**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**
**Centers for Medicare & Medicaid Services**
**Center for Medicare and Medicaid Innovation**

**Initial Announcement**
**Cooperative Agreement**

# Transforming Clinical Practice Initiative (TCPI) Support and Alignment Network (SAN)

**Funding Opportunity Number CMS-1L1-15-002**
**CFDA 93.639**

Applicable Dates:

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| **FOA Posting Date:** | **October 23, 2014** |
| **Letter of Intent to Apply Due Date:** | **November 20, 2014** |
| **Electronic Cooperative Agreement Application Due Date:** | **February 5, 2015 (3:00 p.m. Eastern - Baltimore MD –Time)** |
| **Anticipated Issuance of Notices of Award:** | **April 10, 2015** |
| **Anticipated Cooperative Agreement Period of Performance:** | **May 1, 2015 – April 30, 2019** |

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# I. Executive Summary

The Transforming Clinical Practice Initiative (TCPI) model will test whether a three-pronged approach to national technical assistance will enable large scale transformation of thousands of clinician practices to deliver better care and result in better health outcomes at lower costs for Medicare, Medicaid, and Children's Health Insurance Program (CHIP) enrollees. This technical assistance design includes: (1) aligned federal and state programs and resources moving toward common transformation goals; (2) Practice Transformation Networks (PTN) formed by group practices, health care systems, and others that join together to serve as trusted partners to provide clinician practices with quality improvement expertise, best practices, coaching and help as they prepare and conduct clinical and operational practice transformation; and, (3) Support and Alignment Networks (SANs) formed by professional associations and others that align their memberships, communication channels, continuing medical education credits and other work to support the PTNs and clinician practices.

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| Funding Opportunity Title | Support and Alignment Network (SAN) |
| Announcement Type | New |
| Funding Opportunity Number | CMS-1L1-15-002 |
| Catalog of Federal Domestic Assistance | 93.639 |
| Letter of Intent (highly encouraged) Due Date | November 20, 2014 |
| Cooperative Agreement Application Due Date | February 5, 2015 3:00 p.m. Eastern (Baltimore MD) time. |
| Anticipated Notice of Award | April 10, 2015 |
| Period of Performance | May 1, 2015 – April 30, 2016; May 1, 2016 – April 30, 2017; May 1, 2017 – April 30, 2018; May 1, 2018 – April 30, 2019. Maximum 4 years |
| Anticipated Total Available Funding | Up to $30 Million, pending availability of funds |
| Estimated Number and Type of Awards | 30 Cooperative Agreements |
| Estimated Award Amount | $1 Million up to $3 Million |
| Estimated Award Date | May 1, 2015 |
| Eligible Applicants | Organizations that serve as medical professional associations, specialty societies, and |

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| | organizations that are: 1) involved in generating evidence-based guidelines for clinical practice; 2) promoting measurement through clinical registries and electronic health records; and 3) effectively incorporating safety and patient and family engagement. |

# II. Funding Opportunity Description

## II.1 Purpose

This Funding Opportunity Announcement (FOA) is intended for the SANs. Applicants that are selected as SAN cooperative agreement awardees will work to leverage primary and specialist care transformation work and learning in the field. The action by PTNs and SANs is planned to contribute to the overall operational efficiency and movement of the clinician practices through the 5 Phases of Transformation and their achievement of the TCPI goals. They will utilize their unique and established channels (peer reviewed journals, registries, accreditation and licensure refinement, continuing medical education, maintenance of certification, annual conferences, task forces, newsletters, etc.) with their members, consumers and others to support TCPI action and related results from clinicians and their practices.

## II.2 Authority

Section 1115A of the Social Security Act (the Act), as added by § 3021 of the Affordable Care Act, authorizes the Center for Medicare & Medicaid Innovation (CMMI or the Innovation Center) to test innovative payment and service delivery models with the goal of reducing spending under Medicare, Medicaid, or CHIP while also preserving or enhancing the quality of care furnished to beneficiaries under those programs. The TCPI is a service delivery model that tests whether providing technical assistance in a specific, complex, and adaptive manner will enable clinicians and their practices to rapidly transform the way they deliver care to patients, thereby resulting in improved health outcomes and reduced costs.

The authority for the TCPI model is section 1115A of the Social Security Act (the Act). Under §1115A(d)(1) of the Act, the Secretary of Health and Human Services may waive such requirements of Titles XI and XVIII and of §1902(a)(1), 1902(a)(13), and 1903(m)(2)(A)(iii) as may be necessary solely for purposes of carrying out section 1115A with respect to testing models described in §1115A(b). For this model and consistent with this standard, the Secretary may consider issuing waivers of certain fraud and abuse provisions in §1128A, 1128B, and 1877 of the Act. Waivers are not being issued in this document; waivers, if any, would be set forth in separately issued documentation. Thus, notwithstanding any other provision of this Funding Opportunity Announcement, awardees and sub awardees must comply with all applicable laws and regulations, except as explicitly provided in any such separately documented waiver issued pursuant to §1115A(d)(1) specifically for the TCPI model. Any such waiver would apply solely

to the TCPI model and could differ in scope or design from waivers granted for other programs or models.

## II.3 Background

The Innovation Center is charged with testing and evaluating innovative payment and service delivery models to reduce program expenditures under Medicare, Medicaid and CHIP while preserving or enhancing the quality of care furnished to program beneficiaries. Models that support providers in transforming care are consistent with this change. To date, the Innovation Center has supported model tests through an array of initiatives that are listed on the Innovation Center's website. The initiatives cover a broad range of payment and service delivery models, including accountable care organizations; bundled payment; primary care transformation; initiatives to accelerate the development of new payment and service delivery methods; and initiatives to speed the adoption of best practices.

Information available from these models, coupled with the growing evidence gathered from a body of published literature, indicates that a focused effort on health delivery redesign through clinician practice transformation can improve the quality of care for patients and prepare clinicians to participate in new payment models. This redesign requires a simultaneous change in many independent processes to create a more efficient and effective care delivery system.

Depending on the nature and circumstances of each clinician, there are many possible paths to transformation. Successful clinician practices possess a number of similar traits that include the following variables: committed leadership; an operational culture that emphasizes the use of data to drive decision making; practice redesign and a focus on integrating clinical, administrative, and financial systems as central aspects of implementing quality; and process integration as a business strategy.

## II.4 Initiative Goals

The Transforming Clinical Practice Initiative Model will fund successful applicants as Support and Alignment networks (SANs) that propose the most compelling approaches to assisting clinicians in transforming their practices and that commit themselves and their communities of practice to quantifiable outcomes. These outcomes must be aligned with the overall aims of the TCPI model, including:

1. Support more than 150,000 clinicians in work to achieve practice transformation;
2. Build the evidence base on practice transformation so that effective solutions can be scaled, if successful;
3. Improve health outcomes for 5 million Medicare, Medicaid and CHIP beneficiaries.
4. Reduce unnecessary hospitalizations and other overutilization of other services for 5 million Medicare, Medicaid and CHIP beneficiaries;
5. Sustain efficient care delivery for Medicare, Medicaid and CHIP beneficiaries by moving at least 75% of clinicians that complete the TCPI phases of transformation to participate in incentive programs and practice models that reward value upon completion of TCPI; and
6. Generate savings to the federal government over a period of 4 years through reduced Medicare, Medicaid and CHIP expenditures. In addition, we believe commercial payers may experience savings as a result of this model.

### II.4.1 Model

The Transforming Clinical Practice Initiative model will assist clinicians in changing the way they deliver care by integrating quality and process improvement to build on and spread existing change methodologies, practice transformation tools, published literature, key learnings, and technical assistance programs. For the TCPI model, clinicians include primary care and specialty physicians, nurse practitioners, physician assistants, clinical pharmacists, and their respective practices.

Through a combination of service delivery refinements and innovative technical assistance, the Partnership for Patients (PfP) initiative and the Quality Improvement Organization (QIO) program have together shown promise in making dramatic improvements in quality, outcomes, and cost efficiency in the hospital setting using an adaptive quality improvement approach to model design. Their aligned efforts toward assisting providers with quality improvement activities resulted in decreases in hospital-acquired infections (HAI), hospital-acquired conditions (HAC), and readmission rates. TCPI will use a similar approach to providing technical assistance to transform clinician practices to deliver high-quality care that is evidence based, efficient, coordinated, and patient-centered. We expect that practice transformation will result in improvements in patient health outcomes and reduced health care costs.

- As TCPI wishes to structure participation in the model so as to avoid confounding effects of possible overlap, it will be necessary to track clinician participation in such other

models and programs that involve comprehensive practice transformation, cease technical assistance in these circumstances, and to account for this in the evaluation of savings and other program impacts. We believe that significant overlap between TCPI and the other model/program would exist with the following: the Medicare Shared Savings Program, the Pioneer ACO program, the Multi-payer advanced primary care program, and the Comprehensive primary care initiative. Potential participation in other payment models that have a specific scope/topic (e.g. bundled payment models, and models that cover specific chronic diseases or settings) will need to be evaluated on a clinician-by-clinician basis to see if a substantial proportion (i.e.: 20% or more) of their total estimated payments for clinical services provided to Medicare, Medicaid and CHIP beneficiaries are covered by the model. PTNs will be required to perform an initial and periodic ongoing environmental scans of such APM initiatives that TCPI participating clinicians in their networks may have joined.

The TCPI implementation design is centered on a multifactorial approach that will encompass the following:

1) Identify, engage, and deploy expert faculty;
2) Develop and continuously refine improvement guides and TCPI Change Package for implementation in practices;
3) Establish relationships with other public and private entities;
4) Establish and support a national infrastructure that is funded through cooperative agreements and contracts; and
5) Assist participating clinicians and their practices (including but not limited to clinicians in rural health clinics, rural community health centers, and health professional shortage areas (HPSA) and those clinicians supporting medically underserved populations such as community and migrant health centers) in progressing through various phases of transformation.

By participating in TCPI, practices will be able to receive the technical assistance and peer-level support they need to deliver care in a patient-centric and efficient manner, which is increasingly demanded from health care payers and purchasers as part of a transformed care delivery system. Participating clinicians will thus be better positioned for success in the health care market of the future - one that rewards value and outcomes rather than volume.

The following two figures provide additional perspective and context on the overall design of the TCPI model.

**Figure 1: Pathway to a Transformed Healthcare System**

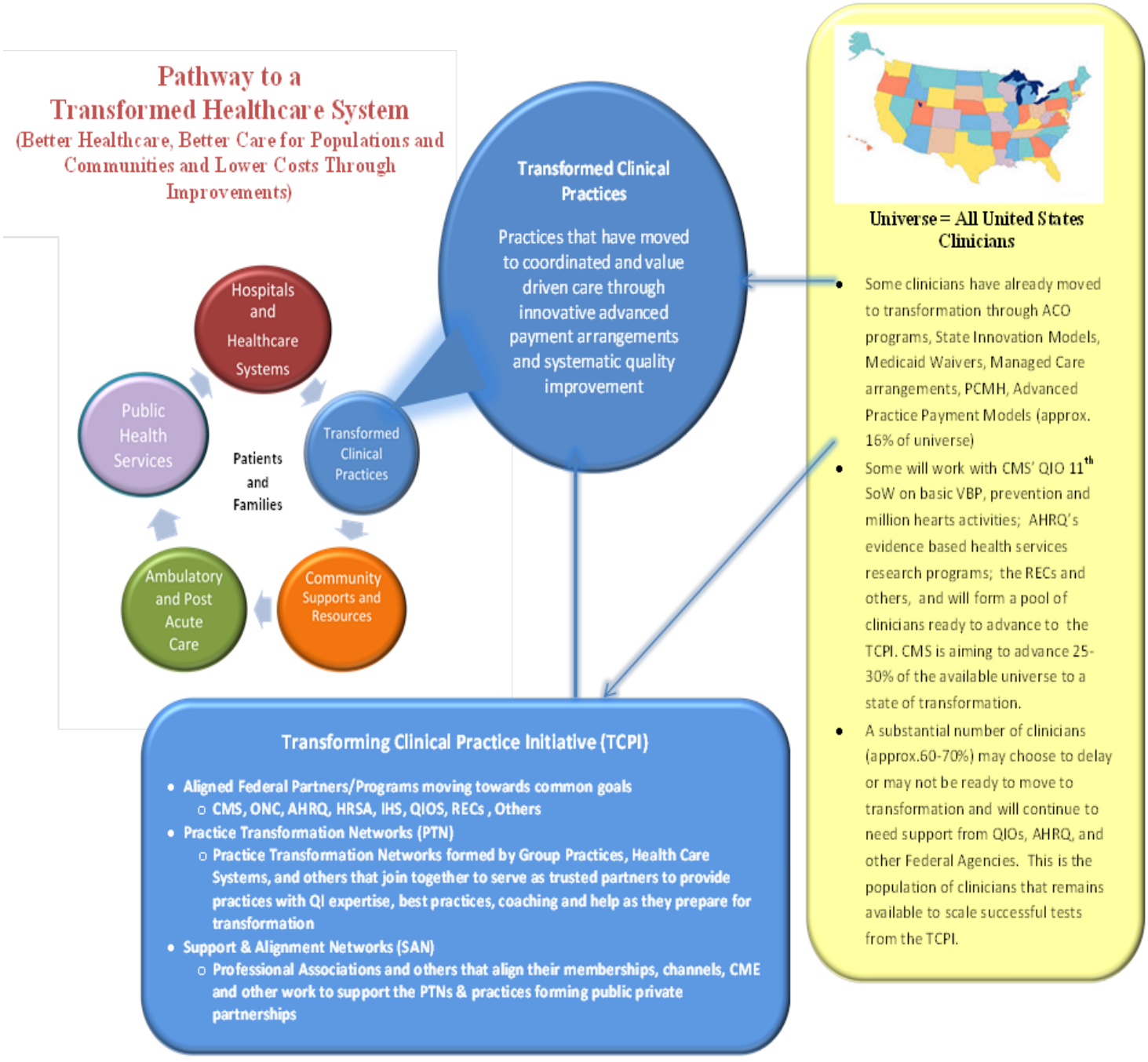
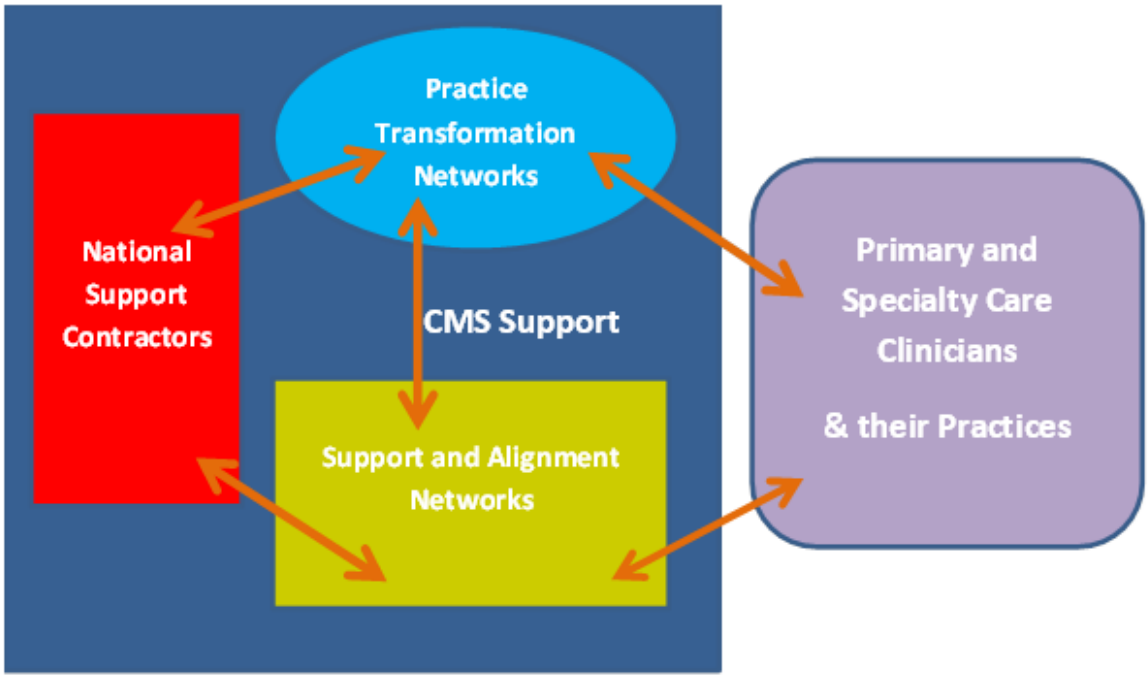



