

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

Integrated Care for Kids (InCK)

Notice of Funding Opportunity Type: New

Funding Opportunity Award Type: Cooperative Agreement

Notice of Funding Opportunity Number: CMS-2B2-20-001

Notice of Funding Opportunity Number CFDA: 93.378

Notice of Funding Opportunity Posting Date: 2/8/2019

Applicable Dates:

Optional Letter of Intent to Apply Due Date: 3/11/2019

Electronic Application Due Date: 6/10/2019

3:00 PM Eastern U.S. Time

Anticipated Issuance Notice(s) of Award: 12/2/2019

Anticipated Period of Performance: 7 years or 84 months

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Executive Summary

The Integrated Care for Kids (InCK) Model provides funding opportunities to states and local organizations to test whether payment supporting integrated service delivery across behavioral health, physical health, and other child services reduces Medicaid and Children's Health Insurance Program (CHIP) expenditures and improves the quality of care for covered children. The InCK Model will assist states and local communities in addressing priority health concerns for children, such as behavioral health challenges, including opioid and other substance use, and the effects of opioid use on families.

CMS will support Awardees in developing state-specific pediatric alternative payment models (APMs) that incorporate provider accountability and focus on meaningful improvements in care quality and health outcomes. Successful Awardees will use model funding to support infrastructure investments and activities necessary to support model planning and operations including (but not limited to): state and local investments in information technology, strategic planning and analysis for model design, model operations and staffing, and federal evaluation activities.

The InCK Model aims to empower states and local organizations to **1) Improve performance on priority measures of child health**, including rates of substance and opiate use; **2) Reduce avoidable inpatient hospitalizations and out-of-home placements** resulting from issues such as family instability driven by substance use; and **3) Create sustainable Alternative Payment Models (APMs)** that ensure provider accountability for cost and quality outcomes. To achieve these goals, the InCK Model uses the following mechanisms:

1. **Early identification and treatment** through population-level surveillance, assessment, and risk stratification of children with multiple physical, behavioral, or other health-related needs and risk factors.
2. **Integrated care coordination and case management** across physical health, behavioral health, and other local service providers for children with health needs that impact their functioning in schools, communities, and homes.
 - a. Coordination of child health services across Medicaid and CHIP physical and behavioral health providers and federal, state, and local child services (e.g., schools, child welfare agencies, child nutrition programs);
 - b. Intensive, team-based case management for children at-risk for, or already in, out-of-home placement.
3. **Development of state-specific APMs** that align payment with care quality and support accountability for improved child health outcomes and long-term health system sustainability.
 - a. State participants in the InCK Model will work with local providers to tailor innovative payment approaches to their local contexts and priorities. Potential approaches include episode-based, shared savings, and population-based payment arrangements that incorporate meaningful quality measures and are designed in a manner that incents providers to adopt high-value, patient-centered practices.

Item	Description
HHS Awarding Agency	Centers for Medicare & Medicaid Services (CMS)
CMS Awarding Center	Center for Medicare & Medicaid Innovation
Notice of Funding Opportunity Title	Integrated Care for Kids
Authorization	Section 1115A of the Social Security Act (the Act) as added by Section 3021 of the Patient Protection and Affordable Care Act (P.L. 111-148)
Funding Opportunity Type	New
Funding Opportunity Number	CMS-2B2-20-001
Type of Award	Cooperative Agreement
Catalog of Federal Domestic Assistance	93.378
Letter of Intent to Apply Due Date (if applicable)	3/11/2019
Application Due Date & Time	6/10/2019 3:00 PM Eastern U.S. Time
Anticipated Issuance Notice(s) of Award	12/2/2019
Anticipated Period of Performance	1/1/2020 12/31/2026
Anticipated Total Available Funding (subject to the availability of funds)	\$128,000,000
Estimated Award Amount:	\$14,500,000 up to \$16,000,000
Estimated Number of Awards	Maximum Eight (8)

Model Overview

The InCK Model is a child-centered *state payment* and *local service delivery* model aimed at reducing expenditures and improving the quality of care for children covered by Medicaid and CHIP through early identification and treatment of priority health concerns like behavioral health conditions, substance use, and physical health needs. CMS will award InCK Model cooperative agreements to partnerships between state Medicaid agencies and local organizations (hereafter called the “Lead Organization”) to leverage and build on existing child service programs. One or more state-driven alternative payment models (APMs) will support these partnerships to improve the coordination and quality of care through

accountability for costs and outcomes. Model Awardees will develop local care delivery approaches and infrastructure to:

- Identify, assess, and risk-stratify children with or at-risk for significant behavioral health, substance use and physical health needs and utilization within their service area;
- Deliver integrated care coordination and case management across local child services, supported by child and family-centered information sharing and alignment of program eligibility and enrollment processes;
- Increase local capacity to shift care for children at-risk for, or already in, out-of-home placement to less costly and more effective home and community-based settings; and
- Implement one or multiple APMs that support the local integrated service delivery model and promote accountability for improved outcomes, such as lower rates of opiate and other substance use, as well as long-term health system sustainability.

A. Program Description

A 1. Purpose

The Centers for Medicare & Medicaid Services (CMS), through its Center for Medicare and Medicaid Innovation (CMMI), will implement a new Medicaid and CHIP state payment and local service delivery model that supports state and locally-driven innovations to improve the health of children. The Integrated Care for Kids (InCK) Model will test whether combining a local service delivery model coordinating integrated child health services and a state-specific alternative payment model (APM) to support coordination of those integrated services reduces health care expenditures and improves the quality of care for pediatric Medicaid and CHIP beneficiaries.

A 2. Authority

Section 1115A of the Social Security Act authorizes the Secretary of the U.S. Department of Health and Human Services to test innovative payment and service delivery models that reduce Medicare, Medicaid and CHIP expenditures while preserving or enhancing the quality of care.

A 3. Background

Behavioral health conditions such as substance use disorders have a serious impact on the health and wellbeing of the American population. Early detection and intervention is critical for the prevention and treatment of behavioral health and substance use disorders. A study of individuals aged 18 to 30 admitted for the treatment of a substance use disorder found that 74 percent of those being treated began their substance use by the age of 17, with 10.2 percent starting by the age of 11 or earlier (Substance Abuse and Mental Health Services Administration, 2014). Furthermore, research has found that half of all lifetime cases of mental illness and substance use disorders start by the age of 14 (Kessler, Chiu, Demler, Merikangas, & Walters, 2005).

Opioid misuse has had a particularly high impact on communities across the country. In 2016 an average of 3.6 percent of adolescents 12-17 years of age misused opioids during the previous year; however, this rate increased to 8 percent by age 21 (Center for Behavioral Health Statistics and Quality, 2017). Early identification and intervention for at-risk children are challenging for children's health care systems, but

critical to improving behavioral health care, treating substance use disorders, stemming the opioid epidemic and improving the health of the next generation. This model offers states and local organizations a framework, funding, and support to address key health priorities like substance use and mental illness through child-centered care integration across behavioral health, physical health, and other child providers for Medicaid and CHIP beneficiaries up to age 21.

CMS released a public [Request for Information \(RFI\)](#) on the design of a pediatric APM in February 2017 in order to understand the challenges and opportunities encountered by providers and child health systems on the front lines of care. CMMI also directly engaged groups representing state Medicaid agencies, children's health systems, and pediatricians (see [RFI responses](#)). Responses yielded consistent recommendations on the best approaches that promote healthy development and mitigate the risks of substance use early in life:

- **Put children and families first and at the center of coordinated care across child programs:** local innovators have demonstrated cost savings and quality improvement by coordinating care across state and federal child programs;
- **Integrate physical and behavioral health care:** pediatric behavioral health conditions are often undertreated, increasing risk for substance use and driving significant health care utilization;
- **Prioritize home and community-based care:** these services are often less expensive and more effective than care delivered in residential and inpatient settings.

These stakeholder recommendations directly informed InCK Model development. They demonstrate broad support for a framework that can guide states and communities to implement the best approaches that promote healthy development and mitigate the risks of substance use early in life.

A 3.1 Statement of Need

Behavioral health conditions and the use of opiates and other substances by children and youth drive significant morbidity, health care utilization, and premature death. Adolescent deaths from drug overdose are increasing, and opioids caused over half of drug-related overdoses among youth in 2015 (Department of Health and Human Services, n.d.). The National Institutes of Health (NIH) reports young adults ages 18-25 as the biggest abusers of prescription opioids, Attention Deficit Hyperactivity Disorder (ADHD), and anti-anxiety drugs; and half of lifetime mental illnesses and substance use disorders develop prior to adulthood by age 14 (National Institutes of Health, 2016). Estimates suggest that there are 119 emergency department visits and 22 treatment admissions for every young adult overdose death, suggesting the solution to this problem might go beyond access to care and instead rest in what care is accessed (Department of Health and Human Services, n.d.). There is a strong relationship between health-risk behaviors like substance use and poor physical and mental health outcomes like serious emotional disturbances, chronic medical conditions, and medically complex conditions. Substance use is often co-occurring with mental illness and both share risk factors. Substance use prevention and coordinated treatment are crucial to reducing the number of deaths and related health care utilization among young Americans. Medicaid and CHIP, as the health insurers for one in three American children, play a significant role in ensuring that pediatric health systems focus on prevention and coordinated treatment (Department of Health and Human Services, 2016).

Preventive measures delivered during the earliest years of life can mitigate the effects of childhood trauma or [adverse childhood experiences](#) (ACEs) that contribute to increased risk of high rates of

behavioral health diagnoses in adolescence and adulthood. Examples of ACEs include household substance abuse; having unemployed parents; being born to teenage parents; being in foster care; and experiencing traumatic life events such as child abuse or exposure to violence. The number of children in the United States that are in foster care has steadily increased each year, with 437,465 children in foster care as of 2016 (Administration for Children and Families, 2016). ACEs are associated with the development of behavioral and physical health conditions in childhood, sometimes leading to substance use disorders and suicide attempts later in life. The greater a child's exposure to ACEs, the greater their risk of developing substance use disorder and other behavioral and physical health conditions later in life (Felitti, et al., 1998).

Medicaid and CHIP cover some of the nation's most vulnerable children: estimates show that more than one in three Medicaid-covered children have emotional or behavioral challenges. Less than one-third of these children currently receive behavioral health care (Center for Health Care Strategies, Inc, 2013), yet these services account for 38% of health care costs (\$19.3 billion in Medicaid spending) (Lloyd, Simon, & Parker, 2015; Medicaid and CHIP Payment and Access Commission, 2015). CMS and states have demonstrated commitment to addressing child health through care redesign and program innovation, such as the Medicaid Health Home state plan benefit, the Medicaid Innovation Accelerator Program, home and community-based services (HCBS) programs, and CMMI models such as the State Innovation Models, the Strong Start for Mothers and Newborns Initiative, and several Health Care Innovation Awards. However, the ongoing opioid crisis has highlighted an opportunity for CMS to foster further innovation to improve the quality of care provided to pediatric Medicaid and CHIP beneficiaries at-risk for, or with, behavioral health challenges.

A 3.2 Considerations for Pediatric Care Innovation

Local, state, and federal child-focused programs such as Medicaid and CHIP, Head Start, child welfare services, and school-based nutrition programs offer children and their families services that can help address ACEs and other health-related needs that drive the development of significant behavioral and physical health conditions. Medicaid-covered children are often eligible for a variety of child service programs such as the Supplemental Nutrition Assistance Program, child care subsidies, or special education; however, access to these services and coordination across them can be challenging for families and providers because each program operates distinctly, may have different eligibility criteria and enrollment processes, and often do not share information with other programs, even for the purposes of care coordination or case management (Petitgout, 2013; Bethell, 2011). Lack of coordinated services leaves children at-risk of developing significant behavioral and physical health challenges, indicating a need for innovation in building the linkages between child programs that would provide children and their families an integrated care experience.

Improved prevention, identification, and treatment of physical and behavioral health challenges and substance use in pediatric populations requires: 1) population-level surveillance and screening for children with multiple physical, behavioral, or other health-related needs and risk factors, 2) child-centered enrollment and coordination of aligned health care and health-related service providers, and 3) intensive engagement of HCBS and other health-related supports¹ to reduce rates of inpatient

¹ For the purposes of this model, "health-related supports" are non-clinical services that support child health and are not covered by Medicaid 1915(c) home-and-community based services. Examples include SNAP, Head Start, and local child welfare.

hospitalization, residential treatment, and out-of-home placement. Pediatric accountable care organizations (ACOs) and behavioral health systems integration models are two promising pediatric care delivery models that demonstrate elements of these strategies. This model combines elements of these models to form an integrated care coordination and case management model supported by state-specific APMs.

A 4. Program Requirements

CMS will use a competitive process to award cooperative agreements to successful applicants (Awardees) to design and implement the InCK Model in their community. Awardees may use funds only to support model planning and implementation activities such as staff time and infrastructure costs. Awardees may not use model funds for the direct provision of services to beneficiaries. Cooperative agreements will consist of up to seven, one-year budget periods. Awardees who achieve satisfactory progress on program milestones will receive additional funding through budget periods two through seven, based on the availability of funds. Awardees must achieve satisfactory performance, as determined by CMS, on required program milestones designated for each performance quarter and year to continue receiving annual funding. Additional funding, which will be tied to Awardee performance on a set of specific program milestones, will be available during budget periods five, six, and seven of the model.

The InCK model will have the following key participants:

Awardee

CMS will award funding for InCK Model implementation through a cooperative agreement to a single entity, either a Lead Organization (see below) or a state Medicaid agency, depending on which of these parties submits the application. The Awardee will be responsible for determining the budget allocations for staff time and infrastructure costs consistent with the terms of the cooperative agreement, and demonstrating how the state Medicaid agency and Lead Organization will use funds to accomplish their respective roles in model implementation. The Awardee will be responsible for the receipt and management of CMMI funding in accordance with the model terms and conditions and applicable federal grant laws. The Awardee will be ultimately responsible for the achievement of all proposed milestones in both pre-implementation and implementation periods on a quarterly or annual basis as stipulated in this NOFO.

- During the Pre-Implementation period the Awardee must:
 - Hire and train Service Integration Coordinators sufficient to administer its state-specific InCK program as detailed in the applicant's proposal and any subsequent completed amendments to the proposal;
 - Hire and train sufficient administrative, ancillary and technical support staff to administer its program as detailed in the applicant's proposal and completed amendments;
 - Implement streamlined eligibility and enrollment (E&E) measures and/or systems as detailed in the applicant's proposal. This may include the functional deployment of any proposed publically-facing technologies, if proposed;
 - Deploy a functional crisis hotline with appropriately trained staff to ensure available 24/7/365 coverage for its attributed population;

- Deploy a mobile response system with appropriately trained staff to ensure available 24/7/365 coverage for its target population;
 - Meet CMS expectations for attendance and participation in scheduled Project Officer calls, timely and complete submissions for quarterly progress reports, attendance at required learning events, and assisting with all CMS model support contractors;
 - Report any substantive operational impediments related to model implementation to CMS Project Officer;
 - Determine needs assessment tools providers will use to determine Service Integration Level (SIL) eligibility;
 - Develop informational materials for clinicians and health-related service providers;
 - Develop promotional materials for prospective beneficiaries (including notice of privacy practices);
 - Sufficiently meet all proposed milestones as detailed in their CMS-approved proposal and completed amendments by the end of their first performance year prior to receiving second performance year funds;
 - Finalize agreed processes and authorization/consent forms for model participation. Awardees must adhere to all applicable Federal, state and local laws and ordinances, and should work with their counsel to determine what patient authorizations and reauthorizations may be required to implement the model as designed. Awardees will be responsible for monitoring and adhering to changes in these and all other applicable laws and regulations over the course of the model.
- During the Implementation period the Awardee must:
 - Implement the InCK Model; unless otherwise specified, maintain the infrastructure, processes, and programs established during the model pre-implementation period throughout the tenure of the model. As detailed above and throughout this notice, these include, but are not limited to, maintaining and supporting required staff to implement the model, continuing E&E measures and/or systems, continuing crisis hotline and mobile response systems, and meeting CMS expectations for attendance and participation in InCK model activities.

Lead Organization

A Lead Organization must be an existing or newly-created business entity (such as a hospital system, managed care plan, or local health department) that meets the definition of a covered entity subject to privacy laws under the Health Insurance Portability and Accountability Act (HIPAA). The Lead Organization will: serve as a community integrator, a trusted organization that can understand and represent the needs of the community; engage all the relevant service providers within a community (including health care services, public health, and human services); and leverage data-driven, community-level quality improvement across sectors toward shared goals for a defined population. The Lead Organization will be responsible for convening and representing the community, and will partner with the state Medicaid agency in developing the InCK Model application and implementing the model if awarded.

The Lead Organization will serve a crucial leadership role in convening partners to integrate the coordination and management of the InCK Model's core child services for the attributed population. It

must be able to convene community partners under a shared mission and vision to integrate child health services at the system level, beyond the individual or practice level. The Lead Organization will be responsible for improving population-level care quality and outcomes, convening and sustaining a Partnership Council (see below), and creating service integration protocols and processes.

The Lead Organization will collaborate with State Executive Office, state Medicaid agency, Medicaid payers (including managed care plans), and other state agencies as appropriate to align the service delivery model with a payment model. This collaboration is particularly important for purposes of identifying children at-risk for significant behavioral health, substance use and physical health needs among attributed populations, and stratifying those who meet the criteria thresholds defined by CMS into SILs.

- During the Pre-Implementation period the Lead Organization must:
 - Execute a formal contract with the state by the end of model year one. The Awardee must submit the executed contract to its Project Officer along with their Non-competitive Continuation Application for model year two.
 - Execute all business associate agreements (BAAs) with any persons or entities that will perform operations under the model that involve the use or disclosure of protected health information on behalf of, or provide services to, the Lead Organization.
 - Establish a Partnership Council and conduct regularly-scheduled meetings to implement the model and conduct ongoing process improvement.
- During the Implementation period the Lead Organization must:
 - Maintain the Partnership Council and conduct regularly-scheduled meetings to implement the model and conduct ongoing process improvement.
 - Continue to support the model as a representative of the community and a partner to the state, fulfilling all ongoing responsibilities initiated during the pre-implementation period for improving population-level care and quality outcomes.

State Medicaid Agency

The state Medicaid agency must commit to partnering with the Lead Organization to implement the InCK Model. The state Medicaid agency will be responsible for supporting local implementation of the model by providing data on the attributed population (e.g., number of Medicaid enrollees), supporting the development of information sharing arrangements and infrastructure, aligning support for the model across child-focused state agencies, and designing and implementing the pediatric APM. States using Medicaid managed care must use the pre-implementation period to work with managed care plans in their InCK Model service area to support APM implementation and ensure that existing managed care plan care coordination and case management efforts are incorporated into the efforts of the Awardee.

- During the Pre-Implementation period the state must:
 - Work with the Lead Organization to conclude a formal contract with the state by the end of model year one. The Awardee must submit the final signed contract to their Project Officer with their Non-Competing Continuation (NCC) application for model year two;
 - Conclude all business associate agreements (BAAs) as needed to conduct all operations;

- Provide the Lead Organization population-level data;
- Provide CMS (either directly or through the Lead Organization) with complete and timely claims and encounter data with unique, traceable identifiers for the model's attributed population and comparison group;
 - Develop a plan to share required claims and encounter data with the CMS Evaluation Contractor in the event of significant difficulties meeting this requirement through the Transformed Medicaid Statistical Information System (T-MSIS); and
- Begin design of the APM(s) including contacting CMCS to initiate securing any necessary state plan amendments (SPAs) and/or waivers as soon as possible after award. CMS will not approve NCC applications for model year three unless any and all SPAs and/or Medicaid waivers necessary for model implementation are in place. The Awardee must inform their Office of Acquisitions and Grants Management (OAGM) grants manager and CMS Project Officer of all milestones and any difficulties in meeting the proposed timeline for these requirements;
- Note: States that predominantly use Medicaid managed care delivery systems will be expected to use the model pre-implementation period to work with the managed care plans as necessary to support implementation of the APM and ensure that existing managed care plan care coordination and case management efforts are aligned with the efforts of the InCK Model.
- During the Implementation period the state Medicaid agency must:
 - Implement the APM(s) for the InCK model population. Specifically, beginning in year 4 (year 2 of performance period) or sooner, all Awardees must implement their APMs, which means at a minimum that Medicaid payments to providers furnishing integrated care coordination and case management services to beneficiaries in SILs 2 and 3 will be paid through the APM(s); and
 - Continue to provide CMS required evaluation data, including complete and timely claims and encounter data for the model's attributed population and comparison group, either through the Transformed Medicaid Statistical Information System (T-MSIS) or other acceptable means approved by CMS.

Partnership Council

The Lead Organization will convene one or multiple Partnership Councils (For more information, see section A 4.2.1.1.4 Partnership Council Convening) that will operate for the tenure of the model. The Partnership Council will comprise of child service system representatives with a vested interest in children's welfare and community-level service integration. The Partnership Council must include representatives from at least each of the model's Core Child Services and any optional service types the Lead Organization elects to include as defined in section A 4.2.1.1.4. The Partnership Council must also include representatives that serve children in the designated geographic service area from the local health department, community stakeholder representatives, and Medicaid payers, including managed care plans in positions that allow them to effect change within their organizations to support the Lead Organization. The Partnership Council's primary responsibility will be to devise strategies for its assigned community to achieve the coordination of service types as described in this NOFO.

