

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

**States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model
Funding Opportunity**

Notice of Funding Opportunity Type: New

Funding Opportunity Award Type: Cooperative Agreement

Notice of Funding Opportunity Number: CMS-4S4-24-001

Federal Assistance Listings Number (CFDA): 93.968

Notice of Funding Opportunity Posting Date: November 16, 2023

Applicable Dates:

Letter of Intent to Apply Due Date:

Cohorts 1 and 2: February 5, 2024

Cohort 3: July 26, 2024

Electronic Application Due Date:

Cohorts 1 and 2: March 18, 2024, 3:00 pm Eastern Standard Time

Cohort 3: August 12, 2024, 3:00 pm Eastern Standard Time

Anticipated Issuance Notice(s) of Award:

Cohorts 1 and 2: May 24, 2024

Cohort 3: October 21, 2024

Anticipated Cooperative Agreement Period of Performance:

Cohort 1: 5.5 years (2024-2029)

Cohort 2: 5.5 years (2024-2029)

Cohort 3: 6 years (2025-2030)

Anticipated Model Implementation Period:

Cohort 1: 9 years

Cohort 2: 8 years

Cohort 3: 8 years

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Executive Summary

This Notice of Funding Opportunity (NOFO) is announcing the opportunity to apply to participate in the States Advancing All-Payer Health Equity Approaches and Development Model (referred to as “AHEAD” or the “AHEAD Model”), including availability of Cooperative Agreement funding of up to \$12 million per award recipient. State Medicaid agencies, state public health agencies, and other state agencies may apply to participate in AHEAD on behalf of their states.

The AHEAD Model is a voluntary, state-based alternative payment and service delivery model designed to curb health care cost growth, improve population health, and advance health equity by reducing disparities in health outcomes. The AHEAD Model will test a flexible framework that includes statewide or sub-state accountability targets for all-payer and Medicare fee-for-service cost growth, primary care investment, and equity and population health outcomes. The Model will include specific components to help each award recipient to achieve these goals, including an initial investment via the Cooperative Agreement award to support planning and implementation activities, Medicare fee-for-service and Medicaid hospital global budgets for participating hospitals, and a primary care program for participating primary care practices.

The AHEAD Model will operate for 11 years (2024-2034). Applicants must select one of three Cohorts to participate in based on their stage of readiness to implement the Model. CMS will select, via a competitive process, up to eight award recipients. Up to \$12 million in Cooperative Agreement award funding will be available to each selected award recipient over the course of up to six years. The Model will conclude for all Cohorts on December 31, 2034.

Item	Description
HHS Awarding Agency	Centers for Medicare & Medicaid Services (CMS)
CMS Awarding Center	Center for Medicare & Medicaid Innovation (CMMI)
Notice of Funding Opportunity Title	States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model
Authorization	Section 1115A of the Social Security Act (the Act)
Federal Assistance Listings Number	93.968
Funding Opportunity Type	New
Funding Opportunity Number	CMS-CMS-4S4-24-001
Type of Award	Cooperative Agreement
Type of Competition	Competitive
Letter of Intent	CMS recommends a letter of intent to apply for this funding opportunity. These are optional. See Section C.3, <i>Letter of Intent</i> for more information.
Application Due Date and Time	Cohorts 1 and 2: March 18, 2024, 3:00 pm Eastern Standard Time Cohort 3: August 12, 2024, 3:00 pm Eastern Standard Time
Anticipated Issuance Notice(s) of Award	Cohorts 1 and 2: May 24, 2024 Cohort 3: October 21, 2024

Item	Description
Cooperative Agreement Period of Performance Start Date	Cohorts 1 and 2: July 1, 2024 Cohort 3: January 1, 2025
Cooperative Agreement Period of Performance End Date	Cohorts 1 and 2: 5.5 years, December 31, 2029 Cohort 3: 6 years, December 31, 2030
Anticipated Total Available Funding	\$96,000,000.00 (subject to availability of funds)
Estimated Maximum Award Amount	\$12,000,000.00
Estimated Maximum Number of Awardees	8

A. Program Description

A1. Purpose

This Notice of Funding Opportunity (NOFO) describes the States Advancing All-Payer Health Equity Approaches and Development Model (referred to herein as “AHEAD” or the “AHEAD Model”) and provides instructions for applicants on how to apply.

CMS, through its Center for Medicare and Medicaid Innovation (“CMMI” or the “Innovation Center”), seeks applications for the AHEAD Model. The voluntary Model will test the effects that holding states accountable for controlling the growth in health care costs has on improving population health and health equity in a state or sub-state region. The Model relies on specific alternative payment and service delivery models to achieve these goals:

- improve population health;
- advance health equity by reducing disparities in health outcomes; and
- curb health care cost growth and reduce expenditures in the Medicare and Medicaid programs.

CMS will evaluate the impact of the AHEAD Model on health care spending and utilization, quality of care, and health equity.¹

¹ CMS defines health equity as the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.

CMS will award, through a competitive process, Cooperative Agreements to up to eight successful applicants (herein referred to as “award recipients” or “recipients”). The Model will operate for 11 years (2024-2034), with Cooperative Agreement funding available for first 5.5 or 6 years (see Section B4, *Cooperative Agreement Period of Performance*).

Award recipients will select to participate in one of three Cohorts based on their stage of readiness to implement the Model:

- Cohort 1: 18-month Pre-Implementation Period begins July 1, 2024; Implementation Period begins January 1, 2026
- Cohort 2: 30-month Pre-Implementation Period begins July 1, 2024; Implementation Period begins January 1, 2027
- Cohort 3: 24-month Pre-Implementation Period begins January 1, 2025; Implementation Period begins January 1, 2027

Award recipients will be required to recruit hospitals and primary care practices to participate in AHEAD, including in the Medicare fee-for-service (FFS) and Medicaid hospital global budgets (see Section A4.5, *Hospital Global Budgets*) and the primary care program, Primary Care AHEAD (see Section A4.6, *Primary Care AHEAD*), respectively.

The parameters for the AHEAD Model are detailed throughout this NOFO. Specific information regarding funding amounts is detailed in Section B, *Federal Award Information*.

A2. Authority

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

A3. Background

The AHEAD Model is the next generation of state-based, multi-payer total cost of care (TCOC) models from the CMS Innovation Center. AHEAD builds on existing state-based models, including the Vermont All-Payer Model (VT APM), Maryland Total Cost of Care Model (MDTCOC), and the Pennsylvania Rural Health Model (PARHM).² CMS and states have learned from these efforts to spur statewide and regional transformation. Preliminary evaluation data from these models indicates that these types of models have potential to generate savings, quality and population health improvements, and system-wide care delivery transformation. AHEAD provides a pathway to scale these initiatives across states with sufficient flexibility to account for each state’s unique health care delivery structures. Scaling these initiatives across multiple states would allow for a greater number of beneficiaries to benefit from these investments in health care transformation.

² CMMI is also integrating lessons learned from Community Health Access and Rural Transformation Model (CHART), particularly around 1) financial methodologies and guardrails needed for rural hospital participation and 2) development of a community-led transformation plan to improve outcomes and advance health equity in rural areas. While CHART was terminated in 2023, CMMI is committed to learning from that model.

AHEAD is aligned with the Innovation Center’s strategic priorities to drive accountable care, advance health equity, support care innovations, improve access by addressing affordability, and continue partnering with states to achieve system transformation.³ Of note, AHEAD encourages a multi-sector approach to promoting equity. Resources can be coordinated to drive health improvements across population groups and address the underlying factors that have consistently led to poor health outcomes in underserved communities.

AHEAD is designed as a flexible framework to align accountability and responsibility for improved health outcomes and reduced health care costs for Medicare FFS and Medicaid beneficiaries and all residents of the state or sub-state region. The Model is intended to integrate seamlessly into ongoing state health reform work – especially in those states that have already invested significant time and resources in reorienting their care delivery systems towards greater preventive and high-value care, including in Medicaid. AHEAD will align Medicare FFS with states’ multi-payer efforts to address affordability, cost growth containment, and care delivery (e.g., establishing cost growth benchmarks, hospital global budgets, primary care minimum spending targets, and Medicaid innovation). This alignment across payers is intended to accelerate transformation across the entire health system.

Innovation Center experience shows that states are well positioned to lead the implementation of the AHEAD Model. States are already able to leverage policy and regulatory levers (e.g., Medicaid policy innovation, commercial market regulation, provider rate setting, incentives, and penalties for exceeding all-payer TCOC spending targets, etc.) to facilitate multi-payer alignment and control TCOC growth. States also have established relationships with provider associations, local governments, communities, and non-profit organizations that can implement interventions to achieve the Model’s goals of improving population health and advancing health equity.

A4. Program Requirements

A4.1. Model Structure

The AHEAD Model tests a flexible framework that includes (*Figure 1*):

- **Agreements (3 types):** Each award recipient (i.e., state agency) will partner with CMS to implement the Model through (1) a **Cooperative Agreement** award for which this NOFO is soliciting applications, and (2) a **State Agreement**. Award recipients will recruit hospitals and primary care providers that will execute individual (3) **Participation Agreements** with CMS.

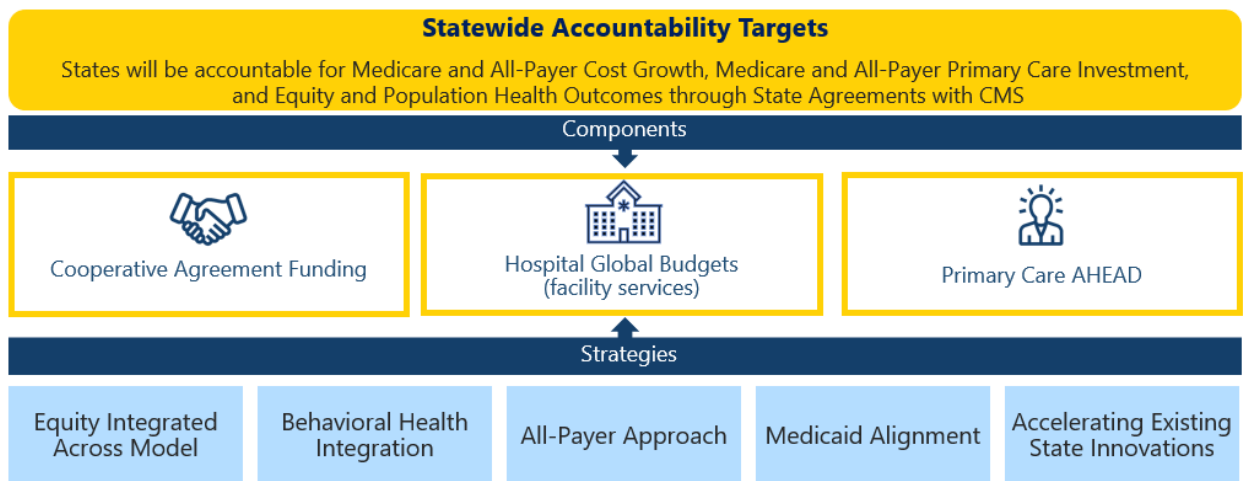
Each award recipient will be required as a term of the Cooperative Agreement award to enter into a State Agreement with CMS. The State Agreement will memorialize the negotiated accountability targets and other requirements of Model participation. The State Agreement must be signed by:

- the award recipient (e.g., state agency);
- the governor;

³ CMS Innovation Center Strategy Refresh, 2023, available [here](#).

- head of the State Medicaid Agency (if different from the award recipient),
 - head of any agency with hospital rate-setting or budget authority (if applicable); and
 - head of the agency responsible for public health activities within the state (if distinct from other entities previously listed).
- **Participating Providers:** The award recipient (e.g., state agencies) will recruit hospitals and primary care practices to participate in hospital global budgets and Primary Care AHEAD, respectively. Hospitals and primary care practices will enter individual Participation Agreements with CMS.
 - **Components:**
 - **Statewide or sub-state accountability targets** for all-payer and Medicare FFS growth, primary care investment, equity, and population health outcomes;
 - **Cooperative Agreement funding** to support Model implementation activities, payment methodology development, and population health activities in the early years of the Model;
 - **Hospital global budgets** (for hospitals) to provide stable payment, constrain costs, and improve population health; and
 - **Primary Care AHEAD** (for primary care practices) to provide primary care investment and support advanced primary care.

Figure 1. AHEAD Model Structure



A4.1.1 Model Governance Structure

Award recipients will be required under the terms of the Cooperative Agreements to establish a multi-sector Model Governance Structure within the state or sub-state region to inform Model activities. State Medicaid and Health agencies must play a leading role in bringing together this group of individuals representing various entities, interests, and geographies within the state or sub-state region. In addition to these agencies, the Model Governance Structure must include:

- representation from other relevant state agencies (e.g., Departments of Insurance or other state agency with hospital rate or budget setting authority);

- community-based organizations from underserved communities;
- patients and consumers from underserved communities (along with associated advocacy organizations);
- health care payers (including commercial payers);
- clinicians and provider organizations, including those from underserved communities; and
- other entities whose policies influence population health (e.g., organizations related to transportation, food insecurity, or housing).

If applicable to the participating state or sub-state region, the Model Governance Structure should also include representatives from the state office of rural health and local tribal communities.

Award recipients can leverage an existing council, workgroup, or equivalent to meet this requirement, but must ensure that the individuals and entities described above are able to participate in Model-related activities and decision-making. The Model Governance Structure must include representation from community-based organizations, patients and consumers, provider organizations and payers that serve, are based in, or are drawn from the population residing in the state, or if an award recipient designates a sub-state region as described in Section C1, *Eligible Applicants*, the sub-state region. Among other potential roles that award recipients may assign to this entity, the Model Governance Structure is responsible for developing and monitoring implementation of the Statewide Health Equity Plan described in Section A4.3.1, *Health Equity*. The Model Governance Structure must be established no later than six months after the award is made.

While award recipients remain ultimately accountable for ensuring that obligations and requirements associated with the Cooperative Agreement are met, the award recipient must designate a formal role for the Model Governance Structure. As a requirement of the Cooperative Agreement, the award recipient is required to work with the Model Governance Structure to:

- plan for and assist with Model implementation, including by: (1) providing input into the selection of statewide population health and quality measures and equity targets described in Section A4.3, *Statewide Quality and Equity Targets*; (2) developing the statewide Health Equity Plan described in Section A4.3.1, *Health Equity* and producing annual reports on progress implementing Health Equity Plan; (3) assisting with the review of Hospital Health Equity Plans described in Section A4.3.1, *Health Equity*; and (4) providing input on the use of Cooperative Agreement funding to support Model activities;
- ensure that Model implementation is informed by diverse perspectives and provide input to the award recipient as it plans investments and activities to meet AHEAD's quality and cost growth objectives described in Sections A4.2, *Statewide Accountability Targets* and A4.3, *Statewide Quality and Equity Targets*. This may include providing input into the establishment of all-payer cost growth and primary care investment targets.

A4.1.2. State Medicaid Agency Requirements

As either the award recipient or subrecipient on the Cooperative Agreement award, the state Medicaid agency (SMA) must be willing to:

- be a signatory on the State Agreement;
- be a participant in the Model Governance Structure;
- aid in primary care practice recruitment for Primary Care AHEAD (see Section A4.6, *Primary Care AHEAD*);
- collaborate with CMS to establish, recruit hospitals for, and participate in, Medicaid hospital global budgets; and
- operate a Medicaid Primary Care APM.⁴

A4.2. Statewide Accountability Targets

Award recipients will be accountable for Medicare FFS and all-payer total cost of care (TCOC) growth and primary care investment targets. Medicare FFS targets include spending for resident Medicare FFS beneficiaries, regardless of where the expense is incurred. All-payer targets include spending, regardless of where the expense is incurred, for all residents of the state or sub-state region, including those with the following types of insurance:

- Medicare (FFS or Medicare Advantage)
- Medicaid (FFS or managed care)
- Commercial insurance, including employer-based insurance, state employee health plans and Marketplace plans

Total Cost of Care (TCOC) Growth Targets: The AHEAD Model aims to rebalance health care spending across the system, leveraging hospital global budgets and primary care investment targets to shift health care spending and utilization from acute care settings over time to primary care and community-based settings. To ensure this rebalance occurs without simply increasing overall spending, recipients will be accountable for constraining Medicare FFS (Parts A and B) and all-payer TCOC growth.

Under the terms of the State Agreement, each award recipient will be expected to generate savings relative to the counterfactual (e.g., compared to the state's projected TCOC growth absent the model) during the Model Implementation Period⁵. CMS will identify state-specific factors (e.g., historic spending) in considering both the construction of the counterfactual as well as the magnitude of expected savings.

⁴ A qualified Medicaid Primary Care APM may be a patient-centered medical home (PCMH) program or another primary care value-based payment arrangement that includes increased accountability and care transformation structure for care coordination, health-related social needs, and behavioral health/specialty integration. CMS expects some variation in the format and goals of these programs, but generally must aim to improve and advance coordinated, whole-person and team based primary care for Medicaid beneficiaries.

⁵ The Implementation Period is the period after Pre-Implementation through the end of the Model (December 31, 2034). This is separate from the Cooperative Agreement Period of Performance. See Section B4, *Cooperative Agreement Period of Performance* for more information.