**Figure 2: Illustration of Model Framework**




## II.4.2 Clinician Practice Alignment with TCPI Aims and CMS Programs

The TCPI model will hold awardees to the bold aims that they submit as a part of their application. It is important that the SAN awardees work effectively with the National Support Contractors and Practice Transformation Networks. The TCPI model seeks to have SAN awardees focus their work on the stated TCPI aims and related milestones. Practice Transformation Networks will commit to generating results through their supported clinicians/practices based on these aims. SANs will support clinician members and play an active role in the alignment of new learning into continuing medical education, certifications, and other quality improvement opportunities. Clinicians participating in the TCPI model will commit to participate in the Physician Quality Reporting Program and Value-Based Payment Modifier Programs. Additional detail about these programs can be found at www.cms.gov or by clicking on the names of each program.

## II.4.3 Key Attributes

The TCPI SANs will be an invaluable asset in attaining the TCPI goals. Examples of the types of organizations that could serve as Support and Alignment Networks include, but are not limited to, medical professional associations and specialty societies, organizations involved in generating evidence-based guidelines for clinical practice, and organizations promoting measurement and improvement through clinical registries and electronic health records. As part of the TCPI technical assistance infrastructure, SANs will work in tandem with the Practice Transformation Networks (PTNs) and facilitate achievement of the following TCPI national milestones:

- Ensure alignment of TCPI National Support Contractor (NSC) content with national evidence-based guidelines of care and best practices;
- Promote evidence-based quality measures that can be collected via registries and Electronic Health Records and Systems;
- Ensure alignment with other public and private entities working in the area of quality improvement and transformation;
- Ensure their support is in alignment with PTNs and participating practices within the context of their medical neighborhoods and communities;
- Promote rural and urban clinician participation in TCPI and work to sustain their active engagement over the life of the model;
- Support their members and practices in work to reduce unnecessary testing and procedures;
- Incorporate TCPI-related content into continuing medical education and ongoing clinician training programs, in their discretion and if they determine the content is appropriate;
- Incorporate TCPI- related content into maintenance of certification requirements, in their discretion and if they determine the content is appropriate;
- Ensure leadership and collaboration in the fomenting and fostering support to integrate patient and family engagement and measurement in the transformed care delivery system;
- Mobilize the professional community on improvement topics and goals;
- Publicize and call attention to best practices and the results of high performing practices in the TCPI;
- Focus on specialty topics by providing high quality advice and guidelines to practices about these "specialty" conditions and how to manage them appropriately (e.g., primary care providers work with diabetes, patients with hypertension, cancer, gastrointestinal problems and heart disease);
- Interface with specialists (e.g. gastroenterologists, cardiologists, and endocrinologists) to assist with registry data for example to improve quality which should overlap with aspects of Choosing Wisely;
- Offer supportive and evolving ideas to create, improve, and expand specialists' interactions with primary care providers to make these relationships work better in the community; and
- Use their unique and established channels (peer reviewed journals, registries, annual conferences, task forces, newsletters, etc.) with members to support action and results on the initiative, as they determine appropriate.

One goal of this process is for each SAN to expand its current involvement in transformation. In each of the applicable above areas, the SANs should detail their current processes, develop a strategy and implementation plan to achieve target goals over the funding period, and detail a roadmap that links the two.

The TCPI Practice Transformation Networks (PTNs) will coach, mentor, and assist clinicians in developing core competencies to assist them in moving through the TCPI Phases of Transformation. Coaching allows for the clinical practices to become actively engaged in the transformation rather than as the recipient of the transformation. Coaching builds the skills of

the clinicians and practices which are more likely to lead to sustained efforts after the TCPI technical assistance (service delivery) model tests are complete. Specifics regarding TCPI PTN responsibilities can be found in Appendix B.

The SANs should actively utilize the following description of the Phases of Transformation, and the characteristics and milestones associated with them as they work with PTNs and their participating clinicians/practices.

**Table 1: TCPI Phases of Practice Transformation: Primary Care descriptive characteristics and associated milestones.**

| | Phase Description | Phase Milestones |
|---|---|---|
| **Phase 1: Setting Aims and developing basic capabilities** | ➢ The practice has the full support of leadership for transformation and develops and commits to a clear statement that outlines the specific goals of transformation, why they are important to the practice and the community they serve, what changes will be made, and how progress will be measured.<br>➢ Learns and integrates a planned care model which includes understanding the intersection of administrative, financial and clinical systems and uses this knowledge to redesign all of these processes toward a leaner and higher performing organization that produces better outcomes.<br>➢ Uses data to better understand practice flow. Implements improvement strategy that relies on routine performance measurement to identify opportunities for improvement and uses rapid cycle change methods to test ideas for change. Intentionally minimizes unnecessary testing and procedures, and measures and reports impact of these changes.<br>➢ Participates in learning collaborative to share its best practices and lessons learned and to benefit from the learning of others.<br>➢ Practice recognizes importance of | ➢ Practice will submit a detailed plan that addresses the specific goals of transformation—what is important to the practice and the aims. This will be submitted within one month of practice joining PTN.<br>➢ Practice starts to perform a self-assessment and starts to collect baseline data on utilization and other quality and outcome measures and identifies problem areas for improvement.<br>➢ Practice starts to train at least 50% of staff in improvement methods and tools. Staff starts to understand the process of improvement and how to test changes in daily workflows. Staff is trained on optimal team-based practice.<br>➢ Practice has a process in place for training staff on data quality problems when they are detected.<br>➢ Practice establishes measures, plans and a baseline for intentionally minimizing unnecessary testing and procedures.<br>➢ Practice has in place mechanisms for addressing the needs of their patients/families to be active partners in care. |

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| | patient and family engagement in care. | |
| **<u>Phase 2:</u> Reporting and using data to generate improvements** | ➢ Acquires core capabilities in improving the health of populations through more cost-effective systems of care. Establishes new relationships within the community and expands the care team.<br>➢ Produces real time reports on how practices, providers and care teams are meeting quality, financial and utilization goals to enhance patient experience of care, eliminate waste and decrease costs.<br>➢ Shares outcomes of quality and clinical measures for the patient population with the PTN. Uses data to analyze potential disparities in care and develops action plans—this allows practices to identify individual patients needing intervention to improve overall practice performance.<br>➢ Practice has integrated specialty care through agreements.<br>➢ The practice identifies ways to increase patient and family engagement in care and identifies barriers to patient and family engagement in care.<br>➢ Practice tracks patients obtaining outside services.<br>➢ Eligible clinicians assess their ability to meet Meaningful Use objectives and develop an EHR integration plan to meet Meaningful Use objectives in Phase 5. | ➢ Practice starts to capture and analyze population, disease specific and relevant quality measures for utilization, billing data and tests ordered from their registry, practice management or EHR system to drive clinical practice improvement and resulting in reducing unnecessary tests and hospitalizations.<br>➢ Practice develops plan to incorporate Meaningful use into their operational redesign.<br>➢ The practice has identified community partners and other points of care that their patients are using and has a formal agreement in place with these partners.<br>➢ The practice has defined improvements in care transition and processes enabled through exchange of essential health information to eliminate waste and decrease costs.<br>➢ At least 50% of the practice's patients have a main clinical point of contact at the practice for their health care needs (i.e. empanelment to provider and care teams).<br>➢ The practice provides care management to at least 50% of highest risk patients (those that are clinically unstable).<br>➢ The practice implements at least three specific care management strategies for patients in higher risk cohorts, samples may include, but are not limited to:<br>o Integration of behavioral health,<br>o Self-management support for at least three high risk conditions<br>o Medication management and review.<br>➢ Monthly reporting will include updating information about the practice's risk stratification methodology, empanelment status, risk stratification data, and other activities.<br>➢ Practice will incorporate regular improvement methodology to execute change ideas in a rapid cycle. Use a |

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| | | plan-do-study-act (PDSA) quality improvement cycle of small scale tests of change in the practice setting. |
| **<u>Phase 3:</u> Achieving aims of lower costs, better care and better health** | ➢ Optimizes care team and utilizes technology to track patient improvements via population based management (use of information on clinical grouping of patients to improve their care and clinical outcomes). Matches and allocates care team functions based on skill, abilities, and credentials to support efficient care delivery.<br>➢ Obtains feedback from patients and family members about their health care experience and uses this information for quality improvement. Provides incentives to care team based on performance. Proactively engages patients and families to expand their role in decision making, health-related behaviors and self-management.<br>➢ Demonstrates improvement on select quality measures.<br>➢ Practice identifies patient risk stratification by disease, health risk and other conditions. | ➢ Practice is optimizing reports in registry, practice management, or EHR system to drive clinical practice improvement on a monthly basis.<br>➢ Practice has reduced unnecessary tests and hospitalizations by at least 25% from baseline.<br>➢ Practice has involved patients, families and staff in quality improvement initiatives.<br>➢ Practice sets clear expectations for each team member's functions and responsibilities to optimize efficiency, outcomes, and accountability.<br>➢ Practice routinely creates and/or maintains shared care plans and utilizes shared decision making tools to incorporate patient preferences and goals in care management processes.<br>➢ Practice routinely exchanges essential health information with other members of care team outside of the practice.<br>➢ Practice has increased the number of patients who have received the appropriate health screenings and completion of referrals.<br>➢ Practice has identified high risk patients and has ensured they are receiving appropriate care and case management services.<br>➢ Practice has a formal written vision related to care coordination.<br>➢ Practice links a patient to a provider and care team so both the patients and team recognize each other as partners in care.<br>➢ Practice ensures that patients are able to see their provider or care team whenever possible.<br>➢ Practice links patients with community resources to facilitate referrals.<br>➢ Practice tracks and supports patients when they obtain services outside the |

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| | | practice.<br>➢ Practice follows up with patients within 24 hours after an emergency room visit or hospital discharge. |
| **Phase 4:** **Getting to benchmark status** | ➢ Manages populations of patients through a panel with significant demonstration of care coordination, including coordinating follow up appointments with patient after emergency room visits or hospitalizations.<br>➢ Provides patients with community resources, tracks and supports patients obtaining outside services.<br>➢ Integrates advanced access to eliminate waits, minimize "no show" rates and streamline workflow, such as 24/7 access to the care team, and scheduling options.<br>➢ Continues to demonstrate improved performance on quality measures and seeks to improve performance relative to local and national benchmarks.<br>➢ Has knowledge of the health status of other populations in the medical neighborhood and contributes to the success of the over health of the community served. | ➢ Practice uses utilization reports on a monthly basis and continuously makes clinical improvement changes such as 24/7 access to care, same as tracking number of patient triaged after hours, number of same day appointments for emergent problems, number of patients being discharged from the hospital and needing an appointment with 24 hours after discharge, and the practice continues to decreases the "no show" rate over time.<br>➢ Practices submit utilization reports to PTN on a monthly basis. Feedback is submitted back to the practice.<br>➢ Practice has reduced unnecessary tests and hospitalizations by at least 20% from baseline.<br>➢ Practice has a process in place for identifying 90% of high risk patients on a monthly basis and has ensured that 75% are receiving appropriate care and case management services as part of their continuous practice improvement plan.<br>➢ Practice tracks patients, on a monthly basis, when they obtain services outside of the practice.<br>➢ The practice has a process in place to link the patient to a care provider and care team so both the patients and team recognize each other as partners in care. |
| **Phase 5:** **Practice has demonstrated capability to generate better care, better health at lower cost.** | ➢ Practice has documented substantial performance improvements. Practice generates significant quality improvements in patient health outcomes and experience of care. Eligible clinicians have completed implementing their integration plans for meeting | ➢ Practice sustains prior improvements in key metrics for at least one year.<br>➢ Practice has developed business acumen in the various types of alternative payment models including understanding of shared savings models with and without risk, various contracting arrangements that a practice |

