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

Initial Announcement
Cooperative Agreement

Transforming Clinical Practice Initiative (TCPI)
Practice Transformation Networks (PTNs)

Funding Opportunity Number CMS-1L1-15-003
CFDA 93.638

Applicable Dates:

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

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I. Executive Summary

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

Funding Opportunity Title	Practice Transformation Network (PTN)
Announcement Type	New
Funding Opportunity Number	CMS-1L1-15-003
Catalog of Federal Domestic Assistance	93.638
Letter of Intent Due Date (link)	November 20, 2014
Cooperative Agreement Application Due Date	February 5, 2015; 3:00 p.m. Eastern (Baltimore MD) time
Anticipated Notice of Award	April 10, 2015
Performance Period	May 1, 2015 – April 30, 2016; May 1, 2016 – April 30, 2017; May 1, 2017 – April 30, 2018; May 1, 2018 – April 30, 2019. Maximum 4 years
Anticipated Total Available Funding	Up to $670 Million, pending availability of funds
Estimated Number and Type of Awards	35 cooperative agreements
Estimated Award Amount	$2 Million to $50 Million
Estimated Award Date	May 1, 2015
Eligible Applicants	Organizations that have pre-existing relationships with multiple clinician practices (primary care and/or specialists) that include data sharing capabilities. See section IV.

II. Funding Opportunity Description

II.1 Purpose

This Funding Opportunity Announcement (FOA) is intended for the PTNs. Applicants that are selected as PTN cooperative agreement awardees will collaboratively lead clinicians and their practices through the TCPI phases of transformation, achieve the TCPI goals, and through adaptive redesign, position these clinicians and their practices to be sustainable components within the changing care delivery system.

II.2 Authority

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

Under section 1115A(d)(1) of the Act, the Secretary of Health and Human Services may waive such requirements of Titles XI and XVIII and of sections 1902(a)(1), 1902(a)(13), and 1903(m)(2)(A)(iii) as may be necessary solely for purposes of carrying out section 1115A with respect to testing models described in section 1115A(b). For this model 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. Waivers are not being issued in this document; waivers, if any, would be set forth in separately issued documentation. Thus, notwithstanding any other provision of this Funding Opportunity Announcement, awardees and subawardees 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 TCPI model. Any such waiver would apply solely to the TCPI model and could differ in scope or design from waivers granted for other programs or models.

II.3 Background

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

Information available from these models, coupled with the growing evidence gathered from a body of published literature including the Commonwealth Fund ‘s 2008 ‘Organizing the US Health Care Delivery System for High Performance’ , indicates that a focused effort on health delivery redesign through clinician practice transformation can improve the quality of care for patients and prepare clinicians to participate in new payment models. This redesign requires a simultaneous change in many independent processes to create a more efficient and effective care delivery system.

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

II.4 Initiative Goals

The Transforming Clinical Practice Initiative model will fund successful applicants as Practice Transformation Networks (PTNs) that propose the most compelling approaches for assisting clinicians in transforming their practices, and commit to meeting quantifiable outcomes. These outcomes must be aligned with the overall aims of the TCPI model, including:

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

II.4.1 Model

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

Through a combination of service delivery refinements and innovative technical assistance, the Partnership for Patients (PfP) initiative and the Quality Improvement Organization (QIO) program have together shown promise in making dramatic improvements in quality, outcomes and cost efficiency in the hospital setting using an adaptive quality improvement approach to program design. Their aligned efforts toward assisting providers with quality improvement activities resulted in decreases in hospital-acquired infections (HAI), hospital-acquired conditions (HAC), and

readmission rates. TCPI will use a similar approach to providing technical assistance to transform clinician practices to deliver high-quality care that is evidence based, efficient, coordinated and patient-centered. We expect that practice transformation will result in improvements in patient health outcomes and reduced health care costs.

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

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

1) Identify, engage, and deploy expert faculty;
2) Develop and continuously refine improvement guides and TCPI Change Package for implementation in practices;
3) Establish relationships with other public and private entities;
4) Establish and support a national infrastructure that is funded through cooperative agreements and contracts; and
5) Assist participating primary care and specialists clinicians and their practices (including clinicians in rural health clinics, rural community health centers, and health professional shortage areas (HPSAs), and those clinicians supporting medically underserved populations such as community and migrant health centers), in progressing through various phases of transformation.

By participating in TCPI, practices will be able to receive the technical assistance and peer-level support they need to deliver care in a patient-centric and efficient manner, which is increasingly being demanded by health care payers and purchasers as part of a transformed care delivery system. Participating clinicians will thus be better positioned for success in the health care market of the future - one that rewards value and outcomes rather than volume. The following two figures provide additional perspective and context on the overall design of the TCPI model.

Figure 1. Pathway to a Transformed Healthcare System

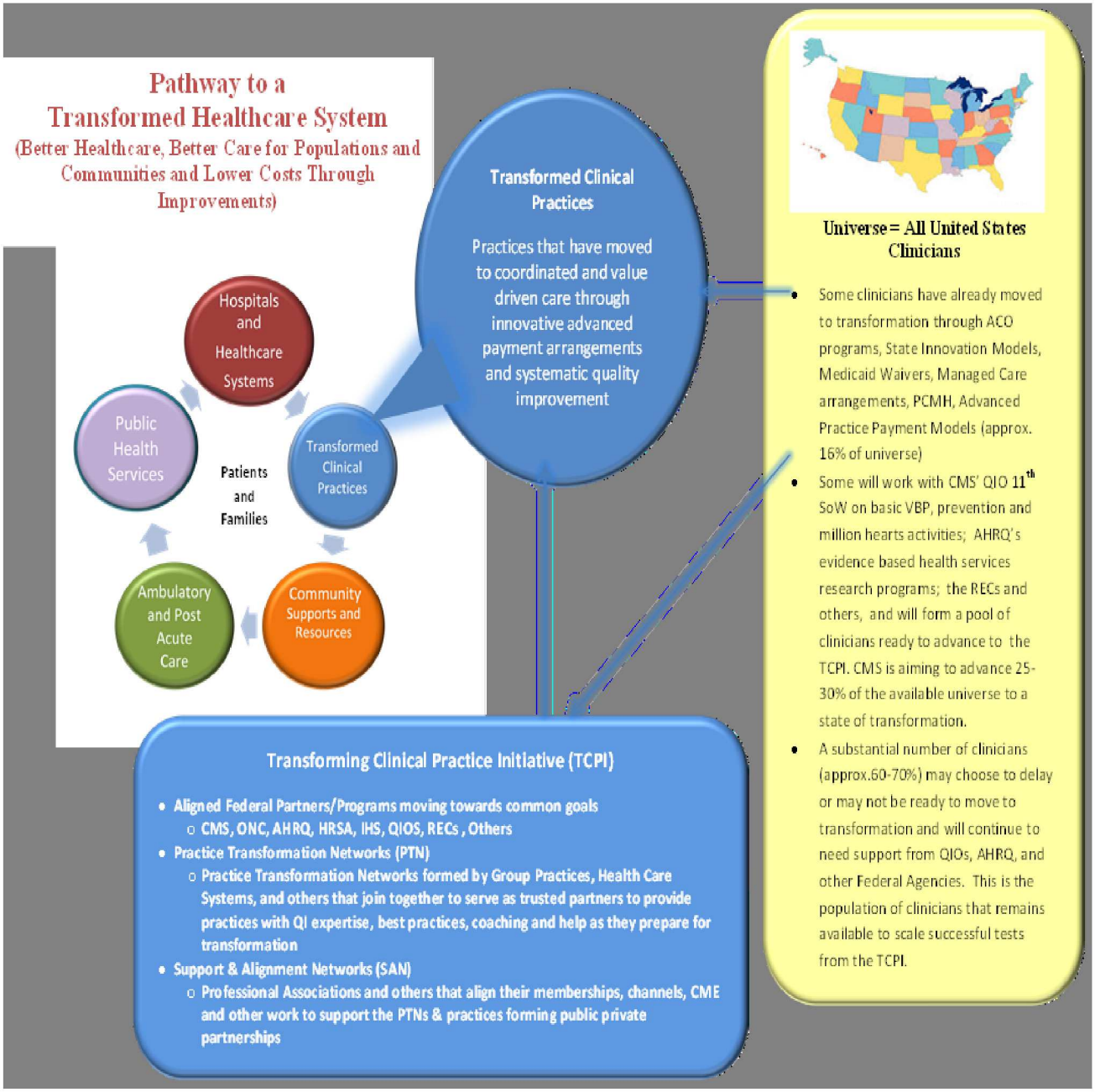
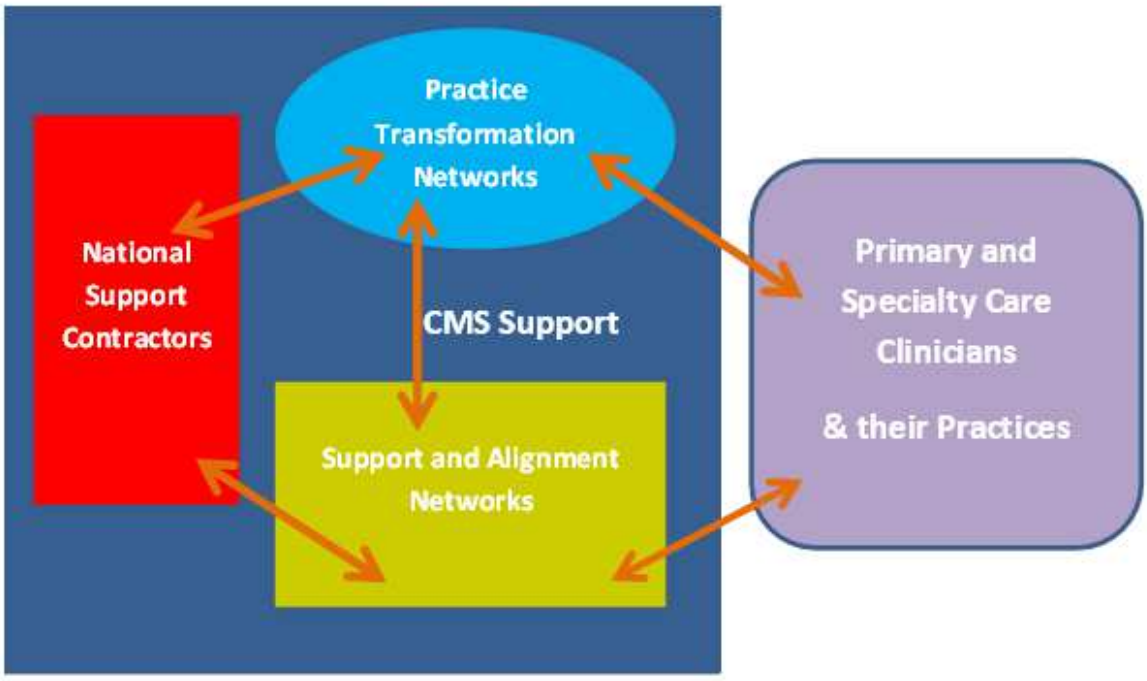


Figure 2: Three levels of clinician support



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

The TCPI model seeks to have PTN applicants to focus their work on the stated TCPI aims and related milestones. Practice Transformation Networks will commit to generating results based on the aims of TCPI. Continuation of PTN funding in future years of the model will be contingent upon producing tangible results that flow from these aims. Clinicians participating in the TCPI model will commit to participate in the Physician Quality Reporting System and Value-Based Payment Modifier Programs. Additional detail about these programs can be found at www.cms.gov or by clicking on the names of each program.

Figure 3 below begins to illustrate the manner in which the TCPI model will hold awardees to the bold aims that they submit as a part of this FOA application in Section VI.1.