Accountability Targets	Description
Medicare FFS TCOC Growth Targets	<p>Each award recipient will be accountable for meeting a target for resident Medicare FFS beneficiaries' TCOC growth on an annual basis. CMS will work collaboratively with each award recipient during the pre-implementation period to set the targets building from a common CMS methodology. The state or sub-state specific Medicare FFS cost growth target and calculation methodology will be outlined in each award recipient's State Agreement. All Medicare FFS spending (Parts A and B) for beneficiaries in the state or region who meet the eligibility criteria (e.g., residents in the state for a minimum defined timeframe) will be included in the Medicare FFS cost growth target calculation. CMS may adjust Medicare FFS hospital global budgets if the state does not meet established state Medicare FFS cost growth targets, following an opportunity for state remediation of the issue.</p>

Accountability Targets	Description
State All-Payer TCOC Growth Targets	<p>Each award recipient will be accountable for meeting a target for all-payer TCOC growth, comprising Medicare, Medicaid, and commercial payers, on an annual basis. For all award recipients, all-payer cost growth targets (or, at minimum, the process to determine such a target) must be memorialized in state Executive Order, statute, or regulatory change 90 days before the start of PY1 and must subsequently be sustained throughout the duration of the Implementation Period. The state or sub-state specific all-payer cost growth target and calculation methodology will be defined and described in each award recipient’s State Agreement once enacted and specified (at minimum, 90 days before the start of PY2). If the state targets are memorialized by Executive Order, statute, or regulation prior to execution of the State Agreement, the methodology and targets will be included in the State Agreement at that time; otherwise, the State Agreement will be amended to reflect these targets at least 90 days before the start of PY2. If the state misses its all-payer TCOC target, CMS may require corrective action and/or adjust Enhanced Primary Care Payments (EPCPs). Data collection and reporting on all-payer cost growth should be coordinated with data collection for the primary care investment target, described below. Award recipients can use existing all-payer cost growth target legislation or regulations to meet requirements for this component of the AHEAD model; however, a state may need to update the applicable legislation or regulation to sustain the targets during the duration of the Implementation Period. Award recipients beginning Model participation without all-payer cost growth targets will be encouraged to leverage the experience of early adopters and build on methodologies used in other existing state cost growth benchmarking programs.⁶</p>

See Appendix XI. *Medicare FFS Total Cost of Care (TCOC) Expenditure Targets* for more detailed information on how the expenditure targets will be calculated, including the expected range.

Primary Care Investment Targets: Award recipients will be accountable for all-payer and Medicare FFS primary care investment targets.

⁶ The Peterson-Milbank Program for Sustainable Healthcare Costs has been tracking these efforts and has additional resources for states. Information on the Peterson-Milbank Program available [here](#).

Investment Targets	Description
<p>Medicare FFS Primary Care Investment Targets</p>	<p>Each award recipient will be accountable for meeting both annual improvement targets throughout the duration of the Implementation Period and a final primary care investment target by the end of the Implementation Period for resident Medicare FFS beneficiaries. These targets will be set by CMS on a state-by-state basis during the pre-implementation period and will be set forth in the award recipient’s State Agreement. CMS anticipates that each award recipient’s final primary care target will be between 6-7% of Medicare TCOC, depending on current Medicare primary care spend in the state or sub-state region.</p> <p>CMS will set a standard definition of primary care for the purpose of measuring Medicare FFS primary care spending, consisting of designated provider specialty codes, Healthcare Common Procedure Coding System (HCPCS) codes, and non-claims-based payments (measurement specifics available upon request).</p> <p>Annually, CMS will produce and share Medicare FFS primary care spending measurement data with award recipients.</p>
<p>All-Payer Primary Care Investment Targets</p>	<p>Each award recipient will be accountable for meeting an all-payer primary care investment target that will be set by CMS on a state-by-state basis and in collaboration with existing state efforts on all-payer primary care investment. The state or sub-state region specific all-payer primary care investment target and calculation methodology will be outlined in each recipient’s State Agreement. The process and authorities for setting All-Payer Primary Care Investment Targets must be memorialized in state Executive Order, statute, or regulatory change at least 90 days prior to the start of PY1; recipients that have existing primary care investment legislation or regulatory activities may leverage that to achieve targets under AHEAD. As with the all-payer cost growth target, the methodology and defined target will be included and described in the State Agreement once defined, no later than 90 days prior to the start of PY2.</p> <p>If a state has an existing all-payer primary care investment target, the state may use their current definition of primary care for measurement, subject to CMS approval. All measurement data must be shared with CMS. If a state</p>

Investment Targets	Description
	<p>does not have an existing definition of primary care for all-payer measurement, they may use the CMS AHEAD definition. This flexibility is included given variations in state primary care priorities, definitions already established in primary care statute or regulation, and the unique population health needs of each state or designated sub-state region. Recipients will be expected to use all tools available at their disposal to increase primary care investment as a proportion of their TCOC, including increasing primary care practice participation in Primary Care AHEAD (see Section A4.6, <i>Primary Care AHEAD</i>) and decreasing TCOC. The award recipient must appoint one state agency or entity that will have overarching responsibility for the coordination of all-payer primary care investment reporting; this should be coordinated with state reporting of TCOC for all payers. Award recipients will be required to obtain primary care spending information for each year from Medicaid and commercial payers.</p>
<p>Primary Care Investment Measurement</p>	<p>During the Pre-Implementation Period, CMS will work with award recipients to identify additional gaps in primary care spend reporting and to establish reporting templates and methodology to be used throughout the Model to support complete data. Award recipients will need to consider non-claims-based payments as part of their calculation of primary care spending and reporting. This data must include all payers to facilitate accurate measurement and tracking of primary care investment as a percentage of the TCOC. To facilitate reporting and minimize burden, CMS will provide award recipients with a reporting template.</p>

A4.3. Statewide Quality and Equity Targets

In collaboration with CMS, award recipients will set statewide or sub-statewide quality and equity targets for driving population health and quality improvement efforts throughout the Model duration (see Appendix X. *Quality and Population Health Strategy*). The targets will be reflected in each award recipient’s State Agreement, and award recipients will be accountable for performance on selected measures over time and will be required to monitor and improve measure performance for identified subpopulations experiencing disparities over the course of the Model. The Model Governance Structure will report performance on these targets to CMS and describe progress in meeting these targets as part of annual Statewide Health Equity Plan updates (see Section A4.3.1, *Health Equity*).

A4.3.1. Health Equity

AHEAD relies on a multi-sector approach that promotes health equity at the state level to drive population health improvement and coordinate resources to address the underlying factors that have led to poorer health outcomes in historically underserved communities. AHEAD's equity approach is modeled after accountable health initiatives that integrate non-clinical population health priorities into health systems to transform health care delivery, promote healthy communities, and build community partnerships under a shared commitment to health.⁷ In addition to payment innovations for hospitals and primary care practices and infrastructure funding provided via the Cooperative Agreement, AHEAD's health equity strategy includes the development of health equity plans at the state- and hospital-levels, enhanced demographic data collection, and health-related social needs screening and referrals.

Statewide Health Equity Plan: As required by both the Cooperative Agreement and State Agreement, award recipients must develop a Statewide Health Equity Plan (herein referred to as "State HEP") to define and guide Model activities aimed at reducing disparities and improving population health (through the Model Governance Structure). With the understanding that states face different gaps and have prioritized different areas for action, State HEPs represent an opportunity to share the state's vision for health equity with CMS, the state hospital community, primary care practices, and other stakeholders.

To create the State HEP, the Model Governance Structure, under the direction of the award recipient, will use a guiding template provided by CMS to:

- identify health disparities and population health focus areas; and
- set measurable goals to reduce disparities and improve population health, including optimizing performance on population health and quality measures and primary care investment targets; and
- identify evidence-based strategies to advance toward those goals; and
- inform plans for allocating resources (e.g., Cooperative Agreement award funding) to support progress toward goals; and
- develop processes to involve a wide range of stakeholders in State HEP implementation.

The State HEP can be informed by existing State Health Improvement Plans, Community Health Needs Assessments, Model Governance Structure perspectives, and other sources of health data, including new sources of data collected over the course of the Model (e.g., prevalence of health-related social needs identified through hospital and primary care screening and referral practices). As required by the Cooperative Agreement and State Agreement, the State HEP must be established by the end of the Pre-Implementation Period and periodically updated thereafter. CMS will hold states accountable for meeting State HEP goals as reported to CMS via their annual updates.

If an award recipient designates a sub-state region to implement AHEAD, as described in Section C1, *Eligible Applicants*, the Health Equity Plan for the sub-state region must include the same elements described above, with goals and strategies that are tailored to the sub-state region. As with statewide HEPs, the HEP for the sub-state region may be informed by existing statewide health equity initiatives and activities. Award recipients will be held accountable for making

⁷ [Demonstrating Success with Accountable Communities for Health](#). CA Accountable Communities for Health Initiative.

progress toward health equity goals that are specific to the sub-state region. Health equity efforts and activities described in HEPs or otherwise connected to AHEAD must not discriminate against any individual on the basis of race, ethnicity, national origin, religion, sex, or gender.

Hospital Health Equity Plan: Participating hospitals (herein referred to as “Participant Hospitals”, as defined in Section A4.5, *Hospital Global Budgets*) in AHEAD will also be required to develop Health Equity Plans (herein referred to as “Hospital HEPs”) to detail observed disparities and identify the approaches and resources they will use to advance equitable outcomes within their patient populations.

As described in the State Agreement, through the Model Governance Structure, award recipients will be required to collect and assess Hospital HEPs. Beginning in PY1, Participant Hospitals will be required to use a guiding template provided by CMS to develop Hospital HEPs and will be required to submit short annual reports to the state on progress toward meeting HEP goals. The Model Governance Structure will be required to review each Hospital HEP, utilizing assessment guidance provided by CMS, based on its robustness and alignment with the State HEP. States will be required to collect annual updates to Hospital HEPs and include these updates as a required component of annual progress reports that the State must submit to CMS.

Enhanced Demographic Data Collection: Under AHEAD, Participant Hospitals and participating Primary Care Practices (herein referred to as “Participant Primary Care Practices”) will be required to collect and report standardized self-reported patient demographic data to CMS. Demographic data can be used to monitor impacts on health disparities and patient outcomes. Technical assistance will be available to all Participant Hospitals and Participant Primary Care Practices, particularly for smaller practices and clinics that may be constrained by limited resources and the technology needed for patient-level data collection and reporting.

Health Related Social Needs Screening and Referral: In addition to collecting demographic data, Participant Hospitals and Participant Primary Care Practices will also be required to screen patients for health-related social needs (HRSN) related to housing, food, and transportation, and make referrals or take other responsive actions to address those needs. These requirements recognize, support, and aim to accelerate the efforts many states are making to use existing or new authorities to identify HRSNs and, in some cases, directly fund HRSN services. CMS will work with states in providing technical assistance to Participant Hospitals and Participant Primary Care Practices on these tools.

A4.4. Cooperative Agreement Funding to Support Model Implementation Activities

Cooperative Agreement funds are intended to support the award recipient’s Model implementation broadly, including:

- recruiting primary care providers and hospitals to participate
- setting statewide TCOC cost growth targets and primary care investment targets
- building behavioral health infrastructure and capacity

- supporting Medicaid and commercial payer alignment across the Model⁸

Applicants must submit a budget narrative (see Section D2.e, *Budget Narrative*) as part of their applications. All proposed activities and use of funds are subject to CMS approval. Examples of how funds might be used include, but are not limited to:

- state agency staffing to implement the Model
- new technology (e.g., implementing, acquiring, or upgrading health IT)⁹
- integration of community services referrals
- supporting demographic data collection
- bolstering health information exchange and creation of provider dashboards
- supporting population health activities
- implementing health-related social needs screening and referral processes
- development of Medicaid and/or commercial hospital global budget methodology
- all other aspects that align with building a population health agenda

After the initial award for Budget Period 1, continuation of the Cooperative Agreement and participation in the Model will be contingent on meeting the following Model milestones:

- Execution of State Agreement at least six months prior to the start of Performance Year (PY) 1.¹⁰
- Implementation of Medicaid Primary Care APM by the beginning of PY1.
- Implementation of Medicaid hospital global budget(s) by the end of PY1.
- Execution of hospital Participation Agreements at least 90 days prior to the start of PY1, such that at least 10% of a state or sub-state region’s Medicare FFS hospital net patient revenue (NPR) will be under a hospital global budget in PY1.¹¹

If an award recipient does not meet these milestones in the indicated timeframe, CMS will terminate the award recipient’s Cooperative Agreement award and Model participation.

CMS may restrict an award recipient’s Cooperative Agreement award funding if the following milestones are not met:

- Memorialized process in state Executive Order, statute, or regulatory change for setting an all-payer cost growth target and all-payer primary care investment target at minimum 90 days prior to the start of PY1.
- All-payer TCOC and primary care investment targets established following the process memorialized in state Executive Order, statute, or regulatory change are reflected in the

⁸ Note: any states that receive Cooperative Agreement funds to support Model Implementation activities cannot also claim federal financial participation for Medicaid administrative costs for the same Model Implementation activities.

⁹ Recipients and subrecipients are required to use health IT that meets standards and Implementation specifications adopted in 45 CFR part 170, Subpart B, if such standards and Implementation specifications can support the activity. Visit <https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-D/part-170/subpart-B> to learn more. See also F5 of this NOFO, *Health Information Technology (IT) Interoperability Language*.

¹⁰ Performance Years or “PYs” refer to the Implementation Period. See Section B4, *Cooperative Agreement Period of Performance* for specific PY dates.

¹¹ Medicare FFS hospital net patient revenue (NPR) is defined as the revenue generated from inpatient and outpatient facility services delivered at acute care and critical access hospitals.

State Agreement, or amendment to the State Agreement, at least 90 days prior to the start of PY2.

- Participation of at least one commercial payer in hospital global budgets by the start of PY2.
- Execution of hospital Participation Agreements at least 90 days prior to the start of PY4, such that at least 30% of a state or sub-state region’s Medicare FFS hospital NPR will be under a hospital global budget in PY4 and all subsequent PYs. Award recipients must maintain at least 10% of Medicare FFS hospital NPR under a hospital global budget prior to this milestone.

If an award recipient does not meet these milestones in the indicated timeframe, in addition to having its Cooperative Agreement funds restricted, they also may be subject to corrective action, which may include termination of the award recipient’s Cooperative Agreement and Model participation, including termination of the State and Participation Agreements. See also the description in Section C6, *Continued Eligibility* as well as Appendix XII, *Milestones and Potential Corrective Action* for a complete list of milestones and deadlines.

A4.5. Hospital Global Budgets

Hospital global budgets will be a critical mechanism for achieving all-payer and Medicare FFS TCOC growth targets, improving hospital quality, and generating spending reductions to offset increased spending on population health, primary care, behavioral health, and health equity. The prospective payments made under a hospital global budget do not change based on volume of services and, therefore, provide hospitals financial stability and flexibility while incentivizing the identification and reduction of potentially avoidable utilization.

Acute care hospitals, critical access hospitals (CAHs), and Rural Emergency Hospitals (REHs) that operate in award recipient states and sub-state regions that elect to participate in the Model and receive Medicare FFS hospital global budgets are referred to as “Participant Hospitals.” REHs will only be able to participate in states that enact enabling legislation regarding REHs prior to or during the performance period. States and other payers can choose to offer Medicaid and/or commercial hospital global budgets to other hospital types not eligible to receive Medicare FFS hospital global budgets.

Overlaps with other Innovation Center models¹²:

- Hospitals may simultaneously participate in AHEAD and Shared Savings Program ACOs.
- Hospitals may not simultaneously participate in the ACO Realizing Equity Access, and Community Health Model (ACO REACH) and AHEAD. Providers practicing at hospitals participating in AHEAD may still participate in ACO REACH.
- CMS will make model-by-model determinations as to whether hospitals that participate in episode-based models are eligible for AHEAD. These decisions will be made based on an assessment of the operational complexity of potential payment overlaps.

¹² See ACO REACH information available [here](#) and Medicare Shared Savings Program information available [here](#).

Medicare FFS Methodology for Hospital Global Budgets: CMS will develop and maintain a Medicare FFS hospital global budget methodology, which will be standardized across Participant Hospitals. A detailed financial methodology for calculating and adjusting Medicare FFS hospital global budgets will be provided prior to a Participant Hospital's signing of their Participation Agreement. However, CMS understands the importance of sharing a financial methodology as early as possible to aid in states' hospital recruitment efforts. As such, CMS has provided a high-level overview of the methodology as part of this NOFO (see Appendix VII. *Medicare FFS Hospital Global Budget Financial Methodology*) and intends to host at least one payment webinar shortly following the publication of this NOFO.

CMS will allow award recipients with statewide hospital rate setting authority or hospital budget setting authority and prior experience with population-based payments or global budgets to develop a state-designed Medicare FFS global budget methodology, subject to CMS approval. States may develop the authority and capacity to create their own Medicare FFS global budget methodology over time. States with hospital rate- or budget-setting authority may submit a state-designed methodology for CMS approval, at least eighteen months in advance of the PY for which it would be effective. Any state-designed methodology must align with CMS methodology on general principles, which will be detailed in the financial specifications of the CMS methodology.

