Health Care Innovation Challenge

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-1C1-12-001

CFDA: 93.610

Applicable Dates:

Letter of Intent to Apply Due: December 19, 2011, by 11:59 p.m. Eastern Time

Electronic Cooperative Agreement Application Due Date: January 27, 2012 by 11:59 p.m. Eastern Time

Anticipated Notice of Cooperative Agreement Award: March 30, 2012

Cooperative Agreement Period of Performance/ March 30, 2012 through March 29, 2015

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OVERVIEW INFORMATION

Agency Name: Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Medicare & Medicaid Innovation

Funding Opportunity Title: Health Care Innovation Challenge

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Date of Issue: November 14, 2011

Letter of Intent Due Date: December 19, 2011, by 11:59 p.m. Eastern Time

Application Due Date: January 27, 2012, by 11:59 p.m. Eastern Time

Anticipated Notice of Award: March 30, 2012

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I. FUNDING OPPORTUNITY DESCRIPTION

1. Purpose

This initiative will fund applicants who propose compelling new models of service delivery/payment improvements that hold the promise of delivering the three-part aim of better health, better health care, and lower costs through improved quality for Medicare, Medicaid, and Children's Health Insurance Program (CHIP) enrollees. Successful models will include plans to rapidly develop and/or deploy the requisite workforce to support the proposed model. Awards will recognize interventions that show capability to improve care within the first six months of the award, while creating a sustainable pathway to net Medicare/Medicaid/CHIP savings within two to three years.

On March 23, 2010, the President signed into law the Patient Protection and Affordable Care Act. On March 30, 2010, the Health Care and Education Reconciliation Act of 2010 was signed into law. The two laws are collectively referred to as the Affordable Care Act. The Affordable Care Act includes a wide variety of provisions designed to provide more health care choices, to enhance the affordability and quality of health care for all Americans, to hold insurance companies more accountable, and to lower health care costs.

2. Authority

Section 1115A of the Social Security Act (added by Section 3021 of the Affordable Care Act) authorizes the Center for Medicare and Medicaid Innovation (Innovation Center) to test innovative health care payment and service delivery models that have the potential to lower Medicare, Medicaid, and CHIP spending while maintaining or improving the quality of beneficiaries' care. Preference is given under the statute to models that improve coordination, efficiency and quality. The Innovation Center will use its authority to test alternative models for care delivery and payment, facilitate learning and diffusing of best practices, and promote the development of a workforce capable of supporting care transformation. Evaluation of the results of this initiative will inform any decision by the Secretary to expand through rulemaking the duration and scope of various models, as specified under Section 1115A(c).

3. Background

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 in 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.

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 mental health condition.
- Medicaid Emergency Psychiatric Demonstration Project (Section 2707): provides up to $75 million in funding to States over three years to help care for Medicaid patients (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

CMS is also pursuing a set of related care transformation initiatives including:

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

- 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.

Together, these demonstrations and innovative models provide a broad array of opportunities for providers to engage with CMS to transform their care systems. We know, however, that these initiatives do not address every opportunity and need for improved care. We also know that innovators in both rural and urban communities have developed other care and payment models that could address some of these needs. The Innovation Center is interested in being an effective partner to such innovators and strengthening the current portfolio of models available for providers to test.

Many employers, health systems, and communities at-large, for example, have expressed the need for health services delivery innovation focused on a variety of populations, including but not limited to, those at risk because of health disparities, multiple chronic conditions, mental health issues, poor health status due to socio-economic and environmental factors, or the frail elderly. Individuals with these complex needs often face obstacles when accessing health services or working towards a healthier lifestyle. The delivery of health services through traditional visit-based, in-office services often does not effectively meet their needs, contributing to poor health outcomes and an increasing trend in the cost of care for these patients.

Across the country innovative organizations, providers, and local communities are developing new care models to improve outcomes and efficiency for these populations and others. These programs, which exist today in small rural towns and large urban cities, have the potential to be expanded to broader populations across the country. For example, health systems are re-engineering care to reduce cost, decrease preventable readmissions, and improve outcomes. Medical and surgical specialty societies are working with their membership to develop improvement opportunities using patient registries. Other providers have developed Improvement Networks that are working cooperatively on strategies for improving health care quality. Many community-based organizations are also pursuing new care models to address critical preventive health issues such as pediatric obesity and improved pediatric oral health. We understand, however, that the opportunities for delivery system reform vary widely. Different communities have different needs and circumstances, and some might require unique and/or locally driven innovations to support delivery system transformation.

One of the factors limiting the diffusion of these ideas has been a shortage of an appropriately trained workforce. A transformed health care system will require a transformed workforce and new infrastructure. The people who will support health system transformation for communities and populations will require different knowledge and skills. It is important to provide support for a health care workforce of the future, one that will be trained in prevention, care coordination, care process re-engineering, dissemination of best practices, team-based care, continuous quality improvement, and the use of data to support a transformed system. Training and educational experiences will be needed to help develop this knowledge and these skills.

A delivery system that improves health, quality, and lowers costs will also require new knowledge transfer and information technology infrastructure. Electronic health records are central to this effort and are being supported through several national initiatives. Population health registries and care design operational expertise, as well as systems to rapidly develop and spread best practices, have all been cited as components of a "learning health system" that would deliver better outcomes.

The energy and activity needed to support delivery system transformation is growing rapidly. The Innovation Center has already received over 400 suggestions and ideas for new care and payment models. With a number of broad-based innovation opportunities now available, the Innovation Center is interested in identifying, funding and testing additional innovative service delivery/payment models that strengthen our current model portfolio and will address some of the unique needs of communities and populations.

4. Program Requirements

The Health Care Innovation Challenge will fund applicants who propose the most compelling new service delivery and payment models that will drive system transformation and deliver better outcomes for Medicare, Medicaid, and CHIP beneficiaries. This is not intended to be a prescriptive solicitation but rather an open invitation to applicants to obtain funding and support for those innovations they believe will most effectively achieve the three-part aim. The objectives of this initiative are to

- Engage a broad set of innovation partners to identify and test new care delivery and payment models that originate in the field and that produce better care, better health, and reduced cost through improvement for identified target populations.

- Identify new models of workforce development and deployment and related training and education that support new models either directly or through new infrastructure activities.

- Support innovators who can rapidly deploy care improvement models (within six months of award) through new ventures or expansion of existing efforts to new populations of patients, in conjunction (where possible) with other public and private sector partners.

4.1 MODEL

CMS anticipates a variety of proposals that respond to the following model description.

Proposals should be focused on innovative approaches to improving health and lowering costs for high risk/high opportunity populations, including Medicare, Medicaid, and CHIP beneficiaries. Proposals are encouraged to focus on high cost/high-risk groups including those populations with multiple chronic diseases and/or mental health or substance abuse issues, poor health status due to socio-economic and environmental factors, multiple medical conditions, high cost individuals, or the frail elderly.