Figure 3

Improvement Area		Within first 12 months of award	By the end of the 4 year period of performance
Enter percentage improvement on quality measures:			
Clinical Outcomes (Note: applicants can	Diabetes	Enter %	Enter %

add rows to more fully describe and delineate project results in this area)	Asthma	Enter %	Enter %
	Heart Failure	Enter %	Enter %
Reduction of unnecessary testing		Enter number	Enter number
Cost savings Sample formula: Cost savings = Total dollars saved divided by total number of patients		Provide $ value or $ value per patient	Provide $ value or $ value per patient
Unnecessary hospitalizations avoided		Enter number	Enter number

II.4.3 Key Attributes

The TCPI infrastructure will include a group of national faculty experts that will support TCPI improvement activities. The national faculty will be supported through a TCPI contract. The national faculty in collaboration with the PTNs will coach and mentor clinicians in developing core competencies to assist them in moving through the TCPI Phases of Transformation and TCPI Change Package. Coaching allows for the clinical practices to become actively engaged in the transformation rather than as the recipient of the transformation. Coaching builds the skills of the clinicians and practices that are more likely to lead to sustained efforts after the TCPI technical assistance (service delivery) model tests are complete. The PTNs will be responsible for the following activities:

- **Recruiting clinician practices and building strategic partnerships**
  - Perform environmental scans to identify and collaborate with community partners that can help to achieve common goals;
  - Collaborate with partners, such as QIOs, to assess and ensure clinician/practice readiness;
  - Recruit clinicians/practices to participate in the Practice Transformation Networks;
    - Emphasize the recruitment of clinicians/practices with the greatest need for technical assistance
    - Emphasize the recruitment of clinicians whose patients include Medicare, Medicaid or CHIP beneficiaries
    - Emphasize the recruitment of clinicians serving in:
      - medically underserved areas (including those practicing in community, migrant, and Indian health centers),
      - health professional shortage areas,
      - rural areas (including rural health clinics, rural community health centers and Indian Health Centers), and
      - Small, rural practices of 9 or fewer clinicians.

- Develop collaborative relationships with purchasers and payers to facilitate multi-payer alignment of financial incentives, quality measures, and methods;
- Collaborate with states (including public health and mental health agencies), regional and community based organizations, and private entities that are participating in transformation activities to ensure synergy and prevent duplication; and
- Develop effective partnerships among clinicians and their respective patients/families.

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

- **Facilitating improved clinical practice management**
  - Identify ways clinician practices can improve quality and access to care.
    - Provide training to clinician practices on how to establish care plans that are sensitive to the language, values, and culture of their patients with complex care needs, while promoting self-management and shared decision making with patients and their family members;
    - Provide exposure to new systems of care and alternative payment models;
    - Coach practices to optimize scheduling so that same day appointments can be offered, and after-hours access to clinician advice is available; and
    - Offer information regarding certification and training requirements as well as CMS program requirements, and ways in which clinicians may effectively meet them.
  - Connect primary care practitioners (PCP) with specialty and ancillary providers in their medical neighborhood that can serve their patient panel;
    - Expand the capacity for team-based practice and optimal integration of non-physician practitioners (including nurse practitioners, physician assistants, clinical pharmacists) into care teams;
    - Promote the use of tools specific to primary and specialty care coordination (such as formalized agreements for care coordination, referrals and co-management plans) that clearly specify roles, responsibilities and expectations in care planning and

management across practices (e.g. timely communication of test results and exchange of clinical information with patients and other providers);
    - Provide information to clinician practices on planning for and facilitating transitions of their patients across care settings and time, including the transfer from pediatric to adult practices; and
    - Explore the use of patient navigators, parent partners, and peer support services in effecting patient engagement and care coordination.
- Use technology to enhance the effective use of administrative, financial and clinical systems
    - Participate in national TCPI webinars and other offerings specific to practice transformation and the use of administrative, financial, and clinical systems
    - Offer frequent webinars on a variety of quality improvement topics and practices; for example, webinars showing providers how to use clinical and other data to risk stratify their population and identify patients at high-risk for hospitalization or complications from chronic conditions, as well as instruction on how to perform timely interventions and monitoring.
    - Offer information regarding certification and training requirements as well as CMS program requirements, and ways they may effectively meet them.

- **Using quality measures and data for improvement**
    - Support improvement on a core set of clinical, operational, quality, and care experience measures;
    - Facilitate practice data reporting as needed, especially for clinicians in small practices or rural settings who may require additional assistance from their PTN;
    - Use practice data for clinical and operational quality improvement, improve practice flow and care management and identify methods to reduce health care disparities;
    - Provide ongoing monitoring and feedback regarding participating practice performance based on the data;
    - Promote the interoperability and effective use of registries, Electronic Health Records, and other practice management systems, while maintaining privacy and security of patient health information, to improve coordination of care delivery between primary and specialty practices, facilitating improved patient outcomes; and
    - Assess the practices' progress in addressing Meaningful Use (MU). More information on meaningful use can be found via the following hyperlink - What is Meaningful Use?

Collaborating with CMS on transformation activities and provide ongoing feedback on the progress toward goals.

- Work with practices to collect data on progress toward goals and facilitating improvement activities when the need for assistance is detected.
- Work with practices to display and communicate progress with their peers across the TCPI community of practice at learning sessions events at least twice each performance period.
- Provide aggregate data to CMS through the specified data collection tools on at least a quarterly basis that shows results by month.
- Provide feedback for improvement on the specified data collection processes to ensure the collection of accurate information without undue burden.

Funding Targeted to Applicants that Commit to Specific Results

Although the awards under this FOA are for a four-year period of performance, CMS is interested in sustainability beyond the initial period of federal investment. CMS is interested in information from applicants regarding sustainability, such as evidence of public-private partnerships or shared savings agreements directly with other payers.

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

- PTNs that support specialty care practices must explain in their applications their plans, milestones and aims for how the specialists would reduce unnecessary testing and procedures.
- Pursue and achieve the aims of the TCPI model;

Ensure support from a robust number of practices willing to participate with the network, including a minimum of 20% of clinicians from practices that are small in size, located in rural areas, and/or that serve medically underserved populations;

- Conduct pre-assessment and on-going assessment of practices' clinical and operational health;
- Engage practice leadership to commit to the goals of TCPI and to dedicate a specific improvement team of individuals;
- Participate and support clinicians participation in PTN-based and national TCPI training events;
- Project clinician enrollment and achievement targets aligned with the TCPI model aims;
- Develop collaborative relationships with purchasers and payers to facilitate multi-payer alignment of financial incentives, quality measures, and program methods;
- Serve as champions for continuous improvement and culture change through engaged leadership, team building, and patient engagement;
- Receive and utilize monthly reporting of results/outcomes from clinicians/ practices for quality improvement, with an intent to converge on core clinical, operational process, outcome, and financial measures over time;
- Collaborate with partners such as other PTNs, QIOs, states (e.g. public health and mental health agencies), rural communities and private entities that are participating in transformation activities to ensure synergy and prevent duplication;
- Provide data to CMS about the clinicians and their practices' performance;
- Work with the clinician practices they serve to ensure compliance with HIPAA;
- Continuously assess patients/families' care experiences;
- Leverage telehealth and other technology to enhance care coordination and link rural participants with more distant urban specialists;
- Provide ongoing coaching, facilitation and technical assistance to practices;
- Disseminate and spread quality improvement and change methodologies, tools, published literature, best practices, and lessons learned on team-based care delivery and other aspects of practice transformation;
- Conduct and ensure clinicians report regular, rapid small tests of change as part of Quality Improvement work;

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

Responsive proposals will include specific discussion and explanation of how applicants will address these points.

Applicants must demonstrate established data sharing capabilities with clinical providers that include the ability to collect, hold, and evaluate personally identifiable information (PII). PII in the TCPI model is defined as "…information which can be used to distinguish or trace an individual's identity, such as their name, Social Security number (SSN), biometric records, etc. alone or when combined with other personal or identifying information which is linked or linkable to a specific individual, such as date and place of birth, mother's maiden name, etc..." [1] PTNs,at a minimum, will provide CMS and its support contractors with aggregate data on clinician/practice clinical, operational and financial improvement results/outcomes at least quarterly. The CMS support contractor will conduct further analysis of TCPI improvements across the cohort of PTNs. This will allow CMMI to compare results across the model with minimal delay. Additionally CMS will use data already being reported by participating clinicians/practices that are captured from other CMS and HHS reporting systems.

The PTNs and the clinician practices that they assist under TCPI are responsible for ensuring compliance with all applicable laws, including HIPAA, with regard to data used or disclosed in connection with the TCPI model.

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

How will the TCPI model utilize measurement for results through quality improvement?

[1] From: OMB Memorandum M-07-16, *Safeguarding Against and Responding to the Breach of Personally Identifiable Information.*

CMS expects PTN applicants to have established systems and measures in place for collecting, assessing, and sharing monthly quality improvement data and results from participating practices. CMS understands PTNs will in many cases be recruiting new clinician practices that may be using the PTN measurement systems for the first time. The TCPI will require ongoing reporting of key metrics, such as population based health improvement measures, quality indicators, cost, and utilization metrics, patient-centered outcomes, and patient satisfaction. Each PTN must have a measurement strategy in place that is designed with consideration of the diverse set of measures and collection methodologies that clinician practices currently may be using. Applicants must propose their initial core set of measures as part of their application. There are a number of national efforts to align measures across programs in both the public and private sector so that practices can report once and satisfy some of the various requirements of multiple programs. PTNs and their participating clinicians/practices should align their measurement strategies with these existing measures and programs. **Over time, PTNs and their participating practices will be expected to increasingly converge on the use of a common set of core measures and have an adaptable reporting system that can capture these measures**. In addition, a central set of measures will be used by the CMS support contractor to evaluate the TCPI model.

CMS will continuously review PTN progress in achieving outcomes aligned with the model aims and objectives using both qualitative and quantitative metrics. TCPI methodology will include readiness assessments to be completed by all clinician practices that apply to join a PTN, continuous measurement and assessment of "advancing" through the various phases (employing a flexible design that allows for measurement across phases), and measurement of the clinician practices' performance on quality of care and cost metrics as they progress through the phases. Quality Improvement Organizations (QIOs) are anticipated to play a key role in assisting PTNs and their practices with the administration of clinical practice readiness assessment and on-going periodic assessments to determine progress through the 5 transformational phases (see Figure 4 on following page).

The CMS TCPI model implementation team will lead the real-time improvement assessment function. PTNs will provide CMS and its support contractors with aggregate data on clinician/practice clinical, operational and financial improvement results/outcomes at least quarterly The CMS support contractors will include an evaluation and a data, feedback and monitoring contractor that will track implementation for the TCPI model and will provide CMS continuous feedback and timely findings of model results achieved.

A core set of measures will be used to inform monitoring, evaluation, and performance improvement across all clinician practices participating in TCPI. The initial set of core measures will be proposed by the PTNs and may be the same measures that PTNs are currently collecting from clinicians. In addition, a menu set of measures established by CMS will be used that can allow for practice and/or region specific measures to drive improvement on a local level. These will likely include measures consistent with the Million Hearts™ initiative and American Board of Internal Medicine's (ABIM) Choosing Wisely® Initiative. The total cost of care will be derived using methods similar to those utilized for the physician value-based payment modifier under the Medicare Physician Fee Schedule. Patient satisfaction will be measured through the survey and methods from the Consumer Assessment of Healthcare Providers and Systems (CAHPS).

How will PTNs support practices and their clinicians through TCPI Phases of Transformation and related milestones?

PTNs will coach and mentor clinicians in developing core competencies to assist them in moving through the TCPI Phases of Transformation. Clinicians and their practices will complete an assessment tool facilitated by the QIOs to determine their current practice state, as defined by the phases described below. PTNs will be accountable to provide the appropriate technical assistance to assist clinicians and their practices with progress through the phases. Periodic assessments will also occur to gauge the progress of practices as the TCPI model matures.

