

Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicare and Medicaid Coordination Office

Center for Medicare & Medicaid Innovation

Cooperative Agreement

Initial Announcement

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Funding Opportunity Announcement Released: March 15, 2012

Notice of Intent to Apply Due: April 30, 2012, by 3:00p.m. Eastern Time (Baltimore, MD)

Electronic Cooperative Agreement Application Due Date: June 14, 2012 by 3:00 p.m.
Eastern Time (Baltimore MD)

Anticipated Notice of Cooperative Agreement Award: August 24, 2012

Anticipated Cooperative Agreement Period of Performance: August 25, 2012 through
August 24, 2016

OVERVIEW INFORMATION

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I. FUNDING OPPORTUNITY DESCRIPTION

1. Purpose

The purpose of this funding opportunity announcement is to solicit applications for participation as “enhanced care & coordination providers” in the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents (“Initiative”).

Under this Initiative, the Centers for Medicare & Medicaid Services (CMS) will select eligible organizations to test a series of evidence-based clinical interventions. The goal of these interventions is to improve the health and health care among nursing facility residents and ultimately reduce avoidable inpatient hospital admissions. Successful applicants will implement such interventions that will have the following objectives:

- Reduce the frequency of avoidable hospital admissions and readmissions;
- Improve resident health outcomes;
- Improve the process of transitioning between inpatient hospitals and nursing facilities; and
- Reduce overall health care spending without restricting access to care or choice of providers.

The interventions shall primarily target long-stay Medicare-Medicaid enrollees in Medicare-Medicaid certified nursing facilities, rather than those likely to experience only a brief post-acute stay and then return home.¹

These activities directly support the CMS Center for Medicare and Medicaid Innovation goals to test models of care that deliver better healthcare, better health, and reduced costs through improvement. For more information, see <http://innovations.cms.gov/>.

The activities in this cooperative agreement support the goals of the Partnership for Patients, a national public-private partnership to help improve the quality, safety, and affordability of health care for all Americans. Both this cooperative agreement and the Partnership for Patients aim to reduce hospital readmissions. More information about the Partnership for Patients can be found at: <http://innovations.cms.gov/>. These activities also support the Million Hearts Campaign, which is a national initiative to prevent one million heart attacks and strokes over the next five years. More information about the Million Hearts Campaign can be found at: <http://millionhearts.hhs.gov/>.

2. Authority

This solicitation is being issued under section 1115A of the Social Security Act (added by section 3021 of the Patient Protection and Affordable Care Act (P.L. 111-148)), hereinafter referred to as the Affordable Care Act, which authorizes the Center for Medicare and Medicaid Innovation (Innovation Center) to test innovative payment and service delivery models to reduce program expenditures under Medicare, Medicaid, and the Children’s Health Insurance Program while preserving or enhancing the quality of care. The Affordable Care Act authorized the establishment of the Federal Coordinated Health Care Office (Medicare-Medicaid Coordination Office) to more effectively integrate benefits for individuals eligible

¹ For the purposes of this Initiative, long-stay residents include those who reside in a nursing facility for 100 days or more or are identified on the Minimum Data Set assessment as residents expected to remain in the facility.

for both Medicare and Medicaid. The Medicare-Medicaid Coordination Office is releasing this cooperative agreement in partnership with the Innovation Center.

3. Background

Nursing facility residents are subject to frequent avoidable inpatient hospitalizations. These hospitalizations are expensive, disruptive, disorienting, and often dangerous for frail elders and people with disabilities. Nursing facility residents are especially vulnerable to the risks that accompany hospitalizations and transitions of care, including medication errors and hospital-acquired infections. Hospital episodes are even more difficult for individuals with dementia. Thus, preventing avoidable hospitalizations of nursing facility residents is an important quality-improvement objective, which may yield cost reductions as well.

The Medicare and Medicaid programs are the major sources of public financing for the medical and long-term care services provided to nursing facility residents (Jones, Dwyer, Bercovitz, & Strahan, 2009). Many nursing facility residents are enrolled in both Medicare and Medicaid programs (Medicare-Medicaid enrollees). Medicare covers basic health care services, post-acute care, and prescription drugs. Medicaid covers additional health care services, long-term care supports and services, and Medicare premiums and cost-sharing. Potentially avoidable hospitalizations of nursing facility residents add substantial cost to these publicly financed programs and reflect problems with quality of care provided in nursing facilities (Grabowski, Stewart, Broderick, & Coots, 2008).

Rate of Avoidable Hospitalizations

Numerous studies have analyzed hospitalizations from nursing facilities. The results consistently suggest that a high percentage of hospitalizations could be avoided.

Most studies use the list of ambulatory care sensitive (ACS) medical conditions, such as pneumonia, urinary tract infections, and congestive heart failure, in hospital claims to estimate the number of avoidable hospitalizations of nursing facility residents. Grabowski and colleagues found that in New York State in 2004, 23 percent of the roughly \$972 million spent on hospitalizations of nursing facility residents was attributable to ACS conditions (Grabowski, O'Malley, & Barhydt, 2007). Intrator, Zinn, and Mor (2004) found that 37 percent of long-stay resident hospitalizations during a 6-month period were for an ACS condition and were potentially avoidable.

Walsh and colleagues focused on hospitalizations among Medicare-Medicaid enrolled nursing facility residents in 2005 (Walsh, Freiman, Haber, Bragg, Ouslander, & Wiener, 2010). The study found that approximately 45 percent of hospitalizations among beneficiaries receiving Medicare skilled nursing facility services or Medicaid nursing facility services were potentially avoidable. Combined Medicare and Medicaid costs for these approximately 314,000 potentially avoidable hospital admissions totaled \$2.7 billion per year, and Medicare costs accounted for \$2.6 billion of that total. These calculations exclude other potential costs associated with hospitalization, including physician services, post-acute care costs following the hospitalization, medication costs, and potentially higher long-term nursing facility payments for beneficiaries who stabilize at a higher level of care. The study also found that five conditions were responsible for 78% of the potentially avoidable hospitalizations: pneumonia, congestive heart failure, urinary tract infections, dehydration, and chronic obstructive pulmonary disease/asthma.

Two studies used physicians to examine medical charts retrospectively to determine appropriateness of hospitalization. Saliba and colleagues (2000) found almost 40 percent of hospital admissions “inappropriate,” meaning that the resident could have been cared for safely at a lower level of care. Ouslander and colleagues (2010), in a recent study of two types of nursing facilities in Georgia, found that more than 60 percent of the hospitalizations were “definitely or probably avoidable.”

These studies vary in their methods, and all include important caveats and limitations. All studies look at hospitalizations after they have occurred using relatively complete after-the-event information, which may indicate the upper bound of potentially avoidable hospitalizations. However, it is clear across the literature that avoidable hospitalizations are a significant issue for nursing facility residents and present a critical opportunity to improve the quality and safety of care for patients and to reduce costs.

Influences in Hospitalization Rates

In addition to resident clinical conditions, there are other influences on the frequency with which nursing facility residents are hospitalized.

Physician preference: Physicians play a major role in the decision to hospitalize a resident in a nursing facility. Most physicians seeing patients in a nursing facility see residents in multiple facilities and maintain a community practice. Some physicians may prefer to send a resident to the hospital, rather than treat the resident in the nursing facility for several reasons, such as lack of access to diagnostic services and scheduling inconvenience (Levy, Epstein, Landry, Kramer, Harvell, & Liggins, 2006).

Skill level of staff: Although Federally-certified nursing facilities are required to have a registered nurse (RN) on staff eight hours a day, many facilities do not have an RN on site during off hours. There is evidence that residents of nursing facilities that rely more heavily on licensed practical nurse (LPN) staff were at greater risk of hospitalization (Carter & Porell, 2003). Several studies have found that increasing RN staffing resulted in better clinical outcomes, including decreased hospitalizations (Dorr, Horn, & Smout, 2005; Horn, Buerhaus, Bergstrom, & Smout, 2005). Konetzka and colleagues found that RN staffing improved outcomes for infections and other conditions associated with avoidable hospitalization, whereas increases in other staffing did not have the same effect (Konetzka, Spector, & Limcangco, 2008).

Financing misalignments: Payment structures in Medicare and Medicaid may fail to adequately incentivize nursing facilities to intervene to reduce preventable hospital utilization.² In particular, transferring Medicare-Medicaid enrollees receiving long-term care in nursing facilities to hospitals may be financially advantageous to facilities and States but raises Medicare spending. By transferring a resident to a hospital, the nursing facility avoids the high costs associated with care that the hospital provides. State bed-hold policies that pay nursing facilities a daily amount while a resident is in the hospital can also affect hospitalization rates; one study found that States with bed-hold policies had hospitalization rates 36 percent higher than States without them (Intrator, Grabowski, Zinn, Schleintz, Feng, Miller, & Mor, 2007). The nursing facility may qualify for a higher payment under Medicare when the beneficiary is readmitted and requires skilled nursing facility services. A State may also benefit when

² Medicare provides a skilled nursing benefit to enrollees needing skilled nursing facility care following a 3-day inpatient hospital stay. Beneficiaries are eligible for this benefit for up to 100 days in a benefit period. Medicaid provides Medicare-Medicaid enrollees with skilled nursing facility care when the Medicare benefit is exhausted. It also provides ongoing custodial care when Medicare-Medicaid enrollees no longer require skilled nursing care but do require a less intense level of nursing care.

beneficiaries qualify for Medicare-covered skilled nursing facility services because its financial liability is to pay only for the copayments and deductibles for Medicare-covered services (Medicare Payment Advisory Commission, June 2010).

Promising Practices

Past interventions have successfully reduced inpatient hospital utilization among nursing facility residents. For example:

- Beginning in 1994, the Health Care Financing Administration (now CMS) sponsored demonstrations with Evercare, a health plan that received capitated payments for the Medicare portion of costs for nursing facility residents. The demonstrations utilized nurse practitioners who collaborated with primary care physicians to provide increased clinical care and intensive management of chronic conditions to prevent flare-ups and manage acute illnesses among nursing facility residents on site at nursing facilities (Kane, Keckhafer, Flood, Bershadsky, & Siadaty, 2003). Evercare provided additional payment to the nursing facility for intensive service days to fund additional staffing resources for acutely ill patients who otherwise might be transferred to the hospital. Evaluations of this program indicate that Evercare reduced hospital admissions by 47% and emergency department use by 49%. (Kane, Flood, Bershadsky, & Keckhafer, 2004).
- The Robert Wood Johnson Foundation supported a demonstration in New York in the mid-1990s where primary care was provided by nursing facility-employed staff providers, compared to provision of care through traditional fee-for-service providers. Hospitalization rates, inpatient costs and emergency department visits were all reduced, and researchers estimated total Medicare Part A and B costs were 16.3% less than the control group. However, the initiative was not sustained in part because the State Medicaid agency, which would have been making the added investments, was not achieving the financial savings (Moore & Martelle, 1996).
- Interventions to Reduce Acute Care Transfers (INTERACT) II, a quality improvement and information exchange intervention, was evaluated in 25 nursing facilities in three States. The intervention included tools, on-site education, and biweekly teleconferences with a nurse practitioner focused on early identification, assessment, communication and documentation of changes in resident status. The evaluation found a 17% reduction in hospital admissions at an average cost of \$7,700 per nursing facility with projected savings to Medicare of \$125,000 per year per 100-bed nursing facility (Ouslander, et. al., 2011).

Other clinical and financial models have great promise for reducing inpatient hospital utilization among nursing facility residents. For example:

- Transitions in settings of care between hospitals and nursing facilities for Medicare-Medicaid enrolled nursing facility residents are often negatively impacted by poor communication, inadequate coordination, and adverse drug events (ADEs). Several evidence-based care transitions models (e.g., Care Transitions Intervention, Transitional Care Model) have been found to improve coordination, safety, and efficiency across care settings. These models have applicability to nursing facility residents, but they have rarely been explicitly tested among nursing facility residents. Appendix E provides recommendations for ensuring safe and effective care transitions.
- Polypharmacy increases the likelihood of ADEs in nursing facilities. Half of ADEs are preventable, and 80% of these preventable ADEs are due to failures in medication monitoring,

rather than medication prescribing (Leape, et. al., 1995; Gurwitz, et. al., 2005; Gurwitz, et. al., 2000). ADEs can also lead to potentially avoidable hospitalizations. The Institute of Medicine recommends active medication monitoring systems to assess the safety of medication (Handler, et. al., 2006). Applying a consensus list of signals to detect potential ADEs in nursing facilities over a one-month period, researchers were able to identify 40% of nursing facility patients with a potential ADE (Handler, et. al., 2010).

- CMS is operating a Nursing Home Value-based Purchasing Demonstration in Arizona, New York and Wisconsin to improve the quality of care of nursing facility residents and achieve Medicare savings by reducing hospitalizations. The participating nursing facilities receive annual payment awards based on attained performance level or improvements across four sets of performance measures; potentially avoidable hospitalizations are one measure of nursing facility performance that makes up 30 percent of an overall quality score. The financial awards are funded by the savings from reduced hospitalizations and subsequent skilled nursing facility stays (CMS, <http://www.cms.gov/demoprojectsevalrpts/md/itemdetail.asp?itemid=CMS1198946>).
- The U.S. Department of Health and Human Services' Office of the National Coordinator for Health Information Technology (ONC) has partnered with Colorado, Maryland, Massachusetts and Oklahoma to make rapid progress in improving secure health information exchange (HIE) between acute and long-term and post-acute care settings. The States are targeting the technology, care delivery and policy interventions needed to achieve timely electronic exchange of clinical summaries, medication lists, advance directives, and functional status content (ONC, <http://healthit.hhs.gov/portal/server.pt?open=512&mode=2&objID=3378>).