Proposals using a service delivery/payment approach should describe the services to be delivered and how payment would be constructed around the delivery model. The proposals should demonstrate how the service/payment approach being tested relates to benefit designs and/or new

payment approaches that CMS can consider for broader application. CMS also invites applicants to introduce tests of scalability for models known to achieve three-part aim outcomes, that is, proposals to diffuse proven interventions to different or broader populations. New payment approaches should focus on alternate payment models that do not simply expand fee-for-service payments. Applicants cannot receive awards for CMS demonstrations, models, or projects that are currently being supported by CMS.

The health care workforce of the future will be highly focused on prevention, care coordination, care process re-engineering, dissemination of best practices, team-based care, community-based care, continuous quality improvement, and the use of data to support new care delivery models. Training and educational experiences will be needed to help develop this knowledge and these skills. Current reimbursement payment policies do not necessarily support such workforce needs. They can, for example, be prescriptive regarding the type of individuals providing care. Yet there are many care coordination models that utilize less expensive but potentially highly effective individuals who are trained to interact with patients in a focused way to address preventive health and chronic conditions (e.g., community health workers). There is a shortage of such individuals today, even as we are moving toward a health care system based on effective care coordination and prevention. Additional examples could include but are not limited to: the use of personal and home care aides to help the elderly age at home; expanding the use of community-based paramedics to provide basic services to extend available primary care resources in rural communities; and the use of community-based nurse teams working with primary care practices to provide intensive care management for the most complex patients.

The Innovation Center also recognizes that new types of infrastructure activity are critical to fully achieving the three-part aim. Enhanced infrastructure is needed to support more effective and efficient system-wide function and the rapid diffusion of best practices. Examples of infrastructure support could include but need not be limited to: models that test the broad implementation of registries; data intermediaries for quality reporting and information sharing to support coordination of care; community-based care coordinating organizations; transparency initiatives; preventive care models; telemedicine and remote monitoring models; medication reconciliation systems; and shared-decision making systems. Other examples include: Innovation or Improvement Networks or community collaboratives; pre-established networks that bring together providers to create new knowledge and best practices that support the three-part aim.

Potential partners for these proposals could include: clinicians, health systems, private and public payers, community colleges/vocational schools, community and faith-based organizations, and local governments that propose an innovative approach towards the three-part aim for targeted populations. Potential applicants should have a track record of success in identifying and caring for these populations, for example in non-traditional care settings, and therefore should be able to quickly expand an existing innovative model or actualize a currently well-developed model. Proposals could address opportunities across the range of services associated with acute care, coordinated care, and/or preventive care.

4.2 KEY ATTRIBUTES

Workforce Development and Deployment: Proposed models should include a significant opportunity to develop and/or deploy health care workers in new, innovative ways. Transforming our health system requires transformation of our health workforce. A critical part of delivery system reform is to identify and test new ways to create the workforce of the future that will deliver and support new care models. This includes identifying new roles for and retooling existing health professionals, identifying necessary skills, training new types of workers to provide non-clinical care, and exploring team-based approaches to better utilize an effective mix of health care practitioners. For example, this could include nurses providing care coordination in primary care settings, new community-health workers serving as a bridge between the health care system and the patients, or community-based teams of practitioners providing clinical care and intensive care management services for the most complex patients. The Innovation Center favors proposals that demonstrate the ability to rapidly develop and deploy such individuals, and thus encourages collaboration among educational institutions, health care practitioners, and delivery systems. Care re-engineering initiatives will also require skilled individuals who can document current processes and help design and implement new processes. Preference will be given to proposals that create such capacity and demonstrate workforce impact and the potential for replication and scale. Applicants can consider deploying newly trained health care workers such as those graduating from community college workforce programs in health information technology with knowledge of care process redesign.

Speed to Implementation: Proposed models should already be operational in related contexts and capable of rapid expansion or sufficiently developed to be rapidly deployed. Proposals will be expected to complete the infrastructure and capacity-related activities within six months of the award and start improving care as rapidly as possible. Preference will be given to projects that implement their care improvement activities faster than six months. Training programs are eligible for funding but should be intensive, brief programs connected to the model being tested.

Model Sustainability: Proposed models are expected to define and test a clear pathway to ongoing sustainability. Funding is intended to support the initial start-up and support over the limited period of time necessary for the model to demonstrate its potential to add value. Each proposal should include a description of the expected positive impact on the three-part aim and a proposed ongoing sustained business model. The business model should include the plan to sustain the activity beyond the three years of the program, describing the anticipated source of ongoing support. Changes in federal funding and innovative payment approaches may be proposed as the mechanism for sustainability, identifying both the source of payment and the anticipated pricing of the service. Such proposals should demonstrate the ability of the program to inform future payment approaches for CMS consideration and recommendations for the scaling and diffusion of the proposed model.

Examples of such sustainability approaches could include:

- public-private partnerships;
- multi-payer approaches;
- new direct payment models for an innovative care model or service delivery;
- shared saving opportunities either directly with CMS or with other payers; and/or
- proposed service delivery agreements with entities such as ACOs or Advanced Primary Care models.

4.3 EVALUATION AND MONITORING

CMMI will be evaluating the funded proposals in accordance with statutory requirements. Each applicant must clearly include quantifiable means for evaluating the impact of the program on the three-part aim of better care, better health, and lower costs through improved quality. Each applicant will be responsible for monitoring, evaluating, and reporting on the progress and impact of their program. In addition to this self-evaluation, CMS contractors will conduct an independent evaluation.

Impact on Better Care and Better Health: Each applicant will provide quality indicators with a continuous improvement method of measurement to be used to evaluate the impact of the proposal on better care and better health.

"Better Care" quality metrics should address the following domains (if relevant):

- Patient satisfaction and/or patient experience
- Utilization
- Clinical quality
- Patient access

Measures should be collected and analyzed on an on-going basis, and enabled where possible by health IT such as certified electronic health records, registries data analytics and electronic reporting mechanisms.

CMS will make more information on standard measures available at www.innovations.cms.gov.

In addition, each applicant will be measured on their ability to achieve "better health." Awardees will be expected to demonstrate improvements in how their strategies will contribute to improving the health of their targeted population.

Impact on Lower Costs: Each model is expected to generate savings for the total cost of care for the beneficiary population its program affects. The Innovation Center will require applicants to complete Budget form SF 424A and a Financial Plan (hereafter referred to as "Financial Plan") from each applicant demonstrating its ability to achieve savings over the three-year term of the award as well as on a projected annualized basis after the term of the award is finished (see Appendix 1). SF 424A (available on Grants.gov) and the Financial Plan template (see Appendix 1) are provided so that each program applicant can demonstrate its anticipated use of funds and explain how its interventions will reduce overall cost of care for the beneficiaries its programs serve. Additionally, we ask applicants to provide detailed back-up financial models explaining the logic driving their forecast cost of care savings (e.g., increased care coordination expenses of X will drive reductions in ER visits representing Y). (For further information on the required financial model, see Section IV, Application and Submission, and Appendix 1.)

