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

Community Health Access and Rural Transformation Model

Community Transformation Track

Notice of Funding Opportunity Type: New

Funding Opportunity Award Type: Cooperative Agreement

Notice of Funding Opportunity Number: CMS-2G2-21-001

CFDA: 93.624

Notice of Funding Opportunity Posting Date: December 29, 2020

Applicable Dates:

Letter of Intent to Apply Due Date: February 17, 2021

Electronic Application Due Date: March 16, 2021 3:00 PM Eastern U.S. Time

Anticipated Issuance Notice(s) of Award: July 15, 2021

Anticipated Period of Performance: 7 years and 5 months (1 Pre-Implementation Period and 6 Performance Periods)

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Executive Summary

The Community Health Access and Rural Transformation (CHART) Model is a voluntary payment model designed to meet the unique needs of rural communities. The CHART Model will test whether aligned financial incentives, increased operational flexibility, and robust technical support promote rural health care providers' capacity to implement effective health care delivery system redesign on a broad scale. The Center for Medicare & Medicaid Innovation (CMMI) will evaluate the impact of the CHART Model on Medicare and Medicaid expenditures, access to care, quality of care, and health outcomes for rural residents.

CHART aligns with CMS's Rethinking Rural Health initiative, which aims to ensure individuals in rural America have access to high quality, affordable health care by offering new and creative payment models.[1] The CHART Model will include two tracks: 1) the Community Transformation Track and 2) the Accountable Care Organization (ACO) Transformation Track. **This Notice of Funding Opportunity (NOFO) is for the Community Transformation Track only.** Under the Community Transformation Track, award recipients will receive cooperative agreement funding and a programmatic framework to assess the needs of their Community (as defined in section ***A.4.3.1. Community Definition*** below) and implement health care delivery system redesign. Hospitals participating in the Community Transformation Track Alternative Payment Model (APM) will receive capitated payments. Capitated payments provide hospitals with a stable revenue stream and incentivize reductions in fixed costs and avoidable utilization.[2] Operational flexibilities will be available for participating hospitals to relieve regulatory burden, emphasize high-value services, and support providers in care management for their beneficiaries.

Under the **ACO Transformation Track**, entities will receive upfront payments to establish or expand rural ACOs that participate in two-sided risk arrangements through the Medicare Shared Savings Program. Building on the success of the ACO Investment Model (AIM), these upfront payments will help rural entities engage in value-based payment reform and support the participation of such rural ACOs in the Medicare Shared Savings Program, several tracks of which are Advanced Alternative Payment Models (Advanced APMs) for 2020.

Information for the ACO Transformation Track will be released at a later date to be specified by CMMI. The ACO Transformation Track is separate from the Community Transformation Track and is not addressed in this NOFO.

Award recipients' (herein referred to as "Lead Organizations") participation in the Community Transformation Track of the CHART Model will begin with a Pre-Implementation Period (17 months), during which they will recruit participating hospitals (herein referred to as "Participant Hospitals" in accordance with section ***A.4.4.2. Participant Hospitals***) and partner with them and other community stakeholders to develop a health care delivery system redesign strategy. Following the Pre-Implementation Period, Lead Organizations, community stakeholders, and

Participant Hospitals will have 6 Performance Periods (6 years) to implement their health care delivery system redesign strategy and participate in the APM.

Item	Description
HHS Awarding Agency	Centers for Medicare & Medicaid Services (CMS)
CMS Awarding Center	Center for Medicare & Medicaid Innovation (CMMI)
Notice of Funding Opportunity Title	Community Health Access and Rural Transformation (CHART) Model: Community Transformation Track
Authorization	Section 1115A of the Social Security Act (the Act) as added by Section 3021 of the Patient Protection and Affordable Care Act (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act (Pub. L. 111-152), referred to collectively as the Patient Protection and Affordable Care Act
Federal Assistance Listing Number	93.624
Funding Opportunity Type	New
Funding Opportunity Number	CMS-2G2-21-001
Type of Award	Cooperative Agreement

Type of Competition	Open to all eligible applicants
Letter of Intent	CMMI highly recommends that interested applicants submit a Letter of Intent; however, a Letter of Intent is not required.
Due Date for Letter of Intent (e.g., MM/DD/YYYY)	02/17/2021
Application Due Date & Time	03/16/2021 3:00 PM Eastern U.S. Time
Anticipated Issuance Notice(s) of Award	07/15/2021
Period of Performance Start Date	08/01/2021
Period of Performance End Date	12/31/2028
Anticipated Total Available Funding	$75,000,000
Estimated Maximum Award Amount	$5,000,000
Estimated Maximum Awards	15

A. Program Description

A.1. Purpose

The Centers for Medicare & Medicaid Services (CMS), through its Center for Medicare & Medicaid Innovation (CMMI), will implement a new Model, the Community Health Access and Rural Transformation (CHART) Model. The CHART Model aims to improve health care quality and reduce Medicare and Medicaid expenditures within rural communities. The CHART Model will harness the drive, creativity, and local expertise of rural communities and leverage national resources to improve access to care, quality of care, and health outcomes for rural residents. CHART's Community Transformation Track aims to catalyze modernization of rural health delivery systems by offering technical support, operational flexibilities, and an APM specifically designed for rural communities.

A.2. Authority to Test the Model

The authority for the CHART Model is section 1115A of the Social Security Act (the Act). Section 1115A of the Act authorizes the Secretary of the Department of Health and Human Services (HHS) to test innovative payment and service delivery models to reduce Medicare, Medicaid, or CHIP expenditures while preserving or enhancing the quality of beneficiaries' care.

A.3. Background

Rural hospitals face significant barriers to maintaining financial stability, including low patient volumes and high average fixed costs, that undermine viability under traditional health care reimbursement mechanisms such as volume-based Fee for Service (FFS). Additionally, rural hospitals have more difficulty attracting and retaining a health care workforce.[3] [4]

A volume-based Fee for Service (FFS) payment structure can exacerbate the adverse conditions experienced by rural health care systems. Under FFS, if volumes decline, the continuation of high-cost but essential service lines, such as obstetrics, gynecology, and cancer care, can become financially unviable. Stakeholders have shared that existing regulatory constraints can drive rural hospitals' to maintain inefficient facility footprints.[5] In Medicare, APMs and Advanced APMs have accelerated the reduction of health care costs and improved quality of

care.[6] However, rural health care providers have adopted Advanced APMs at lower rates compared to urban health care providers due to perceived issues in capacity for implementation and lack of flexibility for rural practices.[7]

To mitigate the barriers rural hospitals face when implementing health care transformation, the Community Transformation Track of the CHART Model offers (1) funding to establish partnerships and technical support, (2) an APM specifically designed for the rural context, and (3) operational flexibilities. Through the CHART Model, health care providers, as well as public and private payers, can collectively invest in increasing access to care, promoting quality, and improving the health outcomes of residents within their Community.

A.4. Program Requirements

A.4.1. Key Terms

TERM	DEFINITION
Acute Care Hospital	A hospital that provides inpatient medical care and other related services for surgery, acute medical conditions, or injuries (usually for a short-term illness or condition).
Advanced Alternative Payment Model (Advanced APM)	As set forth in 42 CFR 414.1305, Advanced APMs are APMs that meet the following three criteria (which are specified in 42 CFR 414.1415): 1. Require participants to use certified EHR technology 2. Provide payment for covered professional services based on quality measures comparable to those used in the MIPS quality performance category; and 3. Either: (1) is a Medical Home Model expanded under CMMI authority or (2) requires a participant to bear more than a nominal amount of financial risk
Advisory Council*	The Advisory Council is a multi-stakeholder organization that will play an advisory role to the Lead Organization as they carry out their funded activities (***Table 2. Funded Activities for Lead Organizations***), such as providing critical feedback in the development and implementation of Transformation Plans and assistance with collaboration efforts with Participant Hospitals, the State Medicaid Agency (SMA), and other key Community stakeholders.

TERM	DEFINITION
Aligned Payer*	An Aligned Payer is an entity that makes payment for health care services and possesses the three aligning characteristics outlined in ***Table 5. Medicaid Participation Targets.***
Alternative Payment Model (APM)	For purposes of this NOFO, an Alternative Payment Model (APM) is a payment approach that gives added incentive payments to provide high quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population. For purposes of the Quality Payment Program, APM is codified in 42 C.F.R. 414.1305.
Capitated Payment Amount (CPA)	Capitated payment amount is the prospectively set annual payment amount for a Participant Hospital for Eligible Hospital Services that the Participant Hospital furnishes. The CPA will be calculated by CMMI.
Collaborative Governance	Collaborative governance refers to the approach of collaboration at the community level that involves shared leadership of rural hospitals and other health care providers (e.g., FQHCs) via governance arrangements (e.g., overlapping council constituents) and possibly shared management, to support cooperation in sharing and/or coordinating resources within a geographic region.
Community*	Community is a geographic area that meets the requirements in section ***A.4.3.1. Community Definition.***
Community Transformation Track*	The Community Transformation Track includes the following: cooperative agreement funding, operational flexibilities, and the Community Transformation Track APM, which prospectively sets an annual payment amount for a defined set of Eligible Hospital Services for Participant Hospitals.[8]
Critical Access Hospital (CAH)	A state that has established a Medicare Rural Hospital Flexibility Program may designate certain facilities as Critical Access Hospitals (CAH). CMS will then certify a state-designated facility as a CAH if the facility meets certain requirements. CAHs receive cost-based reimbursement for most Medicare Part A and Part B services. Eligible

TERM	DEFINITION
	hospitals must, among other requirements, meet the following conditions to obtain CAH designation: 1. Have 25 or fewer acute care inpatient beds 2. Be located more than 35 miles from another hospital or CAH or 15 miles if mountainous terrain with only secondary roads (some exceptions apply) 3. Maintain an annual average length of stay of 96 hours or less for acute care patients 4. Provide 24/7 emergency care services CAHs are defined in section 1861(mm)(1) of the Social Security Act.
Discount Factor*	Discount factor refers to the small percentage discount applied to the capitated payment amount (CPA). The specific discount factor for a Community is determined by its total Medicare FFS revenue under the capitated payment arrangement at the Community-level, as specified in ***Appendix XI. CPA Financial Methodology.***
Eligible Hospital Service	An Eligible Hospital Service is any health care service that meets the following criteria: 1. Is covered under Part A or Part B of Title XVIII of the Act; 2. Meets the Service Inclusion Criteria discussed in section ***A.4.5.1. Capitated Payment***; and 3. Does not meet the Service Exclusion Criteria discussed in section ***A.4.5.1. Capitated Payment***.
Federally Qualified Health Center (FQHC)	Federally Qualified Health Center (FQHC) status is a Centers for Medicare and Medicaid Services (CMS) designation indicating eligibility for reimbursement using specific payment methodologies. Federally Qualified Health Center is defined in sections 1861(aa)(4) and 1905(l)(2)(B) of the Act. The types of FQHCs include: 1. Health Center Program award recipients that receive federal funding under section 330 of the Public Health Service (PHS) Act and entities receiving funding from such a grant as a

TERM	DEFINITION
	subrecipicent of the Health Center Program award recipient. 2. Health Center Program look-alikes. Look-alikes do not receive federal funding under section 330 of the PHS Act; however, to receive look-alike designation and associated Federal benefits, look-alikes must meet the Health Center Program requirements. 3. Outpatient health programs or facilities operated by a Tribe or Tribal/Indian organization under the Indian Self Determination and Education Assistance Act (Public Law 93-638) or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act for the provision of primary health services. The Health Resources and Services Administration (HRSA) administers grant funding (as applicable) and oversight of the first two types of FQHCs (Health Center Program award recipients and look-alikes), both of which must meet a stringent set of requirements. These requirements are detailed in the Health Center Program Compliance Manual available.[9]
Hub-and-Spoke Model	Hub-and-Spoke is a model of care that arranges service delivery assets into a network consisting of an anchor establishment (hub) that offers a full array of services, which is complemented by secondary establishments (spokes) which offer more limited service arrays. Patients who need more intensive services are routed from a spoke to a hub.[10]
Lead Organization*	A Lead Organization is a CHART Model award recipient under the Community Transformation Track. It is responsible for forming the Advisory Council, recruiting Participant Hospitals, engaging the SMA, developing and implementing the Transformation Plan, and overseeing the implementation of the Community Transformation Track APM. There can only be one Lead

TERM	DEFINITION
	Organization per Community. See section ***A.4.3 Lead Organization and the Community.***
Participant Hospital*	A Participant Hospital is an acute care hospital (defined as a "subsection (d) hospital" in section 1886(d)(1)(B) of the Act) or CAH that meets the requirements in section ***A.4.4.2. Participant Hospitals***.
Payer	A Payer is an entity furnishing payments for health care services.
Rural Health Clinic (RHC)	A Rural Health Clinic (RHC) is a clinic located in a rural, medically under-served area in the United States that has a separate reimbursement structure from the standard medical office under the Medicare and Medicaid programs. The RHC program is intended to increase access to primary care services for patients in rural communities. RHCs can be public, nonprofit, or for-profit health care facilities. To receive certification, they must be located in rural, underserved areas. They are required to use a team approach of physicians working with non-physician health care providers such as nurse practitioners (NP), physician assistants (PA), and certified nurse midwives (CNM) to provide services. The clinic must be staffed at least 50% of the time with a NP, PA, or CNM. RHCs are required to provide outpatient primary care services and basic laboratory services. Definitions are set out at sections 1861(aa)(2) and 1905(L)(1) of the Act.
Subrecipient	According to 2 CFR § 200.93, subrecipient means a non-Federal entity that receives a subaward from a pass-through entity to carry out part of a Federal program; but does not include an individual that is a beneficiary of such program. A subrecipient may also be a recipient of other Federal awards directly from a Federal awarding agency.
Transformation Plan*	A Transformation Plan is a detailed description of the health care delivery system redesign strategy that will be carried out under the Community Transformation Track of the CHART Model. Transformation Plan requirements are outlined in

TERM	DEFINITION
	section ***A.4.3.2. Transformation Plan.***

*Key terms marked with an asterisk are specific to the CHART Model

A.4.2. Model Design and Funding Structure

Understanding that rural communities face unique challenges to implementing health care delivery system redesign, the Community Transformation Track of the CHART Model consists of three core program elements designed to set up rural communities for success.

1. **Funding to establish partnerships and technical support.** The Community Transformation Track of the CHART Model will provide Lead Organizations with cooperative agreement funding to implement health care delivery system redesign that is both evidence informed and tailored to the Community's needs. Lead Organizations will be able to use cooperative agreement funding to establish partnerships with community stakeholders to develop a health care delivery system redesign strategy, recruit Participant Hospitals, and procure technical support.

2. **Operational flexibilities.** The CHART Model makes operational flexibilities available to support Communities in implementing health care delivery system redesign. Participant Hospitals may leverage operational flexibilities in their Community to relieve regulatory burden, emphasize high-value services, and support providers in care management for their beneficiaries. Operational flexibilities will be made available through a combination of model design elements and waivers under section 1115A authority as necessary to test the Model.

3. **Value-based payment.** Participant Hospitals will receive capitated payments. This stable revenue stream will incentivize Participant Hospitals to lower fixed costs, reduce potentially avoidable utilization, and improve quality of care.

The Community Transformation Track of the CHART Model will begin with a Pre-Implementation Period, during which a Lead Organization will collaborate with key participants and community stakeholders to develop a strategy to implement health care delivery system redesign (as described in section ***A.4.3.2. Transformation Plan***). In total, Lead Organizations will have six Performance Periods to implement their Transformation Plan. The Lead Organization will receive up to $5M in cooperative agreement funding. All cooperative agreement funding will be tied to performance requirements. The funding amounts, prerequisites, Budget Periods, and Performance Periods are outlined in ***Table 1. Funding Timeline and Prerequisites*** below. ***Table 2. Funded Activities for Lead Organizations*** in section ***A.4.3 Lead Organization and the Community*** describes the activities for which Lead Organizations are expected to use Model funds. To receive funding for the Second Budget Period through the Seventh Budget Period,

Lead Organizations must submit a non-competing continuation application. Additional instructions will be included in the terms and conditions of the cooperative agreement.

Table 1. Funding Timeline and Prerequisites

Cooperative Agreement Timing	Model Timing	Funding Available	Funding Prerequisites
First Budget Period	Pre-Implementation Period	Up to $2,000,000	• Notice of Award (NoA) issued to Lead Organization • Acceptance of cooperative agreement terms and conditions
Second Budget Period	Performance Period 1	Up to $500,000	• Satisfactory participation in the Pre-Implementation Period as described in the cooperative agreement terms and conditions • Transformation Plans approved by CMMI prior to Performance Period 1 • Participant Hospitals' combined Medicare FFS Revenue projected to be under a capitated payment arrangement in Performance Period 1 is greater than or equal to the minimum amount in the CMMI-approved Transformation Plan • Award of non-competing continuation (NCC) for Performance Period 1
Third Budget Period	Performance Period 2	Up to $500,000	• Satisfactory participation in Performance Period 1 as described in the cooperative agreement terms and conditions • Updated Transformation Plans approved by CMMI prior to Performance Period 2

Cooperative Agreement Timing	Model Timing	Funding Available	Funding Prerequisites
			• Participant Hospitals' combined Medicare FFS Revenue projected to be under a capitated payment arrangement in Performance Period 2 is greater than or equal to such amount for Performance Period 1 • Award of NCC for Performance Period 2
Fourth Budget Period	Performance Period 3	Up to $500,000	• Satisfactory participation in Performance Period 2 as described in the cooperative agreement terms and conditions • Updated Transformation Plans approved by CMMI prior to Performance Period 3 • Participant Hospitals' combined Medicare FFS Revenue projected to be under a capitated payment arrangement in Performance Period 3 is greater than or equal to such amount for Performance Period 2 • Award of NCC for Performance Period 3
Fifth Budget Period	Performance Period 4	Up to $500,000	• Satisfactory participation in Performance Period 3 as described in the cooperative agreement terms and conditions • Updated Transformation Plans approved by CMMI prior to Performance Period 4 • Participant Hospitals' combined Medicare FFS Revenue

Cooperative Agreement Timing	Model Timing	Funding Available	Funding Prerequisites
			projected to be under a capitated payment arrangement in Performance Period 4 is greater than or equal to such amount for Performance Period 3 • Award of NCC for Performance Period 4
Sixth Budget Period	Performance Period 5	Up to $500,000	• Satisfactory participation in Performance Period 4 as described in the cooperative agreement terms and conditions • Updated Transformation Plans approved by CMMI prior to Performance Period 5 • Participant Hospitals' combined Medicare FFS Revenue projected to be under a capitated payment arrangement in Performance Period 5 is greater than or equal to such amount for Performance Period 4 • Award of NCC for Performance Period 5
Seventh Budget Period	Performance Period 6	Up to $500,000	• Satisfactory participation in Performance Period 5 as described in the cooperative agreement terms and conditions • Updated Transformation Plans approved by CMMI prior to Performance Period 6 • Participant Hospitals' combined Medicare FFS Revenue projected to be under a capitated payment

Cooperative Agreement Timing	Model Timing	Funding Available	Funding Prerequisites
			arrangement in Performance Period 6 is greater than or equal to such amount for Performance Period 5 • Award of NCC for Performance Period 6

A.4.3 Lead Organization and the Community

CMMI will award cooperative agreement funding for the Community Transformation Track of the CHART Model to a single entity, referred to as a Lead Organization. The Lead Organization will be responsible for driving health care delivery system redesign by leading the development and implementation of Transformation Plans as well as convening and engaging the Advisory Council. Lead Organizations will also be responsible for ensuring compliance with Model requirements and with any requests from CMMI for additional data or other supplemental information. A potential Lead Organization must submit, as part of its application, documentation that demonstrates it meets each of the following requirements for selection:

1. A presence in the Community one year prior to the publication date of this NOFO. Examples of "presence" include advocating for (e.g., a representative organization), providing services to, or otherwise serving beneficiaries within the Community). While a physical presence in the Community is not required, a relationship with the Community is required.
2. Expertise in rural health issues, in particular specific diseases, health disparities, barriers to accessing care, policy, and other key factors that significantly influence health outcomes, particularly those prevalent in the Community.
3. Experience, either through direct management or through a partnership, in designing and implementing APMs.
4. Received and successfully managed one or several health-related grant(s) or cooperative agreement(s) totaling at least $500,000 over the last three years.
5. Experience in each of the following areas:
    a. Engaging and maintaining provider participation in APMs or CMMI demonstration projects/models.

b. Establishing, modifying as needed, and maintaining agreements between health care providers.

c. Conducting outreach, developing, and managing relationships with diverse health care-related stakeholders.

Any organization that does not meet all of the criteria listed above is ineligible to serve as a Lead Organization. Examples of entities eligible to serve as Lead Organizations include, but are not limited to, State Medicaid Agencies (SMAs), State Offices of Rural Health (SORHs), local public health departments, Independent Practice Associations (IPAs), and Academic Medical Centers (AMCs).

A.4.3.1. Community Definition

Lead Organizations will be responsible for defining the parameters of their Community, for the purposes of the CHART Model. Each Community must meet the following criteria:

1. Encompass either (a) a single county or census tract or (b) a set of contiguous or non-contiguous counties or census tracts. Each county or census tract must be classified as rural, as defined by the Federal Office of Rural Health Policy's list of eligible counties and census tracts used for its grant programs.[11]

2. At the time of application submission, include a minimum of 10,000 Medicare FFS beneficiaries whose primary residence is within the Community.

NOTE: Lead Organization's definition of their Community is subject to CMMI review and approval. During application review, CMMI will ensure that there is not overlap between Lead Organizations' defined Communities.

A.4.3.2. Transformation Plan

Lead Organizations will leverage technical support and input from Community Partners, i.e. its Advisory Council, Participant Hospitals, and the SMA as described in section ***A.4.4. Community Partners***, to design and implement Transformation Plans that are both tailored to the Community's needs and informed by best practices.

Transformation Plans are Lead Organizations' descriptions of their health care delivery system redesign strategy. Each Lead Organization, in collaboration with its Advisory Council (including the SMA) and its Participant Hospitals, will develop and submit Transformation Plans. All Transformation Plans must be reviewed and approved by CMMI. A Lead Organization will submit their first Transformation Plan during the Pre-Implementation Period, and subsequently submit updates on an annual basis. At a minimum, CMMI will review each Transformation Plan prior to the start of each Performance Period and provide feedback to the Lead Organization as necessary leading up to Transformation Plan approval**.** A Lead Organization may modify its

Transformation Plan more frequently than the schedule set by CMMI, for example if they want to implement a programmatic change on a more immediate basis. Upon CMMI approval, each Lead Organization must begin implementing its Transformation Plan in Performance Period 1.

CMMI requires Transformation Plans to focus on population health disparities present in the Community. Specifically, Transformation Plans must address at least one of the following: behavioral health treatment, substance use disorder treatment, chronic disease management and prevention, or maternal and infant health. CMMI also requires Transformation Plans to include strategies to expand the use of telehealth and other technology to support care delivery improvement. Communities may leverage regulatory flexibilities under the Model to implement telehealth expansion in regards to Section 1834(m) of the Act. In addition, Communities are encouraged to address social determinants of health in their Transformation Plans. To address the social determinants of health, Lead Organizations may utilize cooperative agreement funding, leverage the transportation Medicare beneficiary engagement incentive (see section ***A.4.6. Operational Flexibilities under the Model***) or engage the SMA to implement a change in Medicaid policy. More information on integrating social determinants within health care delivery system redesign will be made available to Communities that have been selected to participate.

At CMMI's sole discretion and to the extent necessary to test the Model, certain waivers of Medicare and Medicaid requirements will be available to facilitate implementation of Transformation Plans (see sectionA.4.6. Operational Flexibilities under the Model and ***Appendix IX. Medicaid Needs Assessment*** for more information). For example, some Lead Organizations and/or Participant Hospitals may use such waivers to facilitate converting rural hospitals to rural emergency and outpatient-only facilities or establish hub-and-spoke arrangements that distribute and coordinate services by need throughout a Community.