The research findings suggest that well-designed interventions have the potential to reduce avoidable inpatient admissions. However, there is still much to test and learn about the best mechanisms for reducing unnecessary hospitalizations among nursing facility residents. The scope of work below introduces a new initiative to reduce avoidable hospitalizations for nursing facility residents.

4. Program Requirements

Through this cooperative agreement, CMS seeks organizations that can develop and implement interventions that achieve the objectives outlined above under "1. Purpose" (I. Funding Opportunity Description). The sections below further describe the parameters for the Initiative.

4.1 INTERVENTION REQUIREMENTS

CMS is not prescribing any specific clinical model; it is allowing applicants to propose interventions to meet the cooperative agreement's objectives. However, all interventions must include the following activities:

- Hire staff who shall maintain a physical presence at nursing facilities and who shall partner with nursing facility staff to implement preventive services and improve recognition, assessment, and management of conditions such as pneumonia, congestive heart failure, chronic obstructive pulmonary disease and asthma, urinary tract infections, dehydration, skin ulcers, falls, and other common causes of avoidable hospitalizations;
- Work in cooperation with existing providers, including residents' primary care providers, nursing facility staff, and families to implement best practices and improve the overall quality of nursing

facility care, focusing on quality improvement activities that most directly relate to avoidable hospitalizations;

- Facilitate residents' transitions to and from inpatient hospitals and nursing facilities, including facilitating timely and complete exchange of health information among providers and providing support for residents and nursing facility staff to support successful discharge to the community as appropriate;
- Provide support for improved communication and coordination among hospital staff (including attending physicians), nursing facility staff, residents' primary care providers and other specialists, and pharmacies; and
- Coordinate and improve management and monitoring of prescription drugs to reduce risk of polypharmacy and adverse drug events for residents, including inappropriate prescribing of psychotropic drugs.

All interventions must also:

- Demonstrate a strong evidence base;
- Demonstrate strong potential for replication and sustainability in other communities and institutions;
- Supplement (rather than replace) existing care provided by nursing facility staff;
- Coordinate closely with State Medicaid and State survey and certification agencies and State public health and health reform efforts, including other CMS demonstrations and waivers; and
- Allow for participation by nursing facility residents without any need for residents or their families to change providers or enroll in a health plan. (Residents will be able to opt-out from participating, if they choose.)

Proposed interventions may also include, but are not limited to:

- Education efforts with families/caregivers;
- Support for residents and nursing facility staff to facilitate a successful discharge to the community as appropriate;
- Health information technology tools to support sharing of care summaries across transitions in care and maintenance of accurate, up-to-date medication lists; and/or
- Enhanced behavioral health assessments, treatment, and management.

Interventions focused on behavioral health must coordinate with Preadmission Screening and Resident Review (PASRR). The primary target population for the clinical interventions is fee-for-service Medicare-Medicaid enrollees in nursing facilities, but fee-for-service long-stay residents who are not yet Medicare-Medicaid enrollees will also benefit (i.e., Medicare beneficiaries not yet eligible for Medicaid, or Medicaid beneficiaries not yet eligible for Medicare but who represent similar opportunities for inpatient reductions). The clinical interventions will focus on long-stay residents³ rather than those who are likely to experience only a brief post-acute stay and then return home, and applicants must describe how they will target the intervention to long-stay beneficiaries. CMS is not seeking to supplant existing efforts currently being implemented in nursing facilities through this cooperative agreement. Rather, an important goal of this Initiative is to implement clinical interventions meeting the requirements outlined above in nursing facilities that do not have such efforts in place.

³ For the purposes of this Initiative, long-stay residents include those who reside in a nursing facility for 100 days or more or are identified on the Minimum Data Set assessment as residents expected to remain in the facility.

In addition to testing clinical models designed to improve health and health care among nursing facility residents and to ultimately reduce avoidable inpatient hospital admissions, this Initiative will provide information for considering payment reforms that could be tested related to payment for skilled nursing facility services. Any reforms tested would be designed to improve quality of care without increasing Federal spending or designed to reduce Federal spending without reducing quality of care over the long term.

State Partnerships

States, through Medicaid, play a significant role in setting payment policy for nursing facility services, and Medicaid payment policy has been shown to significantly affect hospitalization rates for nursing facility residents (Intrator, Grabowski, Zinn, Schleintiz, Feng, Miller, & Mor, 2007). States also play an important role in monitoring the quality of care in nursing facilities. As a result, States are critical partners in achieving the objectives of this cooperative agreement and in sustaining these interventions in the future, should the Initiative meet its goals as anticipated. Thus, this Initiative requires States to be engaged partners.

Applicants must include a letter(s) from the State Medicaid director and Medicaid survey and certification director expressing support for the application and agreeing to engage in a memorandum of understanding (MOU) upon selection. Applicants may provide one letter with two signatures or two separate letters. States are permitted to support multiple applicants. In each State where this Initiative is implemented, CMS will solidify the commitments initiated with the letter of support by executing a MOU with the State involved (see Appendix B).

Nursing Facility Partnerships

Applicants must demonstrate a high level of engagement with the nursing facilities included in their application. Applications shall include letters of intent (LOIs) from Medicare- and Medicaid-certified nursing facilities agreeing to participate in the intervention described in the application. Applications shall include LOIs from a minimum of 15 nursing facilities in the same State, with an average census of 100 residents or more per facility. CMS will give preference to initiatives in locations where there are high Medicare costs, high hospital readmission rates, and where Medicare-Medicaid enrollees account for a high percentage of nursing facility residents. Success in achieving the aims of this Initiative will depend on both the strength and efficacy of the clinical intervention and the effectiveness of engagement between the enhanced care & coordination provider and its partnering nursing facilities. The enhanced care & coordination provider will support learning among nursing facility partners, including assistance in making mid-course changes to the model, as needed. The enhanced care & coordination provider would implement the clinical intervention consistently across all nursing facility partners.

Restrictions / Limitations

CMS will consider applications from eligible organizations (III. Eligibility Information) to implement the types of interventions described in this cooperative agreement in locations across the U.S. CMS anticipates that each award will take place within one State. CMS will review multi-State applications if activities in each State meet the criteria described in this cooperative agreement (i.e., an applicant may propose to implement an intervention in multiple States but its application must include letters of support from each State Medicaid director and State survey and certification director, as well as letters of intent

from at least 15 Medicare- and Medicaid-certified nursing facilities in each State). There are certain types of nursing facilities where this intervention may overlap with other initiatives. **Therefore, CMS will not allow** the following facilities to participate:

- Facilities in which more than 25% percent of the residents are enrolled in Medicare managed care;
- Hospital-based nursing facilities;
- Special focus facilities;⁴ or
- Nursing facilities with outstanding major survey violations for immediate jeopardy to resident health or safety.

The Federal government is currently supporting several initiatives for reforming the delivery and financing of health care (e.g., Accountable Care Organizations and the Partnership for Patients, including the Community-based Care Transition Program). For more information, see <http://innovations.cms.gov/>. Specifically, the Affordable Care Act has presented several opportunities for reforming the delivery and financing of health care, and many States are implementing ambitious health reforms. The interventions supported through this cooperative agreement must complement and support other health reform efforts, while still maintaining sufficient independence to isolate the effects of this initiative. **CMS is not seeking to fund interventions that compete or interfere with existing demonstrations.** However, CMS may fund complementary demonstrations and programs to further test innovative care models under section 1115A of the Social Security Act authority. To the extent that multiple new models are viable options for the same providers and/or beneficiaries, CMS will take appropriate steps to minimize beneficiary overlap and prohibit duplicate payments for savings generated based on the same beneficiary. For example, CMS may choose to exclude applicants that operate in the same geographical areas as a Medicare shared savings model (e.g. Accountable Care Organizations) with which there is likely to be target population overlap, or establish assignment rules to ensure that beneficiaries are only attributed to one model for the purposes of determining cost/savings impact.

CMS will accept applications from entities participating in other Federal initiatives. However, the applicant must inform CMS of its participation or the participation of any partnering nursing facilities in other Federal initiatives. The applicant must also describe how participation in this Initiative will complement and support other health reforms, without leading to duplicative funding or circumstances where an organization already has an arrangement to share in Medicare savings for the same individuals served through this Initiative. Additionally, the applicant must describe how the CMS evaluation of its intervention would measure the intervention's unique impact (including the unique impact on Federal and State costs), above and beyond existing initiatives. If selected by CMS for participation in this Initiative, the enhanced care & coordination providers shall inform CMS on an ongoing basis of its participation in any other Federal initiatives.

In a separate project, CMS has contracted with 15 States to design new integrated care programs for Medicare-Medicaid enrollees, which could include initiatives for individuals in nursing facilities (for more information, see <http://www.cms.gov/Medicare-Medicaid-Coordination>). CMS will accept applications from entities proposing to operate in those 15 States. However, the applicant will need to present a compelling case that the activities funded through this cooperative agreement would work in synergy and not diminish the value to CMS from funding both initiatives in the same State. In addition to these 15 States, other States are interested in integrating care for their Medicare-Medicaid enrollees. The

⁴ Special focus facilities are those facilities with a history of serious quality issues and are included in a special program to stimulate improvements in their quality of care. For more information, see <https://www.cms.gov/CertificationandCompliance/Downloads/SFFList.pdf>.

full list of States expressing interest to CMS can be found at: https://www.cms.gov/medicare-medicaid-coordination/08_FinancialModelstoSupportStatesEffortsinCareCoordination.asp#TopOfPage.

CMS will prioritize applications that target nursing facilities with a high concentration of Medicare and Medicaid enrollees and prefers facility-wide implementation rather than implementing the approach in only a subset of the facility. CMS will give preference to initiatives in geographic locations where there are high Medicare costs, high hospital readmission rates, and where Medicare-Medicaid enrollees account for a high percentage of nursing facility residents. Applicants may want to review the following resources:

- <https://www.cms.gov/Insight-Briefs/downloads/PAHInsightBrief.pdf>: CMS has analyzed the prevalence and cost of potentially avoidable hospitalizations for individuals who are eligible for both Medicare and full Medicaid benefits. Using data from 2005, this CMS report provides data on potentially avoidable hospitalizations for Medicare-Medicaid enrollees by source and State.
- <http://ltcfocus.org/default.aspx>: This website is a product of the Shaping Long-Term Care in America Project at the Brown University Center for Gerontology and Healthcare Research and supported by the National Institute on Aging. The website contains data on the characteristics of nursing facilities and the residents they serve, including re-hospitalization rates by nursing facility and the percent of residents enrolled in Medicare and Medicaid.
- <http://www.healthindicators.gov/>: The Health Indicators Warehouse is a collaboration of many agencies and offices within the U.S. Department of Health and Human Services, and is maintained by the Center for Disease Control's National Center for Health Statistics. The website contains data on demographic, cost, utilization, and quality indicators for all hospital referral regions and States. For more information regarding hospital referral regions and how to determine which hospital referral region a nursing facility corresponds to, see <http://www.dartmouthatlas.org/downloads/methods/geogappdx.pdf>.
- http://www.cms.gov/DemoProjectsEvalRpts/downloads/CCTP_FourthQuartileHospsbyState.pdf: The CMS Community-based Care Transitions Program (CCTP) has developed a list of "high readmission hospitals," which provides 30-day Medicare hospital readmission rates for acute myocardial infarction, heart failure, and pneumonia by State and city. While this document was developed to determine eligibility for CCTP, it may be helpful in identifying geographical locations with high hospital readmission rates.

CMS will not fund applications that solely replicate models that CMS is currently testing in other initiatives. Finally, given the breadth of models that could be submitted, CMS will not fund applications for interventions that cannot be monitored, evaluated, and tracked for progress and impact on the quality and cost of care.

4.2 ENHANCED CARE & COORDINATION PROVIDER ACTIVITIES

Over the course of the cooperative agreement, CMS will require that the enhanced care & coordination providers complete the following Activities:

1. Activity - Start-up of the Clinical Intervention

1.a – Operations Manual and Beneficiary Notification Protocols and Forms

The enhanced care & coordination provider shall develop an operations manual describing the clinical intervention and how it will be implemented in the partnering nursing facilities. The operations manual shall outline all key elements of the clinical intervention and associated staffing plan to implement it, how staff will cooperate with existing providers, the target population and how these residents will be identified and engaged to participate, and plans for fostering learning and diffusion within the facility.

The enhanced care & coordination provider shall develop, with its nursing facility partners, protocols that participating nursing facilities shall follow to notify beneficiaries of participation in the Initiative. The enhanced care & coordination provider shall also develop standardized forms to notify beneficiaries in the target population (and/or caregivers/family) of nursing facilities' participation in the Initiative. These forms must describe the goals and objectives of the Initiative and the approach being tested, and must state that CMS may provide personally identifiable health information available from Medicare and Medicaid claims data to providers and enhanced care & coordination providers for the purposes of implementing, operating, and evaluating the Initiative. These forms must offer an opportunity to opt-out of participation and provide beneficiaries with instructions on how to submit complaints related to the Initiative. These forms will be reviewed and approved by CMS.

The operations manual and all protocols and notification forms must be developed in advance of beginning the readiness review (Activity 1.b) and submitted to CMS and its operations support contractor no later than 60 calendar days after cooperative agreement start date. CMS retains the right to approve the operations manual and all protocols and notification forms.