Successful applicants will demonstrate the ability to achieve satisfactory improvement in cost of care along the following dimensions:

- Program-level net savings over the duration of each award; and
- Projected medical cost trend reduction that results from building the sustainable new model continuing after the cooperative agreement period is complete.

Operational Performance:

Awardees will be measured on their ability to execute their proposed operational workplan. The components of the operational workplan include, but are not limited to:

- Meeting proposed milestones and deliverables;
- Producing timely and accurate reports with clear progress on quality and cost performance as described above;
- Acquiring, training, and deploying workforce; and
- Building and/or enhancing required infrastructure.

Award recipients will be expected to report their actual performance compared to forecast on cost and quality outcomes and operational performance, and CMS will regularly monitor the results. Awardees will be required to cooperate in providing the necessary data elements to CMS.

In addition to this self monitoring and self-evaluation, CMS will also collect from awardees a standard minimum set of performance indicators through its monitoring and evaluation contractors. CMS will contract with independent entities to assist in monitoring the programs and to conduct an independent evaluation. Awardees will be required to cooperate in providing the necessary data elements to CMS. More details are provided in Section VI.4.A of this funding opportunity announcement.

4.4 LEARNING AND DIFFUSION

Awardees will be required to participate in CMS-sponsored learning sessions about how care delivery organizations can achieve performance improvements quickly and effectively. Also required will be participation in opportunities to share their experiences with one another and with participants in other Innovation Center initiatives both through in-person and online activities. Through this system of shared learning, CMS seeks to identify successful practices and rapidly diffuse them to other participants of this initiative and the health system more broadly.

To best support the broad range of anticipated partners for this initiative, CMS will look for convergence among awardees and create learning networks stratified by model type or other common factors. The goal of these learning networks is to allow awardees to learn best practices from their peers and to further develop their programs throughout the duration of this initiative. The Innovation Center will test various approaches to group learning and exchange, helping initiative participants to effectively share their experiences, track their progress and rapidly adopt new ways of achieving improvements in the three-part aim. CMS therefore expects awardees to actively participate in and shape these shared learning network activities.

4.5 RESTRICTIONS ON AWARDS

The funds shall be used to implement and evaluate models that support system transformation toward higher quality care at lower costs. Award dollars cannot be used for specific components, devices, equipment, or personnel that are not integrated into the entire service delivery and payment model proposal. CMS will not fund proposals that replicate models that CMS is currently testing in other initiatives (see Section I.3). Finally, given the breadth of

models that could be submitted, CMS will not fund proposals that cannot monitor, evaluate, and report on the progress and impact of their program in a timely manner.

4.6 ALIGNMENT OF PROPOSED MODELS

The Innovation Center anticipates that a large number and a wide variety of proposals will be submitted. All Innovation Center programs require evaluation and close operational program monitoring and reporting. In order to facilitate learning that will ultimately inform CMS policy making, the Innovation Center may work with awardees to identify opportunities to align and group proposed models with some shared characteristics.

5. Technical Assistance

Prior to the application deadline, CMS will host a series of Open Door Forums or webinars to provide details about this initiative and to answer any questions from potential applicants. Information about the forums will be posted on the Innovations Center website at http://innovations.cms.gov.

In order to support a broad range of models, CMS is prepared to offer technical assistance to awardees on a case-by-case basis. CMS anticipates contracting with an entity or entities to provide technical assistance, as needed, to awardees as they develop and implement their respective models. The technical assistance contractor(s) will be available to assist awardees to design, develop, rapidly implement, and sustain their models to meet this initiative's programmatic goals.

CMS recognizes that some applicants may be interested in receiving Medicare and Medicaid data to inform and measure their programs. CMS is open to discussing data needs with all awardees and may provide data, when appropriate to the particular care model or infrastructure activity. Existing rules for accessing data will be applied.

II. AWARD INFORMATION

1. Total Funding

The Innovation Center is making up to $1 billion in funding available through as many as two funding cycles to support a diverse portfolio of new and innovative models for achieving better health, better health care, and lower costs through improved quality. Cooperative agreements will be awarded with consideration to: (1) available funding; (2) geographic diversity; and (3) the quality of each application and the ability to meet the goals of the project. Awardees may not receive the award amount requested and may be asked to revise the work plan and budget to reflect the award.

2. Award Amount

The Innovation Center expects to make awards ranging from $1 million to $30 million each to cover a three-year period of performance, depending on the scope and nature of the individual proposals received.

3. Anticipated Award Date

The first round of cooperative agreements will be awarded in March 2012 and will include as much funding as the first round of applications warrant. The second round of cooperative agreements would be awarded in August 2012 and would include as much of the remaining funding (if any) as the second round of applications warrant.

4. Period of Performance

The anticipated period of performance for the 3-year project period is March 30, 2012 through March 29, 2015.

CMS is under no obligation to make additional awards under this program.

5. Number of Awards

The Innovation Center intends to fund the best qualified applications within the scope of available funds.

6. Type of Award

Awards will be made through Cooperative Agreements. CMS will continually evaluate each awardee's performance and ability to show demonstrated progress toward program goals.

Termination of Award

Continued funding is dependent on satisfactory performance against operational performance measures and a decision that continued funding is in the best interest of the Federal Government. Projects will be funded subject to meeting terms and conditions specified and may be terminated if these are not met [see 1115A[42 USC 1315 a](b)(3)(B)].

Anticipated Substantial Involvement by Awarding Office

CMMI is authorized to test innovative health care payment and service delivery models. Because of this level of responsibility, CMMI anticipates substantial involvement in the evaluation and monitoring of the Health Care Innovation Challenge cooperative agreements and their resulting recipient responsibilities. These responsibilities include monitoring, measuring, and evaluating:

- Applicant impact on quality of care and health status
- Impact on costs
- Operational performance, including;
    - Meeting proposed milestones
    - Producing timely and accurate reports with clear progress on quality and cost performance
    - Acquiring, training, and deploying workforce, and
    - Building and/or enhancing required infrastructure.

While awardees are expected to cooperate with, and facilitate the role of, the awarding office and work of the evaluation contractor, it is not necessary to budget for these activities beyond allowance for staff time for interactions and data reporting. For example, the awardee is not expected to provide working space for Federal participants, etc.

Applications should propose plans and budgets without any assumption of operational programmatic support from the awarding office. For example, the awarding office will not make facilities or other resources available beyond the cooperative agreement award amount. Proposals that would require such additional support will be considered non-responsive and will be eliminated from consideration. Proposals that require data from CMS should specify this need.