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| | meaningful use objectives | might consider and how to evaluate the pros and cons for the population they serve. |

**Table 2: TCPI Phases of Practice Transformation: Specialists' descriptive characteristics and associated milestones.**

| Phases of Practice Transformation | Description | Milestones |
|---|---|---|
| **<u>Phase 1:</u>**<br>**Setting aims and developing basic capabilities** | ➢ The specialty clinician/practice has the full support of leadership for transformation and develops and commits to a clear statement of action with specific goals and metrics for delivering well-coordinated, timely, efficient care as part of a patient's care team, that defines their role and responsibilities with respect to the larger medical neighborhood in which they operate.<br><br>➢ Learns and integrates best practices for care coordination and patient co-management with multidisciplinary and inter-professional patient care teams. This includes understanding the intersection of primary care, specialty care, behavioral health, and patient self-management, in providing patient-centered care, and producing optimal patient outcomes.<br><br>➢ Engages in effective electronic, standards-based, bi-directional communication with other providers caring for the same patient. Administrative, financial and clinical | ➢ Specialty clinician/practice will submit a detailed plan that addresses how they will increase access to care, negotiate co-management of patients with other providers, coordinate care with other providers, reduce unnecessary hospitalizations, testing and procedures, and deliver patient-centered care.<br><br>➢ Participates in multidisciplinary learning collaborative to benefit from the learning of others, share best practices and lessons learned.<br><br>➢ Practice starts to perform an assessment of the clinical practice and starts to collect baseline data on comorbidities, referral patterns, utilization, quality and outcome measures, and identifies problem areas for improvement. Practice establishes measures, plans and a baseline for intentionally minimizing unnecessary testing and procedures. |

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| | systems are optimized using this knowledge by redesigning all of these processes toward developing a leaner and higher performing organization that produces better outcomes. | |
| **Phase 2:**<br>**Reporting and using data to generate improvements** | ➢ Same as those listed in Primary Care | ➢ Same as those listed in Primary Care<br>➢ Develops care coordination agreements with other care providers that cover 15% of their patients and defines co-management responsibilities with other care providers.<br>➢ The practice identifies ways to improve care transitions, care processes, workflow; and ways to eliminate waste and decrease costs that are enabled through the exchange of essential health information (electronically or otherwise). |
| **Phase 3:**<br>**Achieving aims of lower costs, better care and better health.** | ➢ Same as those listed in Primary Care | ➢ Same as those listed in Primary Care<br>➢ Develops care coordination agreements with other care providers that cover 30% of their patients their and defines co-management responsibilities with other care providers.<br>➢ Practice routinely exchanges essential health information (electronically or otherwise) with other members of care team outside of practice.<br>➢ Practice has reduced unnecessary hospitalizations, tests, procedures by at least 15% from baseline. |

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| **Phase 4:**<br>**Getting to benchmark status** | ➢ Same as those listed in Primary Care | ➢ Same as those listed in Primary Care<br>➢ Develops care coordination agreements with other care providers that cover 50% of their patients and defines co-management responsibilities with other care providers.<br>➢ Practice has reduced unnecessary hospitalizations, tests, procedures by at least 20% from baseline. |
| **Phase 5:**<br>**Practice has demonstrated capability to generate better care, better health at lower cost.** | ➢ Same as those listed in Primary Care | ➢ Same as those listed in Primary Care |

## II.4.4 Evaluation and Monitoring SAN support of clinicians and practices through TCPI Phases of Transformation and Milestones

The goal of reaching the TCPI aims will include use of a core set of measures to inform monitoring, evaluation and performance improvement across all clinician practices participating in TCPI. In addition to a menu set of measures that can allow for practice and/or region specific measures to drive improvement on a local level. These will likely include measures consistent with the Million Hearts™ initiative and American Board of Internal Medicine's (ABIM) Choosing Wisely® Initiative.

Each SAN applicant must clearly include quantifiable means for generating and documenting their projected impact on the overall initiative and the five key aims outlined in Section II.4. For example, SAN proposals should clearly delineate how they will support participating clinicians and their PTNs in reducing the costs of unnecessary testing and procedures. Strong proposals will establish quantitative targets for overall cost reductions achieved as a result of the activity and work of the SAN. Similar approaches to quantitative targets in other areas will make SAN applications even stronger. CMS will use actual performance on projected SAN impacts to inform judgments on future funding in option years. Some examples of additional items for SAN applicants to potentially address include:

- Demonstrated improvement in the aggregate increase in number of clinician members supported,

- Demonstrated improvement achieved through implementation of alignment activities conducted with clinicians and their practices,
- Effective support provided to primary and specialty care clinicians to promote and sustain their active involvement with their PTNs and in the overall initiative,
- Number and type of SAN programs and activities used to support progress towards the aims of the TCPI (continuing medical education offerings, maintenance of certification, journal articles, newsletter articles, alignment with professional standards, more);
- Increasing the number of participating clinicians,
- Providing supportive learning for clinicians' success in adapting to changes in national standards and guidelines, and
- Improved integration of primary and specialty care clinicians in patient and family engagement and other outreach efforts.

Each SAN applicant will be responsible for monitoring, evaluating, and reporting on the progress and impact of their improvement program goals and success each quarter. In addition to this self-evaluation, CMS contractors will conduct an independent evaluation. These evaluations will be used in determining the SANs' eligibility for further funding.

The PTNs will focus on the recruitment and coaching of practices and provide intensive technical assistance, facilitation, and support to those practices. CMS will share aggregate data received from the Practice Transformation Networks recruitment efforts and performance reports with the SANs. SANs will support primary and specialty care clinicians with tailored services. CMS will also share aggregate PTN performance data on an ongoing basis with the SANs. This may include comparative performance information for each PTN relative to others in the model, and may be stratified by characteristics that are thought to affect performance. The SANs are expected to use this data to continue internal improvement and implement adaptive mechanisms to further advance clinicians and practices through the Phase of Transformation and in achieving the goals of TCPI. SANs will support clinicians in aligning their practice delivery actions to national standards and guidelines and support their learning to adapt to the changes that they will work to incorporate into specialty board exams and other mechanisms as they determine appropriate.

SANs will be required to provide access and data to CMS or its contractors as may be needed for evaluation purposes. The evaluation will include multi-pronged data collection to understand the context of the programs and to capture the nuances occurring at the sites. Data for the analyses will come from sources including, but not limited to: the practice application and readiness assessment; Medicare claims; EHR measures, Choosing Wisely® measures as reported by practices, patient experience surveys; site visits with practices; focus groups with beneficiaries and their caregivers, practice staff, technical assistance providers, and others (e.g., payers); and observation of technical assistance sessions.

## II.4.5 Learning and Diffusion

The TCPI is a service delivery model test of whether a three-pronged approach to national technical assistance will enable large scale transformation of thousands of clinician practices to deliver better care and result in better health outcomes at lower costs. Learning and diffusion

methods are central to transforming clinical practices on a large scale to achieve measurable improvements quickly. Methods such as those utilized in Partnership for Patients and collaborative learning models will be applied to achieve the desired results over a four year period. This will include setting clear and measurable aims across both PTNs and SANs using Plan, Do, Study, Act (PDSA) quality improvement methods within and across practices. A key activity will be to identify and showcase practices that are already successful in implementing changes that lead to full transformation in learning sessions.

Lessons learned from other transformation collaboratives and improvement activities will inform the implementation and management of TCPI. Existing tools (specific to practice transformation; patient safety; effective use of health information and related technology for clinical and operational improvement, patient and family engagement; and other knowledge management resources, communication and related tools utilized in primary, tertiary and specialty care practices) will be employed in this Initiative, while taking into account practices' local context and regional market characteristics. The learning and diffusion strategy across PTNs and SANs will be supported by TCPI Learning Sessions and Change Packages. A change package is a set of improvement tools and implementation instructions for a specific area of improvement that reflects the current knowledge base regarding successful interventions for achieving breakthrough improvements that can be sustained over time. The TCPI Change Package will guide the changes tested and implemented at participating practices and will consist of: common change concepts, interventions and tools. Change Packages when used in combination with small test of change by the clinicians and their practices will serve as one mechanism to allow the networks to operate as a collective through a Transforming Clinical Practice Community of Practice (TCP-CoP). It will also help ensure effective implementation of improvement tools and processes and highlight unique factors that generate success or failure.

Across the networks, TCPI will support communities of practice to: 1) share and generate best practices to support changes across primary and specialty care practice; 2) facilitate communication through Listservs and forums with all participating clinicians; 3) access TCPI generated resources and tools; and 4) foster new tests of changes through rapid cycle evaluation as well as spread of interventions demonstrated to drive results in achieving overall TCPI aims. TCPI will utilize a customized Content and Knowledge Management (KM) Tool similar to the tool used by the Partnership for Patients initiative and QIO program.

### II.4.6 Key Personnel

CMMI desires a balanced team of key personnel to ensure the success of the TCP Initiative model. Applicants must propose required key personnel and identify the relevant titles and qualifications for these positions. Applicants must identify whether the proposed personnel that are part of the primary awardee and those that are subcontractors. The following personnel are designated as "key":

- Program Manager:
  Provide overall management and accountability for meeting TCPI goals and commitments made in the applicant's submission.

- Quality Improvement Advisors:

These individuals will have expertise in quality improvement across several areas to include clinical, operational including finance and business process redesign, patient and family engagement and broad quality improvement including lean methodology.

- Clinical Personnel:
  Extensive experience in producing results both within their practice (primary and specialty care) and in support of other practices and organizations.

The Awardee is encouraged to dedicate key personnel full-time to this effort, unless otherwise specified by the SAN and agreed to by CMS. Key personnel may be assigned to more than one functional area but their time may not exceed on Full Time Equivalent (FTE). Any staff identified as key personnel must have a backup who is properly trained and qualified to act as a fully functioning replacement in the temporary absence of the key person. Key personnel shall be assigned for a minimum of the 12-month base period barring circumstances outside the control of the awardee, e.g., death, and disability. Should any key personnel choose to leave for another reason (e.g., higher pay, job dissatisfaction), their replacement shall be equal or superior qualifications and provided within 30 calendar days of their known departure.

## II.5 Restrictions on Award

- An applicant can only be funded to serve as a Practice Transformation Network or a Support and Alignment Network. An entity or subcomponent of an entity may not perform as both a PTN and a SAN.
- Funds shall be used to implement, manage toward results, and evaluate models that support system transformation toward higher quality care at lower costs. Additionally, the funds shall further healthcare design improvements to support both primary and specialty care. This would include innovations that have been tested and shown to reduce unnecessary testing and eliminate other inefficiencies in specialty care that are of primary interest in the SANs' work.
- Award dollars cannot be used for specific components, devices, equipment, or personnel that are not integrated into the entire service delivery model proposal.
- Funds shall not be used to build or purchase health information technology or other information technology that exceed more than 10% of total costs of the applicant's proposed budget.
- CMS will not fund proposals that replicate models that CMS is currently testing in other initiatives.
- CMS will not review applications that merely restate the text within the FOA. Applicants should detail their approach to achieving the TCPI goals and milestones. Reviewers will note evidence of how effectively the applicant includes these in their overall implementation plan.
- Award dollars may be used for specific components, devices, equipment, software, analytical tools, or personnel provided that they are integrated into the service delivery and payment model.
- Award dollars cannot be used to make permanent improvements to property not owned by the federal government; minor alterations and renovations are permissible under

certain circumstances that will be described in the financial plan template to be provided at a later date.

## II.6 Alignment of Awardees

CMS expects significant proactive alignment and coordination among PTN and SAN awardees. The awardees will likely have differing specialties and strengths, so coordination will enable best practices found in one area to diffuse into other PTNs and SANs. SANs are expected to lead and participate in regular weekly webinars, pacing events, and office-hours events with CMS, PTNs and each other throughout the four-year model of work.

## II.7 Technical Assistance and Information for Potential Applicants

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

## II.8 Preventing Duplication of Effort

TCPI participants will work collaboratively with the CMS Quality Improvement Organizations (QIOs), State Innovation Model, Regional Extension Centers, and other HHS programs for alignment and synergy, and to prevent duplication of efforts. Based on more than two years of collaboration and work between CMS Quality Improvement Organizations (QIOs) and Partnership for Patients (PfP) Hospital Engagement Networks (HENs), the following three proven strategies will be used to maximize synergy and prevent duplication of effort:

- CMS delineates how work funded as part of the Transforming Clinical Practice Initiative is distinct and different from other federally-funded work toward practice improvement with similar aims. CMS has worked extensively with program leads from AHRQ, ONC, HRSA, and the QIO program to offer technical assistance that complements but does not duplicate the work of other initiatives at the program-level as well as at the provider-level. Because TCPI focuses on total practice transformation rather than specific isolated topics (such as assessment and support of the practice's performance in meeting Meaningful Use measures) it is much broader in topic than other large scale technical assistance programs geared toward clinicians. TCPI aims to transform 150,000 clinicians and including specialists and non-physicians, TCPI reaches more types of clinicians on a much larger scale than other clinical, operational, and financial transformation efforts that have targeted between 500 to 8,000 clinicians/practices. In addition, the QIO program is integrally interwoven into TCPI for the specific function of practice assessments. These unique characteristics make TCPI larger in scope than previous clinician transformation initiatives.
- CMS established clear aims for the Transforming Clinical Practice Initiative that helps others (private and public) who want to contribute to this work to self-align their tools, resources, people, and funding in ways that are non-duplicative and maximize synergy.

- CMS requires three actions by federally funded PTN and SAN cooperative agreement recipients that may contribute to this work:
    a. Contact other regional, State, local or private sector entities who are receiving federal funding to do similar work
    b. Establish and document clear local plans that delineate the local solutions for maximizing synergy and eliminating duplication
    c. Share these plans with the appropriate federal project officer for review and affirmation or improvement in an ongoing basis

Accordingly, TCPI Support and Alignment Networks awardees will be required within 90 days of the initial period of performance and on an on-going basis to: 1) scan the local and immediate environment to identify others who may be receiving federal support within HHS or other for related work; 2) reach out and discuss how to prevent duplication of effort and achieve synergy with others who are working in this arena; and 3) document the SANs actions and plans to prevent duplication with their TCPI project officer.