CMMI will use the Transformation Plans to track, monitor, and evaluate Lead Organizations' progress against the Model's Community Transformation Track goals. Cooperative agreement funding for each Performance Period is contingent on CMMI approval of Transformation Plans in budget periods 2 through 7 (see ***Table 1. Funding Timeline and Prerequisites***). ***Appendix X. Transformation Plan Requirements*** outlines the basic components of Transformation Plans. CMMI will provide additional guidance to Lead Organizations on Transformation Plan requirements upon award.

A.4.3.3. Lead Organization Funded Activities

Lead Organizations can use cooperative agreement funding for any of the purposes described in ***Table 2*** below. The Lead Organization will be responsible for determining the budget allocations for staff time and infrastructure costs consistent with the Model terms and conditions, as well as demonstrating how they and their subrecipients will use funds to accomplish their respective roles in Model implementation. The Lead Organization will be

responsible for the receipt and management of this funding in accordance with the Model terms and conditions and applicable federal laws. Additionally, Lead Organizations must demonstrate in their Transformation Plans, that Aligned Payers meet the requirements of the Model (for more information on Aligned Payers, see section ***A.4.5.3. Multi-payer Alignment***).

Table 2. Funded Activities for Lead Organizations

Timing	Lead Organization Activities
Pre-Implementation Period (17 months)	• Constitute and convene the Advisory Council in accordance with the Model terms and conditions • Manage cooperative agreement funds • Partner with the SMA (if the SMA is not the Lead Organization), to ensure necessary Medicaid authorities are in place to align the state's Medicaid program with the Model • Recruit Participant Hospitals to the Model • Recruit commercial payers to participate as Aligned Payers in the Model and oversee their compliance with the requirements outlined in section ***A.4.5.3. Multi-payer Alignment*** • Provide or procure technical assistance to support development of the Transformation Plan and prepare Participant Hospitals to enter capitated payment arrangements with CMS • Create, submit for CMMI approval, revise if needed, and, upon CMMI approval, implement Transformation Plan in partnership with Participant Hospitals, SMA, Advisory Council, and other relevant stakeholders • Emergency response planning for future public health emergencies (PHEs), and/or recovery from COVID-19 PHE • Respond to the evaluator's data related and other requests • Monitor programmatic and budgetary progress, including submitting required data and progress reports to CMMI in accordance with the Model terms and conditions • Execute and submit to the Project Officer with its NCC application for Performance Period 1 legally enforceable agreements as needed, e.g., business associate agreements (BAAs) between the Lead Organization and the SMA
Performance Periods (6 years)	• Update Transformation Plan annually and, upon CMMI approval, implement updated Transformation Plan in partnership with Participant Hospitals, SMA, Advisory Council, and other relevant stakeholders • Convene the Advisory Council at least on a quarterly basis • Manage cooperative agreement funds • Recruit additional Participant Hospitals as necessary

Timing	Lead Organization Activities
	• Recruit additional Aligned Payers and work with payers to identify any legislative or statutory changes necessary to implement the APM • Provide or procure strategic and operational technical assistance, e.g., to support Participant Hospitals, coordinate the Advisory Council, or perform research to identify emerging needs within the Community • Collaborate with the SMA including meeting Medicaid Participation Targets, as described in section ***A.4.5.3.2. Medicaid Alignment***, and ensuring that the Medicaid Needs Assessment, provided in ***Appendix IX. Medicaid Needs Assessment*** is updated in accordance with the Model terms and conditions. • Oversee Aligned Payers compliance with the requirements outlined in section ***A.4.5.3. Multi-payer Alignment*** • Emergency response planning for future public health emergencies (PHEs), and/or recovery from COVID-19 PHE • Respond to data related and other requests for the Model evaluation • Monitor the progress of the Model, including submitting required data and progress reports to CMMI in accordance with the Model terms and conditions and assessing the compliance of all other involved parties with CHART program requirements • Manage any close-out activities, if the Model is not continued

Lead Organizations may use cooperative agreement funds to provide technical support to Participant Hospitals and the SMA through expanding in-house capacity or engaging contractors. Lead Organizations may also use cooperative agreement funds for emergency response planning for future public health emergencies. Lead Organizations may request to receive less cooperative agreement funding in favor of a lower discount factor for their Participant Hospitals, as discussed in section ***A.4.5.1. Capitated Payment***.

A.4.4. Community Partners

Recognizing that stakeholder engagement is key to effective reform, the Community Transformation track of the CHART Model requires that Lead Organizations establish an Advisory Council. Together the Lead Organization and their Advisory Council will forge robust and meaningful partnerships with their Participant Hospitals and SMA.

A.4.4.1. Advisory Council

To ensure that health care delivery system redesign strategies reflect the Community's needs and goals, Lead Organizations are required to assemble an Advisory Council. The Advisory Council will represent the Community's perspective and collectively advise the Lead Organization as they carry out their required activities (described in ***Table 2. Funded Activities for Lead Organizations***). A few key activities the Advisory Council will advise on include, but are not limited to, developing and updating Transformation Plans, hospital and payer recruitment, developing arrangements with payers governing APM alignment and data-sharing, monitoring the progress of the Model, and identifying any necessary changes. The Advisory Council will not manage the Lead Organization or Participant Hospitals. The Advisory Council will not be responsible for management and oversight of Cooperative Agreement funds.

Lead Organizations must convene Advisory Councils at least quarterly. Advisory Councils should encompass a variety of perspectives and reflect the Community's needs. While the specific membership of the Advisory Council will differ by Community, it **must** include the following representatives:

1. The SMA (if the Lead Organization is not the SMA) even if the SMA is physically located outside of the Community.
2. At least one Participant Hospital (see section ***A.4.4.2. Participant Hospitals*** for definition).
3. At least one Aligned Payer (if the Lead Organization has recruited any commercial payers) see section ***A.4.5.3. Multi-payer Alignment*** for definition.
4. At least one beneficiary or unpaid caregiver.

Furthermore, the Advisory Council **must** include a representative from **at least** three distinct entities from the following list:

1. A primary care provider, such as a Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), or physician group practice.
2. A health care provider of substance use disorder treatment and/or mental health services.
3. An additional Participant Hospital.
4. The State Office of Rural Health.
5. An additional Aligned Payer.
6. A community stakeholder group, such as a rural patient advocacy group, Area Agency on Aging, or faith- and community-based organizations.

7. A long-term care facility (e.g., nursing home), home health provider, or hospice provider.
8. An Indian Health Service (IHS) or Tribal health provider or Federally recognized Tribe or Tribal organization.
9. The U.S. Department of Veteran's Affairs (VA).

The Lead Organization may include additional representatives from organizations or governmental entities not included in the list above. To be eligible to serve on the Advisory Council an organization must provide health care services, or services that address health-related social needs, to Community residents. An eligible governmental entity must have jurisdictions that encompass the Community's parameters. For example, Lead Organizations may consider inviting county governments, and state or local public health departments to join the Advisory Council.

Individual Advisory Council representatives do not need to reside or work within the Community. However, each organization represented on the Advisory Council must have a presence within the Community or have a contractual arrangement with a health care provider that furnishes Eligible Hospital Services to beneficiaries living in the Community. For the purposes of this NOFO, any organization that advocates for, provides services to, or otherwise serves beneficiaries within a Community, is considered to have a **presence** within the Community.

A.4.4.2. Participant Hospitals

Lead Organizations will be expected to recruit Participant Hospitals for the Community Transformation Track APM. Each Participant Hospital, identified by its CMS Certification Number (CCN), must be an acute care hospital (defined as a "subsection (d) hospital" in section 1886(d)(1)(B) of the Act) or CAH that either:

1. Is physically located within the Community and receives at least 20% of its Medicare FFS revenue from Eligible Hospital Services provided to residents of the Community; or
2. Is physically located inside or outside of the Community and is responsible for at least 20% of Medicare expenditures for Eligible Hospital Services provided to residents of the Community.

All other types of health care facilities are **ineligible** to be Participant Hospitals. In the event that a hospital system has multiple inpatient campuses and outpatient locations, each inpatient campus and outpatient location will be considered a distinct Participant Hospital as long as it separately meets the eligibility criteria in this section.

Subject to CMS approval, Participant Hospitals may simultaneously participate in the Community Transformation Track and other Medicare value-based programs, models or demonstrations. If a Participant Hospital participates in a Medicare program, demonstration or model, CMS may, in its sole discretion, make adjustments to the Participant Hospital's Capitated Payment Amount (CPA) to avoid duplicative accounting of, and payment or penalties for, amounts received by the Participant Hospital under such Medicare program, demonstration, or model.

Lead Organizations must ensure that each Participant Hospital signs a Participation Agreement with CMMI committing the Participant Hospital to, among other things, (1) assume accountability for hospital expenditures (as specified in ***Appendix XI. CPA Financial Methodology***) for the Medicare beneficiaries they serve that reside in the Community for the full duration of each Performance Period; (2) implement the activities outlined in the Transformation Plan, as applicable; and (3) report necessary quality and other data to CMMI. Lead Organizations, as the named CHART award recipients, will be responsible for ensuring that Participant Hospitals execute certain key model activities to be outlined in forthcoming Participation Agreements and in alignment with the activities described in ***Table 2. Funded Activities for Lead Organizations.***

To ensure their eligibility to participate in CHART, Participant Hospitals must sign Participation Agreements with CMMI in either Performance Period 1 or Performance Period 2. CMMI may allow additional opportunities for Participant Hospitals to sign Participation Agreements. Regardless of when a Participant Hospital signs a Participation Agreement, it will have up to two years to transition back to FFS reimbursement from the effective date of either (1) Model track termination or non-continuation; or (2) termination of the Participant Hospital's Participation Agreement. During this transition period, Participant Hospitals may continue to operate under a capitated payment arrangement until fully transitioned.

A.4.4.3. State Medicaid Agency

SMA participation is required under the Community Transformation Track of the CHART Model. If the Lead Organization is not the SMA, it must partner with the SMA to implement the CHART Model. The SMA must participate in the Advisory Council and serve as an Aligned Payer (see section ***A.4.5.3. Multi-payer Alignment***). To ensure that the SMA has the capacity to carry out CHART's program requirements, the SMA must be a subrecipient of cooperative agreement funding. As a component of the Community Transformation Track application, SMAs must submit a Memorandum of Understanding (MOU) with the potential Lead Organization (see section ***E.1.2.2.3. Health Care Delivery System Redesign Concept*** *15 Points* for MOU requirements).

Table 3. SMA Activities

Timing	SMA Activities
Pre-Implementation Period (17 months)	• Execute and submit to the Lead Organization legally enforceable agreements as needed, including business associate agreements (BAAs) • Participate in the Advisory Council, even if the SMA is located outside of the Community • No later than 45 days after the start of the Pre-Implementation Period, meet with representatives of CMCS to begin designing and implementing any changes to its Medicaid program required to execute CHART financial alignment (see section ***A.4.5.3. Multi-payer Alignment***) • Collaborate with the Lead Organization to submit progress updates on executing CHART financial alignment (including a timeline agreed upon by the state and CMCS) as an appendix to Quarterly Progress Reports (QPRs) (see section ***F.5. Reporting)***
Performance Periods (6 years)	• Participate in the Advisory Council, even if the SMA is located outside of the Community • Collaborate with the Lead Organization to submit progress updates on executing CHART financial alignment (including a timeline agreed upon by the state and CMCS) as an appendix to Quarterly Progress Reports (QPRs) (see section ***F.5. Reporting***) • Align its Medicaid program with the Community Transformation Track APM (see section ***A.4.5. Value-Based Payment***), including receipt of CMS approval of State Plan Amendments (SPA) and/or 1115(a) demonstration application(s) as needed and, if applicable, working with managed care plans to support APM implementation • Meet Medicaid Participation Targets, as discussed in section ***A.4.5.3.2. Medicaid Alignment*** below • The SMA must comply with all data and reporting requirements of the Model, including accurate and timely submission of T-MSIS data (see section ***F.5.3. Evaluation***), and establishing information sharing arrangements and infrastructure

The Medicaid elements of the Model shall operate consistent with existing Medicaid laws and regulations. Acceptance of a Lead Organization into the CHART Model does not constitute approval of any changes to a state's Medicaid program. Information included in a CHART Model application will be used solely for the purpose of application review for the CHART Model and does not represent a formal request for a State Plan Amendment or 1115(a) demonstration approval on the part of the state, nor a commitment to such approval on the part of CMS.

States shall submit those requests through the existing CMS processes. The SMA will not be permitted to claim federal financial participation (FFP) for administrative activities for which the SMA receives cooperative agreement funding through the Model to prevent the duplication of funding by CMS.

Upon award, CMMI will help SMAs and Lead Organizations navigate modifications to their state's Medicaid authorities, if and as needed, to carry out their Transformation Plan. CMMI will work with the Center for Medicaid and CHIP Services (CMCS) to maximize process efficiency for reviewing proposed Medicaid State Plan Amendments (SPAs) and Medicaid waivers. CMMI, in collaboration with CMCS, will begin working with SMAs and Lead Organizations early in the process of developing their Transformation Plans, in order to quickly identify what Medicaid SPA(s) or waiver(s) might be necessary. See ***Appendix IX. Medicaid Needs Assessment*** for information on the pathways available to SMAs to implement the Community Transformation Track APM.

A.4.5. Value-Based Payment

The capitated payment arrangement in the Community Transformation Track is designed to establish the financial flexibility necessary for Participant Hospitals to engage in health care delivery system redesign activities outlined in Transformation Plans. This APM offers a predictable and stable revenue stream, which mitigates financial instability in rural hospitals and improves their capacity to weather volatility. In particular, methodology will incorporate adjustments 1) for service line changes and 2) exogenous factors (i.e., Public Health Emergencies). When Participant Hospitals' revenue is no longer predicated on realized volumes, they will be able to focus on more transformational and collaborative strategies, such as converting to a rural emergency medical center or reconfiguring service lines across multiple Participant Hospitals (e.g., one hospital shuts down an orthopedic line but refers volume to a neighboring hospital who has a larger and higher quality orthopedic program). In contrast to FFS incentives to grow volumes, this APM creates an incentive to reduce potentially avoidable utilization, prevent readmissions, and reduce hospital lengths of stay as appropriate. Participant Hospitals will be able to keep the savings that are generated through these reductions. Moreover, discounts applied to the Participant Hospitals' CPAs would secure first dollar savings for Medicare, Medicaid, and Aligned Payers, as described below. For purposes of the Quality Payment Program, the Community Transformation Track is not an Advanced APM or a MIPS APM.

A.4.5.1. Capitated Payment

This section provides a description of the financial methodology CMMI will use to calculate the Capitated Payment Amount (CPA) for each Participant Hospital. CMMI will calculate CPAs, **not** Lead Organizations. The CPA financial methodology is included in this NOFO for informational

purposes only and may change at CMMI's sole discretion. The final CPA financial methodology will be detailed further in a time and manner to be specified by CMMI.

CMMI will calculate the CPA for each Participant Hospital located in the Community as follows:

1. Determine baseline Medicare FFS revenue using historical expenditures for Eligible Hospital Services.
2. Apply prospective adjustments to baseline revenue.
3. Apply a discount to the adjusted baseline revenue to yield the introductory CPA.
4. Apply mid-year adjustments to the introductory CPA to yield the mid-year CPA.
5. Apply end-of-year adjustments to the mid-year CPA to yield the final CPA.

For purposes of this CPA financial methodology, Eligible Hospital Service means any health care service that meets the following criteria:

1. Is covered under Part A or Part B of Title XVIII of the Act;
2. Meets the Service Inclusion Criteria; and
3. Does not meet the Service Exclusion Criteria.

Service Inclusion Criteria

CMMI will include Medicare FFS expenditures associated with the following health care services, subject to otherwise meeting the definition of Eligible Hospital Service, in each Participant Hospital's CPA:

- Inpatient hospital or inpatient CAH services, including but not limited to physical therapy and certain drugs and biologicals.
- Outpatient hospital or outpatient CAH services, including but not limited to clinic, ED and observation services, X-rays and other radiology services billed by the Participant Hospital, and certain drugs and biologicals.
- Swing bed services rendered by CAHs.

CMMI will provide a more detailed list of included services prior to potential Participant Hospitals signing Participation Agreements with CMMI.

Service Exclusion Criteria

CMMI will exclude Medicare FFS expenditures associated with the following health care services from each Participant Hospital's CPA, and will continue to reimburse such services on a FFS basis using standard payment methodologies:

- Physician services;
- Other professional services;
- Durable medical equipment;
- Hospice care;
- Home Health services;
- Swing bed services for non-CAH facilities; and
- All other services furnished by the Participant Hospital not included in the Service Inclusion Criteria above.

CMMI may modify these Service Inclusion and Service Exclusion criteria from time to time throughout the duration of the Model. For Participant Hospitals that are not located inside the Community, CMMI may modify this CPA financial methodology to account for the Medicare FFS expenditures of beneficiaries located inside the Community only, rather than the total Medicare FFS revenue of the Participant Hospital. Each step of the CPA financial methodology is described in greater detail in ***Appendix XI. CPA Financial Methodology***.

A.4.5.2. Medicare FFS Payment Mechanism

CMMI will replace FFS claims reimbursement for Participant Hospitals with regular, lump sum payments that equal the annual CPA over the course of the Performance Period. Participant Hospitals must continue to submit FFS claims, but CMS will treat claims for Eligible Hospital Services as zero-pay. Continued claims submission is necessary to provide utilization data to inform many of the adjustments outlined in the CPA financial methodology, as well as for program monitoring and quality measurement.

A.4.5.3. Multi-payer Alignment

Multi-payer alignment refers to non-Medicare payers' adoption of the Community Transformation Track APM's financial, operational, and quality processes to ensure that differently insured residents benefit from APM-driven care transformation. The goal of multi-payer alignment in CHART is to increase Participant Hospitals' total revenue from Eligible Hospital Services such that care transformation becomes a more rational business decision. By Performance Period 2, each Lead Organization must secure multi-payer alignment from the SMA, in accordance with this section. Multi-payer alignment from commercial payers is recommended but not required. Requiring multi-payer alignment beginning in Performance Period 2 allows Lead Organizations and Aligned Payers, to address legislative or regulatory barriers to payer participation, and build any IT infrastructure necessary to implement the APM.

A.4.5.3.1. Payer Alignment Characteristics

Lead Organizations and Participant Hospitals must collaborate to establish capitated payment arrangements with Aligned Payers. An Aligned Payer is an entity that makes payment for health care services and possesses the three Aligning Characteristics outlined in ***Table 4. Payer Alignment Characteristics*** below. Each Aligned Payer may implement their capitated payment arrangement with Participant Hospitals differently based on their plan benefits and member populations. For example:

- Aligned Payers may need to modify the financial methodology to account for smaller per-plan enrollment and/or more volatile year-over-year enrollment than Medicare FFS.
- Aligned Payers may not need to align with the adjustments that rely on CAH cost report data, since those are not relevant for other payers besides Medicare FFS.

These modifications from the CPA financial methodology will be subject to CMMI approval in order to satisfy the financial alignment characteristic. Medical assistance payments under Medicaid would remain subject to Medicaid upper payment limits and disproportionate share hospital limits. Please see ***Appendix XI. CPA Financial Methodology*** for details. Each Aligned Payer will be responsible for calculating its non-Medicare FFS CPA for each Participant Hospital.

Table 4. Payer Alignment Characteristics

Characteristic	Description
Financial alignment	The Aligned Payer uses a similar financial methodology as CMMI uses for the Community Transformation Track APM. To implement financial alignment, an Aligned Payer may need to build IT infrastructure or change internal policies (e.g., Medicaid agencies may need to apply for state plan amendments or 1115(a) waivers).
Operational alignment	The Aligned Payer offers changes to health care provider contracts or benefits in compliance with existing law to support care transformation. For example, the Aligned Payer may offer benefit enhancements matching those available in Medicare FFS, or allow Participant Hospitals to make similar changes permitted under a potential Medicare waiver of hospital CoPs.
Quality alignment	The Aligned Payer uses the same set of quality measures to adjust payments or track performance (see section ***A.4.7. Quality Strategy***).

A.4.5.3.2. Medicaid Alignment

At a minimum, Lead Organizations must have the SMA as an Aligned Payer. Medicaid alignment may be achieved through alignment of Medicaid FFS, Medicaid managed care plans, or both.

Lead Organizations, in collaboration with their SMA, will be required to meet the following Medicaid participation targets:

Table 5. Medicaid Participation Targets

Performance Period	Medicaid Participation Target (% of each Participant Hospital's Medicaid revenue under a Capitated Payment Arrangement)
Performance Period 1	0%
Performance Period 2	50%
Performance Period 3	60%
Performance Period 4	75%
Performance Period 5	75%
Performance Period 6	75%

A.4.6. Operational Flexibilities under the Model

The Community Transformation Track will make available certain operational flexibilities to expand Lead Organizations ability to implement health care delivery system redesign and promote Participant Hospitals' capacity to manage their beneficiaries' care. Lead Organizations will be responsible for requesting operational flexibilities in their Transformation Plans in consultation with Participant Hospitals.

These flexibilities will be provided through a combination of the Model Design Flexibilities listed below and as well as through CMMI's authority under section 1115A(d)(1) of the Act to waive certain Medicare and Medicaid requirements, solely as may be necessary to test the Model. CMMI may waive such requirements of Titles XI and XVIII and of sections 1902(a)(1), 1902(a)(13), 1903(m)(2)(A)(iii), and provisions of section 1934 that were added to section 1115A(d)(1) by the PACE Innovation Act as may be necessary solely for purposes of carrying out section 1115A with respect to testing models described in section 1115A(b).

A Lead Organization, in collaboration with Participant Hospitals, may leverage any of the following Model flexibilities in designing and implementing their health care delivery system redesign strategy.

Table 6. Model Design Flexibilities

Model Flexibility	Purpose of Flexibility
Flexibility in Amount of Cooperative Agreement Funding	Before the beginning of Performance Period 1, Lead Organizations may request to receive less cooperative agreement funding in exchange for a lower discount factor for their Participant

Model Flexibility	Purpose of Flexibility
	Hospitals. CMMI may allow additional opportunities for Lead Organizations to request less cooperative agreement funding in exchange for a lower discount on a case by case basis.
Flexibility in Collaborative Funding Use	Lead Organizations may receive up to $5 million of cooperative agreement funding, but may pass some of the funding directly to Participant Hospitals for investing in and successfully implementing care delivery redesign efforts at the hospital-level.
Flexibility in Applying Discounts	Lead Organizations will be able to negotiate participant-level discount factors with Participating Hospitals, subject to CMS approval, so long as the aggregate discount equals the final discount factor for the total revenue in the Community. This will allow Participant Hospitals and Lead Organizations to optimize participant-level discount factors to hospitals of different sizes to help recruit and retain Participant Hospitals.
Flexibility for Service Line Adjustments	When Participant Hospitals shut down a service line, they will lose revenue from that service line while other Participant Hospitals may gain revenue from additional utilization. To the extent that Lead Organizations are able to construct voluntary budget-neutral agreements with multiple Participant Hospitals, CMMI will distribute payments for service line adjustments between hospitals.
Flexibility to Include or Exclude Outliers in the CPA	Participant Hospitals have the ability to elect whether or not to participate in an optional outlier policy if they would like to limit the impact of extraordinarily high cost claims on their CPA.
Flexibility in Care Transformation Strategy	Communities will be able to develop care transformation strategies that are customized to meet the needs of their beneficiaries, improve health outcomes, and maintain or improve access to care. For more information, see the Community Transformation Section.