State oversight of hospital transformation is critical, as the state is ultimately accountable for TCOC, population health, and equity outcomes under the Model. To that end, each award recipient will establish a process for review of individual hospital requests for adjustments to their global budgets pertaining to service line changes (e.g., upward adjustment for service line additions or retaining revenue if a service line is removed). CMS' determinations on whether to approve or deny a proposed adjustment to a hospital's global budget pertaining to a service line change will consider alignment with the statewide health equity plan and population health goals, the potential to achieve savings or budget neutrality for Medicare, input from the Model Governance Structure (MGS), impact on beneficiary access to care, and fulfillment of existing obligations under Medicare and Medicaid. Award recipients will work with CMS during the Pre-Implementation Period to develop this process, which will be defined and described in each award recipient's State Agreement.

Medicaid Methodology for Hospital Global Budgets: CMS will support award recipients in developing a Medicaid hospital global budget methodology. As part of their application, applicants must include a proposed timeline of activities for constructing and implementing a Medicaid hospital global budget methodology (see Section D2.d, *Project Narrative*). The CMS Center for Medicaid and CHIP Services (CMCS) will review the proposed methodologies for award recipients, as well as any state requests for approval of Medicaid authorities required to implement hospital global budgets for Medicaid. The proposed timeline for implementation should include:

- The proposed pathway that offers the most streamlined approach in the context of the applicant's state Medicaid program structure.
- The steps required of the SMA and legislature/various other state entities developing the necessary Medicaid authorities, which could include state plan amendment(s), Medicaid

managed care contract amendments (including implications for rate development and state directed payment prior approval) among others depending on the state's model and existing program structure and authorities.

- The anticipated timeline for each step, such that the Medicaid hospital global budget payment is implemented in time for required Medicaid alignment to AHEAD hospital global budgets (see Appendix VIII. *Medicaid Alignment Criteria* for Medicaid hospital global budget related deadlines).
- List of major stakeholder groups that need to be engaged in developing the payment change, with high-level plans on how and when the state plans to engage these groups throughout the Pre-Implementation process. This should include the proposed process for gathering sufficient Medicaid Managed Care Organization (MCO) buy-in and other contingencies for implementing global budgets in a managed care space.
- Process for contract negotiations with MCOs, if applicable.

Hospital Recruitment: Award recipients are responsible for recruiting hospitals to voluntarily participate in the hospital global budget payment arrangement. As part of their application, applicants must detail their plans for recruiting hospitals (see Section D, *Application and Submission Information*). The value proposition for hospitals joining the Model is focused on:

- stable and predictable funding;
- upfront funding in the first two years of the model to support enhanced care management for Medicare beneficiaries through the Transformation Incentive Adjustment;
- ability to reorient activities to population health management;
- technical assistance and learning resources to aid transformation activities; and
- opportunity to use benefit enhancements available under the Model to support care redesign efforts.

This business case for hospital transformation is strengthened when multiple payers implement global budgets, which is why Medicaid is a required payer beginning in PY1. Participant Hospitals can also realize financial savings from reduced avoidable utilization (e.g., avoidable admissions and emergency visits). Additionally, Participant Hospitals will be rewarded for improvements in quality and health equity, and for controlling TCOC for beneficiaries within their service area. While hospitals may join the Model in any PY, only hospitals joining the Model in PY1 or PY2 of the applicable Cohort will be eligible to receive an upfront adjustment to their Medicare FFS global budgets to invest in the care transformation activities needed to achieve success operating under a global budget (more information on the Transformation Incentive Adjustment can be found in Appendix VII. *Medicare FFS Hospital Global Budget Financial Methodology*). These upfront adjustments must be repaid if a hospital exits the Model prior to the start of their PY6.

A4.6. Primary Care AHEAD

In combination with the statewide primary care investment targets, Primary Care AHEAD is a key component of the AHEAD Model and overall primary care strategy. Primary Care AHEAD is a voluntary program within the Model for Participant Primary Care Practices. Participant Primary Care Practices may include Federally Qualified Health Centers (FQHCs) including

Health Centers and Health Center Look-Alikes¹³, Rural Health Clinics (RHCs), and practices with primary care specialties as defined by CMS.

Existing Medicaid primary care alternative payment methodologies and/or value-based payment arrangements will serve as the foundation for alignment in Primary Care AHEAD. To facilitate alignment, Participant Primary Care Practices are only eligible to participate in Primary Care AHEAD if they participate in a state-based Medicaid patient-centered medical home (PCMH) or other state-based Medicaid advanced primary care program (“Medicaid Primary Care APM”) for the same PY.

The goals of Primary Care AHEAD are to:

- Increase investment in primary care as a proportion of TCOC for Medicare FFS and across all-payers.
- Align Medicare’s primary care strategy with efforts already underway in state Medicaid programs, including enhanced care management, behavioral health integration, and referrals for health-related social needs.
- Target populations most in need of improved access to high-quality primary care by ensuring that FQHCs and RHCs can receive enhanced primary care payments and adjusting payments for medical and social risk given the particular needs of the patients they serve.
- Encourage more providers to build increased capacity to deliver advanced primary care.

Primary Care AHEAD includes three program sub-components:

1. **A Medicare Enhanced Primary Care Payment (EPCP)** to fund advanced care management and behavioral health integration activities for Participant Primary Care Practices’ attributed Medicare FFS beneficiaries. The EPCP will be adjusted for social and medical risk and may be adjusted based on state performance on Medicare FFS TCOC targets and hospital recruitment for global budgets (see Appendix IX. *Enhanced Primary Care Payment Financial Methodology* for additional information on attribution methodology).
2. **Care Transformation Requirements** that participating practices will be required to meet include integrating behavioral health care as a function of primary care, enhanced care management and specialty coordination, and addressing health-related social needs of beneficiaries.
3. **Medicaid Alignment:** Care transformation requirements and prioritized quality measures will be chosen to align with the state’s existing Medicaid advanced primary care transformation and quality priorities.

Participant Primary Care Practices will be required to advance their care transformation activities throughout the duration of the Model. The required activities will be tailored based on the state and community context, the specific needs of the practices’ attributed Medicare FFS and Medicaid populations, and each state’s existing Medicaid primary care transformation efforts, and will be detailed in each Participating Primary Care Practice’s Participation Agreement.

¹³ For more information on Health Center Look-Alikes, see [here](#).

AHEAD also encourages commercial alignment (including Medicare Advantage) with Primary Care AHEAD. CMS will offer learning resources and technical assistance to help states facilitate commercial participation in primary care transformation under AHEAD.

CMS and the award recipient will provide technical assistance and support to practices through the duration of the Model. Award recipients will be required to collaborate with CMS and Participant Primary Care Practices to set care transformation priorities throughout the course of the Model Implementation Period, under the terms of the State Agreements.

Primary Care Practice Recruitment: Recipients will be required to recruit primary care practices, including FQHCs and RHCs, that meet the Primary Care AHEAD provider eligibility requirements to participate in Primary Care AHEAD. As part of their application, applicants must detail their plans for recruiting practices that are already participating in the state Medicaid Primary Care APM to participate in Primary Care AHEAD. An eligible practice selected for participation must sign a Participation Agreement with CMS in advance of the first PY they plan to participate in Primary Care AHEAD.

Overlaps with other Innovation Center models:

- Practices may simultaneously participate in Medicare Shared Savings Program or ACO REACH and Primary Care AHEAD.
- Practices that participate in Primary Care First (PCF), Making Care Primary (MCP), or any other CMS model with a no-overlaps policy are ineligible to participate.

To ensure alignment of incentives across the system and incentivize robust recruitment of both hospitals and practices, hospital-owned practices will only be eligible to participate in Primary Care AHEAD if the affiliated hospital is participating in AHEAD hospital global budgets for that PY.

A4.7. Operational Flexibilities under AHEAD

Section 1115A(d)(1) of the Social Security Act (the Act) authorizes the Secretary of Health and Human Services to waive such requirements of Titles XI and XVIII and of sections 1902(a)(1), 1902(a)(13), 1903(m)(2)(A)(iii), and certain provisions of section 1934 of the Act as may be necessary solely for purposes of carrying out the testing by CMMI of an innovative payment and service delivery model, including the AHEAD Model. Any such waivers would be set forth in documentation separately issued by CMS.

A4.8. Commercial Payer Alignment

States will be expected to leverage available legislative or regulatory authority to hold commercial payers accountable for TCOC growth. Under the State Agreement, states will be accountable for commercial payer spend through the all-payer TCOC cost growth targets and primary care investment targets. This accountability helps ensure that incentives for improved population health and reduced costs are aligned across payers. The state may also choose to convene payers to support multi-payer alignment on primary care transformation and other population health activities.

At least one commercial payer operating in the state or sub-state region must participate in hospital global budgets by the start of PY2 as required in each award recipient's State Agreement and the Cooperative Agreement terms and conditions. Commercial payers may include state employee health plans, Basic Health Plans, Qualified Health Plans, and Medicare Advantage plans (including Dual Eligible Special Needs Plans), among others. If there is not at least one commercial payer participating in hospital global budgets by the start of PY2, the award recipient will be subject to corrective action (see Appendix XII. *Milestones and Potential Corrective Action* for a complete list of actions that may result in corrective action). Commercial payer participation is important for hospital recruitment and the state's ability to meet all-payer TCOC targets.

A.4.9. Optional Partners

Award recipients may choose to partner with other provider types and community-based organizations, either formally (e.g., as subrecipients on the Cooperative Agreement award) or informally (e.g., through existing Memorandums of Understanding, participation in the Model Governance Structure or other support for Statewide Health Equity Plan activities) to implement the Model. For example, award recipients may want to engage with post-acute care providers to facilitate their partnerships with hospitals as part of care transformation activities under a global budget or with behavioral health providers as part of the award recipient's goals to improve access to and quality of behavioral health services. The award recipient may conduct education with these providers to ensure their awareness of the Model and opportunities to participate. Partnerships with the community and other healthcare stakeholders will support implementation of the Model broadly.

A5. Technical Assistance and Information for Prospective Applicants

Prior to the application deadline, CMS will host a series of webinars to provide details about the AHEAD Model and answer questions from potential applicants regarding this funding opportunity. Information about the webinars will be posted on the Innovation Center website at <https://innovation.cms.gov/innovation-models/ahead>

B. Federal Award Information

B1. Total Funding

The total funding available is \$96 million, subject to availability of funds.

B2. Individual Award Amount

Individual awards will not exceed \$12 million. The amount of each Cooperative Agreement award will depend upon the applicant's:

- total proposed budget,
- the allowability and reasonableness of the costs proposed,
- need, as demonstrated in the application submitted in response to this NOFO, and

- availability of funds.

An applicant must provide estimated budgets for all Budget Periods as instructed in Appendix I. *Guidance for Preparing a Budget Request and Narrative*. The total award funds will be distributed through the initial award and subsequent non-competing continuation awards throughout the Cooperative Agreement Period of Performance. See Section C6, *Continued Eligibility* for more information.

B3. Anticipated Award Dates

The anticipated award dates for Cohorts 1, 2, and 3 are detailed in the Executive Summary chart on pages 5-6.

B4. Cooperative Agreement Period of Performance, Pre-Implementation Period and Model Implementation Period

The AHEAD Model will operate for 11 years (2024-2034), with Cooperative Agreement funding available for the first 5.5 years for Cohorts 1 and 2 and for the first 6 years for Cohort 3 (“Cooperative Agreement Period of Performance”). Depending on their Cohort, award recipients will have an 18, 24, or 30-month Pre-Implementation Period prior to the Model Implementation Period. The specific timeframes for each Cohort are outlined in *Table 1*.

Table 1. Cohort 1-3 Performance Timelines

	Cohort 1	Cohort 2	Cohort 3
Pre-Implementation Period	18 months (7/1/24-12/31/25)	30 months (7/1/24-12/31/26)	24 months (1/1/25-12/31/26)
Model Implementation Period	9 years (1/1/26-12/31/34)	8 years (1/1/27-12/31/34)	8 years (1/1/27-12/31/34)
Cooperative Agreement Period of Performance	5.5 years (Ends 12/31/29)	5.5 years (Ends 12/31/29)	6 years (Ends 12/31/30)

The Cooperative Agreement Period of Performance is further divided into Budget Periods of 12-18 months. Budget Periods correspond to the release of award funding. Award recipients in Cohorts 1 and 2 will have one 18-month Budget Period followed by four 12-month Budget Periods during the Cooperative Agreement Period of Performance. Award recipients in Cohort 3 will have six 12-month Budget Periods. The Budget Periods and corresponding funding amounts are outlined in *Table 2*.

Table 2. Cohort 1-3 Funding by Budget Period

	Cohort 1		Cohort 2		Cohort 3	
	Duration	Funding available¹⁴	Duration	Funding available	Duration	Funding available

¹⁴ Up to \$12 million per award recipient is available through the Cooperative Agreement award. The amount of funding available in Table 2 is not guaranteed. See Section B2, *Individual Award Amount* for more information.

	Cohort 1		Cohort 2		Cohort 3	
Budget Period 1*	18 months	\$4M ¹⁵	18 months	\$2.5M	12 months	\$2M
Budget Period 2	12 months	\$2M	12 months	\$2.5M	12 months	\$2M
Budget Period 3	12 months	\$2M	12 months	\$2.33M	12 months	\$2M
Budget Period 4	12 months	\$2M	12 months	\$2.33M	12 months	\$2M
Budget Period 5	12 months	\$2M	12 months	\$2.33M	12 months	\$2M
Budget Period 6	N/A	N/A	N/A	N/A	12 months	\$2M

*Budget Period 1 begins at the start of the Pre-Implementation Period. See *Table 1, Cohort 1-3 Performance Timelines* for Cohort-specific dates.

B5. Number of Awards

The total anticipated number of awards across all three Cohorts is eight. CMS will make awards to up to five applicants for Cohorts 1 and 2 and reserve a minimum of three award slots for Cohort 3. If less than five awards are made for Cohorts 1 and 2, then the number of awards slots in Cohort 3 will increase to allow for a total of eight awards. The number of awards issued for each of the Cohorts is not guaranteed and will also depend upon the number and quality of applications.

B6. Type of Award

The type of award issued under this NOFO is a Cooperative Agreement. The difference between grants and Cooperative Agreements is the degree of federal programmatic involvement rather than the type of administrative requirements imposed. A Cooperative Agreement differs from a grant in that it provides for substantial involvement between the federal awarding agency and the non-federal entity in carrying out the activity contemplated by the federal award. Therefore, statutes, regulations, and policies, that are applicable to grants also apply to Cooperative Agreements, unless the award itself provides otherwise. References throughout this NOFO to grants also apply to Cooperative Agreements unless this NOFO states otherwise. Please refer to Section F4, *Cooperative Agreement Terms and Conditions of Award* for more information about Cooperative Agreements.

B7. Type of Competition

This NOFO is open to all eligible applicants.

C. Eligibility Information

C1. Eligible Applicants

Eligible applicants are state agencies (e.g., SMA, state public health agency, state insurance agency or other entity with rate-setting or budget authority) with the authority and capacity to accept the Cooperative Agreement award funding. Agencies may apply as a joint application on

¹⁵ CMS will release approximately \$2 million in funds at the time of the award for Cohort 1, Budget Period 1. The remaining \$2 million will be released after approximately 12 months; this amount is conditional upon progress as further detailed in the terms and conditions of award.

behalf of several state agencies, however, only one agency can accept the Cooperative Agreement and serve as the award recipient. The SMA must be included as a subrecipient of the Cooperative Agreement if it is not the award recipient.

Eligible applicants are all 50 states, Washington, D.C., and territories¹⁶ that have at least 10,000 resident Medicare FFS beneficiaries enrolled in Medicare Parts A and B residing in the state or sub-state region based on the most recent data available from [CMS Medicare Monthly Enrollment data](#)¹⁷. Applicants may select to participate at the state level or designate a sub-state region, subject to CMS approval during the application review. Award recipients may have the ability to expand the sub-state region during the Pre-Implementation Period subject to approval by CMS. Approval of such requests are not guaranteed. States in which Making Care Primary Model (MCP) is operating on a statewide basis may not participate in AHEAD. If MCP is operating in a sub-state region of a state, that state would be eligible to apply to participate in AHEAD in a different sub-state region with no geographic overlap.

C2. Cost Sharing or Matching

Cost sharing or matching is not applicable for this program.

C3. Letter of Intent

The Innovation Center recommends that interested applicants submit Letters of Intent (LOIs) 45 days before the applications are due. LOIs are optional and help CMS staff to estimate the number of independent reviewers needed.

You may email LOIs to the following address: AHEAD@cms.hhs.gov (refer to cover page for due date). Letters of Intent should include (1) an expression of interest, including the proposed regions of participation, (2) a brief description of the interested organization, and (3) contact information, including the organization's street address and a contact person's name, position, email, and phone number.

C4. Ineligibility Criteria

N/A

C5. Single Application Requirement

Eligible applicants may submit only one application per state. Eligible applicants not selected for a Cohort 1 or 2 award may apply for Cohort 3.

C6. Continued Eligibility

¹⁶ Eligible U.S. territories include American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the United States Virgin Islands.

