data, and/or reports on health care cost, quality, and population health performance, as delineated in the cooperative agreement.
- Community integration of health care

A. Progress Reports

Awardees must agree to cooperate with any federal evaluation of the model and performance results and provide required quarterly, semi-annual (every six months), annual and final (at the end of the cooperative agreement period) reports in a form prescribed by CMS. Reports will be submitted electronically. These reports will include how cooperative agreement funds were used, describe project or model progress, and describe any barriers, delays, and measurable outcomes. CMS will provide the format for project and model reporting and technical assistance necessary to complete required report forms. States must also agree to respond to requests that are necessary for the evaluation of the Model Design, pre-testing assistance, or Model Testing efforts and provide data on key elements of model performance and on results from the cooperative agreement activities.

B. Project Monitoring

CMS will enlist a third party entity to assist in monitoring the model implementation and testing performance results and outcomes. CMS plans to collect data elements to be part of monitoring for all of the different state models, and these monitoring and surveillance elements will feed into the evaluation. All awardees will be required to cooperate in providing the necessary data elements to CMS or a CMS contractor. The contractor would assist CMS in developing cost, quality, beneficiary experience, and population health monitoring and review model performance to ensure model design requirements are met; tracking performance across awardees and providing for rapid cycle evaluation and early detection of model performance issues; developing a system to collect, store, and analyze data to assess health care cost and utilization, quality performance, beneficiary experience, and population health improvements and assisting with state implementation, including coordination between states and CMS and its other contractors.

Data for monitoring will include process, safety, and performance measures including beneficiary experience. It will include, but will not be limited to, data on the background characteristics of the target population and target area, data characterizing the activities of the model testing and a battery of follow-up data describing relevant characteristics of the target population or target area and metrics at selected intervals after commencement of the delivery system and/or payment model. This will include detailed information on participant characteristics and outcomes reported in a standard format. Data for monitoring will be collected from awardees and/or CMS claims data, electronic health record, public health or other sources. The model monitoring aspect of this initiative will balance the examination of the extent to

which awardees demonstrate fidelity to their proposed delivery system and payment models and the potential need to make mid-course corrections that improve or optimize performance of the delivery system or payment models based on feedback from the monitoring and rapid cycle evaluation findings. The evaluation will also assess whether there is evidence of harm or unintended consequences as a result of the models or testing methods.

C. Evaluation

The evaluation strategy for this initiative includes three parts: an overall design and data collection phase, rapid cycle evaluation of state models, and an impact evaluation.

Broadly, CMS will evaluate each design and each state model and then compare all models to identify themes related to improved care and health outcomes and reduced costs. While states must play an active role in these evaluations, particularly in regard to Medicaid and CHIP benefits, so that these evaluation efforts continue after the model funding has ended; CMS has ultimate responsibility for the evaluation process and reports. Each state is encouraged to identify a research group, preferably within the state, that will assist in the evaluation and develop in-state evaluation expertise. An Innovation Center contractor will help develop methodological and data standards, conduct monitoring and rapid-cycle evaluation to promote real-time program improvement, and conduct the impact evaluations.

D. Evaluation Design and Data Collection

An external contractor will support the Innovation Center during the Implementation and Testing process. This Innovation Center evaluator will work with each state to develop standards for data collection and use and for data reporting, as well as requirements for those data elements that will be collected by the states and reported to CMS. The Innovation Center evaluator will also define the measures to be used and evaluation methods to be employed. Data collection is central to the success of the evaluation. Adhering to the data collection requirements will be a condition of participating in this initiative.

States are expected to cooperate in the evaluation process and provide the necessary data to evaluate state models. This data will be shared with the state evaluator team and with Innovation Center evaluation contractors. The evaluation will rely on multi-pronged data collection in order to understand the context of the model and to capture the nuances occurring at the model sites. Data for the analyses will be collected collaboratively between the Innovation Center evaluation contractor and the states themselves, and will come from sources including, but not limited to: provider surveys; Medicare administrative claims; state Medicaid and CHIP programs; beneficiary experience surveys; site visits with practices; and focus groups with beneficiaries and their families and caregivers, practice staff, direct support workers and others (*e.g.*, payers). Additional data requirements may include states providing Medicaid encounter data (baseline

and during the model test period) if relevant to program evaluation. The requirement for data and methods for evaluation will be finalized upon approval of the state model.