Lead Organizations, in collaboration with Participant Hospitals, may request any of the policy flexibilities listed below in the ***A.4.6.1. Benefit Enhancements*** and ***A.4.6.2. Beneficiary Engagement Incentives*** sections. Lead Organizations will also have the ability to request other, specialized waivers of Medicare payment and participation rules. For example, CMMI may remove certain scope-of-practice barriers by waiving direct supervision and physician certification requirements, solely as necessary to test the Model.

A.4.6.1. Benefit Enhancements

CMMI plans to offer benefit enhancements, which may include but are not limited to the Medicare waivers described in ***Table 7*** below.

Table 7. CHART Medicare Program and Payment Policy Waivers

Waiver	Purpose of waiver
SNF 3-Day Rule Waiver (Section 1861(i) of the Act)	This would waive the rule requiring a three-day stay in a Participant Hospital with swing-bed for approval of Medicare post-hospital extended care services prior to admission to a SNF.
Telehealth Expansion (Section 1834(m) of the Act)	This would expand allowable originating sites to include a beneficiary's place of residence for certain synchronous and asynchronous telehealth services. Services would be related to wellness visits, evaluation & monitoring, and analyzing patient images. Additionally, health care providers would be permitted to engage in telehealth services with individuals who are not established patients.
Care Management Home Visits (Section 1835(a)(2)(A) of the Act)	This would allow Participant Hospitals to offer home visits to beneficiaries proactively and in advance of any potential hospitalization, and would waive the homebound requirement for receiving such services.
Waiver of certain Medicare Hospital and/or CAH Conditions of Participation (CoPs)	Waivers of Medicare CoPs could allow Participant Hospitals to make certain changes to their facility structure, and maintain their hospital or CAH status for the purpose of Medicare enrollment and certification, Medicare hospital quality reporting, and in order to receive payments under the capitated payment arrangement.
CAH 96 Hour Certification Rule (Section 1814(a)(8) of the Act and 42 C.F.R. §424.15).	This would waive the condition of payment for inpatient CAH services that a physician must certify that a patient is expected to be discharged or transferred within 96 hours of being admitted into a CAH.

A.4.6.2. Beneficiary Engagement Incentives

CMMI plans to allow beneficiary engagement incentives, which may include but are not limited to the Medicare incentives described in ***Table 8*** below.

Table 8. CHART Beneficiary Engagement Incentives

Beneficiary Engagement Incentive	Purpose of incentive
Cost sharing for Part B services	As a beneficiary engagement incentive, Participant Hospitals will be allowed to reduce or waive the applicable co-insurance on the Medicare allowed amount (estimated at approximately $10 per visit). Examples of potential criteria for waiving cost sharing could include: • Financial need; • Patients with high disease burden that would benefit from more frequent visits to avoid hospitalization and disease progression; and • Patients with recent hospitalizations or ED visits.
Transportation	This will allow Participant Hospitals to offer free or discounted transportation services (to include a ride sharing service and a Participant Hospital's own contracted automobile) for beneficiaries requiring face to face care with a Participant Hospital and to connect beneficiaries with follow up services, including trips to: • A pharmacy or courier service for medication; • An external specialist's office; • Elective procedures; and • Health care providers for other health-related services and activities.
Gift Card Reward for Chronic Disease Management Programs	This would allow Participant Hospitals to provide gift cards to eligible aligned beneficiaries for incentivizing participation and adherence in a chronic disease management program.

A.4.6.3. Fraud and Abuse Waivers

The authority for the CHART Model is section 1115A of the Act. For this Model track and consistent with this standard, the Secretary may consider issuing waivers of certain fraud and abuse provisions in sections 1128A, 1128B, and 1877 of the Act. No fraud or abuse waivers are being issued in this document. Fraud and abuse waivers, if any, will be issued in separate documentation. CHART Model participants and their health care providers/suppliers must comply with all applicable laws and regulations, except as explicitly provided in any such separately documented waiver issued pursuant to section 1115A(d)(1) specifically for the

CHART Model. Any such waiver will apply solely to the Community Transformation Track of the CHART Model and could differ in scope or design from waivers granted for other programs or models.

A.4.7. Quality Strategy

There are notable differences between rural and urban health outcomes and delivery systems that are likely to affect quality measure performance. In rural America, populations have higher rates of chronic illness and have poorer access to health care services.[12] Rural hospitals generally have lower volumes, resulting in data suppression on public reporting sites and greater sensitivity to the effects of outliers. Data collection and reporting also are more challenging for rural health care providers, which often have less staff and fewer financial resources to dedicate to these information gathering activities.[13] Rural hospitals continue to lag behind larger hospitals in urban areas in electronic health record (EHR) adoption rates, limiting their capacity to use health IT (HIT) to support quality-improvement processes and promote case management or care coordination.[14] Beyond the ability to collect and report data, low patient volumes affect the reliability, validity, and utility of performance measures, some of which may be better suited for urban areas.[15]

The CHART Model's quality strategy aligns with the 2019 CMS Quality Strategy and CMS's Meaningful Measures Framework launched in 2017.[16] [17] Similar to these CMS initiatives, the CHART Model's quality strategy aims to:

- Align financial incentives with quality improvement goals;
- Emphasize patient choice and engagement;
- Strengthen beneficiaries' access to and coordination of care;
- Facilitate health care delivery system redesign that aligns with Communities' needs; and
- Address health disparities that may exist in rural communities, including among different demographic groups.

To promote improvement in health outcomes, while minimizing administrative burden, CHART's quality strategy focuses on a limited set of measures relevant to rural populations. CHART's measures target quality at both the Community and Participant Hospital levels, and a majority of the measures are claims-based. Any measures that are not claims-based are associated with high priority clinical outcomes or are components of major CMS quality programs. CMMI will track reporting and performance on each of the CHART quality measures as part of its monitoring strategy and will use performance on the measures to calculate the quality score used to adjust CPAs, as discussed in section ***A.4.5.1. Capitated Payment***.

As a condition of participation Lead Organizations, and Participant Hospitals within their Community, will be required to report on the same six quality measures for the duration of the Model:

1. CMMI will determine the three required measures; and
2. The Lead Organization will select the remaining three measures from a list of options developed by CMMI.

Aligned Payers will be required to report on the same six measures that their Lead Organization selects. ***Table 9*** below outlines the three required measures and the list of measures Lead Organizations may choose from for their remaining three measures.

Table 9. CHART Quality Measures

Quality and Population Health Domains	Measure	Steward	Identifier	Type
All Lead Organizations or Participant Hospitals in the Model must report on the following three measures.				
Chronic Conditions	Inpatient and ED visit for ambulatory care-sensitive conditions	Agency for Health Care Research and Quality	Prevention Quality Indicator 92	Outcome
Care Coordination	Hospital-Wide All-Cause Unplanned Readmission	CMS	National Quality Forum 1769	Outcome
Patient Experience and Engagement	Hospital Consumer Assessment of Health Care Providers and Systems	CMS	National Quality Forum 0166	Outcome
Lead Organizations or Participant Hospitals must report on at least three of the following measures from the following domains.				
Substance Use	Use of Pharmacotherapy for Opioid Use Disorder*	CMS	National Quality Forum 3400	Process
	Use of Opioids at High Dosage in Persons without Cancer	Pharmacy Quality Alliance	National Quality Forum 2940	Process

Quality and Population Health Domains	Measure	Steward	Identifier	Type
Maternal Health	PC-02: Cesarean Birth	The Joint Commission	National Quality Forum 0471	Outcome
	Contraceptive Care - Postpartum	US Office of Population Affairs	National Quality Forum 2902	Outcome
Prevention	Influenza vaccination	CMS	National Quality Forum 1659	Process
	Preventive Care and Screening: Screening for Depression and Follow-up Plan	CMS	National Quality Forum 0418	Process
	Continuity of Primary Care for Children with Medical Complexity	Seattle Children's Research Institute	National Quality Forum 3153	Process

*****All-payer reporting will use NQF 3400 as the measure, however given the availability of data for Medicare FFS, pharmacotherapy for OUD will be collected using CMS' Integrated Data Repository data linked to Part D claims. Using this approach, performance for Medicare FFS will report an inverse value relative to NQF 3400 (i.e., percent of beneficiaries with OUD diagnosis with NO evidence of pharmacotherapy for OUD treatment, rather than percent of beneficiaries with OUD diagnosis with pharmacotherapy treatment administered, as stated for NQF 3400).

The Community's population health needs and goals for health care transformation will inform the Lead Organization's quality measure selection. Lead Organizations will describe their rationales for selecting their three or more chosen measures in their Transformation Plans during the Pre-Implementation Period. In addition, Lead Organizations will be required to implement their own monitoring programs, which may entail tracking additional quality measures, as necessary, to monitor progress toward the stated goals outlined in their Transformation Plans, including measures that capture any unintended or undesired impacts on quality. Participant Hospitals will continue reporting on core measures in Medicaid, quality measures in Medicare, and other existing CMS quality programs.

CHART is exploring alignment between its Quality Strategy and the voluntary Federal Office of Rural Health Policy (FORHP) Medicare Beneficiary Quality Improvement Program (MBQIP). Additionally, CAH participation in CHART's Quality Strategy shall align with the mandatory Quality Assessment and Performance Improvement Program (regulation §485.641, effective March 30, 2021).

In addition, CHART is exploring the ability for these measures to be stratified by different demographic groups where there is sufficient volume and sample size. CHART will also explore additional measures that relate to health equity and reducing health disparities, which may inform Transformation Plan development and quality performance as appropriate.

The FORHP, as well as accrediting organizations such as the National Quality Forum, continually work to identify additional appropriate quality measures for rural communities. CMMI will seek to align with those efforts over the course of the CHART Model. **CMMI reserves the right to modify or add to the list of measures**. In this case, Lead Organizations must modify their measure sets accordingly.

A.4.8. Implementation and Learning Support

The CHART implementation and monitoring contractor will support award recipients with program operations by facilitating reporting requirements, managing program data, and assisting in the monitoring of program implementation and compliance. During the periods of performance, CMMI may request modification to a Lead Organization's Transformation Plan, as detailed in section ***A.4.3.2. Transformation Plan***, or associated documents to ensure continued program integrity and to streamline program operations with contractor functions.

CMMI will provide Lead Organizations and Participant Hospitals with a learning system over the course of the CHART Model. For CHART Model participants, learning system activities may include but are not limited to virtual site visits, virtual/in-person meetings, affinity groups, case studies, and webinars geared towards increasing understanding of Model requirements, sharing best practices on engaging community stakeholders, forging meaningful partnerships, and providing assistance with developing and implementing Transformation Plans. These activities will allow participants to share their experiences, track their progress, glean promising practices from their peers, and rapidly adopt new ways of achieving improvements in care delivery. Lead Organizations and Participant Hospitals are required to participate in learning system activities.

A.4.9. Model Timeline

Lead Organizations' participation in the CHART Model will begin with a Pre-Implementation Period, during which they will regularly convene and collaborate with their Advisory Council, prepare Transformation Plans, and engage Aligned Payers and potential Participant Hospitals. During the Pre-Implementation Period, Lead Organizations will submit, and CMMI will review and approve, Transformation Plans and other requested documentation. During the Pre-Implementation Period, CMMI will conduct program integrity screenings of potential Participant Hospitals and generate respective CPAs. Lead Organizations must ensure relevant parties sign Participation Agreements before the end of the Pre-Implementation Period. Lead Organizations will have six Performance Periods to implement their Transformation Plans and

APM. ***Table 10*** below provides a timeline of the application period, application evaluation, and Model duration.

Table 10. The Community Transformation Track Timeline

Activity	Timing	Duration
Application Period	September 15, 2020 – March 16, 2021	120 business days
Application Evaluation	March 17, 2021 – July 14, 2021	
Anticipated Notice of Award	July 15, 2021	
Pre-Implementation Period	August 1, 2021 – December 31, 2022	17 months
Performance Period 1	January 1, 2023 – December 31, 2023	1 year
Performance Period 2	January 1, 2024 – December 31, 2024	1 year
Performance Period 3	January 1, 2025 – December 31, 2025	1 year
Performance Period 4	January 1, 2026 – December 31, 2026	1 year
Performance Period 5	January 1, 2027 – December 31, 2027	1 year
Performance Period 6	January 1, 2028 – December 31, 2028	1 year
Transition Period*	January 1, 2029 – December 31, 2030	2 years
*Transition Period back to FFS reimbursement in the absence of expansion or extension of CHART		

NOTE: The Model timeline may be subject to change.

B. Federal Award Information

B.1. Total Funding

CMMI intends to award cooperative agreements of up to $5 million to up to 15 award recipients. Award recipients will participate in CHART for seven years and five months (includes one Pre-Implementation Period and six Performance Periods). Cooperative agreements will be awarded in consideration of (1) overall quality of the proposal and the ability to meet project goals; and (2) overall cost effectiveness of applicant's proposal. The amount of funding for each cooperative agreement award will depend on the individual award recipient's need as demonstrated in its responses to this NOFO.

B.2. Award Amount

Cooperative agreements may be up to a maximum of $5,000,000.00, pending availability of funds.

B.3. Anticipated Award Dates

07/15/2021

B.4. Period of Performance

The project period for each cooperative agreement awarded will be approximately seven years from the date of award. The estimated project period is August 1, 2021 – December 31, 2028.

- First budget period (17 months): August 1, 2021 to December 31, 2022
- Second budget period (12 months): January 1, 2023 to December 31, 2023
- Third budget period (12 months): January 1, 2024 to December 31, 2024
- Fourth budget period (12 months): January 1, 2025 to December 31, 2025
- Fifth budget period (12 months): January 1, 2026 to December 31, 2026
- Sixth budget period (12 months): January 1, 2027 to December 31, 2027
- Seventh budget period (12 months): January 1, 2028 to December 31, 2028

There will be a short period that will be determined at a later time by CMMI, between notification of award date and the start of the first budget period. Award recipients will not be able to begin work on the Model or incur costs during that time.

B.5. Number of Awards

The maximum number of awards is 15.

B.6. Type of Competition

These awards will be structured as cooperative agreements.

B.7. Type of Competition

Open to all eligible applications

C. Eligibility Information

C.1. Eligible Applicants

✓ City or township governments

✓ County governments

✓ Faith-based organizations

✓ For profit organizations other than small businesses

✓ Federally recognized Indian Tribes or Tribal organizations (as defined by the Indian Health Care Improvement Act)

✓ Tribal organizations (other than federally recognized Tribal governments)

✓ Nonprofits having a 501(c)(3) status with the IRS, other than institutions of higher education

✓ Nonprofits that do not a 501(c)(3) status with the IRS, other than institutions of higher education

✓ Private institutions of higher education (including academic medical centers)

✓ Public and State controlled institutions of higher education (including academic medical centers)

✓ Small businesses

✓ Special district governments

✓ State governments

C.2. Cost Sharing or Matching

There is no cost sharing or matching requirement in the CHART Model.

C.3. Letter of Intent

CMMI highly recommends that interested applicants submit Letters of Intent (LOIs). You may email LOIs to the following address: CHARTModel@cms.hhs.gov (refer to cover page for due date). Letters of Intent should include (1) an expression of interest, (2) a brief description of the interested organization, (3) a preliminary list of the rural counties or census tracts that may define the Community, and (4) contact information, including the organization's street address and a contact person's name, position, email, and phone number.

C.4. Ineligibility Criteria

Ineligibility Criteria for Lead Organizations (award recipients)

CMS will not allow the same entity to be both an award recipient in the Community Transformation Track and an ACO participating in the ACO Transformation Track. Please see section ***A.4.4.2. Participant Hospitals*** for Participant Hospital ineligibility criteria. Maryland, Vermont, and Pennsylvania are currently testing state-wide, multi-payer Models. The Maryland Total Cost of Care Model, the Vermont All-Payer ACO Model, and the Pennsylvania Rural Health Model, respectively. CHART will not accept applications that propose implementation within these states, unless the performance period of the applicable state-based Model has ended, is anticipated to end prior to the start of CHART's Performance Period 1 (2023), or CMS and the state amend the applicable state agreement or CMS Participation Agreement, as necessary, to

permit Lead Organizations in the relevant state to apply and to permit rural hospitals located within the state to participate in the CHART Model.

C.5. Single Application Requirement

CMMI intends to award one cooperative agreement per Community as defined in section ***A.4.3.1. Community Definition***.

C.6. Continued Eligibility

Award recipients must meet reporting and certification deadlines to be eligible throughout the initial budget period and to remain eligible for a non-competing continuation award for subsequent budget periods in multi-year projects. In addition, award recipients would need to demonstrate strong performance during the previous funding cycle(s) before additional year funding is awarded; or, in the case of awards where all funding is issued in the first year, to ensure continued access to funding. At any time in the award cycle, award recipients could receive decreased funding or their award could be terminated if they fail to perform the requirements of the award.

C.7. EIN, DUNS, and SAM Regulations

In order to apply, all applicants are required to have a valid Employer Identification Number (EIN), otherwise known as a Taxpayer Identification Number (TIN); a Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number; and be registered in the System for Award Management (SAM) database (SAM website) to be able to submit an application at grants.gov. See ***Appendix II. Application and Submission Information*** for descriptions of EIN, DUNS, and SAM.

C.8. Faith-Based Organizations

Faith-Based Organizations are eligible to apply.

C.9. Other Eligibility Requirements

Lead Organizations may be awarded one CHART cooperative agreement only. Specific programmatic eligibility requirements for Lead Organizations are described in section ***A.4.3 Lead Organization and the Community***.

CMMI may reject an application or terminate a cooperative agreement or a Participation Agreement on the basis of the results of a program integrity screening regarding the applicant, Participant Hospitals, and any other relevant individuals or entities. The program integrity screening may include, without limitation, the following:

- Confirmation of current Medicare enrollment status and history of adverse enrollment actions.

- Identification of delinquent debt.
- Review of performance in, and compliance with the terms of, other CMMI models, demonstration programs, and initiatives.
- Review of compliance with Medicare program requirements.
- Review of any administrative audits, investigations, or other activities conducted regarding suspicious billing or other potential program fraud and abuse.
- Review of any civil or criminal actions related to participation in a federal health care program.

D. Application and Submission Information

During the application period, the CHART Model will offer informational events (e.g., webinars and open door forums) for applicants. CMS will gear these events towards increasing understanding of the CHART Model aims, plans, and conditions for participation. These events will provide an opportunity to introduce key concepts to applicants, engage individuals from across the applicant organization, and initiate action planning by applicants. Applicants are encouraged, but not required, to participate in these informational events.

D.1. Address to Request Application Package

Open to All Eligible Applicants - Application materials will be available at https://www.grants.gov. Please note that CMMI requires applications for all NOFOs to be submitted electronically through the Grants.gov website. 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. Refer to ***Appendix II. Application and Submission Information*** for additional requirements.

D.2. Content and Form of Application Submission

a. Application format

Applications determined to be ineligible, incomplete, and/or nonresponsive based on the initial screening may be eliminated from further review. However, in accordance with HHS Grants Policy, the CMS, Office of Acquisition and Grants Management (OAGM), Grants Management Officer in his/her sole discretion, may continue the review process for an ineligible application if it is in the best interests of the government to meet the objectives of the program. Each application must include all contents of the application package, in the order indicated, and conform to the following formatting specifications:

- The following page size must be used: 8.5” x 11” letter-size pages (one side only) with 1” margins (top, bottom, and sides). Other paper sizes will not be accepted. This is

particularly important because it is often not possible to reproduce copies in a size other than 8.5” x 11”.

- All pages of the project and budget narratives as well as other required narrative documents must be paginated in a single sequence.
- Font size must be at least 12-point with an average of 14 characters per inch (CPI).
- The Project Narrative must be double-spaced. The page limit for this document is 60 pages.
- The Budget Narrative may be single or double spaced. The page limit for this document is 10 pages.
- The Business Assessment of Applicant Organization may be single-spaced. The page limit for this document is 10 pages.
- Tables included within any portion of the application must have a font size of at least 12- point with a 14 CPI and may be single-spaced. Tables are counted towards the applicable page limits.
- The project abstract is restricted to a one-page summary, which may be single-spaced.
- The following required application documents are excluded from the page limitations described above: Standard Forms, Copy of Letter of intent (if applicable), Application Cover Letter/Cover Page (if applicable), Project Site Location Form and Indirect Cost Rate Agreement. See text box below for other exclusions.
- Optional Text Box: Memorandums of Understanding (MOUs), Letters of Intent, organizational charts, job descriptions, and resumes attached as appendices will not count towards the page limit.

b. Standard forms:

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

1. Project Abstract Summary

A one-page abstract should serve as a succinct description of the proposed project and must 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. Personal identifying information should be excluded from the abstract. In the Grants Application Package that can be

found at https://www.grants.gov (or alternatively www.GrantSolutions.gov for single-source applications), select the Project Abstract Summary and complete the form.

2. SF-424: Official Application for Federal Assistance

Note: On SF 424 "Application for Federal Assistance"

- On Item 15 "Descriptive Title of Applicant's Project", state the specific grant or cooperative agreement opportunity for which you are applying.
- Refer to section D5. Intergovernmental Review for item 19c.
    - SF-424A: Budget Information Non-Construction
    - SF-424B: Assurances-Non-Construction Programs.
    - SF-LLL: Disclosure of Lobbying Activities.

All applicants must submit this form. If your entity does not engage in lobbying, please insert "Non-Applicable" on the form and include the required Authorized Organizational Representative (AOR) name, contact information, and signature. Please note that the application kit available online on the Grants.gov website is utilized for many programs and therefore Grants.gov may designate this form as optional to allow for flexibility amongst programs. This form is required as part of your application package and must be submitted for your application to be considered eligible for review.

3. Project Site Location Form(s)

All applicants must submit this form. Please note that the application kit available online in Grants.gov is utilized for many programs and therefore Grants.gov may designate this form as optional to allow for flexibility amongst programs. This form is required as part of your application package and must be submitted for your application to be considered eligible for review.

c. Application cover letter or cover page

Applicable - An application cover letter or cover page is applicable

d. Project narrative

The applicant must provide a Project Narrative that articulates in detail the proposed goals, measurable objectives, and milestones to be completed in accordance with the instructions and content requirements provided below, consistent with section ***A.4. Program Requirements***.

e. Budget narrative

Applicants must supplement Form SF-424A with a Budget Narrative. The Budget Narrative must include a yearly breakdown of costs according to a 12-month period. See section ***B. Federal Award Information*** for more information on the performance period. Applicants must include a clear description of the proposed set of services that will be covered with award funds. The Budget Narrative should provide a detailed cost breakdown for each line item outlined in the SF-424A by award year, including a breakdown of costs for each activity/cost within the line item. The proportion of the requested funding designated for each activity should be clearly defined and should justify the applicant's readiness to receive funding. The budget must separate out funding that is administered directly by the lead agency from funding that will be subcontracted to other partners.

For more specific information and instructions for completing the SF-424A and Budget Narrative, please refer to ***Appendix I. Guidance for Preparing a Budget Request and Narrative***.

f. Business assessment of applicant organization (maximum 10 pages)

As required by 45 CFR §75.205 for competitive grants and cooperative agreements, CMS will evaluate the risk posed by an applicant before they receive an award. This analysis of risk includes items such as financial stability, quality of management systems, and the ability to meet the management standards prescribed in 45 CFR Part 75.

An applicant must review, answer, and submit the business assessment questions outlined in ***Appendix III. Business Assessment of Applicant Organization.***

D.3. Unique Entity Identifier and System for Award Management (SAM)

Unless the applicant is an individual or Federal awarding agency that is excepted from those requirements under 2 CFR 25.110(b) or (c), or has an exception approved by the Federal awarding agency under 2 CFR 25.110(d)), each applicant is required to:

I. Be registered in SAM before submitting its application;

II. Provide a valid unique entity identifier in its application; and

III. Continue to maintain an active SAM registration with current information at all times during which it has an active Federal award or an application or plan under consideration by a Federal awarding agency.