Assessment: Practice transformation is a set of discrete changes in the way a practice operates. The degree to which a practice is transformed is dependent on the practice's capacity to provide high quality health care at lower cost in a coordinated manner. Clinicians and their practices will be assessed by CMS through QIOs in partnership with PTNs to determine their current practice state. A baseline assessment will be conducted for clinicians recruited to participate in practice transformation and will be followed by reassessments throughout the period of performance by the Practice Transformation Networks in partnership with the QIOs. The initial assessment tool completed by practices and reviewed by QIOs and PTNs will include assessments of quality improvement methodologies currently employed by the practice, as well as assessments of patient population, clinical results, effective use of health information and related technology for clinical and operational improvement, team-based care delivery models (including roles and services provided by all team members), current business models, and related financial and administrative practices and community resources. The initial assessment results will be used to determine readiness for transformation, and position of the clinician/practice on a continuum of transformation defined by distinct phases that directly map to achievement of the larger goals for the TCPI.

The periodic reassessments will be managed by the QIOs and PTNs and used to determine the clinician/practice's progress in moving upward through the phases, and will be based upon achievement of both quantitative and qualitative milestones. The tables below for primary care and specialists contain a description of the phases of transformation, the activities and characteristics associated with each phase and the performance milestones that clinician practices must meet in order to advance to the next phase. As indicated in the tables, many of the phase descriptions and milestones are the same for primary care and specialists, although there is some variation.

Figure 4A: TCPI Phases of Practice Transformation: Primary Care descriptive characteristics and associated milestones.

	Phase Description	Phase Milestones
Phase 1: **Setting aims and developing basic capabilities**	➢ The practice has the full support of leadership for transformation and develops and commits to a clear statement that outlines the specific goals of transformation, why they are important to the practice and the community they serve, what	➢ Practice will submit a detailed plan that addresses the specific goals of transformation—what is important to the practice and the aims. This will be submitted within one month of practice joining PTN. ➢ Practice starts to perform a self-

	changes will be made, and how progress will be measured. ➢ Learns and integrates a planned care model which includes understanding the intersection of administrative, financial, and clinical systems and uses this knowledge to redesign all of these processes toward a leaner and higher performing organization that produces better outcomes. ➢ Uses data to better understand practice flow. Implements improvement strategy that relies on routine performance measurement to identify opportunities for improvement and uses rapid cycle change methods to test ideas for change. Intentionally minimizes unnecessary testing and procedures, and measures, and reports impact of these changes. ➢ Participates in learning collaborative to share its best practices and lessons learned and to benefit from the learning of others. ➢ Practice recognizes importance of patient and family engagement in care.	assessment and starts to collect baseline data on utilization and other quality and outcome measures and identifies problem areas for improvement. ➢ Practice starts to train at least 50% of staff in improvement methods and tools. Staff starts to understand the process of improvement and how to test changes in daily workflows. Staff is trained on optimal team-based practice. ➢ Practice has a process in place for training staff on data quality problems when they are detected. ➢ Practice establishes measures, plans and a baseline for intentionally minimizing unnecessary testing and procedures. ➢ Practice has in place mechanisms for addressing the needs of their patients/families to be active partners in care.
<u>Phase 2:</u> **Reporting and using data to generate improvements**	➢ Acquires core capabilities in improving the health of populations through more cost-effective systems of care. Establishes new relationships within the community and expands the care team. ➢ Produces real time reports on how practices, providers and care teams are meeting quality, financial and utilization goals to enhance patient experience of care, eliminate waste and decrease costs. ➢ Shares outcomes of quality and clinical measures for the patient population with the PTN. Uses data to analyze potential disparities in care and develops action plans—this	➢ Practice starts to capture and analyze population, disease specific, and relevant quality measures for utilization, billing data and tests ordered from their registry, practice management or EHR system to drive clinical practice improvement and resulting in reduced unnecessary tests and hospitalizations. ➢ Practice has identified community partners and other points of care that their patients are using and has a formal agreement in place with these partners. ➢ Practice has defined improvements in care transition and processes enabled through exchange of essential health information to eliminate waste and decrease costs.

	allows practices to identify individual patients needing intervention to improve overall practice performance. ➢ Practice has integrated specialty care through agreements. ➢ The practice identifies ways to increase patient and family engagement in care and identifies barriers to patient and family engagement in care. ➢ The practice tracks patients obtaining outside services. ➢ Eligible clinicians assess their ability to meet Meaningful Use objectives and develop an EHR integration plan to meet Meaningful Use objectives in Phase 5.	➢ At least 50% of the practice's patients have a main clinical point of contact at the practice for their health care needs (i.e. empanelment to provider and care teams). ➢ The practice provides care management to at least 50% of highest risk patients (those that are clinically unstable). ➢ The practice implements at least three specific care management strategies for patients in higher risk cohorts, samples may include, but are not limited to: o Integration of behavioral health, o Self-management support for at least three high risk conditions o Medication management and review. ➢ Monthly reporting includes updating information about the practice's risk stratification methodology, empanelment status, risk stratification data, and other activities. ➢ Practice incorporates regular improvement methodology to execute change ideas in a rapid cycle. Use a plan-do-study-act (PDSA) quality improvement cycle of small scale tests of change in the practice setting.
<u>Phase 3:</u> **Achieving aims of lower costs, better care, and better health**	➢ Optimizes care team and utilizes technology to track patient improvements via population based management (use of information on clinical grouping of patients to improve their care and clinical outcomes). Matches and allocates care team functions based on skill, abilities, and credentials to support efficient care delivery. ➢ Obtains feedback from patients and family members about their health care experience and uses this information for quality improvement. Provides incentives to care team based on performance. Proactively engages patients and families to expand their role in decision making, health-related	➢ Practice is optimizing reports in registry, practice management, or EHR system to drive clinical practice improvement on a monthly basis. ➢ Practice has reduced unnecessary tests and hospitalizations by at least 25% from baseline. ➢ Practice has involved patients, families and staff in quality improvement initiatives. ➢ Practice sets clear expectations for each team member's functions and responsibilities to optimize efficiency, outcomes, and accountability. ➢ Practice routinely creates and/or maintains shared care plans and utilizes shared decision making tools to incorporate patient preferences and goals in care management processes.

	behaviors and self-management. ➢ Demonstrates improvement on select quality measures. ➢ Practice identifies patient risk stratification by disease, health risk and other conditions.	➢ Practice routinely exchanges essential health information with other members of care team outside of the practice. ➢ Practice has increased the number of patients who have received the appropriate health screenings and completion of referrals. ➢ Practice has identified high risk patients and has ensured they are receiving appropriate care and case management services. ➢ Practice has a formal written vision related to care coordination. ➢ Practice links a patient to a provider and care team so both the patients and team recognize each other as partners in care. ➢ Practice ensures that patients are able to see their provider or care team whenever possible. ➢ Practice links patients with community resources to facilitate referrals. ➢ Practice tracks and supports patients when they obtain services outside the practice. ➢ Practice follows up with patients within 24 hours after an emergency room visit or hospital discharge.
<u>Phase 4:</u> **Getting to benchmark status**	➢ Manages populations of patients through a panel with significant demonstration of care coordination, including coordinating follow up appointments with patient after emergency room visits or hospitalizations. ➢ Provides patients with community resources, tracks and supports patients obtaining outside services. ➢ Integrates advanced access to eliminate waits, minimize "no show" rates and streamline workflow, such as 24/7 access to the care team, and scheduling options. ➢ Continues to demonstrate improved performance on quality measures	➢ Practice uses utilization reports on a monthly basis and continuously makes clinical improvement changes such as 24/7 access to care, 'same as' tracking number of patient triaged after hours, number of same day appointments for emergent problems, number of patients being discharged from the hospital and needing an appointment with 24 hours after discharge, and the practice continues to decrease the "no show" rate over time. ➢ Practices submit utilization reports to PTN on a monthly basis. Feedback is submitted back to the practice. ➢ Practice has reduced unnecessary tests and hospitalizations by at least 20% from baseline.

	and seeks to improve performance relative to local and national benchmarks. ➢ Has knowledge of the health status of other populations in the medical neighborhood and contributes to the success of the over health of the community served.	➢ Practice has a process in place for identifying 90% of high risk patients on a monthly basis and has ensured that 75% are receiving appropriate care and case management services as part of their continuous practice improvement plan. ➢ Practice tracks patients, on a monthly basis, when they obtain services outside of the practice. ➢ Practice has a process in place to link the patient to a care provider and care team so both the patients and team recognize each other as partners in care.
Phase 5: **Practice has demonstrated capability to generate better care, better health at lower cost.**	➢ Practice has documented substantial performance improvements. Practice generates significant quality improvements in patient health outcomes and experience of care. ➢ Eligible clinicians have completed implementing their integration plans for meeting meaningful use objectives.	➢ Practice sustains prior improvements in key metrics for at least one year. ➢ Practice has developed business acumen in the various types of alternative payment models including understanding of shared savings models with and without risk, various contracting arrangements that a practice might consider, and how to evaluate the pros and cons for the population they serve.

Figure 4B: TCPI Phases of Practice Transformation: Specialists' descriptive characteristics and associated milestones.

Phases of Practice Transformation	Description	Milestones
Phase 1: **Setting aims and developing basic capabilities**	➢ The specialty clinician/practice has the full support of leadership for transformation and develops and commits to a clear statement of action with specific goals and metrics for delivering well-coordinated, timely, efficient care as part of a patient's care team, that defines their role and responsibilities with respect to the larger medical neighborhood in	➢ Specialty clinician/practice will submit a detailed plan that addresses how they will increase access to care, negotiate co-management of patients with other providers, coordinate care with other providers, reduce unnecessary hospitalizations, testing and procedures, and deliver patient-centered care. ➢ Participates in multidisciplinary learning collaborative to benefit from the learning of others, share best practices

	which they operate. ➢ Learns and integrates best practices for care coordination and patient co-management with multidisciplinary and interprofessional patient care teams. This includes understanding the intersection of primary care, specialty care, behavioral health, and patient self-management, in providing patient-centered care, and producing optimal patient outcomes. ➢ Engages in effective electronic, standards-based, bi-directional communication with other providers caring for the same patient. Administrative, financial and clinical systems are optimized using this knowledge by redesigning all of these processes toward developing a leaner and higher performing organization that produces better outcomes.	and lessons learned. ➢ Practice starts to perform an assessment of the clinical practice and starts to collect baseline data on comorbidities, referral patterns, utilization, quality and outcome measures, and identifies problem areas for improvement. Practice establishes measures, plans and a baseline for intentionally minimizing unnecessary testing and procedures.
Phase 2: **Reporting and using data to generate improvements**	➢ Same as those listed in Primary Care	➢ Same as those listed in Primary Care ➢ Develops care coordination agreements with other care providers that cover 15% of their patients and defines co-management responsibilities with other care providers. ➢ The practice identifies ways to improve care transitions, care processes, workflow; and ways to eliminate waste and decrease costs that are enabled through the exchange of essential health information (electronically or otherwise).
Phase 3: **Achieving aims of lower costs, better**	➢ Same as those listed in Primary Care	➢ Same as those listed in Primary Care ➢ Develops care coordination agreements with other care providers that cover 30%

care and better health.		of their patients their and defines co-management responsibilities with other care providers. ➢ Practice routinely exchanges essential health information (electronically or otherwise) with other members of care team outside of practice. ➢ Practice has reduced unnecessary hospitalizations, tests, procedures by at least 15% from baseline.
Phase 4: **Getting to benchmark status**	➢ Same as those listed in Primary Care	➢ Same as those listed in Primary Care ➢ Develops care coordination agreements with other care providers that cover 50% of their patients their and defines co-management responsibilities with other care providers. ➢ Reduces unnecessary hospitalizations, tests, procedures by at least 20% from baseline.
Phase 5: **Practice has demonstrated capability to generate better care, better health at lower cost.**	➢ Same as those listed in Primary Care	➢ Same as those listed in Primary Care

II.4.5 Learning and Diffusion

The TCPI is a service delivery model test of whether a three-pronged approach to national technical assistance will enable large scale transformation of thousands of clinician practices to deliver better care and result in better health outcomes at lower costs. Learning and diffusion methods are central to transforming clinical practices on a large scale to achieve measurable improvements quickly. Methods such as those utilized in Partnership for Patients and collaborative learning models will be applied to achieve the desired results over the period of performance. This will include setting clear and measurable aims across both PTNs and SANs using plan-do-study-act (PDSA) quality improvement methods within and across practices. A key activity will be to identify and showcase practices that are already successful in implementing changes that lead to full transformation in learning sessions.