III. ELIGIBILITY INFORMATION

1. Eligible Applicants

The intent of this initiative is to engage with a wide variety of innovators. Interested parties of all types who have developed innovations that will drive significant improvement in three-part aim outcomes are welcome to apply. Examples of the types of organizations expected to apply are: provider groups, health systems, payers and other private sector organizations, faith-based organizations, local governments, and public-private partnerships and for-profit organizations. In addition, certain organizations could be eligible to apply as conveners – assembling and coordinating the efforts of a group of participants. Conveners could serve as facilitators or could be direct award recipients. States are not eligible to apply under this funding opportunity.

Legal Status: To be eligible, an organization must be recognized as a single legal entity by the state where it is incorporated, and must have a unique Tax Identification Number (TIN) designated to receive payment. The organization must have a governing body capable of entering into a cooperative agreement with CMS on behalf of its members.

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 as outlined in Section III, Eligibility Information and, Section IV, Application and Submission Information.
- Page limit: Applications must not be more than 40 pages in length which includes the project abstract, project and budget narratives, and the financial plan. Supporting materials are limited to 30 pages in length. These include documentation related to financial projections, profiles of participating organizations, relevant letters of endorsement, etc. Standard forms are not included in this page limit. For more information, see Section IV.2.A, Content and Form of Application Submission.

Applicants are strongly encouraged to use the review 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 the proposals.

Applications will be considered for funding only if the budget proposed is within the range presented in Section II, Award Information.

2. Central Contracting Registration (CCR) Requirement

All prime awardees must provide a Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number in order to be able to register in the Federal Funding Accountability and Transparency Subaward Reporting System (FSRS) as a prime award user. If your organization does not have a DUNS number, you will need to obtain one from Dun & Bradstreet. Call D&B at 866-705-5711 if you do not have a DUNS number. Once you have obtained a DUNS Number from D&B, you must then register with the Central Contracting Registration (CCR) at

www.ccr.gov. Prime awardees must maintain current registration in the Central Contracting Registration (CCR) database. Prime awardees may make sub-awards 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 of 2006 (Pub. L. 109-282)), as amended by section 6202 of Public Law 110-252 and implemented by 2 CFR Part 170)). After you have completed your CCR registration, you will be able to register in FSRS as a prime awardee user.

3. Cost Sharing or Matching

Cost sharing is not required.

4. Foreign and International Organizations

Foreign and international organizations are ineligible to apply.

5. Faith-Based Organizations

Faith-based organizations are eligible to apply.

IV. APPLICATION AND SUBMISSION INFORMATION

1. Address to Request Application Package

Letter of Intent to Apply

Applicants must submit a non-binding Letter of Intent to Apply. Letters of Intent to Apply provide information that helps CMS in determining expertise and personnel necessary to appropriately review applications and issue awards. Letters of Intent to Apply are due by 11:59 pm Eastern Time on December 19, 2011. Failure to submit a Letter of Intent to Apply will disqualify the application from that organization from being reviewed. The information specified for the Letter of Intent to Apply must be provided through an online form. Additional information and detailed instructions for submitting Letters of Intent to Apply are posted on the Innovation Center website at http://innovations.cms.gov.

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 Financial Plan and the addition of standard forms required by the Federal government for all cooperative agreements.

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 CMMI 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.

- All applicants must have a Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number. 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.

- 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. You should allow a minimum of five days to complete the CCR registration. Information about CCR is available at http://www.ccr.gov. The central contractor registration process is a separate process from submitting an application. In some cases, the registration process can take approximately two weeks to be completed. Therefore, registration should be completed in sufficient time 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. http://grants.gov/applicants/get_registered.jsp. AORs must wait one business day after registration in CCR before entering their profiles in Grants.gov.

- 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 email notification. The email address provided in the profile will be the email 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.

- You must submit all documents electronically in PDF format, including all information included on the SF 424 and all necessary assurances and certifications, and all other attachments.

- Prior to application submission, Microsoft Vista and Office 2007 users should review the Grants.gov compatibility information and submission instructions provided at http://www.grants.gov. Click on "Vista and Microsoft Office 2007 Compatibility Information."

- After you electronically submit your application, you will receive an automatic acknowledgement from http://www.grants.gov that contains a Grants.gov tracking number. HHS will retrieve your application form from Grants.gov.

- After HHS retrieves your application form from Grants.gov, a return receipt will be emailed 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 Registry (CCR). You can register with the CCR online; registration will take about 30 minutes to complete (http://www.ccr.gov).

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 first round of awards must be submitted electronically and be received through http://www.grants.gov by 11:59 pm Eastern Time on January 27, 2012.

All applications for the second round of awards, if any, must be submitted electronically and be received through http://www.grants.gov by 11:59 pm Eastern Time on June 29, 2012.

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

To be considered timely, applications must be sent on or before the published deadline date. However, a general extension of a published application deadline that affects all applicants or only those applicants 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.

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** adhere to the timelines for Central Contractor Registry (CCR) and Grants.gov registration, as well as request timely assistance with technical problems.

Please be aware of the following:

- Search for the application package in Grants.gov by entering the CFDA number. This number is shown on the cover page of this announcement.
- 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).
- 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.
- If it is determined that a waiver is needed from the requirement to submit your proposal electronically, you must submit a request in writing (emails are acceptable) to Mary.Greene@cms.hhs.gov with a clear justification for the need to deviate from our standard electronic submission process.

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

To be considered timely, applications must be sent on or before the published deadline date. However, a general extension of a published application deadline that affects all applicants or only those applicants 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, they can email the Grants.gov contact center at support@grants.gov or call 1-800-518-4726.

2. Content and Form of Application Submission

A. Form of Application Submission

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 no smaller than 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 should be single-spaced.

Applications must not be more than 40 pages in length which includes the project abstract, project and budget narratives, and the financial plan. Supporting materials are limited to 30 pages in length. These include documentation related to financial projections, profiles of participating organizations, relevant letters of endorsement, etc. The total size of all uploaded files may not exceed total file size of 13 MB. Standard forms are NOT included in the page limits.

B. Overview of Cooperative Agreement Application Structure and Content

i. Standard Forms

The following standard forms must be completed with an original 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. Key Personnel

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

a. On Item 11 "Descriptive Title of Applicant's Project", state the specific cooperative agreement opportunity for which you are applying: Health Care Innovation Challenge.
b. Check "No" to item 16b, as Review by State Executive Order 12372 does not apply to these grants.

ii. Cover Letter (to be enclosed with proposal)

A letter is required from the applicant's Authorized Organizational Representative, indicating the title of the project, the principal contact person, amount of funding requested, and the name of the agency that will administer the cooperative agreement.

The letter should be addressed to:

Mary Greene
Grants Management Officer
Office of Acquisition and Grants Management
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Mail Stop B3-30-03
7500 Security Blvd, Baltimore, MD 21218

iii. Project Abstract and Profile

The one-page abstract (single-spaced) should serve as a succinct description of 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.

iv. Application Narrative

The application is expected to address how the applicant will implement the cooperative agreement program, and ultimately, meet the objectives of this project. The required sections of the application are listed below. Also provided is a brief description of the type of information that is required to be addressed within each specific section. The application must be organized by these headings, noted as the operations element sections, outlined below.