¹⁷ Most recent Medicare monthly enrollment data can be found here: <https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/medicare-and-medicaid-reports/medicare-monthly-enrollment>

Award recipients must meet reporting and certification deadlines (as outlined in Section F, *Federal Award Administration Information*) to be eligible throughout the initial Budget period and to remain eligible for a non-competing continuation award for subsequent Budget Periods in multi-year projects. In addition, recipients must demonstrate satisfactory performance during the previous funding cycle(s) to be issued additional year funding; or, in the case of awards where all funding is issued in the first year, to ensure continued access to funding. At any time in the award cycle, recipients could receive decreased funding, or their award could be terminated in accordance with 45 CFR 75.372 “Termination” if they fail to perform the requirements of the award.

Non-competing continuation funding is a recipient’s request for additional funding for the next subsequent Budget Period within an approved competitive segment (i.e., period of performance). Such funding is requested either through an application or a performance report, as explained in the terms and conditions of the award. A non-competing continuation application does not compete with other applications for support. Continued funding is contingent on satisfactory progress, compliance with the terms and conditions, and the availability of funds. Satisfactory progress will include, but is not limited to, meeting milestones described in Section A4.4, *Cooperative Agreement Funding to Support Model Implementation Activities* and listed in Appendix XII. *Milestones and Potential Corrective Action*. Expectations for satisfactory progress will also be included in the Cooperative Agreement terms and conditions.

C7. EIN, UEI, Login.gov and SAM Regulations

All applicants are required to have the following to submit an application to Grants.gov:

- a valid Employer Identification Number (EIN), otherwise known as a Taxpayer Identification Number (TIN)
- a Unique Entity Identifier (UEI)
- a Login.gov account, and
- registration in the System for Award Management (SAM) database (<https://www.sam.gov/>).

See Appendix II. *Application and Submission Information* for descriptions of EIN, UEI, and SAM.

D. Application and Submission Information

D1. Address to Request Application Package

Application materials are available at <https://www.grants.gov>. Please note that CMS requires electronic submission of applications for all Notice of Funding Opportunities through the Grants.gov website. Refer to Appendix II. *Application and Submission Information* for additional requirements and instructions.

D2. Content and Form of Application Submission

a. Application format

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

- The required page size is 8.5” x 11” letter-size pages (one side only) with 1” margins (top, bottom, and sides). CMS does not accept other paper sizes.
- All pages of the project and budget narratives as well as other required narrative documents must be paginated in a single sequence.
- Font size must be at least 12-point with an average of 14 characters per inch (CPI).
- The Project Narrative must be double-spaced. The page limit for this document is 60 pages.
- The Budget Narrative may be single-spaced. The page limit for this document is 15 pages.
- The Business Assessment of Applicant Organization may be single spaced. The page limit for this document is 12 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 that may be single-spaced.
- The following application documents are **excluded** from the page limitations described previously:
 - Standard Forms, Application Cover Letter/Cover Page (optional), copy of Letter of Intent (at least one required), Project/Performance Site Location(s) Form, and Indirect Cost Rate Agreement (NICRA)/Cost Allocation Plan.
- The total number of additional appendices per application may be no more than 35 pages to include SMA Letter of Support (optional), resume and/or curriculum vitae, job descriptions, organization chart, and proposed Medicare FFS hospital global budget methodology (optional). The 35-page limit does not include LOIs from hospitals (at least one LOI for one hospital is **required** as part of the application. An LOI from a hospital is not binding; however, it will help CMS understand how applicants are engaging with hospitals and health systems).

b. Standard forms

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

1. Project Abstract Summary

A one-page abstract serves as a succinct description of the proposed project and includes the goals of the project, the total budget, a description of how the funds will be used, and the proposed Model geographic service area (e.g., state, or sub-state region). 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. Exclude personal identifying information from the abstract. In the Grants Application Package at <https://www.grants.gov>, select the Project Abstract Summary and complete the form.

2. SF-424: Official Application for Federal Assistance

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

- On Item 15 “Descriptive Title of Applicant’s Project,” state the specific Cooperative Agreement funding opportunity for which you are applying.
- Check “No” to item 19c, as Review by State Executive Order 12372 does not apply to this Cooperative Agreement funding opportunity.
- The Authorized Organizational Representative (AOR) completes and signs this form. Note: The signature of the individual that submits the application to Grants.gov populates throughout the application. The signature must match the name of the AOR. Other signatures will not be accepted.

The AOR is the designated representative of the applicant/recipient organization with authority to act on the organization’s behalf in matters related to the award and administration of grants. In signing a grant application, the AOR agrees that the organization will assume the obligations imposed by applicable Federal statutes and regulations and other terms and conditions of the award, including any assurances, if a grant is awarded. These responsibilities include accountability both for the appropriate use of funds awarded and the performance of the grant-supported project or activities as specified in the approved application.

3. SF-424A: Budget Information Non-Construction

4. SF-LLL: Disclosure of Lobbying Activities

All applicants must submit this SF-LLL form. If your entity does not engage in lobbying, please insert “Non-Applicable” on the form and include the required 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. However, this form is **required** as part of the application package and must be submitted for the application to be considered eligible for review.

5. Project/Performance Site Location(s) Form(s)

All applicants must submit this Project Site Location 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. However, this form is **required** as part of the application package and must be submitted for the application to be considered eligible for review.

c. Application cover letter or cover page (optional)

The applicant may choose to include a cover letter or cover page to detail its interest in participation in AHEAD Model.

d. Project Narrative (maximum of 60 pages)

The applicant provides a Project Narrative that articulates in detail the proposed goals, measurable objectives, and milestones in accordance with the instructions and content requirements provided below, consistent with the criteria described in section A4, *Program Requirements*.

Below are the required and optional elements (sections) of the Project Narrative including a brief description of the type of information required within each specific section. The Project Narrative is double-spaced and cannot exceed 60 pages in length. Though referenced here in the Project Narrative, the resumes for key personnel, job descriptions, and organizational charts are listed as required appendices to the application (refer to D2.g, *Appendices* for more information and page limits). Applicants are permitted to upload these documents in either section (Project Narrative or Appendices) but must not exceed the required page limits and should cross-reference between the two sections as necessary).

- I. **Organizational capacity of applicant organization (required):** Applicants must demonstrate their capacity to organize and manage the Model, and to work collaboratively across key state agency, payer, provider, and community-based partners. Applicants must provide a description of their organization, including:
 - staff capacity (e.g., providing job descriptions including positions that may be currently vacant for all key staff that will be involved in the Model; can be included as an appendix),
 - identifying the individual(s) who will have management authority over the Model and provide a resume or CV as an appendix for each identified manager (can be included as appendix),
 - identifying the individual who will be the Project Director (primary liaison to CMMI for the Model) and provide a resume or CV for that person (can be included as an appendix),
 - providing an organizational chart that identifies lines of authority and names the Authorized Organizational Representative (AOR) (can be included as an appendix),
 - describing the anticipated role of any subrecipients or contractors that may be engaged to help implement the Model,
 - describing their experience designing and implementing health care delivery system redesign and associated outcomes, including hospital global budgets and patient-centered medical homes or other state-based Medicaid advanced primary care program, and
 - describing how the applicant will meet the requirements relating to the SMA's involvement in the Model.

- II. **Description of region (required):** Applicants must demonstrate how their proposed region (e.g., state OR sub-state region) would benefit from the AHEAD Model. Describe the population health needs and identified disparities in the proposed region. Describe any health care delivery system redesign that the region has undertaken previously, or is currently undertaking, as well as their outcomes. This may include a description of the state or sub-state region's Medicaid reform history, experience with multi-payer alignment, existing provider participation in value-based payments, and state data/health IT infrastructure. Describe the state or designated sub-state region's population, including rural and urban distributions, demographic trends, and payer mix.

Description of sub-state region (required only if applicable): If applicants opt to designate a sub-state region (see Section C1, *Eligible Applicants*), applicants must provide justification and rationale for their selection. Applicants must provide detailed information on the population health outcomes and healthcare spending in the sub-state region (e.g., chronic disease prevalence; behavioral health needs; health care quality, such as readmissions and avoidable admissions; and the total cost of care). Applicants must describe how representative the designated sub-state region is on various sociodemographic factors, including: race/ethnicity, age, sex/gender; rural/suburban/urban; and Area Deprivation Index or Social Vulnerability Index. Applicants must describe care-seeking patterns of residents in the sub-state region, including how much care is provided by providers within the sub-state region. At least 50% of the TCOC for Medicare FFS beneficiaries residing in the sub-state region must be delivered within the sub-state region. Award recipients may have the ability to expand the sub-state region during the Pre-Implementation Period subject to approval by CMS. Approval of such requests are not guaranteed.

- III. **Statewide Accountability Targets (required):** Describe strategy to measure statewide TCOC and primary care investment across payers over time, including current TCOC and primary care spend on an all-payer basis to the extent possible. Describe current or planned efforts to include all-payer TCOC and primary care investment targets in state executive order, statute, and/or regulation, and any mechanisms for enforcement of such targets. Describe applicant's ability to obtain TCOC and primary care spending information for each year from commercial payers and Medicaid. Describe anticipated policy levers to increase primary care spending by commercial payers and Medicaid. Describe regulatory and policy levers the applicant intends to use to achieve or enforce TCOC cost growth targets across payers. Identify known gaps in the state or sub-state region's TCOC and primary care spending reporting.
- IV. **Hospital recruitment plan (required):** Provide detailed plan for recruitment of hospitals to participate in hospital global budgets (e.g., regulatory levers and strategies the state will use to meet hospital recruitment requirements). Applicants should summarize communications (e.g., conversations, outreach, etc.) with hospitals to-date, including the number of hospitals they aim to recruit, and hospital experience with hospital global budgets or other value-based payment models in their state or designated sub-state region, if applicable. Applicants should provide a timeline for hospital recruitment, including specific recruitment goals, strategy for engaging rural hospitals and safety net

hospitals, and contingency plan if recruitment goals are not met during pre-implementation. Any Letters of Intent (LOIs) from hospitals should be included in the an appendix (LOIs are not included in the appendix page limit). At least one LOI from a hospital is **required** for the application. An LOI from a hospital is not binding; however, it will help CMS understand how applicants are engaging with hospitals and health systems).

V. **Hospital global budget methodology development:**

- a. **State-Designed Medicare FFS Methodology (optional for states who meet specific criteria):** If the state or sub-state region has rate setting authority or hospital budget setting authority and prior experience in population-based payments or global budgets, indicate whether state intends to develop a state-specific Medicare FFS hospital global budget methodology (subject to CMS approval) or use the CMS-designed methodology. (Note: States without this authority and experience will use the CMS-designed methodology.)
- b. **Medicaid (required):** Describe capacity to develop Medicaid hospital global budget methodology in accordance with the timeline and requirements outlined in Appendix XII. *Milestones and Potential Corrective Action*. Recipients must implement Medicaid global budgets prior to or during PY1. Include a proposed timeline of activities for constructing and implementing a Medicaid hospital global budget methodology. Include a proposed approach for developing methodology and engaging hospitals on the methodology prior to the start of PY1. Most important for consideration is the applicant’s proposed regulatory pathway for the change in payment methodology, which likely will be either leveraging managed care contracting tools or an 1115(a) demonstration request, subject to CMS approval. Proposal should also consider plans to gather sufficient Medicaid Managed Care Organization buy-in and other managed care-related considerations for global budget methodology. The proposed timeline should include:
 - The proposed pathway that offers the most streamlined regulatory approach in the context of the applicant’s Medicaid program structure.
 - An outline of applicant’s managed care vs. fee-for-service Medicaid populations and considerations for implementation via managed care organization, if applicable.
 - The steps required of the SMA and legislature/other state entities to construct a state plan amendment or managed care contract change.
 - The anticipated timeline for each step, such that the first global budget payment can be implemented beginning in PY1 for required Medicaid alignment to AHEAD Medicare FFS hospital global budgets.
 - Describe plan for engagement with interested parties (e.g., what stakeholder groups need to be engaged on the global budget methodology development for Medicaid and commercial payers), including a brief, high-level description of when and how the state will engage these groups throughout the Pre-Implementation period.

- VI. **Vision for primary care transformation (required):** Applicant must describe current Medicaid initiatives underway in primary care, especially related to behavioral health integration, health-related social needs, care management, and specialty care coordination. Describe which of the following tool(s) will be leveraged to increase investment in primary care in the Medicaid space: state directed payments for certain primary care services; rate increases and enhanced reimbursement for primary care services; leveraging managed care contract language to push MCOs towards increased primary care investment; and any additional tools the state will consider to rebalance funding across the delivery system. Describe the following:
- tools for increasing access to primary care services;
 - existing Medicaid Primary Care APMs, including current participation of FQHCs and RHCs;
 - how Primary Care AHEAD might align with these existing efforts in the state (see Section A4.6, *Primary Care AHEAD*).

If the applicant plans to implement a new Medicaid Primary Care APM, the applicant should include the proposed authority, eligibility criteria (including eligibility of FQHCs, FQHC lookalikes, RHCs, and small practices), payment model, timeline, and clear commitment to implement by the beginning of PY1.

- VII. **Primary care practice recruitment plan (required):** Provide a detailed plan for Pre-Implementation period identification and recruitment of primary care practices for participation in Primary Care AHEAD (e.g., how the applicant will identify practices participating in state Medicaid primary care value-based payment arrangements and conduct recruitment outreach to those providers). Include description of the types of practices currently participating in the state's Medicaid Primary Care APM, if applicable, including identification of gaps in current participation and plans to address those gaps under Primary Care AHEAD.
- VIII. **Description of state data/health IT infrastructure (required):** Applicants must describe the current capacity and/or planned future capacity of data/health IT infrastructure. Describe existing data infrastructure action plans and governance. Describe staff capacity, data analytic capabilities and experience supporting value-based payment and quality reporting. Describe ability to leverage health IT to meet Model requirements, including data alignment, sharing, flow, and linking capacity across potential partners and participants. Describe current health oversight agency status and/or ability to become a health oversight agency¹⁸ for the purposes of data sharing prior to the start of PY1.
- IX. **Description of current and planned health equity activities (required):** Provide a detailed summary of state engagement in existing health equity initiatives and activities, including, if available, information on State Health Improvement Plans, Community Health Needs Assessments, or equivalent. Describe existing activities aimed at reducing health disparities and identifying and addressing health-related social needs, including

¹⁸ Health oversight agency definition:
https://www.healthit.gov/sites/default/files/phi_permitted_uses_and_disclosures_fact_sheet_012017.pdf.

any state investments or policies that support collection of demographic and health-related social needs data, if any. Describe how the applicant expects to leverage AHEAD Model components (e.g., Cooperative Agreement funding) to facilitate and enhance engagement in the health equity program requirements described in Section A4.3.1, *Health Equity*.

- X. **Description of proposed Model Governance Structure (required):** Describe existing governance structures that can be leveraged to create the Model Governance Structure described in Section A4.1.1, *Model Governance Structure*, if applicable. Describe how the applicant will identify appropriate participants and the anticipated role and responsibilities of the governance structure, including a preliminary list of individuals and/or organizations that could be included.

- XI. **Commercial Payer Alignment (required):** Describe commercial payer participation in state health care reform and population health improvement efforts, if applicable. Describe commercial payer efforts to implement value-based payment and advanced primary care models, if applicable. Describe commercial payer efforts to address affordability and control cost growth, if applicable. Describe state legislative or regulatory authority the state intends to utilize under the Model to facilitate commercial payer participation in hospital global budgets and an aligned primary care program, and to hold commercial payers accountable for TCOC growth (for example, reference-based pricing; premium rate review; D-SNP contracting; all-payer rate setting; hospital budget authority). Describe if and how the applicant intends to include Marketplace QHPs and state employee health plans in hospital global budget payments. Describe approach to hold commercial payers accountable for TCOC growth.

e. Budget Narrative (maximum of 15 pages)

Applicants supplement Form SF-424A with a Budget Narrative that includes a breakdown of costs, for each line item outlined in the SF-424A, according to the Budget Period. Applicants include a clear description of the proposed set of services covered with award funds for each activity/cost within the line item. The application clearly defines the proportion of the requested funding designated for each activity and justifies the applicant's readiness to receive funding. The budget separates out funding administered directly by the lead agency from funding subcontracted to other partners. Voluntary committed cost sharing or matching is not expected unless specifically stated otherwise in Section C2, *Cost Sharing or Matching*.

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

Detailed justifications must be provided for each activity/cost proposed to be funded under this award along with full computations for budget estimates. Applicants must also clearly link each activity to the goals of this NOFO and be consistent with program requirements. Overhead and administrative costs (i.e., indirect or F&A costs) must be reasonable and are only reimbursable in accordance with HHS grants policy.

Sustainability Plan (required): Applicants should present their strategy for sustaining the AHEAD Model after the Cooperative Agreement funding ends (see Section B4, *Period of Performance*). Specifically, applicants should address how they propose to sustain the funding and activities under the Model.

f. Business Assessment of applicant organization (maximum of 12 pages)

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

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

g. Appendices (maximum of 35 pages)

- Letter of support from SMA (required only if applicable): If the SMA is not the applicant, applicant must provide a letter of support confirming that the SMA is ready and committed to being a subrecipient of the Cooperative Agreement award. Letter of support should confirm the SMA is committed to aligning with hospital global budget methodology and has a Medicaid Primary Care APM (or has the capacity to implement a Medicaid Primary Care APM by the beginning of PY1)
- Resumes and/or curriculum vitae (**required** for identified managers, Project Director, and all other Key Personnel identified at the time of application; applicant should cross-reference to the Project Narrative, as appropriate)
- Job Descriptions, if not included in the Projective Narrative (**required**; applicant should cross-reference to the Project Narrative, as appropriate)
- Organization Chart, if not included in the Project Narrative (**required**; applicant should cross-reference to the Project Narrative, as appropriate)
- Letters of Support (from Governor or state legislators, hospitals, primary care providers, others) (optional)
- Proposal for state-designed Medicare FFS Hospital Global Budget Methodology (optional)
- LOIs from hospitals (at least one LOI from one hospital is **required** as part of the application. An LOI from a hospital is not binding; however, it will help CMS understand how applicants are engaging with hospitals and health systems).