- During the Pre-Implementation period the Partnership Council must:

- Enter into written data-sharing arrangements with other Partnership Council members as detailed in their proposal and completed amendments;
- Report all obstacles, proposed modifications, or significant functional impediments to the Lead Organization and/or Awardee for communication to the CMS Project Officer;
- Develop processes for managing care coordination services across Core Child Services; and
- Work cooperatively for the overall achievement of model goals.
- During the Implementation period the Partnership Council must:
 - Continue to support the model and include representatives from all previously listed stakeholder entities, meet regularly with and advise the Lead Organization with regard to its responsibilities under the model.

A 4.1 Application Submission Requirements

A Lead Organization and a state Medicaid agency must partner in completing a single InCK Model application and choose which partner will submit the application. Though there will be one Awardee, the state Medicaid agency and Lead Organization must commit to work together to implement the model if awarded. Each application for the InCK Model must include the documents outlined in Section D2: Content and Format of Application Submission. Applicants will need to review and address the programmatic requirements listed and described below from A 4.2.1 to A 4.2.3 for submission of the following required documents: Project Narrative, Memorandum of Understanding, Partnership Council, and Program Duplication Questionnaire.

A 4.2.1 Model Implementation Plan

A 4.2.1.1 State and Local Community Engagement

A 4.2.1.1.1 Model Service Area

A 4.2.1.1.2 Organizational Capacity

A 4.2.1.1.3 Memorandum of Understanding

A 4.2.1.1.4 Partnership Council Convening

A 4.2.1.2 Service Integration Plan

A 4.2.1.2.1 Care Map

A 4.2.1.2.2 Stratification Plan

A 4.2.1.2.3 Information Sharing Infrastructure

A 4.2.1.3 Medicaid and CHIP Authorities and Alternative Payment Model Proposal

A 4.2.2 Model Impact Analysis

A 4.2.2.1 Root Cause Analysis

A 4.2.2.2 Health Outcomes and Cost Savings Projections

A 4.2.3 Program Duplication Questionnaire

A 4.2 Application Sections

CMS expects that upon award the state Medicaid agency will use Medicaid and CHIP authorities to support model implementation. States may already have the necessary authorities for implementation, or they may need to work with CMS (in particular, the Center for Medicaid and CHIP Services (CMCS)) to

amend their state plan or obtain waiver(s). InCK Model applications must include a description of the Medicaid and CHIP authorities that Awardees anticipate using to implement the model. These details are solely for the purpose of InCK Model application review and do not represent a formal request for a state plan amendment, waiver, or demonstration approval on the part of the state nor a commitment to approval on the part of CMS. If awarded, the state Medicaid agency will work with CMMI, CMCS, and the Consortium for Medicaid and Children’s Health Operations (CMCHO) to refine the concepts detailed in the Medicaid and CHIP authorities proposal during the pre-implementation period of the model.

Applicants should address the following areas as part of their application:

- What Medicaid services authorized under the Social Security Act will be provided?
- What coverage authorities would be necessary to implement these services?
- What is the payment methodology for these services? (Please note that payment methodologies must comply with all Medicaid statutory and regulatory requirements.)
- Who will be providing these services to Medicaid beneficiaries? (Please note that federal matching funds can only be provided for Medicaid authorized services provided by Medicaid qualified providers to eligible Medicaid beneficiaries.)
- What is the allowable source of funding for the non-federal share of the Medicaid payments?
- Will you be operating this model through managed care and/or fee-for-service?

Applicants should include sections covering the following areas:

A 4.2.1 Model Implementation Plan

Applicants must submit information on their ability to engage state and local community partners to support model implementation, their plan to achieve the InCK service integration model, and their approach to designing APMs and supporting model sustainability. Applicants must include all subsections of their implementation plan within their project narrative.

A 4.2.1.1 State and Local Community Engagement

Applicants must provide information to demonstrate state Medicaid agency and local Lead Organization interest in partnering with CMMI to implement the InCK Model. This section should include a narrative description of the Lead Organization, its background as an organization, role in the community where the InCK Model will be implemented, and its capacity to implement the required model activities. Applications should also include a Memorandum of Understanding, detailed in section A 4.2.1.1.3, demonstrating coordination and communication between the state Medicaid agency and Lead Organization, and information on the community-level partners the Lead Organization will convene as a Partnership Council to implement the model as detailed in section A 4.2.1.1.4.

A 4.2.1.1.1 Model Service Area

Applicants must define one or multiple state administrative division(s) that functions as their model service area for this model *and* an in-state comparison population that CMS could potentially use for InCK Model evaluation purposes.

An applicant's model service area may be contiguous or non-contiguous, but it may not be statewide or cross state borders. Awardees must obtain prior approval from CMS before altering their service area during the entire seven-year model period. Awardees must be prepared to serve all Medicaid and, if specified in the Awardee's application, CHIP beneficiaries from the prenatal period up to 21 years of age residing within their model service area; these beneficiaries will make up the attributed population. Throughout this NOFO, CMS will refer to the pediatric beneficiaries residing in the model service area as attributed "child" or "children." Applicants must include all Medicaid- and CHIP-covered children residing in the model service area in their attributed population from birth until their 21st birthday. Including the prenatal period is optional, however, if elected Awardees must define the prenatal period as inclusive of both the health of the fetus and Medicaid-covered pregnant woman, regardless of her age. Awardees may not include any beneficiaries who are aged 21 or older in their attributed population unless they are Medicaid-covered pregnant women.

Applicants must identify a comparison population in their application that mirrors their attributed population as closely as possible on factors such as demographics and prevalence of targeted conditions (see section [F 5.2: Model Evaluation Data](#) for the in-state comparison group requirement). Applicants must clearly designate their proposed model service area and the comparison group in the form of zip codes, counties, metropolitan statistical areas, or other designation that denotes a state administrative division. This information should be submitted as part of the root cause analysis as detailed in section A 4.2.2.1.

This model does not require beneficiaries to change care providers as a result of inclusion in a model's attributed population, or participate in model intervention activities such as integrated care coordination or case management services. However, Awardees must assess the needs of, and collect data on, all attributed beneficiaries for InCK Model monitoring and evaluation purposes. The InCK Model offers Awardees the flexibility to identify subpopulations of their attributed population that may benefit from targeted services as part of broader population health strategies to achieve cost and quality goals.

The Awardee must provide CMMI, or its designated contractor, on an annual basis with 1) a retrospective list of all attributed beneficiaries that had Medicaid (or CHIP, if applicable) coverage for at least one month during the previous 12 months, and 2) a retrospective list of all comparison group beneficiaries that had Medicaid (or CHIP, if applicable) coverage for at least one month during the previous 12 months. Awardees must submit these two lists annually when they submit their Annual Progress Report to CMMI. The retrospective lists must specify the duration of each child's Medicaid or CHIP coverage during the last 12 months and contain a unique identifier for every attributed and comparison group child such that evaluators can trace the beneficiary's claims and encounter data longitudinally.

A 4.2.1.1.2 Organizational Capacity

Each applicant must demonstrate an existing, strong partnership between the Lead Organization and the state Medicaid agency, and significant experience in community leadership and engagement. Applicants should illustrate that they have the capacity to bring community stakeholders together with the Lead Organization and state Medicaid agency to develop population-level goals and implement successful interventions to remove access barriers to integrated care for the pediatric Medicaid population with significant health needs.

A 4.2.1.1.3 Memorandum of Understanding

Applicants must provide a signed Memorandum of Understanding (MOU) between the Lead Organization and the state Medicaid agency that demonstrates evidence of a strong relationship and joint commitment to InCK Model implementation. The MOU must establish the Lead Organization and the state's roles and describe in detail how the entities will work together throughout the model performance period until successful completion. The MOU must also include a statement that describes any restrictions on sharing of protected health information (PHI) and personally identifiable information (PII), for example, any applicable state laws or IRB approval processes. The statement must include an explanation of whether those barriers would prevent the state, Lead Organization, or any community partners participating in the Partnership Council from fully participating in model implementation or evaluation activities. The statement must include, at a minimum:

- Acknowledgement of the obligation of both the state Medicaid Agency and Lead Organization to share attributed individual- and population-level data with CMS and its contractors, as outlined in Section F5 of the NOFO;
- Commitment to providing unique identifiers for the attributed population and comparison group that allow evaluators to trace beneficiaries' claims and encounter data across time; and
- Any anticipated barriers to providing CMMI monitoring or evaluation data, including data lag and legal or other regulatory barriers, and how the applicant proposes to mitigate any negative effects those barriers have on achieving the goals of the model.

A 4.2.1.1.4 Partnership Council Convening

Lead Organizations will convene a Partnership Council comprised of a group of Core Child Service representatives with a vested interest in children's welfare and community system change. Partnership Councils serve as an advisory body to the Lead Organization's population health management strategies, including procedures and processes to integrated care coordination and case management across Core Child Services. At the Lead Organization's discretion, there may be a Lead Organization member who serves on the Council as well.

Partnership Council members must be local leaders in positions that empower them to affect change within their organizations—including coordinated eligibility and enrollment across their child-serving programs—and contribute to InCK Model formation. Existing community groups that meet Partnership Council criteria may serve this role, or be newly convened for the purposes of the InCK Model. In the event that a Lead Organization plans to serve a large service area that contains multiple smaller communities, it may convene a distinct Partnership Council per community, provided that the membership of each Partnership Council have full membership from its community as described here. Partnership Councils must have at least one member from:

- 1) the local health department;
- 2) stakeholder representatives from families and caregivers living in the community;
- 3) Medicaid payers, including all applicable managed care plans and the state Medicaid agency; and
- 4) All applicable organizations delivering Core Child Services listed below

Applicants have the option, and are encouraged, to include other partners listed under the Recommended Optional Partners section.

The Partnership Council must include members that provide the following core child services:

Core Child Services:

(a) Clinical care (physical): At a minimum providers that deliver Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, including oral health, pre-natal services and reproductive health, primary care, well child visits, and emergency/crisis stabilization services. Lead Organizations should also include home-and-community-based services (often covered by Medicaid or Title V), such as care coordination, respite care, environmental modifications, nutrition services, rehabilitative and habilitative services, durable medical equipment and assistive technology, and other services that could benefit their populations.

(b) Clinical care (behavioral): Services that address mental and behavioral health needs such as those that address substance use, intergenerational transmission of trauma or toxic stress, genetic conditions requiring therapeutic services, acute or chronic mental disorders, and various challenges ranging from mild to severe such as emotional disturbance, post-traumatic stress disorder, oppositional defiant disorder, and/or substance use disorders.

(c) School district or equivalent: Health services delivered in schools, including but not limited to food and nutrition and Medicaid-covered services delivered in schools including school nursing services, if present, physical therapy/occupational therapy/speech therapy, and others. HCBS furnished in schools must not be otherwise available to the child through a local educational agency under the Individuals with Disabilities Education Improvement Act or the Rehabilitation Act of 1973.

(d) Housing: Community-based housing services that address any of the five HHS-defined housing instability conditions: high housing costs, poor housing quality, unstable neighborhoods, overcrowding, and homelessness.

(e) Food: Federal, state, and community-based programs that address food insecurity and nutrition such as the Supplemental Nutrition Assistance Program (SNAP), Women, Infants, and Children (WIC), and school lunch/breakfast programs.

(f) Early care and education: Federal, state, school-based and community-based programs that address infant, toddler, and/or young child development, including special education, Early Intervention, home visiting programs, and other related services (if present).

(g) Title V Agencies: Agencies that receive funds from the Maternal and Child Health (MCH) Services Block Grant (Title V of the Social Security Act) to support health and welfare services to mothers and children with special health needs.

(h) Child welfare: State and local child welfare programs.

(ii) Mobile crisis response services. Lead Organizations will develop a system for responding to the initiation of crisis/stabilization services. These services must include behavioral health crises as a minimum including substance use; communities may choose to offer these services for other crises, for example, eviction or domestic violence. The mobile response system must include the ability to send

staff to a child's residence to stabilize the crisis situation and perform a needs assessment. The mobile response system should also include a central hotline that is widely advertised in the target population and can be called to trigger service initiation. Awardees should consider additional pathways to initiate crisis/stabilization services, such as via a clinician, other provider, or law enforcement professional. Awardees must set policies clarifying what types of crises are appropriate for the crisis hotline and which are best addressed by calling 9-1-1.

Recommended Optional Partners (Not Required)

Lead Organizations may consider working with the following entities, if not otherwise represented in the Partnership Council, in order to coordinate child providers in their community.

(j) Law enforcement: Police are often first-responders to address behavioral health crises and/or child welfare issues.

(k) Family/Juvenile Courts: Family and/or juvenile court systems and detention centers are well-positioned to divert youth into community- and home-based services rather than the juvenile justice system.

(l) Civil Legal Aid: Civil legal aid has historically worked to address access to key health-related services, such as Medicaid and public benefits including SNAP.

(m) Other Community Partners: Awardees may identify other key partners, especially other partners that provide health-related child services in the community, to serve as members. Examples of such entities include domestic violence centers, faith-based entities, and therapeutic foster care providers.

As evidence of local engagement and commitment, applicants must submit a separate Partnership Council Charter signed by each participating member of the Council, including a description of the formation of the Charter, the Council's focus and direction, and the core principles for working together. The Partnership Council Charter should include a description of each member's background and experience in integrating care for pediatric Medicaid beneficiaries, and detail their responsibility for care coordination under the model within the target community. The Charter should demonstrate each Council member's commitment to participating in the service integration plan for the life of the model and their preparedness to improve the experience of children served.

A 4.2.1.2 Service Integration Plan

Lead Organizations must coordinate the systematic integration of the Core Child Services within their model service area for the purposes of integrated care coordination and case management as described in Section A 4.2.1.2.2 for SILs 2 and 3. CMS does not fund all of the Core Child Services; Lead Organizations and their community partners will need to coordinate these services so that families receive an integrated experience of care despite separate funding streams. If a Lead Organization also functions as a service provider, it also may provide one or multiple Core Child Services, e.g., if the Lead Organization is a hospital system.

Integration of Core Child Services will be slightly different due to local context and variation in child health programs. The service integration plan goals are 1) **to provide each primary caregiver of a Medicaid- (or CHIP-) covered child in SILs 2 and 3 a single point of coordination for all of their child's providers**, regardless of Core Child Service, and 2) **increase the provision of services at home and in the**

community, rather than inpatient, residential, foster care, juvenile detention, or other out-of-home settings for attributed children.

Lead Organizations and their Partnership Council will employ the following service integration strategies:

- 1) Population-wide service integration level stratification with Service Integration Coordinators (SICs) serving as, or facilitating, points of contact for integrated care coordination and/or case management,
- 2) Information sharing across providers and primary caregivers,
- 3) Coordinated eligibility and enrollment processes, and
- 4) Service Accessibility.

Lead Organizations are encouraged to adapt these service integration strategies to their local context to support the achievement of the model goals.

A 4.2.1.2.1 Service Accessibility and Care Map

The Lead Organization will work with its Partnership Council(s) to increase its capacity to deliver needed home- and community- based services to attributed children in a timely manner. Possible strategies include but are not limited to: telehealth, peer supports, community health workers, onsite technology with interface support, staffing, language services, and coalition building. The applicant must clearly describe in the application its capacity to improve access to the Core Child Services for model participation. Applicants have significant flexibility to demonstrate creativity and innovation in the context of their local setting and available resources. Awardees may consider including some of the features listed below into a plan developed to increase capacity for service accessibility. These are presented as examples only, applicants should not limit their proposed implementation plans to these strategies alone:

- IT: Securing new technologies or expanding existing technologies appropriate for the local context and population.
- Staffing: Increased and/or specialized staffing to interact with children and their families.
- Language Services: Include multi-lingual staff to assist with language translation and/or interpretation with children and their families.
- Coalition building: Identifying mutual benefits, philanthropic and/or humanitarian opportunities for business owners, service providers, and other interested audiences to support Awardee's efforts to deliver services to children in a timely manner.

Care mapping is a family-driven, person-centered process that supports families and providers in coordinating the care of children (a helpful reference may be found at <http://www.childrenshospital.org/integrated-care-program/care-mapping>). This tool is especially effective for children who would be eligible for SILs 2 or 3 (described below) who have needs and access care across multiple service sectors and providers. Applicants must submit 'before' and 'after' care maps that demonstrate how access to and coordination of Core Child Services will change the experience of care for children in SIL 2 or 3 as part of their application.

A 4.2.1.2.2 Stratification Plan

Applicants must describe their plan for attributed population-wide service integration level stratification according to the eligibility criteria listed below. Major sections of the applicant’s plan must include 1) needs assessment, 2) processes and procedures to stratify each attributed child and track stratification across time, 3) information sharing and aligned eligibility and enrollment practices, 4) processes and procedures to deliver integrated care coordination and case management, and 5) service accessibility. The applicant must discuss how their stratification plan connects to their root cause analysis findings and potential for health outcomes and cost savings (Section A 4.2.2 Model Impact Analysis).

Lead Organizations and their Partnership Council(s) have flexibility in determining:

1. what needs assessment tools providers will use to assess attributed children;
2. which Core Child Service providers or staff will perform needs assessment and stratification;
3. how (electronically or otherwise) needs assessments will be performed;
4. when (at what point in care) needs assessments will be performed; and
5. where (what settings) the assessments will be conducted.

The SIL eligibility criteria below is intentionally flexible because each applicant must further define the criteria for the purposes of choosing needs assessment tools and devising stratification processes and protocols. However, the CMMI InCK Model evaluation requires that Lead Organizations and their partners use one set of needs assessment tools consistently across all attributed children during the entirety of the model implementation period. For example, within one InCK Model award, all Core Child Service providers will use the same tool(s) to assess whether an attributed child has a food or housing need, and thus may be considered ‘exhibiting a need in two Core Child Services—Medicaid (already covered) and social services (not yet connected, or connected but has new or continued need).’ Similarly, all providers will assess substance use among attributed children with the same tool(s). Lead Organizations will provide blank copies of their needs assessment tool(s) to CMS for evaluation purposes as often as they are updated.

Lead Organizations must ensure that each attributed child’s SIL enrollment is recorded on a SIL Eligibility Checklist; they should propose a format, e.g., electronic records. The Eligibility Checklist is a form that CMMI and Awardees will develop jointly through the model Learning System during the pre-implementation period. CMS anticipates the Eligibility Checklist will contain high-level information about a child’s SIL eligibility. Lead Organizations must provide one checklist per attributed child assessed at least on an annual basis to the CMMI evaluation contractor for the model duration. Every Eligibility Checklist must contain the child’s unique Medicaid or CHIP identifier and details concerning the child’s SIL eligibility based on needs identified using assessment tool(s). The Awardees must also make attributed children’s completed needs assessment tools available to the CMMI evaluation contractor upon request. The Eligibility Checklists and needs assessment tools will give the CMMI InCK Model evaluation an overall picture of what needs are directing enrollment of children into SILs 2 and 3, and how these differ among programs.

SILs consist of increasing intensity of integrated care coordination and case management appropriate for individual needs:

- **Level 1:** Includes the entire target population. Focuses on basic, preventive care and active surveillance for developing needs and functional impairments.

- **Level 2:** Includes children with needs involving more than one service type and who exhibit a functional symptom or impairment. Focuses on comprehensive needs assessments and integrated care coordination.
- **Level 3:** Includes children who meet Level 2 criteria who are currently, or are at imminent risk of being, placed outside the home. Focuses on child-centered care planning, integrated case management, and home and community-based services.

SIL Eligibility Criteria:

Any attributed beneficiary that opts out of Level 2 or 3 integrated care coordination and case management will continue to receive usual care through existing providers and programs.

1. Level 1

If a child is determined not to meet Level 2 or Level 3 eligibility criteria through needs assessments, the child will remain in Level 1 and receive usual care.

2. Level 2

The child must show evidence of points 1 and 2 below:

- 1) The child has exhibited a need for at least two of the following Core Child Services within the previous 12 months:
 - a. Physical health services
 - b. Behavioral health services
 - c. Home and community based/social services
 - d. Special education or Early Intervention services
 - e. Child welfare services
 - f. Locally-selected optional service types (e.g., Juvenile Justice)

AND

- 2) The child exhibits a functional symptom OR impairment as follows:
 - a. Functional symptoms: at least one of the following:
 - i. Substance use (including in-utero exposure, substance use by a child or primary caregiver)
 - ii. Serious emotional disturbance
 - iii. Chronic medical condition
 - iv. Medically complex condition
 - b. Functional impairments in two or more of the following capacities (compared with expected developmental level):
 - i. Functioning in self-care: consistent inability to perform self-care activities such as personal grooming, hygiene, or nutritional needs.
 - ii. Functioning in the community: consistent lack of age-appropriate decision-making or behavioral controls.
 - iii. Functioning in the family: consistent inability to conform to reasonable limitations and expectations of behavior within a family or equivalent unit, for example repeated violent behavior with a disregard for self or others' safety.

For young children may include significant caregiver stress around infant/toddler behaviors.