SECTION ONE: DESIGN

1.1 Program Goals and Targeting: The application must list, describe, and justify the selected project goals. It must also define the targeted populations (which must include, but need not be limited to, Medicare, Medicaid, and/or CHIP beneficiaries), the number of participants, the services to be delivered, the proposed partners and the geographic area of the

proposed project. A detailed discussion should be included that explains the rationale for why the goals, population, and geographic location of the program selected are important in the context of explaining the overall expected impact of the model and potential suitability for expansion to other settings, areas, and/or populations. It should also include an explanation of why this project is a strategic match for the applicant's overall mission.

1.2 Comprehensive Description of the Model and Supporting Evidence Base: The application must describe the design of the proposed model. The description provided must describe the type, duration, and scope of the services. The description must describe the theory of action for the model and address how the proposed program is evidence-based. It should also explain how the program will affect the targeted population and demonstrate whether and how the proposed program will impact the underserved, address health disparities, reduce the effect of multiple co-morbidities, and/or modify of risk factors. Proposals are expected to describe how the proposed model will transform the existing health workforce and describe opportunities for training and education. The applicant should also identify the primary challenges to successful implementation of the project and explain how these anticipated risks will be mitigated.

1.3 Participant Recruitment and Enrollment: The application must include a description of the recruitment strategies that will be employed, including strategies for identifying and targeting prospective participants. This must include a plan for identifying and managing the applicable population. There should be a discussion of ongoing strategies that promote continuous coverage and retention so that results of the initiative are not confounded due to people cycling through the program during the operational period.

1.4 Education and Outreach: The application must describe the plan for conducting the required outreach and education campaign to ensure potential participants and providers are aware of the program.

1.5 Community Integration: The application must identify and describe the applicant's method for involving external stakeholders in the initial implementation of the program and its method for continuing to have them meaningfully involved throughout the program. The application must also describe how the proposed intervention will be integrated into and collaborate with the broader health care community.

SECTION TWO: ORGANIZATIONAL CAPACITY

2.1 Organization and Administration: The application must describe the guiding principles of the organization and their past experience and track record of performance. It must also demonstrate an understanding of the needs of the community or population that the applicant seeks to target. The application must include a description of the governance, organizational and structural functions that will be in place to implement, monitor, and operate the initiative. The tasks to be conducted by each administrative component must also be described. The organization must demonstrate the financial strength and stability needed to operate the project and the commitment to sustain the project after the completion of the three-year cooperative agreement period. The applicant also demonstrates the organizational capacity across all proposed participants to reach the three-part aims.

2.2 Operational Plan: The applicant must provide a preliminary operational plan that includes a draft work plan showing how it plans to ramp up to operational start and demonstrates the capacity to improve care within six months of receiving funding. The plan should also include roles and responsibilities of key partners and major milestones and dates for successfully executing the operational plan. The applicant must provide an organizational chart that describes the entity that is responsible for the management of this cooperative agreement and must describe the relationship between that entity and all other organizations that will provide services and work with the participants under the project. In addition, the application should show that the organization has the resources and track record needed to operate the project and report on the progress it is making during the operation.

2.3 Organization Structure and Staffing:

Organizational Structure: Applicants must include an organizational chart for the entity that is responsible for the management of the cooperative agreement.

Staffing: Applicants must provide a staffing plan for governance and leadership that describes and explains

- The number, titles of staff, job descriptions, and expected time commitment of staff that will be dedicated to the project, including the roles and responsibilities for each position.
- The percentage of time each individual/position is dedicated to the cooperative agreement.
- How the proposed key staff members have relevant skills and leadership ability to successfully carry out the project.
- Any positions providing In-Kind support to the cooperative agreement.
- The number of contracted individuals supporting the cooperative agreement.
- A résumé of the proposed Project Director

SECTION THREE: WORKFORCE ANALYSIS

3.1 Workforce Development and Deployment Plan:

The application must identify how the proposed model will address the need for a transformed workforce and demonstrate a plan to update skills of existing health professionals, identify and train new types of workers to enhance care delivery, and/or expand the use of team-based care. The application must include an explicit workforce plan that describes how the proposed workforce model will support the three-part aim. The applicant must provide information on how staff will be recruited, hired, trained, and deployed as well as the specific skills for which additional training may be required. To the extent that proposals address the initial education or training of health professionals, these efforts should be clearly spelled out in the workplan with a detailed timeline. The application should include workforce-related metrics which will be used to assess the impact of the model on the health workforce and to evaluate the workforce needs associated with system delivery changes, including the ratio of staff to participants.

SECTION FOUR: EVALUATION AND REPORTING

4.1 Reporting and Evaluation: The application must include a description of the applicant's plan for collecting and producing the data and analysis of the program that will be provided to CMS and its evaluation and monitoring contractors. CMS believes that programs that actively self-evaluate will have the greatest opportunities for improvement in quality and reductions in overall healthcare costs. The application must include detailed information on the self-evaluation plan, including design for process assessment and outcome evaluation, variables, and data sources. Careful evaluation of the effect of the intervention on the quality of care received as well as health care outcomes and costs is expected. Programs are also expected to survey patients about their experience with care as well as provider reactions to the innovation, including its impact on professional satisfaction. Evaluation reports must be provided to CMS quarterly and they must include information on the use of cooperative agreement funding and an assessment of program implementation, lessons learned, patient experience, quality improvements, clinical outcomes, and estimates of cost savings. Note that the participants will also be required to fully cooperate with the monitoring and evaluation contractors in reporting data that they require for the project evaluations.

CMS plans to conduct rigorous evaluation of each of these projects through a separate evaluation contract. This work will entail establishing treatment and control or comparison groups and measuring the program effects on costs and outcomes. Applicants will be expected to facilitate evaluation contractor work in these areas by providing information and access to program records, participants, providers, and collaborators. Projects may be required to report information in standard format and measure and report outcomes in a standardized way, if requested by the evaluation contractor.

v. Budget, Budget Narrative and Financial Plan

SECTION FIVE: FUNDING AND SUSTAINABILITY

5.1 Budget Form SF 424A and Budget Narrative

Form SF 424A

All applicants must submit an SF 424A. Instructions for completing the SF 424A can be found on Grants.gov. For this cooperative agreement the application must include budgets for each year of the 3-year project period.

Budget Narrative

In addition, applicants must supplement Budget Form SF 424A with a Budget Narrative. The Budget Narrative must include a yearly breakdown of costs for the 3-year project period. Specifically, the Budget Narrative should provide a detailed cost breakdown for each line item outlined in the SF424A 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 and justify the organization's readiness to receive funding through 2015 including complete explanations and justifications for the proposed cooperative agreement activities. The budget must separate out funding that is administered directly by the awardee from any funding that will be subcontracted.