# III. Award Information

## III.1 Total Funding

The Innovation Center is making available up to $30 million (pending availability of funds) through this FOA to fund the Support and Alignment Networks. Cooperative agreements will be awarded with consideration to the best value of the proposal for the government, potential impact of the SAN applicant in facilitating improvements in the healthcare system, the quality of each application and the stated commitment and ability to meet the goals of the project, and available funding. Awardees might not receive the full award amount requested and may be asked to revise the work plan and budget to reflect the award.

## III.2 Award Amount

The Innovation Center expects to make awards ranging from approximately $1 million to $3 million each to cover a four-year period of performance. The amount of funding will depend on the scope of each Support and Alignment Network, its projected impact, partners at the local level and other variables detailed in the criteria below (Section IV).

## III.3 Anticipated Award Date

Please refer to the Executive Summary related to the anticipated award date.

## III.4 Period of Performance

The anticipated Period of Performance is **May 1, 2015 through April 30, 2019**. The period of performance includes one 12-month Base Period, with three 12-month option periods. SANs must commit to the aims of the initiative as supported by their own proposed specific targets and milestones. Option period funding will be tied to achieving these milestones and targets. CMS is under no obligation to make additional awards under this initiative.

Year one 12-month project and budget period: May 1, 2015 to April 30, 2016
Year two 12-month project and budget period: May 1, 2016 to April 30, 2017
Year three 12-month project and budget period: May 1, 2017 to April 30, 2018
Year four 12-month project and budget period: May 1, 2018 to April 30, 2019

## III.5 Number of Awards

The Innovation Center intends to fund up to 30 of the best qualified applications within the scope of available funds. The Innovation Center is not obligated to fund a minimum number of applicants or to distribute a minimum amount of funds available under this FOA.

## III.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 model goals along with the SANs' success in achieving the milestones and projected results outlined in their application.

## III.7 Termination of Award

Continued funding is dependent on satisfactory performance against operational performance measures and a decision that continued funding is in the best interest of the Federal Government. CMMI also may terminate or modify an award based upon CMMI's review of an awardee's progress. Proposals will be funded subject to meeting terms and conditions specified in the cooperative agreement, and awards may be terminated if these terms and conditions are not met. See also §1115A(b)(3)(B) of the Social Security Act.

## III.8 Anticipated Substantial Involvement by Awarding Office

CMMI anticipates substantial involvement in the Support and Alignment Network cooperative agreements and their resulting recipient responsibilities. CMMI will monitor and evaluate awardees' activities performed under the cooperative agreement. CMMI will actively work with the Transforming Clinical Practice infrastructure and the supported clinicians and practices on a weekly basis. As a part of the technical assistance design and results, TCPI awardees also will be evaluated with regard to the following:

- Development and continued enhancement of a system of national, state, and regional professional associations and other supports that, in their discretion and if determined appropriate, align their programs and platforms of continuing medical education, maintenance of certification, patient and family engagement;
- Distribution of services provided by the individual SAN to ensure equitable distribution of the services provided among the participating clinicians; and
- Engagement of primary and specialty care clinicians to facilitate achievement through the Phases of Transformation.

While awardees are expected to cooperate with the awarding office and work of the TCPI evaluation contractor, it is not necessary for the SAN applicant to budget for these activities

beyond allowance for staff time for interactions and data reporting. For example, the awardee is not expected to provide working space for Federal participants, etc.

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

# IV. Eligibility Information

## IV.1 Eligible Applicants

Examples of the types of organizations expected to apply are as follows: medical professional associations, specialty societies, and organizations that are: 1) involved in generating evidence-based guidelines for clinical practice; 2) promoting measurement through clinical registries and electronic health records; and 3) effectively incorporating safety and patient and family engagement.

## IV.2 Eligible Applicants – 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 Taxpayer Identification Number (TIN) designated to receive payment. The organization must have a governing body capable of entering into a cooperative agreement with CMS on behalf of its members.

**Eligibility Threshold Criteria**:

- Application deadline: Applications not received by the application deadline through www.grants.gov will not be reviewed.
- Application requirements: Applications will be considered for funding only if the application meets the requirements as outlined in Section IV. Eligibility Information and, Section V. Application and Submission Information.
- Page limit: Applications must not be more than 40 pages in length which includes the project abstract summary, project and budget narratives and financial plan. These include documentation related to financial projections, profiles of participating organizations, relevant letters of endorsement, etc. For more information, see Section V.2 Application Content and Required Form of Application Submission. Applications that exceed 40 pages in length will not be reviewed.
- Standard forms are not included in these page limits.

Applications will be screened to determine eligibility for further review using criteria detailed in this FOA and in applicable law, including 2 CFR Parts 180 and 376. In addition, CMS may deny funding to an otherwise qualified applicant on the basis of information found during a program integrity review regarding the applicant, its affiliates, or any other relevant individuals or entities. Applicants will be required to disclose any sanctions and investigations that have been

imposed on the applicant in the last three years by an accrediting body or state or federal government agency.

Applicants should use the review criteria information provided in Section VI, Application Review Information, to help ensure that the proposal adequately addresses all the criteria that will be used in evaluating the proposals.

CMS expects to receive proposals in the approximate range of $1million to $3 million as presented in Section III, Award Information.

## IV.3 System for Award Management Registration (SAM) Requirement

System for Award Management (SAM) Requirement: All applicants must provide their Data Universal Numbering System (DUNS) and Employee Identification Number/Tax Identification Number (EIN/TIN) numbers in order to be able to register in the System for Award Management (SAM)* https://www.sam.gov/portal/public/SAM/. Please see Appendix D for further information on SAM.

## IV.4 Cost Sharing or Matching

Cost sharing or matching is not required. Awardees may contribute funds or resources of their own including, but not limited to, in-kind contributions of allocated staff time from the awardee or its partners.

## IV.5 Foreign and International Organizations

Foreign and international organizations are ineligible to apply.

## IV.6 Faith-Based Organizations

Faith-based organizations are eligible to apply.

# V. APPLICATION AND SUBMISSION INFORMATION

## V.1 Address to Request Application Package

This Funding Opportunity Announcement serves as the application package for this cooperative agreement and contains all the instructions to enable a potential applicant to apply. The application should be written primarily as a narrative with detailed specific actions highlighted to emphasize the proposed activity of the applicant and include the standard forms required by the Federal government for all cooperative agreements.

# V.2 Application Content and Required Form Submission

## V.2.1 Letter of Intent to Apply

Applicants are highly encouraged to submit non-binding Letters of Intent to Apply (LOI). Letters of Intent to Apply provide information that helps CMS in determining expertise and personnel necessary to review applications and issue awards. To submit your TCPI Letter of Intent, please use the online submission form located at:

http://innovationgov.force.com/tcpiloi

Please refer to the Executive Summary related to the Letter of Intent due date.

## V.2.2 Application Materials

For application materials and guidance, refer to Appendix D. *Application and Submission Information*.

Application must be submitted in the required electronic-format at http://www.grants.gov no later than the established deadline date and time as listed in the Executive Summary.

Please refer to the Executive Summary for deadline date. If an applicant fails to submit all of the required documents or does not address each of the topics, the applicant risks not being awarded a cooperative agreement. See Section VI. Application Review Information.

All applications will receive an automatic time stamp upon submission and applicants will receive an email reply acknowledging the application's receipt. Applications not received by the application deadline through www.grants.gov will not be reviewed.

## V.2.3 Format Requirements of Application Submission

In order to ensure readability by reviewers, fairness in the review process, and consistency among applications, each application must include all content described below, in the order indicated, and in conformance with the listed specifications. Applications that do not follow these specifications will not be reviewed.

- Use 8.5" x 11" letter-size pages 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 inclusive of charts and tables.
- The project abstract summary is restricted to a one-page summary. The project abstract summary may be single-spaced.
- The project narrative of the application must be double-spaced. **This includes all components of the project narrative.**

- Charts and tables may be single-spaced. However, charts and tables should not be used to avoid the double-spaced narrative requirement.
- The budget narrative may be single-spaced.

## V.2.4 Overview of Cooperative Agreement Application Structure and Content

**Standard Mandatory Forms**

The following standard forms are found in the Grants Application Package at Grants.gov and must be completed with an electronic signature and submitted as part of the proposal:

a. SF 424: Official Application for Federal Assistance (see note below)
b. SF 424A: Budget Information Non-Construction
c. SF 424B: Assurances-Non-Construction Programs
d. SF LLL: Disclosure of Lobbying Activities

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

a. On Item 15 "Descriptive Title of Applicant's Project", state the specific cooperative agreement opportunity for which you are applying: Transforming Clinical Practices – Support and Alignment Network.

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

**Project Abstract Summary**

A one-page abstract should serve as a succinct description of the proposed project and should include the goals of the project, the total budget, the number of projected participants, and a description of how the funds will be used. The abstract is often distributed to provide information to the public and Congress, so please write the abstract so that it is clear, accurate, concise, and without reference to other parts of the application. Personally identifiable information should be excluded from the abstract. In the Grants Application Package that can be found at www.Grants.gov; select the TCPI Project Abstract Summary and complete the form.

**Project Narrative**

The project narrative is expected to address how the applicant will carry out the key functions of a Support and Alignment network. Chart 1 below repeats this list in tabular form and includes a brief description of the type of information that is required to be addressed within each specific section. The application must be limited to the topics covered in §I through IV in Chart 1 below, presented in the order specified. In the Grants Application Package that can be found at www.Grants.gov; select the Project Narrative Attachment Form and "Add Mandatory Project Narrative File". In addition to the Project Narrative, the uploaded file will include the Establish Clear Linkage of Proposed Work to Quantitative Results on Aim, Support and Alignment Networks (SANs) Achievement of Milestones, Data Strategy and Organizational Capacity and Project Management Plan as project narrative components.

**Budget Narrative**

The budget narrative should be developed and consistent with the SAN requirements. Overhead and administrative costs must be reasonable, with funding focused on supporting the SAN effort Please refer to Appendix C. *Sample Budget and Narrative Justifications*. Detailed costs and breakdown for each SF 424A line item are as follows:

1. Personnel costs (itemized)
2. Fringe benefit costs
3. Itemized description of contractors and/or vendor services and costs
4. Travel and training cost
5. Other costs please itemize
6. Indirect or overhead cost not itemized above
7. Total requested funding requested
8. Total cost-sharing (if any); identify the source(s) of other funding.

The SAN Budget Narrative can be found in the Grants Application Package at www.Grants.gov; select the Budget Narrative Attachment Form and "Add Mandatory Budget Narrative". Also must complete Standard form SF 424A.

**CHART 1: Application Package**

**The Following documents are required to be submitted with the application. Failure to submit these forms will result in an ineligible application that will not be reviewed.** (Refer to Appendix D. *Application and Submission Information*, Appendix E. *Application Check-Off List Required Contents* for complete list of required forms and documents and VI.1 Evaluation and Selection Criteria for content requirements).

| SAN APPLICATION PACKAGE | Evaluation Points |
|---|---|
| **I. Standard Forms**<br>**A. SF 424**<br>**B. SF 424A**<br>**C. SF 424B**<br>**D. SF LLL** | - |
| **II. TCPI Project Abstract Summary** | - |
| **III. Project Narrative (Includes A. – D. below)** | - |
| A. Establish Clear Linkage of Proposed Work to Quantitative Results on Aim | 25 |
| B. Support and Alignment Networks (SANs) Achievement of Milestones | 25 |
| C. Data Strategy | 20 |

| | |
|---|---|
| D. Organizational Capacity and Project Management Plan | 20 |
| **IV. SAN Budget Narrative** | 10 |
| **TOTAL** | 100 |

## V.3 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.

## V.4 Funding Restrictions

Indirect Costs

If requesting indirect costs, an Indirect Cost Rate Agreement will be required.

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

Direct Services

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

Reimbursement of Pre-Award Costs

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

Prohibited Uses of Cooperative Agreement Funds

- To match any other Federal funds.
- To provide services, equipment, or supports that are the legal responsibility of another party under Federal or State law (e.g., vocational rehabilitation or education services) or under any civil rights laws. Such legal responsibilities include, but are not limited to, modifications of a workplace or other reasonable accommodations that are a specific obligation of the employer or other party.
- To supplant existing State, local, or private funding of infrastructure or services, such as staff salaries, etc.

- To be used by local entities to satisfy State matching requirements.
- Award dollars cannot be used for specific components, devices, equipment, or personnel that are not integrated into the entire service delivery and payment model proposal.

# VI. APPLICATION REVIEW INFORMATION

In order to receive a cooperative agreement, organizations must submit an application in the required format, no later than the established deadline dates and times as listed in the Executive Summary. If an applicant fails to submit all of the required documents or does not address each of the topics described below, the applicant risks not being awarded a cooperative agreement.

As indicated in Section V. Application and Submission Information, all SAN applicants for TCPI awards must submit the following:

- Standard Forms
- Project Abstract Summary
- Project Narrative
  - Establish clear linkage of proposed work to quantitative results on aims
  - Support and Alignment Networks (SANs) achievement of milestones
  - Data strategy
  - Organizational capacity and project management plan
- Budget Narrative

## VI.1 Evaluation and Selection Criteria

This section fully describes the evaluation criteria for this cooperative agreement. In preparing applications, applicants should review the requirements detailed in Section II, Funding Opportunity Description. The application must be organized as detailed in Section V. Application and Submission Information, of this solicitation and follow the guidance found at V.2.3 Format Requirements of Application Submission.

The review criteria for SAN applications are based on a total of 100 points allocated across the following areas:

**Project Abstract Summary** **(Required)**
A one-page abstract should serve as a succinct description of the proposed project and should include the goals of the project, the total budget, and a description of how the funds will be used. The abstract is often distributed to provide information to the public and Congress, so please write the abstract so that it is clear, accurate, concise, and without reference to other parts of the application. Personally identifiable information should be excluded from the abstract. Applicant should use the Project Abstract Summary document that will be included in the application kit.