1.b – Readiness Review

Within 75 days of cooperative agreement start date, the enhanced care & coordination provider will complete a readiness review before beginning the work outlined under Activity 2. The readiness review will be conducted by an operations support contractor designated by CMS and will include:

- A review of the enhanced care & coordination provider's policies and procedures (e.g., including beneficiary notifications, protections, and opt-out forms; complaint procedures; and any terms and conditions of participation);
- Verification that the enhanced care & coordination provider has established policies and procedures to educate all relevant nursing facility staff, residents' primary care providers, hospital staff (including attending physicians), other specialists, pharmacists, and residents and their families about the clinical intervention. The enhanced care & coordination provider shall demonstrate a plan to provide such education on a regular basis;
- Confirmation that all enhanced care & coordination provider staff are hired, qualified, and trained (as indicated by the enhanced care & coordination provider in its response to this cooperative agreement); and
- A site visit by CMS and/or its operations support contractor to at least three of the participating nursing facilities to meet with key staff (e.g., director of nursing, director of operations) involved in implementing the clinical intervention and verify nursing facility leadership has collaborated in planning activities and supports implementation of the clinical intervention. For the remaining nursing facility partners, the contractor shall meet with key nursing facility staff via teleconference (unless other arrangements are made).

Enhanced care & coordination providers will become eligible to receive monthly payment upon completion of Activity 1 and upon beginning Activity 2.

2. Activity - Implementation of the Clinical Intervention

In accordance with the approved work plan (Activity 3.b), each enhanced care & coordination provider shall hire staff who maintain a physical presence in nursing facilities. These staff will execute the clinical intervention to targeted nursing facility residents. Staff present in facilities may include registered nurses, nurse practitioners, and physician assistants, but CMS is open to other staffing models that meet the Intervention Requirements. In addition to clinical staff who maintain a physical presence in the nursing facility, CMS requires each enhanced care & coordination provider to designate a project director and a medical director from its personnel. The enhanced care & coordination provider is required to maintain sufficient staffing to successfully conduct the proposed intervention. Any changes to the intervention, including changes in key staff, must be approved by CMS.

The enhanced care & coordination provider is also required to maintain sufficient organizational resources, including training resources, tools and protocols, information technology, and other resources necessary to implement the proposed intervention.

Enhanced care & coordination providers and nursing facilities are expected to work together as partners throughout the Initiative. The enhanced care & coordination provider's role includes hiring and staffing the intervention, but it shall also coach and support nursing facility staff in testing, monitoring, and adapting the intervention, as necessary, to guide improvement. The enhanced care & coordination provider will guide the testing and implementation of the intervention at the nursing facility level through tracking and collecting data on a concise set of interim progress measures. These measures will supplement data gathered by CMS' operations support and evaluation contractor, with the goal of providing regular checks on the effectiveness of the intervention. The enhanced care & coordination provider will also provide opportunities for partnering nursing facilities to learn from each other about effective implementation of the clinical intervention.

Implementation shall begin no later than 30 calendar days following CMS review and approval of the readiness review.

3. Activity - Communications and Reporting

3.a – Kick-off Teleconference

Within 10 calendar days of cooperative agreement start date, each enhanced care & coordination provider shall conduct a kick-off teleconference with CMS. The kick-off teleconference is the first meeting with the project team members to discuss the project and the work that will be completed. This teleconference introduces the members of the project team and provides the opportunity to discuss the role of each team member in the project work. Other elements in the project may be discussed at this meeting (project task list, deliverables, schedule, lines of communication, etc.).

3.b – Work Plan

Within 15 calendar days of cooperative agreement start date, each enhanced care & coordination provider shall develop, for review by CMS, a project work plan for implementing the proposed intervention. The work plan will identify key milestones, tasks, interdependencies, and the responsible parties for each, as well as a related timeline. The work plan will also incorporate education of providers and residents/caregivers/family and major deliverables to CMS.

The work plan will be reviewed monthly and updated and provided to CMS, as needed. CMS will share it with the State Medicaid agency and State survey and certification agency.

3.c – Communications Plan

The enhanced care & coordination provider shall develop a communications plan to ensure that the Project Officer and other partners are kept informed of the activities and tasks performed under this cooperative agreement. The enhanced care & coordination provider shall submit this communications plan within 10 calendar days of the cooperative agreement start date. The plan shall describe the lines of communication among all of the partners involved in the Initiative, mechanisms for sharing information about any changes in the Initiative, and techniques for sharing best practices or challenges across nursing facility sites.

3.d – Quarterly Progress Reports

The enhanced care & coordination provider shall be responsible for providing ongoing ad hoc status updates at the request of CMS as well as formal quarterly reports to CMS to summarize progress against the milestones identified in the work plan. The quarterly report shall provide analysis of challenges, discuss best practices or key lessons, and provide mitigation strategies for addressing barriers during implementation.

These quarterly reports shall also include an update on operational data describing the participation status among nursing facilities. At a minimum, the quarterly reports will include the following metrics (bulleted below) for each partnering nursing facility. Beyond the first quarterly report, the enhanced care & coordination provider must highlight changes from the previous quarterly report for the following data for each month in the quarter:

- Hired staffing levels;
- Identifying information for all practitioners that the enhanced care & coordination provider employs to support the Initiative in the nursing facility, including names, National Provider Identifiers, and Taxpayer Identification Numbers;
- Hours during the week when enhanced care & coordination provider staff are accessible to each nursing facility;
- Nursing facility resident caseload for each practitioner that the enhanced care & coordination provider employs;
- Roles and responsibilities of enhanced care & coordination provider staff, including how they are working with nursing facility residents, nursing facility staff, hospital staff (including attending physicians), residents' primary care physicians, pharmacists, and residents' families;
- Level of care and amount of time enhanced care & coordination provider staff spend providing bedside care versus communicating with existing providers and caregivers/family;
- For each partnering nursing facility: total number of Medicare-Medicaid enrollees who directly receive the clinical intervention; total number of long-stay Medicare-only or Medicaid-only beneficiaries who directly receive the clinical intervention (if such populations are part of the approved application); Medicare-Medicaid enrollees as a percentage of the total resident population; long-stay Medicare-only or Medicaid-only beneficiaries (if such

- populations are part of the approved application) as a percentage of the total resident population;
- For each nursing facility resident who directly receives the clinical intervention: Medicare ID; Medicaid ID if the resident has no Medicare ID (if such populations are part of the approved application); and Medicare and Medicaid enrollment status;
 - As applicable for each nursing facility resident who directly receives the clinical intervention: nursing facility admission and discharge dates; inpatient hospital admission and discharge dates; nursing facility's reason for transfer to the inpatient hospital; and inpatient hospital diagnosis related to the admission;
 - Total nursing facility occupancy and payer mix;
 - Number of Medicare-Medicaid enrollees residing in the nursing facility;
 - Number of any other long-stay residents in the target population, such as any long-stay Medicare beneficiaries who are not yet eligible for Medicaid, residing in the nursing facility;
 - Results of data collected to guide the testing and implementation of the intervention at the nursing facility;
 - Number of nursing facility resident notifications and the number of residents by facility who opted not to participate. The enhanced care & coordination provider shall raise any concerns with the notification/attestation process with the operations support contractor.
 - Number of referrals to Local Contact Agencies initiated by the enhanced care & coordination provider for residents who express interest in returning to the community (e.g., referrals initiated by responses to Minimum Data Set Version 3.0 Section Q);
 - Communication activities within and across nursing facilities and any key findings; and
 - Any other data necessary for oversight of the Initiative.

The exact form of quarterly reports will be determined in conjunction with CMS and its operations support and evaluation contractors. The enhanced care & coordination provider shall submit the quarterly reports to the designated CMS operations support contractor within 15 calendar days of each month's end and in the form determined by CMS.

3.e – Semi-Annual Funding Reports

The enhanced care & coordination provider shall detail how cooperative agreement funds were used for each six-month period. This information shall be provided to CMS using the SF-424A form and the Monthly Financial Plan template (Appendix D). CMS will use this information, in addition to quarterly progress reports, to monitor operations. Within 30 calendar days of the end of each six-month period, the enhanced care & coordination provider shall provide the completed SF-424A and relevant table from the Monthly Financial Plan.

3.f – Final Report

Within 90 calendar days of the end date of the cooperative agreement, the enhanced care & coordination provider shall submit to CMS a final report, which may inform CMS about potential for the intervention to be replicable and potential future Medicare and Medicaid policy changes. The report shall:

- Define all aspects of the tested clinical model (e.g., types of services provided; staffing mix and frequency present in the nursing facility; staff-to-nursing-facility-resident ratios; how often the intervention was provided; cost to provide the intervention) and any material changes made during the cooperative agreement period of performance;
- Indicate the number of nursing facility residents who directly received the clinical intervention, their Medicare and Medicaid enrollment status, nursing facility admission and

discharge dates, inpatient hospital admission and discharge dates, primary reasons for nursing facility transfer to inpatient hospital, and primary hospital diagnoses related to the inpatient hospital admission;

- Summarize results of data collected to guide the testing and implementation of the intervention at the nursing facility;
- Include the number of referrals to Local Contact Agencies initiated by the enhanced care & coordination provider for residents who express interest in returning to the community;
- Provide analysis of challenges and suggested mitigation strategies for addressing barriers during implementation and those relevant to replicating and scaling the model;
- Identify and describe specific best practices or key lessons from implementation; and
- Describe any and all aspects of the clinical model that the enhanced care & coordination provider would recommend for replication and/or implementation on a broader scale (e.g., staffing, intervention, cost, frequency of delivery). How does this model differ from the model that was tested during the cooperative agreement period of performance? Which components are necessary and which are optional for replication and/or broader scale implementation? Are there any relevant factors (e.g., geographic location, health care marketplace, nursing facility characteristics, and nursing facility resident characteristics) that may change the effectiveness of the model?

The exact form of the final report will be determined in conjunction with the CMS operations support contractor and evaluation contractor.

4. Activity – Participation in CMS Learning Community

The enhanced care & coordination provider will be required to participate in the activities of the CMS Learning Community developed to support this Initiative. These activities will likely include periodic web-based teleconferences, topic-specific webinars and calls, and active sharing of information and learning among partnering entities, including the opportunity for site visits to organizations showing early success. The enhanced care & coordination provider should anticipate participating in the CMS Learning Community via webinar or teleconference at least once each quarter, and these exchanges may occur as frequently as once per month to discuss data provided in quarterly progress reports (Activity 3.d).

4.3 SCHEDULE OF DELIVERABLES

Activity	Deliverable	Due Date
Activity 1.a	Operations manual and beneficiary notification protocols and forms	Completed within 60 calendar days of cooperative agreement start date
Activity 1.b	Readiness reviews	Completed within 75 calendar days of cooperative agreement start date

Activity	Deliverable	Due Date
Activity 2	Implementation of the Clinical Intervention	Begun within 30 calendar days of CMS review and approval of the readiness review
Activity 3.a	Kick-off teleconference	Completed within 10 calendar days of cooperative agreement start date
Activity 3.b	Work plan	Completed within 15 calendar days of cooperative agreement start date Reviewed monthly and updated as needed
Activity 3.c	Communications plan	Completed within 10 calendar days of cooperative agreement start date
Activity 3.d	Quarterly progress reports	Completed within 15 calendar days of each quarter's end
Activity 3.e	Semi-annual funding reports	Completed within 30 calendar days of the end of each six-month period
Activity 3.f	Final report	Completed within 90 calendar days of the end date of the cooperative agreement
Activity 4	Participation in CMS Learning Community	At least quarterly participation in CMS Learning Community

4.4 MONITORING AND EVALUATION

Operations Support Contractor

CMS, with the assistance of its contractors, will conduct program monitoring throughout the cooperative agreement period of performance. While the operations support contractor will provide CMS with assistance in collecting data and monitoring Initiative operations, CMS will review this information and make any decisions about readiness and performance.

Operations monitoring will include, but will not be limited to, review of quarterly progress reports of required data specified in Activity 3.d, including verification of nursing facility resident eligibility to participate in the Initiative. Data submitted by enhanced care & coordination providers to CMS and its contractors may be used to determine (1) the enhanced care & coordination provider's adherence to the clinical model and which nursing facility residents are receiving the intervention; (2) interim

results of the model signaling effectiveness and/or needed adaptations; (3) funding allotments; and (4) supplemental funds.

Other responsibilities of the operations support contractor include:

- Conducting readiness reviews for each enhanced care & coordination provider prior to implementing its clinical intervention;
- Conducting quarterly chart reviews of a sample of nursing facility residents to ensure that hospital care is not being inappropriately withheld;
- Establishing, organizing, and leading learning and diffusion activities;
- Calculating annual quality scores and combined Medicare and Medicaid savings estimates to assist CMS in determining supplemental funds awards; and
- Monitoring enhanced care & coordination provider compliance with Medicare and Medicaid billing restrictions.

Evaluation Contractor

CMS will contract with an independent evaluator to conduct ongoing assessment of the Initiative outcomes, and it will identify a broad set of evaluation measures for the Initiative. These measures will allow CMS to determine the extent to which the Initiative meets its objectives:

- Reduce the frequency of avoidable hospital admissions and readmissions;
- Improve resident health outcomes;
- Improve the process of transitioning between inpatient hospitals and nursing facilities; and
- Reduce overall health care spending without restricting access to care or choice of providers.

Evaluation measures, which will be assessed in annual reports, will include those used to determine enhanced care & coordination provider eligibility for supplemental funds, as discussed in Appendix A. Additional metrics shall be collected and analyzed as part of the overall evaluation of the Initiative.

The review panel will assess the extent to which the proposed approach enables the intervention to be tested and the outcomes to be reasonably attributable to the intervention. It will also consider whether the proposed approach promotes the selection of viable comparison groups. For instance, an applicant may be proposing to implement an intervention in a geographic area with other existing initiatives. If this is the case, the applicant must describe how its proposed intervention is designed to measure its unique impact, above and beyond the existing effort.