The Federal awarding agency may not make a Federal award to an applicant until the applicant has complied with all applicable unique entity identifier and SAM requirements and, if an applicant has not fully complied with the requirements by the time the Federal awarding agency is ready to make a Federal award, the Federal awarding agency may determine that the applicant is not qualified to receive a Federal award and use that determination as a basis for making a Federal award to another applicant.

D.4. Submission Dates and Times

All competitive applications must be submitted electronically and be received through www.grants.gov by the date and time set forth below. All non-competitive (including single source) applications must be submitted electronically and be received through GrantSolutions www.grantsolutions.gov. Applications submitted after 3:00 pm, Eastern Time, of the date set forth below will not be reviewed or considered for award.

Number of Days from Publication: 120 business days

Due Date for Applications (e.g., MM/DD/YYYY): 03/16/2021 3:00 PM Eastern U.S. Time

D.5. Intergovernmental Review

Applications for these awards 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.

D.6. Cost Restrictions

Prohibited Uses of Award Funds

No funds under this award may be used for any of the activities/costs outlined below unless an exception is specifically authorized by statute.

- Model funds cannot be used by an award recipient, or their sub-recipients, to conduct their own evaluations.
- To provide individuals with services that are already funded through any other source, including but not limited to Medicare, Medicaid, and CHIP.
- For specific components, devices, equipment, or personnel that are not integrated into the program proposal.
- To match any other Federal funds.
- To provide services, equipment, or supports that are the legal responsibility of another party under Federal, State, or Tribal 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 provide goods or services not allocable to the approved project.

- To supplant existing State, local, Tribal or private funding of infrastructure or services, such as staff salaries, etc.
- To be used by local entities to satisfy state matching requirements.
- To pay for construction.
- To pay for capital expenditures for improvements to land, buildings, or equipment which materially increase their value or useful life as a direct cost, except with the prior written approval of the Federal awarding agency.
- To pay for the cost of independent research and development, including their proportionate share of indirect costs (unallowable in accordance with 45 CFR 75.476).
- To use as profit to any award recipient even if the award recipient is a commercial organization, (unallowable in accordance with 45CFR 75.216(b)), except for grants awarded under the Small Business Innovative Research (SBIR) and Small Business Technology Transfer Research (STTR) programs (15 U.S.C. 638). Profit is any amount in excess of allowable direct and indirect costs.
- To expend funds related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order proposed or pending before the Congress or any state government, state legislature or local legislature or legislative body

Reimbursement of Pre-Award Costs: No

D.7. Mandatory Disclosure

Submission is required for all applicants, in writing, to the awarding agency and to the HHS Office of Inspector General (OIG), all information related to violations of federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the federal award. Applicants shall also disclose any investigations of, or sanctions on the applicant or individuals in leadership positions in the last five years by an accrediting body or state or federal government agency. Individuals in leadership positions include key executives who manage or have oversight responsibility for the organization, its finances, personnel, and quality improvement, including without limitation, a Chief Executive Officer (CEO), Chief Financial Officer (CFO), Chief Operations Officer (COO), Chief Information Officer (CIO), medical director, compliance officer or an individual responsible for maintenance and stewardship of clinical data. Applicants will also be required to disclose any outstanding debts owed to Medicare.

Disclosures must be sent in writing to:

U.S. Department of Health and Human Services

Centers for Medicare and Medicaid Services

Office of Acquisition and Grants Management

Attn: Director, Division of Grants Management

7500 Security Blvd, Mail Stop B3-30-03
Baltimore, MD 21244-1850

AND

U.S. Department of Health and Human Services

Office of Inspector General

ATTN: Mandatory Grant Disclosures, Intake Coordinator

330 Independence Avenue, SW, Cohen Building

Room 5527

Washington, DC 20201

URL: Health and Human Services OIG website link to fraud reports

(Include "Mandatory Grant Disclosures" in subject line)

Fax: (202) 205-0604 (Include "Mandatory Grant Disclosures" in subject line) or

Email: MandatoryGranteeDisclosures@oig.hhs.gov

Materials should also be scanned and emailed to the Grants Management Specialist assigned to this Funding Opportunity.

D.8. Other Submission Requirements (if applicable)

None.

E. Application Review Information

E.1. Criteria

Applicants must submit applications in the required format, no later than the deadline date. If an applicant does not submit all of the required documents and does not address each of the topics described in D2. Content and Form of Application Submission Information (with cross reference to E1. Criteria), the applicant risks not being eligible and/or awarded. Applications are reviewed in accordance with criteria outlined below.

This section fully describes the evaluation criteria for this cooperative agreement. In preparing applications, applicants should review the requirements detailed in section ***A.4. Program***

Requirements. Applicants must submit applications in the required format, no later than the deadline date. If an applicant does not submit all of the required documents and does not address each of the topics described in section ***D.2. Content and Form of Application Submission,*** the applicant may be disqualified from consideration for award. Technical review panelists will assess and score applicants' responses in accordance with the criteria below, using a scale of 100 total points.

Note to applicants:

- CMMI will consider the geographic diversity of all applications when making final award determinations.
- Awards may be adjusted to a lower amount if the applicant fails to meet programmatic requirements (refer to section ***F.5. Reporting***).
- The application itself is not a legally binding contract and does not require any applicant or CMMI to enter into a cooperative agreement.
- CMMI will select award recipients at CMMI's sole discretion. Such selection will not be subject to administrative or judicial review, per section 1115A(d)(2) of the Act.

Table 11. Required Application Sections and Point Values

Application Section	Point Values	Page Limits
Project Abstract	0 points	1 page
Project Narrative		60 pages
Model Context	15 points	
Implementation Strategy		
Organizational Capacity of Lead Organization	15 points	
Advisory Council	10 points	
Health Care Delivery System Redesign Concept	15 points	
Impact Analysis	10 points	
Sustainability Plan	10 points	
Evaluation	5 points	
Budget Narrative	20 points	10 pages
	Total 100 points	71 pages

NOTE: Organizational charts, MOUs, LOIs, job descriptions, and resumes attached as appendices do not count towards page limits.

E.1.1. Project Abstract

Applicants should submit a one-page, single-spaced abstract to serve as a succinct description of the proposed project. The abstract should include the proposed Model geographic service area, the goals of the project, the total budget, and a description of how the cooperative agreement funds will be used. The abstract is often distributed to provide information to the public and Congress, thus applicants should write the abstract so that it is clear, accurate, concise, and without reference to other parts of the application. Personal identifying information should be excluded from the abstract. Applicants should upload the abstract in the Grants Application Package which can be found at Grants government website select the "Project Abstract Summary," and complete the form.

E.1.2. Project Narrative

Review criteria for the Project Narrative are described below. All elements of the Project Narrative are required and will be used to assess an applicant's ability to design and implement a Model intervention that lowers costs and improves quality of care for rural communities.

Incomplete, unclear, and confusing proposals will receive point deductions. Project Narratives with significant content deficiencies may receive a score of zero. Proposals that merely restate the content of the NOFO, without responding to the Program Requirements and Application Review Criteria, will receive a score of zero.

The Project Narrative must be double-spaced and should not exceed 60 pages in length. This page limit does not include the MOUs, Letters of Intent (LOIs), organizational charts, job descriptions, or resumes, which should be clearly titled and attached as appendices. The LOIs requested in the Project Narrative section of the CHART application are distinct from the general LOI that applicants are encouraged to submit by February 17th, 2021, which signal their intent to submit an application. Each component of the Project Narrative will be weighted as indicated below.

E.1.2.1. Model Context *15 Points*

E.1.2.1.1. Characteristics of Proposed Community

Applicants must populate the following table with data on their Community and submit it with their application. If any of the requested information is not available, the applicant should provide proxy data and provide an explanation of why the proxy data are appropriate. Applicants must provide verifiable sources for all data.

	Community-level Data	Source
A list of the contiguous or non-contiguous rural counties or rural census tracts that comprise the Community		

	Community-level Data	Source
Provide the number and quantify the payer mix for each of the following: (e.g., 2 Critical Access Hospitals in the Community and their payer mix is 35% Medicare beneficiaries, 35% Medicaid beneficiaries, 10% Medicare and Medicaid dual eligible, and 20% Commercial beneficiaries)		
Ambulatory Surgical Centers (ASC)		
Critical Access Hospitals (CAHs)		
Federally Qualified Health Centers (FQHCs)		
Home Health Agencies (HHA)		
Acute Care Hospitals		
Opioid Treatment Programs		
Physician Practices		
Rural Health Clinics (RHCs)		
Skilled Nursing Facilities (SNFs)		
Urgent Care Centers		
Other (please add to the list as appropriate)		
Annual FFS Medicare revenue: • for FY2018 • for FY2019		
Number of beneficiaries whose primary residence is within the Community **and** average annual total cost of care for the following groups: • FFS Medicare beneficiaries (excluding dually-eligible beneficiaries) • FFS Medicaid beneficiaries (excluding dually-eligible beneficiaries) • Medicare and Medicaid managed care beneficiaries • Medicare and Medicaid dual eligible beneficiaries		
Number of beneficiaries with commercial insurance		
Number of uninsured residents		
Additional Information – at the discretion of the applicant, no more than three additional data points that describe the Community:		

	Community-level Data	Source
Additional Data Point 1:		
Additional Data Point 2:		
Additional Data Point 3:		

In addition to the table above, applicants must provide an assessment of legal authorities and barriers to health care delivery system redesign, including a description of existent and planned Certificate of Public Advantage (COPA) arrangements and/or merger activity among health care providers and payers. At a minimum, please describe:

1. Proportion of health care providers the COPA or merger activity served or will serve within each payer's mix;
2. Any price-related details included in the COPA or merger activity such as price growth caps, market share limits, and its effect on prices and available services; and
3. Any mitigation actions or strategies for the identified barriers to the planned health care delivery system redesign.

E.1.2.1.2. Community Selection Rationale and Gap Analysis

Applicants must demonstrate how the proposed Community would benefit from the CHART Model and describe the key issues that would be accounted for in their Transformation Plan. Specifically, applicants must provide the following:

1. A rationale for why they selected their proposed Community (e.g., the area has relatively high need; the Lead Organization's connection with the region; existing health systems infrastructure, etc.). Within their rationale, applicants should justify their Community's geographic parameters.
2. A summary of any health care delivery system redesign (including APMs) that the Community has undertaken previously, or are currently undertaking, as well as their outcomes.
3. A Gap Analysis consisting of a survey of the key issues existent in their community that they want to address in their Transformation Plan, including preliminary information on the population health, access, and quality outcomes of greatest interest to the community (e.g., specific chronic conditions or health disparities).

E.1.2.2. Implementation Strategy

E.1.2.2.1. Organizational Capacity of Lead Organization *15 Points*

Applicants must demonstrate their capacity to organize and manage the Model. Specifically, applicants must:

a) Provide a description of the Lead Organization;

b) Describe how the Lead Organization meets the eligibility requirements, including associated outcomes of those experiences, described in section ***A.4.3 Lead Organization and the Community***;

c) Describe the Lead Organization's community engagement efforts. For example, the Lead Organization's relationship with community based organizations, faith based organizations, and other advocates, particularly those that serve racial and ethnic minority groups.

d) Describe the Lead Organization's experience designing and implementing health care delivery system redesign and associated outcomes;

e) If the SMA is not the Lead Organization, describe the Lead Organization's past relationship with the SMA, and summarize any previous collaborations or partnerships;

f) Describe staff capacity (organizational charts, job descriptions, and resumes should be attached as appendices and do not count towards page limits) by:

   i. Providing job descriptions (including for positions that may be currently vacant) for all key staff that will be involved in the Model;

   ii. Identifying the individual or individuals who will have management authority over the Model and provide a resume or curriculum vitae as an appendix for each identified manager;

   iii. Identifying the individual who will be the project director (primary liaison to CMMI for the Model) and provide a resume or curriculum vitae for that person;

   iv. Providing an organizational chart for the Lead Organization that identifies lines of authority and name the Authorized Organizational Representative;

g) Describe how the Lead Organization, in collaboration with the Advisory Council, will ensure effective collaboration among its Community Partners (see section ***A.4.4. Community Partners***), including any management controls, communication, and coordination mechanisms that will be utilized to ensure the timely, successful, and collaborative execution of this project; and

h) Describe the anticipated role of any subrecipients or contractors the Lead Organization may engage to help implement CHART.

E.1.2.2.2. Advisory Council ***10 Points***

Applicants must establish their Advisory Council before submitting their application. CMMI will evaluate the extent to which the Advisory Council is reflective of the Community's needs. Applicants must describe how its Advisory Council meets the requirements of section ***A.4.4.1. Advisory Council***, including:

a) For each Advisory Council member, provide:

   i. Member's name;

   ii. Legal name of the organization they represent and their position title within that organization;

   iii. Anticipated role and responsibilities on the Advisory Council;

   iv. Which Advisory Council representative category they belong as outlined in section ***A.4.4.1. Advisory Council;*** and

   v. Anticipated time commitment.

b) Provide a description of the Lead Organization's key objectives for the Advisory Council during the Pre-Implementation Period, including a strategy for creating and updating the Transformation Plan (objectives for Performance Periods will be addressed in future Transformation Plans during annual updates).

c) Documentation of Advisory Council: provide a LOI signed by all members of the Advisory Council documenting that the Advisory Council has been formed prior to submission.

E.1.2.2.3. Health Care Delivery System Redesign Concept ***15 Points***

Applicants must include a health care delivery system redesign concept in their applications. CMMI will evaluate concept efficacy, responsiveness to the issues identified in the applicant's gap analysis, and the extent to which applicants identify opportunities to collaborate with stakeholders. Applicants are encouraged to note areas that are not finalized, highlight where they plan to seek stakeholder input, and outline key options. Applicants must submit:

1. A summary of preliminary health care delivery system redesign concepts and, if possible, describe how many beneficiaries they expect will be impacted by each proposed intervention. Applicants are encouraged to refer to ***Appendix VII. Examples of Health Care Delivery System Redesign*** for inspiration.

2. Documentation of Participant Hospital interest. A description of the interest they have received from potential Participant Hospitals (e.g., facility name, facility type, estimated annual FFS Medicare revenue). Each application must include at least one LOI from a potential Participant Hospital. Each potential Participant Hospital's LOI must include:

    a. Hospital type (acute care hospital (defined as a "subsection (d) hospital" in section 1886(d)(1)(B) of the Act) or CAH;

    b. Its annual FFS Medicare revenue for each of the past five years (2014 to 2019);

    c. The number of Medicare FFS beneficiaries from the Community served by the Participant Hospital in each of the past five years; and

    d. Whether the potential Participant Hospital's physical location is in the Community or outside of the Community.

    e. Attestation that the potential Participant Hospital meets the eligibility criteria and is willing to perform required activities, as described in section ***A.4.4.2. Participant Hospitals.***

    NOTE: Applicants with a greater number of LOIs from potential Participant Hospitals, relative to the total number of potential Participant Hospitals within the Community, will be given preference during the application review process.

3. A description of their Participant Hospital recruitment strategy for the Pre-Implementation Period.

4. A description of which operational flexibilities they are interested in using and for what purpose, including how such flexibilities will further CHART's objectives (see section ***A.4.6. Operational Flexibilities under the Model*** for a description of the operational flexibilities).

5. Description of Aligned Payer interest. A description of the interest they have received from potential Aligned Payers. Include the name of the potential Aligned Payers as well as the number and type of members (e.g., Medicaid managed care, Medicare Advantage, employer-sponsored, etc.) they serve in the proposed Community.

6. Documentation of SMA commitment. Applicant must submit a MOU from their SMA that includes the following information:

    a. Attestation that the SMA understands and is willing to perform the activities required of it, as described in sections ***A.4.4.3. State Medicaid Agency*** and ***A.4.5.3. Multi-payer Alignment***.

b. Attestation that the SMA will, no later than 45 days after the start of the Pre-Implementation Period, meet with representatives of CMCS to begin designing and implementing any changes to its Medicaid program required to execute CHART financial alignment.

c. A populated Medicaid Needs Assessment Table, provided in ***Appendix IX. Medicaid Needs Assessment.***

NOTE: Information included in a CHART Model application will be used solely for the purpose of application review and does not represent a formal request for a State Plan Amendment, waiver, or demonstration approval on the part of the state; nor a commitment of approval on the part of CMS.

MOUs and LOIs should be signed by an authorized organizational representative and submitted as appendices. They will not count toward page limits. Upon award, Lead Organizations will finalize, with CMMI review and approval, their health care delivery system redesign strategy in the form of the Transformation Plan by or before the end of the Pre-Implementation Period.

E.1.2.2.4. Impact Analysis ***10 Points***

Applicants should describe specific impact goals and the strategies they plan to implement to achieve them. Applicants should quantify effects as much as possible. Specifically, applicants must:

1. Identify how their proposed interventions will impact quality of care, access to care, and health disparities (especially for primary, behavioral health, substance use disorder treatment, chronic disease management and prevention, and maternal and infant health);

2. Describe how their health care delivery system redesign will yield savings in community-wide health care spending (applicants should consider whether proposed changes could lead to cost increases); and

3. Describe the impact of their proposed program on beneficiaries' health outcomes.

E.1.2.3. Sustainability Plan ***10 Points***

CMMI will use information provided in this section to assess the likelihood that an award would lead to sustained change after the Model Performance Period ends. Applicants must describe their strategy for sustaining their health care delivery system redesign in the event that the Model is **NOT** extended after the final Performance Period. It may not be feasible for an award recipient to sustain the entirety of their program if the Model is not extended. Thus, in this section applicants should:

1. Identify which elements of their health care delivery system redesign strategy could be sustained if the Model was not extended and describe how they would sustain those program elements.

2. If applicable, applicants should describe whether they have secured any supplemental sources of funding, are in the process of securing supplemental funding, or have any plans to explore supplemental funding sources (see ***Appendix VIII. Additional Resources for Applicants: Literature and Funding Opportunities***). NOTE: Securing supplemental funding is **NOT** a program requirement.

E.1.2.4. Evaluation ***5 Points***

Applicants should use this section to describe their strategy for ensuring participation in the CMMI's mandatory Model evaluation from all Model partners and participants, including Participant Hospitals, patients, and any other individuals or entities. Applicants must:

1. A description of how the applicant will ensure they meet the evaluation requirements of the Model.

2. Indicate their willingness to participate in qualitative evaluation tasks, which may include coordinating with the evaluation contractor to arrange site visits, observations, interviews, and focus groups with health care providers and patients as well as program staff.

3. Indicate their willingness and ability to submit program documents, training materials, and any other program-related materials to CMMI and its contractors and to assist in arranging other data gathering activities in accordance with applicable law.

4. Demonstrate their capacity to provide patient- and program-level data, provide personal identifiers that will allow all patients to be identified in Medicaid FFS and managed care claims, and submit patient medical information through a system that complies with all applicable privacy and security requirements, including HIPAA and 42 C.F.R. Part 2; obtaining required consent and authorization; and other activities as needed.

5. Indicate whether there will be any restrictions on applicants' ability to share protected health information (PHI) and/or personally identifiable information (PII) with CMMI, for example, any applicable federal or state laws.

    a. If so, include an explanation of whether those restrictions would prevent the SMA, Lead Organization, or Participant Hospitals from participating in evaluation activities

6. Applicants must describe the Transformed Medicaid Statistical Information System (T-MSIS) data submission status of their SMA. If the applicant's SMA is not submitting production data monthly to T-MSIS and/or their catch-up data files are not current at the time of application, then the applicant must coordinate with the SMA to submit a timeline for achieving timely, monthly production data submission. If the SMA believes it may be unable to submit T-MSIS data for any portion of the CHART Performance Period, the applicant must provide CMMI with a data submission plan for Medicaid claims data.

E.1.3. Additional Required Documentation

E.1.3.1. Model Budget Narrative *20 Points*

Applicants should provide a reasonable justification for the proposed Model budget for the Pre-Implementation Period and each Performance Period. Applicants must respond to each of the requirements set out in section ***A.4. Program Requirements***. Specifically, applicants should provide a budget with sufficient detail that would allow CMMI to understand how the applicant would meet their objectives given their budget and to assess the reasonableness of the proposed budget. Applicants should clearly identify apportionment of funds between the Lead Organization and other entities and provide line items for all activities related to Model implementation. **In particular, per CHART's program requirements (see section *A.4.4.3. State Medicaid Agency*) the SMA must be a named subrecipient of CHART cooperative agreement funding.** The budget must separate out funding that will be administered directly by the Lead Organization from funding that will be subcontracted to other partners. Though the Lead Organization and SMA must partner together to submit an application and implement this award, only one entity will be the award recipient. For more information on subrecipient and contractual relationships, please refer to HHS regulation 45 CFR 75.351 Subrecipient and Contractor Determinations and 75.352 Requirements for pass-through entities. Applicants must verify they understand that they are required to avoid program duplication and ensure that award funds are not used to duplicate or supplant current federal, state, or local funding. Specifically, award funds cannot be used for the non-federal share of Medicaid payments. Finally, applicants should identify what current (not required) or potential future supplemental funding streams could apply to these activities, and identify gaps toward which they could apply Model funding. The Budget Narrative may be single or double-spaced and should not exceed 10 pages in length.

E.2. Review and Selection Process

Please refer to ***Appendix V. Review and Selection Process*** for more information on the review and selection process.

E.3. Federal Awardee Performance Integrity Information System (FAPIIS)

In accordance with 45 CFR Part 75:

I. CMS, prior to making a Federal award with a total amount of Federal share greater than the simplified acquisition threshold, is required to review and consider any information about the applicant that is in the designated integrity and performance system accessible through SAM (currently FAPIIS) (see 41 U.S.C. 2313);

II. An applicant, at its option, may review information in the designated integrity and performance systems accessible through SAM and comment on any information about itself that the HHS awarding agency previously entered and is currently in the designated integrity and performance system accessible through SAM.

III. CMS will consider any comments by the applicant, in addition to the other information in the designated integrity and performance system, in making a judgment about the applicant's integrity, business ethics, and record of performance under Federal awards when completing the review of risk posed by Applicant as described in §75.205.

F. Federal Award Administration Information

F.1. Federal Award Administration Information

If successful, applicant will receive a Notice of Award (NoA) signed and dated by the HHS Grants Management Officer. The NoA is the document authorizing the grant or cooperative agreement award and will be issued to the applicant as listed on the SF-424 and available to the applicant organization through the online grants management system used by CMS and award recipient organizations. Any communication between HHS and applicant prior to issuance of the NoA is not an authorization to begin performance of a project.

If unsuccessful, applicant will be notified by letter, sent electronically or through the U.S. Postal Service to the address as listed on its SF-424, within 30 days of the award date.

F.2. Administrative and National Policy Requirements

A. National/Public Policy Requirements

By signing the application, the authorized organizational official certifies that the organization will comply with applicable public policies. Once a grant is awarded, the award recipient is responsible for establishing and maintaining the necessary processes to monitor its compliance and that of its employees and, as appropriate, subrecipients and contractors under the cooperative agreement with these requirements. Award recipients should consult the applicable Appropriations Law, Exhibit 3 of the HHS Grants Policy Statement, titled Public Policy Requirements, located in Section II, pages 3-6, as well as the terms and conditions of award for information on potentially applicable public policy requirements.