**Project Narrative** **(Required)**
The project narrative is expected to address how the applicant will carry out the design and planning work required to meet/exceed the TCPI goals. The application must be limited to the

topics covered below and presented in the order specified. The details of the applicant's response should include evidence of public and private payer participation.

**Establish clear linkage of proposed work to quantitative results on TCPI aims (25 points)**

CMS believes that SAN applicants will have many and diverse channels and approaches for contributing to progress on the TCPI aims outlined earlier in this funding opportunity announcement. It is critically important that SAN applicants provide clear linkages between proposed work activities and the projected impact of this work on TCPI aims and goals.

Key elements to include: (10 of 25 Points)

1. Each SAN applicant should outline the projected impacts of your proposed program of work in terms of the amount of the quantitative progress you are committing to generate in one (at a minimum) or all (ideally) of the following key dimensions:
    - Reduction of unnecessary testing and procedures
    - Improved clinical outcomes
    - Cost savings
    - Unnecessary hospitalizations avoided
    - Other key areas of alignment & projected quantitative benefits. Examples should include, but are not limited the following:
        - Numbers of clinicians recruited by your SAN to team with a PTN
        - Number of these recruited clinicians who stay in action with their PTN for all four years
        - Numbers of patients supported as active partners with the TCPI infrastructure including PTNs, SANs, and participating practices

2. Please provide estimates of projected impact in the above areas that are associated with the 12 month base period, and for the entire four year model. Express the projected impacts in quantitative terms, to the maximum extent possible. (10 of 25 Points)

3. Additionally, CMS believes that close working partnerships between Support and Alignment Networks and Practice Transformation Networks will be a key to the success of the initiative. Please outline the commitments your SAN would make to support PTNs, and to ensure the success of PTNs and their participating clinicians. (5 of 25 Points)

SAN applicants that align work plans with significant projected impacts in the most compelling ways will be the most competitive in this competition. Option year funding will be linked to the magnitude and attainment of projected impacts.

**Support and Alignment Networks (SANs) achievement of milestones (25 points)**

The TCPI Model has been designed to reflect a quality improvement base and a focus on complex adaptive learning in real time. The inclusion of best practices and tested actions that

have proven successful in moving practices to redesign their care delivery system both internally and through effective collaboration across the community of practice with system administrators, primary and specialty care practitioners, payers, private partners, and local organizations will be shared as a TCPI resource.

A key pillar of successful implementation is the establishment of bold goals and related aims to be defined and focusing the funded infrastructure on the "what needs to be accomplished" and enabling creativity in the "how to accomplish". Applicants should use evidence and partner experience to define their responses.

The purpose of this section is to guide applicants in detailing the number and types of key actions they are committing to undertake in order to achieve progress on the aims of the overall initiative. Some milestones may not apply to all SAN applicants, if this is the case, please note "Not Applicable" for that particular milestone. Additional milestones may be added by individual SAN applicants to reflect key actions they will take to achieve the aims of the initiative. Applicants should be specific in their responses.

Details should be provided and aligned to actions and progress to be achieved during the base Period (within the first 12 months of the award) and by the end of the four year model.

1. Ensure alignment of National Support Contractor (NSC) content with national evidence-based guidelines of care and best practices;
2. Promote evidence-based quality measures that can be collected via registries and EHRs;
3. Ensure alignment with other public and private entities working in the area of quality improvement and transformation including Quality Improvement Organizations (QIOs);
4. Ensure their support is in alignment with PTNs and participating practices within the context of their medical neighborhoods and communities;
5. Promote rural and urban clinician participation in TCPI and work to sustain their active engagement over the life of the model;
6. Support their members and practices in work to reduce unnecessary testing and procedures;
7. Incorporate TCPI-related content into continuing medical education and ongoing clinician training programs as appropriate;
8. Incorporate TCPI- related content into maintenance of certification requirements as appropriate;
9. Support and assist patient and family engagement in care;
10. Mobilize professional community on improvement topics/goals;
11. Publicize and call attention to best practices and results of high performing practices in the TCPI;
12. Focus on specialty topics by providing high quality advice and guidelines to practices about these "specialty" conditions and how to manage them appropriately (e.g. primary care providers work with diabetes, patients with hypertension, cancer, gastrointestinal problems and heart disease);
13. Interface with specialists directly either specialists alone or with specialists as part of embedded primary care practices (e.g. gastroenterologists, cardiologists, and

endocrinologists) to assist with registry data - for example, to improve quality which should overlap with aspects of Choosing Wisely;

14. Offer generative ideas to create, improve, and expand specialists interaction with primary care providers to make these relationships work better in the community; and
15. Use their unique and established channels (peer reviewed journals, registries, annual conferences, task forces, newsletters, etc.) with members to support action and results on the initiative.

**Data Strategy** **(20 points)**

Each SAN applicant will be responsible for monitoring, evaluating, and reporting on the progress and impact of their improvement model goals and success each quarter. In this section, the applicant should clearly define the ways in which results can be seen utilizing their proposed data system structure. The details of this structure shall be included in the measurement strategy methodology. The flow of data needs to align with the overall TCPI goals and milestones to include sharing of results on a quarterly basis. The SANs are expected to use this data to continue internal improvement and implement adaptive mechanisms to further advance clinicians and practices through the Phase of Practice Transformation, achieving the goals and milestones of TCPI. SANs will support clinicians in aligning their practice delivery actions to national standards and guidelines, and support their learning to adapt to the changes that they will work to incorporate into specialty board exams and certification, to the extent they determine appropriate. In addition to this on-going self-evaluation, CMS contractors will also conduct an independent evaluation. These evaluations will be used in determining the SANs' eligibility for further funding.

The applicant should address the TCPI data strategy overview above and utilize a display in the application that in a summary manner defines systems, methods, improvement goals, and the time that each of the proposed goals will be achieved. Additional outcome goals are recommended and may be added by the applicants. The goals should have both qualitative and quantitative metrics.

**The following chart is the recommended format for providing a summary response to the items.** It would complement additional detail included in the narrative response to this section.

| Measure | Improvement Goals | Projected Timeline when the Improvement Goal will be met or exceeded |
|---|---|---|
| Demonstrate improvement in the aggregate increase in number of clinician members supported | | |
| Demonstrate improvement achieved through implementation of alignment activities conducted with clinicians and their practices | | |

| | | |
|---|---|---|
| Demonstrate improvements that facilitate primary and specialty care clinicians' integration of patient and family engagement and other outreach efforts. (this should be a list of at least 7 examples) | | |
| Achievement of anticipated cost reductions from unnecessary testing & procedures | | |

**Organizational Capacity and Project Management Plan** **(20 points)**

Provide a project plan and timeline for completing proposed SAN deliverables. Describe the applicant's strategy for completing the work necessary to develop and deliver a SAN that will support clinicians and practices in achieving the TCPI aims. Provide clear, measureable SAN milestones that are aligned with quantitative progress toward the TCPI goals and that address the commitments made in the application. The staff or consultants proposed to lead the planning effort should have the skills and experience needed to ensure smooth and effective implementation.

**Budget Narrative Attachment Form** **(10 points)**

The proposed budget is carefully developed and consistent with the SAN requirements. Overhead and administrative costs are reasonable, with funding focused on supporting the SAN effort. **Applicant provides a narrative response and completes the budget table formats provided in Appendix C.** ***Sample Budget and Narrative Justifications.*** Specifically, the budget includes:

1. Personnel costs (itemized)
2. Fringe benefit costs
3. Itemized description of contractors and/or vendor services and costs
4. Travel and training cost
5. Other costs please itemize
6. Indirect or overhead cost not itemized above
7. Total requested funding requested
8. Cost sharing (if any); identify the source of other funding.

Budget Narrative must be included in the application submitted to Grants.gov and should correspond directly with figures provided on Standard Form 424A. Failure to submit the budget narrative will result in an ineligible application that will not be reviewed.

## VI.2 Review and Selection Process

A team consisting of qualified experts will review the applications to assess the applicant's readiness to engage in the work required for Support and Alignment Network proposals. CMS

will work closely with the applicant to determine the appropriate funding amount. The review process will include the following:

- Applications will be screened for completeness and adherence to eligibility requirements. **Applications received late or that fail to meet the eligibility requirements detailed in this solicitation or do not include the required forms will not be reviewed.**
- The review panel will assess each eligible application to determine the merits of the proposal and the extent to which the proposed model furthers the purposes of the SAN. In addition to the review panel, CMS will provide an assessment of the applicant's readiness to conduct the work required. CMS reserves the right to request that applicants revise or otherwise modify their proposals and budget based on the staff or review panel recommendations.
- CMS reserves the right to negotiate proposals with the applicants.
- The results of the objective review of the applications by qualified experts will be used to advise the CMS approving official. Final award decisions will be made by a CMS approving official. In making these decisions, the CMS approving official will take into consideration: recommendations of the review panel; the readiness of the applicant to conduct the work required; the scope of overall projected impact on the aims; reviews for programmatic and grants management compliance; the reasonableness of the estimated cost to the government and anticipated results; and the likelihood that the proposed project will result in the benefits expected.
- Successful applicants will receive one cooperative agreement award issued under this announcement. CMS reserves the right to approve or deny any or all proposals for funding. Note that section 3021 of the Affordable Care Act establishes title XI, §1115A of the Social Security Act, which creates the Center for Medicare and Medicaid Innovation (CMMI). Section 1115A(d)(2) states that there is no administrative or judicial review of the selection of organizations, sites, or participants to test models.

## VI.3 Anticipated Announcement and Award Dates

Please refer to the Executive Summary.

# VII. AWARD ADMINISTRATION INFORMATION

## VII.1 Award Notices

Successful applicants will receive a Notice of Award (NoA) signed and dated by the CMS Grants Management Officer that will set forth the amount of the award and other pertinent information. The award will also include standard Terms and Conditions, and may also include additional specific cooperative agreement terms and conditions. Potential applicants should be aware that special requirements could apply to cooperative agreement awards based on the particular circumstances of the effort to be supported and/or deficiencies identified in the application by the review panel.

The NoA is the legal document issued to notify the awardee that an award has been made and that funds may be requested from the HHS payment system. The NoA will be sent electronically

to the Authorized Official and awardee organization as listed on its SF 424. Any communication between CMS and awardees prior to issuance of the NoA is not an authorization to begin performance of a project.

Unsuccessful applicants will be notified by letter, sent electronically to the Authorized Official as listed on its SF 424.

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

## VII.2 Administrative and National Policy Requirements

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

- Specific administrative requirements, as outlined in 2 CFR Part 225 and 45 CFR Part 92, apply to cooperative agreement awarded under this announcement.
- All awardees under this project must comply with all applicable Federal statutes relating to nondiscrimination including, but not limited to:
    - Title VI of the Civil Rights Act of 1964,
    - § 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.

## VII.3 Reporting (Frequency and Means of Submission)

The CMS Center for Clinical Standards and Quality and the CMS Innovation Center will take an active and substantial role in the management, implementation, evaluation, and monitoring of SAN awards. The activities funded under the cooperative agreement and their resulting recipient responsibilities will be part of performance tracking, measuring, and evaluation responsibilities of CMS. CMS will examine how the organizations that receive SAN funds used the money. Quality data will be collected from the SAN and reported to a CMS contractor on a quarterly basis, but should be maintained by the SAN with monthly results.

### VII.3.1 Progress Reports

Awardees must agree to cooperate with any Federal evaluation of the model and performance results and provide required monthly, quarterly, semi-annual (every six months), annual and final (at the end of the cooperative agreement period) reports in a form prescribed by CMS. Reports will be submitted electronically. These reports will include how cooperative agreement funds

were used, describe project or model progress, and describe any barriers, delays, and measurable outcomes. CMS will provide the format for project and model reporting and technical assistance necessary to complete required report forms. Awardees must also agree to respond to requests that are necessary for the evaluation of the Model Design and/or Model Testing efforts and provide data on key elements of model performance and on results from the cooperative agreement activities.

### VII.3.2 **Project Monitoring**

CMS will enlist a third party entity to assist CMS in monitoring the SAN performance results and outcomes. CMS plans to collect data elements to be part of monitoring for all of the different SANs, and these monitoring and surveillance elements will feed into the evaluation. All awardees will be required to cooperate in providing the necessary data elements to CMS or a CMS contractor. The contractor would assist CMS in developing appropriate monitoring protocols and tracking performance across awardees and providing for rapid cycle evaluation and early detection of model performance problems, including coordination between awardees and CMS and its other contractors.

### VII.3.3 **Evaluation**

The goal of the measurement and ability to reach TCPI goals will include use of a core set of measures to inform monitoring, evaluation, and performance improvement across all clinician practices participating in TCPI, in addition to a menu set of measures that can allow for practice and/or region specific measures to drive improvement on a local level. These will likely include measures consistent with the Million Hearts™ initiative and American Board of Internal Medicine's (ABIM) Choosing Wisely® Initiative.

SAN awardees will be responsible for monitoring, evaluating, and reporting on the progress and impact of their improvement model goals and success each quarter. The SANs are expected to use this data to continue internal improvement and implement adaptive mechanisms to further advance clinicians and practices through the Phase of Transformation, achieving the goals of TCPI. In addition to this self-evaluation, CMS contractors will conduct an independent evaluation. These evaluations will be used in determining the SANs' eligibility for further funding. SANs will support primary and specialty care clinicians with tailored services. SANs will support clinicians in aligning their practice delivery actions to national standards and guidelines, and support their learning to adapt to the changes that they will work to incorporate into specialty board exams.