The following budget categories should be addressed (as applicable):

- Personnel
- Fringe benefits
- Contractual costs, including subcontracts
- Equipment
- Supplies
- Travel
- Indirect charges, in compliance with appropriate OMB Circulars. If requesting indirect costs in the budget, a copy of the indirect cost rate is required.
- Other costs, including those not otherwise associated with training and education.

The Budget Narrative should outline the strategies and activities of the program, and provide cost breakdowns for any subcontracts that will be implemented to achieve anticipated outcomes.

The Budget Narrative should also clearly distinguish the funding source of any given activity/cost, as either Federal or Non-Federal. Applicants should pinpoint those costs funded through in-kind contributions. Applicants must include detailed salary and fringe benefit costs for staff dedicated to the project through an in-kind contribution, to include yearly salary costs and the percentage of time dedicated to the project (for any given year).

Organizational Structure: Applicants must also include with the Budget Narrative an organizational chart for the entity that is responsible for the management of the cooperative agreement. In addition, provide a Narrative Staffing Plan to include:

- The number and titles of staff that will be dedicated to the cooperative Agreement program.
- Percentage of time each individual/position is dedicated to the cooperative agreement.
- Brief description of roles/responsibilities of each position.
- How the proposed key staff members have relevant skills and leadership ability to successfully carry out the project.
- Any positions providing In-Kind support to the cooperative agreement.
- Percentage of time each position will provide to the cooperative agreement.
- Number of contracted individuals supporting the cooperative agreement.
- A resume of the proposed Project Director

Note: Rather than duplicating information in their application, applicants should refer to the information provided in response to the requirements specified in Section IV.2.B.iv (2.3) when writing this section.

5.2 Financial Plan and Model Sustainability

<u>Financial Plan</u>

The Financial Plan as described in Section VIII, Appendices, Appendix 1 is provided so applicants can describe an annual summary of the costs of the project in relation to the expected program savings. Data from Form SF 424A and Financial Plan must match.

Applicants must provide a financial plan narrative and supporting schedules explaining the rationale behind all assumptions used to develop the Financial Plan. Some examples of supporting schedules with accompanying narratives include:

- A narrative and supporting schedules explaining the specific mechanisms by which the program will reduce total cost of care (e.g., how cost increases in one category of spend will drive cost reductions elsewhere);
- An account of personnel costs, including detailed salary and fringe benefit costs, as well as identification of the costs associated with the training aspects of the innovation;
- A schedule describing proposed expansion population and patient characteristics that explain projections of total cost of care (e.g., demographics, risk factors, health disparities, etc.);
- A schedule connecting the funding request to detailed expenditures to proposed impact; and
- A detailed breakdown of sources of funding that will drive model sustainability after the end of this cooperative agreement.

Model Sustainability

Each proposal should include a clear description of the expected positive impact on the three-part aim and describe a clear pathway to ongoing sustainability. Each proposal should describe the services being provided, the expected cost of the service provision, and where appropriate, an anticipated approach to reimbursement and/or other financial arrangements that support the business model beyond the 3-year period.

3. Submission Dates and Time

A. Letter of Intent to Apply

Applicants must submit a non-binding Letter of Intent to Apply. Letters of Intent to Apply provide information that helps CMS in determining expertise and personnel necessary to appropriately review applications and issue awards. Letters of Intent to Apply are due by 11:59 pm Eastern Time on December 19, 2011. Failure to submit a Letter of Intent to Apply will disqualify the application from that organization from being reviewed. Letters of Intent should include the following information:

- Name of applicant organization
- Name(s) of any operating partners
- Name of organization point of contact including:
    - Phone number
    - E-mail address
- Proposed target geographic location of project
- Proposed size and type of target population impacted

- Brief summary of the proposal
- Non-binding project budget estimate (if possible)

The information specified for the Letter of Intent to Apply must be provided through an online form. Additional information and detailed instructions for submitting a Letter of Intent to Apply are posted on the Innovation Center website at http://innovations.cms.gov.

B. Cooperative Agreement Applications

All applications are due by January 27, 2012. Applications submitted through http://www.grants.gov by 11:59 p.m. Eastern Time on Friday, January 27, 2012 will be considered "on time." All applications will receive an automatic time stamp upon submission and applicants will receive an automatic e-mail reply acknowledging the application's receipt.

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.
The provisions of OMB Circulars A-87 and A-21 govern reimbursement of indirect costs under this solicitation. Copies of OMB Circulars are available online at:
http://www.whitehouse.gov/omb/circulars

Direct Services

Cooperative Agreement funds may not be used to provide individuals with services that are already funded through Medicare, Medicaid and/or CHIP. These services do not include expenses budgeted for provider and/or consumer task force member participation in conferences, provision of technical assistance, or attendance at technical assistance conferences sponsored by CMS or its national technical assistance providers for the benefit of awardees.

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 supports that are the legal responsibility of another party under Federal or State law (e.g., vocational rehabilitation or education services) 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 State, local, or private funding of infrastructure or services, such as staff salaries, etc.
- 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.

V. APPLICATION REVIEW INFORMATION

In order to receive an award under this funding opportunity announcement, applicants must submit an application, in the required format, no later than the deadline dates.

If an applicant does not submit all of the required documents and 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 applicants must submit the following:

1. Standard Forms
2. Cover Letter
3. Project Abstract
4. Project Narrative
5. Budget and Budget Narrative

1. Criteria

This section fully describes the evaluation criteria for this cooperative agreement program. In preparing applications, applicants are strongly encouraged to review the programmatic requirements detailed in Section I, Funding Opportunity Description. The application must be organized as detailed in Section IV, Application and Submission, of this solicitation.

Applications will be scored with a total of 100 points available. The following criteria will be used to evaluate applications received in response to this solicitation.

Design of Project (30 points)

The proposed project is well-designed to meet the goals of the program, including meeting the goals of the improved three-part aim outcomes for targeted populations. The design is based on relevant evidence and has a high likelihood of success. The project is operationally feasible. The project design is innovative in concept and operational design.

The proposal indicates the overall expected magnitude and breadth of impact of the model on the three-part aim for the population it targets. The goals set for improvement in all three aims are aggressive but credible given the description of the intervention. Proposals that include new infrastructure activities should demonstrate how the model will enable more effective and efficient system-wide function to deliver better care, better health, and reduced costs through improvement.

The proposed project can be replicated and has diffusion capabilities to be productively adopted in other organizations nationwide. The proposed project effectively targets the intended population including health disparities and underserved populations as applicable. The proposal includes plans to effectively integrate the project with relevant community providers of health care and related services, and to coordinate effectively with other relevant groups. The proposal describes new opportunities for training, education and/or skill development of health care practitioners participating in the project.

Organizational Capacity and Management Plan (25 points)

The organization has relevant experience in successfully operating previous innovative and relevant projects. The proposed operational plan is specific and shows a realistic probability of successful implementation. Plans to partner with health care providers and other implementing organizations shows a likelihood of being successful, and the project partners themselves have the administrative ability to carry out their part of the project. The applicant shows evidence that it could implement the project and deploy it as rapidly as possible within six months. Preference will be given to applicants who can demonstrate their ability to begin care improvement activities earlier than six months. The applicant also demonstrates the organizational capacity across all proposed participants to reach the specified three-part aims.