- iv. Functioning in social relationships: consistent inability to develop and sustain satisfactory relationships with adults and peers. Includes inability to communicate needs or engage in age-appropriate parent-child interaction.
- v. Functioning at school/work/early learning settings: consistent inability to pursue education goals within average time frame due to consistent suspension, expulsion, or truancy, or other consistent inability to maintain volunteer service or employment.

Level 2 features integrated care coordination across Core Child Services to facilitate individualized, family- and child-driven, and ethnically, culturally, and linguistically appropriate care delivery. Activities at the care coordination level should foster a supportive, collaborative relationship with the child and primary caregivers while organizing and matching services across model providers and child-serving systems to enable the child to be served in the home and community. The Lead Organization and its Partnership Council(s) are responsible for determining the processes and information technology required to form a network capable of providing integrated care coordination, with Awardees carrying out the activities to implement the required processes and information technology. Children in SIL 2 receiving services in a community setting, must be re-assessed at a minimum of every 12 months while they remain in SIL 2.

Care Coordination functions include:

- Helping families enroll in child health programs;
- Arranging service appointments, conducting follow-up, and coordinating the beneficiary's care on an ongoing basis with service providers; and
- Facilitating effective communication across child-serving systems, state and local government agencies, children, and families.

3. Level 3

The child must show evidence of points 1 and 2 below:

- 1) Level 2 eligibility;

AND

- 2) The child either
 - a. currently resides in or is at imminent risk of out-of-home placement; OR
 - b. has had prolonged or multiple inpatient admissions as a result of chronic or medically complex conditions during the previous 12 months.

Awardees must ensure that children in Level 3 receive the integrated care coordination services provided at Level 2 as well as integrated team-based care through a care planning team. Care planning teams should be multi-disciplinary teams that include the parent/guardian/legal representative and the beneficiary, when appropriate, and should meet regularly to undertake a collaborative process of assessment, planning, facilitation, care coordination, and evaluation for options and services to address the child and family's comprehensive health needs. The care planning team should be led by an individual whose function is to convene and coordinate the care planning team and provide an initial

point of contact and coordination for the child and primary caregivers. The goal of Level 3 integrated case management should be to provide quality services in the most integrated and least restrictive setting appropriate. For children currently residing in an out-of-home placement, Level 3 integrated case management should ideally help address the child's needs such that they are able to return to their home or community. Children eligible for SIL 3 but receiving necessary services available only in an institutional setting may still be considered "in SIL 3" for the purposes of this model. Both these children and children in SIL 3 receiving services in a community setting must be re-assessed at a minimum of every 6 months while they remain in SIL 3.

The child's main point of contact for coordination and management of care should convene the appropriate team members to form a child's care planning team with input from the child's caregiver(s) and, if appropriate, the child as the center of the team. For example, care planning team members might include additional family members, providers of Core Child Services such as primary and specialty care clinicians, social workers, a school representative from a child's Individualized Education Program team, or a school nurse.

Care Planning Team functions include:

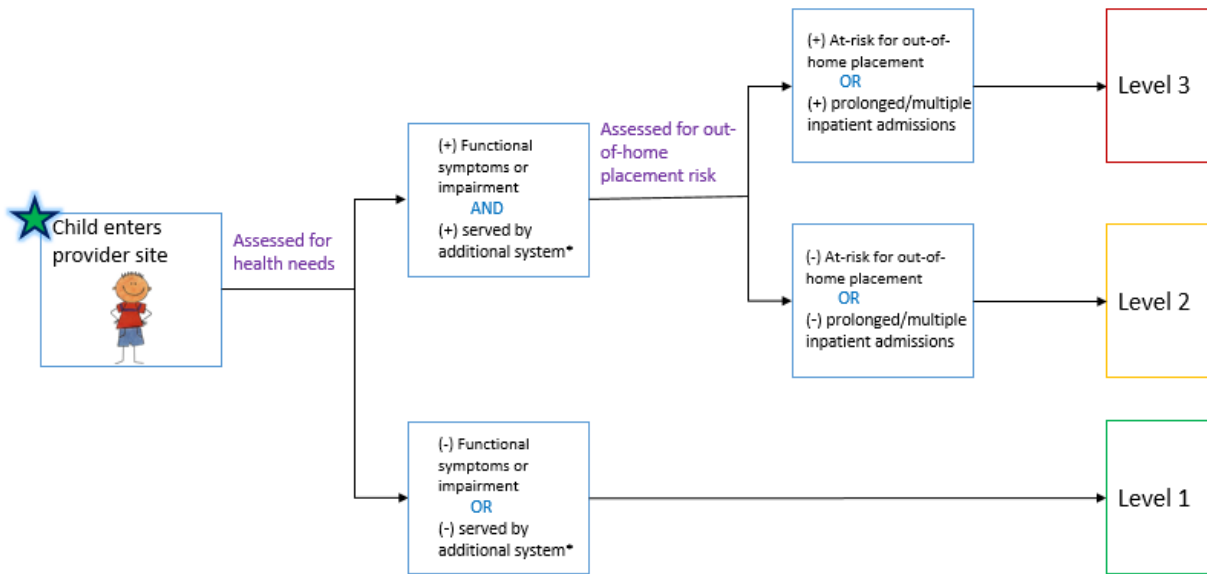
- Collaborative care planning for the improvement of the child's outcomes and functioning (every child at this level has a person-centered care plan)
- Working to ensure that the child receives the individualized and appropriate care they need in order to be healthy.

Important recommendations for stratification:

- Applying a two-generational approach to integrated service delivery can have profound impacts on a child's health outcomes because children are reliant on caregivers to meet their needs. For young children from birth to age six, Lead Organizations should consider setting a policy allowing assessment of parent/guardian needs and stratifying the child based on the parent/guardian meeting this criteria. For example, under Level 2 eligibility criteria part 2b. functional impairments, parental impairment in self-care, the community, or similar settings would enhance early childhood risk management, as would considering an incarcerated parent. A similar approach should be considered for pregnant mothers included in the model. This is similar to the reasoning behind recent Medicaid guidance regarding covering maternal depression screening based on the child's beneficiary status. CMS encourages Lead Organizations, the state Medicaid agencies, and their Partnership Council(s) to collaborate on operationalizing two-generational strategies where possible, especially given the consequences of primary caregiver substance use on a child's health. Preference will be given to applicants proposing two-generational strategies.
- Lead Organizations may use a variety of approaches to determine if the child meets a need for these Core Child Services. For example, providers may use tools that screen for Adverse Childhood Experiences (including domestic violence, child abuse, substance use), or other health determinants such as housing or food insecurity.
- Communities may use references from the Substance Abuse and Mental Health Services Administration (SAMHSA) to define children with serious emotional disturbance and/or substance use disorder using the Diagnostic and Statistical Manual of Mental Disorders. For the purpose of this model, Awardees may define childhood SED in a population up to age 21 and include intellectual disabilities, developmental delays, and/or substance use disorders "that

resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities”.

Figure 1. Service Integration Level Stratification



*For example, behavioral/mental health, special education, child welfare, juvenile justice

Service Integration Coordinator Role

Service Integration Coordinators (SICs) will be individuals employed or contracted by the Lead Organization or any Partnership Council members. The function of a SIC is to ensure that an attributed child’s primary caregivers have one reliable main point of contact they can reach for the integrated care coordination and/or case management of all Core Child Services.

Lead Organizations have ample flexibility to define one or multiple roles of SICs to achieve the goal of one reliable main point of contact; they must determine how many SICs are needed and their specific responsibilities. For example, Lead Organizations and their Partnership Council may decide to form coordination hubs which act as the central point of communication for attributed children and their primary caregivers for the purposes of care coordination and/or case management. In this example, SICs may build the relationships between existing care coordinators and case managers of the Core Child Services and set up the processes and information infrastructure in the hub by which referrals are made, completed, and tracked across the different service types. In another example, a Lead Organization and their Partnership Council may opt to train existing managed care plan care coordinators expanding their role to connect children to both clinical and non-clinical Core Child Services via a robust referral and follow-up system. In this example, SICs may also facilitate relationship building between Core Child Service providers, and set up processes and information infrastructure to support the expanded managed care plan care coordinator role.

SICs do not directly deliver any services to attributed children or their families in their capacity as a SIC using InCK Model funding. At the discretion of the Lead Organization and Partnership Council,

individuals functioning as SICs may separately serve as a service provider such as a care coordinator (in Level 2) or case manager (in Level 3) for one of the core or recommended optional InCK service types; under these circumstances, the Lead Organization and SIC must ensure that these two roles are separately managed and operated, for example by accounting the amount of time and percent of effort expended by the SIC in these distinct roles. Such accounting will help ensure that SIC services, which are allowable funds under the InCK Model cooperative agreement, are not separately paid for by Medicaid or CHIP as part of service provision. If a SIC is employed by an organization other than the Lead Organization they must meet the definition of a covered entity subject to privacy laws as defined under HIPAA, or their organization must have a business associate agreement with the Lead Organization allowing them to use or disclose beneficiary data for population health management activities.

For SIL 3, InCK Model policy does not require that SICs convene or manage care planning teams; the Lead Organization has flexibility in who convenes or manages the care planning team. However, the convener, whether a SIC, case manager, or other individual, must be a covered entity subject to privacy laws as defined under HIPAA or an employee of an organization that has a business associate agreement (as defined under HIPAA) with the Lead Organization (that must be a covered entity).

A 4.2.1.2.3 Information Sharing and Aligned Eligibility and Enrollment Practices

Lead Organizations will oversee the development and implementation of information technology to facilitate coordinated delivery of services, including 1) needs assessments, 2) eligibility determinations and stratification, 3) enrollment in services and programs, and 4) reduced duplication of similar services, assessments, and enrollment forms for each child. The purpose of this program requirement is to 1) improve information sharing among a range of providers to bring a complete picture of the child's health to their care team, 2) provide an integrated experience of care for the child and primary caregivers, and 3) reduce families' burden to navigate differing procedures and processes for the various organizations and programs that provide the Core Child Services and reduce their churn in and out of these programs.

Applicants must include how their strategies achieve a streamlined experience for families while navigating privacy laws and regulations, the constraints of information exchange systems, and insufficient knowledge and coordination on the part of providers and other staff of the involved programs. Examples of strategies include but are not limited to use of consumer/parent/caregiver online portals, custom built or existing data systems used by involved programs, including registries or health information exchanges, and cloud-based integrated record systems with user roles protecting privacy and controlling providers' ability to see and edit a child's record.

Applicants must consider the consequences of a child losing Medicaid or CHIP coverage for a variety of reasons, for example income change, or aging out of the foster care system. Applicants must propose transition strategies for these inevitable circumstances to limit churn and facilitate smooth transitions from one insurance coverage to another with as little disruption to care as possible.

Applicants must include a description of how their strategies achieve a streamlined experience for families while navigating privacy laws and regulations, addressing constraints of varied information exchange systems, and other known or potential impediments to data sharing, including insufficient knowledge and coordination on the part of providers and other staff of the involved programs. Examples of strategies include but are not limited to custom-built data systems that integrate existing data

systems used by involved programs, and cloud-based integrated record systems with user roles protecting privacy and controlling providers' ability to see and edit child's record. Possible strategies also include but are not limited to: a comprehensive enrollment process in which primary caregivers update information periodically and are enrolled in the appropriate programs simultaneously rather than separately; family-friendly access to services in which eligible siblings are enrolled simultaneously; periodic review of a family's enrollment profile to determine the appropriateness of enrollment in certain programs, and incorporate a mechanism for individual program disenrollment. Applicants should include a brief description of their intended approach to standardizing common data elements and supporting interoperability across state-level systems. Please refer to the Office of the National Coordinator's Interoperability Standards Advisory to review standards which might be appropriate (<https://www.healthit.gov/isa/>) . Consideration will be given to applicants who intend to develop or utilize reusable systems which support scalability and sustainability.

A 4.2.1.3 Medicaid and CHIP Authorities and Alternative Payment Model Proposal

The InCK Model requires state Medicaid agencies to implement one or more payment models to support the InCK models integrated care coordination, case management, and mobile crisis response services. Fee-for-service based payment systems incentivize a focus on the volume of health care delivered and make it difficult for providers to institute and sustain changes in care delivery that might have greater impact on advancing health but reduce the utilization of services. Successful health care system transformation must combine changes in the approach to care delivery with funding systems that support those changes. Therefore applications must include a preliminary proposal for an Alternative Payment Model to support the InCK Model and should include information on other sources of funding that may be used to sustain the model. Please note that APMs developed for purposes of InCK are not "Alternative Payment Models" defined in 42 CFR 414.1305 for the Quality Payment Program (QPP). Please refer to the InCK APM requirements as defined in the paragraphs below.

The state Medicaid agency will work with CMMI, CMCS, and CMCHO to develop and implement one or multiple child-focused alternative payment models (APMs) adherent to InCK Model requirements as described below. State Medicaid agencies should design their APM(s) to meet the unique characteristics and needs of their target population. Lead Organizations must implement their service integration model beginning in year 3 of the InCK model. States have the option to implement their APM at the beginning of year 3 of the InCK model or they may use year 3 as a transition period between their existing payment model and the new APM. States must implement their APM by the start of year 4 of the InCK model. This means that Medicaid payments to providers furnishing integrated care coordination and case management services to beneficiaries in SILs 2 and 3 will be paid through the APM(s) by year 4 of the InCK model.

State Medicaid agencies must develop and implement an APM(s) that compensates Medicaid providers who serve the attributed population for integrated care coordination, case management, and mobile crisis response efforts, including provider participation in care planning teams for children in SIL 3. The APM must be designed using the appropriate Medicaid and/or CHIP program waiver authorities to pay for these services using Medicaid and CHIP funds. States may administer their APM(s) directly, or work with their managed care plans to implement the APM(s). States may not use their Medicaid and CHIP APMs to directly pay for any services, including InCK Model Core Child Services, which are ineligible for

reimbursement using Medicaid or CHIP funding. State Medicaid agencies may identify opportunities to align Medicaid and CHIP funding for care coordination and case management services with funding for other non-Medicaid or CHIP child services to simplify and align efforts across providers and organizations that support population health management.

The application should include a description of the state's proposed APM approach that includes the following:

- the provider types to be paid under the APM;
- the service types and units to be paid under the APM;
- the basis and/or rate determination methods the state anticipates using to develop the APM
- whether payment will be made directly from the state or under a managed care arrangement;
- how the non-federal portion of payments will be funded;
- what type(s) of performance based payments will be made under the APM and how they will be developed;
- how the Population-Based Payments will be developed and what data and sources of data will be used; and
- how the quality of care will be measured and the APMs will be evaluated.

Additional APM Guidelines

CMS encourages state Medicaid agencies to consider the following three principles when designing their APM(s):

- 1) value-based payment incentives for clinicians and other providers should be significant enough to motivate providers to invest in and adopt new approaches to care delivery without facing financial and clinical risk they cannot manage;
- 2) pediatric APMs should maximize long-term opportunities for returns on investment and reward short-term outcomes that contribute to managing long-term risk; and
- 3) to achieve person-centered care, it is essential to empower individuals and their families/caregivers as partners in health care transformation.

The state Medicaid Agency will work with CMMI, CMCS, CMCHO, and the Lead Organization to design and implement one or more APMs that adhere to model guidelines below. The APM(s) must support the integration of the health-related child services and local service delivery model described in the Service Integration Model section. The state's APM(s) must meet the following requirements:

1. The APM(s) must include integrated care coordination, case management, and mobile crisis response services using the appropriate Medicaid and/or CHIP authorities to pay for these services with Medicaid and CHIP funds.
2. The APM(s) must utilize a clear method of patient attribution with a clear process for communicating patient attribution to providers. Ideally, the APM would use prospective patient attribution when feasible.
3. Downside financial risk sharing is not required, however, states that include a risk sharing element in an APM may not begin to utilize downside risk until model year 5.
4. The APM must conform to one of the following approaches:
 - a. **Fee-For-Service (FFS).** States may design APMs that build on existing FFS architecture by providing mechanisms that connect payment to health care service quality and efficiency. Payments are based on performance against a cost target (and potentially,

utilization), and structured to encourage providers to deliver effective and efficient care through quality targets. Although cost (and/or occasionally utilization) performance is the distinguishing component of this payment arrangement, payments hold providers accountable for a wider range of activities and outcomes. Participating providers are paid on a FFS basis with retrospective reconciliation of the FFS payments (i.e. costs incurred) against the benchmark, or target, for the total cost of care during the period of performance.

- b. **Population-Based Payment.** Population-based payments compensate providers for caring for a defined patient population over a fixed period of time. This approach holds providers accountable for cost and quality for the defined population across the continuum of care and generally rewards providers for achieving population-level quality targets. States may design APMs that provide prospective, population-based payments for case management and care coordination services and encourage providers to deliver well-coordinated, high-quality, person-centered care. Population-based payments must incorporate measures of appropriate care that serve as additional safeguards against incentives that limit necessary care; these payments must incentivize health and wellness throughout the care continuum by providing a single predominantly prospective payment that reflects the total cost of care for: (1) a broad array of pediatric services; (2) treating a primary (typically chronic) condition; (3) a more limited set of specialty services (e.g., primary care or behavioral health); or (4) comprehensive pediatric care for the entire attributed population.

States may design their APM(s) to target a subset of the population. For example, a state may design an APM such that a SIL 1 attributed beneficiary is not covered under the APM unless they enter SILs 2 or 3. States should consider the following voluntary guidelines:

- APMs based on population-based payment should incorporate valid, reliable quality measures of appropriate care and link payment to them. Payers should make these quality measures available to providers on a timely basis.
- APMs structured using either of the approaches described above should include a total cost of care measure.
- The APM payment structure should incentivize providers to focus on supporting and improving overall population health.

A 4.2.2 Model Impact Analysis

CMS will give priority to InCK Model applications that demonstrate the ability to offset the up to \$16M investment of CMMI model funding through reduced Medicaid or CHIP costs while preserving or enhancing the quality of care for the Medicaid (and, if applicable, CHIP) attributed children. Applicants must submit 1) a Root Cause Analysis, and 2) a projection of Health Outcomes and Cost Savings impacts. The purpose of these application requirements is to identify applicants with both a high need for service integration and strong potential to impact both the cost and quality of care. Applicants must include all subsections of the impact analysis in their project narrative.

A 4.2.2.1 Root Cause Analysis

Applicants must identify health conditions that are the root causes of 1) out-of-home placements of their attributed population (to include any institutional or residential setting of care, foster care, and juvenile detention) and 2) prolonged or multiple inpatient admissions in their attributed population. Applicants must specifically discuss the prevalence of substance use disorders and other behavioral and mental health conditions in addition to any other health conditions they identify as root causes.

The Root Cause Analysis should:

1. Clearly identify the model service area for the Lead Organization.
2. Provide detailed information on the size and characteristics of at least 80% of pediatric Medicaid (and, if applicable, CHIP) population living in the model service area (i.e. the attributed population for the model). Characteristics should include any significant needs that impact the population's health, and details on any subpopulations with special health needs.
3. Provide detailed information on the size and characteristics of a potential in-state comparison population for the purposes of the CMS model evaluation. (See Section [F 5.2: Model Evaluation Data](#) for the in-state comparison group requirement).
4. Provide details on the rates of out-of-home placement, inpatient admissions, and emergency department visits as described above for the attributed population and any subpopulations with special health needs.
5. Provide estimates of the portion of the attributed population who are at-risk of inpatient admissions, emergency department utilization, residential placement, and out-of-home placement.
6. Provide the prevalence of conditions, including substance use disorders and behavioral and mental health conditions, associated with the attributed population's out-of-home placement, residential placement, emergency department utilization, and prolonged or multiple inpatient admissions.
7. Provide a brief narrative with accompanying data explaining how the health conditions identified in the analysis impact the rates of out-of-home placement, residential placement, emergency department utilization, and inpatient admissions.
8. Identify gaps in the integration of services for the overall attributed population, and the portion of the attributed population with the highest rates of inpatient admissions, emergency department utilization, residential placement, or out-of-home placement.
9. Applicants must also state whether their state Medicaid agency has or is applying for Substance Use Disorder section 1115 waiver and if so, the extent to which they would need to rely on institutions for mental diseases for short-term care while protecting children from improper institutionalization consistent with requirements in the recently enacted Family First Act.

Strategies that applicants may use to conduct a root cause analysis include, but are not limited to: child beneficiary/primary caregiver interviews, care coordinator/case manager interviews, Medical record reviews, process mapping, cause-and-effect diagrams, and the 5 Whys method.

A 4.2.2.2 Health Outcomes and Cost Savings Projection

The applicant must submit a Health Outcomes and Cost Savings Projection that describes how their proposal to implement the InCK Model would impact the health care outcomes and Medicaid and, if applicable, CHIP spending of the attributed population over the performance period of the award, as well as on a projected annualized basis for three years following close of award period.

The analysis must identify 1) how the model could impact quality of care, including specific goals for quality improvement and the strategies that would be implemented to achieve them, and 2) an estimate of the potential impact of the model on Medicaid and, if applicable, CHIP spending.