Cooperation of Enhanced Care & Coordination Providers

The enhanced care & coordination providers are required to cooperate, and shall require any other individuals or entities performing functions or services related to Initiative activities to cooperate, with the independent evaluator by providing data needed to assess the impact of the Initiative. Data include but are not necessarily limited to information documented in quarterly progress reports (as outlined in Activity 3.d). CMS shall have full rights to use such data to disseminate successful care management techniques, including factors associated with performance, to other providers and suppliers and the public and to evaluate the Initiative. The enhanced care & coordination providers shall cooperate, and shall require any other individuals or entities performing functions or services

related to Initiative activities to cooperate in any site visits conducted by CMS or its designee(s). CMS or its designee(s) shall schedule the site visit with the enhanced care & coordination provider no less than 15 days in advance for purposes of evaluation, learning, and documenting best practices. Please note that existing Medicare and State survey and certification procedures shall continue to apply throughout the Initiative to all participating nursing facilities. CMS Initiative staff or its contractor(s) will not participate in the investigation but may contact the facility and/or Federal/State surveyors to understand how their investigation relates to the Initiative. More details are provided in VI. Award Administration Information.

4.5 PAYMENT AND RESTRICTIONS ON BILLING

To fund the proposed clinical intervention, enhanced care & coordination providers meeting operational performance parameters (see Operational Performance, below) shall be eligible to receive funds from the Payment Management System on a monthly basis, upon completion of Activity 1 and upon beginning Activity 2. Monthly payment allotments shall be determined based on a per facility fee, which shall be based on the size of the target population. These allotments will be based on amounts in the Monthly Financial Plan section of the application (IV. Application and Submission Information and Appendix D). The reasonableness of the payment rates relative to the proposed approach is one of the evaluation factors in selecting enhanced care & coordination providers. Any supplemental funds (see below and Appendix A) would not be included in these amounts. CMS anticipates awards to approximately seven enhanced care & coordination providers.

If an enhanced care & coordination provider terminates participation in the cooperative agreement, CMS will terminate further payment. CMS reserves the option to withhold payment if the enhanced care & coordination provider is not fulfilling Activities as outlined under Enhanced Care & Coordination Provider Activities (I. Funding Opportunity Description), which are required.

Practitioners funded through this cooperative agreement will not be permitted to separately bill Medicare or Medicaid for services delivered to the nursing facility residents involved in this Initiative. For example, if an enhanced care & coordination provider hires nurse practitioners as part of this Initiative, those nurse practitioners cannot also bill Medicare or Medicaid for services rendered to nursing facility residents at the facilities participating in this Initiative.

CMS reserves the option to re-negotiate payment rates associated with activities at any facility where there is a material change in total occupancy, payer mix, or other changes that would fundamentally change the scope of the Initiative. CMS also reserves the option to change disbursement methods.

4.6 SUPPLEMENTAL FUNDS

Based on specific criteria, enhanced care & coordination providers may receive supplemental funds. These criteria, which are outlined in Appendix A, prioritize reduction of potentially avoidable hospitalizations, quality of care provided to long-stay residents, and minimal survey deficiencies. Enhanced care & coordination providers may qualify for supplemental funds based on meeting operational criteria, results of quality measures, and on a determination by CMS that the enhanced care & coordination provider has reduced combined Medicare and Medicaid program expenditures. For the supplemental funds, CMS may allocate up to an additional \$6.4 million to all enhanced care & coordination providers. The supplemental funds would be in addition to the per facility fee paid to implement the clinical intervention.

4.7 OPERATIONAL PERFORMANCE

Awardees will be funded based on their ability to execute their approved work plan. The components of the work plan include, but are not limited to:

- Meeting proposed milestones and deliverables as outlined in the work plan and communications plan;
- Satisfying all Enhanced Care & Coordination Provider Activities (I. Funding Opportunity Description), including a) submitting quarterly progress reports as scheduled and providing complete and accurate information for all required data fields in those reports (Activity 3.d) and b) submitting timely, complete, and accurate semi-annual funding reports (Activity 3.e) that show efficient use of cooperative agreement funds;
- Participating in ongoing learning and diffusion activities, including those offered through the CMS Learning Community; and
- Cooperating with operations support and evaluation efforts, including adapting models based on needed mid-course corrections.

Awardees will be required to cooperate in providing the necessary data elements to CMS. CMS will contract with independent entities to assist in monitoring the programs and to conduct an independent evaluation. More details are provided in VI. Award Administration Information.

4.8 DATA COLLECTION

The enhanced care & coordination providers shall collect data as necessary from nursing facility partners, including data required for quarterly progress reports (Activity 3.d). The enhanced care & coordination providers shall assist CMS in establishing any Information Exchange Agreements with participating nursing facilities as required to facilitate data exchange.

4.9 RESTRICTIONS ON AWARDS

Award dollars cannot be used:

- 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 application.
- To pay for construction or alteration and renovation of real property (A&R).
- To pay for information technology (IT) equipment exceeding 10 percent of the total award. Any equipment, which includes IT, over \$5,000 must be approved by CMS.

- To pay States for the use of any of their data made available for this Initiative.

5. Technical Assistance

Prior to the application deadline, CMS will host one or more 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 Medicare and Medicaid Coordination website at:

<https://www.cms.gov/medicare-medicaid-coordination/>.

After award, limited technical assistance will be available to awardees through the operations support contractor. Technical assistance may include providing guidance to awardees on submitting data required for quarterly progress reports.

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 in accordance with applicable laws and policies, when appropriate to the particular intervention. Existing CMS rules and procedures will apply and are described at

http://www.resdac.org/Medicare/requesting_data.asp.

II. AWARD INFORMATION

1. Total Funding

Total funding for this Initiative is up to \$128 million to support a diverse portfolio of evidence-based clinical interventions to improve the health and health care among nursing facility residents and ultimately reduce avoidable inpatient hospital admissions. Cooperative agreements will be awarded based on criteria outlined in V. Application Review Information. Awardees may not receive the award amount requested but may be asked to revise the work plan and budget to reflect the award amount determined by CMS.

In addition to funding provided to enhanced care & coordination providers to implement the Initiative, CMS may allocate up to an additional \$6.4 million for supplemental funds. Supplemental funds would be awarded based on an enhanced care & coordination provider's implementation of the program across all of its partnering nursing facilities. For more information, see Appendix A.

2. Award Amount

The Medicare-Medicaid Coordination Office expects to make awards ranging from \$5 million to \$30 million each to cover a four-year cooperative agreement period of performance, and CMS reserves the right to award less or more depending on the scope and nature of the individual applications received. Awardees may not receive the total award amount requested but may be asked to revise the work plan and budget to reflect the funding that CMS will award.

3. Anticipated Award Date

CMS anticipates making cooperative agreements awards by August 23, 2012.

4. Period of Performance

The anticipated cooperative agreement period of performance for the 4-year Initiative period is August 25, 2012 through August 24, 2016. Funding will be awarded in 12-month budget periods.

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

5. Number of Awards

The Medicare-Medicaid Coordination Office intends to fund the best qualified applications within the scope of available funds. It is anticipated that approximately seven awards will be made.

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, ongoing evaluation results, and whether 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

The Medicare-Medicaid Coordination Office and the Innovation Center anticipate substantial involvement in the evaluation and monitoring of the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents cooperative agreements and their resulting recipient responsibilities.

While awardees are expected to cooperate with and facilitate the role of the awarding office and work of the operations support contractor and 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. Applications that would require such additional support will be considered non-responsive and will be eliminated from consideration. Applications that require data from CMS should specify this need.

III. ELIGIBILITY INFORMATION

1. Eligible Applicants

CMS will consider applications from organizations (referred to as enhanced care & coordination providers) that demonstrate the capacity to adequately implement the types of initiatives described above. Enhanced care & coordination providers may include, but are not limited to:

- Organizations that provide care coordination, case management, or related services;
- Medical care providers, such as physician practices;
- Health plans (although this Initiative will not be capitated managed care, and will not apply to beneficiaries enrolled in Medicare Advantage);
- Public or not-for-profit organizations, such as Aging and Disability Resource Centers, Area Agencies on Aging, Behavioral Health Organizations, Centers for Independent Living, universities, or others;
- Integrated delivery networks, if they extend their networks to include unaffiliated nursing facilities.

Nursing facilities, entities controlled by nursing facilities, or entities for which the primary line of business is the delivery of nursing facility/skilled nursing facility services are excluded from serving as enhanced care & coordination providers under this cooperative agreement.

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.

Application Eligibility Threshold Criteria

Applications not meeting threshold criteria will not be reviewed. Threshold criteria include:

- Application deadline: Applications must be received in Grants.gov by the application deadline
- Applications shall have required letters of support from State Medicaid and State survey and certification directors and letters of intent from at least 15 Medicare- and Medicaid-certified nursing facilities in the same State with an average census of 100 residents per facility.
- Applications shall include standard forms, Tables 1-3 (Appendix C), and Monthly Financial Plan (Tables 4-7, Appendix D))
- Page limit: Applications must not be more than 40 pages in length and separate appendices must not exceed 80 pages in length. Thus, the application with the appendices shall not exceed 120 pages in length. This includes duplicate information. Please check your application so that there is no duplicate information provided as it will be counted in the application page limits.
- Application requirements: In addition to timely submission and submitting required letters of support from the State and letters of intent from nursing facilities and other required forms, applications will be considered for funding only if the application meets the requirements as outlined in III. Eligibility Information and IV. Application and Submission Information.

The application narrative shall include (not to exceed 40 pages in length):

- Proposed Approach
- Organizational Capacity and Management Plan
- Evaluation and Reporting
- Budget, Budget Narrative and Monthly Financial Plan

The appendices shall include (not to exceed 80 pages in length):

- Project summaries of past experience
- Detailed vitae of key personnel
- State letters of support and commitment
- Letters of intent from nursing facilities
- Nursing facility partner characteristics (Tables 1-3, Appendix C)
- Monthly Financial Plan (Tables 4-7, Appendix D)

Other required materials NOT included in page limits are:

- Cover letter
- Abstract
- Standard forms (see Overview of Cooperative Agreement Application Structure and Content)
- Indirect Cost Rate Agreement
- Any nursing facility and/or State surveys of nursing facility residents.

More information can be found in IV. Application and Submission Information.

Applicants are strongly encouraged to use the review criteria information, provided in V. Application Review Information, to help ensure that the application adequately addresses all the criteria that will be used in evaluating the applications.

2. Central Contractor Registration (CCR) Requirement

For any organization not currently registered with CCR and DUNS, the CCR/DUNS process should begin as soon as possible as the process can take a significant period of time to complete.

All prime awardees must provide a Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number and an EIN/TIN 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 Contractor Registration (CCR) at <http://www.ccr.gov/>. Prime awardees must maintain current registration in the Central Contractor 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 <http://www.ccr.gov/> by the end of the month following the month in which this award is made, and annually thereafter (based on the reporting requirements of the Federal Funding Accountability and Transparency Act (FFATA) of 2006 (Pub. L. 109-282)), as amended by section 6202 of Public Law 110-252 and implemented by 2 CFR Part 170)). 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

Awardees are not required to make a State match contribution to the design, development, and/or implementation of the cooperative agreement.

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

Notice of Intent to Apply

Potential applicants must submit a non-binding Notice of Intent to Apply by April 30, 2012 in order to be eligible for a funding award. Receipt of such notices enables CMS to better plan for the application review process. These notices must include the following information and are limited to no more than one page:

- Name of the applicant organization;
- Name(s) of any operating partners;
- Name of organization point of contact including:
 - Phone number;
 - Email address;
- The organization's location;
- Proposed target geographic location of the proposed intervention; and
- State in which it is considering implementing the Initiative.

Notices of Intent to Apply are due by 3:00 p.m. Eastern Time (Baltimore, MD) on April 30, 2012, and shall be submitted via link:

<http://www.cms.gov/Medicare-Medicaid-Coordination>. Upon successful submission of the Notice of Letter of Intent to Apply, you will be assigned a tracking number. Please keep record of this tracking number as you will be required to enter it on the SF-424: Official Application for Federal Assistance, at the time of application submission.

Application Materials

This Funding Opportunity Announcement contains all of the instructions for a potential applicant to apply.

Application materials will be available for download at <http://www.grants.gov/>. Please note that U.S. Department of Health and Human Services (HHS) requires applications for all announcements to be submitted electronically through <http://www.grants.gov/>. For assistance with <http://www.grants.gov/>, contact support@grants.gov or call 1-800-518-4726. The Funding Opportunity Announcement can also be viewed on the MMCO website at <https://www.cms.gov/medicare-medicaid-coordination/>. Below are specific instructions for applications submitted via <http://www.grants.gov/>:

- You can access the electronic application for this funding opportunity announcement at <http://www.grants.gov/>. Search for the funding opportunity by using the CFDA Number or the Funding Opportunity 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 under this announcement must have an Employer Identification Number (EIN), otherwise known as a Taxpayer Identification Number (TIN), to apply. **Please note, the time needed to complete the EIN/TIN registration process is substantial, and applicants should therefore begin the process of obtaining an EIN/TIN immediately to ensure this information is received in advance of application deadlines.**
- 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: <http://www.dnb.com/> or call 1-866-705-5711. This number should be entered in the block 8c (on the Form SF-424, Application for Federal Assistance). The organization name and address entered in block 8a and 8e should be exactly as given for the DUNS number. **Applicants should obtain this DUNS number immediately to ensure all registration steps are completed in time.**
- The applicant must also register in the Central Contractor Registration (CCR) database in order to be able to submit the application. **Applicants should begin the CCR registration process immediately 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 at least one business day after registration in CCR before entering their profiles in Grants.gov. **Applicants should complete this process as soon as possible after successful registration in CCR to ensure this step is completed in time to apply before application deadlines.**
 - When an AOR registers with Grants.gov to submit applications on behalf of an organization, that organization's E-Biz point-of-contact will receive an 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 point of contact (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.
 - The AOR and the DUNS must match. If your organization has more than one DUNS number, be sure you have the correct AOR for your application.
- **Any files uploaded or attached to the Grants.gov application must be PDF file format and must contain a valid file format extension in the filename.** Even though Grants.gov allows applicants to attach any file format as part of their application, CMS restricts this practice and only accepts PDF file format. **Any file submitted as part of the Grants.gov application that is not in a PDF file format, or contains password protection, will not be accepted for processing and will be excluded from the application during the review process.** In addition, the use of compressed file formats such as ZIP, RAR or Adobe Portfolio will not be accepted.