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. register in SAM.gov 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. 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 <https://www.grants.gov> by the date and time set forth below. Applications received after 3:00 pm, Eastern Time, of the date set forth below will not be reviewed or considered for award.

Due Date for Applications

Cohorts 1 and 2:
March 18, 2024
3:00 PM Eastern U.S. Time (Baltimore, MD)

Cohort 3:
August 12, 2024
3:00 PM Eastern U.S. Time (Baltimore, MD)

D5. Intergovernmental Review

Program is not subject to 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 Executive Order 12372 does not apply to these Cooperative Agreements.

D6. Cost Restrictions

Direct Costs

Funding under this NOFO can only cover functions of the AHEAD Model and cannot be used to duplicate or supplant other funding sources. Funding awarded through this NOFO cannot cover other services that are provided after, or because of, the Cooperative Agreement Period of Performance.

Indirect Costs

See Section F2, *Administrative and National Policy Requirements* for more information on indirect costs.

Prohibited Uses of Award Funds

CMS prohibits funds under this award for any of the activities/costs outlined below unless an exception is specifically authorized by statute or otherwise stated in this NOFO.

- To reimburse for pre-award costs.
- 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 pay for certain telecommunications and video surveillance equipment. See 2 CFR 200.216 to make sure this does to apply to any proposed equipment in your application.
- To pay for meals unless in limited circumstances such as:
 - Subjects and patients under study;
 - Where specifically approved as part of the project or program activity (not grantee specific), e.g., in programs providing children's services; and
 - As part of a per diem or subsistence allowance provided in conjunction with allowable travel.
- 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.

D7. Mandatory Disclosures

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. HHS Form 690

If you receive an award, you must follow all applicable nondiscrimination laws. You agree to this when you register in SAM.gov. You must also submit an Assurance of Compliance (HHS690). To learn more, see the HHS Office for Civil Rights website.

The HHS 690 form may be filed electronically via the U.S. Department of Health and Human Services’ Assurance of Compliance online portal at:

<https://ocrportal.hhs.gov/ocr/aoc/instruction.jsf>

Subrecipients that receive funding from recipients (including contractors under grants) rather than directly from CMS, also are required to file an HHS 690. The applicant/recipient is responsible for determining whether those organizations have the required Assurance on file and, if not, ensuring that it is filed with OCR.

E. Application Review Information

E1. Criteria

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

In preparing applications, applicants should review the requirements detailed in Section A4., Program Requirements. Technical review panelists will assess and score applicants' responses in accordance with the criteria below, using a scale of 135 total base points.

All applicants must submit the following:

- Cover Letter (optional)
- Standard Forms (including Project Abstract and Project/Performance Site Location(s) Form)
- A Project Narrative
- A Budget Narrative
- Business Assessment of Applicant Organization
- Federally Negotiated Indirect Cost Rate Agreement (if applicable)
- Appendices (cross-reference to the Project Narrative, as appropriate):
 - Letter of Support from the SMA (required if SMA is not the applicant)
 - Resumes or Curriculum Vitae for Key Personnel (required for identified managers, Project Director, and all other Key Personnel identified at the time of application)
 - Job Descriptions (required)
 - Organization chart (required)
 - Letters of Support (from Governor or state legislators, hospitals, primary care providers, others) (optional)
 - Proposal for state-designed Medicare FFS Hospital Global Budget Methodology (optional)
 - LOIs from hospitals (at least one LOI is **required** from one hospital as part of the application. An LOI from a hospital is not binding; however, it will help CMS understand how applicants are engaging with hospitals and health systems).

Project Narrative and Budget Narrative

Below are the review criteria for the Project Narrative and Budget Narrative. All elements of the Project Narrative and Budget Narrative are used to assess an applicant's ability to implement an intervention that aims to improve health outcomes and health equity for individuals residing in the state or designated sub-state region and produce cost savings to Medicare and on an all-payer basis. Incomplete, unclear, and confusing proposals will receive point deductions. Project Narratives with significant content deficiencies may receive a score of zero. Proposals that merely restate the content of the NOFO, without responding to the Program Requirements and Application Review Criteria, will receive a score of zero. Each element of the Project Narrative is weighted as indicated below. The scoring criteria breakdown is reflective of the total possible number of points available, but each item is scored on a range starting from zero. Points are awarded based on the quality of the applicant's response.

Section	Topics	Total Available Points	Scoring Criteria Breakdown
Project Narrative and Appendices			

Section	Topics	Total Available Points	Scoring Criteria Breakdown
II. and III.	Organizational capacity of applicant organization	6	<p>(2 Pts) Description of entity that will perform the Cooperative Agreement activities under this NOFO.</p> <ul style="list-style-type: none"> • If the applicant is not the SMA, the SMA must be a participant in the application submission and be listed as a subrecipient on the Cooperative Agreement award. The applicant must describe the applicant’s relationship to the SMA, proposed role of SMA in AHEAD, and summarize any previous collaborations or partnerships with the SMA. A letter of support from SMA indicating capacity must be included as an appendix. <p>(2 Pts) Description of key personnel including identifying one individual to serve as Project Director.</p> <ul style="list-style-type: none"> • Include a resume or curriculum vitae for everyone identified as key personnel in the organizational chart included as an appendix to the application submitted in response to this NOFO. If key personnel have not yet been hired, applicants should provide a hiring strategy and job descriptions should be included as an appendix. <p>(2 Pts) An organizational chart to be included as an appendix clearly identifies the reporting relationships of key personnel assigned to oversee this intervention. Organizational chart must specify Authorized Organizational Representative (AOR).</p>

Section	Topics	Total Available Points	Scoring Criteria Breakdown
IV.	Description of region OR description of sub-state region	3	<p>(2 Pts) Description of state OR sub-state region, including summary of health care delivery system redesign in the region and, if proposing sub-state region, rationale for proposed sub-state region, including description of care-seeking patterns of residents in the sub-state region.</p> <p>(1 Pt) Brief description of support from entities in the state or sub-state region (e.g., entities that might serve on the Model Governance Structure, interested hospitals, primary care practices, local government organizations, agencies, etc.). If entities have not been engaged as part of the application submission, applicant must briefly (in 1 paragraph or less) describe plan for engaging interested parties.</p>
V.	Statewide or sub-statewide Accountability Targets	17	<p>(4 Pts) Description of plan for measurement of TCOC and primary care spending for all payers, including:</p> <ul style="list-style-type: none"> • Data collection mechanisms available for Medicaid and commercial TCOC and primary care spending, including non-claims-based-payments. • Identification of tools and policy levers to make TCOC and primary care spend reporting a requirement for commercial payers. • Identification of gaps and challenges for TCOC and primary care spend reporting/areas where technical assistance will be needed and timeline for filling identified gaps. <p>(4 Pts) Plan for memorializing TCOC and primary care investment targets in statute, executive order, and/or regulation, or extending existing target duration to continue through the Model implementation period.</p>

Section	Topics	Total Available Points	Scoring Criteria Breakdown
			<p>(2 Pts) Regulatory and policy levers the state intends to use to increase Medicaid and commercial primary care spending.</p> <p>(5 Pts) Regulatory and policy levers the state is currently using or intends to use for enforcement of TCOC cost growth targets.</p> <p>(2 Pts) Anticipated challenges for meeting TCOC and primary care spending benchmarks for all payers.</p>
VI.	Hospital recruitment plan	20	<p>(20 Pts) Description of hospital recruitment plan, including robust explanation of what strategies and state regulatory levers will be employed to recruit hospitals and to maintain their participation throughout the Model. Recruitment plan should include:</p> <ul style="list-style-type: none"> • (5 Pts) Summary of interest from hospitals in state or designated sub-state region, if applicable (note: CMS recommends gauging interest from hospitals prior to submitting application). Summary of conversations with other interested parties (e.g., state and hospital associations). • (4 Pts) Anticipated percent of hospital services and percent of total cost of care for resident beneficiaries in the state or sub-state region anticipated to be under a global budget in the AHEAD model. • (3 Pts) Proposed timeline for hospital recruitment during Pre-Implementation period, including strategy for engaging rural hospitals and/or safety net hospitals, including critical access hospitals. • (4 Pts) Specific state policy and regulatory levers the state

Section	Topics	Total Available Points	Scoring Criteria Breakdown
			<p>anticipates using to incentivize hospital participation.</p> <ul style="list-style-type: none"> (4 Pts) Specific recruitment goals, including potential recruitment challenges/barriers to entry for hospitals, and contingency plan if applicant does not meet recruitment goals, if chosen to participate in AHEAD.
VII.	Hospital global budget methodology	8	<p>(2.5 Pts) Description of statewide hospital rate setting authority or hospital budget setting authority, if applicable (i.e., statute). Description of state’s prior experience in population-based payments or global budgets, if applicable.</p> <p>(5.5 Pts) Description of state’s capacity to develop and implement Medicaid hospital global budget methodology by the end of PY1. This would include the proposed authority or mechanism for making payments and considerations for the state’s unique Medicaid context (e.g., population in managed care or FFS).</p>
VIII.	Vision for primary care transformation	15	<p>(5 Pts) Description of the applicant’s current primary care transformation initiatives and goals under Medicaid Primary Care APM.</p> <p>(2 Pts) Description of applicant’s plan for aligning Primary Care AHEAD Enhanced Primary Care Payment care transformation to current Medicaid primary care initiatives.</p> <p>(2 Pts) Description of specific tools that will be used to increase primary care investment in Medicaid.</p> <p>(2 Pts) Identification of specific policy tools that will be used to increase access to primary care services.</p>

Section	Topics	Total Available Points	Scoring Criteria Breakdown
			<p>(2 Pts) Description of existing or planned programs for state Medicaid Primary Care APM that will be implemented by the start of PY1.</p> <p>(2 Pts) Description of current participation of FQHCs and RHCs in an existing state Medicaid Primary Care APM, or eligibility of FQHCs and RHCs in a planned Medicaid Primary Care APM.</p>
IX.	Primary care practice recruitment plan	10	<p>(5 Pts) Description of primary care practice recruitment plan, including robust explanation of what strategies will be employed to recruit practices. Recruitment plan should include:</p> <ul style="list-style-type: none"> • Summary of state experience and level of primary care participation in Medicaid Primary Care APM. • Summary of interest from primary care practices in the state, if applicable. • Proposed timeline for primary care recruitment during Pre-Implementation Period, including strategy for engaging small practices, FQHCs, RHCs, and other safety net providers. <p>(5 Pts) Description of specific recruitment goals, including potential recruitment challenges/barriers to entry for practices, and how the state intends to create alignment between their Medicaid Primary Care APM and Medicare’s Primary Care AHEAD program.</p>
X.	Description of state data/health IT infrastructure	6	<p>(4 Pts) Description of current statewide or regional data/health IT infrastructure and/or future planned statewide or regional data/health IT infrastructure. This should include:</p> <ul style="list-style-type: none"> • (1 Pts) Description of existing data infrastructure action plans and governance.

Section	Topics	Total Available Points	Scoring Criteria Breakdown
			<ul style="list-style-type: none"> • (1 Pts) Description of staff capacity, data analytic capabilities, and experience supporting value-based payment and quality reporting. • (2 Pts) Description of ability to leverage health IT to meet Model requirements, including data alignment, sharing/flow/linking capacity across potential partners and participants. • (2 Pts) Description of applicant’s ability to become a health oversight agency for the purposes of data sharing by the start of PY1.
XI.	Description of health equity activities	10	<p>(4 Pts) Description of recent or current state strategies that direct the design and implementation of population health activities to improve health equity, including information on State Health Improvement Plans, Community Health Needs Assessments, or equivalent, if applicable.</p> <p>(2 Pts) Description of how state health equity activities could be leveraged to support performance on statewide measures such as the representative list described in Appendix XIV. <i>Quality and Population Health Strategy</i>.</p> <p>(2 Pts) Description of state-level requirements and investments, if any, aimed at identifying and addressing health-related social needs (including capacity for data-sharing via Health Information Exchanges or equivalents) among health care organizations and insurers. If no such requirements and investments exist, describe state-level initiatives to address food insecurity, housing insecurity, and/or transportation challenges.</p>

Section	Topics	Total Available Points	Scoring Criteria Breakdown
			(2 Pts) Summary of how state plans to use AHEAD Model components (e.g., Cooperative Agreement funding, technical assistance, etc.) to meet health equity objectives and program requirements.
XII.	Description of proposed Model Governance Structure	5	<p>(2 Pts) Description of existing governance structure that can be leveraged to create the Model Governance Structure, if any. If no governance structure exists, description of how AHEAD resources will support the creation of the Model Governance Structure.</p> <p>(2 Pts) Composition of existing or planned Model Governance Structure, including leadership by the State Medicaid and State Department of Health agencies, and diverse and multi-sectoral representation of other stakeholders (e.g., which state agencies will be involved, how payers, providers, community organizations, individuals, and caregivers will be engaged, etc.).</p> <p>(1 Pt) Vision for the role that the Model Governance Structure may play in planning and Implementation of the Model (e.g., process for providing input and influencing model decision-making).</p>
XIII.	Commercial payer alignment	5	<p>(2 Pts) Description of current or planned commercial payer participation in care delivery reform, value-based payment, population health improvement, and affordability activities in the state, if applicable.</p> <p>(2 Pts) Description of state legislative or regulatory authority state intends to utilize to align commercial payers with model activities.</p> <p>(1 Pt) Description of how the state intends</p>

Section	Topics	Total Available Points	Scoring Criteria Breakdown
			to include Marketplace QHPs, BHPs, and/or state employee health plans in hospital global budget payments.
Budget Narrative			
	Budget Narrative	30	<p>(15 Pts) Detailed budget, adhering to the format outlined in Appendix I. <i>Guidance for Preparing a Budget Request and Narrative</i>, for the Cooperative Agreement Period of Performance.</p> <p>(10 Pts) Reasonableness of requested funding to support activities:</p> <ul style="list-style-type: none"> • (5 Pts) Funds requested are reasonable based on the total available Cooperative Agreement funding (a maximum of \$12 million) and each activity is linked to the goals of this NOFO and consistent with the AHEAD Model Program Requirements (Section A4, <i>Program Requirements</i>). • (5 Pts) Funds requested are reasonable to support personnel costs. If using a subrecipient or contractor to assist with Model implementation, then the applicant has described what specific tasks this entity will be responsible for. <p>(5 Pts) Detailed Sustainability Plan: Strategy for sustaining the Model after Cooperative Agreement funding ends, including plans for sustaining activities under the Model and identifying potential additional funding needed. Description of work plan, including timeline and contingency plan, for identifying additional funding needed.</p>

Section	Topics	Total Available Points	Scoring Criteria Breakdown
Total Available Points			135

E2. Merit Review and Selection Process

Merit Review and Selection Process

CMS will consider the geographic diversity and scale of all applications, as well as the quality of applications, in making final award determinations. CMS reserves the right to consider the distribution of high/low-cost states when making final decisions about awards. CMS will do this by ranking all states from highest to lowest cost, based on Medicare fee-for-service spending, and then dividing them into four equal quartiles (low-cost states will equate to a lower quartile or lower spending).

The application itself is not a legally binding contract and does not require any applicant or CMS to enter into a Cooperative Agreement. CMS will select recipients at CMS’s sole discretion unless statutorily prohibited. Such selection will not be subject to administrative or judicial review, per Section 1115A(d)(2)(B) of the Act.

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

E3. Federal Awardee Performance Integrity Information System (FAPIIS)

In accordance with 45 CFR Part 75:

- i. CMS, prior to making a federal award with a total amount of Federal share greater than the simplified acquisition threshold¹⁹, is required to review and consider any information about the applicant that is in the designated integrity and performance system accessible through SAM (currently FAPIIS) (see 41 U.S.C. 2313);
- ii. An applicant, at its option, may review information in the designated integrity and performance systems accessible through SAM and comment on any information about itself that the HHS awarding agency previously entered and is currently in the designated integrity and performance system accessible through SAM.
- iii. CMS will consider any comments by the applicant, in addition to the other information in the designated integrity and performance system, in making a judgment about the applicant’s integrity, business ethics, and record of performance under Federal awards when completing the review of risk posed by applicant as described in §75.205.

¹⁹ *Simplified acquisition threshold* means the dollar amount below which a non-Federal entity may purchase property or services using small purchase methods. Non-Federal entities adopt small purchase procedures to expedite the purchase of items costing less than the simplified acquisition threshold. The simplified acquisition threshold is set by the Federal Acquisition Regulation at 48 CFR Subpart 2.1 (Definitions) and in accordance with 41 U.S.C. 1908.