The Health Outcomes and Cost Savings Projection should:

1. Report the total and per member per month (PMPM) cost of Medicaid-covered services, and the total and PMPM costs and rates of emergency department visits and inpatient admissions for the attributed population, as well as out-of-home placement, and residential placement rate for the attributed population.
2. Provide specific health outcomes goals/targets that align with the root cause analysis for the attributed population and the expected reductions in out-of-home placement, residential placement, inpatient admissions, and emergency department visits.
3. Provide the financial models explaining the logic driving the forecasted impact on spending, including the baseline total and per member per month (PMPM) Medicaid and CHIP spending as well as the estimated total and PMPM Medicaid and CHIP spending as assumed **with** and **without** the InCK Model intervention.

Applicants may submit an external actuarial certification of their Financial Analysis with their application but it is not required. CMS will review the reasonableness of the estimated cost to the Federal government and the potential for federal savings.

A 4.2.3 Program Duplication Questionnaire

Applications must include a completed program duplication questionnaire. Applicants should conduct a budget analysis to identify current funding streams they propose to apply to care coordination and service integration activities, if any. As part of this analysis, applicants should also identify new and distinct service integration activities toward which they could apply model funding. While we expect applicants already working on service integration to propose the use of model funding to support the expansion of current activities, we must emphasize that Awardees must not use model funding to supplant or duplicate current funding activities. This means that model funding may not be used to reimburse providers for the provision of Medicaid-funded services. The following information on program duplication provides more direction on how an applicant should incorporate information in their application about their understanding of program duplication risk and their plan for avoiding program duplication.

Applicants must submit the program duplication questionnaire found in Appendix F as part of their application. CMS will consider an applicant's understanding of program duplication risks as well as the thoroughness of their plan to avoid program duplication during application review. The U.S. Government Accountability Office (GAO) defines program duplication as two or more agencies or programs engaged in the same activities or providing the same services to the same beneficiaries (2017 Annual Report: Additional Opportunities to Reduce Fragmentation, Overlap, and Duplication and Achieve Other Financial Benefits, 2017).

CMMI encourages applicants to use model funding to build upon service integration advances they have already made. Applicants should assess their current goals and budget and identify gaps in funding

toward which they can apply model funds. CMS intends for Awardees to use model funding for staff time and infrastructure costs incurred due to activities that are required to design, implement and operate the model. Below we list examples for demonstration purposes only of potentially allowable expenses for model funding (assuming other federal, state, or local programs do not already fund these expenses):

- Enrollment and assessment systems development, adaption, or expansion;
- Staff training on model activities;
- Promotional material for beneficiary outreach;
- Coalition building activities between Partnership Council members;
- Population health management activities related to the Model (i.e. data analysis, strategic planning, and process improvement);
- Mobile crisis system development, adaptation, or expansion;
- Participation in CMS evaluation activities, including data collection and reporting; and
- Annual independent audit of staff time and effort accounting

Consistent with the federal government's aim to avoid program duplication, CMMI prohibits the use of InCK model funding to supplant funding for services already provided by federal, state or local agencies, programs, or models. In addition, CMS prohibits the use of InCK Model funding for any direct service provision. In their response to the Program Duplication Assessment Questionnaire, each applicant must detail how they will avoid using model funds to duplicate services already available through other programs:

- When they provide direct care coordination or case management services to the attributed population that are funded by Medicaid, Title V agencies, or other federal, state or local programs; and
- When some or all of their attributed population is also participating in a separate program, model, demonstration or alternative payment model similar to the InCK model, if applicable.

It will be the Awardee's responsibility to help prevent program duplication by ensuring that model funding is not used to supplant or duplicate current or future funding from other sources. It will be the Awardee's responsibility to report and mitigate any program duplication. CMS provides this duplication background and the assessment questionnaire only to assist applicants in understanding program duplication risks. If the applicant is unclear about whether an activity is an allowable cost under the InCK Model, consider the following questions, at a minimum:

1. Is this expense paid for by another federal, state or local program (i.e., Medicaid, Medicare, Title V block grant funds, the local health department, or another innovation model)?
2. Is the activity a service provided directly to an attributed beneficiary?
3. Will I submit a claim to Medicaid or other entity (i.e., managed care organization or Medicare) to reimburse for this expense?

If the answer is yes to these three questions, then the activity is not an allowable cost.

Hypothetical scenarios with program duplication implications are included below to provide further clarity. These hypothetical scenarios are examples only; they are not an exhaustive description of all potential areas of program duplication.

Scenario 1: **Staff Overlap and Program Duplication**

The Awardee uses Medicaid *and* model funding to pay for the salary of a SIC. The SIC provides care coordination services to Medicaid beneficiaries and develops population stratification standard operating procedures to which all SICs working within the model must abide. In this example, the Awardee must ensure the SIC is properly accounting for their time and effort for separate tasks: care coordination (direct service provision) and population stratification SOP development (model activity). The Awardee must take care to avoid using model funding for the direct service provision (provision of care coordination services) by the SIC. The Awardee may *not* use InCK funding to cover the portion of the SIC's time spent delivering direct care coordination services.

Scenario 2: **Care Coordination Systems and Program Duplication**

The Lead Organization and its Partnership Council decide to form new coordination hubs to act as the central point of communication for attributed children and their primary caregivers for the purposes of care coordination and/or case management. No other federal, state or local agency or program funds the creation of these hubs. The Awardee may use InCK funds to build the relationships between existing care coordinators and case managers of the Core Child Services, and to set up the processes and information infrastructure in the hub used to make, complete, and track referrals across the different service types. The Awardee may *not* use InCK funds to pay staff providing care coordination services to a Medicaid beneficiary through the hub.

Scenario 3: **Enrollment Systems and Program Duplication**

As part of model development, a Lead Organization develops a new streamlined enrollment and intake system. No other federal, state or local agency or program funds the creation of the system. After the new enrollment system is live, a Lead Organization staff member provides direct enrollment assistance and needs assessment services to a Medicaid beneficiary. The Awardee may use InCK funds to develop and enhance the enrollment and intake system. The Awardee may *not* use InCK funds to provide direct enrollment or evaluation services to individual beneficiaries.

A 4.3 Waivers

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). The Secretary is not issuing any waivers of federal fraud and abuse provisions in sections 1128A, 1128B, and 1877 of the Act or of any other Medicare or Medicaid laws as part of this Notice of Funding Opportunity. Waivers, if any would be set forth in separately issued documentation. Thus, notwithstanding any other provision of this Notice of Funding Opportunity, all awardees, subawardees, and all other relevant individuals or entities 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 InCK Model.

Additionally, CMS provides no opinion on the legality of any contractual or financial arrangement that the award recipients, sub-award recipients, clinicians, affiliated entities or any other relevant individuals or entities may propose, implement, or document. The receipt by CMS of any such documents in the course of the application process or otherwise shall not be construed as a waiver or modification of any applicable laws, rules or regulations, and will not preclude CMS, HHS or its Office of Inspector General, a

law enforcement agency, or any other federal or state agency from enforcing any and all applicable laws, rules and regulations.

A 5. Technical Assistance and Information for Prospective Applicants

Please refer to following website <https://innovation.cms.gov/initiatives/integrated-care-for-kids-model/> for additional information on InCK and upcoming webinars.

B. Federal Award Information

B 1. Total Funding

CMS will award up to eight cooperative agreements of up to \$16 million per award, subject to availability of funds. Funding will be awarded over a total model period of 7 years. The funding period is divided into two parts: a two year pre-implementation period spanning years 1-2 of the model (“Pre-Implementation Period”), and a five year performance period spanning years 3-7 of the model (“Performance Year”).

B 2. Award Amount

The amount available during the pre-implementation period, years 1 and 2 of the model, is up to \$3 million per awardee per year for a total amount of up to \$6 million. The amount available during the performance period, years 3-7 of the model, is up to \$2 million per awardee per year for a potential total amount of \$10 million during the performance period. Continuation of funding each year is dependent on Awardees’ completion of certain milestones related to program operations (“Operational Milestones”) during each previous award year and subject to the availability of funds. During years 5-7 of the model funding period, \$500,000 of the \$2 million available each year will be contingent upon the Awardee’s ability to meet specific Performance Milestones (\$100,000 per Milestone for up to 5 milestones). For additional details on Performance Milestones and their link to funding see Section F 5.1.1.

B 3. Anticipated Award Dates

January 1, 2020

B 4. Period of Performance

Period	Amount	Amount
Pre-Implementation	Operational Milestones	Performance Milestones (0 measures)
Year 1	\$3 million	Not applicable
Year 2	\$3 million	Not eligible
Total pre-implementation	\$6 million	\$0
Performance	Operational Milestones	Performance Milestones (5 milestones \$100,000) Funding is restricted pending satisfactory performance on milestones
Year 1	\$2 million	Not eligible

Period	Amount	Amount
Year 2	\$2 million	Not eligible
Year 3	\$1.5 million	Max \$500,000
Year 4	\$1.5 million	Max \$500,000
Year 5	\$1.5 million	Max \$500,000
Total performance	\$8.5 million	Max: \$1.5 million
TOTAL MODEL AWARD	\$14.5 million	Eligible for max of \$1.5 million

B5. Number of Awards

Maximum number of awards: 8

B6. Type of Award

Cooperative Agreement

B7. Type of Competition

These awards will be structured as Cooperative Agreements. The Federal Grant and Cooperative Agreement Act of 1977, 31 U.S.C. 6301, defines the cooperative agreement as an alternative assistance instrument to be used in lieu of a grant whenever substantial federal involvement with the recipient during performance is anticipated. The difference between grants and cooperative agreements is the degree of federal programmatic involvement rather than the type of administrative requirements imposed. Therefore, statutes, regulations, policies, and the information contained in the HHS Grants Policy Statement that are applicable to grants also apply to cooperative agreements, unless the award itself provides otherwise.

C. Eligibility Information

C1. Eligible Applicants (select all that apply)

- City or township governments
- County governments
- Faith-based organizations
- For profit organizations other than small businesses
- Foreign and international organizations
- Independent school districts
- Individuals
- Native American tribal organizations (other than federally recognized tribal governments)
- Nonprofits having a 501(c)(3) status with the IRS, other than institutions of higher education
- Private institutions of higher education
- Public and State controlled institutions of higher education

- Public housing authorities/Indian housing authorities
- Small businesses
- Special district governments
- State governments
- Unrestricted
- Other

C2. Letter of Intent

- Mandatory
- Optional
- N/A

Applicants are highly encouraged (but not required) to submit a non-binding Letter of Intent (LOI) to apply by 3/11/19. Information from the LOI assists CMS with planning for the application review process. To submit your InCK LOI, please use the online LOI submission form located at: grants.gov.

C3. Ineligibility Criteria

CMS reserves the right to disqualify an applicant based on the following criteria:

- **Incomplete application**, including:
 - Omission of a Memorandum of Understanding signed by the state Medicaid agency and Lead Organization;
 - Omission of a Partnership Council Charter;
 - Omission of a Project Narrative (inclusive of Model Implementation Plan and Model Impact Analysis);
 - Omission of a Budget Narrative;
 - Omission of a completed Program Duplication Questionnaire; or
 - Failure to specify geographic target area, attributed population or comparison target area.
- **Insufficient supporting detail** provided in the application; CMS will give less consideration toward applications that merely restate the text within the NOFO. Applicants should detail their approach to achieving program goals and milestones. Reviewers will note evidence of how effectively the applicant includes these elements in their application.
- **Program integrity concerns.** CMS may deny selection to an otherwise qualified applicant on the basis of information found during a program integrity review regarding the Lead Organization, its community partners or any other relevant individuals or entities.
- **Disregard of maximum page limits** stipulated in the notice of funding opportunity.
- **Late submission** of an application (See Section D4).

- **Overlap with another model**, demonstration or program, including a CMMI model, which may result in duplicate payments for similar services or other waste of federal funds. A program overlap may include as overlap in service area, participating organizations or providers, or beneficiaries. A Lead Organization may not apply to the InCK Model and also participate in a Maternal Opioid Misuse (MOM) model application as a Care-Delivery Partner. A Lead Organization applicant may participate in a MOM model application as a Care-Delivery Partner if the Lead Organization’s state partner is the InCK Model applicant. In addition, a Lead Organization that applies to the InCK model but is not selected for participation may be eligible to participate in a MOM application as a Care-Delivery Partner.
- **Inability or unwillingness to collect and share monitoring and evaluation data** with CMS or its contractors. ‘Inability’ to collect and share data does not include where collection or sharing of data is prohibited by law.
- **Insufficient detail in proposal for utilization of Medicaid and CHIP authorities.** Applicants must describe how they intend to use Medicaid and CHIP authorities to implement the InCK model. CMS expects these proposals will require additional refinement and discussion with CMCS during the model pre-implementation period. CMS may deny the selection to an otherwise qualified applicant due to insufficient detail in submitted proposals.

C4. Single Application Requirement

CMS intends to award one cooperative agreement per state. A State Medicaid agency, or its partner Lead Organization, may submit multiple applications to participate in the model, as long as each application is sufficiently different. For example, 1) the Lead Organization must be different on each application, and 2) the model service areas must also be different.

C5. Continued Eligibility Requirements

Award recipients must meet reporting and certification deadlines (as outlined in Section F) to be eligible throughout the initial 12-month budget period and to remain eligible for a non-competing continuation award for subsequent budget periods in multi-year projects. In addition, grantees would need to demonstrate strong performance by meeting model Operational Milestones and Performance Measure Milestones during the previous funding cycle(s) before additional yearly funding is awarded; or, to ensure continued access to funding. At any time in the award cycle, grantees could receive decreased funding or their grant could be terminated if grantees fail to perform the requirements of the award.

C6. EIN, DUNS, and SAM Regulations

In order to apply, applicants must provide a valid Employer Identification Number (EIN), otherwise known as a Taxpayer Identification Number (TIN); a Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number; and be registered in the System for Award Management (SAM) database (<https://www.sam.gov/portal/public/SAM/>) to be able to submit an application at grants.gov. See [Appendix B](#) for descriptions of EIN, DUNS, and SAM.

C7. Foreign and International Organizations

C8. Faith-Based Organizations

C9. Other Eligibility Requirements

D. Application and Submission Information

D1. Address to Request Application Package

Application materials will be available at <http://www.grants.gov>. Please note that CMS requires applications for all announcements to be submitted electronically through the Grants.gov website. Applicants will be able to download a copy of the application packet, complete it off- line, and then upload and submit the application via the Grants.gov website. **Refer to Appendix B. Application and Submission Information, for additional details.**

For assistance with Grants.gov, contact Support@Grants.gov or call (800) 518-4726. **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.

D2. Content and Format of Application Submission

a. Application format

Please note that applications that fail to follow the strict formatting requirements outlined below regarding formatting, font size, and page limitations will be deemed ineligible and their applications will not be considered for review.

Please note that some items must be double-spaced and other items may be single-spaced. Proposals that do not adhere to this strict page limitation will not be reviewed and will be rejected.

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

Each application must include all contents of the application package, in the order indicated, and conform to the following formatting specifications:

- The following page size must be used: 8.5" x 11" letter-size pages (one side only) with 1" margins (top, bottom, and sides). Other paper sizes will not be accepted. This is particularly important because it is often not possible to reproduce copies in a size other than 8.5" x 11".
- All pages of the project and budget narratives and implementation plan must be paginated in a single sequence.

- Font size must be at least 12-point with an average of 14 characters per inch (CPI).
- The Project Narrative must be double-spaced and includes the Implementation Plan (see A 4.2.1 to A 4.2.1.3) and Model Impact Analysis (see A 4.2.2 to 4.2.2.2). The page limit for the Project Narrative is 55 pages. The Memorandum of Understanding, Partnership Council Charter, and Program Duplication Questionnaire should be submitted separately. The page limits for those documents are outlined below.
- The Budget Narrative may be single-spaced. The page limit for this document is 10 pages.
- The Business Assessment of Applicant Organization may be single spaced. The page limit for this document is 10 pages.
- Tables included within any portion of the application must have a font size of at least 12-point with a 14 CPI and may be single spaced. Tables are counted towards the applicable page limits.
- The project abstract is restricted to a one-page summary which may be single-spaced.
- The following required application documents are excluded from the page limitations described above: Standard Forms, Copy of Letter of intent (if applicable), Application Cover Letter/Cover Page (if applicable), Project Site Location Form and Indirect Cost Rate Agreement. See text box below for other exclusions.
- The Memorandum of Understanding is a standalone document and may be single-spaced. The page limit is 10 pages.
- The Partnership Council Charter is a standalone document and may be single-spaced. The page limit is 5 pages.
- The Program Duplication Questionnaire is a standalone document and may be single-spaced. The page limit is 5 pages.
- The total number of appendices per application may be no more than 5, to include the Memorandum of Understanding, Partnership Council Charter, Program Duplication Questionnaire; the page limits for each of the appendices are stated above. Other optional standalone appendices (2 max), if submitted, may be single-spaced and each page limit is 2 pages.

504 Compliance - Recipients of federal financial assistance (FFA) from Health and Human Services (HHS) must administer their programs in compliance with federal civil rights laws. This means that recipients of HHS funds must ensure equal access to their programs without regard to a person's race, color, national origin, disability, age and, in some circumstances, sex and religion. It is HHS' duty to ensure access to quality, culturally competent care, including long-term services and supports, for vulnerable populations.

HHS provides guidance to recipients of FFA on meeting their legal obligation to take reasonable steps to provide meaningful access to their programs by persons with limited English proficiency. In addition, recipients of FFA have specific legal obligations for serving qualified individuals with disabilities by providing information in alternate formats.

Several sources of guidance provided below:

- <http://www.hhs.gov/civil-rights/index.html>
- <http://www.hhs.gov/ocr/civilrights/resources/laws/summaryguidance.html>

- <https://www.minorityhealth.hhs.gov/>
- <http://www.hhs.gov/ocr/civilrights/understanding/section1557/index.html>
- [HHSAR 352.270-1](https://www.hhs.gov/ocr/civilrights/understanding/disability/index.html)
- <http://www.hhs.gov/ocr/civilrights/understanding/disability/index.html>

Please contact the HHS Office for Civil Rights for more information about obligations and prohibitions under federal civil rights laws at <https://www.hhs.gov/ocr/about-us/contact-us/index.html> or call 1-800-368-1019 or TDD 1-800-537-7697.

b. Standard forms

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

- **Project Abstract Summary**
A one-page abstract should serve as a succinct description of the proposed project and must include the goals of the project, the total budget, and a description of how the funds will be used. The abstract is often distributed to provide information to the public and Congress, so please write the abstract so that it is clear, accurate, concise, and without reference to other parts of the application. Personal identifying information should be excluded from the abstract. In the Grants Application Package that can be found at www.grants.gov, select the Project Abstract Summary and complete the form.
- **SF-424: Official Application for Federal Assistance**
Note: On SF 424 “Application for Federal Assistance”:
 - On Item 15 “Descriptive Title of Applicant’s Project,” state the specific cooperative agreement opportunity for which you are applying: Integrated Care for Kids (InCK).
 - Check “No” to item 19c, as Review by State Executive Order 12372 does not apply to this cooperative agreement funding opportunity.
 - SF-424A: Budget Information Non-Construction.
 - SF-424B: Assurances-Non-Construction Programs.
 - SF-LLL: Disclosure of Lobbying Activities.

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

- **Project Site Location Form(s)**

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

c. Application cover letter (maximum 1 Page)

Optional, limit to 1 page.

d. Project narrative (maximum 55 pages)

The applicant must provide a Project Narrative that articulates in detail the proposed goals, measurable objectives, and milestones to be completed in accordance with the instructions and content requirements provided in sections [A 4.2.1 Model Implementation Plan](#) (see A 4.2.1 to A 4.2.2.2) and [A 4.2.2 Model Impact Analysis \(see A 4.2.2.1 to A 4.2.2.2\)](#). Specific scoring criteria is described in [E1. Application Review Criteria](#). Please include the title “Project Narrative” at the beginning of the Project Narrative. The Memorandum of Understanding, Partnership Council Charter, and Program Duplication Questionnaire are separate, stand-alone documents which are outlined below.

Budget narrative

- Applicants must supplement Form SF-424A with a Budget Narrative. The Budget Narrative must include a yearly breakdown of costs according to a 12-month period. See Section B. Federal Award Information for more information on the performance period. Applicants must include a clear description of the proposed set of expenses that will be covered with grant funds. The Budget Narrative should provide a detailed cost breakdown for each line item outlined in the SF-424A by grant year, including a breakdown of costs for each activity/cost within the line item. The proportion of the requested funding designated for each activity should be clearly defined and should justify the applicant’s readiness to receive funding. In addition, each applicant must describe the nature of the financial relationships that it foresees using in an effort to achieve the goals of the InCK model (e.g., financial relationships involving the state Medicaid agency, Lead Organization, Partnership Council(s), SICs, core child service providers, and others). The budget must separate out funding that will be administered directly by the Awardee from funding that will be subcontracted to other partners. Though the Lead Organization and state Medicaid Agency must partner together to submit an application and implement this award, only one entity will be the Awardee. For more information on subrecipient and contractual relationships, please refer to HHS regulation 45 CFR 75.351 *Subrecipient and Contractor Determinations* and 75.352 *Requirements for pass-through entities*.

For more specific information and instructions for completing the SF-424A and Budget Narrative, please refer to [Appendix A. Guidance for Preparing a Budget Request and Narrative](#).