The state evaluation contractor will be expected to create State evaluations relevant to all populations and payer involved in the State initiative; data collection, storage, cleaning and creation of analytic datasets; continuous quality improvement and analysis of evaluation metrics on a quarterly basis; and working with the Innovation Center evaluator to supply necessary data. The State evaluation contractor needs to be an independent entity. The State's agreement with their evaluation contractor will be reviewed by CMS to ensure the evaluator's capabilities.

CMS will use qualitative interviews with state administrators and providers to understand the organizational structures, the approaches to overcoming barriers, and the kinds of facilitators at the state level that are associated with success.

The Innovation Center evaluation contractor will be asked to work closely with CMS to establish key measures to be used across evaluations for all models from participating states. The Innovation Center has developed a core measure set which will be enhanced to include priority metrics of success for delivering better health care, better health, and reduced cost. One particular focus of this effort will be an evaluation of the state model on population health metrics to better understand how state approaches influence broad determinants of health and the metrics of population health.

The precise analytic methods are not yet available but will depend on the state model being tested and will be determined in collaboration with the Innovation Center evaluation contractor and CMS. CMS will identify the best methodology available for the state model being implemented. Where appropriate, our preference is to use an in-state control group for each state. CMS will request that states hold back a certain equivalent population that will not be enrolled in the intervention. This population can serve as a concurrent control group for the within-state evaluation. Some states may not be able to withhold the intervention from anyone within the state. In those cases, our next most preferred methodology will be to identify a control group from another state. Data collection will be an important concern for controls from outside the state. CMS may have to identify a single, large state that we will fund to collect data from Medicaid and CHIP managed care programs to be sure that we have a reliable source to identify control beneficiaries. Other methods may be considered, depending on the model being implemented and the likelihood of alternative evaluation methods yielding testable results.

For each of the measures of interest (quality, access to care, health care cost and utilization patterns, supplemental expenditures, beneficiary experience, population health and others), one of several statistical techniques will be employed to evaluate the effect of the model approach and intervention on outcomes of interest. The plan is to use difference-in-difference models or time trend analyses (segmented linear regression models) to study the experience over time of

the states relative to the comparison groups in a way that controls for as many relevant confounding variables as possible.

The Innovation Center evaluation will assess the impact of the models on the quality of care, health outcomes, community health, and net saving in total costs. Key evaluation questions for each state will include:

1. Does the model reduce expenditures in absolute terms, create net savings, and/or reduce health care cost trends? Does the model reduce or eliminate variations in utilization and/or expenditures that are not attributable to differences in health status? If so, how have they been accomplished?

2. Does the model achieve better care coordination? If so, how does the model improve care coordination and for which beneficiaries?

3. Does the model deliver better quality of care and/or improve beneficiary experiences of care and services? If so, how does the model improve quality and beneficiary experience and for which beneficiaries?

4. Did the payment model align provider behavior to continuous performance improvement and outcomes or did payment model result in any unintended consequences, including adverse selection, access issues, lower quality of care, cost shifting beyond the agreed upon episode, evidence of withholding appropriate care, anti-competitive effects on local health care markets, or evidence of inappropriate referrals practices? If so, how, to what extent, and for which beneficiaries or providers?

5. What factors are associated with the pattern of results (above)? Specifically, are they related to:

    a. Characteristics of the models?

    b. Characteristics of the participating providers' approach to their chosen model?

    c. Characteristics of the participating providers' specific features and ability to carry out their proposed intervention?

    d. Characteristics of the market or particular populations?

e. Programmatic changes undertaken in response to CMS-sponsored learning and diffusion activities and/or rapid-cycle evaluation results?

E. Monitoring and Rapid-Cycle Evaluation within States

The Innovation Center evaluator will conduct rapid-cycle evaluations for all CMS beneficiaries affected by the SIM initiative. These results will inform learning and diffusion collaborations.