F. Federal Award Administration Information

F1. Federal Award Notices

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

If unsuccessful, CMS notifies the applicant electronically to the email 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. Each 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 award with these requirements. Recipients should consult the applicable Appropriations Law, Exhibit 3 of the HHS Grants Policy Statement, titled Public Policy Requirements, located in Section II, pages 2-6²⁰, as well as the terms and conditions of award for information on potentially applicable public policy requirements.

Recipients should review and comply with the reporting and review activities regarding accessibility requests outlined in Appendix IV. *Accessibility Provisions*.

B. Administrative Requirements

- All equipment, staff, and other budgeted resources and expenses must be used exclusively for the projects identified in the applicant's original application or agreed upon subsequently with CMS 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 note of the following information found in 45 CFR Part 75:

²⁰ HHS Grants Policy Statement, available here: <https://www.hhs.gov/sites/default/files/grants/grants/policies-regulations/hhsgps107.pdf>.

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 and Cooperative Agreement awards provide for reimbursement of actual, allowable costs incurred and are subject to the Federal cost principles. The cost principles establish standards for the allowability of costs, provide detailed guidance on the cost accounting treatment of costs as direct or indirect, and set forth allowability and allocability principles for selected items of cost. Applicability of a set of cost principles depends on the type of organization. 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 (2) 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 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

CMS 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, except for those non-Federal entities described in Appendix VII(D)(1)(b) to 45 CFR part 75, 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.

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 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://www.hhs.gov/about/agencies/asa/psc/indirect-cost-negotiations/index.html>. 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 Notice of Funding Opportunity 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 circumstances of the effort to be supported and/or deficiencies identified in the application by the HHS review panel.

HHS regulation (45 CFR Part 75) supersedes information on administrative requirements, cost principles, and audit requirements for grants and Cooperative Agreements included in the current HHS Grants Policy Statement where differences are identified. Recipients must also agree to respond to requests that are necessary for the evaluation of national efforts and provide data on key elements of their own grant or Cooperative Agreement activities.

Non-Discrimination Legal Requirements for Recipients of Federal Financial Assistance

A recipient must follow all applicable nondiscrimination laws. Applicants agree to this when they register in SAM.gov. Applicants must also submit an Assurance of Compliance (HHS-690). To learn more, see the HHS Office for Civil Rights website.

Material Noncompliance

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

Bankruptcy. In the event a recipient or one of its subrecipients enters proceedings relating to bankruptcy, whether voluntary or involuntary, the recipient agrees to provide written notice of the bankruptcy to CMS. The recipient must furnish the written notice 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 includes:

- the date on which the bankruptcy petition was filed,
- the identity of the court in which the bankruptcy petition was filed,
- a copy of all the legal pleadings, and
- a listing of Government grant and Cooperative Agreement numbers and grant offices for all, and
- Government grants and Cooperative Agreements against which final payment has not been made.

Intellectual Property

Recipients under this funding opportunity 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.

Prohibition on certain telecommunications and video surveillance services or equipment:

As described in 2 CFR 200.216, recipients and subrecipients are prohibited to obligate or spend grant funds (to include direct and indirect expenditures as well as cost share and program) to:

- (1) Procure or obtain;
- (2) Extend or renew a contract to procure or obtain; or
- (3) Enter into contract (or extend or renew contract) to procure or obtain equipment, services, or systems that use covered telecommunications equipment or services as a substantial or essential component of any system, or as critical technology as part of any system. As described in Pub. L. 115-232, section 889, covered telecommunications equipment is telecommunications equipment produced by Huawei Technologies Company or ZTE Corporation (or any subsidiary or affiliate of such entities).

i. For public safety, security of government facilities, physical security surveillance of critical infrastructure, and other national security purposes, video surveillance and telecommunications equipment produced by Hytera Communications Corporation, Hangzhou Hikvision Digital Technology Company, or Dahua Technology Company (or any subsidiary or affiliate of such entities).

ii. Telecommunications or video surveillance services provided by such entities or using such equipment.

iii. Telecommunications or video surveillance equipment or services produced or provided by an entity that the Secretary of Defense, in consultation with the Director of the National Intelligence or the Director of the Federal Bureau of Investigation, reasonably believes to be an entity owned or controlled by, or otherwise, connected to the government of a covered foreign country.

F4. Cooperative Agreement Terms and Conditions of Award

The administrative and funding instrument used for this program is a Cooperative Agreement, an assistance mechanism used when CMS anticipates substantial CMS programmatic involvement with each Recipient during the performance of the activities. Under each Cooperative Agreement, CMS' purpose is to support and stimulate the recipients' 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 and Medicaid Services

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

- Technical Assistance – CMS hosts opportunities for training and/or networking, which may include conference calls, topic-specific webinars, office hours, and other vehicles.
- Collaboration – CMS actively coordinates with other relevant Federal Agencies including, but not limited to, the Indian Health Service, the Internal Revenue Service, the Department of Homeland Security, the Administration for Children and Families, the Health Resources and Services Administration, the Centers for Disease Control and Prevention, and the Social Security Administration. In this way, CMS facilitates compliance with the terms of the Cooperative Agreement and effectively supports recipients.
- Learning System – award recipients will be required to participate in and provide support to regional learning and learning communities in pursuit of a shared vision for population health and health equity outcomes within the state, including Participant Hospitals and Primary Care Practices, commercial payers and other stakeholders including beneficiary groups and community-based organizations. CMS will partner with awardees through the learning system to operationalize a data-driven and goal-oriented learning system to enable the success of all participants in the Model that builds from existing infrastructure and capacity within the state. Model participants will also have opportunities to join learning communities with other award recipients and access tools and supports to help them adopt new payment and care delivery methods.
- Project Officers and Monitoring – The recipient can expect substantial collaboration, participation, and/or intervention in the oversight of the project by CMS. Substantial involvement may include collaboration or participation by CMS program staff in activities specified in the Notice of Award (NoA) and, as appropriate, decision-making at specified milestones related to performance, e.g., requiring CMS approval before undertaking the next phase of a project, collaborating in the design of a service delivery model, etc. Substantial involvement pertains to programmatic involvement **not** administrative oversight.
- CMS Grants Management Officers, Grants Management Specialists, and Project Officers will monitor and provide administrative oversight, on a regular basis, on the progress of each recipient throughout the Period of Performance. This monitoring may be by phone, document review, on-site visit, other meeting and by other appropriate means, such as reviewing program progress reports and Federal Financial Reports (FFR or SF-425). This monitoring will be to determine compliance with programmatic and financial requirements.
- Monitoring and Implementation Support – CMS conducts several in-person and desk audits of recipients, as well as initial assessments, with the intention of understanding the recipients' processes and assisting recipients with Implementation support needs, as appropriate. CMS will also use these activities to identify recipient issues, and to help

recipients maintain compliance with the grant program and the terms identified in this NOFO.

Award Recipients

Award recipients and assigned points of contact retain the primary responsibility and dominant role for planning, directing, and executing the proposed project as outlined in the terms and conditions of the Cooperative Agreement and with substantial CMS involvement. 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 Model evaluations.
- Technical Assistance – participate in technical assistance activities as appropriate.
- Learning System – participate in targeted learning activities throughout the course of the AHEAD Model; respond to surveys or other mechanisms to assist CMS in identifying recipient learning needs; and other items listed in Section F5.a.iii, *Learning System Participation*.
- Audits and Initial Assessments – cooperate with any audit(s) and initial assessment(s) of award recipient interventions, data collection, data reporting, and other Model terms. Initial assessments occur during the first 12 months of the Cooperative Agreement Period of Performance.
- 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. Health Information Technology (IT) Interoperability Language

Successful award recipients under this NOFO agree that:

Where award funding involves:	Recipients and subrecipients are required to:
Implementing, acquiring, or upgrading health IT for activities by any funded entity	Use health IT that meets standards and implementation specifications adopted in 45 CFR part 170, Subpart B, if such standards and implementation specifications can support the activity. Visit https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-D/part-170/subpart-B to learn more.

Where award funding involves:	Recipients and subrecipients are required to:
Implementing, acquiring, or upgrading health IT for activities by eligible clinicians in ambulatory settings, or hospitals, eligible under Sections 4101, 4102, and 4201 of the HITECH Act	Use health IT certified under the ONC Health IT Certification Program, if certified technology can support the activity. Visit https://www.healthit.gov/topic/certification-ehrs/certification-health-it-1 to learn more.

If standards and implementation specifications adopted in 45 CFR part 170, Subpart B cannot support the activity, recipients, and subrecipients are encouraged to utilize health IT that meets non-proprietary standards and implementation specifications developed by consensus-based standards development organizations. This may include standards identified in the ONC Interoperability Standards Advisory, available at <https://www.healthit.gov/isa/>.

F6. Reporting

Integrity and Performance Reporting. The NoA will contain a provision for integrity and performance reporting in FAPIIS, as required in 45 CFR part 75 Appendix XII.

a. Progress Reports

Each recipient will be required to submit quarterly progress reports, annual progress reports, and a final progress report. CMS provides the recipient with guidance and/or a template related to progress report submissions. These reports include narrative updates on model activities as well as information on operational and performance milestones in accordance with the AHEAD Model Cooperative Agreement.

b. Financial Reports

HHS recipients are required to record recipient expenses in real-time as well as submit semi-annual or annual expenditure FFRs as described below.

Semi-Annual, Annual, and Final Expenditure Reporting. Recipient must report on Federal expenditures, recipient Share (if applicable), and Program Income (if applicable and/or allowable) at least annually via the Payment Management System. Frequency of required expenditure reporting, whether semi-annually or annually, is stipulated in the program terms and conditions of award. Expenditures, recipient Share, and Program Income is reflected through completion of lines 10.d through 10.o of the FFR.

c. 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 \$30,000 or more in Federal funds and executive total compensation for the recipients' and

subrecipients' five most highly compensated executives as outlined in Appendix A to 2 CFR Part 170 (available online at <https://www.fsrs.gov/>).

d. Audit Requirements

Recipients 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>.

e. Payment Management System Reporting Requirements

Once CMS issues an award, the funds are posted in recipient accounts established in the Payment Management System (PMS). Recipients may then access their funds by using the PMS funds request process.

The PMS funds request process enables recipients to request funds using a Personal Computer with an Internet connection. The funds are delivered to the recipient via Electronic Funds Transfer (EFT). If you are a new 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.

f. Government-wide Suspension and Debarment Reporting Requirements

Debarment, Suspension, Ineligibility, and Voluntary Exclusion Certification:

- 1) You certify on behalf of the applicant organization, by submission of your proposal, that neither you nor your principals are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency.
- 2) Failure to make required disclosures can result in any of the remedies described in 45 CFR § 75.371, including suspension or debarment. (See also 2 CFR parts 180 and 376, and 31 U.S.C. § 3354).
- 3) If you are unable to attest to the statements in this certification, you must include an explanation and insert in “Other Relevant Documents.”

G. CMS Contacts

Applicants should refer to the sources listed below for application questions including administrative, budgetary, or program requirements. Please reference “NOFO Inquiry” in the email subject line.

G1. Programmatic Questions

For Programmatic questions about this funding opportunity, please contact:

Name: AHEAD Model
AHEAD@cms.hhs.gov

G2. Administrative/Budget Questions

For administrative or budget questions about this funding opportunity, please contact:

Name: AHEAD Model
AHEAD@cms.hhs.gov

H. Other Information

Publication of this NOFO does not oblige CMS to award any specific project or to obligate any available funds. Additionally, CMS may cancel or withdraw this NOFO at any time. Award decisions are discretionary and are not subject to appeal to any CMS or HHS official or board.

Applicants must identify proprietary information.

Please visit <https://innovation.cms.gov/innovation-models/ahead> for additional details regarding this the AHEAD Model.

Appendix I. Guidance for Preparing a Budget Request and Narrative

Applicants must request funding only for activities that will support this specific Notice of Funding Opportunity. All applicants must submit the Standard Form SF-424A as well as a Budget Narrative. The Budget Narrative provides 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 Cooperative Agreement Period of Performance. Please review the directions below to ensure both documents are accurately completed and consistent with application requirements.

Standard Form SF-424A (Budget Information for Non-Construction Programs)

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 Notice of Funding Opportunity (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) reflects the overall total requested on the SF-424A (Budget Information – Non-Construction) for the entire Period of Performance.
- Each SF-424A reflects information for up to four years of the Cooperative Agreement Period of Performance. As a result, applicants to this Notice of Funding Opportunity will utilize a second SF-424A form.
 - First SF-424A = reflects years 1-4 of AHEAD Cooperative Agreement Period of Performance
 - Second SF-424A = reflects overall amount requested (years 5-6 plus cumulative total from years 1-4)

Section A – Budget Summary

- *Grant Program Function or Activity* (column a) = Enter “Name of Notice of Funding Opportunity” in row 1.
- *New or Revised Budget, Federal* (column e) = Enter the Total Federal Budget Requested for the project period in rows 1 and 5.
- *New or Revised Budget, Non-Federal* (column f) = Enter Total Amount of any Non-Federal Funds Contributed (if applicable) in rows 1 and 5. Voluntary committed cost sharing or matching is not expected unless specifically stated otherwise in section C2.
- *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 Period of Performance. *Applicants to this Notice of Funding Opportunity will 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 are reflected in row j. The total for direct and indirect charges for all year-1 line items is entered in column 1, row k (sum of row i and j).
- Column (2) = 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 are reflected in row j. The total for direct and indirect charges for all year-2 line items is 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 are reflected in row j. The total for direct and indirect charges for all year 3 line items are 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 are reflected in row j. The total for direct and indirect charges for all year 4 items are entered in column 4, row k (sum of row i and j).
- Column (5) = Enter total costs for years 1-4 for each line item (rows a-h), direct total costs (row i), and indirect costs (row j). The total costs for all line items are entered in row k (sum of row i and j). The total in column 5, row k should match the total provided in Section A – Budget Summary, New or Revised Budget, column g, row 5.
- Since this period of performance exceeds a 5-year Period of Performance, please complete a second SF-424A form and upload it as an attachment to the application (this specific attachment does not count towards the page limit).
 - Cohorts 1 and 2:
 - Year 5 information is included in column 1 of Section B of this second SF-424A.
 - Enter the total for years 1-4 (per the first SF-424A form) in column 2 of Section B of this second SF-424A form.
 - Cohort 3:
 - Year 5 information is included in column 1 of Section B of this second SF-424A.
 - Year 6 information is included in column 2 of Section B of this second SF-424A.
 - Enter the total for years 1-4 (per the first SF-424A form) in column 3 of Section B of this second SF-424A form.
 - The second SF-424A form will compute columns 1-3 (as applicable by Cohort), 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 (Budget Information for Non-Construction Programs) can be found at Grants.gov: <https://www.grants.gov/web/grants/forms/sf-424-individual-family.html#sortby=1>

Budget Narrative – Sample Narrative and Instructions

Applicants must complete a Budget Narrative and upload it to the Budget Narrative Attachment Form in the application kit. Applicants request funding only for activities not already funded/supported by other funding sources. Awards support separate activities and new federal funding cannot be supplanted by other federal funding. In the budget request, applicant distinguishes between activities 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. Voluntary committed cost sharing or matching is not expected unless specifically stated otherwise in section C2. Insufficient budget detail and justification may negatively impact the review of the application.

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 (FTE or level of effort); 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.

Note: As stated in applicable Appropriations Law, none of the funds appropriated shall be used to pay the salary of an individual, through a grant or other extramural mechanism, at a rate in excess of Executive Level II. This salary cap applies to direct salaries and to those salaries covered under indirect costs, also known as facilities and administrative (F & A). Please consult the following link to determine the applicable current salary cap: <https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/>

Sample Budget

<i>Personnel Total</i> \$_____
<i>Grant</i> \$_____
<i>Recipient Share</i> \$_____
<i>Sources of Funding</i> _____

Position Title	Name (if known)	Annual	Time	Months	Amount Requested
Project Director	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 Director-- (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 CMS. 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 (reference NICRA if applicable). 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

<i>Fringe Benefits Total</i> \$_____
<i>Grant</i> \$_____
<i>Recipient Share</i> \$_____
<i>Sources of Funding</i> _____

Fringe Benefit	Rate	Salary Requested	Amount Requested
FICA	7.65%	\$45,000	\$3443
Worker's Compensation	2.5%	\$14,250	\$356

Fringe Benefit	Rate	Salary Requested	Amount Requested
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 are for **applicant staff travel only**. Travel for consultants is in the consultant category. Allowable travel for other participants, advisory committees, review panel, etc. is itemized in the same way specified below and placed in the “**Other**” category. Travel incurred through a contract is in the contractual category.

Provide a narrative describing the travel staff members will perform. This narrative includes a justification of 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 are 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

<i>Fringe Benefits Total</i> \$_____
<i>Grant</i> \$_____
<i>Recipient Share</i> \$_____
<i>Sources of Funding</i> _____

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

Purpose of Travel	Location	Item	Rate	Cost
		Luggage Fees	\$50/flight x 2 persons	\$100
		Hotel	\$140/night x 2 persons x 3 nights	\$840
		Per Diem (meals)	\$49/day x 2 persons x 4 days	\$392
		Transportation (to and from airport)	\$50/shuttle x 2 persons x 2 shuttles	\$200
		Transportation (to and from hotel)	\$25/shuttle x 2 persons x 2 shuttles	\$100
				\$2,700

Sample Justification

The Project Coordinator and the Outreach Supervisor will travel to (location) to attend a conference on the following topic XXXX 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 is 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 and 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 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.