Please also refer to [E1. Application Review Criteria](#) which expands upon how the budget narrative will be evaluated.

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

An applicant must review, answer, and submit the business assessment questions outlined in [Appendix D, Business Assessment of Applicant Organization](#).

f. Memorandum of Understanding (maximum 10 pages)

Applicants must provide a signed Memorandum of Understanding (MOU) between the Lead Organization and the state Medicaid agency that demonstrates evidence of a strong relationship and joint commitment to InCK Model implementation. For additional details, see section [A 4.2.1.1.3 Memorandum of Understanding](#). Specific scoring criteria is described in [E1. Application Review Criteria](#).

g. Partnership Council Charter (maximum 5 pages)

As evidence of local engagement and commitment, applicants must submit a separate Partnership Council Charter signed by each participating member of the Council. The applicant's Partnership Council Charter should include a description of the formation of the Charter, the Council's focus and direction, and the core principles for working together. For additional details, see [A 4.2.1.1.4 Partnership Council Convening](#) and specific language on the charter at the [end of the section](#). Specific scoring criteria is described in [E1. Application Review Criteria](#).

h. Program Duplication Questionnaire (maximum 5 pages)

Applicants should provide an explanation of how they would use InCK funds to provide new and distinct intensive care coordination support to the attributed population in the target area. The explanation should identify how the applicant would build upon current programs and initiatives, if applicable, while avoiding duplication with Medicaid, Title V, and any other federal, state, or local funding used for care coordination expenses for or related to the attributed population. For more details on this section, see [A 4.2.3 Program Duplication Questionnaire](#). Specific scoring criteria is described in [E1. Application Review Criteria](#).

D3. Unique Entity Identifier and System for Award Management (SAM)

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

- i. Be registered in SAM before submitting its application;
- ii. Provide a valid unique entity identifier in its application; and
- iii. Continue to maintain an active SAM registration with current information at all times during which it has an active Federal award or an application or plan under consideration by a Federal awarding agency.

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

D4. Submission Dates and Times

All applications must be submitted electronically and be received through <http://grants.gov> by the date and time set forth below. Applications submitted after 3:00 pm, Eastern Time, of the date set forth below will not be reviewed or considered for award.

[Click here to enter date.](#)

3:00 PM Eastern U.S. Time

Late applications: Any application that is received after the due date and time shall be deemed a “late application” and shall not be reviewed.

D5. Intergovernmental Review

Applications for these awards are not subject to review by states under Executive Order 12372, “Intergovernmental Review of Federal Programs” (45 CFR 100). Please check box “C” on item 19 of the SF 424 (Application for Federal Assistance) as Review by State Executive Order 12372, does not apply to cooperative agreements under the InCK Model.

D6. Cost Restrictions

Indirect Costs

If applicant is requesting indirect costs, they are required to use a current negotiated indirect cost rate. Any non-Federal entity that has never received a negotiated indirect cost rate, except for those non-Federal entities described in Appendix VII to Part 75 – States, Local and Indian Tribe Indirect Cost Proposals may elect to charge a de minimus rate of 10% of the modified total direct cost (MTDC) which may be used indefinitely. There is no universal rule for classifying certain costs as either direct or indirect (also known as Facilities & Administration (F&A) costs) under every accounting system. A cost may be direct with respect to some specific service or function, but indirect with respect to the Federal award or other final cost objective. Therefore, it is essential that each item of cost incurred for the same purpose be treated consistently in like circumstances either as a direct or F&A cost in order to avoid double-charging of Federal awards. Guidelines for determining direct and F&A costs charged to Federal awards are provided in 45 CFR §§75.412 to 75.419. Requirements for development and submission of indirect (F &A) cost rate proposals and cost allocation plans are contained in Appendices III-VII and Appendix IX to Part 75.

Complete details and guidance on cost allocation is in accordance with 45 CFR §75.416.

Prohibited Uses of Award Funds

- No funds under this award may be used for any of the activities/costs outlined below unless an exception is specifically authorized by statute.
- To match any other Federal funds.
- To provide services, equipment, or supports that are the legal responsibility of another party under Federal, State, or Tribal law (e.g., vocational rehabilitation or education services) or under any civil rights laws. Such legal responsibilities include, but are not limited to, modifications of a

workplace or other reasonable accommodations that are a specific obligation of the employer or other party.

- To provide goods or services not allocable to the approved project.
- To supplant existing State, local, Tribal or private funding of infrastructure or services, such as staff salaries, etc.
- To be used by local entities to satisfy state matching requirements.
- To pay for construction.
- To pay for capital expenditures for improvements to land, buildings, or equipment which materially increase their value or useful life as a direct cost, except with the prior written approval of the Federal awarding agency.
- To pay for the cost of independent research and development, including their proportionate share of indirect costs (unallowable in accordance with 45 CFR 75.476).
- To use as profit to any award recipient even if the award recipient is a commercial organization, (unallowable in accordance with 45 CFR 75.216(b)), except for grants awarded under the Small Business Innovative Research (SBIR) and Small Business Technology Transfer Research (STTR) programs (15 U.S.C. 638). Profit is any amount in excess of allowable direct and indirect costs.
- To expend funds related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order proposed or pending before the Congress or any state government, state legislature or local legislature or legislative body.

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

- Yes
 No

D7. Mandatory Disclosure

Submission is required for all applicants, in writing, to the awarding agency and to the HHS Office of Inspector General (OIG), all information related to violations of federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the federal award. Disclosures must be sent in writing to:

U.S. Department of Health and Human Services
Centers for Medicare and Medicaid Services
Office of Acquisition and Grants Management
Attn: Director, Division of Grants Management
7500 Security Blvd, Mail Stop B3-30-03
Baltimore, MD 21244-1850

AND

U.S. Department of Health and Human Services
Office of Inspector General
ATTN: Mandatory Grant Disclosures, Intake Coordinator
330 Independence Avenue, SW, Cohen Building
Room 5527
Washington, DC 20201

URL: <https://oig.hhs.gov/fraud/report-fraud/index.asp>

(Include "Mandatory Grant Disclosures" in subject line)

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

Email: MandatoryGranteeDisclosures@oig.hhs.gov

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

D8. Other Submission Requirements (if applicable)

N/A

E. Application Review Information (please refer to Appendix E for specific information about the Review and Selection process)

E1. Application Review Criteria

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

MODEL IMPLEMENTATION PLAN 60 points

A. STATE AND LOCAL COMMUNITY ENGAGEMENT (20 POINTS)

Organizational capacity

Applicants should tell us their experience working with the state and target community, and what steps they have taken thus far to engage the state and target community in meaningful discussions about improving care service delivery for children in the target community, especially those with complex medical and social needs. Successful applicants must demonstrate that the Lead Organization and state Medicaid agency have the organizational capacity to be a champion of the model through 1) an existing, strong relationship between both partners and 2) significant Lead Organization experience in community leadership and

engagement, including coalition building; coordinating health and related social services; and data sharing between core child service providers.

Memorandum of Understanding

As evidence of a strong relationship between the state Medicaid agency and the Lead Organization and their joint commitment to InCK Model implementation, applicants must provide a Memorandum of Understanding (MOU) between the Lead Organization and the state Medicaid agency, signed by relevant leadership in both organizations. The MOU should establish the roles of the Lead Organization and the state Medicaid agency, and describe in detail how the entities will work together throughout the life of the cooperative agreement to successfully implement the model. The MOU should also include a statement of understanding regarding the model's data submission requirements, including:

- 1) acknowledgement of the obligation of both the state Medicaid agency and Lead Organization to share data with CMS as outlined in Section F5 of the NOFO;
- 2) identifiers for attributed population and comparison group; and
- 3) any barriers to getting CMMI monitoring and evaluation data. The statement should describe any restrictions on sharing PHI and PII, including state laws or IRB approval processes, and an explanation of whether those barriers would prevent them from fully participating in model evaluation activities.

Partnership Council

Applicants must establish a Partnership Council that includes at least one organization representing each required Core Child Service, the state Medicaid and Title V agencies, and representatives of the families and children served for the target community. The Partnership Council must be a central player in the planning and implementation of model-related improvements to the system of care and service delivery.

As evidence of local engagement and commitment, applicants must submit a separate Partnership Council Charter signed by each participating member of the Council. The applicant's Partnership Council Charter should include a description of the formation of the Charter, the Council's focus and direction, and the core principles for working together. The Partnership Council Charter should include a description of each member's background and experience in integrating care for pediatric Medicaid beneficiaries, and detail their responsibility for care coordination under the model within the target community. The Charter should demonstrate each Council member's commitment to participating in the service integration plan for the life of the model and their preparedness to improve the experience of children served.

B. SERVICE INTEGRATION PLAN (25 POINTS)

Care Map

In their Service Integration Plan, applicants should provide an overview of the current health status of the attributed population and detail how and when they intend to improve the system of care for pediatric Medicaid beneficiaries in their target community(ies), especially those who

have complex health and social needs. Specifically, applicants should provide current and future state “care maps” that illustrate how the Lead Organization, state Medicaid agency and Council will leverage model funding to build on existing programs and infrastructure and mitigate current hurdles to integrated home and community based services for the attributed population, especially the portion of the population at risk for out of home placement and inpatient admissions.

Stratification Plan

Providers participating in the model would assess attributed children’s needs according to the service integration level criteria listed in Section A 4.2.1.2 and stratify those served into SILs for the purposes of care coordination and case management. In their plan, applicants should provide a population-wide service integration level stratification process that identifies which needs would be elevated for Level II and III intensive integrated coordination. The application should describe the role of the Service Integration Coordinator and detail how many SICs would be needed, as well as their specific responsibilities to achieve the goal of one point of contact per attributed child’s primary caregivers. In addition, applicants should also describe their plan for collecting, aggregating, and reporting to CMS on outcomes and quality measures for the attributed population by the benchmarks provided in the NOFO. Preference will be given to applicants using two-generational approaches to assessing and stratifying young children.

Information Sharing Infrastructure

Lead Organizations will oversee the development and implementation of information technology and processes for screening, care coordination and care management practices. Applicants should detail the process they plan to implement for information sharing across providers and sectors. Specifically, applicants should explain how members of the Council, along with other community partners and families, would share information through a safe and expedient system that will allow for intensive care coordination and an improved care experience for the attributed population. Applicants should also describe in detail their plan for use of a coordinated eligibility and enrollment system. Applicants should include how their strategies would achieve a streamlined experience for families while complying with all applicable privacy laws and regulations, constraints of information exchange systems, and coordination on the part of providers and other staff of the involved programs.

C. MEDICAID AND CHIP AUTHORITIES AND PAYMENT MODEL PROPOSAL (15 POINTS)

Applicants should provide a proposal detailing the Medicaid and CHIP authorities they would use to operate the model and describe how they would implement an Alternative Payment Model (APM) to make their system changes sustainable so that they continue once the model period is complete. Specifically, applicants should provide a thorough description of the services to be provided, the Medicaid and CHIP authorities they plan to use to deliver those services and rationale for the APM that will be used including the type, structure, scale and scope, including a description of the payer, providers and services that would be included in the APM. Applicants should also provide a description of the role of managed care organizations in the APM. Finally,

applicants should explain how the APM would include coverage for integrated care coordination and case management under Levels II and III and describe how they would measure the quality of a beneficiary's care experience in the APM. Applicants should also describe any other funding mechanisms available to support sustained care innovation within their community.

MODEL IMPACT ANALYSIS 30 points

A. ROOT CAUSE ANALYSIS (15 POINTS)

In their population scan and root cause analysis, applicants should provide background population level demographic information of the target community and identify the root causes for the attributed population of out of home placements and prolonged or multiple inpatient admissions as a result of chronic or medically complex conditions. Specifically, applicants should clearly identify the target population and comparison group, and provide details on the prevalence of conditions correlated with out of home placement, inpatient admissions and emergency department visits, including substance use disorder and behavioral health conditions. Applicants should explain current barriers to accessing integrated home and community-based services (HCBS), identify the root causes of access challenges, and explain the relationship between challenges to HCBS access and inpatient admissions, out of home placement and emergency room visits for the attributed population.

B. HEALTH OUTCOMES AND COST SAVINGS PROJECTION (15 POINTS)

In their health outcomes and cost savings projection, applicants should provide detail on how their model would impact the health care outcomes of the attributed population and how it would impact Medicaid spending for the attributed population. Specifically, applicants should explain how their model would mitigate population health challenges identified in their root cause analysis. For example, if applicants aim to decrease the incidence of opioid addiction in older children, or decrease the rate of out of home placement for children of parents with substance use disorder, they should detail that goal and strategy in their analysis. Applicants should also provide the financial models explaining the logic driving the forecasted impact on spending including the baseline total and per member per month (PMPM) Medicaid and CHIP spending as well as the estimated total and PMPM Medicaid and CHIP spending as assumed **with** and **without** the InCK model intervention.

Model Budget Narrative and Program Duplication Questionnaire

20 points

A. BUDGET NARRATIVE (15 POINTS)

Applicants should provide a reasonable justification and rationale for the proposed model budget for the pre-implementation and implementation period. Specifically, applicants should provide a budget with sufficient detail that would allow CMS to understand how the applicants would meet their objectives given their budget and to assess the reasonableness of the proposed budget. Applicants should clearly identify apportionment of funds between the state Medicaid agency and Lead organization and provide line items for all activities related to model implementation. Finally, applicants should identify what current or potential future funding streams pay could apply to these activities, and identify gaps toward which they could apply model funding.

B. PROGRAM DUPLICATION QUESTIONNAIRE (5 POINTS)

Applicants should provide an explanation of how they would use InCK funds to provide new and distinct intensive care coordination support to the attributed population in the target area. The explanation should identify how they would build upon current programs and initiatives, if applicable, while avoiding duplication with Medicaid, Title V, and any other federal, state, or local funding used for care coordination expenses for or related to the attributed population. In addition, applicants should describe their strategy for avoiding program duplication if they are simultaneously participating in a similar program serving Medicaid pediatric beneficiaries in the target or comparison group area, including a medical home or care management demonstration.

E2. Review and Selection Process (select one)

- Anticipated Federal Review
- Anticipated Mix of Federal and Non-Federal Review

E3. Federal Awardee Performance Integrity Information System (FAPIS)

- i. CMS, prior to making a Federal award with a total amount of Federal share greater than the simplified acquisition threshold, is required to review and consider any information about the applicant that is in the designated integrity and performance system accessible through SAM (currently FAPIS) (see 41 U.S.C. 2313);
- ii. An applicant, at its option, may review information in the designated integrity and performance systems accessible through SAM and comment on any information about itself that the HHS awarding agency previously entered and is currently in the designated integrity and performance system accessible through SAM.
- iii. CMS will consider any comments by the applicant, in addition to the other information in the designated integrity and performance system, in making a judgment about the applicant's integrity, business ethics, and record of performance under Federal awards when completing the review of risk posed by Applicant as described in §75.205.

F. Federal Award Administration Information

F1. Federal Award Notices

CMS may redistribute cooperative agreement funds based upon the number and quality of applications received for each cooperative agreement opportunity. CMS will not fund activities that are duplicative of efforts funded through its grant programs or other federal resources.

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

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

F2. Administrative and National Policy Requirements

A. National/Public Policy Requirements

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

Non-Discrimination

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

- a. Title VI of the Civil Rights Act of 1964,
- b. Section 504 of the Rehabilitation Act of 1973,
- c. The Age Discrimination Act of 1975, and
- d. Title II, Subtitle A of the Americans with Disabilities Act of 1990.

Accessibility Provisions

Award recipients, as recipients of federal financial assistance (FFA) from Health and Human Services (HHS), must administer their programs in compliance with federal civil rights laws. This means that award recipients must ensure equal access to their programs without regard to a person's race, color, national origin, disability, age and, in some circumstances, sex and religion. It is HHS' duty to ensure access to quality, culturally competent care, including long-term services and supports, for vulnerable populations.

HHS provides guidance to award recipients on meeting their legal obligation to take reasonable steps to provide meaningful access to their programs by persons with limited English proficiency. In addition,

award recipients will have specific legal obligations for serving qualified individuals with disabilities by providing information in alternate formats.

Several sources of guidance are provided below:

1. <http://www.hhs.gov/civil-rights/for-providers/index.html>
2. <http://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/index.html>
3. <http://www.hhs.gov/ocr/civilrights/understanding/section1557/index.html>
4. [HHSAR 352.270-1](#)
5. <http://www.hhs.gov/ocr/civilrights/understanding/disability/index.html>

Award recipients will be required to review and comply with the Accessibility Requirements outlined in Appendix J to this NOFO.

Please contact the HHS Office for Civil Rights for more information about obligations and prohibitions under federal civil rights laws at <https://www.hhs.gov/ocr/about-us/contact-us/index.html> or call 1-800-368-1019 or TDD 1-800-537-7697.

B. Administrative Requirements

- All equipment, staff, and other budgeted resources and expenses must be used exclusively for the projects identified in the Applicant's original grant application or agreed upon subsequently with HHS, and may not be used for any prohibited uses.
- Consumers and other stakeholders must have meaningful input into the planning, implementation, and evaluation of the project.
- This award is subject to 45 CFR Part 75, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS awards [available at <http://www.ecfr.gov/cgi-bin/text-idx?node=pt45.1.75>], which implements 2 CFR Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards ("Uniform Guidance") effective December 26, 2014. See below for more information.

Uniform Administrative Requirements, Cost Principles, and Audit Requirements

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

Uniform Administrative Requirements

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

In accordance with 45 CFR §75.113, Mandatory Disclosures, the non-Federal entity or applicant for a Federal award must disclose, in a timely manner, in writing to the HHS awarding agency or pass-through entity all violations of Federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the Federal award. Non-Federal entities that have received a Federal award including the term and condition outlined in Appendix XII to 45 CFR Part 75 are required to report certain civil, criminal, or administrative proceedings to SAM. Failure to make the required disclosures can result in the imposition

of any of the remedies described in §75.371, including suspension or debarment. (See also 2 CFR Parts 180 and 376, and 31 U.S.C. 3321). For specific information on reporting such disclosures to CMS and HHS please see Section [F3. Terms and Conditions](#) of this NOFO.

Cost Principles

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

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

Indirect Costs

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

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

Commercial (For-Profit) Organizations: Indirect Costs are allowable under awards to for-profit organizations. The for-profit recipient must have a federally-approved indirect cost rate agreement covering the grant supported activities and period of performance. Indirect cost rates for for-profit entities are negotiated by DFAS in the Office of Acquisition Management and Policy, National Institutes of Health (if the preponderance of their federal awards are from HHS), available at <http://oamp.od.nih.gov/dfas/indirect-cost-branch>, or other federal agency with cognizance for indirect cost rate negotiation. If there is no federally-approved indirect cost rate for the specific period of

performance and the for-profit recipient has never received an indirect cost rate, then the non-federal entity may elect to charge a de minimis rate of 10% of MTDC.

Cost Allocation

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

Public Assistance Cost Allocation Plans

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

Audit Requirements

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

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

F3. Terms and Conditions

This announcement is subject to the Department of Health and Human Services Grants Policy Statement (HHS GPS) at <http://www.hhs.gov/sites/default/files/grants/grants/policies-regulations/hhsgps107.pdf>. The general terms and conditions in the HHS GPS will apply as indicated unless there are statutory, regulatory, or award-specific requirements to the contrary. Standard and program specific terms of award will accompany the NoA. Potential applicants should be aware that special requirements could apply to cooperative agreement awards based on the particular circumstances of the effort to be supported and/or deficiencies identified in the application by the HHS review panel. The recently released HHS regulation (45 CFR Part 75) supersedes information on administrative requirements, cost principles, and audit requirements for grants and cooperative agreements included in the current HHS Grants Policy Statement where differences are identified. Awardees must also agree to respond to requests that are necessary for the evaluation of national efforts and provide data on key elements of their own cooperative agreement activities.

CMS may impose additional conditions, as described in 45 CFR § 75.207, on any awardee that fails to comply with Federal statutes, regulations, or the terms and conditions of a Federal award. In addition, CMS may take one or more of the actions set forth at § 75.371, as appropriate in the circumstances, in the event that CMS determines that noncompliance cannot be remedied by imposing additional conditions.

The award may be terminated in whole or in part as set forth in 45 CFR § 75.372. As explained therein, CMS may terminate the award for an awardee's noncompliance with the terms and conditions of the award. In the event a Recipient or one of its subrecipients enters into proceedings relating to bankruptcy, whether voluntary or involuntary, the Recipient agrees to provide written notice of the bankruptcy to CMS. This written notice shall be furnished within five (5) days of the initiation of the proceedings relating to bankruptcy filing and sent to the CMS Grants Management Specialist and Project Officer. This notice shall include the date on which the bankruptcy petition was filed, the identity of the court in which the bankruptcy petition was filed, a copy of any and all of the legal pleadings, and a listing of Government grant and cooperative agreement numbers and grant offices for all Government grants and cooperative agreements against which final payment has not been made.

Intellectual Property

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

The Federal Government has the right to:

- (1) Obtain, reproduce, publish, or otherwise use the data produced under a Federal award; and
- (2) Authorize others to receive, reproduce, publish, or otherwise use such data for Federal purposes.