Each state will select an internal evaluation contractor as part of the application process. This in-state evaluation contractor will provide data to both CMS evaluators and the Innovation Center external evaluation contractor(s). CMS evaluators will work with the Innovation Center external contractor(s) and state evaluators to learn and adopt best practices. The goal is for states to be able to continue these evaluations once the SIM initiative is complete.

F. Impact Evaluation

Towards the end of the Model Test, the Innovation Center evaluation contractor will conduct impact evaluations of the effectiveness of each state model on key outcomes for target Medicare, Medicaid, and CHIP beneficiaries. Again, either difference-in-difference or time trend models, using concurrent controls, will be used to evaluate the impact of the models.

The Innovation Center will attempt several approaches, as follows, to identify the effect of each reform in the context of other interventions such as ACOs:

- A conservative approach, dropping all consumers who have been subject to multiple interventions, will allow for direct comparison between intervention and control groups.
- Additional regression analyses will be conducted on consumers who are subject to multiple interventions to evaluate the incremental effects of adding one payment reform in the setting of another.
- The analyses will be repeated with interaction terms to explore whether certain combinations of reforms have disproportionately greater effects on outcomes of interest.

The Innovation Center evaluation contractor will also conduct comparative analyses and assess differences in performance between states. The goal will be to both compare the results in different states and also to look at the qualitative results in order to link contextual factors with performance. Doing so will allow the Innovation Center evaluator to better understand the relationship between different state-level strategies to coordinate care, different portfolios of interventions, and the outcomes that were measured.

This Innovation Center's impact evaluation should provide key messages about what types of state strategies are associated with success. While we will not be able to definitely isolate many of these strategies in Innovation Center evaluation, we will find important relationships about how the context in which the state operates influences outcomes.

States with approved models will be responsible for including the state's contracted evaluators and for funding data collection and performance reporting in its implementation and testing budget.

Depending on the mix of awarded models, the Innovation Center evaluation will examine the

proposed models independently, but will group similar models and analyze the groups accordingly. Ultimately, the evaluation results from all models will be reconciled in order to identify and characterize the most effective models to inform future policy making around improving beneficiary care, improving beneficiary health, and reducing costs.

The Innovation Center evaluator, with assistance of the awardees, will be expected to identify control/comparison groups who did not participate in one of the interventions to examine the effect of the interventions on outcomes of interest. Difference-in-difference models and segmented linear regression models with concurrent controls will be employed to examine the effects of each intervention group compared to controls. Sensitivity analyses combining similar models will also be conducted to examine broad program effects. Sensitivity analyses examining specific geographic regions will be conducted to attempt to disentangle intervention effects in sites where multiple interventions are implemented.

The Innovation Center evaluation will be sensitive to the continual need for rapid-cycle and close-to-real-time production of findings that can be used by awardees and policy makers to make decisions about programmatic changes throughout the life of the project. The Innovation Center evaluation will gather quantitative and qualitative data and use claims data to both assess real time performance and feed that information back to states for ongoing improvement. Qualitative approaches such as interviews, site visits and focus groups are envisioned in order to compare the planned and actual performance of each state's model. Multiple cycles of interviews may be necessary due to the changing nature of the models used by the states in response to rapid-cycle feedback.

G. Federal Financial Report

The Federal Financial Report (FFR or Standard Form 425) has replaced the SF-269, SF-269A, SF-272, and SF-272A financial reporting forms. All grantees must utilize the FFR to report cash transaction data, expenditures, and any program income generated.

States must report on a quarterly basis cash transaction data via the Payment Management System (PMS) using the FFR in lieu of completing a SF-272/SF272A. The FFR, containing cash transaction data, is due within 30 days after the end of each quarter. The quarterly reporting due dates are as follows: 4/30, 7/30, 10/30, 1/30. A Quick Reference Guide for completing the FFR in PMS is at: www.dpm.psc.gov/grant_recipient/guides_forms/ffr_quick_reference.aspx.

In addition to submitting the quarterly FFR to PMS, states must also provide, on an annual basis, a hard copy FFR to CMS which includes their expenditures and any program income generated in lieu of completing a Financial Status Report (FSR) (SF269/269A). Expenditures and any program income generated should only be included on the annually submitted FFR, as well as the final FFR. Annual hard-copy FFRs should be mailed and received within 30 calendar days

of the applicable year end date. The final FFR should be mailed and received within 90 calendar days of the project period end date.