The application must be submitted in a file format that can easily be copied and read by reviewers. It is recommended that scanned copies not be submitted through Grants.gov unless the applicant confirms the clarity of the documents. Pages cannot be reduced resulting in multiple pages on a single sheet to avoid exceeding the page limitation. All documents that do not conform to the above will be excluded from the application during the review process.

- 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 email notification from Grants.gov that contains a Grants.gov tracking number. **Please be aware that this notice does not guarantee that the application will be accepted by Grants.gov. It is only an acknowledgement of receipt.** All applications that are successfully submitted must be validated by Grants.gov before they will be accepted. Please note applicants may incur a time delay before they receive acknowledgement that the application has been validated and accepted by the Grants.gov system. In some cases, the validation process could take up to 48 hours. If for some reason your application is not accepted, then you will receive a subsequent notice from Grants.gov citing that the application submission has been rejected. **Applicants should not wait until the application deadline (date and time) to apply because notification by Grants.gov that the application fails validation and is rejected may not be received until close to or after the application deadline, eliminating the opportunity to correct errors and resubmit the application. Applications that fail validation and are rejected by Grants.gov after the deadline will not be accepted and/or granted a waiver.** For this reason CMS recommends submission of applications prior to the due date and time.
 - The most common reasons why an application fails the validation process and is rejected by Grants.gov are:
 - CCR registration cannot be located and validated
 - CCR registration has expired
 - The AOR is not authorized by the E-Biz POC to submit an application on behalf of the organization
 - File attachments do not comply with the Grants.gov file attachment requirements
- **HHS retrieves applications from Grants.gov only after Grants.gov validates and accepts the applications. Applications that fail validations and are rejected by Grants.gov are not retrieved by HHS, and HHS will not have access to rejected applications.**
- After HHS retrieves your application from Grants.gov, you will receive an email notification from Grants.gov stating that the agency has received your application and once receipt is processed, you will receive another email notification from Grants.gov citing the Agency Tracking Number that has been assigned to your application. It is important for the applicant to keep these notifications and know the Grants.gov Tracking Number and Agency Tracking Number associated with their application submission.

- Each year organizations and entities registered to apply for Federal grants and cooperative agreements through 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/>. **Failure to renew CCR registration prior to application submission will prevent an applicant from successfully applying.**

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

All applications must be submitted electronically and be **received** through Grants.gov by 3:00 p.m. Eastern Time (Baltimore, MD) on **June 14, 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 received in Grants.gov on or before the published deadline date and time. 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 have adhered to the timelines for obtaining a DUNS number, registering with the Central Contractor Registration (CCR), registering as an Authorized Organizational Representative (AOR), obtaining an Employer/Taxpayer Identification Number (EIN/TIN), completing Grants.gov registration, as well as requesting timely assistance with technical problems. **Applicants that do not adhere to timelines and/or do not demonstrate timely action with regards to these steps will not be considered for waivers based on the inability to receive this information in advance of application deadlines.** Please be aware of the following:

- Search for the application package in Grants.gov by entering the CFDA Number or Funding Opportunity Number. These numbers are shown on the cover page of this announcement.
- If you experience technical challenges while submitting your application electronically, please contact Grants.gov Support directly at: support@grants.gov or (800) 518-4726. **Customer Support is available to address questions 24 hours a day, 7 days a week (except on Federal holidays).** CMS encourages applicants not to wait until close to the due date to submit the application.
- Upon contacting Grants.gov, obtain a helpdesk 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 application 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 must be received in the Office of Acquisition and Grants Management, Division of Grants Management by the application due date and time.

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.
- All narrative portions of the application (project and budget) must be **DOUBLE-SPACED** including charts and tables.
Applicants shall use the Project Abstract Summary form template to complete the application abstract.

The application with the appendices shall not exceed 120 pages in length.

The application narrative shall include (not to exceed 40 pages in length):

- Proposed Approach
- Organizational Capacity and Management Plan
- Evaluation and Reporting
- Budget, Budget Narrative and Monthly Financial Plan

The appendices shall include (not to exceed 80 pages in length):

- Project summaries of past experience
- Detailed vitae of key personnel
- State letters of support and commitment
- Letters of intent from nursing facilities
- Nursing facility partner characteristics (Tables 1-3, Appendix C)
- Monthly Financial Plan (Tables 4-7, Appendix D)

Other required materials NOT included in page limits are:

- Cover letter
- Abstract
- Standard forms (see Overview of Cooperative Agreement Application Structure and Content)
- Indirect Cost Rate Agreement
- Any nursing facility and/or State surveys of nursing facility residents.

The total size of all uploaded files may not exceed total file size of 13 MB.

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

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 application:

- 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

Note: On SF-424 “Application for Federal Assistance”:

On Item 15 “Descriptive Title of Applicant’s Project,” state the specific cooperative agreement opportunity for which you are applying: Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents.

- a. Check “C” to item 19, as Review by State Executive Order 12372 does not apply to these grants.
- b. On item 4 “Applicant Identifier,” enter the tracking number assigned to you by CMS for the submission of your Notice of Intent to Apply.**
- c. Item 18 “Estimated Funding,” shall contain the amount of Federal funding requested for the FIRST FUNDING PERIOD (12 months) of the project only.**

ii. Application Narrative - Project and Budget Narrative

- a. Proposed Approach
- b. Organizational Capacity and Management Plan
- c. Evaluation and Reporting

- d. Budget, Budget Narrative and Monthly Financial Plan

iii. Appendices

The appendices shall include:

- e. Project summaries of past experience
- f. Detailed vitae of key personnel
- g. State letters of support and commitment
- h. Letters of intent from nursing facilities
- i. Nursing facility partner characteristics (Tables 1-3, Appendix C)
- j.** Monthly Financial Plan (Tables 4-7, Appendix D)

iv. Cover Letter (not subject to the page limits)

The letter should be included as a PDF and uploaded into the application. The letter shall 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

v. Project Abstract and Profile

The one-page abstract (single-spaced) shall serve as a succinct description of the proposed intervention, including the goals of the project, the total budget, the projected size of the target population, the proposed target geographic location of the proposed intervention, and the State in which it is considering implementing the Initiative. 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. Information specific to an individual should be excluded from the abstract. Applicants shall use the Project Abstract Summary Form to complete the project abstract.

vi. 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: PROPOSED APPROACH

1.1 Comprehensive Description of the Model and Supporting Evidence Base: The application shall describe the proposed intervention and explain how the model satisfies all the activities and characteristics required of clinical interventions, which are outlined under Intervention Requirements (I. Funding Opportunity Description). The description must describe the theory of action for the model and the evidence base supporting the proposed intervention. The application shall explain how the proposed intervention differs from existing practices among the proposed nursing facility partners. It shall discuss how the applicant will integrate the intervention into the highly regulated nursing facility environment, including how it coordinates with residents' plans of care. In addition, the application shall identify the other primary challenges to successful implementation of the project and explain how these anticipated risks will be addressed and minimized. The application shall describe how the applicant will ensure effective ongoing communication and learning about operational best practices within and among its nursing facility partners.

1.2 Staffing of the Intervention Model: The application shall include qualifications of staff involved in the day-to-day work with nursing facility residents, staffing levels (including number of staff per nursing facility resident), hours during the week when staff will be at and accessible to each nursing facility, roles and responsibilities of each position, and how those staff will work in cooperation with nursing facility residents, nursing facility staff, hospital staff (including attending physicians), residents' primary care physicians, pharmacists, and residents' families and improve communication among these individuals. The proposed responsibilities and percentage of time that key personnel would dedicate to the project should also be included. Required personnel include clinical staff who maintain a physical presence in the nursing facility, a project director, and a medical director.

The application shall include a description of the organizational resources that will support day-to-day activities and how they will be deployed. Organizational resources may include training resources, tools and protocols, information technology, and capacity to track data required for quarterly and semi-annual reports.

1.3 Targeting and Potential Impact: The application shall identify those long-stay beneficiaries that will be the focus of its intervention. The applicant shall indicate whether it plans to also target any long-stay residents who are not yet Medicare-Medicaid enrollees (Medicare beneficiaries not yet eligible for Medicaid or Medicaid beneficiaries not yet eligible for Medicare but who represent similar opportunities for inpatient reductions). All beneficiaries that meet designated criteria shall be considered enrolled in the Initiative for the purposes of evaluation, effective the date that all criteria are first met, including as applicable those beneficiaries that meet criteria upon initiation of the Initiative. The applicant shall also indicate the estimated total and annual number of residents or percentage of residents per facility who will be targeted for the intervention. CMS prefers implementation of the intervention with all long-stay Medicare-Medicaid enrollees residing in a participating nursing facility rather than implementing the approach with only a subset of long-stay Medicare-Medicaid enrollees in the nursing facility.

The application shall describe geographic areas in which the applicant is proposing to implement the proposed intervention.

The application shall indicate in quantitative percentage terms the estimated impact (e.g., 15%) that the proposed intervention is expected to have on reducing potentially avoidable hospitalizations, over what time frame, and rationale to validate the assumptions.

1.4 Letters of Support: The applicant shall attach letter(s) of support from the State Medicaid director and State survey and certification director from each State in which the applicant is proposing to implement the intervention. These letters of support are an application requirement; CMS will only review applications that include letters of support. Applicants may also attach letters from additional organizations, such as resident councils, advocacy groups, Local Area Networks for Excellence associated with the Advancing Excellence in America's Nursing Homes campaign, or other partners for the Initiative.

1.5 Nursing Facility Partnerships: The applicant shall describe Medicare- and Medicaid-certified nursing facilities that have agreed to participate in this Initiative and attach letters of intent (LOIs) from partnering nursing facilities. Applications must include LOIs from a minimum of 15 Medicare- and Medicaid-certified nursing facilities in the same State with an average census of 100 residents or more per facility. These letters of intent are an application requirement; CMS will only review applications that include at least 15 letters of intent.

Applicants shall attest that none of the proposed nursing facility partners are among those facilities restricted from participating in the Initiative (i.e., facilities in which more than 25% of the residents are enrolled in Medicare managed care; hospital-based nursing facilities; special focus facilities; or nursing facilities with outstanding major survey violations for immediate jeopardy to resident health or safety). Applicants must include a table listing the nursing facilities that have submitted a letter of intent and key data points, as outlined in Table 1, Table 2, and Table 3 (Appendix C). These tables may be included in separate Appendices that shall not exceed 80 pages. *Please note that if the nursing facility and/or State routinely surveys residents about their satisfaction with their care, the applicant shall include a copy of that survey or those surveys in without page limitations.*

SECTION TWO: ORGANIZATIONAL CAPACITY

2.1 Description of the Applicant: The application shall describe lines of business, ownership and affiliates, mission statement, total annual revenue, current staffing level, geographic areas of operation, and other factors necessary for CMS to understand the applicant's organization. It shall describe any ownership relationships with nursing facilities or providers of nursing facility management services. This description shall not exceed five pages and shall be included within the application page limits (not to exceed 40 pages).

2.2 Past Performance: The application shall describe the applicant's past performance partnering with nursing facilities, including demonstrated knowledge of effectuating practice change within nursing facilities; supporting Medicare and Medicaid beneficiaries during transitions between settings (including inpatient hospitals, nursing facilities, and home and community-based settings); partnering with State Medicaid agencies and State survey and certification agencies; and collecting and working with data on staffing levels, nursing facility residents, and other data relevant to this Initiative.

Please be as specific as possible in describing prior work with nursing facilities and nursing facility residents, citing actual facilities, numbers of residents served, outcomes from those past efforts, and key best practices learned in effectuating practice change within nursing facilities. The application shall explain the applicant's past performance partnering with State Medicaid agencies and State survey and certification agencies and the nature of that collaboration. The application shall reflect and apply an understanding of how the current health care delivery system functions for Medicare-Medicaid enrollees and the applicant's experience in nursing facilities, along with an understanding

for how to implement a package of interventions, how to measure progress, and how to implement rapid cycle improvements.

2.3 Work Plan, Communication Plan, and Facilities: The application shall include a preliminary work plan describing how it would organize and manage the project, in what time frames, and what management control and coordination tools would be used to assure the timely and successful implementation of the Initiative. The plan shall describe the activities to be conducted by each administrative component. The plan shall address the process for managing interventions in multiple nursing facilities and other deliverables simultaneously. The application shall also include a communications plan describing the lines of communication among all of the partners involved in the Initiative. The application shall indicate the organizational capacity to effectively conduct this project, including having information systems established to track data for reporting on its progress throughout the cooperative agreement period of performance. It shall show availability of and access to requisite resources to operate the project and facilities, such as computer and technical equipment, particularly those inherent to the protection of proprietary and confidential data and analysis. It shall also demonstrate that the applicant has the capacity to respond to ongoing rapid cycle improvement and course correction feedback, including making timely adjustments in the applicant's approach.