F4. Cooperative Agreement Terms and Conditions of Award

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

Cooperative Agreement Roles and Responsibilities are as follows:

Centers for Medicare & Medicaid Services

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

- Technical Assistance – CMS will host opportunities for training and/or networking, including conference calls and other vehicles.
- Collaboration – To facilitate compliance with the terms of the Cooperative Agreement and to support recipients more effectively, CMS will actively coordinate with other relevant Federal Agencies including but not limited to the Indian Health Service, the Internal Revenue Service, the Department of Homeland Security, the Administration for Children and Families, and the Social Security Administration.
- Program Evaluation – CMS will work with award recipients to implement lessons learned.
- Project Officers and Monitoring – CMS will assign specific Project Officers to each Cooperative Agreement award to support and monitor recipients throughout the period of performance. CMS Grants Management Officers, Grants Management Specialists, and Project Officers will monitor, on a regular basis, progress of each recipient. This monitoring may be by phone, document review, on-site visit, other meeting and by other appropriate means, such as reviewing program progress reports and Federal Financial Reports (FFR or SF-425). This monitoring will be to determine compliance with program and financial requirements under the model.

Recipients

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

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

F5. Reporting

All Awardees are required to submit the following:

a. Financial Reports

Quarterly Cash Transaction Financial Reporting

Recipient must report, on a quarterly basis, cash transaction data via the Payment Management System (PMS) using the Federal Financial Report (SF-425 or FFR) form. The FFR combines the information that grant recipients previously provided using two forms: the Federal Cash Transactions Report (PSC-272) and the Financial Status Report (SF-269). Cash transactions data is reflected through completion of lines 10a-10c on the FFR. Recipient must include information on indirect costs if approved as part of grant award. The quarterly FFR is due within (30) days after the end of each quarter.

Semi-Annual, Annual, and Final Expenditure Reporting

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

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

b. Federal Funding Accountability and Transparency Act Reporting Requirements

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

c. Audit Requirements

Grantees must comply with audit requirements outlined in HHS regulation 45 CFR Part 75 (implementing 2 CFR Part 200). See Subpart F – Audit Requirements. <http://www.ecfr.gov/cgi-bin/text-idx?node=pt45.1.75#sp45.1.75.f>.

d. Payment Management System Reporting Requirements

Once an award is made, the funds are posted in recipient accounts established in the Payment Management System (PMS). Grantees may then access their funds by using the PMS funds request process. Recipients must submit a quarterly SF-425 via PMS. The report identifies cash transactions against the authorized funds for the award. Failure to submit the report may result in the ability to access funds.

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

In addition to the reporting requirements listed above, Awardees will be required to cooperate with CMS monitoring, evaluation, and learning system efforts. Data from Awardees is central to the model’s quality strategy, necessary to support program monitoring and quality improvement, and critical in the development of a thorough and robust CMS-led model evaluation. To these ends, CMS requires the provision of model monitoring and evaluation data for all Awardees’ attributed population as well as any state-held data for the participant’s identified comparison group. CMS will provide Awardees guidance on the format and process for data submission and Awardees will be required to submit data to submit

data to CMS in accordance with that guidance.

CMS requires each Awardee to fully cooperate with the model's evaluation and implementation contractors, each of which may require different data submissions. CMS will assign a project officer to each Awardee, who will serve as liaison to evaluation and implementation contractor staff. In addition, the project officer will monitor Awardee activities and provide technical consultation regarding program procedures.

F 5.1. Monitoring

Awardees will be required to fully comply with CMS's and any CMS contractor's efforts to monitor the InCK Model. A central goal of program monitoring is to ensure that Awardees adhere to the award Terms and Conditions. CMS will primarily monitor awards through data collection and reporting to CMMI and the Office of Acquisitions and Grants Management (OAGM). CMS' goal is to monitor and measure model activities in a manner that optimizes its usefulness for both Awardees and CMMI. CMMI will closely track model progress through project officers and an implementation contractor. A key monitoring activity is the provision of feedback to Awardees that ensures model implementation occurs in compliance with the Terms and Conditions of the cooperative agreement (e.g., that Awardees' interventions are implemented with fidelity to model instructions), per 45 CFR §75.371-373 Remedies for noncompliance. A timeline of reporting tasks can be found in the Gantt chart in Appendix G.

CMMI's monitoring priorities include but are not limited to:

- Awardee provision of key service integration requirements, such as population stratification;
- Awardee successful development and implementation of at least one APM; and
- Awardee establishment and effective implementation of the Partnership Council.

Awardees will participate in model monitoring activities that include but are not limited to:

- Submission of quarterly and annual progress reports;
- Regular telephonic conferences with a CMS project officer;
- Regular learning system event attendance and participation; and
- Submission of other standalone documents, as specified below.

F 5.1.1. Quarterly and Annual Progress Reporting

Awardees will be required to submit quarterly progress reports (QPR) and annual progress reports (APR). CMS will provide Awardees with guidance and templates ahead of the due date for QPR and APR submissions. These reports will include narrative updates on model activities as well as information on operational and performance milestones in accordance with the InCK Model cooperative agreement. CMMI will use the quarterly and annual reports to track progress on model goals, identify technical assistance needs, and inform learning activities for all Awardees. The operations and performance milestones will support CMMI efforts to confirm that Awardees are able to meet care delivery requirements and deliver high quality care. CMMI will also share these findings with Awardees individually on an ongoing basis for quality improvement purposes. Awardees must maintain records of all source data used to calculate program milestone measures and make such data available to CMMI

for periodic audits. CMS may consider for corrective action, funding restrictions, or termination any Awardee that does not meet the model requirements outlined in the cooperative agreement Notice of Award, Terms and Conditions, or other federal award documentation.

Operational Milestones

CMMI will monitor Awardee progress on the service integration plan and APM components of its model implementation plan based in part on its review of Operational Milestones submissions. A list of specific operational milestones that Awardees must report on to CMS is included in Table 1 below. CMS reserves the right to revise these operational milestones based upon Agency needs and on individual Awardee’s implementation plans and unforeseen circumstances that arise during model pre-implementation and implementation periods.

Table 1: InCK Model Operational Milestones	
Operational Milestone	Description
Learning system attendance and participation	See detailed description of learning system activities in Section F 5.3.
Medicaid or CHIP SPA/program waiver timeline	Awardees must meet with CMCS immediately upon award to begin the process of state plan amendment (SPA) or program waiver approval necessary to implement their InCK Model. Awardees must submit a timeline for SPA/program waiver approval agreed-upon by the state and CMCS as an appendix to their QPR submission in model year 1 quarter 1. Every quarter thereafter, the Awardees must update the timeline and their progress toward SPA/program waiver approval in subsequent QPRs until obtaining final CMCS approval. Awardees must inform their project officers of changes as they occur during regular telephonic conferences. Awardees must obtain any SPA or program waiver approvals from CMCS that are necessary for model implementation by the time of their non-competitive continuation application submissions in model year 2 quarter 3.
Documentation of managed care plan participation (if applicable)	If applicable, Awardees must submit documentation such as an MOU or contract language reflecting managed care plans’ agreement to participate in InCK model APMs as an appendix to the QPR submitted by the end of model year 2 quarter 3 at the time of non-competitive continuation application submission for model year 3 and provide updates annually thereafter. Awardees must inform their project officers of changes as they occur during regular telephonic conferences.

<p>Updated Partnership Council Charter</p>	<p>Awardees must submit a revised copy of their charter as an appendix to their QPR by the end of model year 1 quarter 3. Awardees must revise their Charter annually thereafter, and submit to CMS as a standalone document at the time of Annual Progress Reports. Awardees must inform their project officers of changes as they occur during regular telephonic conferences.</p>
<p>Updated implementation plan</p>	<p>Awardees must submit a revised copy of their Implementation Plan as a standalone document by the end of model year 1 quarter 1. Awardees must revise their Implementation Plan annually thereafter, and submit to CMS as a standalone document at the time of Annual Progress Reports. Awardees must inform their project officers of changes as they occur during regular telephonic conferences.</p>
<p>Contractual agreement between state Medicaid agency and Lead Organization</p>	<p>The state Medicaid agency and Lead Organization must submit their signed contractual agreement as a standalone document by the end of model year 1 quarter 3, at the time of non-competitive continuation application submission for model year 2. Awardees must submit updated contractual agreements annually thereafter (including a tracked changes version) if substantive changes have been made.</p>
<p>Beneficiary Data</p>	<p>Starting in year 2 Awardees must provide CMS the following information on an annual basis at the time of the APM submission:</p> <ul style="list-style-type: none"> • Aggregate count of unique attributed children as of the end of the prior quarter. • Estimate of the total number attributed children that will be assessed for SIL eligibility in the upcoming model year <p>Starting in year 3 quarter 1 Awardees must provide CMS the following information on a quarterly basis at the time of the QPR submission:</p> <ul style="list-style-type: none"> • Aggregate count of unique attributed children assessed for SIL eligibility • Aggregate count unique attributed children found to be eligible for SIL 2 and SIL 3. (Note: SIL 2 and SIL 3 data must be reported as separate categories, not combined) • Aggregate count of unique attributed children

	<p>who received services under SIL 2 and SIL 3. (Note: SIL 2 and SIL 3 data must be reported as separate categories, not combined)</p> <p>Note: The aggregate counts are de-identified and will be used by the CMMI Model team for program monitoring.</p>
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Performance Measure Milestones

Awardees must report a set of Performance Measure Milestones covering at least 80% of their attributed population to CMS. Performance Measure Milestones will be used to support CMS program monitoring activities and track Awardee impacts on key measures of child health and wellness in their attributed populations across five measure domains: Clinical Care, Care Coordination, Education, Food Insecurity, and Housing Instability. The specific measures in these domains are listed in Table 2 below. Awardees will be required to report on all of the measures listed in Table 2 for the duration of the model period unless otherwise advised by CMS. A subset of the Performance Measure Milestones will be linked to the model funding as detailed later in this section.

In addition to the measures listed in Table 2, CMS intends to develop a measure focused on out-of-home placement among children attributed to the model. Reducing the rate of out-of-home placement is a primary focus area for the InCK Model and Awardees are expected to participate in the development process and data reporting for a measure to track this issue as part of model participation. The measure development process will be done in consultation with Awardees and, once defined, may be incorporated into the list of Performance Measure Milestones for future Model Years.

CMS reserves the right to change the measure set based on Agency needs, in the event that a measure is determined to no longer be valid, or in the event that as otherwise valid measure cannot be reasonably applied to an Awardees beneficiary population.

Reporting Timeline

Source data will be due on an annual basis as part of their second Quarterly Progress Reports starting in model year 2 and continuing until the end of model. The source data submitted should reflect performance on measures from the prior model year. For example, data submitted in Q2 of model year 2 should reflect performance from model year 1. Awardees must report on the same measures for each of the domains listed in Table 2 for the duration of the model unless otherwise advised by CMS. CMS reserves the right to revise Performance Measure Milestones based on individual Awardee’s implementation plans and unforeseen circumstances that arise during model pre-implementation and implementation periods. CMS also reserves the right to revise the method of data submission to CMS based on new information or unforeseen circumstances that arise during model implementation.

Performance Measures Linked to Funding

A subset of the Performance Measure Milestones will be linked to award performance-based funding in years 5-7 of the model. A portion of model funding, totaling \$500,000 per year in each of years 5-7, will be based on reporting and performance on this subset of the Performance Measure Milestones (\$100,000 per Performance Milestone for up to 5 milestones). This funding is not guaranteed and will be

restricted (unavailable for Awardee use) unless the Awardee achieves satisfactory performance on the selected Performance Measure Milestones. CMS has selected three of the measures that will be linked to funding; Awardees may select the two remaining CMS-approved measures from the list provided below.

The three CMS-selected measures linked to funding will be:

- NQF Measure #0004: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment
- NQF Measure #3148: Screening for Clinical Depression and Follow-Up Plan
- NQF Measure #2843: Family Experiences with Coordination of Care (FECC) – Question 3: Care coordinator helped to obtain community services

Awardees may select two of the following CMS-approved measures to link to funding:

- Kindergarten School Readiness
- Food Insecurity
- Housing Stability Assessment

Benchmarks for the measures linked to funding will be determined by the start of model year 3 by CMS using the baseline data submitted by Awardees during the model pre-implementation period (model years 1 and 2). CMS reserves the right to renegotiate benchmarks annually after the initial benchmarks are determined. There will be a 1-year delay between Awardee performance on a measure and the availability of funding linked to that measure. This delay is intended to provide the necessary time for states to generate final action claims and analyze the claims data, and for CMS to verify the reported values using the underlying source data retained by the Awardee. This means that funding for model years 5, 6, and 7 will be based on the Awardees performance on measures in model years 3, 4, and 5 respectively. For example, Awardee performance in model year 3 will be reported in the second quarter QPR in model year 4. CMMI will review and verify the Awardees stated performance on the measures during the third quarter of year 4 and notify the Awardee of their funding determination so that the Awardee may include any additional funds earned in their budget planning for model year 5.

Maintenance of Records

Awardees are required to maintain a record of all identifiable source data used to generate the values reported for the Performance Measure Milestones and must submit this data to CMS for program monitoring, auditing, and evaluation purposes.

Summary

Reporting requirements for the 5 domains are:

- Clinical care and care coordination domains: required aggregate reporting annually on a minimum of 80% of the attributed population using CMS-specified measures in Table 1.
- Education, food insecurity, and housing instability domains: required aggregate reporting annually on a minimum of 80% of the attributed population using either Awardee defined measures submitted to CMS for approval or CMS defined measures indicated in Table 1.

Table 2: InCK Model Performance Measure Milestones

Performance Measure Milestone	Measure Source	Description
Domain 1 – Clinical Care (Behavioral and Medical)		
<p>Well-Child Visits in the First 15 Months of Life</p> <p>NQF Measure #1392</p> <p>Measure Steward: National Committee for Quality Assurance (NCQA)</p>	<p>Medicaid Child Core Set, 2018</p>	<p>The percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a primary care practitioner (PCP) during their first 15 months of life:</p> <ul style="list-style-type: none"> - No well-child visits - One well-child visit - Two well-child visits - Three well-child visits - Four well-child visits - Five well-child visits - Six or more well-child visits
<p>Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life</p> <p>NQF Measure #1516</p> <p>Measure Steward: National Committee for Quality Assurance (NCQA)</p>	<p>Medicaid Child Core Set, 2018</p>	<p>Percentage of patients 3-6 years of age who received one or more well-child visits with a PCP during the measurement year</p>
<p>Adolescent Well-Care Visits, Ages 12-21</p> <p>Measure not NQF Endorsed</p> <p>Measure Steward: Healthcare Effectiveness Data and Information Set (HEDIS)</p>	<p>Medicaid Child Core Set, 2018</p>	<p>Percentage of adolescents ages 12 to 21 who had at least one comprehensive well-care visit with a primary care practitioner (PCP) or an obstetric/gynecologic (OB/GYN) practitioner during the measurement year.</p>
<p>Ambulatory Care: Emergency Department Visits</p> <p>Measure not NQF Endorsed</p> <p>Measure Steward: National Committee</p>	<p>Medicaid Child Core Set, 2018</p>	<p>The rate of emergency department visits per 1,000 member months among children up to age 19</p>

for Quality Assurance (NCQA)		
<p>Follow-Up After Hospitalization for Mental Illness</p> <p>NQF Measure #0576</p> <p>Measure Steward: National Committee for Quality Assurance (NCQA)</p>	<p>Medicaid Child Core Set, 2018</p>	<p>The percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported: - The percentage of discharges for which the patient received follow-up within 30 days of discharge - The percentage of discharges for which the patient received follow-up within 7 days of discharge.</p>
<p>Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics</p> <p>NQF Measure #2801</p> <p>Measure Steward: Agency for Healthcare Research and Quality (AHRQ)–CMS CHIPRA National Collaborative for Innovation in Quality Measurement (NCINQ)</p>	<p>Medicaid Child Core Set, 2018</p>	<p>The percentage of children and adolescents 1–17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.</p>
<p>Screening for Clinical Depression and Follow-Up Plan</p> <p>NQF Measure #0418</p> <p>Measure Steward: Centers for Medicare & Medicaid Services (CMS)</p>	<p>Medicaid Child Core Set, 2018</p>	<p>Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented</p>
<p>Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment</p> <p>NQF Measure #0004</p>	<p>Medicaid Adult Core Set, 2018</p>	<p>The percentage of adolescent and adult patients with a new episode of alcohol or other drug (AOD) dependence who received the following.</p> <ul style="list-style-type: none"> - Initiation of AOD Treatment. The percentage of patients who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.

Measure Steward: National Committee for Quality Assurance (NCQA)		- Engagement of AOD Treatment. The percentage of patients who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.
Domain 2 – Care Coordination		
Family Experiences with Coordination of Care (FECC) – Question 3: Care coordinator helped to obtain community services NQF Measure #2843 Measure Steward: Seattle Children's Research Institute	Strengthening the Core Set of Healthcare Quality Measures for Children Enrolled in Medicaid and CHIP, 2017	The FECC Survey is composed of 20 separate and independent quality indicators related to care coordination for children with medical complexity. Each indicator's numerator is determined by caregiver response to specific questions, as described in the detailed measure specifications section of the candidate measure submission form.
Domain 3 – Education		
Kindergarten Readiness	Awardee Defined	A number of states have mandated school readiness assessments. There is no single standard across states. CMS would like model Awardees to propose an approach to collecting school readiness data. Awardees may propose assessment tools that are currently in use in their community.
Chronic Absence from school (K-12)	Awardee Defined	There is no single standard across states. CMS would like model Awardees to propose an approach to collecting chronic school absenteeism data. Awardees may use assessment tools that are currently in use in their community.
Domain 4 – Food Security		
Food Insecurity Assessment	Awardee Option	<p>There is no single standard across states.</p> <p>CMS recommends that model Awardees collect and report data on the Children's HealthWatch Hunger Vital Sign™ two question assessment:</p> <ol style="list-style-type: none"> 1. Within the past 12 months we worried whether our food would run out before we got money to buy more. <ul style="list-style-type: none"> • (Often True, Sometimes True, Never True) 2. Within the past 12 months the food we bought just didn't last and we didn't have money to get more." <ul style="list-style-type: none"> • (Often True, Sometimes True, Never True) <p>If the community the Awardee is serving has already established an alternative measure to track food insecurity</p>

		the Awardee may propose that measure to CMMI for consideration as a substitute to the Children’s Health Watch assessment.
Domain 5 – Housing		
Housing Stability Assessment	Awardee Option	<p>There is no single standard across states.</p> <p>CMS recommends that model Awardees collect and report data on the Children’s HealthWatch Housing Stability Vital Sign™ three question assessment:</p> <ol style="list-style-type: none"> 1. Within the past 12 months was there a time when you were not able to pay the mortgage or rent on time? <ul style="list-style-type: none"> • Yes/No, positive screen if answer is yes 2. Within the past 12 months was there a time when you did not have a steady place to sleep or slept in a shelter (including now)? <ul style="list-style-type: none"> • Yes/No, positive screen if answer is yes 3. Within the past 12 months how many places have you lived? <ul style="list-style-type: none"> • Answer is # of places lived, positive screen if answer is 3 or more <p>If the community the Awardee is serving has already established an alternative measure to track housing instability the Awardee may propose that measure to CMMI for consideration as a substitute to the Children’s Health Watch assessment.</p>

F 5.2 Evaluation

CMS will conduct a formal and concurrent evaluation of each Awardee’s performance to assess model impact. The primary goal of the evaluation will be to assess the effects of integrated care and APMs on resource utilization and health status for attributed children. More specifically, the evaluation will focus on the extent to which the intervention reduced inpatient utilization and out-of-home placement for all enrolled children in addition to other cost, quality, and health outcomes. This evaluation will look at all attributed children, and, in particular, focus on children at-risk for significant behavioral health, substance use, and physical health needs (i.e., those children stratified into SILs 2 and 3). This evaluation is expected to span the model’s 2-year pre-implementation period in addition to the 5-year performance period. The evaluation contractor will develop a HIPAA-compliant system for required data submission. Awardees are solely responsible for any Institutional Review Board (IRB) procedures and approvals or any other permissions from their organizations or states that may be needed to submit these data.