More details will be outlined in the Notice of Award.

H. Transparency Act Reporting Requirements

New awards issued under this FOA are subject to the reporting requirements of the Federal Funding Accountability and Transparency Act of 2006 (Pub. L. 109–282), as amended by section 6202 of Public Law 110–252 and implemented by 2 CFR Part 170. Grant and cooperative agreement recipients must report information for each first-tier sub-award of $25,000 or more in Federal funds and executive total compensation for the recipient's and sub-recipient's five most highly compensated executives as outlined in Appendix A to 2 CFR Part 170 (available online at www.fsrs.gov). Competing Continuation awardees may be subject to this requirement and will be so notified in the Notice of Award.

I. Audit Requirements

States must comply with the audit requirements of Office of Management and Budget (OMB) Circular A-133. Information on the scope, frequency, and other aspects of the audits can be found on the Internet at www.whitehouse.gov/omb/circulars.

J. Payment Management Requirements

States must submit a quarterly electronic SF-425 via the Payment Management System. The report identifies cash expenditures against the authorized funds for the cooperative agreement. Failure to submit the report may result in the inability to access funds. The SF-425 Certification page should be faxed to the PMS contact at the fax number listed on the SF-425, or it may be submitted to:

Division of Payment Management
HHS/ASAM/PSC/FMS/DPM
PO Box 6021
Rockville, MD 20852
Telephone: (877) 614-5533

VII. AGENCY CONTACTS

1. PROGRAMMATIC CONTACT INFORMATION

All programmatic questions about the SIM initiative must be directed to the program e-mail address: SIM@cms.hhs.gov. This e-mail address is regularly monitored, and a response to questions will be posted on http://innovations.cms.gov within 48 business hours. If a response to a question is not posted within the designated timeframe, the submitter may direct a follow-up question to:

James T. Johnston
Centers for Medicare & Medicaid Services
Center for Medicare & Medicaid Innovation
Phone: 410-786-2817 or e-mail: James.Johnston@cms.hhs.gov

2. ADMINISTRATIVE QUESTIONS

Administrative questions about the SIM initiative may be directed to:

Grants Management Officer, Michelle Feagins
Centers for Medicare & Medicaid Services
Office of Acquisitions and Grants Management
Phone: 301-492-4312 or email: Michelle.Feagins@cms.hhs.gov

VIII. APPENDICES

APPENDIX 1: INNOVATION CENTER & OTHER AFFORDABLE CARE ACT INITIATIVES

The Innovation Center is charged with testing, evaluating and spreading new innovative health care delivery and payment models that support providers in transforming the care system. To date, the Innovation Center has supported this care transformation effort through an array of initiatives that include:

- The Partnership for Patients: a public-private initiative to test different models for improving patient care and patient engagement to reduce hospital acquired conditions and to improve care transitions in hospitals nationwide.

- The Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration: to assess the impact that additional support has on FQHCs transforming their practice and becoming formally recognized as patient-centered medical homes.

- The Pioneer ACO Model: an alternative accountable care organization (ACO) model designed for organizations with experience providing integrated care across settings testing a rapid transition to a population-based model of care, and requiring organizations to engage other payers in moving towards outcome-based contracts.

- The Bundled Payment for Care Improvement Initiative: to test episode-based payments as a driver of care redesign.

- The Comprehensive Primary Care Initiative: to test the ability of public and private collaboration to significantly strengthen primary care.

- Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees: in collaboration with the Medicare and Medicaid Coordination Office, to test the ability of states to deliver more integrated care for dually eligible Medicare and Medicaid beneficiaries through two financial models, a capitated model and a managed fee-for-service model.

- Strong Start for Mothers and Newborns**:** as part of the Partnership for Patients initiative, the Innovation Center is working with our hospital partners to reduce preterm births; in addition the Innovation Center is working in collaboration with the Center for Medicaid and CHIP services to test various models designed to reduce preterm births for Medicaid beneficiaries.

- Health Care Innovation Awards**:** to test local innovation in communities across the nation to achieve better care, better health and lower costs through continuous improvement.