Lessons learned from other transformation collaboratives and improvement activities will inform the implementation and management of TCPI. Existing tools (specific to practice transformation, patient

safety, effective use of health information and related technology for clinical and operational improvement, patient and family engagement, and other knowledge management resources and tools utilized in primary, tertiary, and specialty care practices) will be employed in this initiative, while taking into account practices' local context and market characteristics. The learning and diffusion strategy across PTNs and SANs will be supported by the TCPI Learning Sessions and the TCPI Change Package. A change package is a set of improvement tools and implementation instructions for a specific area of improvement that reflects the current knowledge base regarding successful interventions for achieving breakthrough improvements that can be sustained over time. The TCPI Change Package will consist of: 1) common change concepts in primary and specialty care, 2) interventions and tools, and 3) mechanisms to allow the networks to operate as a collective through a Transforming Clinical Practice Community of Practice (TCP-CoP). Its use will ensure effective implementation of improvement tools and processes, and will serve as a guide to test and highlight unique factors that generate success or failure.

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

II.4.6 Key Personnel

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

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

- Quality Improvement Advisors:
  These individuals will have expertise in quality improvement across several areas to include clinical, operational including finance and business process redesign, and broad quality improvement including lean methodology.

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

The Awardee shall dedicate all key personnel full-time to this effort, unless otherwise agreed to by CMS. Key personnel may be assigned to more than one functional area but their time may not exceed one Full Time Equivalent (FTE). Any staff identified as key personnel must have a backup who is properly trained and qualified to act as a fully functioning replacement in the temporary

absence of the key person. Key personnel shall be assigned for a minimum of the 12-month base period barring circumstances outside the control of the awardee, e.g., death, and disability. Should any key personnel choose to leave for another reason (e.g., higher pay, job dissatisfaction), their replacement shall possess equal or superior qualifications, and be on staff within 30 calendar days of their predecessor's known departure.

II.5 Restrictions on Awards

- An applicant can only be funded to serve as a Practice Transformation Network or a Support and Alignment Network. An entity or subcomponent of an entity cannot serve as both a PTN and a SAN.
- The TCPI FOA funds shall be used to implement, and manage toward results that support system transformation toward higher quality care at lower costs. Award dollars cannot be used for specific components, devices, equipment, or personnel that are not integrated into the entire service delivery model proposal.
- Funds shall not be used to build or purchase health information technology or other information technology that exceed more than 10% of total costs of the applicant's proposed budget.
- CMS will not fund proposals that replicate models that CMS is currently testing in other initiatives.
- CMS will not review applications that merely restate the text within the FOA. Applicants should detail their approach to achieving the TCPI goals, milestones, and phases of transformation. Reviewers will note evidence of how effectively the applicant includes these in their overall implementation plan.
- Award dollars cannot be used to make permanent improvements to property not owned by the federal government; minor alterations and renovations permissible under certain circumstances that will be described in the financial plan template to be provided at a later date.

II.6 Alignment of Awardees

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

II.7 Technical Assistance and Information for Potential Applicants

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

II.8 Preventing Duplication of Effort

TCPI participants will work collaboratively with the CMS Quality Improvement Organizations (QIOs), State Innovation Model, Regional Extension Centers, and other HHS programs for alignment and synergy, and to prevent duplication of efforts. The following three proven strategies will be used to maximize synergy and prevent duplication of effort.

- CMS delineates how work funded as part of the Transforming Clinical Practice Initiative is distinct and different from other federally-funded work toward practice improvement with similar aims. CMS has worked extensively with program leads from AHRQ, ONC, HRSA, and the QIO program to offer technical assistance that complements but does not duplicate the work of other initiatives at the program-level as well as at the provider-level. Because TCPI focuses on total practice transformation rather than specific isolated topics (assessment and support of the practice's performance in meeting Meaningful Use measures), it is much broader in topic than other large scale technical assistance programs geared toward clinicians. TCPI aims to transform 150,000 clinicians and including specialists and non-physicians, TCPI reaches more types of clinicians on a much larger scale than other clinical, operational, and financial transformation efforts that have targeted between 500 to 8,000 clinicians/practices. In addition, the QIO program is integrally interwoven into TCPI for the specific function of practice assessments. These unique characteristics make TCPI larger in scope than previous clinician transformation initiatives.
- CMS established clear aims for the Transforming Clinical Practice Initiative that help others (private and public) who want to contribute to this work to self-align their tools, resources, people, and funding in ways that are non-duplicative and maximize synergy.
- CMS requires three actions by federally funded PTN and SAN cooperative agreement recipients that may contribute to this work:
    a. Contact other regional, State, local, or private sector entities who are receiving federal funding to do similar work;
    b. Establish and document clear local plans that delineate the local solutions for maximizing synergy and eliminating duplication; and
    c. Share these plans with the appropriate federal project officer for review and affirmation or improvement on an ongoing basis

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

III. Award Information

III.1 Total Funding

The Innovation Center is making available up to $670 million (pending availability of funds) through this FOA to support Practice Transformation Networks. Cooperative agreements will be awarded with consideration to: 1) best value of the proposal for the government as a ratio of the

number of clinicians to be supported compared to the proposal costs; 2) diversity of practices served (i.e., include both primary and specialty care practices in portfolio); 3) the quality of each application and the stated commitment and ability to meet the quantitative aims of the model; and 4) available funding. Awardees might not receive the award amount requested and may be asked to revise the work plan and budget to reflect the award. This may include PTN applicants focused on primary care only, specialty care only, system based applicants, and those proposing to support a mix of primary and specialty providers.

III.2 Award Amount

The Innovation Center expects to make awards ranging from approximately $2 million to $50 million each to cover a four-year period of performance. Exceptions to this approximate range may be considered, but are not encouraged. The amount of funding will depend on the scope of each practice transformation network, its projected impact and its partners at the local level along with other variables detailed in the criteria below (Section V.2.4).

III.3 Anticipated Award Date

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

III.4 Period of Performance

The anticipated period of performance is **May 1, 2015 through April 30, 2019.** The four-year period of performance for this model includes one 12-month base period and three option periods of 12 months each. PTNs must commit to the aims of the initiative as supported by their own proposed specific targets and milestones. Option period funding will be tied to achieving these milestones and targets. CMS is under no obligation to award option period funding under this FOA.

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

III.5 Number of Awards

The Innovation Center intends to fund up to 35 cooperative agreements for the best qualified applications within the scope of available funds. The Innovation Center is not obligated to fund a minimum number of applicants or to distribute a minimum amount of funds available under this FOA.

III.6 Type of Award

Awards will be made through cooperative agreements. CMS will continually evaluate each awardee's performance and ability to show demonstrated progress toward initiative goals and

associated milestones along with the PTN's success in moving the clinicians through each of the Transformation Phases over time.

III.7 Termination of Award

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

III.8 Anticipated Substantial Involvement by Awarding Office:

CMMI anticipates substantial involvement in the Practice Transformation Network cooperative agreements. CMMI will monitor and evaluate awardees' activities performed under the cooperative agreement, including recruiting clinician practices and monitoring, measuring, and evaluating their progress in reaching TCPI goals. CMMI will actively work with the TCPI supported infrastructure, clinicians, and practices on a weekly basis. As a part of the technical assistance design and results, TCPI awardees also will be evaluated with regard to the following:

- Awardee impact on clinician/practice quality of care and patient population's health status
- Clinical practices achievement of the milestones of the Practice Transformation Phases
- Impact on costs
- Operational performance, including;
    - Meeting proposed milestones
    - Producing timely and accurate reports with clear progress on quality and cost performance
    - Practice financial systems and management
    - Acquiring, training, and deploying workforce, and
    - Building and/or enhancing required infrastructure.

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

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

IV. Eligibility Information

IV. 1 Eligible Applicants

Applicants must demonstrate pre-existing relationships with multiple clinician practices (primary care and/or specialists) that include data sharing capabilities.

Examples of the types of organizations expected to apply are as follows:

- Health Systems
- Regional Extension Centers
- Quality Improvement Organizations
- Large Group Practices
- Regional and state-based Health Collaboratives
- Hospital Systems

IV. 2 Eligible Applicants – Legal Status

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

Eligibility Threshold Criteria:

- Application deadline: Applications not received by the application deadline through www.grants.gov will not be reviewed.
- Application requirements: Applications will be considered for funding only if the application meets the requirements outlined in Section IV Eligibility Information, Section V Application and Submission Information, and Section VI Application Review Information. Applications that do not meet these requirements will not be reviewed.
- Page limit: Applications shall not be more than 40 pages in length. Applications that exceed the 40 page limit will not be reviewed.
- Optional: Applications should also include an update (up to two pages) of the number of clinicians and practices that are expected to participate as a part of the applicant's network if funded. This update should be based on the number of clinicians and practices projected in the letter of intent. It should include the number of clinicians and practices and describe further actions taken by the applicant to ensure commitment from the clinicians and practices. For example, the applicant may have signed business operations agreements with the clinicians and practices that were not signed at the time the Letter of Intent was submitted. This update will not be included in the page limit for applications but must be specifically identified as the "Update" in order to not be counted in the 40 page limit.
- Standard forms are not included in these page limits.

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

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

CMS expects to receive proposals in the approximate range of $2 million to $50 million as presented in Section III.2, Award Amount.

IV.3 System for Award Management (SAM) Requirement

System for Award Management (SAM) Requirement: All applicants must provide their DUNS and EIN/TIN numbers in order to be able to register in the System for Award Management (SAM)* https://www.sam.gov/portal/public/SAM/. See Appendix C for more information about SAM.

IV.4 Cost Sharing or Matching

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

IV.5 Foreign and International Organizations

Foreign and international organizations are ineligible to apply.

IV.6 Faith-Based Organizations

Faith-based organizations are eligible to apply.

V. APPLICATION AND SUBMISSION INFORMATION

V.1 Address to Request Application Package

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

V.2 Application Content and Required Form Submission

V.2.1 Letter of Intent to Apply

Applicants are highly encouraged to submit non-binding Letters of Intent to Apply (LOI). Letters of Intent to Apply provide information that helps CMS in determining expertise and personnel

necessary to review applications and issue awards. To submit your TCPI Letter of Intent, please use the online LOI submission form located at:

http://innovationgov.force.com/tcpiloi

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

V.2.2 Application Materials

For application materials and guidance, refer to Appendix C: Application and Submission Information.

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

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

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

V.2.3 Format Requirements for Applications

In order to ensure readability by reviewers, fairness in the review process, and consistency among applications, each application must include all contents described below, in the order indicated, and in conformance with the listed specifications.

Applications that do not follow these specifications will not be reviewed.

- Use 8.5" x 11" letter-size pages with 1" margins (top, bottom, and sides). Other paper sizes will not be accepted. This is particularly important because it is often not possible to reproduce copies in a size other than 8.5" x 11".
- All pages of the project narrative must be paginated in a single sequence.
- Font size must be no smaller than 12-point with an average character density no greater than 14 characters per inch, inclusive of charts and tables.
- The project abstract is restricted to a one-page summary. The project abstract may be single-spaced.
- The project narrative must be double spaced. This includes all components of the project narrative.
- The budget narrative may be single-spaced.
- Charts and tables may be single-spaced. However, charts and tables should not be used to avoid the double-spaced narrative requirement.