CMMI will evaluate each Awardee using the most rigorous evaluation design feasible, applying appropriate quantitative and qualitative methods to examine program outcomes and the processes that

lead to successes or challenges. CMS will require Awardees to provide the evaluation contractor data including, but not limited to:

- **Claims and Encounter Data.** Beginning the second quarter of the first award year, and every quarter thereafter for the duration of the 7-year model period, Awardees must provide all Medicaid and CHIP (if applicable) claims and encounter data with unique, traceable identifiers for the individual beneficiaries attributed to their InCK model for at least one month within the previous 12 months. Awardees may submit these data through Transformed Medicaid Statistical Information System (T-MSIS); if CMS/CMMI does not receive all necessary claims and encounter data for attributed beneficiaries through T-MSIS, the Awardee is responsible for obtaining and submitting the required claims and encounters through an alternative mechanism approved by CMMI.
- **Service Integration Level (SIL) Eligibility Checklists.** Awardees will submit SIL eligibility checklists for at least 80 percent of the attributed population to the Model evaluation contractor or via other CMS-designated format no less than once per model quarter beginning model year 1 quarter 1. Checklists will identify all attributed beneficiaries/children eligible for Level 2 and Level 3 services as identified by the Awardee's assessment tool. The assessments for attributed beneficiaries may also be required.
- **Qualitative Data.** Beginning the second quarter of the first award year, and every quarter thereafter for the duration of the 7-year model period, Awardees and their program partners will assist the model evaluation contractor with the acquisition of qualitative data. Data collection activities that may require Awardee to cooperate/participate in include but are not limited to arranging and granting interviews; assisting in recruiting for focus groups and individual interviews with model-associated staff, beneficiaries, and beneficiary caregivers; allowing observations of any model-funded activities; providing program documents such as patient education and staff training materials; surveys of staff and/or beneficiary families; and any other necessary activities.
- **Core Child Services.** Awardees must provide the model evaluation contractor with Core Child Services data on all attributed beneficiaries/children no less than twice per year beginning the second quarter of the first model year. Potential data elements include but are not limited to special education enrollment or the provision of social supports (such as housing, child welfare, or food assistance not covered under the Home-and-Community Based waiver). Transmission may be made through the state's Medicaid Office or Department of Health & Human Services, depending on the individual states' functional responsibilities.
- **Medicaid and CHIP Identifiers.** CMS must have access to claims and encounter data with identifiers sufficient to longitudinally track beneficiaries for all Medicaid and/or CHIP children in the intervention AND comparison group for the 7-year model period. Awardees must provide CMMI with Medicaid (and CHIP if applicable) identifiers for all attributed and in-state comparison group children to facilitate claims matching. The comparison population must be distinct from the intervention population, with no service overlap between the two groups. The two groups must be as similar in size and demographic composition as possible. The evaluation contractor may ultimately establish a final comparison group that differs from the one proposed in the application. In the event that this occurs, the Awardee must make identifiers available for the comparison population established by the evaluation contractor.
- **Retrospective list of attributed and control populations.** On an annual basis, the Awardee will provide CMMI with a retrospective list of attributed beneficiaries to confirm beneficiaries'

Medicaid or CHIP coverage status throughout the previous year for both the Awardee's program population and the in-state comparison group. This submission will also detail the number of beneficiaries identified for Level 1, 2, and 3 services. Awardees must submit complete lists of 1) all beneficiaries residing in the model service area and 2) all beneficiaries residing in the control service area covered by Medicaid, or CHIP if applicable, for at least 1 month during the previous 12 months to the CMS evaluation contractor starting at the end of model year 1 quarter 4 and annually thereafter. These lists must contain a unique Medicaid or CHIP identifier for each child that the CMS evaluators can use to longitudinally link beneficiaries to claims and encounter data acquired through T-MSIS (or a backup method approved by CMMI).

F 5.3 Learning System Participation

CMMI will design, implement, and manage a learning system, and tailor it to the needs of the InCK Model's Awardees. The goals of the learning system are to accelerate the implementation and improve the success of the Model through achieving Model Aims. The primary learning system functions by: 1) identifying and packaging new knowledge and practice, 2) leveraging data and participant input to guide change/improvement, and 3) building learning communities and networks to share and spread new knowledge and practice.

Awardees must participate in learning activities distinguished by period (pre-implementation and implementation) and participant type. State Medicaid agencies will focus on developing and implementing alternative payment models, while Lead Organizations will concentrate on integrating service delivery. Overall, the types of learning activities Awardees can expect will vary, and may include peer-to-peer learning, virtual site visits, face-to-face visits, in person meetings, teleconferences, webinars, training exchanges, report-outs, affinity groups, integrated learning events, case studies, vignettes, training videos and in-person attendance once per year at a CMS designated conference in the Baltimore/District of Columbia area. Peer-to-peer learning among states is a key activity because state-to-state knowledge transfer about model implementation in unique state environments is crucial to successful future model adoption by other states.

CMS will provide Awardees with InCK Model learning support and activities to include didactic presentations and interactive discussions, both live and asynchronous, and up to one in-person CMS designated conference per year in the Baltimore/District of Columbia area to accelerate Model performance. The Awardee shall:

1. Participate in targeted learning on the InCK Model Driver Diagram and within the first year of pre-implementation develop and submit to CMS, or its contractors, an individualized Awardee Driver Diagram (after submission to CMS, the Awardee Driver Diagram should be maintained and updated by the Awardee throughout the life of the grant as a framework to guide and align intervention design and implementation activities and shared with CMS upon request);

2. Respond to CMS and its contractors and staff when using various mechanisms such as surveys or interviews to identify Awardee learning needs;
3. Participate in the identification and dissemination of promising practices which may involve sharing lessons learned with other Model participants (i.e. presenting on webinars);
4. Participate in up to two virtual InCK Model learning activities every month during the 7-year model period, beginning year 1;
5. Share information on state and federal programs that complement InCK Model interventions in the communities they serve;
6. Develop, track and report to CMS on quality improvement efforts, activities, and program measures, at regular intervals; and
7. Participate, in-person, at up to one CMS designated conference per year in the District of Columbia/Baltimore to learn, collaborate, and disseminate InCK Model promising practices.

G. CMS Contacts

G1. Program Questions: Taiwana Lucienne, HealthyChildrenandYouth@cms.hhs.gov

G2. Administrative/Budget Questions: Jamie Atwood, HealthyChildrenandYouth@cms.hhs.gov

Appendix A. Guidance for Preparing a Budget Request and Narrative

Applicants should request funding only for activities which will be funded by this specific Notice of Funding Opportunity. All applicants must submit the Standard Form SF-424A as well as a Budget Narrative. The Budget Narrative should provide detailed cost itemizations and narrative supporting justification for the costs outlined in SF-424A. Both the Standard Form SF-424A and the Budget Narrative must include a yearly breakdown of costs for the entire project period. Please review the directions below to ensure both documents are accurately completed and consistent with application requirements.

Standard Form SF-424A

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

- **Note:** The directions in the NOFO may differ from those provided by Grants.gov. Please follow the instructions included in this NOFO as outlined below when completing the SF-424A.
- **Note:** The total requested on the SF-424 (Application for Federal Assistance) should be reflective of the overall total requested on the SF-424A (Budget Information – Non-Construction) for the entire project period.

Section A – Budget Summary

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

Section B – Budget Categories

- Enter the total costs requested for each Object Class Category (Section B, number 6) for each year of the project period. Notice of Funding Opportunities with a 5-year project period will need to also utilize a second SF-424A form.
- Column (1) = Enter Year 1 costs for each line item (rows a-h), including the sum of the total direct charges (a-h) in row i. Indirect charges should be reflected in row j. The total for direct and indirect charges for all year 1 line items should be entered in column 1, row k (sum of row i and j).
- Column (2) = (If applicable) Enter Year 2 estimated costs for each line item (rows a-h), including the sum of the total direct charges (a-h) in row i. Indirect charges should be reflected in row j.

The total for direct and indirect charges for all year 2 line items should be entered in column 2, row k (sum of row i and j).

- Column (3) = (If applicable) Enter Year 3 estimated costs for each line item (rows a-h), including the sum of the total direct charges (a-h) in row i. Indirect charges should be reflected in row j. The total for direct and indirect charges for all year 3 line items should be entered in column 3, row k (sum of row i and j).
- Column (4) = (If applicable) Enter Year 4 estimated costs for each line item (rows a-h), including the sum of the total direct charges (a-h) in row i. Indirect charges should be reflected in row j. The total for direct and indirect charges for all year 4 items should be entered in column 4, row k (sum of row i and j).
- Column (5) = Enter total costs for the first 4 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 should be entered in row k (sum of row i and j). The total in column 5, row k should match the total provided in Section A – Budget Summary, New or Revised Budget, column g, row 5.
- If the NOFO is for a 7-year project period, please complete a second SF-424A form and upload it as an attachment to the application (this specific attachment will not be counted towards the page limit). Years 5-7 information should be included in columns 1-3 of Section B of the second SF-424A form. Then enter the total for years 1-4 (per the first SF-424A form) in column 4 of Section B of the second SF-424A form. The second SF-424A form will compute columns 1-4, reflecting total costs for the entire project period. This total should be consistent with the total Federal costs requested on the SF-424, Application for Federal Assistance. A blank SF-424A form can be found at Grants.gov: <http://www.grants.gov/web/grants/forms/sf-424-individual-family.html#sortBy=1>

Budget Narrative – Sample Narrative and Instructions

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

A sample Budget Narrative is included below.

A. (Personnel) Salaries and Wages

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

Sample Budget

Personnel Total \$ _____

Grant \$ _____

Funding other than Grant \$ _____

Sources of Funding _____

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

Sample Justification

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

Job Description: Project Coordinator - (Name)

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

B. Fringe Benefits

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

Sample Budget

Fringe Benefits Total \$ _____

Grant \$ _____

Funding other than Grant \$ _____

Sources of Funding _____

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

C. Travel

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

Provide a narrative describing the travel staff members will perform. Applicants should plan for minimal staff to attend one in-person event in the Baltimore/D.C. metro area annually. This narrative must include a justification which explains why this travel is necessary and how it will enable the applicant to complete program requirements included in the Notice of Funding Opportunity. List where travel will be undertaken, number of trips planned, who will be making the trip, and approximate dates. If mileage is to be paid, provide the number of miles and the cost per mile. The mileage rate cannot exceed the rate set by the General Services Administration (GSA). If travel is by air, provide the estimated cost of airfare. The lowest available commercial airfares for coach or equivalent accommodations must be used. If per diem/lodging is to be paid, indicate the number of days and amount of daily per diem as well as the number of nights and estimated cost of lodging. Costs for per diem/lodging cannot exceed the rates set by GSA. Include the cost of ground transportation when applicable. Please refer to the GSA website by using the following link <http://www.gsa.gov/portal/content/104877>.

Sample Budget

Travel Total \$ _____

Grant \$ _____

Funding other than Grant \$ _____

Sources of Funding _____

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

Sample Justification

The Project Coordinator and the Outreach Supervisor will travel to (location) to attend a conference on the following topic XXXX. This conference is only held once a year in Chicago, IL. Attending this conference is directly linked to project goals/objectives and is a necessity because XXXX. The information and tools we will gather from attending this conference will help us to accomplish project objectives by XXXX. A sample itinerary can be provided upon request. The Project Coordinator will also make an estimated 25 trips to birth center sites to monitor program implementation (# of birth centers, # of trips per site). We are still in the process of identifying all birth center sites, but have identified an average mileage total for each site. This travel is necessary to ensure birth center sites are consistently and systematically collecting birth center data and submitting by deadlines provided. On-site monitoring will enable us to immediately address concerns. This travel also furthers our efforts to accomplish specific project goals for the following reasons...

D. Equipment

Equipment is tangible nonexpendable personal property, including exempt property, charged directly to the award having a useful life of more than one year and an acquisition cost of \$5,000 or more per unit. However, consistent with recipient policy, lower limits may be established. Technology items such as computers that do not meet the \$5,000 per unit threshold or an alternative lower limit set by recipient policy that may therefore be classified as supplies, must still be individually tagged and recorded in an equipment/technology database. This database should include any information necessary to properly identify and locate the item. For example: serial # and physical location of equipment (e.g. laptops, tablets, etc.).

Provide justification for the use of each item and relate it to specific program objectives. Maintenance or rental fees for equipment should be shown in the "Other" category. All IT equipment should be uniquely identified. Show the unit cost of each item, number needed, and total amount.

Sample Budget

Equipment Total \$_____

Grant \$_____

Funding Other than Grant \$_____

Sources of Funding_____

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

Sample Justification

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

E. Supplies

Supplies includes all tangible personal property with an acquisition cost of less than \$5,000 per unit or an alternative lower limit set by recipient policy. Individually list each item requested. Show the unit

cost of each item, number needed, and total amount. Provide justification for each item and relate it to specific program objectives. If appropriate, General Office Supplies may be shown by an estimated amount per month times the number of months in the budget category.

Sample Budget

Supplies Total \$ _____

Grant \$ _____

Funding Other than Grant \$ _____

Sources of Funding _____

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

Sample Justification

General office supplies will be used by staff members to carry out daily activities of the program.

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

F. Consultant/Subrecipient/Contractual Costs

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

REQUIRED REPORTING INFORMATION FOR CONSULTANT HIRING

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

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

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

REQUIRED REPORTING INFORMATION FOR SUBRECIPIENT APPROVAL

The costs of project activities to be undertaken by a third-party subrecipient should be included in this category. Please see 45 CFR Part 75.351, *Subrecipient and contractor determinations*. Applicants must submit information on the (a) Statement of Work; (b) Period of Performance; and (c) Itemized Budget and Justification. If this information is unknown at the time the application is submitted, the information may be submitted at a later date as a revision to the budget. In the Budget Narrative, a summary should be provided of the proposed sub-awards (subrecipients), the work to be completed, and amounts for each. Recipient must not incur costs for subrecipient activities until the aforementioned information is provided for each subrecipient and CMS approval obtained.

REQUIRED REPORTING INFORMATION FOR CONTRACT APPROVAL

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

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

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

G. Construction (not applicable)

H. Other

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

Sample Budget

Other Total \$ _____

Grant \$ _____

Funding Other than Grant \$ _____

Sources of Funding _____

Item(s)	Rate	Cost
Telephone	\$45 per month x 3 employees x 12 months	\$1,620
Postage	\$250 per quarter x 4 quarters	\$1,000
Printing	\$0.50 x 3,000 copies	\$1,500
Equipment Rental *specify item	\$1,000 per day for 3 days	\$3,000
Internet Provider Service	\$20 per month x 3 employees x 12 months	\$720
Word Processing Software (specify type)	1 @ \$400	\$400
Total:		\$8,240

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

Sample Justification

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

I. Total Direct Costs \$_____

Show total direct costs by listing totals of each category.

J. Indirect Costs \$ _____

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

Sample Budget

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

Personnel \$ _____

Fringe \$ _____

Travel \$ _____

Supplies \$ _____

Other \$ _____

Total \$ _____ x ____% = Total Indirect Costs

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

Appendix B. Application and Submission Information

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

EIN, DUNS, AND SAM REQUIREMENTS (ALL APPLICATIONS)

Employer Identification Number

All applicants under this 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.**

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

All applicants must have a Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number. The DUNS number is a nine-digit number that uniquely identifies business entities. To obtain a DUNS number access the following website: <https://www.dnb.com/duns-number.html> or call 1-866-705-5711. This number should be entered in block 8c (on Form SF-424, Application for Federal Assistance). The organization name and address entered in block 8a and 8e should be exactly as given for the DUNS number. **Applicants should obtain this DUNS number as soon as possible after the announcement is posted to ensure all registration steps are completed in time.**

System for Award Management (SAM)

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.**

SAM registration process is a separate process from submitting an application. Applicants are encouraged to register early, and must provide their DUNS and EIN/TIN numbers in order to do so. **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.**

Each year organizations and entities registered to apply for Federal grants through Grants.gov (or GrantSolutions as applicable) must renew their registration with SAM. **Failure to renew SAM registration prior to application submission will prevent an applicant from successfully applying via Grants.gov (or GrantSolutions as applicable). Similarly, failure to maintain an active SAM registration during the application review process can prevent HHS from issuing your agency an award.**

Applicants must also successfully register with SAM prior to registering in the Federal Funding Accountability and Transparency Act Subaward Reporting System (FSRS) as a prime Awardee user. Please also refer to F5.C. (Federal Funding Accountability and Transparency Act Reporting Requirements) of this Funding Opportunity for more information. Primary Awardees must maintain a current registration with the SAM database, and **may make subawards only to entities that have DUNS numbers.**

Organizations must report executive compensation as part of the registration profile at <https://www.sam.gov/portal/public/SAM/> by the end of the month following the month in which this

award is made, and annually thereafter (based on the reporting requirements of the Federal Funding Accountability and Transparency Act (FFATA) of 2006 (Pub. L. 109-282), as amended by Section 6202 of Public Law 110-252 and implemented by 2 CFR Part 170). The Grants Management Specialist assigned to monitor the sub-award and executive compensation reporting requirements is Jamie Atwood, who can be reached at HealthyChildrenandYouth@cms.hhs.gov.

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

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.**
- Authorized Organizational Representative: The Authorized Organizational Representative (AOR) who will officially submit an application on behalf of the organization must register with Grants.gov for a username and password. AORs must complete a profile with Grants.gov using their organization's DUNS Number to obtain their username and password at http://grants.gov/applicants/get_registered.jsp. AORs must wait one business day after successful registration in SAM before entering their profiles in Grants.gov. **Applicants should complete this process as soon as possible after successful registration in SAM to ensure this step is completed in time to apply before application deadlines. Applications that are not submitted by the due date and time as a result of AOR issues will not be reviewed.**
- When an AOR registers with Grants.gov to submit applications on behalf of an organization, that organization's E-Biz POC will receive an email notification. The email address provided in the profile will be the email used to send the notification from Grants.gov to the E-Biz POC with the AOR copied on the correspondence.
- The E-Biz POC must then login to Grants.gov (using the organization's DUNS number for the username and the special password called "M-PIN") and approve the AOR, thereby providing permission to submit applications.
- **Any files uploaded or attached to the Grants.gov application must be PDF file format and must contain a valid file format extension in the filename.** Even though Grants.gov allows applicants to attach any file formats as part of their application, CMS restricts this practice

and only accepts PDF file formats. Any file submitted as part of the Grants.gov application that is not in a PDF file format, or contains password protection, will not be accepted for processing and will be excluded from the application during the review process. In addition, the use of compressed file formats such as ZIP, RAR, or Adobe Portfolio will not be accepted. The application must be submitted in a file format that can easily be copied and read by reviewers. It is recommended that scanned copies not be submitted through Grants.gov unless the applicant confirms the clarity of the documents. Pages cannot be reduced in size, resulting in multiple pages on a single sheet, to avoid exceeding the page limitation. **All documents that do not conform to the above specifications will be excluded from the application materials during the review process.** Please also refer to [Section D2. Content and Format of Application Submission](#).

- After you electronically submit your application, you will receive an acknowledgement from <http://www.grants.gov> that contains a Grants.gov tracking number. HHS will retrieve your application package from Grants.gov. **Please note, applicants may incur a time delay before they receive acknowledgement that the application has been accepted by the Grants.gov system. Applicants should not wait until the application deadline to apply because notification by Grants.gov that the application is incomplete may not be received until close to or after the application deadline, eliminating the opportunity to correct errors and resubmit the application. Applications submitted after the deadline, as a result of errors on the part of the applicant, will not be reviewed.**
- After HHS retrieves your application package from Grants.gov, a return receipt will be emailed to the applicant contact. This will be in addition to the validation number provided by Grants.gov.

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

All grant applications must be submitted electronically and be received through <http://www.grants.gov> by 3:00 p.m. Eastern Standard or Daylight Time (Baltimore, MD) for the applicable deadline date. Please refer to the [Program Description](#) summary table 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: <https://www.grants.gov/web/grants/support.html> 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.

Appendix C. Application Check-Off List Required Contents

Required Contents

A complete proposal consists of the materials organized in the sequence below. Please ensure that the project and budget narratives are page-numbered and the below forms are completed with an electronic signature and enclosed as part of the proposal. **Everything listed below must be submitted through <http://www.grants.gov>, and formatting requirements followed.**

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

Section D & Appendix B: Application and Submission Information

Section E: Application Review Information

Appendix A: Guidance for Preparing a Budget Request and Narrative

Standard Forms

- SF 424: Application for Federal Assistance
- SF-424A: Budget Information
- SF-424B: Assurances-Non-Construction Programs
- SF-LLL: Disclosure of Lobbying Activities
- Project Abstract Summary
- Project Site Location Form

Narrative Documents

- Project Narrative
- Budget Narrative
- Business Assessment of Applicant Organization
- Program Duplication Assessment Questionnaire
- Partnership Council Charter
- Memorandum of Understanding

Appendix D. Business Assessment of Applicant Organization

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

A. General Information

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

B. Accounting System

1. Is there a chart of accounts?
2. Is a double-entry accounting system used?
3. Does the organization maintain the basic books of account as applicable?
 - a. General ledger
 - b. Operating ledger
 - c. Project (Job) cost ledger
 - d. Cash receipts journal
 - e. Cash disbursement journal
 - f. Payroll journal
 - g. Income (sales) journal
 - h. Purchase journal
 - i. General journal
4. Does the accounting system adequately identify receipt and disbursement for each grant (or contract)?

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

C. Budgetary Controls

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

D. Personnel

1. Are personnel policies established in writing or in the process of preparation which detail at a minimum:
 - a. Duties and responsibilities of each employee's position?
 - b. Qualifications for each position?
 - c. Salary ranges associated with each job?
 - d. Promotion Plan?
 - e. Equal Employment Opportunity?
 - f. Annual performance appraisals?
 - g. Types and levels of fringe benefits paid to professionals, nonprofessionals, officers, or governing agency members?
2. Is employee compensation reasonable and comparable to that paid for similar work in the competitive labor market?
3. Are salary comparability surveys conducted? How often?
4. Are salaries of personnel assigned to Government projects about the same as before assignment? Identify reasons for significant increases.
5. Does the organization maintain a payroll distribution system which meets the required standards as contained in the applicable cost principles for that organization?
6. Does the organization maintain daily attendance records for hourly employees? Does this show actual time employees sign in and out?