The Affordable Care Act also directed CMS to test several other models for care transformation, including:

- Independence at Home (Section 3024): to test a new model of utilizing primary care teams to deliver certain services to Medicare beneficiaries in their homes.

- Medicaid State Option to Provide Health Homes for Enrollees with Chronic Conditions (Section 2703): enhanced Federal Medicaid matching funds for states that opt to provide a health home to support and enhance medical care for persons with at least one chronic condition and a risk of another, or with a serious and persistent behavioral health conditions, including mental health or substance abuse disorders.

- Medicaid Emergency Psychiatric Demonstration Project (Section 2707): provides up to $75 million in funding to states over three years to help care for Medicaid beneficiaries (aged 21 through 64) with psychiatric emergencies, in private inpatient institutions for mental diseases.

- Medicaid Incentives for Prevention of Chronic Disease (Section 4108): grants to states to test incentives to Medicaid beneficiaries who participate in chronic disease prevention programs and demonstrate changes in health risk and outcomes, including the adoption of healthy behaviors.

In addition, CMS and HHS are pursuing a set of related care transformation initiatives, including:

- Physician Group Practice Transition Demonstration: to continue testing pay-for-performance incentives for physicians to coordinate the overall care delivered to Medicare beneficiaries.

- Multi-payer Advanced Primary Care Practice Demonstration: working with existing state multi-payer health reform initiatives to test the ability of advanced primary care practices to increase the availability and delivery of care in underserved areas.

- Medicare Health Care Quality Demonstration: to improve the quality and efficiency of the health care sector to provide better care for beneficiaries.

- 5 Star Quality Bonus Demonstration: to test whether providing incentives to Medicare Advantage Plans such as scaled bonuses and fewer enrollment restrictions for high scoring plans will increase quality performance.

- Rating Program for Medicare Advantage Plans: To help educate consumers on quality and make quality data more transparent.

- Aging and Disability Resource Center Grants (ACA Section 2405): The Administration for Community Living (ACL) seeks to ensure that older adults, individuals with disabilities and family caregivers have clear and ready access to integrated systems of health and human services. The Aging and Disability Resource Center (ADRC) Program model supports this objective by facilitating their access to long-term services and support, through a uniform, statewide system.

APPENDIX 2: GUIDANCE FOR RESPONDING TO SF 424A

PREPARING A BUDGET REQUEST AND NARRATIVE IN RESPONSE TO SF 424A

INTRODUCTION

This guidance is offered for the preparation of a budget request. Following this guidance will facilitate the review and approval of a requested budget by ensuring that the required or needed information is provided. This is to be for done for each 12 month period of the cooperative agreement project period. Applicants should be careful to only request funding for activities that will be funded by the SIM cooperative agreement award program. Any other grant/cooperative agreement funding provided by CMS, should not be supplanted by this SIM initiative cooperative agreement program funding. In the budget request, awardees should distinguish between activities that will be funded under this agreement and activities funded with other sources. Other funding sources include other HHS agreement programs, and other federal funding sources as applicable.

Please refer to Section IV of this FOA for more information on the Budget and Budget Narrative.

A. Salaries and Wages

For each requested position, provide the following information: name of staff member occupying the position, if available; annual salary; percentage of time budgeted for this program; total months of salary budgeted; and total salary requested. Also, provide a justification and describe the scope of responsibility for each position, relating it to the accomplishment of program objectives.

Sample budget

Personnel

Total $_____
SIM Cooperative agreement $_____
Funding other than SIM Cooperative agreement $_____
Sources of Funding_____

Position Title and Name	*Annual*	*Time*	*Months*	*Amount Requested*
Project Coordinator Susan Taylor	*$45,000*	*100%*	*12 months*	*$45,000*
Finance Administrator John Johnson	*$28,500*	*50%*	*12 months*	*$14,250*
Outreach Supervisor (Vacant)*	*$27,000*	*100%*	*12 months*	*$27,000*

Sample Justification
The format may vary, but the description of responsibilities should be directly related to specific program objectives.
Job Description: Project Coordinator - (Name)
This position directs the overall operation of the project; responsible for overseeing the implementation of project activities; coordination with other agencies; development of materials, provisions of in service and training; conducting meetings; designs and directs the gathering, tabulating and interpreting of required data; responsible for overall program evaluation and for staff performance evaluation; and is the responsible authority for ensuring necessary reports/documentation are submitted to HHS. This position relates to all program objectives.