V.2.4 Overview of Cooperative Agreement Application Structure and Content

Standard Mandatory Forms

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

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

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

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

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

Project Abstract

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

Project Narrative

The project narrative is expected to address how the applicant will carry out the design and planning work required to meet/exceed the TCPI goals. All applicants should ensure that at least 20% of their participating clinicians are from small practices (9 or fewer clinicians), practices located in rural areas, and/or practices serving the medically underserved. In the Grants Application Package that can be found at www.Grants.gov, select the Project Narrative Attachment Form and "Add Mandatory Project Narrative File".

Budget Narrative

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

1. Personnel costs (itemized)
2. Fringe benefit costs
3. Itemized description of contractors and/or vendor services and costs
4. Travel and training cost
5. Other costs please itemize

6. Indirect or overhead cost not itemized above
7. Total requested funding requested
8. Total cost-sharing (if any); identify the source(s) of other funding.

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

Chart 1 below repeats this list in tabular form. Specific information for each part of the Project Narrative is in Section VI Application Review Information. The application must be limited to the topics covered in Chart 1 below and presented in the order specified.

CHART 1: Application Package. The Following documents are required to be submitted with the application. Failure to submit these forms will result in an ineligible application that will not be reviewed.

PTN APPLICATION PACKAGE	Points
I. Standard Forms **A. SF 424** **B. SF 424A** **C. SF 424B** **D. SF LLL**	
II. TCPI Project Abstract Summary	
III. Project Narrative (includes A. – E. below)	
A. Practice Transformation Network Recruitment/Enrollment/Value	20
B. Clinician Transformation Goals/Alignment with the TCPI National Aims	15
C. Data Strategy	20
D. Organizational Capacity and Project Management Plan	20
E. Clinician Enrollment and Progress Strategy	15
IV. PTN Budget Narrative	10
TOTAL	**100**

V.3 Intergovernmental Review

Applications for these cooperative agreements are not subject to review by States under Executive Order 12372, "Intergovernmental Review of Federal Programs" (45 CFR 100). Please check box

"C" on item 19 of the SF 424 (Application for Federal Assistance) as Review by State Executive Order 12372, does not apply to these cooperative agreements.

V.4 Funding Restrictions

Indirect Costs
If requesting indirect costs, an Indirect Cost Rate Agreement will be required.
The provisions of OMB Circulars A-87 and A-21 govern reimbursement of indirect costs under this solicitation. Copies of OMB Circulars are available online at:
http://www.whitehouse.gov/omb/circulars

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

Reimbursement of Pre-Award Costs
No cooperative agreement funds awarded under this solicitation may be used to reimburse pre-award costs.

Prohibited Uses of Cooperative Agreement Funds

- To match any other Federal funds.
- To provide services, equipment, or supports that are the legal responsibility of another party under Federal or State law (e.g., vocational rehabilitation or education services) or under any civil rights laws. Such legal responsibilities include, but are not limited to, modifications of a workplace or other reasonable accommodations that are a specific obligation of the employer or other party.
- To supplant existing State, local, or private funding of infrastructure or services, such as staff salaries, etc.
- To be used by local entities to satisfy State matching requirements.
- Award dollars cannot be used for specific components, devices, equipment, or personnel that are not integrated into the entire service delivery model proposal.

VI. APPLICATION REVIEW INFORMATION

In order to receive a cooperative agreement, organizations must submit an application in the required format, no later than the established deadline dates and times as listed in the Executive Summary.
If an applicant fails to submit all of the required documents, or does not address each of the topics described below, the applicant risks not being awarded a cooperative agreement.
As indicated in Section IV, Application and Submission Information, all PTN applicants for TCPI awards must submit the following:

- Standard Forms

- Project Abstract Summary
- Project Narrative
  - Practice Transformation Network Recruitment/ Enrollment/ Value
  - Clinician Transformation Goals
  - Data Strategy
  - Organizational Capacity and Project Management Plan
  - Clinician Enrollment and Progress Strategy
- Budget Narrative

VI.1 Evaluation and Selection Criteria

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

** **Note to applicants:**

- Overall Value: It is the intent of the model to group applications during the review process relative to the number of clinicians they are proposing to support.
- Review of the applicant's proposal and the geography of the clinicians and practices they are proposing to support will be a variable in final determinations of awardees.
- It is also likely that awards may be adjusted to a lower amount if the applicant fails to finalize recruitment of the proposed number of clinicians in the first 9 months of the initial period of performance.
- Applicants will not be funded to serve as both a PTN and a SAN.

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

The review criteria for PTN applications are based on a total of 100 points allocated across the Project Narrative and Budget Narrative.

Project Narrative

A. Practice Transformation Network Recruitment/ Enrollment/ Value (20 points)
The following chart is the recommended format for providing a summary response to the items. It would complement additional detail included in the narrative response to this section.

Recruitment*	**Applicant Response**	**Points Available**

Primary Care clinicians	Enter number of clinicians:	-
Number committed at time of application		
Total number targeted during the TCPI Model		
Specialty Care clinicians	Enter number of specialty clinicians:	-
Number committed at time of application		
Total number targeted during the TCPI Model		
Total number of clinicians that the PTN will enroll	Enter total number of clinicians that the PTN will enroll)	-
Small, rural and/or serving the medically underserved Does the number of clinicians from small practices, practices located in rural areas, and/or practices serving the medically underserved include at least 20% of total clinicians? ** Applicant shall not double count (i.e. a FQHC that is located in a rural area)	Enter (Yes or No):	5
What percentage of the total clinicians practice in Federally Qualified Health Centers ?	Enter percentage:	5
Overall Value = Total requested funding divided by the total number of clinicians to be supported	Enter Ratio: This ratio will be utilized as one of the determining factors in selecting the final group of awardees	10

*** PTN Awardees will be required to submit the NPIs and TINs of clinicians and practices recruited for their networks.**

In the narrative for this section the applicant shall address how recruitment, enrollment and value will be accomplished including current support of clinicians.

Applicant shall **specifically address:** 1) implementation plans, including whether they utilize an applicant's own resources, 2) demonstrated alignment of practice transformation with state Medicaid/ CHIP programs to incentivize development of streamlined healthcare improvement projects which leverage use of federal funds across Medicare, Medicaid, and CHIP, 3) delineation of how the applicant will avoid duplication of effort by coordinating and aligning with state, regional and private initiatives, including but not limited to AHRQ's Accelerating Patient Centered Outcomes Research (PCOR) initiative, and 4) delineation of a recruitment strategy that emphasizes the selection of clinicians/practices inclusive of 20% clinicians directly serving patients with the

greatest need for technical assistance (e.g. those in small practices of 9 or fewer in rural areas, rural health clinics, and rural community health centers, practices located in health professional shortage areas, or otherwise medically underserved areas).

B. Clinician Transformation Goals/Alignment with the TCPI National Aims (15 points)

In the narrative for this section the applicant shall: 1) Define how clinician practices will be recruited and engaged and 2) Indicate how this will be accomplished and detail a proposed number of clinicians recruited and supported for each year of the initiative.

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

The applicant should provide projected improvement in the listed areas.

Improvement Area		**Within first 12 months of award**	**By the end of the 4 year period of performance**
Enter percentage improvement on quality measures:			
Clinical Outcomes (Note: applicants can add rows to more fully describe and delineate project results in this area)	Diabetes	Enter %	Enter %
	Asthma	Enter %	Enter %
	Heart Failure	Enter %	Enter %
Reduction of unnecessary testing		Enter number	Enter number
Cost savings Sample formula: Cost savings = Total dollars saved divided by total number of patients		Provide $ value or $ value per patient	Provide $ value or $ value per patient
Unnecessary hospitalizations avoided		Enter number	Enter number

C. Data Strategy: (20 points)

PTNs must already have established data sharing capabilities with clinical providers that include the ability to collect, hold, and evaluate information on patient health outcomes. PTNs may receive PII data based on their data use agreement with participating practices. The PTNs will provide monthly aggregate data (no Personally Identifiable Information (PII)) to CMS on a quarterly basis to support the quality improvement process and be used by the CMS support

contractor for overall TCPI model implementation analysis and evaluation. Use of these results across the PTNs awardees will enable practices to compare their improvement with other TCPI clinicians/practices of similar size and population. This will allow CMS to compare results across the model with minimal delay at multiple levels. PTNs should plan with their practices to converge on systematic use of a common set of core measures with other PTNs and practices by the end of the first 12 month option period.

The proposal should detail 1) applicant's existing data reporting systems, 2) information currently being collected, and 3) a summary of the number of practices that have utilized the system as well as the results those practices achieved in the last 12 to 18 months, if available.

The proposal should detail any existing data reporting information that the PTN applicant currently provides, as well as provide a list of clinical and operational measures that the applicant is currently using with clinician practices. Please include for each measure definitions for the numerator and denominator. Please also include any other specifics in the measure details that may be helpful.

In the narrative for this section the applicant shall:

1. Describe existing data sharing capabilities with clinical providers that includes the ability to collect, hold, and evaluate personally identifiable information (PII).

2. Describe ability to provide monthly aggregate data to the supported clinician practices that will enable practices to compare their improvement with other clinician/practices in the PTN of similar size and population.

3. Describe how aggregate information (based on the PTN's data use agreements with participating practices) will be provided to a CMS support contractor for overall TCPI model implementation analysis.

4. Provide a list of current clinical and operational measures that you intend to use and that your current system can capture. Provide the numerator, denominator, and any additional measure details (in the following format).

Clinical Measure	Number of clinicians reporting measures	Numerator	Denominator	Measure Details

D. Organizational Capacity and Project Management Plan (20 points)

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

The applicant should provide evidence of how they have secured commitments from clinicians and practices at the time of the application submission and their plan to finalize these commitments from clinicians and practices within 45 days of receiving an award. This finalization also includes their plan to resolve any potential "duplicate recruitment" after announcement of award.

In the narrative for this section the applicant shall:

1. Provide a project plan and timeline for completing the PTN deliverables in the following format:

Components	Project Plan Actions and Timing	Deliverables

2. Provide a statement of no more than 50 words that describes your overall vision.

3. Describe the applicant's strategy for completing the work necessary to develop and deliver a PTN that moves the clinicians through the Transformation Phases at the times reported in the table above.

4. Describe existing quality improvement and health reform efforts and how they will be integrated or support the TCPI (in the following format).

Existing Quality Improvement/ Health Reform Effort	Projected Results	How will efforts be incorporated and support TCPI?

5. Provide a project organization chart and describe the roles of various key staff who will be involved in implementation of the TCPI Model (in the following format).

Staff Name	Brief Description of Role	Percentage of Effort

6. Provide a list in table format that includes the name and a brief description of stakeholders, other payers, health plans, or other partners that will be involved in the transformation process, and the amount of financial or in-kind resources (if any) they will provide (in the following format).

Name	Brief Description of Stakeholders/Other Payers/ Health Plans or other Partners	Planned Resources to be provided

7. Demonstrate the organizational capacity and expertise to successfully implement the TCPI model.

8. Provide a project management plan that includes evidence of skills and experience of staff or consultants proposed to lead the planning effort to assure smooth and effective implementation.

E. Clinician Enrollment and Progress Strategy (15 points)

A primary responsibility of the PTN is to recruit, engage and support clinician practices. The proposal should indicate how the PTN expects to accomplish this and detail a proposed number of clinicians recruited and supported for each year of the model and how many will progress through the phases of transformation each year. Applicant should detail their process for enrolling and sustaining clinician involvement.