A. SANs aligned in actions toward progress to be achieved during the base Period (within the first 12 months of the award) and by the end of the four year Model. (See Section V.4)

B. Additional Monthly and Quarterly
    1. Support SAN members, consumers, practices and/or others in work to reduce unnecessary testing and procedures;
    2. Incorporate TCPI-related content into continuing medical education programs as appropriate;

3. Ensure leadership and collaboration in the fomenting and fostering support to integrate patient and family engagement and measurement in the transformed care delivery system;
4. Mobilize professional community on improvement topics/goals;
5. Publicize and call attention to best practices and results of high performing practices in the TCPI; and
6. Use SAN's unique and established channels with members (peer reviewed journals, registries, annual conferences, task forces, newsletters, etc.) to support action and results of the model.

### VII.3.4 Federal Financial Report

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

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

In addition to submitting the quarterly FFR to PMS, Grantees must also provide, on an annual basis, a report to be uploaded into Grant Solutions which includes their expenditures and any program income generated in lieu of completing a Financial Status Report (FSR) (SF269/269A). Expenditures and any program income generated should only be included on the annually submitted FFR, as well as the final FFR. Annual hard-copy FFRs should be mailed and received within 30 calendar days of the applicable year end date. The final FFR should be uploaded in Grants Solutions within 90 calendar days of the project period end date.

More details will be outlined in the Notice of Award.

### VII.3.5 Transparency Act Reporting Requirements

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

### VII.3.6 Audit Requirements

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

### VII.3.7 Payment Management Requirements

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

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

## VII.4 Terms and Conditions

Cooperative agreements issued under this FOA are subject to the *Health and Human Services Grants Policy Statement (HHS GPS)* at http://www.hhs.gov/grantsnet/adminis/gpd/. Standard Terms and Special Terms and Program Specific Terms and Conditions (including the awardee commitments listed below) 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).

**Support and Alignment Network Commitments**

All Support and Alignment Network awardees will be expected to commit to, and will be held accountable for, the following list of commitments. Failure to meet these may result in termination of the award or option year funding.

| Support and Alignment Network Commitments |
|---|
| **Application** |
| 1. Commit to the Aims of the TCP Initiative, together with specific targets and milestones on aim achievement. (Option year funding will be tied to these milestones and targets). |
| 2. Ensure and document alignment with other public and private entities working in the area of quality improvement and transformation including Quality Improvement Organizations (QIOs). |
| **Pre-Award** |
| 1. Promote small practices, practices located in rural areas, and practices caring for medically underserved populations to participate in TCPI and work to sustain their |

| |
|---|
| active engagement over the life of the model. |
| **Within 90 Days of Award** |
| 1. Ensure alignment of National Support Contractor (NSC) content with national evidence-based guidelines of care and best practices. |
| 2. Promote evidence-based quality measures that can be collected via registries, EHRs, or other approved methods of transmitting data. |
| **Monthly/ Quarterly** |
| 1. Support PTN and SAN members, consumers, practices and/or others in work to reduce unnecessary testing and procedures. |
| 2. Incorporate TCPI-related content into continuing medical education programs, in the SAN's discretion and if determined appropriate. |
| 3. Ensure leadership and collaboration in the fomenting and fostering support to integrate patient and family engagement and measurement in the transformed care delivery system; |
| 4. Mobilize professional community on improvement topics/goals; |
| 5. Publicize and call attention to best practices and results of high performing practices in the TCPI; and, |
| 6. Use SAN's unique and established channels with members (peer reviewed journals, registries, annual conferences, task forces, newsletters, etc.) to support action and results of the model, in the SAN's discretion and if determined appropriate. |
| **Annually** |
| 1. Incorporate TCPI- related content into maintenance of certification requirements, in the SAN's discretion and if determined appropriate. |

# VIII. Agency Contacts

## VIII.1 Programmatic Contact Information:

All programmatic questions about the Transforming Clinical Practice must be directed to the program email address: transformation@cms.hhs.gov. This email address is constantly monitored, and a response to questions will be provided within 48 business hours. If a response to a question is not provided within the designated timeframe, the submitter may direct a follow-up question to:

LT Fred Butler Jr.
Centers for Medicare & Medicaid Services
Center for Medicare and Medicaid Innovation and
Center for Clinical Standards and Quality
Quality Improvement and Innovation Models Testing Group
fred.butler@cms.hhs.gov

## VIII.2 **Administrative Questions**

Administrative questions about the Transforming Clinical Practice Initiative model may be directed to:

Angela Reviere
Grants Management Specialist
Centers for Medicare & Medicaid Services
Office of Acquisitions and Grants Management
TCPI@cms.hhs.gov

# Appendix A. Example of measures to be considered for PTN performance improvement and model evaluation

Note: These are important for the SANs to be aware of as they move to continuously align with the PTN and overall TCPI model.

| TCPI Domain | Measure Under Consideration | Alignment with other CMS\HHS programs | Operational in 2015/Mechanism for Reporting |
|---|---|---|---|
| **Quality** | Controlling High Blood Pressure for Hypertensive (NQF 018) | EHR Incentive Program, PQRS, Medicaid Adult Core Set | Certified EHR technology or registry |
| | Preventive Care and Screening : High Blood Pressure | PQRS | Certified EHR technology or registry |
| | Preventive Care and Screening: Cholesterol – Fasting and Low Density Lipoprotein (LDL) Test Performed AND Risk Stratified Fasting LDL | EHR Incentive Program, PQRS | Certified EHR technology or registry |
| | Achieving cholesterol at goal (MU eCQM) | EHR Incentive Program, PQRS | Certified EHR technology |
| | Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic (NQF 0068) | EHR Incentive Program, PQRS | Certified EHR technology or registry |
| | Ischemic Vascular Disease (IVD): Complete Lipid Panel and Low Density Lipoprotein (LDL-C) Control (NQF 0075) | EHR Incentive Program, PQRS | Certified EHR technology or registry |
| | Diabetes A1c control (NQF 59) | EHR Incentive Program, PQRS, Medicaid Adult Core Set | Certified EHR technology or registry |
| | Diabetes LDL-C screening | Medicaid Adult Core Set | |
| | Tobacco use: screening and cessation intervention (adults) (NQF 0028) | EHR Incentive Program, PQRS, Medicaid Adult Core Set, | Certified EHR technology or registry or Survey data |
| | Screening for Clinical Depression and Follow-up Plan | Medicaid Adult Core Set | Multi-payer claims |
| | Antidepressant Medication Management | Medicaid Adult Core Set | Multi-payer claims |
| | Depression Response at Twelve Months- Progress Towards Remission | EHR Incentive Program, PQRS | Certified EHR technology or registry Patien Reported Outcome |
| | Follow-Up After Hospitalization for Mental Illness | Medicaid Adult Core Set, Medicaid Child Core Set | Multi-payer claims or other data |
| | Follow-Up care for children prescribed attention deficit hyperactivity disorder (ADHD) medication | Medicaid Child Core Set | |
| | Behavioral Health Risk Assessment for Pregnant Women | Medicaid Child Core Set | |

| | | | |
|---|---|---|---|
| | Timeliness of Prenatal Care | Medicaid Child Core Set | |
| | Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents. | Medicaid Child Core Set | |
| | Childhood immunization status | Medicaid Child Core Set | |
| | Developmental Screening in 1st 3 years of life | Medicaid Child Core Set | |
| | Human Papillomavirus Screening (HPV) Vaccine for female adolescents | Medicaid Child Core Set | |
| | Medication Management for People with Asthma | Medicaid Adult Core Set, Medicaid Child Core Set | |
| | Hospital 30-day Risk-standardized Acute Myocardial Infarction (AMI) Mortality eMeasure | PQRS, EHR Incentive Program | Certified EHR technology or registry |
| | Asthma control measure (PRO)* | | Possibly through EHRs |
| | Appropriate Antibiotic Use in Ear Infections | EHR Incentive Program, Choosing Wisely | Certified EHR technology or registry |
| | Adult Body Mass Index (BMI) Assessment | Medicaid Adult Core Set | Multi-payer claims or other data |
| | Flu Shots for Adults 50 to 64 | Medicaid Adult Core Set | Survey data or other data |
| | Breast Cancer Screening | Medicaid Adult Core Set | Multi-payer claims or other data |
| | Cervical Cancer Screening | Medicaid Adult Core Set | Multi-payer claims or other data |
| | Chlamydia Screening in Women 21 to 24 | Medicaid Adult Core Set, Medicaid Child Core Set | Multi-payer claims or other data |
| | Postpartum Care rate | Medicaid Adult Core Set | Multi-payer claims or other data |
| | Medication Persistence Ratio | UNK | Multi-payer claims |
| | Annual Monitoring for Patients on Persistent Medications | Medicaid Adult Core Set | Multi-payer claims |
| | | | |
| **Utilization** | All Cause 30 Day Readmission Rate | PQRS, CMMI evaluation Medicaid Adult Core Set | Medicare claims |
| | AHRQ PQI 01: Diabetes Short-Term Complications Admission Rate | Medicaid Adult Core Set | Multi-payer claims |
| | AHRQ PQI 05: Chronic Obstructive Pulmonary Disease (COPD) Admission Rate | Medicaid Adult Core Set | Multi-payer claims |
| | AHRQ PQI 08: Congestive Heart Failure (CHF) Admission Rate | Medicaid Adult Core Set | Multi-payer claims |
| | AHRQ PQI 15: Adult Asthma Admission Rate | Medicaid Adult Core Set | Multi-payer claims |
| | CHF Readmission Rate | | Medicare claims |
| | Asthma specific ED measure | | Multi-payer claims |
| | All-Cause Unplanned Admissions for Patients with Diabetes | PQRS | PQRS claims |

| | | | |
|---|---|---|---|
| | All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions | PQRS | Medicare claims |
| | Ambulatory Care Sensitive hospitalizations | AHRQ, CMMI evaluation | Medicare claims |
| | Overuse of Diagnostic Imaging for Uncomplicated Headache | PQRS, EHR Incentive Program, Choosing Wisely | Certified EHR technology or registry |
| | Appropriate Use of DXA Scans in Women Under 65 Who Do Not Meet the Risk Factor Profile | PQRS and EHR incentive Program | Certified EHR technology or registry |
| | Appropriate use of imaging for non-traumatic knee pain | PQRS, similar to Choosing Wisely | TBD |
| | Appropriate use of imaging for non-traumatic shoulder pain | PQRS, similar to Choosing Wisely | TBD |
| | Adolescent Well Care Visit | Medicaid Child Core Set | |
| | Well-Child Visits in the 1st 15 Months of Life | Medicaid Child Core Set | |
| | Well Child Visits in the 3rd, 4th, 5th, and 6th Years of Life | Medicaid Child Core Set | |
| | Frequency of Ongoing Prenatal Care | Medicaid Child Core Set | |
| **Cost** | Total Medicare Costs (PBPM) | CMMI evaluation | Medicare claims |
| **Patient Experience** | Patient satisfaction and access | PCMH CAHPS | CAHPS survey via TBD contractor |
| | Patient Activation Measures | Community-based Care Transition Program | PAM tool via TBD contracto |
| | Access to Primary Care Practitioners | Medicaid Adult Core Set, Medicaid Child Core Set | |

# Appendix B. Practice Transformation Networks (PTNs) will be responsible for the following activities:

- **Recruiting clinician practices and building strategic partnerships**
  - Perform environmental scans to identify and collaborate with community partners that can help to achieve common goals;
  - Collaborate with partners such as QIOs to ensure clinician/practice readiness;
  - Recruit clinicians/practices to participate in the Practice Transformation Networks;
    - Emphasize the recruitment of clinicians/practices with the greatest need for technical assistance
    - Emphasize the recruitment of clinicians serving in:
      - Medically underserved areas [including those practicing in community, migrant, and Indian health centers]),
      - Healthcare provider shortage areas,
      - Rural areas [including rural health clinics, rural community health centers and Indian Health Centers], and
      - Small, rural practices of nine or fewer clinicians.
  - Develop collaborative relationships with purchasers and payers to facilitate multi-payer alignment of financial incentives, quality measures, and model methods;
  - Collaborate with states (including public health and mental health agencies) community based organizations, and private entities that are participating in transformation activities to ensure synergy and prevent duplication; and
  - Develop effective partnerships among clinicians and their respective patients/families.

- **Serving as champions for continuous improvement and culture change**
  - Support culture change in clinician practices through engaged leadership, team building, and patient engagement;
  - Identify top-performing practices in the network and showcase their work to network members;
  - Provide ongoing coaching, facilitation and technical assistance to practices;
  - Disseminate and spread quality improvement (QI) and change methodologies, tools, published literature, best practices and lessons learned on practice transformation; and
  - Create community based peer groups that can share QI resources and expertise to improve specific aspects of their practices and coordinate care in a common medical neighborhood, achieving measurable improvements in care and efficiency through rapid cycle evaluation:
    - Improve partnerships among primary and specialty care clinicians that support their medical neighborhood.
    - Integrate local and community resources with team-based care that supports access to care and patient self-management support.

- **Facilitating improved clinical practice management**
  - Identify ways clinician practices can improve quality and access to care.
    - Provide training to clinician practices on how to establish care plans that are sensitive to the language, values, and culture of their patients with complex care

needs while promoting self-management and shared decision-making with patients and their family members;
- Provide exposure to new systems of care and alternative payment models;
- Coach practices to optimize scheduling so that same day appointments can be offered and after-hours access to clinician advice is available; and
- Offer information regarding certification and training requirements as well as CMS program requirements, and ways in which clinicians may effectively meet them.

- Connect primary care practitioners (PCP) with specialty and ancillary providers in their medical neighborhood that can serve their patient panel;
  - Expand the capacity for team-based practice and optimal integration of non-physician practitioners (including nurse practitioners, physician assistants, clinical pharmacists) into care teams;
  - Promote the use of tools specific to primary and specialty care coordination, such as formalized agreements for care coordination, referrals and co-management plans that clearly specify roles, responsibilities and expectations in care planning and management across practices (e.g. timely communication of test results and exchange of clinical information with patients and other providers);
  - Provide information to clinician practices on planning for and facilitating transitions of their patients across care settings and time, including the transfer from pediatric to adult practices; and
  - Explore the use of patient navigators, parent partners, and peer support services in effecting patient engagement and care coordination.
- Use technology to enhance the effective use of administrative, financial, and clinical systems
  - Offer frequent webinars on a variety of quality improvement topics and practices; for example, webinars showing providers how to use clinical and other data to risk stratify their population and identify patients at high-risk for hospitalization or complications from chronic conditions, and instruction on how to perform timely interventions and monitoring.