B. Fringe Benefits

Fringe benefits are usually applicable to direct salaries and wages. Provide information on the rate of fringe benefits used and the basis for their calculation. If a fringe benefit rate is not used, itemize how the fringe benefit amount is computed.

Sample Budget
Fringe Benefits

Total $_____
SIM Cooperative agreement $_____
Funding other than SIM Cooperative agreement $_____
Sources of Funding_____

25% of Total salaries = Fringe Benefits

If fringe benefits are not computed by using a percentage of salaries, itemize how the amount is determined.

Example: Project Coordinator — Salary $45,000

Retirement 5% of $45,000	=	*$2,250*
FICA 7.65% of $45,000	=	*3,443*
Insurance	=	*2,000*
Workers' Compensation	=	_____
	Total:	

C. Consultant Costs

This category is appropriate when hiring an individual to give professional advice or services (e.g., training, expert consultant, etc.) for a fee but not as an employee of the awardee organization. Hiring a consultant requires submission of the following information to HHS **(see Required Reporting Information for Consultant Hiring later in this Appendix)**:

1. Name of Consultant;
2. Organizational Affiliation (if applicable);
3. Nature of Services to be Rendered;
4. Relevance of Service to the Project;
5. The Number of Days of Consultation (basis for fee); and
6. The Expected Rate of Compensation (travel, per diem, other related expenses)—list a subtotal for each consultant in this category.

If the above information is unknown for any consultant at the time the application is submitted, the information may be submitted at a later date as a revision to the budget. In the body of the budget request, a summary should be provided of the proposed consultants and amounts for each.

D. Equipment

Provide justification for the use of each item and relate it to specific program objectives. Maintenance or rental fees for equipment should be shown in the "Other" category. All IT equipment should be uniquely identified. As an example, we should not see a single line item for "software." Show the unit cost of each item, number needed, and total amount.

Sample Budget

Equipment

Total $_____
SIM Cooperative agreement $_____
Funding other than SIM Cooperative agreement $_____
Sources of Funding_____

Item Requested	*How Many*	*Unit Cost*	*Amount*
Computer Workstation	*2 ea.*	*$2,500*	*$5,000*
Fax Machine	*1 ea.*	*600*	*600*
			Total $5,600

Sample Justification

Provide complete justification for all requested equipment, including a description of how it will be used in the program. For equipment and tools which are shared among programs, please cost allocate as appropriate. States should provide a list of hardware, software and IT equipment which will be required to complete this effort. Additionally, they should provide a list of non-IT equipment which will be required to complete this effort.

E. Supplies

Individually list each item requested. Show the unit cost of each item, number needed, and total amount. Provide justification for each item and relate it to specific program objectives. If appropriate, General Office Supplies may be shown by an estimated amount per month times the number of months in the budget category.

Sample Budget
Supplies

Total $_____
SIM Cooperative agreement $_____
Funding other than SIM Cooperative agreement $_____
Sources of Funding_____

General office supplies (pens, pencils, paper, etc.)		
12 months x $240/year x 10 staff	=	*$2,400*
Educational Pamphlets (3,000 copies @) $1 each)	=	*$3,000*
Educational Videos (10 copies @ $150 each)	=	*$1,500*
Word Processing Software (@ $400—specify type)	=	*$ 400*

Sample Justification
General office supplies will be used by staff members to carry out daily activities of the program. The education pamphlets and videos will be purchased from XXX and used to illustrate and promote safe and healthy activities. Word Processing Software will be used to document program activities, process progress reports, etc.

F. Travel

Dollars requested in the travel category should be for **staff travel only**. Travel for consultants should be shown in the consultant category. Travel for other participants, advisory committees, review panel, etc. should be itemized in the same way specified below and placed in the **"Other"** category.