Non-Discrimination

All award recipients receiving awards under this cooperative agreement project must comply with all applicable Federal statutes relating to nondiscrimination, including, but not limited to:

a. Title VI of the Civil Rights Act of 1964,

b. Section 504 of the Rehabilitation Act of 1973,

c. The Age Discrimination Act of 1975, and

d. Title II, Subtitle A of the Americans with Disabilities Act of 1990.

e. Section 1557 of the Affordable Care Act;

f. Title IX of the Education Amendments of 1972; and

g. Applicable federal religious nondiscrimination laws, HHS agency website link to religious freedom and applicable federal conscience protection and associated anti-discrimination laws HHS agency website link to conscience protections information

Accessibility Provisions

Recipients of federal financial assistance (FFA) from HHS must administer their programs in compliance with federal civil rights laws that prohibit discrimination on the basis of race, color, national origin, disability, age and, in some circumstances, religion, conscience, and sex. This includes ensuring programs are accessible to persons with limited English proficiency. The HHS Office for Civil Rights provides guidance on complying with civil rights laws enforced by HHS. Please see HHS agency website link to provider obligations and HHS agency website link to understanding section 1557

Recipients of FFA must ensure that their programs are accessible to persons with limited English proficiency. HHS provides guidance to recipients of FFA on meeting their legal obligation to take reasonable steps to provide meaningful access to their programs by persons with limited English proficiency. Please see HHS agency website link to fact sheet guidance and Limited English Proficiency agency website. For further guidance on providing culturally and linguistically appropriate services, recipients should review the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care at HHS Minority Health agency website.

- Recipients of FFA also have specific legal obligations for serving qualified individuals with disabilities. Please see HHS agency website link to understanding disability

- HHS funded health and education programs must be administered in an environment free of sex discrimination, including sexual harassment. Please see HHS agency website link to sex discrimination and U.S Department of Education.

- Recipients of FFA must also administer their programs in compliance with applicable federal religious nondiscrimination laws and applicable federal conscience protection and associated anti-discrimination laws. Collectively, these laws prohibit exclusion, adverse treatment, coercion, or other discrimination against persons or entities on the basis of their consciences, religious beliefs, or moral convictions. Please see: HHS agency website link to conscience protections and HHS agency website link to religious freedom.

Recipients should review and comply with the reporting and review activities regarding accessibility requests outlined in ***Appendix IV: Accessibility Requirements*** of this Notice of Funding Opportunity.

Please contact the HHS Office for Civil Rights for more information about obligations and prohibitions under federal civil rights laws at HHS agency OCR website or call 1-800-368-1019 or TDD 1-800-537-7697.

B. Administrative Requirements

- All equipment, staff, and other budgeted resources and expenses must be used exclusively for the projects identified in the applicant's original application or agreed upon subsequently with HHS, and may not be used for any prohibited uses.

- Consumers and other stakeholders must have meaningful input into the planning, implementation, and evaluation of the project.

- This award is subject to 45 CFR Part 75, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS awards [available at Electronic Code of Federal Regulations website] which implements 2 CFR Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards ("Uniform Guidance") effective December 26, 2014. See below for more information.

Uniform Administrative Requirements, Cost Principles, and Audit Requirements

Applicant and award recipients should take particular note of the following information found in 45 CFR Part 75:

Uniform Administrative Requirements

In accordance with 45 CFR §75.112, all award recipients receiving federal funding from CMS must establish and comply with the conflict of interest policy requirements outlined by CMS (available for applicant upon request).

In accordance with 45 CFR §75.113, Mandatory Disclosures, the non-Federal entity or applicant for a Federal award must disclose, in a timely manner, in writing to the HHS awarding agency or pass-through entity all violations of Federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the Federal award. Non-Federal entities that have received a Federal award including the term and condition outlined in Appendix XII to 45 CFR Part 75 are required to report certain civil, criminal, or administrative proceedings to SAM. Failure to make the required disclosures can result in the imposition of any of the remedies described in §75.371, including suspension or debarment. (See also 2 CFR Parts 180 and 376, and 31 U.S.C. 3321). For specific information on reporting such disclosures to CMS and HHS please see section ***F.3. Terms and Conditions*** of this NOFO.

Cost Principles

CMS grant and cooperative agreement awards provide for reimbursement of actual, allowable costs incurred and are subject to the Federal cost principles. The cost principles establish standards for the allowability of costs, provide detailed guidance on the cost accounting treatment of costs as direct or indirect, and set forth allowability and allocability principles for selected items of cost. Applicability of a particular set of cost principles depends on the type of organization. Award recipients must comply with the cost principles set forth in HHS regulations at 45 CFR Part 75, Subpart E with the following exceptions: (1) hospitals must follow Appendix IX to part 75 and commercial (for-profit) organizations are subject to the cost principles located at 48 CFR subpart 31.2. As provided in the cost principles in 48 CFR subpart 31.2, allowable travel costs may not exceed those established by the Federal Travel Regulation (FTR).

There is no universal rule for classifying certain costs as either direct or indirect (also known as Facilities & Administration (F&A) costs) under every accounting system. A cost may be direct with respect to some specific service or function, but indirect with respect to the Federal award or other final cost objective. Therefore, it is essential that each item of cost incurred for the same purpose is treated consistently in like circumstances either as a direct or F&A cost in order to avoid double-charging of Federal awards. Guidelines for determining direct and F&A costs charged to Federal awards are provided in 45 CFR §§75.412 to 75.419. Requirements for development and submission of indirect (F&A) cost rate proposals and cost allocation plans are contained in Appendices III-VII, and Appendix IX to Part 75.

Indirect Costs

HHS will reimburse indirect costs to award recipients under an award if (1) allowable under the governing statute, regulations, or HHS grants policy; (2) the award recipient requests indirect costs; and (3) the award recipient has a federally approved indirect cost rate agreement covering the grant supported activities and period of performance or the non-federal entity has never received an indirect cost rate and elects to charge a de minimis rate of 10% of Modified Total Direct Costs (MTDC).

If the applicant entity has a current negotiated indirect cost rate agreement (NICRA) and is requesting indirect costs, a copy of the current NICRA must be submitted with the application. Any non-Federal entity that has never received a negotiated indirect cost rate, except for those non-Federal entities described in Appendix VII(D)(1)(b) to 45 CFR part 75, may elect to charge a de minimis rate of 10% of MTDC which may be used indefinitely.

Commercial (For-Profit) Organizations: Indirect Costs are allowable under awards to for-profit organizations. The for-profit award recipient must have a federally-approved indirect cost rate agreement covering the grant supported activities and period of performance. Indirect cost rates for for-profit entities are negotiated by DFAS in the Office of Acquisition Management and Policy, National Institutes of Health (if the preponderance of their federal awards are from HHS), available at NIH Office of Management, Office of Acquisition Management and Policy website, or other Federal agency with cognizance for indirect cost rate negotiation. If there is no federally-approved indirect cost rate for the specific period of performance and the for-profit award recipient has never received an indirect cost rate, then the non-federal entity may elect to charge a de minimis rate of 10% of MTDC.

Cost Allocation

In accordance with 45 CFR §75.416 and Appendix V to Part 75 – State/Local Government-wide Central Service Cost Allocation Plans, each state/local government will submit a plan to the HHS Cost Allocation Services for each year in which it claims central service costs under Federal awards. Guidelines and illustrations of central service cost allocation plans are provided in a brochure published by the HHS entitled "A Guide for State, Local and Indian Tribal Governments: Cost Principles and Procedures for Developing Cost Allocation Plans and Indirect Cost Rates for Agreements with the Federal Government." A copy of this brochure may be obtained from the HHS Cost Allocation Services at HHS agency program support center website. A current, approved cost allocation plan must be provided to CMS if central service costs are claimed.

Public Assistance Cost Allocation Plans

Appendix VI to Part 75 – Public Assistance Cost Allocation Plans, provides that state public assistance agencies will develop, document and implement, and the Federal Government will review, negotiate, and approve, public assistance cost allocation plans in accordance with Subpart E of 45 CFR part 95. The plan will include all programs administered by the state public assistance agency. Where a letter of approval or disapproval is transmitted to a state public assistance agency in accordance with Subpart E, the letter will apply to all Federal agencies and programs. This Appendix (except for the requirement for certification) summarizes the provisions of Subpart E of 45 CFR part 95.

Audit Requirements

The audit requirements in 45 CFR Part 75, Subpart F apply to each award recipient fiscal year that begins on or after December 26, 2014. A non-Federal entity that expends $750,000 or more during the non-Federal entity's fiscal year in Federal awards must have a single or program-specific audit conducted for that year in accordance with the provisions of Subpart F, Audit Requirements.

Commercial Organizations (including for-profit hospitals) have two options regarding audits, as outlined in 45 CFR §75.501 (see also 45 CFR §75.216).

F.3. Terms and Conditions

This Notice of Funding Opportunity is subject to the Department of Health and Human Services Grants Policy Statement (HHS GPS) at HHS agency website.

The general terms and conditions in the HHS GPS will apply as indicated unless there are statutory, regulatory, or award-specific requirements to the contrary. Standard and program specific terms of award will accompany the NoA. 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 HHS review panel. HHS regulation (45 CFR Part 75) supersedes information on administrative requirements, cost principles, and audit requirements for grants and cooperative agreements included in the current HHS Grants Policy Statement where differences are identified. Recipients must also agree to respond to requests that are necessary for the evaluation of national efforts and provide data on key elements of their own grant or cooperative agreement activities.

HHS may terminate any CMS award for material noncompliance.
Material noncompliance includes, but is not limited to, violation of the terms and conditions of the award; failure to perform award activities in a satisfactory manner; improper management or use of award funds; or fraud, waste, abuse, mismanagement, or criminal activity.

In the event an award recipient or one of its subrecipients enters into proceedings relating to bankruptcy, whether voluntary or involuntary, the award recipient agrees to provide written notice of the bankruptcy to CMS. This written notice shall be furnished within five (5) days of the initiation of the proceedings relating to bankruptcy filing and sent to the CMS Grants Management Specialist and Project Officer. This notice shall include the date on which the bankruptcy petition was filed, the identity of the court in which the bankruptcy petition was filed, a copy of any and all of the legal pleadings, and a listing of Government grant and cooperative agreement numbers and grant offices for all Government grants and cooperative agreements against which final payment has not been made.

Intellectual Property

Award recipients under this solicitation must comply with the provisions of 45 CFR § 75.322, Intangible property and copyrights. The non-Federal entity may copyright any work that is subject to copyright and was developed, or for which ownership was acquired, under a Federal award. The Federal awarding agency reserves a royalty-free, nonexclusive, and irrevocable right to reproduce, publish, or otherwise use the work for Federal purposes, and to authorize others to do so. The non-Federal entity is subject to applicable regulations governing patents and inventions, including government-wide regulations issued by the Department of Commerce at 37 CFR part 401.

The Federal Government has the right to:

1) Obtain, reproduce, publish, or otherwise use the data produced under a Federal award; and

2) Authorize others to receive, reproduce, publish, or otherwise use such data for Federal purposes.

F.4. Cooperative Agreement Terms and Conditions of Award

The administrative and funding instrument used for this program will be a Cooperative Agreement, an assistance mechanism in which substantial CMS programmatic involvement with the award recipient is anticipated during the performance of the activities. Under each Cooperative Agreement, CMS's purpose is to support and stimulate the award recipient's activities by involvement in, and otherwise working jointly with, the award recipient in a partnership role. To facilitate appropriate involvement during the period of this Cooperative Agreement, CMS and the award recipient will be in contact at least once a month, and more frequently when appropriate.

Cooperative Agreement Roles and Responsibilities are as follows:

Centers for Medicare and Medicaid

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

- Technical Assistance – CMS will host opportunities for training and/or networking, including conference calls and other vehicles.

- Collaboration – To facilitate compliance with the terms of the Cooperative Agreement and to support recipients more effectively, CMS may actively coordinate with other relevant Federal Agencies including but not limited to the Indian Health Service, the Internal Revenue Service, the Department of Homeland Security, the Administration for Children and Families, the Health Resources and Services Administration, the Centers for Disease Control and Prevention, and the Social Security Administration.

- Program Evaluation – CMS will work with award recipients to implement lessons learned.
- Project Officers and Monitoring – CMS will assign specific Project Officers to each Cooperative Agreement award to support and monitor award recipients throughout the period of performance. CMS Grants Management Officers, Grants Management Specialists, and Project Officers will monitor, on a regular basis, progress of each award recipient. This monitoring may be by phone, document review, on-site visit, other meeting and by other appropriate means, such as reviewing program progress reports and Federal Financial Reports (FFR or SF-425). This monitoring will be to determine compliance with programmatic and financial requirements.

Recipients

Award recipients and assigned points of contact retain the primary responsibility and dominant role for planning, directing and executing the proposed project as outlined in the terms and conditions of the Cooperative Agreement and with substantial CMS involvement. Award recipients shall engage in the following activities:

- Reporting – comply with all reporting requirements outlined in this funding opportunity and the terms and conditions of the Cooperative Agreement to ensure the timely release of funds.
- Program Evaluation – cooperate with CMS-directed national program evaluations.
- Technical Assistance - Participate in technical assistance venues as appropriate.
- Program Standards – comply with all applicable current and program requirements and standards, as detailed in regulations, guidance, and the cooperative agreement terms and conditions provided with the NoA.

F.5. Reporting

Each Lead Organization must meet the reporting requirements discussed in this section.

F.5.1. Financial Reports

Quarterly Cash Transaction Financial Reporting

Award recipients must report, on a quarterly basis, cash transaction data via the Payment Management System (PMS) using the Federal Financial Report (SF-425 or FFR) form.
The FFR combines the information that award recipients previously provided using two forms: the Federal Cash Transactions Report (PSC-272) and the Financial Status Report (SF-269). Cash transactions data is reflected through completion of lines 10a-10c on the FFR. Award recipient

must include information on indirect costs if approved as part of grant (or cooperative agreement) award. The quarterly FFR is due within (30) days after the end of each quarter.

Semi-Annual, Annual, and Final Expenditure Reporting

Award recipient must also report on Federal expenditures, award recipient Share (if applicable), and Program Income (if applicable and/or allowable) at least annually. Frequency of expenditure reporting, whether semi-annually or annually, is stipulated in the Program Terms and Conditions of award. This information is reflected through completion of lines 10d through 10o of the FFR. Award recipient must include information on indirect costs if approved as part of grant (or cooperative agreement) award.

Additional information on financial reporting will be provided in the terms and conditions of award.

Federal Funding Accountability and Transparency Act Reporting Requirements.

New awards issued under this NOFO 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 award recipients must report information for each first-tier sub- award of $25,000 or more in Federal funds and executive total compensation for the award recipients and subrecipient's five most highly compensated executives as outlined in Appendix A to 2 CFR Part 170 (available online on The Federal Funding Accountability and Transparency Act Subaward Reporting System website)

Audit Requirements

Award recipients must comply with audit requirements outlined in HHS regulation 45 CFR Part 75 (implementing 2 CFR Part 200). See Subpart F – Audit Requirements.

Payment Management System Reporting Requirements

Once an award is made, the funds are posted in award recipient accounts established in the Payment Management System (PMS). Award recipients may then access their funds by using the PMS funds request process.

The PMS funds request process enables award recipients to request funds using a Personal Computer with an Internet connection. The funds are then delivered to the award recipient via Electronic Funds Transfer (EFT). If you are a new award recipient, please go to PMS Access Procedures to find information to register in PMS. If you need further help with that process, please contact the One-DHHS Help Desk via email at pmssupport@psc.gov or call (877) 614-5533 for assistance.

Frequency of expenditure reporting is stipulated in the Program Terms and Conditions of award. Additional information on financial reporting will be provided in the terms and conditions of award.

F.5.2. Monitoring

CMMI Monitoring Plan

As part of the Community Transformation Track of the CHART Model, CMMI will implement a monitoring plan designed to protect beneficiaries and address potential program integrity risks. CMMI will employ a range of methods to monitor and assess compliance by the Lead Organization and Participant Hospitals to ensure compliance with the terms of the Cooperative Agreement and the Participation Agreements with Participant Hospitals. CMMI monitoring activities may include, but are not limited to:

- Claims analyses to identify fraudulent behavior or program integrity risks such as inappropriate reductions in care, overutilization, and cost-shifting to other payers or populations;
- Interviews with any individual or entity participating in the Model including members of leadership and management and associated health care providers and suppliers;
- Interviews with CHART beneficiaries and their caregivers;
- Audits of charts, medical records, Implementation Plans, and other data from participating hospitals and health care providers;
- Site visits to participating hospitals; and
- Documentation requests sent to the hospitals including surveys and questionnaires

Quarterly and Annual Performance Progress Reports:

Each Lead Organization will be required to submit quarterly progress reports (QPR) and annual performance progress reports (APR). CMMI will provide Lead Organizations with guidance and a template for progress report submissions. These reports will include narrative updates on Model activities as well as information on operational and performance requirements in accordance with the CHART Model cooperative agreement. CMMI will use the quarterly and annual reports to track progress on Model goals, identify technical assistance needs, and inform learning activities for all participants. The operations and performance requirements will support CMMI efforts to confirm that each Lead Organization is delivering high quality care to beneficiaries. CMMI will also share these findings with Lead Organizations individually on an ongoing basis for quality improvement purposes. CMMI will consider Lead Organizations for corrective action, funding restrictions, or termination if they do not meet the Model reporting

requirements outlined in their cooperative agreement Notice of Award and Terms and Conditions or other federal award documentation.

F.5.3. Evaluation

CMMI will evaluate the CHART Model pursuant to section 1115A (b)(4) of the Act. Lead Organizations will be required to provide data and interact with CMMI and the CMMI independent evaluation contractor in accordance with 42 C.F.R. § 403.1110. Evaluation data may include, but is not limited to, individually identifiable health information that is needed to carry out CMMI's evaluation of the CHART Model, hosting and managing site visits, and making staff available for interviews (on site or telephonic). Lead Organizations will be responsible for ensuring that aligning payers report quarterly and annual utilization and monthly expenditures. CMMI will not collect individually identifiable information from Aligned Payers. CMMI will seek to reduce burden in requests for additional evaluation data from Lead Organizations and Participant Hospitals. IRB approval or any other permissions are the sole responsibility of applicants and their partners.

CMMI will utilize data from the Transformed Medicaid Statistical Information System (T-MSIS) to monitor and evaluate Medicaid outcomes. Lead Organizations are responsible for coordinating with SMAs to ensure they are submitting accurate and complete T-MSIS data. CMMI will require that a Lead Organization demonstrate its SMA's ability to submit T-MSIS data of sufficient quality and completeness, both when the Lead Organization responds to this NOFO and when it submits its Transformation Plans annually.

G. CMS Contacts

G.1. Programmatic Questions

For programmatic questions about this funding opportunity, please contact: Sally Caine Leathers at CHARTModel@cms.hhs.gov.

G.2. Administrative/Budget Questions

For administrative or budget questions about this funding opportunity, please contact: Shamia Cunningham at CHARTModel@cms.hhs.gov.

Appendix I. Guidance for Preparing a Budget Request and Narrative

Applicants should request funding only for activities which will be funded by this specific Notice of Funding Opportunity. All applicants must submit the Standard Form SF-424A as well as a Budget Narrative. The Budget Narrative should provide detailed cost itemizations and narrative supporting justification for the costs outlined in SF-424A. Both the Standard Form SF-424A and the Budget Narrative must include a yearly breakdown of costs for the entire project period.

Please review the directions below to ensure both documents are accurately completed and consistent with application requirements.

Standard Form SF-424A

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

- Note: The directions on SF-424A forms provided on Grants.gov only pertain to programs with a four-year budget period. Therefore, please follow the instructions included in this NOFO as outlined below when completing the SF-424A.
- Note: The total requested on the SF-424 (Application for Federal Assistance) should be reflective of the overall total requested on the SF-424A (Budget Information – Non-Construction) for the entire project period.

Section A – Budget Summary

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

Section B – Budget Categories

- Enter the total costs requested for each Object Class Category (Section B, number 6) for each year of the project period. Notice of Funding Opportunities with a 5-year project period will need to also utilize a second SF-424A form.
- Column (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) = (If applicable) Enter Year 2 estimated 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) = (If applicable) Enter Year 3 estimated 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 3 line items should be entered in column 3, row k (sum of row i and j).
- Column (4) = (If applicable) Enter Year 4 estimated 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 4 items should be entered in column 4, row k (sum of row i and j).
- Column (5) = Enter total costs for 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 should be entered in row k (sum of row i and j). The total in column 5, row k should match the total provided in Section A – Budget Summary, New or Revised Budget, column g, row 5.
- Since this NOFO is for a 7-year project period, please complete two SF-424A forms (one for years 1-4 and the second for years 5-7) and upload them as attachments to the application (this specific attachment will not be counted towards the page limit). Year 5 information should be included in column 1-2 of Section B. Then enter the total for years 1-4 (per the first SF-424A form) in column 3 of Section B. The second SF-424A form will compute columns 1-3, reflecting total costs for the entire project period. This total should be consistent with the total Federal costs requested on the SF-424, Application for Federal Assistance. A blank SF-424A form can be found at Grants.gov: https://www.grants.gov/web/grants/forms/sf-424-individual-family.html#sortby=1

Budget Narrative – Sample Narrative and Instructions

Applicants must complete a Budget Narrative and upload it to the Budget Narrative Attachment Form in the application kit. Applicants must request funding only for activities not already funded/supported by a previous award. Awards should support separate activities and new federal funding should not be supplanted by prior federal funding. In the budget request, applicant should distinguish between activities that will be funded under this application and activities funded with other sources. Other funding sources include other HHS grant programs, and other federal funding sources as applicable.

A sample Budget Narrative is included below.

A. (Personnel) Salaries and Wages

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

Sample Budget

Personnel Total	*$_____*
Grant	*$_____*
Funding other than Grant	*$_____*
Sources of Funding	_____

Position Title	Name (if known)	Annual	Time	Months	Amount Requested
Project Coordinator	Susan Taylor	$45,000	100%	12 months	$45,000
Finance Administrator	John Johnson	$28,500	50%	12 months	$14,250
Outreach Supervisor	Vacant	$27,000	100%	12 months	$27,000
Total:					$86,250

NOTE: This award is subject to the "Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2020, Public Law No: 116-94. As is noted under Division B, Title II, General Provisions, Section 202, none of the funds appropriated in this title 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. This salary cap applies to direct salaries and to those salaries covered under indirect costs, also known as facilities and administrative (F & A) https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/. Please consult the following link to determine the applicable current salary cap.

Sample Justification

The format may vary, but the description of responsibilities should be directly related to specific program objectives.

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

B. Fringe Benefits

Fringe benefits are usually applicable to direct salaries and wages. Provide information on the rate of fringe benefits used and the basis for their calculation. If a fringe benefit rate is not used, itemize how the fringe benefit amount is computed. This information must be provided for each position (unless the rates for all positions are identical).

Sample Budget

Fringe Benefits Total	*$_____*
Grant	*$_____*
Funding other than Grant	*$_____*
Sources of Funding	_____

Fringe Benefit	Rate	Salary Requested	Amount Requested
FICA	7.65%	$45,000	$3443
Worker's Compensation	2.5%	$14,250	$356
Insurance	Flat rate - $2,000 (100% FTE for 12 months)	$2,000	$2,000
Retirement	5%	$27,000	$1,350
Total			$7,149

C. Travel

Dollars requested in the travel category should be for staff travel only. Travel for consultants should be shown in the consultant category. Allowable travel for other participants, advisory committees, review panel, etc. should be itemized in the same way specified below and placed in the “Other” category. Travel incurred through a contract should be shown in the contractual category.

Provide a narrative describing the travel staff members will perform. This narrative must include a justification which explains why this travel is necessary and how it will enable the applicant to complete program requirements included in the Notice of Funding Opportunity. List where travel will be undertaken, number of trips planned, who will be making the trip, and approximate dates. If mileage is to be paid, provide the number of miles and the cost per mile. The mileage rate cannot exceed the rate set by the General Services Administration (GSA). If travel is by air, provide the estimated cost of airfare. The lowest available commercial airfares for coach or equivalent accommodations must be used. If per diem/lodging is to be paid, indicate the number of days and amount of daily per diem as well as the number of nights and estimated cost of lodging. Costs for per diem/lodging cannot exceed the rates set by GSA.

Include the cost of ground transportation when applicable. Please refer to the GSA website to access portal.