- **Using quality measures and data for improvement**
  - Support improvement on a core set of clinical, operational, quality, and care experience measures;
  - Facilitate practice data reporting as needed, especially for clinicians in small practices or rural settings who may require additional assistance from their PTN;
  - Use practice data for clinical and operational quality improvement, improve practice flow and care management, and identify methods to reduce health care disparities;
  - Provide ongoing monitoring and feedback regarding participating practice performance based on the data; and,
  - Promote the interoperability and effective use of registries, EHRs, and other practice management systems, while maintaining privacy and security of patient health information, to improve coordination of care delivery between primary and specialty practices, facilitating improved patient outcomes.

**Funding Targeted to Applicants that Commit to Specific Results**

Although the awards under this FOA are for a four-year period of performance, CMS is interested in sustainability beyond the initial period of federal investment. CMS is interested in information regarding sustainability, such as evidence of public-private partnerships or shared savings agreements directly with other payers. PTNs that support specialty care practices must explain in their applications their plans, milestones, and aims for how the specialists would reduce unnecessary testing and procedures.

CMS is interested in funding Practice Transformation Networks who will commit to:

- Pursue and achieve the aims of the initiative;
- Ensure support from a robust number of practices willing to participate with the network, including a minimum of 20% of clinicians from small, rural and/or practices that serve medically underserved populations;
- Conduct pre-assessment and on-going assessment of the practice's clinical and operational health;
- Engage practice leadership to commit to the goals of TCPI and to dedicate a specific improvement team of individuals;
- Participate in PTN-based and national TCPI training events;
- Project clinician enrollment and achievement targets aligned with the TCPI model aims;
- Develop collaborative relationships with purchasers and payers to facilitate multi-payer alignment of financial incentives, quality measures, and model methods;
- Serve as champions for both continuous improvement and culture change through engaged leadership, team building, and patient engagement;
- Receive and utilize monthly reporting of results/outcomes from clinicians/practices for quality improvement, supported health care delivery systems of for quality improvement, with an intent to converge on core clinical, operational process and outcome, and financial measures over time;
- Collaborate with partners such as other PTNs, QIOs, states (e.g. public health and mental health agencies), rural communities and private entities that are participating in transformation activities to ensure synergy and prevent duplication;
- Provide data to CMS about the clinicians and their practices' performance;
- Work with clinician practices they serve to ensure compliance with HIPAA;
- Continuously assess patients/families' care experiences;
- Leverage tele-health and other technology to enhance care coordination and link rural participants with more distant urban specialists;
- Provide ongoing coaching, facilitation and technical assistance to practices;
- Disseminate and spread quality improvement and change methodologies, tools, published literature, best practices and lessons learned on team-based care delivery and other aspects of practice transformation;
- Conduct regular, rapid small tests of change as part of Quality Improvement work;
- Create community-based peer groups that can share QI resources and expertise to improve specific aspects of their practices and to coordinate care in a common medical neighborhood, achieving measurable improvements in care and efficiency through rapid cycle evaluation;

- Facilitate improved clinical practice management by connecting primary care practitioners (PCP) with specialty and ancillary providers in their medical neighborhood that can serve their patient panel and by encouraging the use of tools specific to primary and specialty care coordination, such as formalized agreements for care coordination, referrals and co-management plans that clearly specify roles, responsibilities and expectations in care planning and management across practices;
- Use data and results for improvement on a core set of clinical and operational quality measures (improve practice flow and care management, quality and care experience);
- Provide ongoing monitoring and feedback regarding participating practice performance to improve coordination of care delivery between primary care and specialty practices, facilitating improved patient outcomes; and
- Sustain practice changes and improvements beyond the formal clinician engagement.

# Appendix C. Sample Budget and Narrative Justifications

## Detailed Budget and Expenditure Plan

All applicants must submit a Form SF 424A and Budget Narrative Attachment Form. For this cooperative agreement the application must include budgets for each year. Project proposals should include leveraging other funding resources, including private payers, foundations, and internal funding. Overhead and administrative costs must be reasonable, with a strong focus on operational implementation of the model. Budget and Expenditure Plans should include the cost of data collection, performance monitoring, and project expenditure reporting.

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 entire project period. Specifically the Budget Narrative should provide a detailed cost breakdown for each line item outlined in the SF 424A by year, including a breakdown of costs for each activity/cost within the line item. The Budget Narrative should reflect the organization's readiness to receive funding, providing 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.

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

<u>Section A – Budget Summary</u>

- *Grant Program Function or Activity* (column a) = Enter "Transforming Clinical Practices – Practice Transformation Networks" in row 1.
- *New or Revised Budget, Federal* (column e) = Enter the Total Federal Budget Requested for the project period in rows 1 and 5.
- *New or Revised Budget, Non-Federal* (column f) = Enter Total Amount of any Non-Federal Funds Contributed (if applicable) in rows 1 and 5.
- *New or Revised Budget, Total* (column g) = Enter Total Budget Proposed in rows 1 and 5, reflecting the sum of the amount for the Federal and Non-Federal Totals.

<u>Section B – Budget Categories</u>

- Enter the total costs requested for each Object Class Category (Section B, number 6) for each year of the 4-year project period. A fifth budget period may be included for data reporting.
- Column (1) = Enter the heading for this column as Year 1. Enter Year 1 costs for each line item (rows a-h), including the sum of the total direct charges (a-h) in row i. Indirect

charges should be reflected in row j. The total for direct and indirect charges for all year 1 line items should be entered in column 1, row k (sum of row i and j).

- Column (2) = Enter the heading for this column as Year 2 (as applicable). Enter Year 2 costs for each line item (rows a-h), including the sum of the total direct charges (a-h) in row i. Indirect charges should be reflected in row j. The total for direct and indirect charges for all year 2 line items should be entered in column 2, row k (sum of row i and j).
- Column (3) = Enter the heading for this column as Year 3 (as applicable). Enter Year 3 costs for each line item (rows a-h), including the sum of the total direct charges (a-h) in row i. Indirect charges should be reflected in row j. The total for all year 3 line items should be entered in column 3, row k (sum of row i and j).
- Column (4) = Enter the heading for this column as Year 4 (as applicable). Enter Year 4 costs for each line item (rows a-h), including the sum of the total direct charges (a-h) in row i. Indirect charges should be reflected in row j. The total for all year 4 line items should be entered in column 3, row k (sum of row i and j).
- Column 6 = Enter total costs for all four years of the project period for each line item (rows a-h), direct total costs (row i), and indirect costs (row j). The total costs for all line items for the three years should be entered in row k (sum of row i and j). The total in column 6, row k should match the total provided in Section A – Budget Summary, New or Revised Budget, column g, row 5.

Allowable Costs

Allowable costs include (but are not limited to):

- Contractors to facilitate and support meeting model aims through learning and improvement activities built from the TCPI Change Package concepts and best practices
- (e.g., webinars, meetings, workgroups)
- Staff participation and travel to learning collaboratives and workshops and other learning and diffusion opportunities. All travel must include information as to who is traveling, where, flight or mileage, per diem, hotel, etc. Information as to how the travel is necessary to achieve the goals of the program must be included.
- Data collection and cost and utilization pattern analysis
- Performance measure development and evidence-based improvement.
- Business process analysis and requirement system analysis

**Detailed costs and breakdown for each SF 424A line item:**

### A. Personnel:

An employee of the applying agency whose work is tied to the application

**Table 1: FEDERAL REQUEST**

| Position | Name | Annual Salary/Rate | Level of Effort | Cost |
|---|---|---|---|---|
| Program Director | John Doe | $150,000 | 10% | $15,000 |
| Project Coordinator | To be selected | $50,000 | 100% | $50,000 |
| | | | TOTAL | $65,000 |

**NARRATIVE JUSTIFICATION:** Enter a description of the Personnel funds requested and how their use will support the purpose and goals of this proposal. Be sure to describe the role, responsibilities and unique qualifications of each position. For each requested position, provide the following information: name of staff member occupying the position, if available; annual salary; percentage of time budgeted for this model; total months of salary budgeted; and total salary requested.

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 ($181,500/year).

**FEDERAL REQUEST** (enter in Section B column 1 line 6a of form SF424A for year 1): **$65,000**

### B. Fringe Benefits

Fringe benefits may include contributions for social security, employee insurance, pension plans, etc. Only those benefits not included in an organization's indirect cost pool may be shown as direct costs. If a fringe benefit rate is not used, itemize how the fringe benefit amount is computed. List all components of fringe benefits rate.

**Table 2: Federal Request**

| Component | Rate | Wage | Cost |
|---|---|---|---|
| FICA | 7.65% | $65,000 | $4,973 |
| Workers | 2.5% | $65,000 | $1,625 |

| Component | Rate | Wage | Cost |
|---|---|---|---|
| Compensation | | | |
| Insurance | 10.5% | $65,000 | $6,825 |
| | | TOTAL | $13,423 |

**NARRATIVE JUSTIFICATION:** Enter a description of the Fringe funds requested, how the rate was determined, and how their use will support the purpose and goals of this proposal.

**FEDERAL REQUEST** (enter in Section B column 1 line 6b of form SF424A)**: $13,423**

**C. Travel:**

Explain need for all travel. The lowest available commercial fares for coach or equivalent accommodations must be used. Do not exceed GSA rates.

1. Elaborate and justify the necessity of the travel/training/conference.
2. For each occurrence, please provide the following:
    - A copy of the agenda/training syllabus.
    - Identify which staff will be traveling.
    - How will this travel/conference/training impact the implementation of the model? Is it necessary to implement the award?
    - Travel costs (mileage, flight, hotel, and per diem), etc.
3. What evaluation mechanism will be used to determine the impact of this training/conference on the outcomes of the award?

If approved, a conference summary is required 30 days after the meeting date. A summary should respond to the following questions:

1. As a result of this training/conference, the following impact was made on our project:
2. We anticipate these changes will affect our outcomes in the following ways (describe anticipated changes in the following areas):
3. The annual report should include follow-up information as to whether or not these changes were realized.

**Table 3: Federal Request**

| Purpose of Travel | Location | Item | Rate | Cost |
|---|---|---|---|---|
| Patient Visits | Neighboring | Mileage= | $.056 x 2 persons | $400 |

| Purpose of Travel | Location | Item | Rate | Cost |
|---|---|---|---|---|
| | areas of XXX | | | |
| Training (name) | Chicago, IL | Airfare | $200/flight x 2 persons | $400 |
| | | Hotel | $140/night x 2 persons x 3 nights | $800 |
| | | Per Diem (meals) | $49/day x 2 persons x 4 days | $400 |
| | | | TOTAL | $2,000 |

**NARRATIVE JUSTIFICATION**: Describe the purpose of travel and how costs were determined. See below CMS travel/conference guidelines.

**FEDERAL REQUEST** (enter in Section B column 1 line 6c of form SF424A): **$2,000**

**D. Equipment:**

Permanent equipment is defined as nonexpendable personal property having a useful life of more than one year and an acquisition cost of $5,000 or more. If applicant agency defines "equipment" at lower rate, then follow the applying agency's policy.

**Table 4: Federal Request**

| Item(s) | Rate | Cost |
|---|---|---|
| None | | 0 |
| | TOTAL | |

**NARRATIVE JUSTIFICATION**: Enter a description of the Equipment and how its purchase will support the purpose and goals of this proposal.

**FEDERAL REQUEST** (enter in Section B column 1 line 6d of form SF424A): **$ 0**

**E. Supplies:** Materials costing less than $5,000 per unit and often having one-time use

**Table 5: Federal Request**

| Item(s) | Rate | Cost |
|---|---|---|
| General office supplies | $50/mo. x 12 mo. | $600 |
| Postage | $50/mo. x 12 mo. | $600 |
| Laptop Computer | $500 x 2 | $1000 |
| Printer | $300 | $300 |
| Cell Phones | $100 x 2 | $200 |
| Copies | 8000 copies x .10/copy | $800 |
| Computer update (if needed) | | $477 |
| | TOTAL | $4,077 |

**NARRATIVE JUSTIFICATION**: Enter a description of the Supplies requested and how their purchase will support the purpose and goals of this proposal. For all electronic and computing devices (laptops, tablets, cell phones, etc.) under the $5,000 threshold, a control system must be developed to ensure adequate safeguards to prevent loss, damage, or theft of the property. This control system should include any information necessary to properly identify and locate the item. For example: serial # and physical location of laptops and tablets. Please list staff assignments and percent of effort for laptops, IPad, cell phones, etc.

**FEDERAL REQUEST** (enter in Section B column 1 line 6e of form SF424A): **$4,077**

**F. Contracts:**

The costs of project activities to be undertaken by a third-party contractor should be included in this category as a single line item charge. Cooperative Agreement recipients must submit to HHS the required information establishing a third-party contract to perform program activities, a complete itemization of the costs should be attached to the budget, see Appendix D. *Application and Submission Information; Required Information for Contract Approval*. If there is more than one contractor, each must be budgeted separately and must have an attached itemization. A consultant is a non-employee who provides advice and expertise in a specific program area. Hiring a consultant requires submission of consultant information to HHS; see Appendix D.

*Application and Submission Information; Required Reporting Information for Consultant Hiring.*

**Table 6: Federal Request**

| **Name** | | **Cost** |
|---|---|---|
| 1. To be selected | Environmental Strategy Consultation<br>Rate is $150/day for 40 days = $6,000<br>Travel 175 miles @ .565/mile = $100 | $6,100 |
| 2. To be selected | Media 1.5 minute Public Service Announcement (PSA) | $3,000 |
| 3. To be selected | Evaluation Report | $4,000 |
| 4. To be selected | Training for Staff members<br>Trainers: rate is $300/day for 4 days = $1,200<br>Materials: approx. $5/person x 25 people = $125<br>Room Rental = $75<br>Travel for Trainers = Flight $300/person x 2 people = $600<br>Per Diem - $50/day x 4 days x 2 people = $400 | $2,400 |
| 5. To be selected | Data Analysis | $2,000 |
| 6. To be selected | Responsible Server Training<br>Trainer: rate $500/day | $500 |
| 7. To be selected | Television advertising to run ads<br>5x/week x $50/ad x 52 wks. | $13,000 |
| | TOTAL | $31,000 |

**NARRATIVE JUSTIFICATION:** Explain the need for each agreement and how their use will support the purpose and goals of this proposal. For those contracts already arranged, please provide the proposed categorical budgets. For those subcontracts that have not been arranged, please provide the expected Statement of Work, Period of Performance and how the proposed costs were estimated and the type of contract (bid, sole source…etc.)