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

In the event that any overlaps occur, the PTN and the clinician(s) will either 1) end the clinician(s) participation in TCPI or 2) document approaches to prevent duplication of effort and send these approaches to the relevant CMS project officers for review and decision. Criteria to determine whether TCPI technical assistance should cease would include: 1) whether a substantial proportion of the participant's total estimated payments (20% or more) are covered by the model, 2) whether the participant desires to be in both models, and 3) whether PTNs and participants can effectively document whether and how involvement in both models will not be duplicative.

Goals of TCPI and Phases of Transformation

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

Example: 1000 clinicians are proposed by the PTN applicant

	Year 1	Year 2	Year 3	Year 4
Phase 1	600			
Phase 2	300	500		
Phase 3	100	300	300	
Phase 4		200	400	200
Phase 5			300	800
Total	1000	1000	1000	1000

The applicant should provide projections to define the number of clinicians that the PTN will support and assist through phases of transformation in each year of the model. The applicant will be held accountable for these projected targets. Failure to meet the targets may result in termination of the award or option year funding.

	Year 1	Year 2	Year 3	Year 4
Phase 1				
Phase 2				
Phase 3				
Phase 4				
Phase 5				
Total				

Budget Narrative Attachment Form (10 points)
The proposed budget is carefully developed and consistent with the PTN requirements. Overhead and administrative costs are reasonable, with funding focused on supporting the PTN effort. Applicants should indicate the expected amount expended per clinician. Applicant provides narrative response and completes the budget table in the format provided in Appendix B. Specifically, the budget includes:

a. Personnel costs (itemized by FTE)
b. Fringe benefit costs
c. Itemized description of services and costs
d. Complete breakdown of equipment and supplies. For computers, cell phones, etc. list those staff/FTEs that will use these items.
e. Travel and training cost broken out by hotel, per diem, etc.
f. Contractual costs, broken down for each contract to include all cost categories.
g. Other costs (please itemize)
h. Indirect or overhead costs not itemized above
i. Total funding requested
j. Cost Sharing (if any): Total other revenue or in-kind support, identify the source of other funding.

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

VI.2 Review and Selection Process

A team consisting of qualified experts will review the applications to assess the degree of responsiveness, creativity and clarity in their plan to meet the TCPI goals, Phases of Transformation and related milestones. CMS will work closely with the applicant to determine the appropriate funding amount. The review process will include the following:

- Applications will be screened for completeness and adherence to eligibility. **Applications received late or that fail to meet the eligibility requirements detailed in this solicitation or do not include the required forms will not be reviewed.**
- The objective review panel will assess each application to determine the merits of the proposal and the extent to which the proposed response furthers the purposes of the TCPI. Reviews will be done via panels where applicants who propose supporting similar sizes of clinician/practices will be reviewed with other applicants proposing similar size of clinicians/practices. In addition to the review panel, CMS will provide an assessment of the organization's readiness to conduct the work required. CMS reserves the right to request that applicants revise or otherwise modify their proposals and budget based on CMS recommendations.
- 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 the designated approving official. In making these decisions, the CMS approving official will take into consideration: recommendations of the review panel; the readiness of the PTN applicant to

finalize commitment of clinicians and practices to be a part of their network; the value of the proposal in meeting the needs of the government; reviews for programmatic and grants management compliance; the reasonableness of the estimated cost to the government and anticipated results; geographic proximity of PTN applicants; and the likelihood that the proposed actions will result in reaching the TCPI aims, Phases of Transformation and associated milestones.

- Successful applicants will receive one cooperative agreement award issued under this announcement. CMS reserves the right to approve or deny any or all proposals for funding. Note that section 1115A(d)(2) of the Social Security Act states that there is no administrative or judicial review of the selection of organizations, sites, or participants to test models.
- CMS reserves the right to conduct negotiations with applicants upon receipt of their proposals.

VI.3 Anticipated Announcement and Award Dates

Please refer to the Executive Summary.

VII. AWARD ADMINISTRATION INFORMATION

VII.1Award Notices

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

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

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

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

sub-recipient's five most highly compensated executives as outlined in Appendix A to 2 CFR Part 170 (available online at www.fsrs.gov).

VII.2 Administrative and National Policy Requirements

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

- Specific administrative requirements, as outlined in 2 CFR Part 225 and 45 CFR Parts 74 and 92, apply to cooperative agreements awarded under this announcement.
- All awardees under this project must comply with all applicable Federal statutes relating to nondiscrimination including, but not limited to:
    - Title VI of the Civil Rights Act of 1964,
    - Section 504 of the Rehabilitation Act of 1973,
    - The Age Discrimination Act of 1975,
    - Hill-Burton Community Service nondiscrimination provisions, and
    - Title II Subtitle A of the Americans with Disabilities Act of 1990,
- All equipment, staff, other budgeted resources, and expenses must be used exclusively for the project identified in the awardee's original cooperative agreement application or agreed upon subsequently with HHS, and may not be used for any prohibited uses.

VII.3 Reporting (Frequency and Means of Submission)

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

VII.3.1 Progress Reports

Awardees must agree to cooperate with any Federal evaluation of the model and performance results and provide required quarterly, semi-annual (every six months), annual and final (at the end of the cooperative agreement period) reports in a form prescribed by CMS. In the implementation of TCPI, applicants will receive qualitative and quantitative data from their recruited practices as frequently as each month. Applicants selected as PTNs will submit reports electronically. These reports will include how cooperative agreement funds were used, describe project or model progress, and describe any barriers, delays, and measurable outcomes. CMS will provide the format for project and model reporting and technical assistance necessary to complete required report forms. Awardees must also agree to respond to requests that are necessary for the evaluation of the TCPI model and provide data on key elements of model performance and on results from the cooperative agreement activities.

VII.3.2 Project Monitoring

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

VII.3.3 Evaluation

Clinician Engagement

Practice transformation is a set of discrete changes in the way a practice operates. The degree to which a practice is transformed is dependent on the practice's capacity to provide high quality health care at lower cost in a coordinated manner.

The following considerations will inform use of measures to guide and demonstrate the performance improvement as well as overall impact of TCPI. The goal will be to use a core set of measures to inform monitoring, evaluation, and performance improvement across all clinician practices participating in TCPI, in addition to a menu set of measures that can allow for practice and/or region specific measures to drive improvement on a local level.

- Sustainability of transformation competencies. Building transformation capacity within practices (for example, to run registry/population reports and then conduct basic PDSA cycles) is an essential component of improvement.
- Technical feasibility. Minimizing operational hurdles can increase the adaptive reserves[2] of practices and the likelihood of intervention success.
- Actionable. Large number of practices must be able to intervene on chosen quality and cost metrics in a timely, direct manner; be accountable for those metrics; and be enabled to produce required data and reports.
- Tangible quality or cost outcomes. Quality and cost measures will be evidence-based, aligned with other CMS/HHS initiatives, but also aligned to higher-level or more complex emerging measures, such as Choosing Wisely® recommendations or address total cost of care.
- Monthly progress reporting by clinicians to their PTNs.

Practice success will also be assessed by using a core set of evaluation metrics in addition to supplemental metrics that address the variation among participating practices. The evaluation will

[2] Nutting, P. A., Miller, W. L., Crabtree, B. F., Jaen, C. R., Stewart, E. E., & Stange, K. C. 2009. "Initial Lessons from the First National Demonstration Project on Practice Transformation to a Patient-Centered Medical Home. The Annals of Family Medicine 7(3): 254-260.

employ quantitative metrics which will measure practice success against identified outcome measures. It will also include qualitative metrics which will seek to capture the evolving nature of the activities of the practices, perceptions of the clinicians, barriers to change, practice culture, patient engagement (including health literacy), patient activation (a measure of a patient's abilities and confidence to manage their own care), and patient satisfaction.

Within 90 days of Award Evaluation Metrics

Within 90 days of project period start date, awardees will be expected to:

1. Proactively foster communication with organizations conducting quality improvement activities in the community. Define areas of support to prevent duplication of effort in writing and provide to CMS.
2. Provide a sample of the report to CMS that describes the supported clinicians and their practice's performance.
3. Address cost competency that aligns with proposed model of implementation plan that shows efficiency. The efficiency should be specific and relate to the support requested based on the number of supported clinicians proposed through the phases of transformation and aligned with the broader TCPI aims.
4. Engage with the QIOs, State Innovation Models, and Regional Extension Centers that are also supporting practices that are being recruited.
5. Provide signed agreements from practice leadership showing commitment to the TCPI work inclusive of their commitment to share results with the PTN on a monthly and quarterly basis (depending on the measure).
6. Design and implement a plan to ensure PTN leadership and staff participation and that of supported clinicians/ practices in weekly and monthly communication from CMS.
7. Develop collaborative relationships with purchasers and payers to facilitate multi-payer alignment of financial incentives, quality measures, and model methods.
8. Create community based peer groups that can share QI resources and expertise to improve specific aspects of their practices and coordinate care in a common medical neighborhood, achieving measurable improvements in care and efficiency through rapid cycle evaluation.
9. Connect primary care practitioners (PCP) with specialty and ancillary providers in their medical neighborhood that can serve their patient panel.
10. Use technology to enhance the effective use of administrative, financial and clinical systems.
11. Provide training in how to establish care plans for individuals with complex care needs, promote self-management, and engage in shared decision making with patients and their family members.
12. Provide exposure to new systems of care and alternative payment models.
13. Offer information regarding certification and training requirements as well as CMS program requirements, and ways they may effectively meet them.

CMS will be continuously measuring PTNs success and improvement in meeting the PTN milestones defined, including but not limited to: recruiting practices and building strategic

partnerships, serving as champions for continuous improvement and culture change, facilitating improved clinical practice management, and using quality measures and data for improvement.

CMS will monitor the PTNs through regular reporting requirements to ensure they enroll and support an adequate mix of clinicians that are not already participating in similar models and those that could benefit the most from technical assistance through TCPI. As practices are identified the clinicians must be licensed by state medical boards to be eligible to apply. PTN applicants should make a specific and concentrated effort to ensure representation of small and rural practices, as well as practices supporting the medically underserved are represented. Toward that end, PTNs and participating clinicians are also encouraged to leverage telehealth technology to enhance care coordination and link rural participants with more distant urban specialists.

Quarterly Evaluation Metrics:

CMS plans to provide feedback reports to PTN and SAN awardees at least quarterly. This will include reports on the information used in monitoring, and the performance milestones that they are responsible for achieving. This will help awardees in continuous improvement of their own performance and will allow for swift intervention to correct any deficiencies in progress. This will also keep the TCPI model on target in achieving its larger goals. We also intend to provide comparative reports at least once annually, which will incorporate some less frequently available data, such as survey data and data from other CMS programs.

CMS will utilize each PTN aggregate reporting of results from clinicians to create a baseline for the improvement effort and serve as a quarterly analysis of the overall progress of the PTNs in achieving the goals established by awardees at the beginning of the initiative. These PTN-reported data will also be used in evaluating the success of the overall TCPI model of clinical over time along with existing CMS data on clinicians and outcomes measures groups electing to participate in PTN networks. TCPI will also utilize relevant clinician/practice quality and performance information reported through existing CMS programs to provide benchmarks for overall improvement of the care delivery system. The intent is to minimize reporting burden on clinicians and to leverage the existing quality and performance information currently being reported by clinical practices. While a potential set of measures has been defined in the FOA, additional measures may be identified as helpful to support the transformation of clinicians and their practices.

The following specific measures will be included in the Performance Report:

1. Improvement in the report of the number of clinicians that have committed each month (including by practice setting, such as serving rural or underserved populations), and are sharing results.
2. Documentation that captures the plan-do-study-acts (PDSAs) that are successful in cost savings, clinical and operational quality improvement and improvements in health outcomes; continuously update this information.
3. Improvement from process and outcomes measurement baseline and improvements by PTN clinicians/ practices. This report would include an executive summary, analysis, and both qualitative and quantitative date.
4. Consistent shared reports that a) identify top-performing practices in the network and b) define PTN processes in place to showcase their work publicly and to TCPI network members.