In-State Travel—Provide a narrative justification describing the travel staff members will perform. List where travel will be undertaken, number of trips planned, who will be making the trip, and approximate dates. If mileage is to be paid, provide the number of miles and the cost per mile. If travel is by air, provide the estimated cost of airfare. If per diem/lodging is to be paid, indicate the number of days and amount of daily per diem as well as the number of nights and estimated cost of lodging. Include the cost of ground transportation when applicable.

Out-of-State Travel—Provide a narrative justification describing the same information requested above. Include HHS meetings, conferences, and workshops, if required by HHS. Itemize out-of-state travel in the format described above.

Sample Budget
Travel (in-State and out-of-State)

Total $_____
SIM Cooperative agreement $_____
Funding other than SIM Cooperative agreement $_____
Sources of Funding_____

In-State Travel:

1 trip x 2 people x 500 miles r/t x .27/mile	=	*$ 270*
2 days per diem x $37/day x 2 people	=	*148*
1 nights lodging x $67/night x 2 people	=	*134*
25 trips x 1 person x 300 miles avg. x .27/mile	=	*2,025*
	Total	*$ 2,577*

Sample Justification

The Project Coordinator and the Outreach Supervisor will travel to (location) to attend an eligibility conference. The Project Coordinator will make an estimated 25 trips to local outreach sites to monitor program implementation.

Sample Budget

Out-of-State Travel:

1 trip x 1 person x $500 r/t airfare	=	*$500*
3 days per diem x $45/day x 1 person	=	*135*
1 night's lodging x $88/night x 1 person	=	*88*
Ground transportation 1 person	=	*50*
Total		*$773*

Sample Justification

The Project Coordinator will travel to HHS, in Atlanta, GA, to attend the HHS Conference.

G. Other

This category contains items not included in the previous budget categories. Individually list each item requested and provide appropriate justification related to the program objectives.

Sample Budget

Other

Total $_____
SIM Cooperative agreement $_____
Funding other than SIM Cooperative agreement $_____
Sources of Funding_____

Telephone	
($ ___ per month x ___ months x #staff)	= *$ Subtotal*
Postage	
($ ___ per month x ___ months x #staff)	= *$ Subtotal*
Printing	
($ ___ per x ___ documents)	= *$ Subtotal*
Equipment Rental (describe)	
($ ___ per month x ___ months)	= *$ Subtotal*
Internet Provider Service	

($___ per month x ___ months) *= $ Subtotal*

Sample Justification
Some items are self-explanatory (telephone, postage, rent) unless the unit rate or total amount requested is excessive. If the items are not self-explanatory and/or the cost is excessive, include additional justification. For printing costs, identify the types and number of copies of documents to be printed (e.g., procedure manuals, annual reports, materials for media campaign).

H. Contractual Costs

Cooperative Agreement States must submit to HHS the required information establishing a third-party contract to perform program activities **(see Required Information for Contract Approval later in this Appendix)**.

1. Name of Contractor;
2. Method of Selection;
3. Period of Performance;
4. Scope of Work;
5. Method of Accountability; and
6. Itemized Budget and Justification.

If the above information is unknown for any contractor at the time the application is submitted, the information may be submitted at a later date as a revision to the budget. Copies of the actual contracts should not be sent to HHS, unless specifically requested. In the body of the budget request, a summary should be provided of the proposed contracts and amounts for each.

I. Total Direct Costs $_____

Show total direct costs by listing totals of each category.

J. Indirect Costs $_____

To claim indirect costs, the applicant organization must have a current approved indirect cost rate agreement established with the Cognizant Federal agency. A copy of the most recent indirect cost rate agreement must be provided with the application.

Sample Budget
The rate is ___% and is computed on the following direct cost base of $_____.

Personnel	*$*	
Fringe	*$*	
Travel	*$*	
Supplies	*$*	
Other$_____		
Total	*$*	*x ___% = Total Indirect Costs*

If the applicant organization does not have an approved indirect cost rate agreement, costs normally identified as indirect costs (overhead costs) can be budgeted and identified as direct costs.