The operational plan is well-described and shows evidence of effectively supporting the project. The applicant organization has the needed facilities and infrastructure to carry out the project.

The applicant organization shows 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.

The staff proposed to lead the program has the skills and experience needed to assure smooth and effective implementation.

Workforce Goals (15 points)

The proposal identifies and develops models of rapid workforce development and deployment that support the three-part aim. The applicant has a high quality proposal that will identify and hire, train and/or retool, and fully deploy staff to transform health care delivery. The applicant describes how this new workforce model supports health quality and efficiency and the metrics by which progress toward workforce goals will be assessed. The application demonstrates the workforce impact of the proposed model and the potential for replication and scale.

Budget, Budget Narrative, Financial Plan, and Model Sustainability (20 points)

The proposed Budget, Budget Narrative, Financial Plan, and path to sustainability are carefully developed, with plans for efficient use of funds. Overhead and administrative costs are reasonable, with funding focused on operations rather than administration. It is desirable for the proposal to include cost sharing from the sponsoring organization or other partners to demonstrate financial support from other entities or otherwise leverage financial resources.

The Budget and Financial Plan has a thoughtful, data-driven evidence-base that informs its projections. The awardee must describe a track record or a path to establishing the required process and infrastructure to achieve projections (e.g. having patient recruitment processes in place, an identified new workforce, necessary infrastructure to implement programs, etc.). The project has a likelihood of being cost-effective, saving money for the Medicare, Medicaid, and/or CHIP programs and for the health care system at large. Priority will be given to proposals that include public/private partnerships and multi-payer approaches. Every Budget, Financial Plan and/or supporting narrative/schedule must demonstrate a potential pathway to financial sustainability after the period of Federal cooperative agreement funding ends. Preference will be given to applicants who can demonstrate financial sustainability sooner than three years.

Evaluation and Reporting (10 points)

The applicant includes a well-designed and credible plan to provide regular reporting of performance and quantitative data for monitoring the progress of the project including information on staffing and staff development, quality of services delivered, numbers of people included in the program, frequency and nature of contacts with participants, and other process and quality data that give a full picture of the progress of the applicant in carrying out the project proposed. Each applicant clearly includes a quantifiable means for monitoring the progress of their project and evaluating the impact of the program on the three-part aim of better care, better health, and lower costs through improvement.

2. Review and Selection Process

A team consisting of staff from HHS and other outside experts will review all applications. The review process will include the following:

- Applications will be screened to determine eligibility for further review using the criteria detailed in this solicitation. Applications received late or that fail to meet the eligibility requirements as detailed in the solicitation or do not include the required forms will not be reviewed.

- The review panel will assess each application to determine the merits of the proposal and the extent to which the proposed program furthers the purposes of the program. CMS reserves the right to request that applicants revise or otherwise modify their proposals and budget based on the recommendations of the panel.

- The results of the objective review of the applications by qualified experts will be used to advise the approving HHS official. Final award decisions will be made by an HHS program official. In making these decisions, the HHS program official will take into consideration: recommendations of the review panel; the geographic diversity of awardees; the range of service delivery and payment models proposed; reviews for programmatic and grants management compliance; the reasonableness of the estimated cost to the government and anticipated results; and the likelihood that the proposed project will result in the benefits expected.

- Successful applicants will receive one cooperative agreement award issued under this announcement.

CMS intends to fund projects in communities with a wide variety of geographic and socio-economic characteristics, including underserved urban and rural areas.

CMS reserves the right to approve or deny any or all proposals for funding. Note that section 3021 of the Affordable Care Act establishes title XI, section 1115A of the Social Security Act, which creates the Center for Medicare and Medicaid Innovations (CMMI). Section 1115A(d)(2) states 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: **November 14, 2011**

Awards: Anticipated date of First round awards **March 30, 2012**

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 that will set forth the amount of the award and other pertinent information. The award will also include standard Terms and Conditions, and may also include additional specific cooperative agreement terms and conditions. Potential applicants should be aware that special requirements could apply to cooperative agreement awards based on the particular circumstances of the effort to be supported and/or deficiencies identified in the application by the review panel.

The NoA is the legal document issued to notify the awardee that an award has been made and that funds may be requested from the HHS payment system. The NoA will be sent through the U.S. Postal Service to the awardee organization as listed on its SF 424. Any communication between CMS and awardees prior to issuance of the NoA is not an authorization to begin performance of a project.

Unsuccessful applicants will be notified by letter, sent through the U.S. Postal Service to the applicant organization as listed on its SF 424, no later than April 30, 2012.

Federal Funding Accountability and Transparency (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 administrative requirements, as outlined in 2 CFR Part 225 and 45 CFR Part 92, apply to cooperative agreement 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,
    - Hill-Burton Community Service nondiscrimination provisions, 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 awardee's original cooperative agreement application or agreed upon subsequently with HHS, and may not be used for any prohibited uses.

3. 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 and Program Specific Terms and Conditions 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).

4. Reporting (Frequency and Means of Submission)

A. Progress Reports

Awardees must agree to cooperate with any Federal evaluation of the program 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 outline how cooperative agreement funds were used, describe program progress, and describe any barriers and measurable outcomes. CMS will provide the format for program reporting and technical assistance necessary to complete required report forms. Awardees must also agree to respond to requests that are necessary for the evaluation of the national efforts and provide data on key elements of their own cooperative agreement activities.

Program Monitoring

CMS will award a third party entity to assist CMS in monitoring the programs. CMS plans to collect data elements to be part of monitoring for all of the different 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 a quality monitoring and review program to ensure program requirements are met; tracking performance across awardees and providing for early detection of quality problems; developing a system to collect, store, and analyze data to assess quality of care, costs, utilization, and assisting with awardee implementation, including coordination between awardees and CMS and its other contractors.

Data for monitoring will include process, safety, and performance measures. 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 program, 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 program 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 sources. The program monitoring aspect of

this initiative will balance the examination of the extent to which awardees demonstrate fidelity to their proposed models of care and the potential need to make mid-course corrections that improve the models of care based on feedback from the monitoring and evaluation findings. Moreover, the evaluation will assess whether there is evidence of harm or unintended consequences as a result of the intervention.

Evaluation

For purposes of continuous program improvement, and reporting of progress, accomplishments and difficulties encountered, each awardee must conduct their own evaluation of their respective programs on the impact on the three-part aim. In addition, CMS will contract with a third party entity to conduct an independent evaluation of the models. All awardees will be required to cooperate with the independent evaluator to track and provide required performance data as needed for the evaluation. The evaluation will assess the impact of the models on the three-part aim of better care, better health, and lower costs. This will include assessments of patient experience of care, health services utilization, health outcomes, Medicare, Medicaid, and/or CHIP expenditures, provider costs, quality, and access to care.