5. Implementation of methods identified as ways practices can improve access to care (e.g. optimize scheduling so that same day appointments can be offered, and after hour access to clinician advice is available).
6. Measured utilization and related outcomes of tools specific to primary and specialty care coordination, such as formalized agreements for care coordination, referrals and co-management plans that clearly specify roles, responsibilities and expectations in care planning and management across practices (e.g. timely communication of test results and exchange of clinical information to patients and other providers).
7. Clinician participation in monthly national webinars and sharing of learning utilizing TCPI knowledge management technology. PTN participation in weekly pacing events and office hours. PTN delivery of other webinars, learning sessions and other quality improvement supports on timely and appropriate topics. For example, show providers how to use clinical and other data to risk stratify their population and identify patients at high-risk for hospitalization or complications from chronic conditions, and instruct on how to perform timely interventions and monitoring.

On-Going and Annual Evaluation Metrics:

The on-going evaluation of the PTN will also include real time utilization of results to coach PTNs in methods and processes that will facilitate learning and utilization of successful methods across the PTN infrastructure. This coaching will occur through mechanisms such as web based interactions, consultations with the CMS project Officers, periodic improvement huddles with CMS TCPI leadership, and other ways that may be adopted in the adaptive improvement effort.

PTNs will be assessed on the following:

1. Operational mechanisms provided that are incorporated to rapidly, flexibly, and reliably report practice progress, minimizing the level of effort for practices to the maximum extent possible.
2. Accountable actions to prevent and document throughout the award period of performance how they have, and will continue to avoid, duplication of effort by coordinating and aligning with state, regional, private initiatives and CMS' Quality Improvement Organizations.
3. Implementation of plan to support culture change through engaged leadership, team building, and patient engagement.
4. Coaching, facilitation, and technical assistance provided to practices to reinforce the TCPI Change Package and associated tools and resources.
5. Dissemination and spread of quality improvement and change methodologies, tools, published literature, best practices and lessons learned on practice transformation.

Interaction with CMS funded Quality Improvement Organizations:

One example of alignment includes coordination with the CMS QIOs 11th statement of work (SoW). The QIOs have a long history of working with clinical practices to advance common quality improvement goals under the Medicare program. This expectation will continue in the next QIO SoW. As such, CMS will strive to ensure that the TCPI model is synergistic and non-duplicative of the QIO program and QIO performance requirements.

Currently, the 11th SoW requires QIOs to work with clinicians to help them be successful in the Physician Value-Based Modifier Program (VM) program. While this is a start toward helping providers prepare for the evolving payment models that will be prevalent in the future, additional assistance from QIOs will be required to provide information to providers that will allow them to prepare themselves to enter into the various tests and models offered by CMS through either CMMI, the Center for Medicare, State models, and other options. While QIOs are working with practices to facilitate their success in the VM program, the QIOs will also perform periodic assessments of the providers to inform and prepare them to enter into other models. Once an assessment is performed, practices will be informed of options to consider for transforming their practices.

Under the 11th SOW, and as part of their fulfillment of QIO responsibilities independent of this model, QIOs will provide technical assistance in meeting data requirements and in applying quality improvement principles for organizational management and improved workflow for physician practices. These activities will place the QIOs in a position of serving as one of several sources for identifying potential TCPI participants. Additionally, to the extent permitted by applicable law, the QIOs will provide information (gathered in the course of performing QIO functions that occur separate from this model) to the PTNs and the evaluation contractor, in an effort to ensure alignment and avoid duplication. *See* 42 C.F.R. Part 480.

PTNs are expected to work collaboratively with the QIN-QIOs under the new 11th Statement of Work (SOW). PTNs must develop, and maintain a synergistic relationship with the QIOs, and avoid duplicating the work QIOs may be performing with clinicians that participate in their PTN. QIOs will be teaming with PTNs in order to support the TCPI initiative. They will supplement the recruitment of TCPI participants, assess level of readiness of clinician practices in collaboration with the TCPI PTNs; and provide validation support for information reported to CMS and make recommendations for course corrections when the need is identified.

Data required for Evaluation

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

VII.1.1 Federal Financial Report

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

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

In addition to submitting the quarterly FFR to PMS, Grantees must also provide, on an annual basis, a report to be uploaded into GrantSolutions which includes their expenditures and any program income generated in lieu of completing a Financial Status Report (FSR) (SF269/269A).

Expenditures and any program income generated should only be included on the annually submitted FFR, as well as the final FFR. Annual hard-copy FFRs should be mailed to PMS and received within 30 calendar days of the applicable year end date. The final FFR should be uploaded in GrantSolutions within 90 calendar days of the project period end date.

More details will be outlined in the Notice of Award.

VII.1.2 Transparency Act Reporting Requirements

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

VII.1.3 Audit Requirements

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

VII.1.4 Payment Management Requirements

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

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

VII.2 Terms and Conditions

Cooperative agreements issued under this FOA are subject to the *Health and Human Services Grants Policy Statement (HHS GPS)* at http://www.hhs.gov/grantsnet/adminis/gpd/. Standard Terms and Special Terms and Program Specific Terms and Conditions (including the awardee commitments listed below) will accompany the Notice of Award. Potential awardees should be aware that special requirements could apply to awards based on the particular circumstances of the effort to be supported and/or deficiencies identified in the application by the HHS review panel. The General Terms and Conditions that are outlined in Section II of the HHS GPS will apply as indicated unless there are statutory, regulatory, or award-specific requirements to the contrary (as specified in the Notice of Award).

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

Practice Transformation Network Awardee Commitments
Awardees
1. Commit to the TCPI Aims and defined milestones and specific outcome targets for cost savings and health care quality improvements.**
2. Provide a description of the data plan in place with screen shots and a process map of the proposed plan to receive results from the clinicians/ practices.
3. Define the plan to address HIPAA compliance in the sharing of results from practices to the PTN and steps the PTN will take to ensure HIPAA is addressed prior to sharing any information with CMS.
4. Describe the process planned to capture participation of clinicians/ practices in developing regular, rapid small tests of change.
5. Commit to identify opportunities to build TCPI into regional / national events where presentations can highlight the TCPI Aims.
6. Provide a description of the data plan in place with screen shots and a process map of the proposed plan to receive results from the clinicians/ practices.
7. Provide reports with signed agreements from practice leadership commitment to the TCPI work inclusive of their commitment to share results with the PTN on a monthly and quarterly basis (depending on the measure).

8. Document recruited clinicians' commitment to participate in the Physician Quality Reporting System. Eligible clinicians should report applicable TCPI quality measures through PQRS.
9. Document recruited clinician's commitment to participate in the Value Modifier Programs.
Pre-Award After being notified of selection as a PTN and before the period of performance begins
1. Proactively foster communication with quality improvement activities being hosted in the community.
2. Provide a sample of the report to CMS that describes the supported clinicians and their practice's performance.
3. Address cost competency that aligns with proposed model of implementation plan that shows efficiency. The efficiency should be specific and relate to the support requested based on the number of supported clinicians proposed through the phases of transformation and aligned with the broader TCPI aims.
4. Define areas of support to prevent duplication of effort in writing and provide to CMS.
5. Engage with the Quality Improvement Organizations that are supporting practices that are being recruited.
Within 90 days of the beginning of the Initial Period of Performance
1. Conducting pre-assessment and on-going assessment of the practice's clinical and operational health.
2. Interact with Support and Alignment Awardees.
3. Engage with the Quality Improvement Organizations that are supporting practices that are being recruited.
4. Demonstrate alignment of practice transformation with state Medicaid/ CHIP programs to incentivize development of streamlined healthcare improvement projects which leverage use of federal funds across Medicare, Medicaid, and CHIP.
5. Provide report with signed agreements from practice leadership commitment to the TCPI work inclusive of their commitment to share results with the PTN on a monthly and quarterly basis (depending on the measure).

6. Design and implement a plan to ensure PTN leadership and staff participation and that of supported clinicians/ practices in weekly and monthly communication from the TCPI National Team.
7. Develop collaborative relationships with purchasers and payers to facilitate multi-payer alignment of financial incentives, quality measures, and model methods.
8. Create community based peer groups that can share QI resources and expertise to improve specific aspects of their practices and coordinate care in a common medical neighborhood, achieving measurable improvements in care and efficiency through rapid cycle evaluation. Ensure participating clinicians are registered for TCPI associated listservs.
9. Connect primary care practitioners (PCP) with specialty and ancillary providers in their medical neighborhood that can serve their patient panel.
10. Use technology to enhance the effective use of administrative, financial and clinical systems.
11. Provide training in how to establish care plans for individuals with complex care needs, promote self-management, and engage in shared decision making with patients and their family members.
12. Provide exposure to new systems of care and alternative payment models.
13. Offer information regarding certification and training requirements as well as CMS model requirements, and ways they may effectively meet them.
Monthly/ Quarterly
1. Share report of the number of clinicians that have committed each month (including by practice setting, such as serving rural or underserved populations), and are sharing results.
2. Create a document that captures the plan-do-study-acts (PDSAs) that are successful in cost savings, clinical, and operational quality improvement and improvements in health outcomes; continuously update this information.
3. Report process and outcomes measure baseline and improvements by PTN clinicians/ Practices. This report would include an executive summary, analysis, and both qualitative and quantitative date.
4. Design and submit a report that a) identifies top-performing practices in the network and b) defines PTN processes in place to showcase their work publicly and to TCPI network members.

5. Identify ways practices can improve access to care (e.g. optimize scheduling so that same day appointments can be offered, and after hour access to clinician advice is available).
6. Promote the use of tools specific to primary and specialty care coordination, such as formalized agreements for care coordination, referrals and co-management plans that clearly specify roles, responsibilities and expectations in care planning and management across practices (e.g. timely communication of test results and exchange of clinical information to patients and other providers).
7. Offer webinars, learning sessions, and other quality improvement supports on timely and appropriate topics. For example, show providers how to use clinical and other data to risk stratify their population and identify patients at high-risk for hospitalization or complications from chronic conditions, and instruct on how to perform timely interventions and monitoring.
Ongoing
1. Provide a clear statement of accountability to prevent and document throughout the award period of performance how they will avoid duplication of effort by coordinating and aligning with state, regional, private initiatives and CMS' Quality Improvement Organizations.
2. Define and implement plan to support culture change through engaged leadership, team building, and patient engagement.
3. Provide coaching, facilitation, and technical assistance to practices to reinforce the TCPI Change Package and associated tools and resources.
4. Disseminate and spread quality improvement and change methodologies, tools, published literature, best practices and lessons learned on practice transformation.

** Note: Regarding Assessment
A baseline assessment will be conducted for clinicians recruited to participate in practice transformation and will be followed by reassessments throughout the four year model by QIOs in partnership with the PTNs. The initial assessment will include: assessments of quality improvement methodology currently employed by the practice, work flow, health information technology capability, approaches to care planning and coordination, as well as assessments of patient population, clinical results, current business models, and related financial and administrative practices and community resources. The initial assessment will be used to determine readiness for transformation, and position of the clinician/practice on a continuum of transformation defined by distinct phases that directly map to achievement of the larger goals for the TCPI model.

The periodic reassessments will be used to determine whether a clinician/practice is moving upward through the phases, and will be based upon achievement of both quantitative and qualitative milestones. The practices will be assessed against quantitative milestones tied to the phases such as having the majority of patients empaneled/attributed to specific providers, patients having access to 24 hour care, patients followed up with after urgent or acute care episodes within a specified timeframe, reducing the use of ED and inpatient care for ambulatory care sensitive conditions, and reducing unnecessary utilization of diagnostic testing. A description of the phases of transformation, the activities and characteristics associated with each phase, and the performance milestones for clinicians and their practices that must be met for mastery of a phase, and movement upward in the continuum can be found in the Section II.4.4.