SECTION THREE: REPORTING AND EVALUATION

3.1 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 for Quarterly Progress Reports that will be provided to CMS and its operations support and evaluation contractors. Progress reports must be provided to CMS on a quarterly basis and they must include information outlined in Activity 3.d (I. Funding Opportunity Description). Semi-annual reports must include information on the use of cooperative agreement funding Activity 3.e (I. Funding Opportunity Description). Note that the participants will also be required to fully cooperate with the operations support and evaluation contractors in reporting data that they require for the project evaluations.

CMS plans to conduct rigorous evaluation of each of the interventions 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, and providers.

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 in accordance with applicable laws and policies, when appropriate to the particular intervention. Existing CMS rules and procedures will apply and are described at http://www.resdac.org/Medicare/requesting_data.asp.

Awardees may be required to report information in standard format and measure and report outcomes in a standardized way, if requested by the evaluation contractor.

The applicant shall describe its participation and participation by any partnering nursing facilities in any other Federal initiative to reform the delivery and financing of health care and how participation

in this Initiative would be complementary and support other health reforms, rather than compete with existing demonstrations. The applicant shall also describe how the CMS evaluation would measure the unique impact of this initiative on quality of care and Federal and State costs, relative to other Federal initiatives. If the applicant is proposing to implement an intervention in one of the 15 States with which CMS has contracts to design integrated care programs for Medicare-Medicaid enrollees, the applicant shall describe how the two projects will work in synergy in the same State and how the CMS evaluation would measure the unique impact of this initiative on quality of care and Federal and State costs. If the applicant targets Medicaid-only beneficiaries, the evaluation should separately evaluate the impact on Medicaid beneficiaries and costs. The applicant shall also provide this information if it is proposing to implement an intervention in one of the other States or District of Columbia which have expressed interest in integrating care for their Medicare-Medicaid enrollees. The application shall also state that the applicant will advise CMS in advance of any future participation in such a Federal initiative, allowing CMS to make adjustments as necessary.

SECTION FOUR: FUNDING

4.1 Form SF-424A: Budget Information – Non-Construction Programs and Budget Narrative:

Form SF-424A: Budget Information – Non-Construction Programs

All applicants must submit an SF-424A. Instructions for completing the SF-424A can be found on Grants.gov.

As per the SF-424A instructions:

“For other programs, grantor agencies may require a breakdown by function or activity, Sections A, B, C, and D should include budget estimates for the whole project except when applying for assistance which requires Federal authorization in annual or other funding period increments. In the latter case, Sections A, B, C, and D should provide the budget for the first budget period (12 months) and Section E should present the need for Federal assistance in the subsequent budget periods.”

This program is funded in annual or other funding period increments. Therefore, the applicant shall ensure that all amounts entered in Sections A, B, C, D, and F are for the FIRST FUNDING PERIOD of the project only. Federal funds requested for future funding periods shall be entered in Section E.

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 four-year cooperative agreement period of performance. Specifically, the Budget Narrative should provide a detailed cost breakdown for each line item outlined in the SF-424A by year including a breakdown of costs for each activity/cost within the line item. The proportion of cooperative agreement funding designated for each activity should be clearly outlined and justify the organization’s readiness to receive funding through 2016 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
 - NOTE: Consistent with section 203 of the Consolidated Appropriations Act, 2012 (P.L. 112-74) none of the funds appropriated in this law shall be used to pay the salary of an individual, through a grant or other extramural mechanism, at a rate in excess of Executive Level II (\$179,700).
- 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 approved indirect cost rate is required.
- Other costs, including those not otherwise associated with training and education.

The Budget Narrative shall 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 shall 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;
- Percentage of time and total hours per month 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;
- Number of contracted individuals supporting the cooperative agreement; and
- A resume of the proposed Project Director and Medical Director.

Note: Rather than duplicate information in their application, applications should refer to the information provided in response to the information specified in Overview of Cooperative Agreement Application Structure and Content when writing this section.

4.2 Monthly Financial Plan

The Monthly Financial Plan as described in Appendix D is provided so that applicants can describe a monthly summary of the costs by nursing facility. These monthly per facility costs shall be based on the size of the target population in each facility and shall serve as the basis for determining the per facility fee. Enhanced care & coordination providers shall be eligible to receive payment upon completion of Activity 1 and upon beginning Activity 2 should they meet operational performance parameters (I. Funding Opportunity Description). Totals from Form SF-424A and Monthly Financial Plan must match. The total use of funds will sum to the requested award.

CMS reserves the right to request that applicants revise or otherwise modify their applications and budget based on the recommendations of the review panel. CMS reserves the option to re-negotiate payment rates associated with activities at any facility where there is a material change in total occupancy, payer mix, or other changes that would fundamentally change the scope of the Initiative.

Applicants must provide a monthly financial plan narrative and supporting information explaining the rationale behind all assumptions used to develop the Monthly Financial Plan. In particular, applicants shall include:

- 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 intervention; and
- Estimated size of the target population (with a breakdown of long-stay residents who are Medicare-Medicaid enrollees and any long-stay residents who are not yet Medicare-Medicaid enrollees) for each nursing facility for each year of the cooperative agreement period of performance.

3. Submission Dates and Time

A. Notice of Intent to Apply

Potential applicants must submit a non-binding Notice of Intent to Apply by April 30, 2012 in order to be eligible for a funding award. Receipt of such notices enables CMS to better plan for the application review process. These notices may be submitted in any format, but shall include the following information and are limited to no more than one page:

- Name of the applicant organization;
- Name(s) of any operating partners;
- Name of organization point of contact including:
 - Phone number;
 - Email address;
- The organization's location;
- Proposed target geographic location of the proposed intervention; and
- State in which it is considering implementing the Initiative.

Notice of Intent to Apply are due by 3:00 p.m. Eastern Time (Baltimore, MD) on **April 30, 2012**, and should be sent to:

<http://www.cms.gov/Medicare-Medicaid-Coordination>.

Upon successful submission of the Notice of Letter of Intent to Apply, you will be assigned a tracking number. Please keep record of this tracking number as you will be required to enter it on the SF-424: Official Application for Federal Assistance, at the time of application submission.

B. Cooperative Agreement Applications

All applications are due by June 14, 2012. Applications received through <http://www.grants.gov> by 3:00 p.m. Eastern Time (Baltimore, MD) on June 14, 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. This serves as the official date/time that an application is received.

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 approved 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 thru 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 application.
- To pay for construction or alteration and renovation of real property (A&R).
- To pay for information technology (IT) equipment exceeding 10 percent of the total award. Any equipment, which includes IT, over \$5,000 must be approved by CMS.
- To pay States for the use of any of their data made available for this Initiative.

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 date.

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 IV. Application and Submission Information, all applicants must submit the following

1. Application Narrative
 - a. Proposed Approach
 - b. Organizational Capacity and Management Plan
 - c. Evaluation and Reporting
 - d. Budget, Budget Narrative and Monthly Financial Plan
2. Appendices
 - a. Project summaries of past experience
 - b. Detailed vitae of key personnel
 - c. State letters of support and commitment
 - d. Letters of intent from nursing facilities
 - e. Nursing facility partner characteristics (Tables 1-3, Appendix C)
 - f. Monthly Financial Plan (Tables 4-7, Appendix D)
3. Other required materials NOT included in page limits are:
 - a. Cover letter
 - b. Abstract
 - c. Standard forms (see Overview of Cooperative Agreement Application Structure and Content)
 1. SF-424: Official Application for Federal Assistance (see note below)
 2. SF-424A: Budget Information Non-Construction
 3. SF-424B: Assurances-Non-Construction Programs
 4. SF-LLL: Disclosure of Lobbying Activities
 - d. Indirect Cost Rate Agreement
 - e. Any nursing facility and/or State surveys of nursing facility residents.

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 I. Funding Opportunity Description. The application must be organized, as detailed in IV. Application and Submission Information, and be submitted by an eligible applicant as defined in III. Eligibility Information.

Applications received by the due date will first be reviewed for required a) letters of support from the State Medicaid and State survey and certification directors and b) at least 15 letters of intent from Medicare- and Medicaid-certified nursing facilities in the same State with an average census of 100 residents per facility. These letters are application requirements. Applications including these required letters and other required forms (standard forms, Tables 1-3 (Appendix C), and Monthly Financial Plan (Tables 4-7, Appendix D)) will be reviewed in the technical review process. If not, the applicant's submission will not receive further consideration and will not be eligible for award.

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 funding opportunity announcement.

Proposed Approach (45 points)

The proposed model is appropriately designed to meet all requirements outlined under Intervention Requirements (I. Funding Opportunity Description). The application clearly articulates the clinical model, required staffing (who will maintain a physical presence in the nursing facilities), appropriateness of the staffing, staffing levels (including the number of staff per resident), and key activities by clinical and non-clinical staff. The application presents a clear and robust strategy explaining how those staff would work in cooperation with nursing facility residents, nursing facility staff, hospital staff (including attending physicians), residents' primary care physicians, pharmacists, and residents' families and improve communication among these individuals. The proposed responsibilities and percentage of time that key personnel would devote to the project shall be included. The proposal timeline for implementing the approach is reasonable.

The proposed model is evidence based and addresses the primary causes of potentially avoidable hospitalizations among nursing facility residents. It articulates the overall expected magnitude and breadth of impact of the model (in percentage terms). The expected magnitude and impact reflect valid assumptions of potential impact, indicating that the proposed model would likely have a significant, downward impact on potentially avoidable hospitalizations during the cooperative agreement period of performance. In addition to the estimated magnitude of impact, the application shall explain the rationale supporting the estimated impact.

The proposed approach can be replicated and have a robust strategy to foster effective ongoing communication and learning about operational best practices within and across its nursing facility partners. The proposed approach clearly outlines an effective strategy to target the intervention to long-stay Medicare-Medicaid enrollees. (CMS prefers implementation of the intervention with all long-stay Medicare-Medicaid enrollees residing in a participating nursing facility rather than implementing the approach with only a subset of long-stay Medicare-Medicaid enrollees in the nursing facility.) If the applicant plans to also target any long-stay Medicare beneficiaries not yet eligible for Medicaid or long-stay Medicaid residents not yet eligible for Medicare, the applicant describes how those residents represent similar opportunities for reductions in inpatient admissions, and the application outlines an effective strategy for identifying such beneficiaries. The applicant describes the geographic areas in which it would implement the proposed intervention and when it would be prepared to implement.

The letters of support from the State(s) indicate a partnership from the State(s) and other relevant organizations.

The letters of support from nursing facility partners indicate a partnership from Medicare- and Medicaid-certified nursing facilities. CMS is more interested in the quality of nursing facility partners than the

overall number of partners, but it encourages proposing more than 15 Medicare- and Medicaid-certified nursing facility partners in the same State. The proposed model does not supplant activities/models already underway in proposed nursing facility partners. The application attests that none of the proposed nursing facility partners are among those facilities restricted from participating in the Initiative (i.e., facilities in which more than 25% of the residents are enrolled in Medicare managed care; hospital-based nursing facilities; special focus facilities; or nursing facilities with outstanding major survey violations for immediate jeopardy to resident health or safety). The application includes all requested data, including Tables 1-3 (Appendix C), to describe those facilities. These data indicate a high concentration of Medicare-Medicaid enrollees in proposed nursing facilities and suggest that the applicant would target geographic areas with high Medicare costs.

Organizational Capacity and Management Plan (25 points)

The ownership structure, mission statement, and organization described in the application are conducive to successful implementation of this Initiative. The application demonstrates relevant experience partnering with nursing facilities, including demonstrated knowledge of effectuating practice change within nursing facilities; supporting Medicare and Medicaid beneficiaries during transitions between settings (including inpatient hospitals, nursing facilities, and home and community-based settings); partnering with State Medicaid agencies and State survey and certification agencies; and collecting and working with data on staffing levels, nursing facility residents, and other data relevant to this Initiative. The application describes the number of nursing facilities and residents served and outcomes from those past efforts, and past performance indicates that the applicant has the experience to successfully implement and manage a clinical intervention of the size and scope proposed in its application.

The application indicates that the applicant's size and staffing level demonstrate sufficient capacity to successfully implement this Initiative. The proposed work plan is specific and shows a realistic probability of successful implementation. The application shows evidence that the applicant could pass readiness reviews and implement the model within 75 calendar days of cooperative agreement start date. The proposed communications plan clearly describes the lines of communication among all of the partners involved in the Initiative and indicates an effective strategy for keeping all partners informed of activities and tasks performed under this cooperative agreement.

The application indicates that the applicant organization has the needed facilities and infrastructure to carry out the project. In particular, the application indicates an ability and information systems to manage all aspects of the proposed intervention, including executing the proposed clinical model; soliciting and managing interventions in numerous facilities; budget; progress reports; and any subcontractors. It demonstrates an ability to identify, address, resolve and communicate problems with CMS staff. The application demonstrates the capacity to coach and guide partner nursing facilities in the implementation of the intervention, using rigorous learning approaches and modern improvement methodology. In addition, the application has the organizational resources, including training resources, tools and protocols, information technology, and capacity to track data required for quarterly and semi-annual reports. It has appropriate and sufficient procedures and facilities to protect proprietary and confidential data and analysis related to the Initiative. The application demonstrates that the applicant has the capacity to provide information necessary to evaluate Initiative results, cooperate with the independent evaluator, and respond to ongoing rapid cycle improvement and course correction feedback, including making timely adjustments in its approach.