Sample Budget

Fringe Benefits Total	*$_____*
Grant	*$_____*
Funding other than Grant	*$_____*
Sources of Funding	_____

Purpose of Travel	Location	Item	Rate	Cost
Site Visits	Neighboring areas of XXX	Mileage	$0.545 x 49 miles (use mileage rate in effect at time of mileage incurrence) x 25 trips	$668
Training (ABC)	Chicago, IL	Airfare	$200/flight x 2 persons	$400
		Luggage Fees	$50/flight x 2 persons	$100
		Hotel	$140/night x 2 persons x 3 nights	$840
		Per Diem (meals)	$49/day x 2 persons x 4 days	$392
		Transportation (to and from airport)	$50/shuttle x 2 persons x 2 shuttles	$200
		Transportation (to and from hotel)	$25/shuttle x 2 persons x 2 shuttles	$100
				$2,700

Sample Justification

The Project Coordinator and the Outreach Supervisor will travel to (location) to attend a conference on the following topic XXXX. This conference is only held once a year in Chicago, IL. Attending this conference is directly linked to project goals/objectives and is a necessity because XXXX. The information and tools we will gather from attending this conference will help us to accomplish project objectives by XXXX. A sample itinerary can be provided upon request. The Project Coordinator will also make an estimated 25 trips to birth center sites to monitor

program implementation (# of birth centers, # of trips per site). We are still in the process of identifying all birth center sites, but have identified an average mileage total for each site. This travel is necessary to ensure birth center sites are consistently and systematically collecting birth center data and submitting by deadlines provided. On-site monitoring will enable us to immediately address concerns. This travel also furthers our efforts to accomplish specific project goals for the following reasons

D. Equipment

Equipment is tangible nonexpendable personal property, including exempt property, charged directly to the award having a useful life of more than one year and an acquisition cost of $5,000 or more per unit. However, consistent with award recipient policy, lower limits may be established. Technology items such as computers that do not meet the $5,000 per unit threshold or an alternative lower limit set by award recipient policy that may therefore be classified as supplies, must still be individually tagged and recorded in an equipment/technology database. This database should include any information necessary to properly identify and locate the item. For example: serial # and physical location of equipment (e.g., laptops, tablets, etc.).
Provide justification for the use of each item and relate it to specific program objectives. Maintenance or rental fees for equipment should be shown in the "Other" category. All IT equipment should be uniquely identified. Show the unit cost of each item, number needed, and total amount.

Sample Budget

Equipment Benefits Total	*$_____*
Grant	*$_____*
Funding other than Grant	*$_____*
Sources of Funding	_____

Item(s)	Rate	Cost
All-in-one Printer, Copier, and Scanner (large scale)	1 @ $5,800	$5,800
X-Ray Machine	1 @ $8,00	$8,000
Total:		$13,800

Sample Justification

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

E. Supplies

Supplies includes all tangible personal property with an acquisition cost of less than $5,000 per unit or an alternative lower limit set by award recipient policy. Individually list each item requested. Show the unit cost of each item, number needed, and total amount. Provide justification for each item and relate it to specific program objectives. If appropriate, General Office Supplies may be shown by an estimated amount per month times the number of months in the budget category.

Sample Budget

Supplies Total	*$_____*
Grant	*$_____*
Funding other than Grant	*$_____*
Sources of Funding	_____

Item(s)	Rate	Cost
Laptop Computer	2 @ $1,000	$2,000
Printer	1 @ $200	$200
General office supplies	12 months x $24/mo x 10 staff	$2,880
Educational pamphlets	3,000 copies @ $1 each	$3,000
Educational videos	10 copies @ $150 each	$1,500
Total:		$9,580

Sample Justification

General office supplies will be used by staff members to carry out daily activities of the program. The project coordinator will be a new position and will require a laptop computer and printer to

complete required activities under this Notice of Funding Opportunity. The price of the laptop computer and printer is consistent with those purchased for other employees of the organization and is based upon a recently acquired invoice (which can be provided upon request). The pricing of the selected computer is necessary because it includes the following tools XXXX (e.g., firewall, etc.). The education pamphlets and videos will be purchased from XXX and used to illustrate and promote safe and healthy activities. Usage of these pamphlets and videos will enable us to address components one and two of our draft proposal. Word Processing Software will be used to document program activities, process progress reports, etc.

F. Consultant/Subrecipient/Contractual Costs

All consultant/subrecipient/contractual costs should include complete descriptions and cost breakdowns – for each consultant, subrecipient or contract. The following information, outlined below, should be provided for each consultant, sub-award (subrecipient) or contract.

REQUIRED REPORTING INFORMATION FOR CONSULTANT HIRING

This category is appropriate when hiring an individual who gives professional advice or provides services (e.g., training, expert consultant, etc.) for a fee and who is not an employee of the grantee organization. Submit the following required information for consultants:

1. Name of Consultant: Identify the name of the consultant and describe his or her qualifications.
2. Organizational Affiliation: Identify the organizational 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. Justification of expected compensation rates: Provide a justification for the rate, including examples of typical market rates for this service in your area.

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

If the above information is unknown for any consultant at the time the application is submitted, the information may be submitted at a later date as a revision to the budget. In the Budget Narrative, a summary should be provided of the proposed consultants, the work to be completed, and amounts for each. Award recipient must not incur costs for consultant activities until the aforementioned information is provided for each consultant and CMS approval obtained.

REQUIRED REPORTING INFORMATION FOR SUBRECIPIENT APPROVAL

The costs of project activities to be undertaken by a third-party subrecipient should be included in this category. For more information on subrecipient and contractual relationships, please refer to HHS regulation 45 CFR 75.351 *Subrecipient and Contractor Determinations* and 75.352 *Requirements for pass-through entities*. If this information is unknown at the time the application is submitted, the information may be submitted at a later date as a revision to the budget. In the Budget Narrative, a summary should be provided of the proposed sub-awards (subrecipients), the work to be completed, and amounts for each. Award recipient must not incur costs for subrecipient activities until the aforementioned information is provided for each subrecipient and CMS approval obtained.

REQUIRED REPORTING INFORMATION FOR CONTRACT APPROVAL

All award recipients must submit to HHS the following required information for establishing a third-party contract to perform project activities.

1. Name of Contractor: Who is the contractor? Identify the name of the proposed contractor and indicate whether the contract is with an institution or organization.
2. Method of Selection: How was the contractor selected? State whether the contract is sole source or competitive bid. If an organization is the sole source for the contract, include an explanation as to why this institution is the only one able to perform contract services.
3. Period of Performance: How long is the contract period? Specify the beginning and ending dates of the contract.
4. Scope of Work: What will the contractor do? Describe in outcome terms, the specific services/tasks to be performed by the contractor as related to the accomplishment of program objectives. Deliverables should be clearly defined.

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

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

If the above information is unknown for any contractor at the time the application is submitted, the information may be submitted at a later date as a revision to the budget. Copies of the actual contracts should not be sent to HHS, unless specifically requested. In the Budget Narrative, a summary should be provided of the proposed contracts, the work to be completed, and amounts for each. Award recipient must not incur costs for contractual activities until the aforementioned information is provided for each contract and CMS approval obtained.

G. Construction (not applicable)

H. Other

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

Sample Budget

Other Total	*$_____*
Grant	*$_____*
Funding other than Grant	*$_____*
Sources of Funding	_____

Item(s)	Rate	Cost
Telephone	$45 per month x 3 employees x 12 months	$1,620
Postage	$250 per quarter x 4 quarters	$1,000
Printing	$0.50 x 3,000 copies	$1,500
Equipment Rental *specify item	$1,000 per day for 3 days	$3,000

Internet Provider Service	$20 per month x 3 employees x 12 months	$720
Word Processing Software (specify type)	1 @ $400	$400
Total:		$8,240

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

Sample Justification
We are requesting costs to accommodate telephone and internet costs for the 3 new hires that will be working on this project in the new space designated. We are also requesting printing and postage costs to support producing fliers to disseminate in the community and brochures to educate participants enrolled in the program. The word processing software will be used to help us track data and compile reports. To track and compile the data, we will need to rent _____. Without this equipment, we will not be able to produce this information in an accurate and timely manner.

I. Total Direct Costs

$_____

Show *total direct costs by listing totals of each category.*

J. Indirect Costs

$_____

To claim indirect costs, the applicant organization must have a current approved indirect cost rate agreement established with the Cognizant Federal agency unless the organization has never established one (see 45 CFR §75.414 for more information). If a rate has been issued, a copy of the most recent indirect cost rate agreement must be provided with the application.

Sample Budget

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

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

If the applicant organization has never received an indirect cost rate, except for those non-Federal entities described in Appendix VII(D)(1)(b) to 45 CFR part 75, the applicant may elect to charge a de minimis rate of 10% of modified total direct costs (MTDC). If the applicant has never received an indirect cost rate and wants to exceed the de minimis rate, then costs normally identified as indirect costs (overhead costs) can be budgeted and identified as direct costs. These costs should be outlined in the "other" costs category and fully described and itemized as other direct costs.

Appendix II. Application and Submission Information

Please CTRL/Click to access links or paste to your browser. Please note these are the most up-to-date directions and links we have. Applicants are advised to check the websites for any changes. Also, phone numbers are provided if additional assistance is needed as several websites have made recent changes to links and directions.

This NOFO 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.

EIN, DUNS, AND SAM REQUIREMENTS (ALL APPLICATIONS)

Employer Identification Number

All applicants under this Notice of Funding Opportunity 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 Notice of Funding Opportunity is posted to ensure this information is received in advance of application deadlines. The process to obtain an EIN typically takes up to 5 weeks.**

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. The DUNS number is a nine-digit number that uniquely identifies business entities. To obtain a DUNS number access the following website: SAM webform for D&B D-U-N-S Request Service or call 1-866-705-5711. This number should be entered in block 8c (on Form SF-424, Application for Federal Assistance). The organization name and address entered in block 8a and 8e should be exactly as given for the DUNS number.

Applicants should obtain this DUNS number as soon as possible after the Notice of Funding Opportunity is posted to ensure all registration steps are completed in time.

System for Award Management (SAM)

The applicant must register in the System for Award Management (SAM) database in order to be able to submit the application. Applicants can access SAM website and complete the online registration. DUNS and EIN/TIN numbers are required to complete the registration process. To register one or more domestic entities and appoint an entity administrator, the applicant organization must send a notarized letter to SAM. **Applicants should begin the SAM registration process as soon as possible after the Notice of Funding Opportunity is posted to ensure that it does not impair your ability to meet required submission deadlines. The process to register in SAM can take 2 weeks or more following receipt of the notarized letter (additional 5 weeks if an EIN must be established first).**

Each year organizations and entities registered to apply for Federal grants or cooperative agreements through Grants.gov (or GrantSolutions as applicable) 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 (or GrantSolutions as applicable). Similarly, failure to maintain an active SAM registration during the application review process can prevent HHS from issuing your agency an award.**

Applicants must also successfully register with SAM prior to registering in the Federal Funding Accountability and Transparency Act Subaward Reporting System (FSRS) as a prime awardee user. Please also refer to Federal Funding Accountability and Transparency Act Reporting Requirements of this Funding Opportunity for more information. Primary award recipients 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 on SAM website 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).

APPLICATION MATERIALS AND INSTRUCTIONS TO APPLY VIA GRANTS.GOV (COMPETITIVE APPLICATIONS)

How to Submit an Application to CMS via Grants.gov

CMS requires applications for all competitive Notice of Funding Opportunities to be submitted electronically through Grants government website. For assistance with this process contact support@grants.gov or 1-800-518-4726. Below is an overview of the instructions from the Grants.gov website. Applicants are encouraged to access the site directly for more detailed information.

How to Register to Apply through Grants.gov

- *Obtain A DUNS number.*
- *Complete SAM registration.*
- *Register*. Click the Register link and complete the on-screen instructions or refer to detailed instructions here: Grants government website link to registration
- *Add a Profile to the Account*: The profile corresponds to a single applicant organization the user represents (i.e., an applicant) or an individual applicant. If you work for or consult with multiple organizations and have a profile for each, you may log in to one Grants.gov account to access all of your grant applications. To add an organizational profile enter the DUNS Number for the organization in the UEI (Unique Entity Identifier) field while adding a profile. For more detailed instructions about creating a profile refer to: Grants government website link to add profile
- *EBiz POC Authorized Profile Roles*: After you register and create an Organization Applicant Profile, the organization applicant's request for Grants.gov roles and access is sent to the EBiz POC. The EBiz POC will then log in and authorize the appropriate roles, which may include the AOR role, thereby giving you permission to complete and submit applications on behalf of the organization. You will be able to submit your application online any time after you have been assigned the AOR role. For more detailed instructions about creating a profile refer to:
  Grants government website
- *Track Role Status*: To track your role request, refer to:
  Grants government website
- *Electronic Signature*: When applications are submitted through Grants.gov, the name of the organization applicant with the AOR role that submitted the application is inserted into the signature line of the application, serving as the electronic signature. The EBiz POC **must** authorize people who are able to make legally binding commitments on

behalf of the organization as a user with the AOR role; **this step is often missed and it is crucial for valid and timely submissions.**

How to Submit an Application to CMS via Grants.gov

Grants.gov applicants can apply online using Workspace. Workspace is a shared, online environment where members of a grant team may simultaneously access and edit different webforms within an application. For each Notice of Funding Opportunity (alternatively, may be referred to as Funding Opportunity Announcement (FOA)), you can create individual instances of a workspace. *Note:* Search for the application package in by entering the Federal Assistance Listings (CFDA) number. This number is shown on the Federal Assistance Listings (or CFDA) on SAM website and cover page of the funding opportunity.

Applications cannot be accepted through any email address. Full applications can only be accepted through Grants government website. Full applications cannot be received via paper mail, courier, or delivery service.

Below is an overview of submitting an application. For access to complete instructions on how to apply for opportunities, refer to: Grants government website link to overview

1) *Create a Workspace*: Creating a workspace allows you to complete it online and route it through your organization for review before submitting.

2) *Complete a Workspace*: Add participants to the workspace to work on the application together, complete all the required forms online or by downloading PDF versions, and check for errors before submission. The Workspace progress bar will display the state of your application process as you apply. As you apply using Workspace, you may click the blue question mark icon near the upper-right corner of each page to access context-sensitive help.

a. *Adobe Reader*: If you decide not to apply by filling out webforms you can download individual PDF forms in Workspace. The individual PDF forms can be downloaded and saved to your local device storage, network drive(s), or external drives, then accessed through Adobe Reader.

NOTE: Visit the Adobe Software Compatibility page on Grants.gov to download the appropriate version of the software at: Grants government website link to software compatibility

b. *Mandatory Fields in Forms:* In the forms, you will note fields marked with an asterisk and a different background color. These fields are mandatory fields that must be completed to successfully submit your application.

c. *Complete SF-424 Fields First*: The forms are designed to fill in common required fields across other forms, such as the applicant name, address, and DUNS Number. Once it is completed, the information will transfer to the other forms.

3) *Submit a Workspace*: An application may be submitted through workspace by clicking the Sign and Submit button on the Manage Workspace page, under the Forms tab. **Grants.gov recommends submitting your application package at least 24-48 hours prior to the close date to provide you with time to correct any potential technical issues that may disrupt the application submission.**

4) *Track a Workspace Submission*: After successfully submitting a workspace application, a Grants.gov Tracking Number (GRANTXXXXXXXX) is automatically assigned to the application. The number will be listed on the Confirmation page that is generated after submission. Using the tracking number, access the Track My Application page under the Applicants tab or the Details tab in the submitted workspace.

For additional training resources, including video tutorials, refer to: Grants government website link to training resources

Applicant Support: 24/7 support is available via the toll-free number 1-800-518-4726 and email at support@grants.gov. For questions related to the specific grant opportunity, contact the number listed in the application package of the grant you are applying for.

If you are experiencing difficulties with your submission, it is best to call the Grants.gov Support Center and get a ticket number. The Support Center ticket number will assist CMS with tracking your issue and understanding background information on the issue.

Timely Receipt Requirements and Proof of Timely Submission

All grant and cooperative agreement applications must be submitted electronically and **received** through Grants government website by 3:00 p.m. Eastern Standard or Daylight Time (Baltimore, MD) by the applicable deadline date. Please refer to the Executive Summary of this Notice of Funding Opportunity for submission deadline date.

Proof of timely submission is automatically recorded and an electronic date/time stamp is generated within the system when the application is successfully **received** by Grants.gov. The AOR who submits the application on behalf of the organization will receive an acknowledgement of receipt and a tracking number (GRANTXXXXXXXX) with the successful transmission of their application, as well as the official date/time stamp and Grants.gov tracking number in an email serving as proof of their timely submission. When CMS successfully retrieves the application from Grants.gov, and acknowledges the download of submissions, Grants.gov will provide an electronic acknowledgment of receipt of the application to the email address of the AOR who submitted the application. Again, proof of timely submission shall be

the official date and time that Grants.gov **receives** your application. Applications received after the established due date for the program will be considered late and will not be considered for funding by CMS.

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.

Applicants using slow internet, such as dial-up connections, should be aware that transmission can take some time before your application is received. Again, Grants.gov will provide either an error or a successfully received transmission in the form of an email sent to the applicant with the AOR role attempting to submit the application. The Support Center reports that some applicants end the transmission because they think that nothing is occurring during the transmission process. Please be patient and give the system time to process the application.

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 within an application package, the individual can e-mail the contact center at support@grants.gov for help, or call 1-800-518-4726.

Appendix III. Business Assessment of Applicant Organization

An applicant must review and answer the business assessment questions outlined below. There are ten (10) topic areas labeled A-J, with a varying number of questions within each topic area. Applicant MUST provide an answer to each question. Moreover, the applicant should refrain from solely answering “yes” or “no” to each question or solely providing web site address(es) – i.e., a brief, substantive answer should be given for almost all questions (referring to sections of official agency policy is acceptable). If the answer to any question is non-applicable, please provide an explanation. Please note, if CMS cannot complete its review without contacting the applicant for additional clarification, the applicant may not be selected for award.

A. General Information

1. Does the organization have a Board of Directors with specific functions and responsibilities (by-laws)?
2. Are minutes of the Board of Directors' meetings maintained?
3. Is there an organizational chart or similar document establishing clear lines of responsibility and authority?
4. Are duties for key employees of the organization defined?
5. Does the organization have grants or cost-reimbursement contracts with other U.S. Department of Health and Human Services components or other Federal agencies?
6. Have any aspects of the organization's activities been audited recently by a Government agency or independent public accountant?
7. Has the organization obtained fidelity bond coverage for responsible officials and employees of the organization?
8. Has the organization obtained fidelity bond insurance in amounts required by statute or organization policy?

B. Accounting System

1. Is there a chart of accounts?
2. Is a double-entry accounting system used?
3. Does the organization maintain the basic books of account as applicable?
    i. General ledger
    ii. Operating ledger
    iii. Project (Job) cost ledger
    iv. Cash receipts journal
    v. Cash disbursement journal
    vi. Payroll journal
    vii. Income (sales) journal
    viii. Purchase journal
    ix. General journal

4. Does the accounting system adequately identify receipt and disbursement for each grant (or contract)?
5. Does the accounting system provide for the recording of expenditures for each program by required budget cost categories?
6. Does the accounting system provide for recording the non-Federal share and in-kind contributions (if applicable for a grant program)?
7. Does the organization prepare financial statements at least annually? If not, how often?
8. Have the financial statements been audited within the past 2 years by an independent public accountant?
9. Does the organization have a bookkeeper or accountant? If no, who is in charge of the accounting section?
10. Is there an accounting instruction manual?

C. Budgetary Controls

1. Does the organization use an operating budget to control project funds?
2. Are persons in the organization who approve budget amendments authorized to do so by the Agency of Directors or top management?
3. Are there budgetary controls in effect to preclude incurring obligations in excess of:
    i. Total funds available for an award?
    ii. Total funds available for a budget cost category?
4. Are cash requirements and/or drawdowns limited to immediate need?

D. Personnel

1. Are personnel policies established in writing or in the process of preparation which detail at a minimum:
    i. Duties and responsibilities of each employee's position?
    ii. Qualifications for each position?
    iii. Salary ranges associated with each job?
    iv. Promotion Plan?
    v. Equal Employment Opportunity?
    vi. Annual performance appraisals?

vii. Types and levels of fringe benefits paid to professionals, nonprofessionals, officers, or governing Agency members?

2. Is employee compensation reasonable and comparable to that paid for similar work in the competitive labor market?
3. Are salary comparability surveys conducted? How often?
4. Are salaries of personnel assigned to Government projects about the same as before assignment? Identify reasons for significant increases.
5. Does the organization maintain a payroll distribution system which meets the required standards as contained in the applicable cost principles for that organization?
6. Does the organization maintain daily attendance records for hourly employees? Does this show actual time employees sign in and out?
7. Does the payroll distribution system account for the total effort (100%) for which the employee is compensated by the organization?
8. Who signs and certifies work performed in items 5, 6, and 7 above?
9. Where duties require employees to spend considerable time away from their offices, are reports prepared for their supervisors disclosing their outside activities?

E. Payroll

1. Does preparation of the payroll require more than one employee?
2. Are the duties of those individuals preparing the payroll related?
3. Are the names of employees hired reported in writing by the personnel office to the payroll department?
4. Are the names of employees terminated reported in writing by the personnel office to the payroll department?
5. Is the payroll verified at regular intervals against the personnel records?
6. Are all salaries and wage rates authorized and approved in writing by a designated official or supervisor?
7. Are vacation and sick leave payments similarly authorized and approved?
8. Is there verification against payments for vacation, sick leave, etc., in excess of amounts approved and/or authorized?
9. Is the payroll double-checked as to:

i. Hours?

ii. Rates?

iii. Deductions?

iv. Extensions, etc.?

10. Are signed authorizations on file for all deductions being made from employees' salaries and wages?

11. Is the payroll signed prior to payment by the employee preparing the payroll? The employee checking the payroll?

12. Are salary payrolls approved by an authorized official prior to payment?

13. Are employees paid by check or direct deposit? If no, how are they paid?

14. If paid by check, are the checks pre-numbered?

15. Are checks drawn and signed by employees who do not:

    i. Prepare the payroll?

    ii. Have custody of cash funds?

    iii. Maintain accounting records?

16. Are payroll checks distributed to employees by someone other than the supervisor?

17. Is there a payroll bank account? If no, will one be opened if award recipient is selected for award?

18. Is the payroll bank account reconciled by someone other than payroll staff or personnel who sign and distribute the pay checks?

F. Consultants

1. Are there written policies or consistently followed procedures regarding the use of consultants which detail at a minimum:

    ii. Circumstances under which consultants may be used?

    iii. Consideration of in-house capabilities to accomplish services before contracting for them?

    iv. Requirement for solicitation or bids from several contract sources to establish reasonableness of cost and quality of services to be provided?

    v. Consulting rates, per diem, etc.?

2. Are consultants required to sign consulting agreements outlining services to be rendered, duration of engagement, reporting requirements, and pay rates?

G. Property Management

1. Are records maintained which provide a description of the items purchased, the acquisition cost, and the location?
2. Are detailed property and equipment records periodically balanced to the general ledger?
3. Are detailed property and equipment records periodically checked by physical inventory?
4. Are there written procedures governing the disposition of property and equipment?
5. Are periodic reports prepared showing obsolete equipment, equipment needing repair, or equipment no longer useful to the organization?
6. Does the organization have adequate insurance to protect the Federal interest in equipment and real property?

H. Purchases

1. Does the organization have written purchasing procedures? If not, briefly describe how purchasing activities are handled.
2. Does the purchasing policy/procedure consider such matters as quality, cost, delivery, competition, source selection, etc.?
3. Has the responsibility for purchasing been assigned to one department, section, or individual within the organization? If not, explain.
4. Is the purchasing function separate from accounting and receiving?
5. Are competitive bids obtained for items such as rentals or service agreements over certain amounts?
6. Are purchase orders required for purchasing all equipment and services?
7. Is control maintained over items or dollar amounts requiring the contracting or grants management officer's advance approval? Describe controlling factors.
8. Is the accounting department notified promptly of purchased goods returned to vendors?
9. Is there an adequate system for the recording and checking of partial deliveries and checking deliveries against purchase orders?