VIII. Agency Contacts

VIII.1 Programmatic Contact Information:

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

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

VIII.2 Administrative Questions

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

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

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

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

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

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

Appendix B. **Sample Budget and Narrative Justification**

Detailed Budget and Expenditure Plan

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

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

The Budget Narrative may be single-spaced. Chart and tables may be single-spaced.

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

Section A – Budget Summary

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

Section B – Budget Categories

- Enter the total costs requested for each Object Class Category (Section B, number 6) for each year of the 4-year project period. A fifth budget period may be included for data reporting.
- Column (1) = Enter the heading for this column as Year 1. Enter Year 1 costs for each line item (rows a-h), including the sum of the total direct charges (a-h) in row i. Indirect charges should be reflected in row j. The total for direct and indirect charges for all year 1 line items should be entered in column 1, row k (sum of row i and j).
- Column (2) = Enter the heading for this column as Year 2 (as applicable). Enter Year 2 costs for each line item (rows a-h), including the sum of the total direct charges (a-h) in row i. Indirect charges should be reflected in row j. The total for direct and indirect charges for all year 2 line items should be entered in column 2, row k (sum of row i and j).
- Column (3) = Enter the heading for this column as Year 3 (as applicable). Enter Year 3 costs for each line item (rows a-h), including the sum of the total direct charges (a-h) in row i. Indirect charges should be reflected in row j. The total for all year 3 line items should be entered in column 3, row k (sum of row i and j).
- Column (4) = Enter the heading for this column as Year 4 (as applicable). Enter Year 4 costs for each line item (rows a-h), including the sum of the total direct charges (a-h) in row i. Indirect charges should be reflected in row j. The total for all year 4 line items should be entered in column 3, row k (sum of row i and j).
- Column 6 = Enter total costs for all four years of the project period for each line item (rows a-h), direct total costs (row i), and indirect costs (row j). The total costs for all line items for the three years should be entered in row k (sum of row i and j). The total in column 6, row k should match the total provided in Section A – Budget Summary, New or Revised Budget, column g, row 5.

Allowable Costs

Allowable costs include (but are not limited to):

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

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

A. Personnel:

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

Table 1: FEDERAL REQUEST

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

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

Note: Consistent with Section 203 of the Consolidated Appropriations Act, 2012 (P.L.112-74) none of the funds appropriated in this law shall be used to pay the salary of an individual through a grant or other extramural mechanism, at a rate in excess of Executive Level II ($181,500/year).

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

B. Fringe Benefits

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

Table 2: Federal Request

Component	Rate	Wage	Cost
FICA	7.65%	$65,000	$4,973
Workers Compensation	2.5%	$65,000	$1,625
Insurance	10.5%	$65,000	$6,825
		TOTAL	$13,423

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

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

C. Travel:

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

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

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

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

Table 3: Federal Request

Purpose of Travel	Location	Item	Rate	Cost
Patient Visits	Neighboring areas of XXX	Mileage=	$.056 x 2 persons	$400
Training (name)	Chicago, IL	Airfare	$200/flight x 2 persons	$400
		Hotel	$140/night x 2 persons x 3 nights	$800
		Per Diem (meals)	$49/day x 2 persons x 4 days	$400
			TOTAL	$2,000

NARRATIVE JUSTIFICATION: Describe the purpose of travel and how costs were determined.

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

D. Equipment:

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

Table 4: Federal Request

Item(s)	Rate	Cost
None		0
	TOTAL	

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

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

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

Table 5: Federal Request

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

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

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

F. Contracts:

The costs of project activities to be undertaken by a third-party contractor should be included in this category as a single line item charge. Cooperative Agreement recipients must submit to HHS the required information establishing a third-party contract to perform program activities, a complete itemization of the costs should be attached to the budget, see Appendix C, *Application and Submission Information; Required Information for Contract Approval*. If there is more than one

contractor, each must be budgeted separately and must have an attached itemization. A consultant is a non-employee who provides advice and expertise in a specific program area. Hiring a consultant requires submission of consultant information to HHS; see Appendix C, *Application and Submission Information; Required Reporting Information for Consultant Hiring*.

Table 6: Federal Request

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

NARRATIVE JUSTIFICATION: Explain the need for each agreement and how their use will support the purpose and goals of this proposal. For those contracts already arranged, please provide

the proposed categorical budgets. For those subcontracts that have not been arranged, please provide the expected Statement of Work, Period of Performance and how the proposed costs were estimated and the type of contract (bid, sole source…etc.)

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

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

Table 7: Federal Request

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

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

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

H. Total Direct Charges: Sum of Total Direct Costs

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

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

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

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

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

Program Income

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

Budget Period:

Anticipated Amount:

Sources:

Appendix C. Application and Submission Information

WE STRONGLY RECOMMEND THAT ALL APPLICANTS THOROUGHLY REVIEW THIS INFORMATION AS IT IS CRUCIAL IN THE SUBMISSION OF THE APPLICATION. FAILURE TO FOLLOW THIS INFORMATION COULD RESULT IN AN INELIGIBLE APPLICATION OR ONE THAT WILL NOT BE ACCEPTED BY GRANTS.GOV.

Employer Identification Number

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

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

All applicants must have a Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number in order to apply. The DUNS number is a nine-digit identification number that uniquely identifies business entities. Obtaining a DUNS number is easy and free. To obtain a DUNS number, access the following website: www.dunandbradstreet.com or call 1-866-705-5711. This number should be entered in block 8c (on the Form SF-424, Application for Federal Assistance). The organization name and address entered in block 8a and 8e should be exactly as given for the DUNS number**.**

System for Award Management (SAM)

All applicants must register in the System for Award Management (SAM)* database (https://www.sam.gov/portal/public/SAM/) in order to be able to submit an application at http://www.grants.gov. In order to register, applicants must provide their DUNS and EIN numbers. Each year organizations and entities registered to apply for Federal grants through grants.gov must renew their registration with SAM. **Failure to renew SAM registration prior to application submission will prevent an applicant from successfully applying via grants.gov. Similarly, failure to maintain an active SAM registration during the application review process can prevent HHS from issuing your agency an award under this model or could result in an application that cannot be accepted by Grants.gov.**

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

Organizations must report executive compensation as part of the registration profile at https://www.sam.gov/portal/public/SAM/ by the end of the month following the month in which this award is made, and annually thereafter (based on the reporting requirements of the Federal Funding Accountability and Transparency Act (FFATA) of 2006 (Pub. L. 109-282), as amended by Section 6202 of Public Law 110-252 and implemented by 2 CFR Part 170). The Grants Management Specialist assigned to monitor the subaward and executive compensation reporting

requirements is Iris Grady, who can be reached at divisionofgrantsmanagement@cms.hhs.gov.

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

Cost Sharing or Matching

Cost sharing or matching is not required.

Application Information

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

Application Materials

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

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

- You can access the electronic application for this project at http://www.grants.gov. You must search the downloadable application page by the CFDA number.
- At the http://www.grants.gov website, you will find information about submitting an application electronically through the site, including the hours of operation. HHS strongly recommends that you do not wait until the application due date to begin the application process through http://www.grants.gov because of the time needed to complete the required registration steps. **Applications not submitted by the due date and time are considered late and will not be reviewed.**
- All applicants under this announcement must have an Employer Identification Number (EIN), otherwise known as a Taxpayer Identification Number (TIN), to apply. **Please note, applicants should begin the process of obtaining an EIN/TIN as soon as possible after**

the announcement is posted to ensure this information is received in advance of application deadlines.

- All applicants must have a Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number. **Applicants should obtain this DUNS number as soon as possible after the announcement is posted to ensure all registration steps are completed in time.**
- The applicant must also register in the System for Award Management (SAM) database in order to be able to submit the application. Applicants are encouraged to register early, and must have their DUNS and EIN/TIN numbers in order to do so. Information about SAM is available at https://www.sam.gov/portal/public/SAM/. The SAM registration process is a separate process from submitting an application. **Applicants should begin the SAM registration process as soon as possible after the announcement is posted to ensure that it does not impair your ability to meet required submission deadlines.**
- Authorized Organizational Representative: The Authorized Organizational Representative (AOR) who will officially submit an application on behalf of the organization must register with grants.gov for a username and password. AORs must complete a profile with grants.gov using their organization's DUNS Number to obtain their username and password at http://grants.gov/applicants/get_registered.jsp. AORs must wait one business day after successful registration in SAM before entering their profiles in grants.gov. **Applicants should complete this process as soon as possible after successful registration in SAM to ensure this step is completed in time to apply before application deadlines. Applications that are not submitted by the due date and time as a result of AOR issues will not be reviewed.**
- When an AOR registers with grants.gov to submit applications on behalf of an organization, that organization's E-Biz POC will receive an email notification. The email address provided in the profile will be the email used to send the notification from grants.gov to the E-Biz POC with the AOR copied on the correspondence.
- The E-Biz POC must then login to grants.gov (using the organization's DUNS number for the username and the special password called "M-PIN") and approve the AOR, thereby providing permission to submit applications.
- **Any files uploaded or attached to the grants.gov application must be PDF file format and must contain a valid file format extension in the filename. Even though grants.gov allows applicants to attach any file formats as part of their application, CMS restricts this practice and only accepts PDF file formats. Any file submitted as part of the grants.gov application that is not in a PDF file format, or contains password protection, will not be accepted for processing and will be excluded from the application during the review process. In addition, the use of compressed file formats such as ZIP, RAR, or Adobe Portfolio will not be accepted. The application must be submitted in a file format that can easily be copied and read by reviewers. It is recommended that scanned copies not be submitted through grants.gov unless the applicant confirms the clarity of the documents. Pages cannot be reduced in size, resulting in multiple pages on a single sheet, to avoid exceeding the page limitation.**
- After you electronically submit your application, you will receive an acknowledgement from http://www.grants.gov that contains a grants.gov tracking number. HHS will retrieve your

application package from grants.gov. **Please note, applicants may incur a time delay before they receive acknowledgement that the application has been accepted by the grants.gov system. Applicants should not wait until the application deadline to apply because notification by grants.gov that the application is incomplete may not be received until close to or after the application deadline, eliminating the opportunity to correct errors and resubmit the application. Applications submitted after the deadline, as a result of errors on the part of the applicant, will not be reviewed.**

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

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

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

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

Please be aware of the following:

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

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

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

Required Reporting Information for Consultant Hiring

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

1. Name of Consultant: Identify the name of the consultant and describe his or her qualifications.
2. Organizational Affiliation: Identify the organization affiliation of the consultant, if applicable.
3. Nature of Services to be Rendered: Describe in outcome terms the consultation to be provided including the specific tasks to be completed and specific deliverables. A copy of the actual consultant agreement should not be sent to HHS.
4. Relevance of Service to the Project: Describe how the consultant services relate to the accomplishment of specific model objectives.
5. Number of Days of Consultation: Specify the total number of days of consultation.
6. Expected Rate of Compensation: Specify the rate of compensation for the consultant (e.g., rate per hour, rate per day). Include a budget showing other costs such as travel, per diem, and supplies.
7. Method of Accountability: Describe how the progress and performance of the consultant will be monitored. Identify who is responsible for supervising the consultant agreement.

Required Information for Contract Approval

All contracts require reporting the following information to HHS.

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

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

Appendix D. Application Check-Off List Required Contents

Required Contents

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

Project Narratives must be:

- in 12 point font or larger (including charts and tables)
- double spaced

Budget Narratives must be:

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

FORMS

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

Application Kit

- ☐ TCPI Project Abstract Summary
- ☐ Project Narrative Form that includes:
  - Project Narrative
    - Practice Transformation Network Recruitment/Enrollment/Value
    - Clinician Transformation Goals/Alignment of the TCPI National Aims
    - Data Strategy
    - Organizational Capacity and Project Management Plan
    - Clinician Enrollment and Progress Strategy
- ☐ PTN Budget Narrative Form that will include the budget narrative and expenditure plan.

Acronyms

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