REQUIRED REPORTING INFORMATION FOR CONSULTANT HIRING

This category is appropriate when hiring an individual who gives professional advice or provides services for a fee and who is not an employee of the awardee organization. Submit the following required information for consultants:

1. Name of Consultant: Identify the name of the consultant and describe his or her qualifications.

2. Organizational Affiliation: Identify the organization affiliation of the consultant, if applicable.

3. Nature of Services to be Rendered: Describe in outcome terms the consultation to be provided including the specific tasks to be completed and specific deliverables. A copy of the actual consultant agreement should not be sent to HHS.

4. Relevance of Service to the Project: Describe how the consultant services relate to the accomplishment of specific program objectives.

5. Number of Days of Consultation: Specify the total number of days of consultation.

6. Expected Rate of Compensation: Specify the rate of compensation for the consultant (e.g., rate per hour, rate per day). Include a budget showing other costs such as travel, per diem, and supplies.

7. Method of Accountability: Describe how the progress and performance of the consultant will be monitored. Identify who is responsible for supervising the consultant agreement.

REQUIRED INFORMATION FOR CONTRACT APPROVAL

All contracts require reporting the following information to HHS.

1. Name of Contractor: Who is the contractor? Identify the name of the proposed contractor and indicate whether the contract is with an institution or organization.

2. Method of Selection: How was the contractor selected? State whether the contract is sole source or competitive bid. If an organization is the sole source for the contract, include an explanation as to why this institution is the only one able to perform contract services.

3. Period of Performance: How long is the contract period? Specify the beginning and ending dates of the contract.

4. Scope of Work: What will the contractor do? Describe in outcome terms, the specific services/tasks to be performed by the contractor as related to the accomplishment of program objectives. Deliverables should be clearly defined.

5. Method of Accountability: How will the contractor be monitored? Describe how the progress and performance of the contractor will be monitored during and on close of the contract period. Identify who will be responsible for supervising the contract.

6. Itemized Budget and Justification: Provide an itemized budget with appropriate justification. If applicable, include any indirect cost paid under the contract and the indirect cost rate used.

APPENDIX 3: STATE HEALTH CARE INNOVATION PLAN

In the deliverable under the Model Design cooperative agreements, and as part of the application for Model Testing agreements, States will need to:

1. Provide a Vision Statement for health system transformation.
2. Describe population demographic including Medicaid and CHIP populations.
3. Describe population health status and issues or barriers that need to be addressed.
4. Describe health system models "current as is" and "future to be" States, including the level of integration of behavioral health, substance abuse, developmental disabilities, elder care, community health, and home and community-based support services.
5. Report on opportunities or challenges to adoption of Health Information Exchanges (HIE) and meaningful use of electronic health record technologies by various provider categories, and potential strategies and approaches to improve use and deployment of HIT.
6. Describe delivery system payment methods both "current as is" and "future to be" payment methods.
7. Describe health care delivery system performance "current as is" and "future to be" performance measures.
8. Describe the current health care cost performance trends and factors affecting cost trends (including commercial insurance premiums, Medicaid and CHIP information, Medicare information, *etc.*).
9. Describe the current quality performance by key indicators (for each payer type) and factors affecting quality performance.
10. Describe population health status measures, social/economic determinants impacting health status, high risk communities, and current health status outcomes and the other factors impacting population health.
11. Describe specific special needs populations (for each payer type) and factors impacting care, health, and cost.

Health System Design and Performance Goals

12. Describe delivery system cost quality and population health performance targets that will be the focus of delivery system transformation.
13. State goals for improving care, population health and reducing health care cost.
14. Describe delivery system models and approaches including how public health care entities, such as publicly-supported university hospitals and faculty practices will transition to value-based business and clinical models.
15. Describe proposed payment and service delivery models.

Roadmap for Health System Transformation

16. Provide a timeline for transformation
17. Review milestones and opportunities
18. Describe policy, regulatory and/or legislative changes necessary to achieve the State's vision for a transformed health care delivery system. States are encouraged to describe their approach to using the broad array of policy levers available to create a statewide policy context that supports and drives delivery system transformation. This should also document how proposed multi-payer supported service delivery and/or payment models fit into this context and how data and evidence will be collected and used to support the state goals and strategies.
19. Describe any waiver or State plan amendment requirements and their timing to enable key strategies for transformation, including changes or additions required to position the Medicaid and CHIP programs to take advantage of broad health care delivery system transformation.