The applicant organization shows plans for project accountability, including plans to report on intervention operations, cooperate with government monitoring plans, and provide information needed to evaluate project results.

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

Budget, Budget Narrative, and Monthly Financial Plan (15 points)

The proposed Budget, Budget Narrative, and Monthly Financial Plan (including information requested in Tables 4-7, which are shown in Appendix D), are carefully developed and reflect efficient and reasonable use of funds. Overhead and administrative costs are reasonable, with funding focused on operations rather than administration. The proposed budget request reflects a promising investment given the expected impact of the intervention.

The evaluation will consider whether the applicant includes a comprehensive budget reflecting all costs of staffing and implementing the intervention, including information requested in the Monthly Financial Plan (Appendix D).

Evaluation and Reporting (15 points)

The application includes a well-designed and credible plan to provide regular reporting of performance and quantitative data for monitoring the progress of the Initiative including, but not limited to, all elements required for quarterly progress reports (Activity 3.d, I. Funding Opportunity Description). The proposed approach can be rigorously evaluated. In particular, the proposed approach allows for selection of viable comparison groups and enables the intervention to be tested and the unique outcomes and financial impact to be measured for the intervention.

If the applicant organization is proposing to implement an intervention in one of the 15 States with which CMS has contracts to design integrated care programs for Medicare-Medicaid enrollees or in one of the other States or District of Columbia which expressed interest in integrating care for these enrollees, the applicant describes how its intervention will work in synergy with the existing effort. The applicant describes how its intervention is designed to measure its unique impact on quality of care as well as Federal and State costs, above and beyond the existing effort. If the applicant or its partnering nursing facilities are participating in any other Federal health care reform initiative (e.g., Accountable Care Organizations, Partnership for Patients, including the Community-based Care Transitions Program and Patient Safety Hospital Engagement Contractor), the applicant makes a compelling case that participating in this Initiative would complement existing initiatives and allow for evaluation of its unique impact, above and beyond existing initiatives. If the applicant also targets Medicaid-only beneficiaries, the impact of this Initiative on beneficiaries and costs should be tracked separately. The application makes a commitment to advising CMS in advance on any future participation in a Federal health care reform initiative throughout the cooperative agreement period of performance.

2. Review and Selection Process

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.
- Applications must include the required letters of support from State Medicaid and State survey and certification directors and at least 15 letters of intent from Medicare- and Medicaid-certified nursing facilities in the same State with an average census of 100 residents per facility. If an application includes these required letters and includes all other required forms (standard forms, Tables 1-3 (Appendix C), and Monthly Financial Plan (Tables 4-7, Appendix D)), the application will be reviewed in the technical review process outlined below. If not, the applicant's submission will not receive further consideration and will not be eligible for award.
- A team consisting of staff from HHS and other outside experts will review all applications. The review panel will assess each application to determine the merits of the application and the extent to which the proposed program furthers the purposes of the program. CMS reserves the option to request that applicants revise or otherwise modify their applications 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; diversity in the clinical models; diversity in enhanced care & coordination providers; strength of partnerships with nursing facilities and States; number of nursing facility partners and size of target population; the geographic diversity of locations; feasibility of evaluating the proposed interventions; the reasonableness of the estimated cost to the government and anticipated results; likelihood that the proposed project will result in the benefits expected; and availability of funding.
- Successful applicants will receive one cooperative agreement award issued under this announcement.

CMS reserves the right to approve or deny any or all applications for funding. Section 1115A(d)(2) of the Social Security Act states that there is no administrative or judicial review of the selection of organizations, sites, or participants to test models under section 1115A.

3. Anticipated Announcement and Award Dates

Opportunity Announcement: **March 15, 2012**

Anticipated Awards Announcement: **August 24, 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 Management 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 implementation 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.

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 <https://www.fsrc.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 agreements awarded under this announcement.
- All awardees under this project must comply with all applicable Federal statutes relating to nondiscrimination including, but not limited to:
 - Title VI of the Civil Rights Act of 1964,
 - Section 504 of the Rehabilitation Act of 1973,
 - The Age Discrimination Act of 1975,
 - 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://dhhs.gov/asfr/ogapa/aboutog/grantsnet.html>. General Terms, 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, and final reports in a form prescribed by CMS. See Activity 3.d and Activity 3.e (I. Funding Opportunity Description) for more information about these reports. Reports shall be submitted electronically.

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 (i.e., operations support contractor) to assist CMS in monitoring enhanced care & coordination provider activities. While the operations support contractor will provide CMS with assistance in collecting data and monitoring Initiative operations, CMS will review this information and make any decisions about readiness and performance.

CMS plans to collect data elements to be part of ongoing 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 and its contractors.

Monitoring will include, but will not be limited to, review of quarterly progress reports of required data specified in Activity 3.d (I. Funding Opportunity Description) and reported in a standard format. Data submitted by enhanced care & coordination providers to CMS and its contractors will be used to determine (1) the enhanced care & coordination provider's adherence to the clinical model and which nursing facility residents are receiving the intervention; (2) interim results of the model signaling effectiveness and/or needed mid-course corrections; (3) funding allotments; and (4) supplemental funds..

Other responsibilities of the operations support contractor include:

- Conducting readiness reviews for each enhanced care & coordination provider prior to implementing its clinical intervention;
- Conducting quarterly chart reviews of a sample of nursing facility residents to ensure that hospital care is not being inappropriately withheld;
- Establishing, organizing, and leading learning and diffusion activities;

- Calculating annual quality scores and combined Medicare and Medicaid savings estimates to assist CMS in determining supplemental funds awards; and
- Monitoring enhanced care & coordination provider compliance with Medicare and Medicaid billing restrictions.

Evaluation

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 process of transitioning between inpatient hospitals and nursing facilities; resident health outcomes; health care spending, and avoidable hospital admissions and readmissions.

The independent evaluator will identify a broad set of evaluation measures for the Initiative. Evaluation measures will include those used to determine enhanced care & coordination provider eligibility for supplemental funds, as discussed in Appendix A. Additional metrics shall be collected and analyzed as part of the overall evaluation of the Initiative. Data to be provided to the evaluator will include, but is not limited to, the data discussed in Activity 3.d (I. Funding Opportunity Description). The independent evaluation will include qualitative and quantitative approaches.

Evaluation questions may include but are not limited to:

- Do the models tested under the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents provide better health outcomes for Medicare-Medicaid enrollees? If so, how much improvement was seen and which participant characteristics were associated with greater benefit?
- Do the models provide improved communication and coordination? If so, how and for which participants?
- Do the models facilitate residents' transitions to and from inpatient hospitals and nursing facilities, including facilitating timely and complete exchange of health information among providers and providing support for residents and nursing facility staff to support successful discharge to the community?
- Do the models reduce overall health care spending without restricting access to care or choice of providers?
- Do the models reduce the frequency of avoidable hospital admissions and readmissions?
- For all of the above, how have the models accomplished these changes? Are the models well received by hospital staff (including attending physicians), nursing facility staff, residents' primary care providers and other specialists, and pharmacies?
- What factors are associated with the pattern of results (above)?

Ultimately, the evaluation results from all of the models will be reconciled in order to identify and characterize the most promising models to inform future policy making around improving beneficiary care, improving beneficiary health, and reducing costs.

The evaluator will identify control/comparison groups that did not participate in one of the interventions to examine the effect of the interventions on outcomes of interest.

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 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.

Data Collection

The enhanced care & coordination providers shall collect data as necessary from nursing facility partners, including data required for quarterly progress reports (Activity 3.d, I. Funding Opportunity Description). The enhanced care & coordination providers shall assist CMS in establishing any Information Exchange Agreements with participating nursing facilities as required to facilitate data exchange.

B. Federal Financial Report

Awardees are required to submit the SF-425 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 <https://www.frs.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 http://www.whitehouse.gov/omb/circulars_default.

E. Payment Management Requirements

Awardees must submit a semi-annual electronic SF-425 via the Payment Management System and to the CMS Office of Acquisition and Grants Management. 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 Payment Management System 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 Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents may be directed to the program email address: NFInitiative2012@cms.hhs.gov.

Interested parties may also contact:

Melissa Seeley
Centers for Medicare & Medicaid Services
Medicare-Medicaid Coordination Office
Phone: 212-616-2329 or email: Melissa.Seeley@cms.hhs.gov

B. Administrative Questions:

Administrative questions about the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents may be directed to:

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

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IX. APPENDICES

APPENDIX A: PROPOSED MEASURES AND SUPPLEMENTAL FUNDS CRITERIA

APPENDIX B: DRAFT MEMORANDUM OF UNDERSTANDING

APPENDIX C: NURSING FACILITY CHARACTERISTICS

APPENDIX D: MONTHLY FINANCIAL PLAN

APPENDIX E: REQUIREMENTS FOR GOOD CARE TRANSITIONS

APPENDIX A: PROPOSED MEASURES AND SUPPLEMENTAL FUNDS CRITERIA

Enhanced care & coordination providers may be eligible for supplemental funds based on meeting operational criteria, a composite score, and having generated combined Medicare and Medicaid savings across all partnering nursing facilities. The composite score will be based on the three factors below and may include a fourth factor, which is under development:

1. Appropriate Hospitalizations Domain
2. Minimum Data Set (MDS Version 3.0) Domain
3. Survey Deficiencies Domain
4. Care Coordination Domain (under development)

In addition to the composite score, eligibility for supplemental funds would also be based on net reductions to combined Medicare and Medicaid expenditures. CMS may provide supplemental funds which would be in addition to the per facility fee provided to enhanced care & coordination providers to implement the Initiative. For supplemental funds, CMS may allocate up to an additional \$6.4 million to the enhanced care & coordination providers across the four years of the Initiative. Supplemental funds will focus on improvement and will be awarded based on an enhanced care & coordination provider's reaching criteria across all of its partnering nursing facilities.

The criteria are derived from the methodologies used in the CMS Nursing Home Value-Based Purchasing Demonstration. Technical aspects of the criteria methodology may be subject to change before awards are executed. These criteria are to be used to determine nursing facility eligibility for supplemental funds, but they represent just a portion of the broader evaluation measures to be examined for this Initiative.

Each awardee must submit a budget to be reviewed by CMS for any supplemental funds that may be awarded. All supplemental funds must be used to support goals and objectives of the Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents.

Further information about the supplemental funds would be provided in the Notice of Award.

Eligibility Criteria

Supplemental funds, if available, would be paid according to the following criteria:

- Composite score. Each year CMS will sum the points across the weighted measures (outlined below, but subject to change based on further analysis and/or adjustment in the domains) to yield a composite score for each nursing facility. These facility-specific composite scores will be aggregated to develop one composite score for each enhanced care & coordination provider.

- Appropriate hospitalizations domain (50% of composite score): Potentially avoidable inpatient hospitalizations will include hospitalizations for a set of conditions: for example, respiratory infection, urinary tract infection electrolyte imbalance, heart failure and anemia. The potentially avoidable inpatient hospitalization measures will be risk-adjusted.
- MDS Outcomes Domain (25%): CMS will use six of the long-stay quality measures endorsed by the National Quality Forum and posted on Nursing Home Compare:
 - Percent of residents whose need for help with daily activities has increased;
 - Percent of high-risk residents with pressure ulcers;
 - Percent of residents who have/had a catheter inserted and left in their bladder;
 - Percent of residents who were physically restrained;
 - Percent of residents experiencing one or more falls with a major injury; and
 - Percent of residents with urinary tract infection.
- Survey Deficiencies Domain (25%): This measure will reflect the extent to which facilities participating in the Initiative receive a citation for substandard quality of care or receive one or more citations for actual harm or higher, within the cooperative agreement period of performance. Values will be assigned based on the scope and severity of deficiencies and the regulatory areas where deficiencies occur. Those facilities found to have such citations related to activities of the enhanced care & coordination provider, as determined by CMS, will not be eligible for supplemental funds.
- Care Coordination (Under development). The clinical interventions require facilitating transitions to and from inpatient hospitals and nursing facilities and improving communication and coordination among hospital staff (including attending physicians), nursing facility staff, residents' primary care providers, and others. This measure will reflect the extent to which the enhanced care & coordination provider is facilitating improved care coordination.
- **Combined Medicare and Medicaid savings.** In addition to the composite score, the enhanced care & coordination provider must demonstrate combined Medicare and Medicaid savings across all of its partnering nursing facilities. At the conclusion of each cooperative agreement year, CMS will analyze Medicare Part A and B expenditures and Medicaid (all categories, total Federal and State shares combined) expenditures to determine if the activities of the enhanced care & coordination provider achieved overall savings. Savings calculations would net out payments made to enhanced care & coordination providers to implement the Initiative.
 - To qualify for supplemental funds, net savings must exceed a minimum savings rate that would be established by CMS. The minimum savings rate will consider the size of the target population and be set at a level that minimizes the probability that any savings are due to normal variation in expenditures rather than the Initiative. The minimum savings rate calculations will be based on at least a 90% confidence level.
 - In calculating the minimum savings rate and assessing savings, CMS will truncate expenses per beneficiary at the 99th percentile of all target population beneficiaries. Truncation is performed to reduce the effect of an unexpectedly high number of high-cost residents in the target population in any given year. These high-cost residents could negatively impact the calculation of savings and truncation significantly reduces this impact.

- Both the minimum savings rate and the actual savings will be calculated based on the entire target population in each enhanced care & coordination provider's network of partnering nursing facilities. Although enhanced care & coordination providers will report data on the actual residents served in any given month, the calculations will be independent from those reports.