10. When only a partial order is received, is the project account credited for the undelivered portion of the purchase order?

11. Are the vendor invoices checked for:

    i. Prices and credit terms?

    ii. Extensions?

    iii. Errors and omissions?

    iv. Freight charges and disallowances?

12. Are vouchers, supporting documents, expenses, or other distributions reviewed and cleared by designated staff before payment is authorized?

I. Travel

1. Does the organization have formal travel policies or consistently followed procedures which, at a minimum, state that:

    ii. Travel charges are reimbursed based on actual costs incurred or by use of per diem and/or mileage rates?

    iii. Receipts for lodging and meals are required when reimbursement is based on actual cost incurred?

    iv. Per Diem rates include reasonable dollar limitations? Subsistence and lodging rates are comparable to current Federal per diem and mileage rates?

    v. Commercial transportation costs are incurred at coach fares unless adequately justified? Travel requests are approved prior to actual travel?

    vi. Travel expense reports show purpose of trip?

J. Internal Controls

1. Is there a separation of responsibility in the receipt, payment, and recording of cash?

    ii. For example: Are the duties of the record keeper or bookkeeper separated from any cash functions such as the receipt or payment of cash?

    iii. Or, is the signing of checks limited to those designated officials whose duties exclude posting and/or recording cash received, approving vouchers for payment, and payroll preparation?

2. Are all checks approved by an authorized official before they are signed?

3. Are all accounting entries supported by appropriate documentation (e.g., purchase orders, vouchers, vendor payments)?
4. Does the organization have an internal auditor or internal audit staff?
5. Is there a petty cash fund where responsibility is vested in one individual; limited to a reasonable amount; restricted as to purchase; and counted, verified, and balanced by an independent employee at time of reimbursement?
6. Are all checks pre-numbered and accounted for when general purpose bank account is reconciled?
7. If a mechanical or facsimile signature is used for cash disbursements, is the signature plate, die, key, electronic card, etc., under strict control?
8. Are bank accounts reconciled by persons not handling cash in the organization? Are all employees who handle funds required to be bonded against loss by reason of fraud or dishonesty?

Appendix IV: Accessibility Requirements

CMS and its grantees are responsible for complying with federal laws regarding accessibility as noted in the Award Administration Information/Administration and National Policy Requirements Section.

The grantee may receive a request from a beneficiary or member of the public for materials in accessible formats. All successful applicants under this Notice of Funding Opportunity must comply with the following reporting and review activities regarding accessible format requests:

Accessibility Requirements:

1. Public Notification: If you have a public facing website, you shall post a message no later than 30 business days after award that notifies your customers of their right to receive an accessible format. Sample language may be found at: Medicare government website Your notice shall be crafted applicable to your program.

2. Processing Requests Made by Individuals with Disabilities:

a. Documents:

i. When receiving a request for information in an alternate format (e.g., Braille, Large print, etc.) from a beneficiary or member of the public, you must:

1. Consider/evaluate the request according to civil rights laws.

2. Acknowledge receipt of the request and explain your process within 2 business days.

3. Establish a mechanism to provide the request.

ii. If you are unable to fulfill an accessible format request, CMS may work with you in an effort to provide the accessible format. You shall refer the request to CMS within 3 business days if unable to provide the request. You shall submit the request, using encrypted e-mail (to safeguard any personally identifiable information), to the AltFormatRequest@cms.hhs.gov mailbox with the following information:

1. The e-mail title shall read "Grantee (Organization) Alternate Format Document Request."

2. The body of the e–mail shall include:

a. Requester's name, phone number, e-mail, and mailing address.

b. The type of accessible format requested, e.g., audio recording on compact disc (CD), written document in Braille, written document in large print, document in a format that is read by qualified readers, etc.

c. Contact information for the person submitting the e-mail: Organization (Grantee), name, phone number and e-mail.

d. The document that needs to be put into an accessible format shall be attached to the e-mail.

e. CMS may respond to the request and provide the information directly to the requester.

iii. The Grantee shall maintain record of all alternate format requests received including the requestor's name, contact information, date of request, document requested, format requested, date of acknowledgment, date request provided, and date referred to CMS if applicable. Forward quarterly records to the AltFormatRequest@cms.hhs.gov mailbox.

b. Services

i. When receiving request for an accessibility service (e.g., sign language interpreter) from a beneficiary or member of the public, you must:

1. Consider/evaluate the request according to civil rights laws.

2. Acknowledge receipt of the request and explain your process within 2 business days.
3. Establish a mechanism to provide the request.

ii. If you are unable to fulfill an accessible service request, CMS may work with you in an effort to provide the accessible service. You shall refer the request to CMS within 3 business days if unable to provide the service. You shall submit the request, using encrypted e-mail (to safeguard any personally identifiable information), to the AltFormatRequest@cms.hhs.gov mailbox with the following information:

1. The e-mail title shall read "Grantee (Organization) Accessible Service Request."
2. The body of the e–mail shall include:
   a. Requester's name, phone number, e-mail, and mailing address.
   b. The type of service requested (e.g., sign language interpreter and the type of sign language needed).
   c. The date, time, address and duration of the needed service.
   d. A description of the venue for which the service is needed (e.g., public education seminar, one-on-one interview, etc.)
   e. Contact information for the person submitting the e-mail – Organization (Grantee), name, phone number and e-mail.
   f. Any applicable documents shall be attached to the e-mail. CMS will respond to the request and respond directly to the requester.

iii. The Grantee shall maintain record of all accessible service requests received including the requestor's name, contact information, date of request, service requested, date of acknowledgment, date service provided, and date referred to CMS if applicable. Forward quarterly records to the AltFormatRequest@cms.hhs.gov mailbox.

3. Processing Requests Made by Individuals with Limited English Proficiency (LEP):

a. Documents:

i. When receiving a request for information in a language other than English from a beneficiary or member of the public, you must:

1. Consider/evaluate the request according to civil rights laws.

2. Acknowledge receipt of the request and explain your process within 2 business days.
3. Establish a mechanism to provide the request as applicable.

ii. If you are unable to fulfill an alternate language format request, CMS may work with you in an effort to provide the alternate language format as funding and resources allow. You shall refer the request to CMS within 3 business days if unable to provide the request. You shall submit the request, using encrypted e-mail (to safeguard any personally identifiable information), to the AltFormatRequest@cms.hhs.gov mailbox with the following information:

1. The e-mail title shall read "Grantee (Organization) Alternate Language Document Request."
2. The body of the e–mail shall include:
    a. Requester's name, phone number, e-mail, and mailing address.
    b. The language requested.
    c. Contact information for the person submitting the e-mail: Organization (Grantee), name, phone number and e-mail.
    d. The document that needs to be translated shall be attached to the e-mail.
    e. CMS may respond to the request and provide the information directly to the requester.

iii. The Grantee shall maintain record of all alternate language requests received including the requestor's name, contact information, date of request, document requested, language requested, date of acknowledgment, date request provided, and date referred to CMS if applicable. Forward quarterly records to the AltFormatRequest@cms.hhs.gov mailbox.

b. Services

i. When receiving request for an alternate language service (e.g., oral language interpreter) from a beneficiary or member of the public, you must:

1. Consider/evaluate the request according to civil rights laws.
2. Acknowledge receipt of the request and explain your process within 2 business days.
3. Establish a mechanism to provide the request as applicable.

ii. If you are unable to fulfill an alternate language service request, CMS may work with you in an effort to provide the alternate language service as funding and resources allow. You shall refer the request to CMS within 3 business days if unable to provide the service. You shall submit the request, using encrypted e-mail (to safeguard any personally identifiable information), to the AltFormatRequest@cms.hhs.gov mailbox with the following information:

1. The e-mail title shall read "Grantee (Organization) Accessible Service Request."
2. The body of the e–mail shall include:
    a. Requester's name, phone number, e-mail, and mailing address.
    b. The language requested.
    c. The date, time, address and duration of the needed service.
    d. A description of the venue for which the service is needed (e.g., public education seminar, one-on-one interview, etc.)
    e. Contact information for the person submitting the e-mail: Organization (Grantee), name, phone number and e-mail.
    f. Any applicable documents shall be attached to the e-mail.
    g. CMS will respond to the request and respond directly to the requester.

iii. The Grantee shall maintain record of all alternate language service requests received including the requestor's name, contact information, date of request, language requested, service requested, date of acknowledgment, date service provided, and date referred to CMS if applicable. Forward quarterly records to the AltFormatRequest@cms.hhs.gov mailbox.

Please contact the CMS Office of Equal Opportunity and Civil Rights for more information about accessibility reporting obligations at AltFormatRequest@cms.hhs.gov.

Appendix V. Review and Selection Process

The review and selection process will include the following:

i. Applications will be screened to determine eligibility for further review using the criteria detailed in section ***C. Eligibility Information***, and section ***D. Application and Submission Information*** (with cross-reference to ***Appendix II***. Application and Submission Information), of this

Notice of Funding Opportunity (NOFO). Applications that are received late or fail to meet the eligibility requirements as detailed in this NOFO or do not include the required forms will not be reviewed. However, the CMS/OAGM/GMO, in her or her sole discretion, may continue the review process for an ineligible application if it is in the best interest of the government to meet the objectives of the program.

ii. Procedures for assessing the technical merit of grant applications have been instituted to provide for an objective review of applications and to assist the applicant in understanding the standards against which each application will be judged. The Review criteria described in section ***E.1. Criteria***, will be used. Applications will be evaluated by an objective review committee. The objective review committee may include Federal and/or non-Federal reviewers. Applicants should pay strict attention to addressing all these criteria, as they are the basis upon which the reviewers will evaluate their applications.

iii. 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.

iv. As noted in 45 CFR Part 75, CMS will do a review of risks posed by applicants prior to award. In evaluating risks posed by applicants, CMS will consider the below factors as part of the risk assessment (applicant should review the factors in their entirety at §75.205)

a. Financial stability;

b. Quality of management systems and ability to meet the management standards prescribed;

c. History of performance (including, for prior award recipients of Federal awards: timeliness of compliance with applicable reporting requirements, conformance to the terms and conditions of previous federal awards, extent to which previously awarded amounts will be expended prior to future awards);

d. Reports and findings from audits performed under Subpart F of 45 CFR Part 75 and

e. Applicant's ability to effectively implement statutory, regulatory, and other requirements imposed on non-federal entities.

v. HHS reserves the right to conduct pre-award Negotiations with potential award recipients.

Appendix VI. 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 and budget narratives are page-numbered and the below forms are completed with an electronic signature and enclosed as part of the proposal. Applicants must ensure all documents listed below comply with formatting requirements and are submitted as a complete application to Grants government website

For specific requirements and instructions on application package, forms, formatting, content, please see:

- *Section D. Application and Submission Information*
- *Appendix II. Application and Submission Information*
- *Section E. Application Review Information*
- *Appendix I. Guidance for Preparing a Budget Request and Narrative*
- *Appendix IX. Medicaid Needs Assessment*

Standard Forms

✓ SF 424: Application for Federal Assistance

✓ SF-424A: Budget Information

✓ SF-424B: Assurances-Non-Construction Programs

✓ SF-LLL: Disclosure of Lobbying Activities

✓ Project Abstract Summary

✓ Project Site Location Form

Narrative Documents

✓ Project Narrative

✓ Budget Narrative

✓ Business Assessment of Applicant Organization

✓ SMA MOU

✓ Advisory Council LOI

✓ Participant Hospital LOI(s)

Appendix VII. Examples of Health Care Delivery System Redesign

This section contains examples of health care delivery system redesign strategies that applicants may wish to research and assess for applicability within model Transformation Plans, as well as model Terms and Conditions. CMMI does not endorse any example, but has listed these to help award recipients in generating ideas for transformation activities.

- Rural Emergency Medical Centers[18]
- Hub-and-Spoke Referral and Treatment Networks for Specialty Care[19]
- Collaborative Governance and Care Coordination with Community Safety Net Providers[20]
- Hospital at Home[21]
- Nurse Practitioner-Led Service Delivery with Statewide Telehealth[22]
- Community Pharmacy Networks with Pharmacist Care Management Support[23]
- Virtual Neonatal Intensive Care Units (NICUs) and Regional Pediatric Telehealth[24]
- Community Health Workers in Field-based Biometric Screenings and Peer Counseling[25]
- Intensive, 90-Day Telemedicine-Supported Home-Based Intervention for Medically and Socially Complex Patients[26]
- Home-Based Tele-Monitoring Equipment[27] for Behavioral Health Comorbidities and Chronic Disease Self-Management[28]
- Addressing Social Determinants of Health,[29] Health Disparities, and Health Inequities[30] [31] [32]

Appendix VIII. Additional Resources for Applicants: Literature and Funding Opportunities

Literature

1. The Rural Health Info Hub

   This hub contains a repository of literature and case studies that can help interested applicants understand the evidence base behind potential care redesign strategies, as well as examples of successfully implemented projects from rural communities around the country.

   i. Link to key publications on rural health organization website

   ii. Link to project examples on rural health organization website

2. National Organization of State Offices of Rural Health – Resources by Topic

   This membership organization for state-based rural health groups collects resources on various topics, including emergency medical services, population health, and value-based payment.

   i. National Organization of State Office of Rural Health website link to educational resources

3. National Rural Health Resource Center – Hospital Spotlight

   This center supports CAHs and highlights successfully implemented projects from innovative CAHs in various localities.

   i. Rural Center Organization Website link to hospital spotlights

4. Rural Health Research Gateway – Publications by Topic

   This research gateway allows interested applicants to review the scientific literature on rural health based on specific health conditions and other topics of interest.

   i. Rural Health Research Organization website link to topics

Grants and Technical Assistance from the Health Resources Services Administration (HRSA) and its Partners

1. Office for the Advancement of Telehealth (OAT) Programs

   i. Point of contacts for the various grant programs can be found here: HRSA website link to telehealth

   ii. Technical Assistance for Telehealth from local Telehealth Resource Centers can be found here: Telehealth Resource Center website link to find your TRC

2. Resources from State Offices of Rural Health and Similar Organizations for Hospitals

   i. Grants: HRSA website to link to rural hospital programs

   ii. Technical Assistance from the Small Rural Hospital Transition (SRHT) Project, which helps rural hospitals transition to new care delivery & payment Models: Rural Center Organization website

3. Rural Community Programs

   i. Grants: HRSA website link for more information on rural health community

Appendix IX. Medicaid Needs Assessment

The following questionnaire is a required component of the CHART application. The SMA must submit this questionnaire within their MOU, as described in section ***E.1.2.2.3. Health Care Delivery System Redesign.*** SMAs are encouraged to note any areas of uncertainty and/or any items that are yet to be determined. To assist SMAs with the questionnaire, guidance on how different Medicaid payment models can be leveraged to meet CHART's financial alignment requirement is provided below the questionnaire section. The Medicaid Needs Assessment Questionnaire will be used to expedite collaboration between the SMA and CMS, if the applicant is selected to participate in the CHART Model. Responses to this questionnaire are not considered final and do not represent a formal request for a State Plan Amendment, waiver, or demonstration nor a commitment to approval on the part of CMS. The state's Medicaid aligned CHART payment model must meet Medicaid federal statutory and regulatory requirements in order to be eligible for federal financial participation.

Medicaid Needs Assessment Questionnaire

SMA Point of Contact

CMS may contact the SMA with clarifying questions upon review of their questionnaire (the applicant would be copied on any such communication). Accordingly, please provide the following information for a SMA point of contact.

Name:

Job Title:

Email:

Phone Number:

General Questions:

1. Please provide a broad timeline for request and approval of the authorities you will use that is aligned with the CHART Model Timeline (see section ***A.4.9. Model Timeline***).
2. Which funding mechanism(s) does the state intend to implement to constitute the state share (e.g., what, if any, intergovernmental transfer agreements, provider taxes, or similar non-federal financing tools will be utilized)?
3. Does the SMA plan to waive statewideness, freedom of choice, and /or comparability? If so, identify which authority will be used.
    a. If the state is planning to implement the CHART Model on a sub-state basis and does not believe a statewideness waiver is needed, please provide a rationale.

A. State Plan Amendment (SPA)

If the SMA intends to modify the Medicaid state plan to implement CHART, please provide the following information (if the SMA does not plan to modify the Medicaid state plan, do not respond to the following questions and proceed to section B. Medicaid Managed Care Authority):

Please describe your intended design by answering the following:

1. What changes does the SMA intend to make to the state plan?
2. Which Medicaid benefit categories would the proposed services fall under?
3. What payment methodology would be used to cover the proposed services?
    - NOTE: payment methodologies must comply with all Medicaid statutory and regulatory requirements.
4. Who would provide the proposed services to Medicaid beneficiaries?
    - NOTE: federal matching funds can only be provided for Medicaid authorized services provided by Medicaid qualified providers to eligible Medicaid beneficiaries.

Please elaborate on how you would implement this design by answering the following:

5. Would the state's planned CHART Model be operated through managed care, fee-for-service, or both?
6. Does the state's planned CHART Model change eligibility, benefits, and/or services for some but not all Medicaid beneficiaries? If so, is the state planning to request an Amount Duration and Scope (ADS) waiver and/or a comparability waiver?

B. Medicaid Managed Care Authority

If the SMA intends to implement CHART using Managed Care Authority, please provide the following information (if the SMA does not plan to use Managed Care Authority, do not respond to the following questions and proceed to section C. 1115(a) Demonstration):

1. Will this payment arrangement be operationalized for services/beneficiaries covered under risk-based Medicaid managed care contracts (MCO, PIHP, or PAHP)?
2. Which managed care programs will be impacted by this payment arrangement?
3. What is the rating period(s) that will be affected?
4. Is the state directing how plans pay their providers (referred to as a state directed payment and defined in 42 C.F.R. § 438.6(c)); or is the state pursuing a withhold or incentive arrangement for the plans (defined in 42 C.F.R. § 438.6(b))?
5. If the state is pursuing a state directed payment as defined in 42 C.F.R. § 438.6(c):

a. What providers/services will be affected?

b. Is the payment arrangement going to replace the rates negotiated by plans with providers for services covered under the contract or would the payments be in addition to negotiated rates?

c. If the payments would be in addition to the rates negotiated between the plans and providers, what is the estimated total dollars that would be added to the rate certification for such payments? What do you expect the effect to be on total reimbursement for the providers (e.g., would the total rate paid to the provider (negotiated rates plus state directed payments) be above Medicare)?

d. Does the state intend to incorporate a value-based purchasing model? What is the anticipated role of risk-sharing?

e. What are the conditions that providers must meet to obtain payment?

f. Do providers have to achieve performance on a select set of quality measures? If so, what is the measurement period for determining payment?

g. Are payments tied to the delivery of services under the contract rating period? For example, if operating as a PMPM payment model based on historical utilization, is the state going to require any reconciliation processes to ensure that payments are linked to actual services covered under the contract?

6. If the state is pursuing an incentive arrangement for the plans as defined in 42 C.F.R. § 438.6(b), will the payments be within 105 percent of the approved capitation payments attributable to the enrollees or services covered under the managed care contract?

7. If the state is pursuing a withhold arrangement for the plans as defined in 42 C.F.R. § 438.6(b), will the withhold arrangement ensure that the capitation payment, minus any portion of the withhold that is not reasonably achievable, be actuarially sound? Will the total amount of the withhold, achievable or not, be reasonable?

C. 1115(a) Demonstration

If the SMA intends to pursue an 1115(a) demonstration to implement CHART, please provide the following information:

Please describe your intended design by answering the following:

1. Does the state intend to submit a new or amend an existing 1115(a) demonstration application?

    a. If amending an existing demonstration, please include the demonstration number you wish to amend and the expiration date.

2. What new services would be covered under the 1115(a) demonstration?

3. Does the state expect to need any additional demonstration waiver authorities under 1115(a)(1) to implement the model? If so, please describe the authorities to be requested.

4. Does the state intend to request expenditure authority under 1115(a)(2) to implement the model?

    a. If yes, what services would expenditure authority be requested for?

    b. Are the people receiving the services already Medicaid eligible?

Please elaborate on how you would implement this design by answering the following:

5. Does the state's planned CHART Model change eligibility, benefits, and/or services for some but not all Medicaid beneficiaries? If so, is the state planning to request an Amount Duration and Scope (ADS) waiver and/or a comparability waiver?

Medicaid Pathway Guidance

A. Alignment through State Plan Amendments

Capitated Payments for Hospitals under State Plan Authority

CMS will consider state plan payment methodologies that include downside risk for providers through value-based advanced payment strategies, where providers receive an advanced payment amount to care for individuals attributed to them based on historic Medicaid expenditures as well as care patterns and outcomes of care. This payment methodology may align with the capitated payment arrangement in the Community Transformation Track. States that wish to pursue this payment model must receive approval from CMS for these payment models and the Medicaid payments under the state plan must comply with section 1902(a)(30)(A) of the Social Security Act. States will be expected to ensure, through an approved reconciliation process, that total payments are consistent with "efficiency, economy and quality of care," and are also "sufficient to enlist enough providers…" to meet statutory access requirements, of section 1902(a)(30)(A) of the Act. In reviewing state proposed methodologies, CMS will ensure payments are consistent with all requirements in section 1902(a)(30)(A) of the Act, including "efficiency, economy, and quality of care." CMS is available to work with states to develop reconciliation processes that would comport with applicable statutory requirements.

After conducting the reconciliation, states could potentially hold providers at risk for losses in the event that actual care expenditures for attributed beneficiaries exceed the monthly payments that have been paid over a defined period. States also could reward providers when quality is improved and care expenditures fall below the monthly payments made to providers by allowing them to retain some or all amount identified through reconciliation as exceeding

actual care expenditures. Importantly, to ensure consistency with section 1902(a)(30)(A) of the Act, when care expenditures fall below monthly payments and quality improvements are not evident, a provider would need to return the portion of the monthly payments to the state representing the monthly payments paid in excess over actual care expenditures. States may define reasonable thresholds for what may be acceptable provider losses or gains in such arrangements, to ensure that provider gains and losses are moderated, where appropriate or necessary to satisfy the requirements of section 1902(a)(30)(A) of the Act. Moreover, CMS will review state proposals to ensure state defined thresholds are consistent with requirements in section 1902(a)(30)(A).

Considerations for Advanced Payment Methodologies with a SPA

We encourage states to work closely with CMS when developing advanced payment methodologies to achieve their intended goals for value-based payment (VBP) reform. As always, state plan amendments must be consistent with federal requirements and should advance improved care for beneficiaries, smarter spending, and healthier communities. To that end, CMS has released the Value-Based Care Opportunities in Medicaid State Medicaid Director Letter (VBC SMDL).[33] The VBC SMDL offers states planning and methodological considerations that should be factored into any value-based payment that aligns with the CHART payment model, as well as technical guidance that CMS expects states will address in VBP SPAs. We expect states to consider each of the methodological components described in the VBC SMDL to ensure consistency with section 1902(a)(30)(A) of the Act as states develop a proposal for CMS to review. We note all federal statutory and regulatory requirements on state financing to fund the non-Federal share apply under VBP methodologies. Importantly, consistent with the VBP strategies discussed within the VBC SMDL, we expect advanced payments to improve quality and health outcomes and for states to have meaningful quality strategies in place to ensure the methods are not detrimental to quality and access to care, which would be inconsistent with section 1902(a)(30)(A) of the Act. Advanced payment methods should not be based only on cost savings or result in harm to Medicaid beneficiaries. CMS will review proposed advanced payment methodologies to ensure they comply with all statutory and regulatory financing requirements. As states develop proposed advanced payment methodologies, they must meet the expectations in the VBC SMDL and in general should consider the following questions (do not need to answer at this point, during the application process):

- Does the methodology partially or fully align with an Innovation Center model? What are any material differences? If the methodology aligns with an existing Innovation Center model, could the state use existing Medicaid authorities to replicate or simulate the model in their program?