**FEDERAL REQUEST** (enter in Section B column 1 line 6f of form SF424A): **$31,000**

**G. Other:** Expenses not covered in any of the previous budget categories

**Table 7: Federal Request**

| Item | Rate | Cost |
|---|---|---|
| 1. Rent | $500/mo. x 12 mo. | $6,000 |
| 2. Telephone | $100/mo. x 12 mo. | $1,200 |
| 3. Student Surveys | $1/survey x 3000 | $3,000 |
| 4. Brochures | .80/brochure x 1500 brochures | $1,200 |
| 5. Web Service | $100/mo. x 12 mo. | $1,200 |
| | TOTAL | $12,600 |

**NARRATIVE JUSTIFICATION**: Explain the need for each item and how their use will support the purpose and goals of this proposal. Be sure to break down costs into cost/unit: i.e. cost/square foot and explain the use of each item requested.

**FEDERAL REQUEST** (enter in Section B column 1 line 6h of form SF424A): **$12,600**

**H. Total Direct Charges: Sum of Total Direct Costs**

**FEDERAL REQUEST** (enter in Section B column 1 line 6i of form SF424A)

**I. Indirect Charges: Please attach approved Indirect Cost (IDC) rate and explain calculation.**

**FEDERAL REQUEST** (enter in Section B column 1 line 6j of form SF424A)

**J. TOTALS: Sum of Total Direct Costs and Indirect Costs for Year 1**

**FEDERAL REQUEST** (enter in Section B column 1 line 6k of form F424A)

**Program Income**

Application must indicate whether program income is anticipated. If program income is anticipated, use the format below to reflect the amount and sources(s).

Budget Period:

Anticipated Amount:

Sources:

# Appendix D. Application and Submission Information

**Employer Identification Number**

All applicants must have a valid Employer Identification Number (EIN), otherwise known as a Taxpayer Identification Number (TIN) assigned by the Internal Revenue Service.

**Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS number)**

All applicants must have a Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number in order to apply. The DUNS number is a nine-digit identification number that uniquely identifies business entities. Obtaining a DUNS number is easy and free. To obtain a DUNS number, access the following website: www.dunandbradstreet.com or call 1-866-705-5711. This number should be entered in 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**.**

**System for Award Management (SAM)**

All applicants must register in the System for Award Management (SAM)* database (https://www.sam.gov/portal/public/SAM/) in order to be able to submit an application at http://www.grants.gov. In order to register, applicants must provide their DUNS and EIN numbers. Each year organizations and entities registered to apply for Federal grants through Grants.gov must renew their registration with SAM. **Failure to renew SAM registration prior to application submission will prevent an applicant from successfully applying via Grants.gov. Similarly, failure to maintain an active SAM registration during the application review process can prevent HHS from issuing your agency an award under this model.**

Applicants must successfully register with SAM prior to submitting an application or registering in the Federal Funding Accountability and Transparency Act Subaward Reporting System (FSRS) as a prime awardee user. Primary awardees must maintain a current registration with the SAM database, and **may make subawards only to entities that have DUNS numbers**

Organizations must report executive compensation as part of the registration profile at

https://www.sam.gov/portal/public/SAM/ 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). The Grants Management Specialist assigned to monitor the sub-award and executive compensation reporting requirements is Iris Grady, who can be reached at divisionofgrantsmanagement@cms.hhs.gov.

*Applicants were previously required to register with the Central Contractor Registration. The CCR was a government-wide registry for organizations that sought to do business with the federal government. CCR collected, validated, stored, and disseminated data to support a variety of federal initiatives. This function is now fulfilled by SAM. SAM has integrated the CCR and will also incorporate 7 other Federal procurement systems into a new, streamlined system. If an applicant had an active record in CCR prior to the rollout of SAM, an active record would be available in SAM. However, more than a year has passed since the rollout of SAM, so entities must ensure its registration with CCR (through SAM) is still active prior to applying under this funding opportunity. Please consult the SAM website listed above for additional information.

**Cost Sharing or Matching**

Cost sharing or matching is not required.

**Application Information**

This FOA contains all the instructions to enable a potential applicant to apply. The application should be written primarily as a narrative with the addition of standard forms required by the Federal government for all grants and cooperative agreements.

**Application Materials**

Application materials will be available for download at http://www.grants.gov. Please note that HHS requires applications for all announcements to be submitted electronically through http://www.grants.gov. For assistance with http://www.grants.gov, contact support@grants.gov or 1-800-518-4726. At http://www.grants.gov, applicants will be able to download a copy of the application packet, complete it off-line, and then upload and submit the application via the Grants.gov website.

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

- You can access the electronic application for this project at http://www.grants.gov. You must search the downloadable application page by the CFDA number.
- At the http://www.grants.gov website, you will find information about submitting an application electronically through the site, including the hours of operation. HHS strongly recommends that you do not wait until the application due date to begin the application process through http://www.grants.gov because of the time needed to complete the required registration steps. **Applications not submitted by the due date and time are considered late and will not be reviewed.**
- All applicants under this announcement must have an Employer Identification Number (EIN), otherwise known as a Taxpayer Identification Number (TIN), to apply. **Please note, applicants should begin the process of obtaining an EIN/TIN as soon as possible after the announcement is posted 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. **Applicants should obtain this DUNS number as soon as possible after the announcement is posted to ensure all registration steps are completed in time.**
- The applicant must also register in the System for Award Management (SAM) database in order to be able to submit the application. Applicants are encouraged to register early, and must have their DUNS and EIN/TIN numbers in order to do so. Information about SAM is available at https://www.sam.gov/portal/public/SAM/. The SAM registration process is a separate process from submitting an application. **Applicants should begin the SAM registration process as soon as possible after the announcement is posted to ensure that it does not impair your ability to meet required submission deadlines.**
- Authorized Organizational Representative: The Authorized Organizational Representative (AOR) who will officially submit an application on behalf of the organization must register with Grants.gov for a username and password. AORs must complete a profile with Grants.gov using their organization's DUNS Number to obtain their username and password at http://grants.gov/applicants/get_registered.jsp. AORs must wait one business day after successful registration in SAM before entering their profiles in Grants.gov. **Applicants should complete this process as soon as possible after successful registration in SAM to ensure this step is completed in time to apply before application deadlines. Applications that are not submitted by the due date and time as a result of AOR issues will not be reviewed.**
- When an AOR registers with Grants.gov to submit applications on behalf of an organization, that organization's E-Biz POC will receive an email notification. The email address provided in the profile will be the email used to send the notification from Grants.gov to the E-Biz POC with the AOR copied on the correspondence.
- The E-Biz POC must then login to Grants.gov (using the organization's DUNS number for the username and the special password called "M-PIN") and approve the AOR, thereby providing permission to submit applications.

- **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 formats as part of their application, CMS restricts this practice and only accepts PDF file formats. Any file submitted as part of the Grants.gov application that is not in a PDF file format, or contains password protection, will not be accepted for processing and will be excluded from the application during the review process. In addition, the use of compressed file formats such as ZIP, RAR, or Adobe Portfolio will not be accepted. The application must be submitted in a file format that can easily be copied and read by reviewers. It is recommended that scanned copies not be submitted through Grants.gov unless the applicant confirms the clarity of the documents. Pages cannot be reduced in size, resulting in multiple pages on a single sheet, to avoid exceeding the page limitation. All documents that do not conform to the above specifications will be excluded from the application materials during the review process. Refer to Section V.2.3. Format Requirements of Application Submission.**
- After you electronically submit your application, you will receive an acknowledgement from http://www.grants.gov that contains a Grants.gov tracking number. HHS will retrieve your application package from Grants.gov. **Please note, applicants may incur a time delay before they receive acknowledgement that the application has been accepted by the Grants.gov system. Applicants should not wait until the application deadline to apply because notification by Grants.gov that the application is incomplete may not be received until close to or after the application deadline, eliminating the opportunity to correct errors and resubmit the application. Applications submitted after the deadline, as a result of errors on the part of the applicant, will not be reviewed.**
- After HHS retrieves your application package from Grants.gov, a return receipt will be emailed to the applicant contact. This will be in addition to the validation number provided by Grants.gov.

Applications cannot be accepted through any email address. Full applications can only be accepted through http://www.grants.gov. Full applications cannot be received via paper mail, courier, or delivery service.

All grant applications must be submitted electronically and be received through http://www.grants.gov by 3:00 p.m. Eastern Standard or Daylight Time (Baltimore, MD) for the applicable deadline date. Please refer to the Executive Summary for submission date.

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

Please be aware of the following:

1) Search for the application package in Grants.gov by entering the CFDA number. This number is shown on the cover page of this announcement.
2) If you experience technical challenges while submitting your application electronically, please contact Grants.gov Support directly at: www.grants.gov/customersupport or (800) 518-4726. Customer Support is available to address questions 24 hours a day, 7 days a week (except on Federal holidays).
3) Upon contacting Grants.gov, obtain a tracking number as proof of contact. The tracking number is helpful if there are technical issues that cannot be resolved.

To be considered timely, applications must be received by the published deadline date. However, a general extension of a published application deadline that affects all State applicants or only those in a defined geographical area may be authorized by circumstances that affect the public at large, such as natural disasters (e.g., floods or hurricanes) or disruptions of electronic (e.g., application receipt services) or other services, such as a prolonged blackout. This statement does not apply to an individual entity having internet service problems. In order for there to be any consideration there must be an effect on the public at large.

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 e-mail the Grants.gov contact center at support@grants.gov for help, or call 1-800-518-4726.

**Required Reporting Information for Consultant Hiring**

This category is appropriate when hiring an individual who gives professional advice or provides services for a fee and who is not an employee of the grantee organization. Submit the following required information for consultants; see Appendix C. *Sample Budget and Narrative Justification Required Format*; *Contracts*.

1. Name of Consultant: Identify the name of the consultant and describe his or her qualifications.
2. Organizational Affiliation: Identify the organization affiliation of the consultant, if applicable.
3. Nature of Services to be Rendered: Describe in outcome terms the consultation to be provided including the specific tasks to be completed and specific deliverables. A copy of the actual consultant agreement should not be sent to HHS.
4. Relevance of Service to the Project: Describe how the consultant services relate to the accomplishment of specific program objectives.
5. Number of Days of Consultation: Specify the total number of days of consultation.

6. Expected Rate of Compensation: Specify the rate of compensation for the consultant (e.g., rate per hour, rate per day). Include a budget showing other costs such as travel, per diem, and supplies.
7. Method of Accountability: Describe how the progress and performance of the consultant will be monitored. Identify who is responsible for supervising the consultant agreement.

**Required Information for Contract Approval**

All contracts require reporting the following information to HHS.

1. Name of Contractor: Who is the contractor? Identify the name of the proposed contractor and indicate whether the contract is with an institution or organization.
2. Method of Selection: How was the contractor selected? State whether the contract is sole source or competitive bid. If an organization is the sole source for the contract, include an explanation as to why this institution is the only one able to perform contract services.
3. Period of Performance: How long is the contract period? Specify the beginning and ending dates of the contract.
4. Scope of Work: What will the contractor do? Describe in outcome terms, the specific services/tasks to be performed by the contractor as related to the accomplishment of program objectives. Deliverables should be clearly defined.
5. Method of Accountability: How will the contractor be monitored? Describe how the progress and performance of the contractor will be monitored during and on close of the contract period. Identify who will be responsible for supervising the contract.
6. Itemized Budget and Justification: Provide an itemized budget with appropriate justification; see Appendix C. *Sample Budget and Narrative Justifications*. If applicable, include any indirect cost paid under the contract and the indirect cost rate used.

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.

# Appendix E. Application Check-Off List Required Contents

**Required Contents**

A complete proposal consists of the materials organized in the sequence below. Please ensure that the project narrative is page-numbered and the following forms are completed with an electronic signature and enclosed as part of the proposal:

Project narratives must be:
- in 12 point font or larger (including charts and tables)
- double spaced

Budget Narratives must be:
- in 12 point font or large (including charts and tables)
- The one-page Project Abstract, Project narrative, and Budget narratives all together are limited to and no greater than 40 pages in length. Applications that exceed this page limit are ineligible and will not be reviewed.

FORMS

- ☐ SF 424: Application for Federal Assistance
  - ☐ Organization's DUNS Number
  - ☐ Registered with the System for Award Management (formerly CCR)
- ☐ SF-424A: Budget Information
- ☐ SF-424B: Assurances-Non-Construction Programs
- ☐ SF-LLL: Disclosure of Lobbying Activities

Application Kit

- ☐ TCPI Project Abstract Summary
- ☐ Project Narrative Attachment Form that includes:
  - Project Narrative;
  - Establish Clear Linkage of Proposed Work to Quantitative Results on Aim;
  - Support and Alignment Networks (SANs) Achievement of Milestones;
  - Data Strategy and
  - Organizational Capacity and Project Management Plan
- ☐ SAN Budget Narrative that will include the budget narrative and expenditure plan.

# Acronyms

| | |
|---|---|
| **CMS** | Centers for Medicare & Medicaid Services |
| **CMMI** | Center for Medicare and Medicaid Innovation |
| **CCSQ** | Center for Clinical Standards and Quality |
| **FQHC** | Federally Qualified Health Centers |
| **HHS** | Department of Health and Human Services |
| **PTN** | Practice Transformation Network |
| **QIO** | Quality Improvement Organizations |
| **QIIMTG** | Quality Improvement and Innovation Models Testing Group |
| **SAN** | Support and Alignment Network |