7. Does the payroll distribution system account for the total effort (100%) for which the employee is compensated by the organization?
8. Who signs and certifies work performed in items 5, 6, and 7 above?
9. Where duties require employees to spend considerable time away from their offices, are reports prepared for their supervisors disclosing their outside activities?

E. Payroll

1. Does preparation of the payroll require more than one employee?
2. Are the duties of those individuals preparing the payroll related?
3. Are the names of employees hired reported in writing by the personnel office to the payroll department?
4. Are the names of employees terminated reported in writing by the personnel office to the payroll department?
5. Is the payroll verified at regular intervals against the personnel records?
6. Are all salaries and wage rates authorized and approved in writing by a designated official or supervisor?
7. Are vacation and sick leave payments similarly authorized and approved?
8. Is there verification against payments for vacation, sick leave, etc., in excess of amounts approved and/or authorized?
9. Is the payroll double-checked as to:
 - a. Hours?
 - b. Rates?
 - c. Deductions?
 - d. Extensions, etc.?
10. Are signed authorizations on file for all deductions being made from employees' salaries and wages?
11. Is the payroll signed prior to payment by the employee preparing the payroll? The employee checking the payroll?
12. Are salary payrolls approved by an authorized official prior to payment?
13. Are employees paid by check or direct deposit? If no, how are they paid?
14. If paid by check, are the checks pre-numbered?
15. Are checks drawn and signed by employees who do not:
 - a. Prepare the payroll?
 - b. Have custody of cash funds?
 - c. Maintain accounting records?
16. Are payroll checks distributed to employees by someone other than the supervisor?
17. Is there a payroll bank account? If no, will one be opened if recipient is selected for award?
18. Is the payroll bank account reconciled by someone other than payroll staff or personnel who sign and distribute the pay checks?

F. Consultants

1. Are there written policies or consistently followed procedures regarding the use of consultants which detail at a minimum:
 - a. Circumstances under which consultants may be used?
 - b. Consideration of in-house capabilities to accomplish services before contracting for them?
 - c. Requirement for solicitation or bids from several contract sources to establish reasonableness of cost and quality of services to be provided?
 - d. Consulting rates, per diem, etc.?
2. Are consultants required to sign consulting agreements outlining services to be rendered, duration of engagement, reporting requirements, and pay rates?

G. Property Management

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

H. Purchases

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

10. When only a partial order is received, is the project account credited for the undelivered portion of the purchase order?
11. Are the vendor invoices checked for:
 - a. Prices and credit terms?
 - b. Extensions?
 - c. Errors and omissions?
 - d. Freight charges and disallowances?
12. Are vouchers, supporting documents, expenses, or other distributions reviewed and cleared by designated staff before payment is authorized?

I. Travel

1. Does the organization have formal travel policies or consistently followed procedures which, at a minimum, state that:
 - a. Travel charges are reimbursed based on actual costs incurred or by use of per diem and/or mileage rates?
 - b. Receipts for lodging and meals are required when reimbursement is based on actual cost incurred?
 - c. Per Diem rates include reasonable dollar limitations? Subsistence and lodging rates are comparable to current Federal per diem and mileage rates?
 - d. Commercial transportation costs are incurred at coach fares unless adequately justified? Travel requests are approved prior to actual travel?
 - e. Travel expense reports show purpose of trip?

J. Internal Controls

1. Is there a separation of responsibility in the receipt, payment, and recording of cash?
 - a. For example: Are the duties of the record keeper or bookkeeper separated from any cash functions such as the receipt or payment of cash?
 - b. Or, is the signing of checks limited to those designated officials whose duties exclude posting and/or recording cash received, approving vouchers for payment, and payroll preparation?
2. Are all checks approved by an authorized official before they are signed?
3. Are all accounting entries supported by appropriate documentation (e.g., purchase orders, vouchers, vendor payments)?
4. Does the organization have an internal auditor or internal audit staff?
5. Is there a petty cash fund where responsibility is vested in one individual; limited to a reasonable amount; restricted as to purchase; and counted, verified, and balanced by an independent employee at time of reimbursement?
6. Are all checks pre-numbered and accounted for when general purpose bank account is reconciled?
7. If a mechanical or facsimile signature is used for cash disbursements, is the signature plate, die, key, electronic card, etc., under strict control?

8. Are bank accounts reconciled by persons not handling cash in the organization?
9. Are all employees who handle funds required to be bonded against loss by reason of fraud or dishonesty?

Appendix E. Review and Selection Process

The review and selection process will include the following:

- i. Applications will be screened to determine eligibility for further review using the criteria detailed in Section C. Eligibility Information, and Section D. Application and Submission Information (with cross-reference to Appendix B), of this NOFO. Applications that are received late or fail to meet the eligibility requirements as detailed in this NOFO or do not include the required forms will not be reviewed. However, the CMS/OAGM/GMO, in his or her sole discretion, may continue the review process for an ineligible application if it is in the best interest of the government to meet the objectives of the program.
- ii. Procedures for assessing the technical merit of grant applications have been instituted to provide for an objective review of applications and to assist the applicant in understanding the standards against which each application will be judged. The Review criteria described in Section E1. Criteria, will be used. Applications will be evaluated by an objective review committee. The objective review committee may include Federal and/or non-Federal reviewers. Applicants should pay strict attention to addressing all these criteria, as they are the basis upon which the reviewers will evaluate their applications.
- iii. The results of the objective review of the applications by qualified experts will be used to advise the CMS approving official. Final award decisions will be made by a CMS approving official. In making these decisions, the CMS approving official will take into consideration: recommendations of the review panel; the readiness of the applicant to conduct the work required; the scope of overall projected impact on the aims; reviews for program and grants management compliance; the reasonableness of the estimated cost to the government and anticipated results; and the likelihood that the proposed project will result in the benefits expected.
- iv. As noted in 45 CFR Part 75, CMS will do a review of risks posed by applicants prior to award. In evaluating risks posed by applicants, CMS will consider the below factors as part of the risk assessment (applicant should review the factors in their entirety at §75.205)
 - a. Financial stability;
 - b. Quality of management systems and ability to meet the management standards prescribed;
 - c. History of performance (including, for prior recipients of Federal awards: timeliness of compliance with applicable reporting requirements, conformance to the terms and conditions of previous federal awards, extent to which previously awarded amounts will be expended prior to future awards);
 - d. Reports and findings from audits performed under Subpart F of 45 CFR Part 75 and
 - e. Applicant's ability to effectively implement statutory, regulatory, and other requirements imposed on non-federal entities.
- v. HHS reserves the right to conduct pre-award Negotiations with potential Awardees.

Appendix F. Program Duplication Assessment Questionnaire

Lead Organization Name _____

- 1. Are you aware of your responsibility to report and mitigate program duplication?

Yes_ No_

- 2. If you are awarded InCK funding, will you ensure award funds are not used to duplicate or supplant current federal, state or local funding? Yes_ No_

- 3. Will you be involved in any alternative payment and/or delivery reform programs or demonstrations during the model implementation phase (calendar years 2019-2026)?

Yes_ No_

If you answered "Yes" to Question 3, please complete question 4. If you answered "No" to question 3, please skip Question 4 and move to Question 5.

- 4. Please provide detail on which other programs you will be participating in during model implementation, and a process for avoiding duplication with model funding. The description of the program should include, at a minimum, the payer(s) of the program services and the authority for the alternative payment model (if applicable), how much and which aspects of your attributed population would be included, and a description of the program objectives and allowed expenses. The description should also state 1) how payment under InCK would not result in their receiving payment for the same services twice and 2) the percentage of the attributed population that would fall under both programs, with a plan to avoid program duplication without excluding the portion of the attributed population involved in both programs.

- 5. Please provide a summary of your processes and procedures for avoiding duplication with Medicaid, Title V, and any other federal, state, or local funding used for direct care coordination or case management services expenses for or related to the attributed population and the InCK model. For example, if you have specific billing procedures for avoiding duplicating funding for the same expense, please explain here.

6. Do you plan to apply InCK funds to activities for which there are other current or future funding sources?

Yes_ No_

If yes, please provide a description of those activities and the current funding source.

Please describe how you will use model funds to implement practices and procedures that are different from your existing care model. These practices can build upon an existing care model, but the model funding should not be used to supplant current funding or be duplicative of current funding.

Appendix G. Reporting Milestones

This Milestones Chart depicts what all InCK Model Awardees must report or submit to CMMI by quarter/year during the 7-year model period.

Operational Milestone Reporting	
Performance Milestone Reporting Tied to Additional CMMI Funding	

	Pre-Implementation Period								Performance Period																												Post Award Period
	Year 1				Year 2				Year 3				Year 4				Year 5				Year 6				Year 7				90 Days								
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	After Award				
Operational Milestones																																					
Awardee Requirements																																					
Learning System attendance and participation																																					
Updated Model Implementation Plan																																					
Updated Partnership Council Charter																																					
Contractual agreement between state and Lead Organization																																					
Obtain CMS-approved SPA and/or Waiver (if applicable)																																					
Submit Quarterly Progress Report																																					
Awardee-specific needs assessment and SIL2 and SIL 3 enrollment targets																																					
Number of attributed beneficiaries assessed, stratified, and served																																					
Medicaid or CHIP SPA or waiver timeline (appendix)																																					
MCP participation documentation (appendix)																																					
Performance measure milestone reports*																																					
Submit Annual Progress Report																																					
Submit Model Evaluation Data																																					
Retrospective list of attributed beneficiaries																																					
Completed Eligibility Checklists and needs assessments of attributed population																																					
Medicaid and CHIP (if applicable) Claims and Encounter Data for Each Attributed Child																																					
Non-claims Data (e.g. qualitative data)																																					
Submit Final Model Report																																					
Performance Milestones [*Measures]																																					
Lead Organization & State: Reporting Requirements																																					
Clinical/Behavioral																																					
Care Coordination																																					
Housing																																					
Education																																					
Nutrition/Food Insecurity																																					

Appendix H: Timeline for Data Reporting Chart(s)

Quarterly Timeline for InCK Model Measure Reporting <i>Performance Year = PY Model Year = MY</i>	Year 1 <i>Test Report Process No Link to Funds</i>				Year 2 <i>Baseline Reporting No Link to Funds</i>				Year 3 <i>PY:1 Linked to Funds in MY:5</i>				Year 4 <i>PY:2 Linked to Funds in MY:6</i>				Year 5 <i>PY:3 Linked to Funds in MY:7</i>				Year 6 <i>PY:4 Measurement & Eval Only</i>				Year 7 <i>PY:5 Measurement & Eval Only</i>				Post Award Final Report	After Model Eval Period
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	90 Days	TBD
	Measurement Period																													
Claims Run-Out Period																														
Data Analysis and Reporting to CMMI																														
Measure Performance Review and Verification																														
Awardee Notification of Review Results for NCC Planning																														
Awardee Submission of NCC																														
CMS Reviews and Approves/Denies NCC																														
Notice of Award																														
Award Funding Expended																														

Appendix I: Glossary

TERM	DEFINITION
Behavioral Health	Behavioral health is an inclusive term for mental health and substance use conditions and disorders, per SAMHSA’s use of the term (for example, https://www.samhsa.gov/capt/practicing-effective-prevention/prevention-behavioral-health , and https://www.samhsa.gov/behavioral-health-equity)
Care coordination	Care coordination provides a bridge across multiple systems that serve children and families, including health care providers, schools, Head Start, and community-based organizations, to facilitate the delivery of safe, appropriate, comprehensive, individualized and effective health care services (Making Connections: Strengthening Care Coordination in the Medicaid Benefit for Children & Adolescents, 2014). Care coordination activities include but are not limited to identifying an individual child’s needs and preferences; helping families enroll in child-serving programs; organizing care activities (e.g. arranging appointments, transportation, reminders, and follow-up); facilitating effective information sharing among providers, children, families/caregivers across the health system and other systems that serve children; and marshalling the personnel and other resources needed to carry out all required care activities.
Case management	A collaborative process of assessment, planning, facilitation, coordination, and evaluation of, and advocacy for options and services to address a child’s and primary caregivers’ comprehensive physical health, behavioral health, oral health, and other health needs through communication and available resources to promote quality cost-effective outcomes.
Child and youth health	<p>“The extent to which an individual child or groups of children are able or enabled to a) develop and realize their potential; b) satisfy their needs and c) develop the capacities to allow them to interact successfully with their biological, physical and social environment” (National Research Council; Institute of Medicine, 2004). In other words, child and youth health is the “full range of health constructs, including physical health, developmental, social, emotional and behavioral health, oral health, nutrition, and physical activity” (U.S. Department of Health and Human Services; U.S. Department of Education).</p> <p>Three child and youth health domains are distinguished: health conditions (disorders or illnesses of body systems); functioning (how health manifests in daily life); health</p>

	potential (development of competence, capacity, and development potential) (National Research Council; Institute of Medicine, 2004).
Child and youth health care	“Physical, mental, and behavioral health care, oral health care, nutrition supports, and developmental services that include appropriate screening and referral and the entities that directly provide or indirectly support the provision of that care” (U.S. Department of Health and Human Services; U.S. Department of Education).
Child health services	Refers to services meant to address child and youth health (as defined in this glossary), including child and youth health care (as defined in this glossary) and Core Child Service Types (as defined in this glossary).
Child-serving agency	A federal, state, local, or tribal entity that pays for and/or provides services pertaining to child and youth health as defined in this glossary.
Family-centered services	Family-centered is defined as considering the role of the family in prevention and treatment, including “...promoting and supporting healthy attachment and relationships between parents and children...” (https://www.womenshealth.gov/files/documents/white-paper-opioid-508.pdf)
Home- and Community-based services (HCBS)	“Refers to an array of services and supports delivered in the home or other integrated community setting that promote the independence, health and well-being, self-determination, and community inclusion of a person of any age who has significant, long-term physical, cognitive, sensory, and/or behavioral health needs.” (National Quality Forum)
Core Child Service Types	The types of child services that must be included and integrated under this model. These include physical and mental/behavioral clinical care, school-based services, housing, food, early childhood services and child welfare services (see InCK Services for more information).
Lead Organization	Organization responsible for improving population-level care quality and outcomes, forming Partnership Councils, and determining service integration protocols and processes
Partnership Council	Group of system representatives who have a vested interest in the welfare of children and system change in their community.
Provider	Providers furnishing InCK clinical and non-clinical core services to the target population.
Out-of-home placement	For the purposes of the InCK Model, out-of-home placement is defined as placement in a psychiatric hospital, residential care center, skilled nursing facility, correctional

	facility, foster care (including groups homes and therapeutic foster care), or juvenile detention.
Usual care	Usual care describes the routine clinical care received by patients for the prevention or treatment of disease or injury. Usual care means care that would be routinely provided to the attributed child regardless of whether they receive an intervention under the model, and includes care that would otherwise be covered under Medicaid or CHIP. For purposes of this NOFO, usual care includes but is not limited to federal and state reporting requirements (e.g., mandatory reporting of child abuse and neglect), recommended screenings, and institutional and individual practice protocols (e.g., hospital guidelines and procedures).

Appendix J: 504 Compliance

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

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

Accessibility Requirements:

1. **Public Notification:** If you have a public facing website, you shall post a message no later than **30** business days after award that notifies your customers of their right to receive an accessible format. Sample language may be found at: <http://www.medicare.gov/aboutus/nondiscrimination/nondiscrimination-notice.html>. Your notice shall be crafted applicable to your program.
2. **Processing Requests Made by Individuals with Disabilities:**
 - a. **Documents:**
 - i. When receiving a request for information in an alternate format (e.g., Braille, large print, etc.) from a beneficiary or member of the public, you must:
 1. Consider/evaluate the request according to civil rights laws.
 2. Acknowledge receipt of the request and explain your process within **2** business days.
 3. Establish a mechanism to provide the request.
 - ii. If you are unable to fulfill an accessible format request, CMS may work with you in an effort to provide the accessible format. You shall refer the request to CMS within **3** business days if unable to provide the request. You shall submit the request, using encrypted e-mail (to safeguard any personally identifiable information), to the AltFormatRequest@cms.hhs.gov mailbox with the following information:
 1. The e-mail title shall read “Grantee (Organization) Alternate Format Document Request.”
 2. The body of the e-mail shall include:

- a. Requester's name, phone number, e-mail, and mailing address.
 - b. The type of accessible format requested, e.g., audio recording on compact disc (CD), written document in Braille, written document in large print, document in a format that is read by qualified readers, etc.
 - c. Contact information for the person submitting the e-mail – Organization (Grantee), name, phone number and e-mail.
 - d. The document that needs to be put into an accessible format shall be attached to the e-mail.
 - e. CMS may respond to the request and provide the information directly to the requester.
- iii. The Grantee shall maintain record of all alternate format requests received including the requestor's name, contact information, date of request, document requested, format requested, date of acknowledgment, date request provided, and date referred to CMS if applicable. Forward quarterly records to the AltFormatRequest@cms.hhs.gov mailbox.
- b. Services
- i. When receiving request for an accessibility service (e.g., sign language interpreter) from a beneficiary or member of the public, you must:
 - 1. Consider/evaluate the request according to civil rights laws.
 - 2. Acknowledge receipt of the request and explain your process within **2** business days.
 - 3. Establish a mechanism to provide the request.
 - ii. If you are unable to fulfill an accessible service request, CMS may work with you in an effort to provide the accessible service. You shall refer the request to CMS within **3** business days if unable to provide the service. You shall submit the request, using encrypted e-mail (to safeguard any personally identifiable information) to the AltFormatRequest@cms.hhs.gov mailbox with the following information:
 - 1. The e-mail title shall read "Grantee (Organization) Accessible Service Request."
 - 2. The body of the e-mail shall include:
 - a. Requester's name, phone number, e-mail, and mailing address.
 - b. The type of service requested (e.g., sign language interpreter and the type of sign language needed).
 - c. The date, time, address and duration of the needed service.
 - d. A description of the venue for which the service is needed (e.g., public education seminar, one-on-one interview, etc.)
 - e. Contact information for the person submitting the e-mail – Organization (Grantee), name, phone number and e-mail.
 - f. Any applicable documents shall be attached to the e-mail.
 - g. CMS will respond to the request and respond directly to the requester.
 - iii. The Grantee shall maintain record of all accessible service requests received including the requestor's name, contact information, date of request, service requested, date of acknowledgment, date service provided, and date referred to CMS

if applicable. Forward quarterly records to the AltFormatRequest@cms.hhs.gov mailbox.

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

a. Documents:

- i. When receiving a request for information in a language other than English from a beneficiary or member of the public, you must:
 1. Consider/evaluate the request according to civil rights laws.
 2. Acknowledge receipt of the request and explain your process within **2** business days.
 3. Establish a mechanism to provide the request as applicable.
- ii. If you are unable to fulfill an alternate language format request, CMS may work with you in an effort to provide the alternate language format as funding and resources allow. You shall refer the request to CMS within **3** business days if unable to provide the request. You shall submit the request, using encrypted e-mail (to safeguard any personally identifiable information), to the AltFormatRequest@cms.hhs.gov mailbox with the following information:
 1. The e-mail title shall read “Grantee (Organization) Alternate Language Document Request.”
 2. The body of the e-mail shall include:
 - a. Requester’s name, phone number, e-mail, and mailing address.
 - b. The language requested.
 - c. Contact information for the person submitting the e-mail – Organization (Grantee), name, phone number and e-mail.
 - d. The document that needs to be translated shall be attached to the e-mail.
 - e. CMS may respond to the request and provide the information directly to the requester.
- iii. The Grantee shall maintain record of all alternate language requests received including the requestor’s name, contact information, date of request, document requested, language requested, date of acknowledgment, date request provided, and date referred to CMS if applicable. Forward quarterly records to the AltFormatRequest@cms.hhs.gov mailbox.

b. Services

- i. When receiving request for an alternate language service (e.g., oral language interpreter) from a beneficiary or member of the public, you must:
 1. Consider/evaluate the request according to civil rights laws.
 2. Acknowledge receipt of the request and explain your process within **2** business days.
 3. Establish a mechanism to provide the request as applicable.
- ii. If you are unable to fulfill an alternate language service request, CMS may work with you in an effort to provide the

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

1. The e-mail title shall read “Grantee (Organization) Accessible Service Request.”
 2. The body of the e-mail shall include:
 - a. Requester’s name, phone number, e-mail, and mailing address.
 - b. The language requested.
 - c. The date, time, address and duration of the needed service.
 - d. A description of the venue for which the service is needed (e.g., public education seminar, one-on-one interview, etc.)
 - e. Contact information for the person submitting the e-mail – Organization (Grantee), name, phone number and e-mail.
 - f. Any applicable documents shall be attached to the e-mail.
 - g. CMS will respond to the request and respond directly to the requester.
- iii. The Grantee shall maintain record of all alternate language service requests received including the requestor’s name, contact information, date of request, language requested, service requested, date of acknowledgment, date service provided, and date referred to CMS if applicable. Forward quarterly records to the AltFormatRequest@cms.hhs.gov mailbox.

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