Note: 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 equipment item and relate it to specific program objectives. List maintenance or rental fees for equipment in the “Other” category. Ensure that all IT equipment is uniquely identified. Show the unit cost of each item, number needed, and total amount.

Sample Budget

<i>Equipment Benefits Total \$_____</i>
<i>Grant \$_____</i>
<i>Recipient Share \$_____</i>
<i>Sources of Funding_____</i>

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 the program utilizes the equipment. For equipment and tools shared amongst programs, please cost allocate as appropriate. Applicant should provide a list of hardware, software and IT equipment that will be required to complete this effort. Additionally, they should provide a list of non-IT equipment that 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. Classify technology items such as computers that do not meet the \$5,000 per unit threshold or an alternative lower limit set by recipient policy as **supplies** and individually tag and record in an equipment/technology database. 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

<i>Supplies Total \$_____</i>
<i>Grant \$_____</i>
<i>Recipient Share \$_____</i>
<i>Sources of Funding_____</i>

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

A complete description and cost breakdown, as outlined below, is provided for each consultant, 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 recipient organization. Submit the following required information for consultants:

1. Name of Consultant: Identify the name of the consultant and describe the person's 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.
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 applicant monitors progress and performance of the consultant. Identify who is responsible for supervising the consultant agreement.

REQUIRED REPORTING INFORMATION FOR SUBRECIPIENT APPROVAL

The costs of project activities to be undertaken by a subrecipient is included in this category. Please use formats from “Sample Budget” and “Sample Justification” above. 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*.

REQUIRED REPORTING INFORMATION FOR CONTRACT APPROVAL

All recipients must submit to CMS the following required information for establishing a 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 performed by the contractor as related to the accomplishment of program objectives. Clearly define the deliverables.
5. Method of Accountability: Describe the monitoring plan of the progress and performance of the contractor 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.

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

<i>Other Total</i> \$ _____
<i>Grant</i> \$ _____
<i>Recipient Share</i> \$ _____
<i>Sources of Funding</i> _____

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 negotiated indirect cost rate agreement (NICRA) 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 \$_____.

<i>Personnel</i> \$ _____
<i>Fringe</i> \$ _____
<i>Travel</i> \$ _____
<i>Supplies</i> \$ _____
<i>Other</i> \$ _____
<i>Total</i> \$ x _____% = <i>Total Indirect Costs</i>

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

Appendix II. Application and Submission Information

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

This NOFO contains all the instructions to enable a potential applicant to apply. The application is written primarily as a narrative with the addition of standard forms required by the Federal government for all grants and Cooperative Agreements.

With respect to electronic methods for providing information about funding opportunities or accepting applicant" submissions of information, CMS complies with Section 508 of the Rehabilitation Act of 1973 (29 U.S.C. 794d).

EIN, UEI, LOGIN.GOV AND SAM REQUIREMENTS (ALL APPLICATIONS)

Employer Identification Number

All applicants under this Notice of Funding Opportunity must have an Employer Identification Number (EIN), otherwise known as a Taxpayer Identification Number (TIN), to apply. **Please note, applicants should begin the process of obtaining an EIN/TIN as soon as possible after the Notice of Funding Opportunity is posted to ensure this information is received in advance of application deadlines. The process to obtain an EIN typically takes up to 5 weeks.**

Unique Entity Identifier (UEI)

Applicants must have a UEI number to apply.

Applicants should obtain a Unique Entity Identifier (UEI) number as soon as possible after the Notice of Funding Opportunity is posted to ensure all registration steps are completed in time.

See the following links for additional information on obtaining a UEI:

GAO: <https://www.gsa.gov/about-us/organization/federal-acquisition-service/office-of-systems-management/integrated-award-environment-iae/iae-systems-information-kit/unique-entity-identifier-update>

Grants.gov: <https://www.grants.gov/web/grants/forms/planned-uei-updates.html>

Login.gov

Users must sign in to Grants.gov with Login.gov credentials.

<https://grantsgovprod.wordpress.com/2022/05/04/how-to-create-a-grants-gov-account-and-link-to-a-login-gov-account/#CreateALoginGovAccount>

System for Award Management (SAM)

The applicant must register in the System for Award Management (SAM) database to be able to submit the application. Applicants can access <https://www.sam.gov/> and complete the online

registration. UEI and EIN/TIN numbers are required to complete the registration process. To register one or more domestic entities and appoint an entity administrator, the applicant organization must send a notarized letter to SAM.

Applicants should begin the SAM registration process as soon as possible after the Notice of Funding Opportunity is posted to ensure that it does not impair your ability to meet required submission deadlines. The process to register in SAM typically takes up to 2 weeks following receipt of the notarized letter (additional 5 weeks if an EIN must be established first).

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

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

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

CMS requires applications for all competitive Notice of Funding Opportunities to be submitted electronically through <http://www.grants.gov/>. For assistance with this process contact <https://www.grants.gov/web/grants/support.html> or 1-800-518-4726. Below is an overview of the instructions from the Grants.gov website. Applicants can access the site directly for more detailed information.

How to Register to Apply through Grants.gov

- *Obtain A UEI number.*
- *Complete SAM registration*
- *Create a Login.gov Account (Users must sign in to Grants.gov with Login.gov credentials)*

<https://grantsgovprod.wordpress.com/2022/05/04/how-to-create-a-grants-gov-account-and-link-to-a-login-gov-account/#CreateALoginGovAccount>

- *Register to obtain a Grants.gov username and password.* Click the Register link and complete the on-screen instructions or refer to detailed instructions here: <https://www.grants.gov/web/grants/register.html>.
- *To link your Grants.gov account to a Login.gov account.* See detailed instructions here: <https://grantsgovprod.wordpress.com/2022/05/04/how-to-create-a-grants-gov-account-and-link-to-a-login-gov->
- *Add a Profile to the Account:* The profile corresponds to a single applicant organization the user represents (i.e., an applicant) or an individual applicant. If you work for or consult with multiple organizations and have a profile for each, you may log in to one Grants.gov account to access all your grant applications. To add an organizational profile, enter the UEI (Unique Entity Identifier) for the organization in the field while adding a profile. For more detailed instructions about creating a profile refer to: <https://www.grants.gov/web/grants/applicants/registration.html>.
- *eBiz POC Authorized Profile Roles:* eBiz POCs will no longer use their UEI or DUNS Number during login. eBiz POCs will use an applicant account associated with their email address and UEI (Unique Entity Identifier) by using an existing applicant account or **registering a new one**. Beginning January 21, 2023, any applicant user whose Grants.gov account and profile is associated with the same email address and UEI as the eBiz POC registered in SAM.gov will be recognized as the eBiz POC in Grants.gov. If the eBiz POC email address in SAM.gov changes, then the user will no longer be recognized as the eBiz POC in Grants.gov. However, this user will retain the Expanded AOR role until it is removed by another Expanded AOR. <https://grantsgovprod.wordpress.com/2022/12/14/improvements-to-ebiz-account-management/>
- *Track Role Status:* To track your role request, refer to: <https://www.grants.gov/web/grants/applicants/registration.html>.
- *Electronic Signature:* When applications are submitted through Grants.gov, the name of the organization applicant with the AOR role that submitted the application is inserted into the signature line of the application, serving as the electronic signature. The eBiz POC **must** authorize people who are able to make legally binding commitments on behalf of the organization as a user with the AOR role; **this step is often missed, and it is crucial for valid and timely submissions.**

How to Apply to CMS via Grants.gov

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

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

Below is an overview of applying. For access to complete instructions on how to apply for opportunities, refer to:

<https://www.grants.gov/web/grants/applicants/workspace-overview.html>

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

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

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

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

<https://www.grants.gov/web/grants/applicants/adobe-software-compatibility.html>

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

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

3) *Submit a Workspace*: An application may be submitted through workspace by clicking the Sign and Submit button on the Manage Workspace page, under the Forms tab.

Grants.gov recommends submitting your application package at least 24-48 hours prior to the close date to provide you with time to correct any potential technical issues that may disrupt the application submission.

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

For additional training resources, including video tutorials, refer to:

<https://www.grants.gov/web/grants/applicants/applicant-training.html>

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

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

Timely Receipt Requirements and Proof of Timely Submission

All grant and Cooperative Agreement applications must be submitted electronically and **received** through <https://www.grants.gov> by 3:00 p.m. Eastern Standard or Daylight Time (Baltimore, MD) by the applicable deadline date. Please refer to the Executive Summary of this Notice of Funding Opportunity for submission deadline date.

Proof of timely submission is automatically recorded, and an electronic date/time stamp is generated within the system when the application is successfully received by Grants.gov. The applicant with the AOR role who submitted the application will receive an acknowledgement of receipt and a tracking number (GRANTXXXXXXXX) with the successful transmission of their application. This applicant with the AOR role will also receive the official date/time stamp and Grants.gov Tracking number in an email serving as proof of their timely submission.

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, because of errors on the part of the applicant, will not be reviewed.

When CMS successfully retrieves the application, and acknowledges the download of submissions, Grants.gov will provide an electronic acknowledgment of receipt of the application to the email address of the applicant with the AOR role who submitted the application. Again, proof of timely submission shall be the official date and time that Grants.gov receives your application. Applications received after the established due date for the program will be considered late and will not be considered for funding by CMS.

Applicants using slow internet, such as dial-up connections, should be aware that transmission can take some time before your application is received. Again, Grants.gov will provide either an error or a successfully received transmission in the form of an email sent to the applicant with the AOR role attempting to submit the application. The Support Center reports that some applicants end the transmission because they think that nothing is occurring during the transmission process. Please be patient and give the system time to process the application. To be considered timely, applications must be received by the published deadline date. However, a general extension of a published application deadline that affects all state applicants or only those in a defined geographical area may be authorized by circumstances that affect the public at

large, such as natural disasters (e.g., floods or hurricanes) or disruptions of electronic (e.g., application receipt services) or other services, such as a prolonged blackout. This statement does not apply to an individual entity having internet service problems. For there to be any consideration there must be an effect on the public at large.

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

Appendix III. Business Assessment of Applicant Organization

Applicants review and answer the business assessment questions outlined below. There are eleven (11) topic areas labeled A-K, with a varying number of questions within each topic area. **Applicants MUST provide a brief substantive answer to each question (and supporting documentation as applicable).** If the answer to any question is non-applicable, please provide an explanation. Please note, if CMS cannot complete its review without contacting the applicant for additional clarification, the applicant risks selection for award.

A. General Information

1. Provide organization:
 - a. Legal name:
 - b. EIN (include PMS prefix and suffix, if applicable-ex. **1-12356789-A1**):
 - c. Organizational Type:
2. What percentage of the organization's capital is from Federal funding? (percentage = total Federal funding received in previous fiscal year / organization's total gross revenue in previous fiscal year).
3. Does/did the organization receive additional oversight (ex: Corrective Action Plan, Federal Awardee Performance and Integrity Information System (FAPIIS) finding, reimbursement payments for enforcement actions) from a Federal agency within the past 3 years due to past performance or other programmatic or financial concerns with the organization)?
 - a. If yes, please provide the following information: Name of the Federal agency; reason for the additional oversight as explained by the Federal agency
 - b. If resolved, please indicate how the issue was resolved with the agency.
4. Does the organization currently manage grants with other U.S. Department of Health and Human Services components or other Federal agencies?
5. Explain your organization's process to ensure annual renewal in System for Award Management (to include FAPIIS).
6. Explain your organization's process to comply with (a) [45 CFR 75.113](#) Mandatory Disclosures and (b) your organization's process to comply with FFATA requirements.
7. Do you have conflict of interest policies? Does your organization or any of its employees have any personal or organizational conflicts of interest related to the possible receipt of these CMS award funds? If yes, please explain and provide a mitigation plan.
8. Does your organization currently, or in the past, had delinquent Federal debt in the last 3 years? If yes, please explain.
9. Has the organization obtained fidelity bond insurance coverage for responsible officials and employees of the organization in amounts required by statute or organization policy? What is that amount?
10. Do you have (and briefly describe) policies and procedures in place to meet the requirements below? If not, explain your plan and estimated timeline for establishing these policies and procedures if selected for award.
 - a. make determinations between subrecipients versus contracts in accordance

- with [45 CFR 75.351](#)?
- b. notify entities at the time of the award/agreement if they are a subrecipient in compliance with [45 CFR 75.352](#)?
 - c. manage, assess risk, review audits, and monitor the subrecipients as necessary to ensure that subawards are used for authorized purposes in compliance with laws, regulations, and terms and conditions of the award and that established subaward performance goals are achieved (45 CFR § [75.351–75.353](#))?

B. Accounting System

1. Does the organization have updated (last two years) written accounting policies and procedures to manage federal awards in accordance with 45 CFR Part 75?
 - a. If no, please provide a brief explanation of why not.
 - b. Describe the management of federal funds and how funds are separated (not co-mingling) from other organizational funds.
2. Briefly describe budgetary controls in effect to preclude incurring obligations more than:
 - a. Total funds available for an award.
 - b. Total funds available for a budget cost category.
3. Has any government agency rendered an official written opinion within the last 3 years concerning the adequacy of the organization's accounting system for the collection, identification, and allocation of costs under Federal awards?
 - a. If yes, please provide the name and address of the Agency that performed the review.
 - b. Provide a summary of the opinion.
 - c. How did your organization resolve any concerns?
4. How does the accounting system provide for recording the non-Federal share and in-kind contributions (if applicable for a grant program)?
5. Does the organization's accounting system provide identification for award funding by federal agency, pass-through entity, Assistance Listing (CFDA), award number and period of funding? If yes, how does your organization identify awards? If not, please explain why not.

C. Budgetary Controls

1. What are the organization's controls utilized to ensure that the Authorized Organizational Representative (AOR), as identified on the SF-424, approves all budget changes for the federal award?
2. Describe the organization's procedures for minimizing the time between transfer of funds from the U.S. Treasury (e.g., Payment Management System) and disbursement for grant activities (See 45 CFR §75.305, "Payment.").

D. Personnel

1. Does the organization have a current organizational chart or similar document establishing clear lines of responsibility and authority?
 - a. If yes, please provide a copy.
 - b. If no, how are lines of responsibility and authority determined?

2. Does the organization have updated (last two years) written Personnel and/or Human Resource policies and procedures? If no, provide a brief explanation.
3. Does the organization pay compensation to Board Members?
4. Are staff responsible for fiscal and administrative oversight of HHS awards (Grants Manager, CEO, Financial Officer) familiar with federal rules and regulations applicable to grants and Cooperative Agreements (e.g. [45 CFR Part 75](#))?
5. Please describe how the payroll distribution system accounts for, tracks, and verifies the total effort (100%) to determine employee compensation.

E. Payroll

1. In preparation of payroll is there a segregation of duties for the staff who prepare the payroll and those that sign the checks, have custody of cash funds, and maintain accounting records? Please describe.

F. Consultants (See Appendix I. *Guidance for Preparing a Budget Request and Narrative* in the NOFO for relevant information)

1. Are there written policies or consistently followed procedures regarding the use of consultants which detail the following (include explanation for each question below)?
 - a. Briefly describe the organization’s method or policy for ensuring consultant costs and fees are allowable, allocable, necessary, and reasonable.
 - b. Briefly describe the organization’s method or policy to ensure prospective consultants prohibited from receiving Federal funds are not selected.

G. Property Management

1. Briefly describe the system for property management (tangible or intangible) utilized for maintaining property records consistent with 45 CFR 75.320(d).
**Refer to ([45 CFR 75.2](#)) for definitions of property to include personal property, equipment, and supplies.
2. Does the organization have adequate insurance to protect the Federal interest in equipment and real property (see [45 CFR §75.317](#), “[Insurance coverage.](#)”)? How does the organization calculate the amount of insurance?

H. Procurement

Describe the organization’s procurement procedures (in accordance with [45 CFR §75.326--§75.335](#), “Procurement procedures”)? If there are no procurement procedures, briefly describe how your organization handles purchasing activities. A. Include individuals responsible and their roles. B. Describe the competitive bid process for procurement purchases of equipment, rentals, or service agreements that are over certain dollar amounts.

I. Travel

1. Describe the organizations written travel policy. Ensure, at minimum, that:
 - a. Travel charges are reimbursed based on actual costs incurred or by use of per diem and/or mileage rates (see [45 CFR §75.474](#), “Travel costs.”).

- b. Receipts for lodging and meals are required when reimbursement is based on actual cost incurred.
- c. Subsistence and lodging rates are equal to or less than current Federal per diem and mileage rates.
- d. Commercial transportation costs incurred at coach fares unless adequately justified. Lodging costs do not exceed GSA rate unless adequately justified (e.g., conference hotel).
- e. Travel expense reports show purpose and date of trip.
- f. Travel costs are approved by organizational official(s) and funding agency prior to travel.

J. Internal Controls

- 1. Provide a brief description of the applicant’s internal controls that will provide reasonable assurance that the organization will manage award funds properly. (see [45 CFR §75.303](#), “Internal controls.”)
- 2. What is your organization’s policy on separation of duties as well as responsibility for receipt, payment, and recording of cash transactions?
- 3. Does the organization have internal audit or legal staff? If not, how do you ensure compliance with the award? Please describe.
 - 4. If the organization has a petty cash fund how is it monitored?
- 5. Who in the organization reconciles bank accounts? Is this person familiar with the organization’s financial activities? Does your organization authorize this person to sign checks or handle cash?
- 6. Are all employees who handle funds required to be bonded against loss by reason of fraud or dishonesty?