Additional Details

If supplemental funds are available, the following will be considered:

- Enhanced care & coordination providers that demonstrate a specified level of improvement (to be finalized prior to implementing the Initiative) on their composite score and a reduction in combined Medicare and Medicaid expenditures would qualify should supplemental funds be available.
- For each future year during the cooperative agreement period of performance in which an enhanced care & coordination provider maintains these improvements or demonstrates additional improvements in its composite score and reduction in combined Medicare and Medicaid expenditures, the enhanced care & coordination provider would qualify for supplemental funds,
- Supplemental funds would be split evenly across the four years of the cooperative agreement.
- Enhanced care & coordination providers would be free to share supplemental funds with nursing facilities participating in the Initiative but are not required to do so.
- Appeals of supplemental funds amounts, methodology or eligibility, will not be permitted.

APPENDIX B: DRAFT MEMORANDUM OF UNDERSTANDING

Draft Memorandum of Understanding

Between

The Centers for Medicare & Medicaid Services (CMS)

And

[Name of State] Medicaid Agency

And

[Name of State] Survey and Certification Agency

Regarding the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents

This MOU is made between CMS, the State Medicaid Agency, and the State Survey and Certification Agency for the purposes of implementing an initiative to reduce avoidable hospitalizations among nursing facility residents, hereinafter referred to as the Initiative, under the authority of section 1115A of the Social Security Act.

Section 1: Terms of MOU

This MOU is effective for up to a maximum of four years beginning _____ and ending _____.

Section 2: State Medicaid Agency Responsibilities

The State Medicaid Agency will:

1. Identify Federal, State, and local policy or regulatory barriers to implementing the Initiative and work with CMS and Enhanced Care & Coordination Provider to eliminate or mitigate these barriers;
2. Provide Medicaid claims data to CMS and/or its evaluation contractor in a timely manner, subject to CMS and its contractors executing all necessary data use agreements. Through the use of its contractors, CMS will minimize any analysis required by the State;
3. Respond to a limited number of inquiries and requests made by CMS and its contractors in a timely manner;
4. Participate in a limited number of interviews or surveys necessary for CMS to evaluate the Initiative; and

5. Participate via webinar and teleconference in learning and diffusion opportunities to the extent available and interested.

Section 3: State Survey and Certification Agency Responsibilities

The State Survey and Certification Agency will:

1. Communicate the State's support of the Initiative to surveyors and participating nursing facilities;
2. Identify Federal, State, and local policy or regulatory barriers to implementing the Initiative and work with CMS and Enhanced Care & Coordination Provider to eliminate or mitigate these barriers;
3. Notify CMS of any complaints or concerns about the Initiative;
4. Respond to a limited number of inquiries and requests made by CMS and its contractors in a timely manner;
5. Participate in a limited number of targeted interviews necessary for CMS to evaluate the Initiative; and
Participate via webinar and teleconference in learning and diffusion opportunities to the extent available and interested.

Section 4: CMS Responsibilities

CMS will:

1. Make monthly payments to Enhanced Care & Coordination Providers to implement the Initiative, per the terms of the cooperative agreement;
2. Respond in a timely manner to State questions or concerns related to the Initiative;
3. Share work plans with the State Medicaid Agency and State Survey and Certification Agency.
4. Notify State in advance of any major changes in the Initiative model;
5. Review Enhanced Care & Coordination Provider performance on agreed upon measures, and share findings with State officials;
6. Consider awarding supplemental funds to qualifying Enhanced Care & Coordination Providers, per the terms of the cooperative agreement;
7. Provide the Enhanced Care & Coordination Providers and the State with annual or more frequent evaluation results;
8. Conduct readiness reviews prior to implementing the Initiative monitor the Enhanced Care & Coordination Provider's performance, and conduct routine site visits;
9. Coordinate and host the CMS Learning Community;
10. Notify the State in advance of official site visits to nursing facilities participating in the Initiative;

11. Evaluate compliance with terms of the cooperative agreement, reporting requirements, and the quality, appropriateness and timeliness of services performed by the Enhanced Care & Coordination Providers;
12. Designate a project management team to monitor compliance with terms of the cooperative agreement; and
13. Publicly report findings from the Initiative, including performance measure results.

In witness whereof, the parties hereby execute this MOU.

For the State Medicaid Agency

Printed Name

Title

Signature

Date

Address

For the State Survey and Certification Agency

Printed Name

Title

Signature

Date

Address

For the Centers for Medicare & Medicaid Services

Printed Name

Title

Signature

Date

Address

APPENDIX C: NURSING FACILITY CHARACTERISTICS

Table 1: Characteristics of Partnering Nursing Facilities

Nursing Facility Name and Provider ID	City	State	Resident Census ^a	Medicare- and Medicaid-Certified? (Yes or No)	Number of Residents Whose Primary Payer is Medicare (i.e., Part A Skilled Nursing Facility Benefit) ^a	Number of Residents Whose Primary Payer is Medicaid (i.e., Medicaid NF benefit) ^a	Number of Residents Whose Primary Payer is Neither Medicare Nor Medicaid ^a	Ownership Status (For-Profit, Not-For-Profit, Government) ^b	Owned or Leased by Multi-Facility Organization ^b

^aInclude data from the most recently completed Form CMS-672.

^bInclude response provided on the most recently completed Form CMS-671 and note any pending or actual change since Form CMS-671 was last completed.

Table 2: Nursing Facility Staffing and Resident Satisfaction

Nursing Facility Name and Provider ID	State	RN/Director of Nursing Hours Per Resident Day (2011) ^c	Total Licensed Nursing Hours (RN/DON/LPN) Per Resident Day (2011) ^c	Certified Nurse Aide Hours Per Resident Day (2011) ^c	Does the Facility and/or State Routinely Survey Residents about Satisfaction of Care? ^d (Yes or No)

^cInclude data from the most recently completed Form CMS-671.

^dCMS seeks to identify State and nursing facility-based resident satisfaction surveys that may be useful in measuring resident satisfaction. If the applicant responds “yes”, please include the survey(s) in the Appendices.

Table 3: Proposed Geographic Locations

Nursing Facility Name Provider ID	State	Hospital Referral Region ^e	Hospital Referral Region 30-Day Readmission Rate for Acute Care Transfers ^f (2008)	Does the Nursing Facility Transfer to a High Readmission Hospital? ^g (Yes or No) If Yes, Include Hospital Name

^eFor more information on Hospital Referral Regions (HRR) and how to determine which HRR corresponds to a particular nursing facility, see: <http://www.dartmouthatlas.org/downloads/methods/geogappdx.pdf>.

^fReadmission Rate for Acute Care for Transfers is defined as the percent of inpatient readmissions within 30-days of an acute hospital stay in the calendar year. CMS recommends using the Health Indicators Warehouse at: <http://iom.edu/Activities/HealthServices/GeographicVariation/Data-Resources.aspx>, which provides these data by Hospital Referral Region for 2008.

^gHigh readmission hospital is defined as those included on the CMS Community-based Care Transitions Program list at: http://www.cms.gov/DemoProjectsEvalRpts/downloads/CCTP_FourthQuartileHospbyState.pdf.

APPENDIX D: MONTHLY FINANCIAL PLAN

1. Monthly Financial Plan

The Monthly Financial Plan document is supplemental to Form SF-424A. Each applicant is required to submit a Monthly Financial Plan and supporting information that provide an explanation of estimated costs of implementing the proposed intervention in each partnering nursing facility. These monthly per facility costs shall be based on the size of the target population in each facility and shall serve as the basis for determining the per facility fee. Enhanced care & coordination providers shall receive monthly payment upon completion of Activity 1 and upon beginning Activity 2, should they meet operational performance parameters (I. Funding Opportunity Description). Totals from Form SF-424A and Monthly Financial Plan must match. The total use of funds will sum to the requested award.

Applicants must provide a monthly financial plan narrative and supporting information explaining the rationale behind all assumptions used to develop the Monthly Financial Plan. In addition to completing Tables 4-7, applicants shall also include:

- An account of personnel costs, including detailed number of staff and title, hours per month dedicated to the project, and associated salary and fringe benefit costs, as well as identification of the costs associated with the training aspects of the intervention;
- Estimated “caseload” of nursing facility residents for each staff member who will maintain a physical presence in the nursing facility;
- Estimated size of the target population (with a breakdown of long-stay residents who are Medicare-Medicaid enrollees and any long-stay residents who are not yet Medicare-Medicaid enrollees) for each nursing facility for each year of the cooperative agreement period of performance; and
- Any assumed case-mix adjustment.

CMS reserves the right to request that applicants revise or otherwise modify their applications and budget based on the recommendations of the review panel. CMS reserves the option to re-negotiate payment rates associated with activities at any facility where there is a material change in total occupancy, payer mix, or other changes that would fundamentally change the scope of the Initiative.

As part of the semi-annual funding reports (Activity 3.e, I. Funding Opportunity Description), awardees shall provide updated Monthly Financial Plan information 30 days after the end of each six-month period.

Table 6: Cost by Activity in Year 3 (in dollars per month)

Nursing Facility Name	Number of Nursing Facility Residents in Target Population	Activity 2 Implementation of Clinical Intervention	Activity 3.b Work Plan	Activity 3.d Progress Reports	Activity 3.e Semi-Annual Funding Reports	Activity 4 Participation in CMS Learning Community	Total Cost Year 3
Total							

Table 7: Cost by Activity in Year 4 (in dollars per month)

Nursing Facility Name	Number of Nursing Facility Residents in Target Population	Activity 2 Implementation of Clinical Intervention	Activity 3.b Work Plan	Activity 3.d Progress Reports	Activity 3.e Semi-Annual Funding Reports	Activity 4 Participation in CMS Learning Community	Total Cost Year 4	Total Cost Years 1-4
Total								

APPENDIX E: REQUIREMENTS FOR GOOD CARE TRANSITIONS

Transitions in setting of care (e.g., hospital to nursing facility or rehabilitation services or from facility to hospital) for people living with serious and complex illnesses are prone to errors. Poor communication, inadequate coordination, and lack of attention to patient and caregiver activation have been shown to be the main drivers of poor care transitions. Medication adverse events and errors are the most common adverse care transitions events.

An understanding and consensus is emerging of what is needed for providers and communities to ensure safe and effective transitions of care from one health care setting to another. Good care transitions and reduced risk of readmissions require cooperation, coordination, and communication among providers of medical services, social services, and support services in the community and in long term care facilities. Establishing standard practices and building seamless connections between the primary care providers, the hospital, rehabilitation, and nursing facilities are important. A range of evidence-based interventions, resources, and tools are available to guide providers in establishing safe and effective care transitions. Information on these governmental programs, interventions and resources is available on the Partnership for Patients website <http://www.healthcare.gov/compare/partnership-for-patients/index.html>.

The Administration on Aging also hosts a tool kit to help prepare organizations to for a role in care transitions. More information is available at: http://www.aoa.gov/AoARoot/AoA_Programs/HCLTC/ADRC_CareTransitions/Toolkit/index.aspx.

These 'Requirements for Good Transitions' are not direct contract requirements, per se. However, we strongly encourage applicants to consider these elements in developing an approach in response to this solicitation.

Elements essential to safe, effective and efficient care transitions include the following:

- Person-centered care plans, negotiated with patient and family and responsive to the medical and social situation and the availability of services that are shared across settings of care;
- Standardized and accurate communication and information exchange between the transferring and the receiving provider in time to allow the receiving provider to effectively care for the patient;
- Patient (and/or caregiver) training to increase activation and self-care skills;
- Medication reconciliation and safe medication practices;
- Follow-up with the patient and/or nursing facility within 48 hours after discharge from a setting;
- Procurement and timely delivery of durable medical equipment; and
- The sending provider maintaining responsibility for the care of the patient until the receiving clinician/location confirms the transfer and assumes responsibility.

The minimal information that must be provided across care settings include:

- Primary diagnoses and major health problems;
- Care plan that includes patient goals and preferences, diagnosis and treatment plan, and community care/service plan (if applicable);
- Patient's goals of care, advance directives and power of attorney;
- Emergency plan and contact number and person;
- Reconciled medication list;
- Identification of, and contact information for, transferring clinician/institution;
- Patient's cognitive and functional status;
- Test results/pending results and planned interventions;
- Follow-up appointments schedule;
- Formal and informal caregiver status and contact information; and
- Designated community based care provider, long term services, and social supports as appropriate.

Each element of the care transition must be performed on every patient transitioning to another care setting. These elements must also be documented in the patient's health record. Due to variation in the way primary care practices are structured and the relationships with other providers in the networks, the person/entity responsible for performing the activities and ensuring that the patient's health record includes all the necessary information from each point of care may vary.

For more information:

Advancing Excellence (in America's Nursing Homes): <http://www.nhqualitycampaign.org/>

Interventions to Reduce Acute Care Transfers (INTERACT): <http://interact2.net/>

STate Action on Avoidable Rehospitalizations (STAAR) Initiative: <http://www.ihl.org/offerings/Initiatives/STAAR/Pages/Materials.aspx>

Agency for Healthcare Research and Quality TeamSTEPPS: <http://teamstepps.ahrq.gov/>

Examples of State-specific continuity of care / transfer forms:

Massachusetts: <http://www.mass.gov/eohhs/docs/dph/quality/hcq-circular-letters/dhcq-1101545-transition-form.pdf>

New Jersey: http://web.doh.state.nj.us/apps2/documents/ad/hcab_hfel7_0610.pdf

New York: <http://www.ccitiny.org/CCITINYTransferForm.htm>

Rhode Island: <http://www.health.ri.gov/healthcare/about/continuity/index.php>