- Does the methodology apply to services available statewide to all individuals under the state plan or does it limit benefits to geographic regions or to populations residing in geographic regions in the state? If a state intends to add new benefits via this methodology and geographically limit their provision, the state may need to obtain 1115 waiver authority. We note advanced payment methodologies under the state plan may only be based on Medicaid coverable services consistent with section 1905(a) of the Act.
- Are the payments under the methodology available to all Medicaid providers or are they limited based on provider eligibility criteria? What are the provider eligibility criteria?
- What beneficiary notification and protection processes (e.g., beneficiary complaint lines, state Medicaid ombudsman, etc.) are in place to ensure no harm results from the advanced payment model, and how will Medicaid program requirements be ensured (e.g., maintenance of free provider choice, no reduction in amount, duration and scope of a medically necessary service, etc.)?
- What methodology will be used to attribute beneficiaries to providers?
- What claims and payment data will be used to determine advanced payments, including: the source of data, the time period of the data and how the data will account for population cost variation?
- Are claims reviews conducted to prevent up-coding and inappropriate restrictions on care (e.g., providers are providing and appropriately coding for necessary care, and not restricting their provision of certain expensive procedures to limit expenditures for attributed beneficiaries)?
- What are the timeframes and procedures for conducting reconciliation and returning FFP to CMS, where appropriate? (Please note, in the case of an excess of advance payments in relation to actual services furnished, states must return the federal share of amounts repaid by providers in accordance with 42 CFR Part 433, Subpart F. Claims for FFP for advanced payments and any related reconciliation payments are subject to the two-year timely filing requirements described at 45 CFR Part 95, Subpart A.)
- Does the state conduct reviews at least annually and make necessary adjustments to the methodology to ensure consistency with economy, efficiency and quality care, as well as sufficient access to covered services for beneficiaries?
- What are the quality measures, reporting processes and appropriate incentives to maximize the likelihood that the methodology will result in better care and better value?

B. Alignment through Managed Care

CMS recognizes that the majority of Medicaid beneficiaries are served in managed care arrangements. The Medicaid managed care regulations in 42 C.F.R. part 438 permit a variety of mechanisms that states can utilize to address delivery system reforms and value-based payments through their managed care plan contracts. These include:

Directed Payments (42 C.F.R. § 438.6(c)). Federal Medicaid managed care regulations include requirements for how states may implement delivery system and provider payment initiatives through Medicaid managed care. With limited exceptions, Medicaid managed care regulations generally prohibit states from directing a managed care plan's expenditures to providers for services that are covered under contract. States must develop actuarially sound rates that cover the costs for delivery of services under the contract; managed care plans, as risk-bearing entities, have the responsibility to manage risk for delivery of those services. In order to do that, managed care plans must be able to fully utilize the payment under the contract for the delivery of services. When states direct managed care plan expenditures under the contract, doing so can undermine the risk-based nature of the contract and distort payments based on arbitrary state financing mechanisms rather than service utilization or provider performance. However, pursuant to 42 C.F.R. § 438.6(c), CMS sets forth exceptions to the general prohibition on state direction of how much and through what kind of arrangement a managed care plan pays providers who furnish covered services. The exceptions include state-directed implementation of value-based purchasing models and other service payment models, participation in delivery system reform or performance improvement initiatives, and certain minimum fee schedules. The payment arrangements identified in 42 C.F.R. § 438.6(c) permit states to direct specific payments made by managed care plans to providers under certain circumstances ("state directed payments") and can assist states in furthering the goals and priorities of their Medicaid programs, including to promote VBP initiatives. For example, a state may require managed care plans to adopt specific VBP models (e.g., Accountable Care Organizations) or incentive payments (e.g., incentive payments based on reducing potentially preventable readmissions).

State directed payment arrangements under 42 C.F.R. § 438.6(c) are required, among other things, to be based on the utilization and delivery of services to Medicaid beneficiaries covered under the contract rating period; to direct expenditures equally for a defined class of providers using a common set of performance measures; and to advance at least one of the goals and objectives in the state's quality strategy. States are required to receive written prior approval from CMS using the preprint form posted on the Medicaid.gov website. In addition, all payment arrangements approved under 42 C.F.R. § 438.6(c) are required to conform to federal regulatory requirements, including that they be incorporated into managed care contracts and rate certifications. Approval of a state directed payment under 42 C.F.R. § 438.6(c) does not constitute approval of the financing mechanism for the non-federal share, and states will need

to work with the appropriate CMS staff to obtain the necessary approvals of a financing mechanism.

States interested in incorporating state directed payments into their managed care programs, including those to align with CHART, should consult the resources available on Medicaid government website on managed care and state directed payments guidance, including the Appendix to our November 2017 CIB on State Directed Payments, which provides more detail on the Accountable Care Organization model as well as the incentive payments based on reducing potentially preventable readmissions mentioned above. We encourage states to reach out early for technical assistance to expedite CMS' review of preprint proposals, including to discuss essential parameters, such as evaluation and quality metrics. Please e-mail StateDirectedPayment@cms.hhs.gov with questions or requests for technical assistance.

Managed Care Plan Incentive Payments (42 C.F.R. § 438.6(b)(2)). States may also use incentive payments to reward managed care plans that accelerate provider adoption of VBP in line with performance targets specified in the managed care plan contract, including implementation of a mandatory performance improvement project under 42 C.F.R. § 438.330(d) that focuses on adoption of VBP models and percentage of plans' provider payments through VBP arrangements. These incentive payments represent additional funds over and above the capitation rates. Incentive payments must comply with all requirements in 42 C.F.R. § 438.6(b)(2), including that managed care plan contracts incorporating incentive payments must not provide for payment in excess of 105 percent of the approved capitation payments attributable to the enrollees or services covered by the incentive arrangement.

In the 2016 managed care final rule (81 FR 27498, 27530 (May 6, 2016)), CMS specified that incentive payments made to a managed care plan in accordance with 42 C.F.R. § 438.6(b)(2) should not be included in the denominator of the medical loss ratio (MLR), as such payments are in addition to the capitation payments received under the contract. However, these MLR standards can support states and managed care plans in their efforts to design and implement comprehensive VBP acceleration strategies by ensuring amounts can be appropriately identified and classified within each managed care plan's MLR.

Managed Care Plan Contracting Strategies. States may also develop and implement specific managed care plan procurement and contracting strategies to promote CHART goals. For example, states may require managed care plans, through their plan contracts, to adopt a specific VBP model that was developed by the Medicaid agency or other stakeholders and payers, including requiring participation in a multi-payer VBP initiative, provided that the requirements in 42 C.F.R. § 438.6(c) are met. Such an approach – particularly if aligned with commercial, Medicare, Marketplace, and other payers with longer term contracts – may promote consistency, reduce the burden on providers to participate, align incentives, and enable the state to accelerate VBP across Medicaid and beyond.

States also may contractually implement a generic requirement for managed care plans to utilize VBP or alternative payment arrangements when the state does not mandate a specific payment methodology and managed care plans retain the discretion to negotiate with network providers the specific terms for the amount, timing, and mechanisms of such VBP or alternative care arrangements. While states may design the specific requirements in line with their VBP goals, states may consider an approach whereby the proportion of each managed care plan's provider payments tied to VBP models increases over time (e.g., 5 percent in Year 1; 10 percent in Year 2; 15 percent in Year 3, etc.). In addition, or as an alternative to the state defining specific VBP goals, states may allow managed care plans to submit proposed VBP arrangements for approval and demonstrate achievement of the contracted benchmark by providing supporting data, as requested and required by the state.

C. Alignment through 1115 Demonstration Authority

CMS acknowledges that there may be instances when a state requires additional flexibility to adopt an Innovation Center model or pursue other delivery system reforms that are not available through the authorities described above. These instances should be limited to when a state wants to pilot a geographically limited payment or delivery system model, limit benefits to certain populations, and offer benefits not available under any other regulatory authority. In such circumstances, CMS welcomes the opportunity to work with states on state-driven proposals that take into account their unique needs and capabilities, consistent with the principles and reflecting the lessons outlined above.

In these cases, a state may need section 1115(a)(2) expenditure authority in order to make an advance payment to a provider for a service that has not yet been rendered to a Medicaid beneficiary. In this case, the state would describe its payment methodology and how it aligns with the CMMI CHART model (including patient attribution, applicable measures, achievement targets, approach to risk-bearing, and incentive payment methodology) and that methodology would be subject to CMS approval as part of a Medicaid section 1115(a) demonstration. This expenditure authority would only be necessary if there are no other pathways to implement this payment model.

As with any section 1115 demonstration, states will be expected to follow the transparency requirements as outlined at 42 C.F.R. § 431.408 and to provide information to ensure that the demonstration will be budget neutral. Federal Medicaid expenditures in the state, with the demonstration, may not exceed what expenditures would have been without the demonstration, across the same time period. Finally, states will be required to monitor the demonstrations and regularly report to CMS on a set of defined metrics and milestones and to ensure an independent evaluation of demonstration impacts and outcomes.

CMS welcomes states to engage with CMS as they plan an approach to the CHART Model that addresses unique state needs. CMS and states will work together to identify available

authorities and submit the required applications and amendments as needed. CMS is available to provide technical assistance to states on how to meet federal transparency requirements as well as to preview states' draft 1115 proposals and public notice documentation to help ensure states successfully meet federal requirements.

Appendix X. Transformation Plan Requirements

Core components of Transformation Plans are outlined below for informational purposes and may change at CMMI's sole discretion. CMMI will provide award recipients a final, more specific list of Transformation Plan requirements at a time and in a manner to be specified by CMMI.

1. A survey of the Community's key strengths and challenges to be leveraged and addressed through CHART participation, including a preliminary assessment of the population health, access, and quality outcomes of greatest interest to the community (e.g., specific chronic conditions of focus or health disparities to target).

2. A description of the health care delivery system redesign strategy that the Lead Organization, SMA, and Participant Hospitals plan to pursue to improve health outcomes and lower health care costs, as well as supporting documentation including:

    a. A description of the role of each Participant Hospital in the health care delivery system redesign strategy including the following elements:

        i. A recruitment and engagement plan for Participant Hospitals that will occur in the following Performance Period and

        ii. A transition plan, developed with Participant Hospitals, that describes:

            1. How and when Participant Hospitals may revert from a CPA back to Medicare FFS (as described in section ***A.4.4.2. Participant Hospitals***),

            2. How such transition may affect beneficiaries and other health care providers in the Community, and

            3. A mitigation strategy to address those risks;

    b. A description of planned changes to health care services provided in the region;

    c. A description of how approved operational flexibilities, as discussed in section ***A.4.6. Operational Flexibilities under the Model***, will be implemented by Participant Hospitals to support the Community's transformation goals and the anticipated impact on the Model population; and

    d. A quality strategy, in accordance with section ***A.4.7. Quality Strategy***, that identifies the quality measures that Participant Hospitals will report and

additional measures Lead Organizations will use to monitor for potential unintended or undesired impacts on quality during Model participation.

3. A Lead Organization-directed plan for potential Aligned Payers and Participant Hospitals to implement the APM described in section ***A.4.5. Value-Based Payment***.
4. A description of the agreed upon support and/or participation of involved parties (e.g., Participant Hospitals, the SMA, and Aligned Payers) in the health care delivery system redesign strategy.
5. A description of existing programs and models in the Community that identifies the potential for duplicative overlaps, as well as an explanation of strategies to ensure that CHART funding will not duplicate other CMS Models or CMS programs. CMMI will use this information to verify that cooperative agreement funds are not used to supplant or duplicate funds from other CMMI Models or CMS programs.

Appendix XI. CPA Financial Methodology

The CPA financial methodology is included in this NOFO for informational purposes and may change at CMMI's sole discretion, changes may include but are not limited to modifications for exogenous factors (i.e., Public Health Emergencies or PHEs, such as COVID-19) and to ensure CMS savings. The CPA financial methodology will be detailed further by CMMI prior to the start of the Pre-Implementation Period. For purposes of this CPA financial methodology, expenditures refer to the amount CMS paid out to Participant Hospitals for Eligible Hospital Services, and revenue refers to the amount Participant Hospitals received from CMS for Eligible Hospital Services.

Step 1. Determine baseline revenue using historical expenditures for Eligible Hospital Services.

For the first Performance Period that a Participant Hospital participates in the Community Transformation Track APM, each Participant Hospital's baseline CPA will be based on the portion of services that it provides to the Community, as defined by section ***A.4.3.1. Community Definition,*** using the simple average of hospital expenditures from the two calendar years starting three years prior to the first period the Participant Hospital joins up to one year prior to the hospital's first performance year (e.g., CYs 2019-2020 for Performance Period 1 scheduled to occur in 2022, but subject to change). The average will be calculated after each historical year has been adjusted according to the prospective adjustments defined in Step 2 below, to ensure that the years are comparable. For subsequent years that a Participant Hospital participates in the APM, the Participant Hospital's baseline revenue will be equal to the CPA for the prior Performance Period (e.g., the baseline revenue for Performance Period 2 will be equal the CPA for Performance Period 1). The CPA will be updated as mid-year and end-of-year adjustments are made to the prior Performance Period's CPA.

Step 2. Apply prospective adjustments.

Each Participant Hospital's baseline revenue will be adjusted to account for differences in either 1) between the baseline years and Performance Period 1, or 2) between the previous Performance Period and the current Performance Period (for Performance Period 2 through Performance Period 6). There are two categories of prospective adjustments made to baseline revenue prior to the start of each Performance Period: unit price and population adjustments.

Unit price adjustments for acute care hospitals. Unit price adjustments differ for acute care hospitals and CAHs. For acute care hospitals, the following elements are included in the unit price adjustment:

> **Trend**: A trend representing the expected percentage change in Medicare FFS expenditures from the baseline year to the Performance Period. CMMI, in consultation with the CMS Office of the Actuary (OACT), will calculate a prospective trend based on recent national data. If the observed regional trend differs from the projected national trend by more than three percentage points, CMS may retrospectively update the trend at the time that end-of-year adjustments are performed.
>
> **Geographic Adjustment Factor**: The year-over-year change in the wage index is applied to the labor portion of expenditure amounts (operational portion of the inpatient expenditures and 60 percent of the outpatient expenditures), and the year-over-year change in the capital geographic adjustment factor is used to adjust the capital expenditure amount of inpatient claims.
>
> **Quality adjustment**:
>
> For Performance Period 1, the change in adjustments between the baseline year and Performance Period 1 for the Participant Hospital's performance in the following quality programs, as applicable, is taken into account:
>
> - Value-based purchasing program: Applied to the labor and non-labor portion of expenditure amounts of inpatient claims.
> - Hospital acquired condition (HAC) reduction program: The change in HAC score (Total HAC score greater than the 75th percentile of all Total HAC scores will be subject to a 1 percent payment reduction) is used to adjust the labor and non-labor portion of expenditure amounts of inpatient claims.
> - Hospital Readmissions Reduction Program (HRRP): The year-over-year change in HRRP payment adjustment factor is used to adjust the relevant expenditure amounts of inpatient claims.

Beginning in Performance Period 2 and all subsequent Performance Periods, each Participant Hospital's CPA will also be adjusted based on its performance on CHART quality measures. Beyond current Medicare quality programs, the additional CHART Quality adjustment will impact no more than 2% of the CPA. See section ***A.4.7. Quality Strategy*** for more details on the CHART quality measures. This adjustment will be applied at the Community level to incent all Participating Hospitals within the Community to collaborate. Additionally, this adjustment will be applied during annual reconciliation. Award recipients will receive further guidance on how CPAs will be adjusted for quality for Participant Hospitals, including hospitals paid under the Inpatient Prospective Payment System and Critical Access Hospitals, before the start of Pre-Implementation Period.

Population adjustment: The population adjustment accounts for differences in the population served by the Participant Hospital between the baseline years and the Performance Period. It captures differences in population size, demographics such as age, and shifts in Eligible Hospital Services between hospitals. The population size adjustment will be defined as a change in beneficiary months for the defined Community. Beneficiaries are aligned if they are eligible and reside in the Community for the majority of the alignment period. The alignment period is the 12-month period beginning 18 months prior to the respective baseline or Performance Period. The beneficiary must not move out of the Community before or during the respective baseline or Performance Period. The population demographic will be defined as a change in the demographic-only HCC Risk Score. The shift in Eligible Hospital Services adjustment will be defined as a change in the distribution of service between hospitals. The population adjustment will avoid over-payment for Eligible Hospital Services by reducing revenue from a Participant Hospital's baseline CPA if the population served by the Participant Hospital decreased between the baseline years and the Performance Period or if Eligible Hospital Services shifted between health care providers between the baseline years and the Performance Period. In CMMI's experience with payment mechanisms similar to capitated payments, the predictability of payment is not only attractive to hospitals in periods of decline, but also to hospitals in periods of growth. The population adjustment will allow CMMI to appropriately adjust CPAs to account for either scenario. Mid-year and end-of-year population adjustments will correct for any differences between projected and observed shifts in Eligible Hospital Services.

Unit price adjustments for CAHs. For CAHs, the unit price adjustment consists of the change in the interim payment rate between the cost report that the CAH submitted for the baseline years and the most recently available, adjudicated cost report. Starting in Performance Period 2, each participating CAH's CPA may also be adjusted for its performance on CHART quality

measures. Award recipients will receive further guidance on how CPAs will be adjusted for participant hospitals quality prior to the start of the Pre-Implementation Period.

Step 3. Apply a Discount

In order for payers to realize savings, a small percentage discount will be applied to the CPA. It is expected that Participant Hospitals can achieve savings, despite the presence of a discount, through reductions in potentially avoidable utilization. Acknowledging the financial instability of many rural hospitals and the time it may take for Transformation Plans to result in reduced potentially avoidable utilization, the discounts will start at 0.5 percent and increase slowly. Each Participant Hospital will have a 0.5 percent discount applied in Performance Period 1 and 1.0 percent discount applied in Performance Period 2. Beginning in Performance Period 3, each Participant Hospital's discount will vary depending on the total revenue the Community. These discounts increase for the remainder of the Model.

Starting in Performance Period 3, CMMI will apply lower discounts to CPAs in Communities with higher total revenue under a capitated payment arrangement. This variance provides an incentive for Communities to recruit more hospitals to participate in the APM by Performance Period 3 and increases the likelihood that the APM will yield savings that meet or exceed the amount of the cooperative agreement funding. Based on the total Medicare FFS revenue under the capitated payment arrangement, the discount is based on a schedule of discounts listed in the **Capitated Payment Arrangement Discounts** table below:

Capitated Payment Arrangement Discounts

Total Medicare FFS Revenue in the Community under a Capitated Payment Arrangement (x) at or below:	**Performance Period**					
	1	**2**	**3**	**4**	**5**	**6**
0 < *x* ≤ 15 million (M)	0.5%	1.0%	2.5%	3.0%	3.5%	4.0%
15 < x ≤ 20 M	0.5%	1.0%	2.4%	2.9%	3.4%	3.9%
20 < x ≤ 25 M	0.5%	1.0%	2.3%	2.8%	3.3%	3.8%
25 < x ≤ 30 M	0.5%	1.0%	2.2%	2.7%	3.1%	3.5%
30 < x ≤ 35 M	0.5%	1.0%	2.1%	2.6%	3.0%	3.3%
35 < x ≤ 40 M	0.5%	1.0%	2.0%	2.5%	2.9%	3.1%
40 < x ≤ 45 M	0.5%	1.0%	1.9%	2.4%	2.8%	3.0%
45 < x ≤ 50 M	0.5%	1.0%	1.8%	2.3%	2.7%	2.9%
50 < x ≤ 55 M	0.5%	1.0%	1.7%	2.2%	2.6%	2.8%
55 < x ≤ 60 M	0.5%	1.0%	1.6%	2.1%	2.5%	2.7%

60 < x ≤ 70 M	0.5%	1.0%	1.5%	2.0%	2.4%	2.6%
70 < x ≤ 80 M	0.5%	1.0%	1.4%	1.9%	2.3%	2.5%
80 < x ≤ 90 M	0.5%	1.0%	1.3%	1.8%	2.2%	2.4%
90 < x ≤ 100 M	0.5%	1.0%	1.2%	1.7%	2.1%	2.3%
100 < x ≤ 120 M	0.5%	1.0%	1.1%	1.6%	2.0%	2.2%
120 < x ≤ 140 M	0.5%	1.0%	1.0%	1.5%	1.9%	2.1%
140 < x ≤ 160 M	0.5%	1.0%	1.0%	1.4%	1.8%	2.0%
160 < x ≤ 180 M	0.5%	1.0%	1.0%	1.3%	1.7%	1.9%
180 < x ≤ 200 M	0.5%	1.0%	1.0%	1.2%	1.6%	1.8%
200 < x ≤ 220 M	0.5%	1.0%	1.0%	1.1%	1.5%	1.7%
220 < x ≤ 240 M	0.5%	1.0%	1.0%	1.0%	1.4%	1.6%
240 < x ≤ 260 M	0.5%	1.0%	1.0%	1.0%	1.3%	1.5%
260 < x ≤ 280 M	0.5%	1.0%	1.0%	1.0%	1.2%	1.4%
280 < x ≤ 300 M	0.5%	1.0%	1.0%	1.0%	1.1%	1.2%
300 M < x	0.5%	1.0%	1.0%	1.0%	1.0%	1.0%

As detailed in ***A.4.5.3.1. Payer Alignment Characteristics***, each Aligned Payer, including Medicaid, must possess the Financial Alignment Characteristic demonstrated through aligning with the CPA financial methodology and providing CPAs to Participant Hospitals. Each Aligned Payer may implement its capitated payment arrangement with modifications based on their plan benefits and member populations. One modification available to Aligned Payers is the option to remove the discount factor from their respective CPA. Specific to Medicaid, CMMI and CMCS will collaborate to issue guidance on how Medicaid savings will accrue for SMAs that maintain the discount factor in their CPA. All CPA financial methodology modifications will be subject to CMMI approval.

Step 4. Apply mid-year adjustments to CPAs

As the Performance Period progresses and additional data become available, several adjustments will be applied to CPAs, including but not limited to:

> **Population adjustment**: A mid-year population adjustment will be applied as additional data on population size, demographics, and shifts between hospitals become available.
>
> **CAH interim payment rate adjustment**: If CMMI adjudicates a new cost report for a participating CAH after the calculations of the prospective CPA, the CPA will be updated mid-year to account for the updated interim payment rate.
>
> **Adjustment for mid-year and end-of-year adjustments to the prior year's CPA**: Because the calculation of the CPA is prospective, it may be calculated for the upcoming Performance Period before mid-year and end-of-year adjustments have been applied to

the current Performance Period. Therefore, a given Performance Period's CPA will be adjusted as additional data from the mid-year and end-of-year adjustments to the prior Performance Period's CPA become available.

Step 5. Apply end-of-year adjustments to CPAs

The following adjustments will be applied after the end of each Performance Period, with six months of claims run-out. If the adjustments indicate that additional payment is owed to the Participant Hospital, or that the CPAs made to the Participant Hospital were too high, CMMI may either reconcile the discrepancy through a one-time payment or adjust the following Performance Period's CPA to make up the difference.

Population adjustment: The population adjustment will be applied again after the end of the Performance Period, when full utilization data are available for the Performance Period.

Outlier adjustment: During the pre-implementation period, CMS may allow Participant Hospitals the ability to elect whether or not to participate in an optional outlier policy to protect Participant Hospitals from unexpected, catastrophically expensive utilization not accounted for in their prospective CPAs. Participant Hospitals may elect not to participate in such an arrangement if they believe that their cost-reduction efforts will impact outlier costs (which has been observed in preliminary evaluation results for the Next Generation Accountable Care Organization or NGACO Model).

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