The independent evaluation will include multi-pronged data collection efforts, including qualitative and quantitative approaches. Primary data collection will be needed to acquire qualitative information from providers to understand their perceptions, including satisfaction with the intervention, barriers to implementation and enablers to care improvement. Primary data collection will also include patient and provider surveys to understand perceptions of self-reported health (patient), perceptions of care (patient and provider), and perceptions of the intervention (patient and provider). The evaluators will also utilize existing CMS data resources such as claims and performance monitoring data. Evaluation questions include but are not limited to:

- Do the models of care being tested under the Health Care Innovation Challenge provide better quality of care and/or better patient experiences of care for high risk target populations? If so, how much improvement was seen and which participant characteristics were associated with greater benefit?
- Do the various models reduce expenditures in absolute terms? Do they slow the growth in expenditures? Do the models reduce or eliminate variations in utilization and/or expenditures that are not attributable to differences in health status?
- Do the various models provide better care coordination? If so, how and for which participants?
- Do the various models fill health care workforce gaps that impede care coordination?
- Do they reduce disparities in care? If so, how have they accomplished these changes?
- Are the models well received by the practitioners implementing them?
- What factors are associated with the pattern of results (above)? Specifically, are they related to:

    - Characteristics of the models?
    - Characteristics of the Health Care Innovation Challenge awardees' approaches to their chosen model? (e.g., types and nature of participating providers, utilization of non-traditional types of providers who can interact with patients in their respective

communities, specific care coordination interventions used, specific payment or incentives, etc.)
- Characteristics of the Health Care Innovation Challenge awardees' specific features and ability to carry out their proposed intervention?
- Characteristics of the Health Care Innovation Challenge awardees' market or patient populations?
- Programmatic changes undertaken in response to CMS-sponsored learning and diffusion activities and/or rapid-cycle evaluation results?

Depending on the mix of awarded models, the evaluation will examine the proposed models independently, but will group similar models and analyze the groups accordingly. Ultimately, the evaluation results from all of the 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 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 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 evaluation will gather quantitative and qualitative data and use claims data to both assess real time performance and feed that information back to awardees 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 awardee's model. Multiple cycles of interviews may be necessary due to the changing nature of the models used by the awardees in response to rapid-cycle feedback.

B. Federal Financial Report

Awardees are required to submit the FFR SF425 on a semi-annual basis. More details will be outlined in the Notice of Award.

C. Transparency Act Reporting Requirements

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). Competing Continuation awardees may be subject to this requirement and will be so notified in the Notice of Award.

D. Audit Requirements

Awardees 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.

E. Payment Management Requirements

Awardees 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

A. Programmatic Contact Information:

All programmatic questions about the Health Care Innovation Challenge must be directed to the program email address: InnovationChallenge@cms.hhs.gov. This email address is constantly 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:

Dorothy Frost Teeter, MHA
Centers for Medicare & Medicaid Services
Center for Medicare & Medicaid Innovation
Phone: 410-786-0660

B. Administrative Questions

Administrative questions about the Health Care Innovation Challenge may be directed to:

Grants Management Officer, Mary Greene
Centers for Medicare & Medicaid Services
Office of Acquisitions and Grants Management
Phone: 410-786-5239 or email: Mary.Greene@cms.hhs.gov

VIII. APPENDICES

1. Financial Plan

This Financial Plan is supplemental to Form SF 424A. Each proposed model in this portfolio is expected to submit a Financial Plan and supplemental narrative and schedules that provide an explanation of how it expects to meaningfully reduce medical cost trend for their identified population. The following Financial Plan template is provided so that each program awardee can demonstrate its anticipated use of funds and explain how its interventions will reduce overall cost of care for the beneficiaries its programs touch.

The Financial Plan requires awardees to provide the following:

- **Uses of Funds:** Awardees should enter proposed use of funds in the Financial Plan template. These funds must match Form SF 424A. Applicants should provide yearly line-item projections on how awarded funds will be allocated. The total use of funds will sum to the requested award.

- **Savings:**

    - Data under **Current Census** should describe services currently provided to program participants. Applicants are requested to provide data on the number of participants in applicant programs, the current baseline Per Beneficiary Per Year ("PBPY") Total Cost of Care for Participants touched by programs, and the proposed percent cost reduction the award funding will facilitate in those costs.
    - Data under **Proposed Expansion** should describe the impact on the proposed expansion population that award funding will facilitate. Applicants are requested to provide data on the number of participants targeted, the baseline PBPY Total Cost of Care for participants in targeted expansion area, and the proposed percent cost reduction the award funding will facilitate.

Applicants are required to provide supplemental narrative and supporting schedules with detailed information on the specific intervention expected to reduce cost and the estimated reduction in expenditures by funding source resulting from said intervention by service type and by funding source, including estimates for the number of affected individuals. Applicants should provide backup documentation, e.g., research studies, evidence of reduced cost from existing intervention, et cetera, as available. Applicants are encouraged to provide clear, detailed reports to facilitate objective, data-driven reviews.

The Innovation Center recognizes that these are estimates and applicants will encounter constraints on completing the Financial Plan as described. Innovation Center staff will be provide further materials and host a series of webinars to assist program applicants with their Financial Plan. More information including dates and times will be posted at a later date at www.innovations.cms.gov.

Applicants should show credible, favorable performance along the following dimensions:

- Meaningful reduction in PBPY of impacted populations;

- Strong return on investment over the three-year period;
- Rapid "Payback" period (though awardees are not being asked to payback their awards, this will help Innovation Center staff see how quickly program participants are generating savings); and
- Annualized program run-rate savings. This is the reduction in PBPY savings multiplied by the number of program participants.
- Percentage reduction in PBPY for program participants.

Financial Plan Template

	Current	Year 1	Year 2	Year 3	3-Year Total
USES OF FUNDS					
Direct Charges					
Personnel		$	$	$	$
Fringe Benefits		$	$	$	$
Travel		$	$	$	$
Equipment		$	$	$	$
Supplies		$	$	$	$
Contractual		$	$	$	$
Construction		$	$	$	$
Other		$	$	$	$
Total Direct Charges		**$**	**$**	**$**	**$**
Total Indirect Charges		$	$	$	$
Total Uses of Funds		**$**	**$**	**$**	**$**
SAVINGS					
Current Program Census					
Number of Program Participants	#	#	#	#	#
Baseline					
Total PBPY Cost of Care of Program Participants	$	$	$	$	$
Total Affected Spend	$	$	$	$	$
% Reduction in Total Cost of Care from Funding		%	%	%	
Proposed Expansion					
Number of New Participants Targeted		#	#	#	#
Baseline					
Total PBPY Cost of Care of Program Participants	$	$	$	$	$
Total Affected Spend	$	$	$	$	$
% Reduction in Total Cost of Care from Funding		%	%	%	