K. Audit

- 1. What is your organization’s fiscal year?
- 2. Did the organization expend \$750,000 or more in Federal awards from all sources during its most recent fiscal year?
- 3. Has your organization submitted;
 - (a) an audit report to the *Federal Audit Clearing House (FAC)* in accordance with the Single Audit Act in the last 3 years? (see 45 CFR §75.501, “Audit requirements” and 45 CFR §75.216 “Special Provisions for Awards to Commercial Organization as recipient.”) **or**
 - (b) an independent, external audit? If no, briefly explain. If yes, address the following:
 - i. The date of the most recently submitted audit report.
 - ii. The auditor's opinion on the financial statement.
 - iii. If applicable, indicate if your organization has findings in the following areas: 1) internal controls, 2) questioned or unallowable costs, 3) procurement/suspension and debarment, 4) cash management of award funds, and 5) subrecipient monitoring.
 - iv. Include (if applicable):

1. A description of each finding classified as Material Weakness.
 2. A description of each finding classified as Significant Deficiency.
4. Does the organization have corrective actions in the past 2 years for the findings identified above (3(iii))? If yes, describe the status (closed or open) and progress made on those corrective actions.

Appendix IV. Accessibility Requirements

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

The recipient may receive a request from a beneficiary or member of the public for information in accessible formats. All successful applicants under this Notice of Funding Opportunity must comply with the following reporting and review activities regarding accessibility 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: <https://www.medicare.gov/about-us/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 to provide the accessible 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 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 recipient 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 auxiliary aids and services (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 to provide the accessible 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 type of service requested (e.g., sign language interpreter and the type of sign language needed).
 - c. The date, time, address, and duration of the needed service.
 - d. A description of the venue for which the service is needed (e.g., public education seminar, one-on-one interview, etc.)
 - e. Contact information for the person submitting the e-mail – Organization (Grantee), name, phone number and e-mail.
 - f. Any applicable documents shall be attached to the e-mail. CMS will respond to the request and respond directly to the requester.

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

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

Appendix V. Merit 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 Sections C. Eligibility Information, and D. Application and Submission Information (with cross-reference to Appendix II), 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 their 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 based on merit 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 a merit review committee. The merit 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 merit 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 merit review panel; the readiness of the applicant to conduct the work required; the scope of overall projected impact on the aims; reviews for programmatic and grants management compliance; the reasonableness of the estimated cost to the government and anticipated results; the geographic diversity of all applications; 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. CMS reserves the right to conduct pre-award Negotiations with potential recipients.

Appendix VI. Application Check-off List

Required Contents

A complete application 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 application. **Everything listed below must be submitted through <https://www.grants.gov/web/grants/home.html> and formatting requirements followed. Documents without specific placeholders in the application kit available on Grants.gov should be uploaded under “Other Attachments Form.”**

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

- Section D and Appendix II: Application and Submission Information
- Section E: Application Review Information
- Appendix I: Guidance for Preparing a Budget Request and Narrative

- Required Forms/Mandatory Documents (with an electronic signature by AOR)
 - Project Abstract
 - SF-424: Application for Federal Assistance
 - SF-424A: Budget Information
 - SF-LLL: Disclosure of Lobbying Activities
 - Project/Performance Site Location(s) Form(s)
- Applicant’s Application Cover Letter (optional, **excluded from page limitations**)
- Project Abstract
- Project Narrative
- Budget Narrative
- Business Assessment of Applicant Organization
- Appendices
 - Letter of support from SMA (required only if applicable): If the SMA is not the applicant, applicant must provide a letter of support confirming that the SMA is ready and committed to being a subrecipient of the Cooperative Agreement award. Letter of support should confirm the SMA is committed to aligning with hospital global budget methodology and has a Medicaid Primary Care APM (or has the capacity to implement a Medicaid Primary Care APM in PY1)

- Resumes and/or curriculum vitae (**required** for identified managers, Project Director, and all other Key Personnel identified at the time of application; applicant should cross-reference to the Project Narrative, as appropriate)
- Job Descriptions, if not included in the Projective Narrative (**required**; applicant should cross-reference to the Project Narrative, as appropriate)
- Organization Chart, if not included in the Project Narrative (**required**; applicant should cross-reference to the Project Narrative, as appropriate)
- Letters of Support (from Governor or state legislators, hospitals, primary care providers, others) (optional)
- Proposal for state-designed Medicare FFS Hospital Global Budget Methodology (optional)
- LOIs from hospitals (at least one LOI from one hospital is **required** as part of the application)

- Negotiated Indirect Cost Rate Agreement (NICRA) or Cost Allocation Plan (CAP), if applicable (excluded from page limitations)

Appendix VII. Medicare FFS Hospital Global Budget Financial Methodology

Introduction to Hospital Global Budgets

A hospital global budget is a type of alternative payment arrangement that pays hospitals a prospectively set budget based on historical expenditures for certain services provided to a patient population (e.g., Medicare FFS beneficiaries) over a period of time rather than on an FFS-basis or cost-based reimbursement. Global budgets provide hospitals with stable, predictable funding as an incentive to manage their patients' health in a manner that improves health outcomes. Hospitals receiving global budget payments may realize savings generated from reductions in avoidable utilization (e.g., avoidable admissions and emergency room visits) and gains in care delivery efficiency. CMMI has expertise in designing and operationalizing hospital global budgets through the Maryland All-Payer Model, Maryland Total Cost of Care Model, and Pennsylvania Rural Health Model. AHEAD's global budget methodology builds on lessons learned from these models.

Medicare FFS Hospital Global Budgets in AHEAD

As noted in Section A4.5, *Hospital Global Budgets*, award recipients with statewide hospital rate setting authority or hospital budget setting authority and prior experience with population-based payments or hospital global budgets can propose state-specific Medicare FFS global budget methodologies. State-designed methodologies must align with the *Hospital Global Budget Alignment Principles for State-Designed Methodologies* detailed later in this appendix and are subject to CMS approval. Hospital global budgets for Participant Hospitals in a state with a CMS-approved state-designed methodology will be calculated according to such methodology.

CMS-Designed Medicare FFS Hospital Global Budget Methodology

This appendix includes an overview of the CMS-designed methodology for informational purposes; however, the methodology as described below is subject to change at CMS' sole discretion. This methodology will be detailed further by CMS prior to the start of the Pre-Implementation Period in a detailed financial specifications document.

CMS will determine a prospectively set, annual Medicare FFS hospital global budget covering services otherwise paid in Medicare under IPPS and OPSS for each Participant Hospital. For the CMS-designed methodology, Participant Hospitals will receive a fixed global budget in the form of prospective, bi-weekly payments from Medicare in place of payments for FFS claims, beginning January 2026 or January 2027 depending on which Cohort the award recipient selects. Hospitals will continue to submit Medicare FFS inpatient and outpatient claims and Medicare Hospital Cost Reports to CMS as they normally would for monitoring, quality measurement purposes, and to calculate expenditures for purposes of shared savings programs or other payment models, and other utilization and performance metrics. However, Participant Hospitals will not be paid via the standard Medicare FFS system for services covered under the hospital global budgets (note: beneficiary cost-sharing would remain as normal). CMS will apply a standardized global budget calculation methodology across Participant Hospitals, but each Participant Hospital's global budget payment will be calculated based on its own historical revenue, which is then adjusted as described below.

Global Budget Calculation Methodology (Acute care hospitals): When calculating global budgets for PPS hospitals, CMS will generally follow the steps outlined below. Hospitals may elect to begin participation in the Model at the beginning of any year during the Implementation Period with the exception of the final year.

Determine global budget baseline using historical revenue.

To calculate the baseline global budget for a Participant Hospital, CMS will calculate a weighted average of the hospital’s historical revenue from Inpatient Prospective Payment System (IPPS) and Outpatient Prospective Payment System (OPPS) payments using the three most recent years preceding the first year in which the hospital joins the Model for which sufficiently complete claims data are available, referred to as the Base Years (BY). Percentage weightings will be applied to the historical revenue for each Base Year, with the most recent Base Years weighted more heavily. The applicable Base Years and the weighting that will be applied to each are described in *Table 2*.

CMS will monitor CY2022 hospital data for impacts due to the COVID-19 public health emergency (PHE) and will revisit baseline hospital global budget calculations if necessary.

Table 2. Weighting Applied to Historical Revenue

Year	Description	Worked Example: First Year Participating in HGB is 2027	Percentage Weighting
Base Year 1	Hospital’s first PY minus 4 years	2023	10%
Base Year 2	Hospital’s first PY minus 3 years	2024	30%
Base Year 3	Hospital’s first PY minus 2 years	2025	60%

Beneficiary cost sharing as well as new technology adjustments and pass-through adjustments (e.g., bad debt, Graduate Medical Education (GME), nursing and allied health education (NAHE), organ acquisition) will be removed from historical revenue and not included in baseline hospital global budgets. Additionally, certain payment adjustments for hospital-specific quality program performance and IPPS/OPPS factors will be removed from historical revenue so these adjustments are not accounted for both in the baseline and in the hospital global budget payment amount (see *Adjustments to reflect hospital performance under hospital global budgets*).

Note: States with statewide hospital rate setting authority or hospital budget setting authority and prior experience in population-based payments or global budgets that wish to use their own methodology must outline in their proposal to CMS how they plan to calculate baseline global budgets and should consult the *Hospital Global Budget Alignment Principles for State-Designed Methodologies* at the end of this appendix in defining such methodology.

Apply certain adjustments to the baseline hospital global budget to arrive at the payment amount.

CMS will apply various adjustments to the historical revenue used to calculate hospital global budgets (the baseline hospital global budgets) to account for differences between the Base Years and Performance Year 1. These same adjustments will also be applied on an annual basis to each Participant Hospital's baseline global budget to develop the global budget payment amount for the following performance year.

The adjustments will include, but are not limited to:

Adjustments to reflect changes in the patient population or services provided:

- **Risk Adjustment:** AHEAD will apply adjustments to global budgets to account for hospital-to-hospital differences in the patient population's medical and social risk. CMS may measure relative risk using Hierarchical Condition Category (CMS-HCC), Area Deprivation Index (ADI) at the state and national level, dual/partial dual status, and Part D Low-Income Subsidy (LIS), though the specific indices that will be used are subject to change.
- **Demographic Shifts:** Hospital global budgets will be adjusted based on trends in a geographic area's patient population, such as those related to population size, age, and volume.
- **Inflation:** Historical revenue and past performance years' global budgets will be trended forward using a price inflation factor or index specific to Medicare FFS.
- **Market Shifts:** Hospital global budgets will be adjusted for material shifts in volume for specific services between hospitals.
- **Service Line Changes:** Hospital global budgets may be adjusted to account for service line additions, expansions, eliminations, or contractions.

Adjustments to hospital global budgets to reflect hospital performance:

- **Quality Adjustment:** Starting in a Participant Hospital's first performance year, CMS will apply an adjustment to the Medicare FFS hospital global budget based on the Participant Hospital's performance on CMS national hospital quality programs (e.g., Hospital-Acquired Condition Reduction Program (HACRP), Hospital Readmissions Reduction Program (HRRP), Hospital Inpatient Quality Reporting Program (IQR), Hospital Outpatient Quality Reporting Program (OQR), Hospital Value-Based Purchasing Program (VBP)). Generally, the methodology will approximate the revenue at risk under the CMS national hospital quality programs and apply the scoring on these programs to the hospital global budgets.
- **Health Equity Improvement Bonus:** Starting in PY2 of the applicable Cohort, Participant Hospitals will be accountable for performance on select quality measures focused on promoting equity. Participant Hospital performance on those measures will determine the degree of an upward adjustment that will be applied to the hospital global budget in a future performance year. The upward adjustment must be applied to a future

performance year to allow for the data collection and evaluation process that begins after the end of a performance year.

- **Total Cost of Care (TCOC) Performance Adjustment:** Participant Hospitals will be accountable for the TCOC of beneficiaries within their geographic service area. Starting in PY2 of the applicable Cohort, a Participant Hospital's TCOC performance will serve as the basis for adjustments to hospital global budgets in a future Performance Year. For example, the TCOC adjustment to each Participant Hospital's PY4 hospital global budget will be based on performance in PY2; the TCOC adjustment to each Participant Hospital's PY5 hospital global budget will be based on PY3 performance. The TCOC adjustments made in PY4, based on PY2 performance, will be upward only. The TCOC adjustments made in PY5, based on PY3 performance, and all future performance years, will be both upward and downward.
- **Effectiveness Adjustment:** Starting in PY2 of the applicable Cohort, a portion of Participant Hospitals' calculated potentially avoidable utilization (PAU) will serve as the basis for downward adjustments applied to the hospital global budget. This adjustment further incentivizes hospitals to implement interventions that reduce unnecessary or avoidable care. PAU can include, for example, readmissions, avoidable admissions (calculated by the Prevention Quality Indicator PQI 90), avoidable ED visits (calculated by the NYU ED algorithm), low-value care (as defined by MedPAC), and other indicators. The effectiveness adjustment will increase gradually over time up to a maximum as hospitals gain additional experience with implementing processes to control PAU and form partnerships with primary care providers, post-acute care providers, and community-based organizations that can address social drivers of health.

Other adjustments:

- **Baseline Adjustments:** The methodology will also include adjustment factors to the Medicare baseline global budget including adjustments for Medicare Disproportionate Share Hospitals (DSH), Indirect Medical Education (IME), Low Volume Adjustment, Outlier Adjustment, Uncompensated Care (UCC), Wage Index updates, and for Sole Community Hospitals (SCH) or Medicare Dependent Hospitals (MDH).
- **Transformation Incentive Adjustment:** An upward adjustment of 1% of the Medicare baseline global budget will be applied to the hospital global budgets for PY1 and PY2 of the respective Model Cohort to facilitate investment in the infrastructure and capacity development needed for enhanced care management services. If a hospital exits the model prior to the state's PY6, the hospital will be required to repay the Transformation Incentive Adjustment.
- **Exception-Based Factors:** Participant Hospitals may request exception-based adjustments, subject to CMS approval.
- **Other:** CMS will also consider on a case-by-case basis whether to apply adjustments to hospital global budgets for changes in federal policy including, but not limited to, payment rate changes. Any such adjustment will be at the sole discretion of CMS.

Global Budget Calculation Methodology for Critical Access Hospitals and Safety Net Hospitals: Participation in AHEAD hospital global budgets will mean a departure from

traditional Medicare FFS reimbursements, including cost-based reimbursement for Critical Access Hospitals (CAHs). CMS does not plan to reconcile CAH global budgets back to costs at the end of each Performance Year. However, CMS recognizes that CAHs and other safety net hospitals (SNHs)²¹ have unique characteristics, including geography, patient volume, and fixed cost ratios, which may impact their decision to participate in a hospital global budget structure. CMS will use a similar methodology as described above. CAHs or SNHs will also receive Transformation Incentive Adjustments (1% for PY1 and PY2 of the Model Cohort), which will offer a source of upfront funding to support enhanced care management services. However, CMS will offer several modifications to the Medicare FFS hospital global budget methodology specifically for CAHs and SNHs that participate in AHEAD, which include but are not limited to:

- The CAH Quality Adjustment program, a 2% upside-only adjustment for pay-for-reporting before moving to pay-for-performance in later years of the Model (see Appendix XII. *Quality and Population Health Strategy*).
- The effectiveness adjustment will begin being applied to CAH and SNH hospital global budgets one performance year later than it will be applied to acute care hospitals (adjustments starting in PY3 of the applicable Cohort).
- The TCOC performance adjustment applied to CAH and SNH hospital global budgets will begin as upward-only (adjustments to hospital global budgets during PY4 and PY5 of the applicable Cohort based on PY2 and PY3 performance); CAHs and SNFs will be subject to upward and downward adjustments to hospital global budgets starting in PY6 (adjustments to PY6 hospital global budgets based on PY4 performance).
- AHEAD will provide a reimbursement “floor” to ensure CAH hospital global budget baselines cover the latest cost reporting at the point of Model entry. For future performance years, CMS will continue to monitor sufficiency of hospital global budgets based on finalized cost reports and additional data sources, ensuring that CAHs and SNHs can continue to cover their ratios of fixed costs (defined as capital and non-labor) to variable costs (defined as labor).

Beyond the modifications to the methodology listed above, additional support will be available to CAHs and SNHs:

- CMS will allow award recipients with CAHs and SNHs within their state or selected sub-state region to allocate some portion of the Cooperative Agreement award to providing technical assistance and other resources to CAHs and SNHs to support their participation in the Model (e.g., coaching, assistance in quality reporting, implementing technology upgrades, or staff training).
- CMS will work with CAHs, SNHs, the Medicare Administrative Contractors, and other entities on cost-reporting processes under this Model.

Hospital Global Budget Alignment Principles for State-Designed Methodologies

²¹ CMS will provide a definition of Safety Net Hospitals for the purposes of the AHEAD Model in forthcoming financial specifications.

As noted above, CMS will allow states with statewide hospital rate setting authority or hospital budget setting authority and prior experience in population-based payments or global budgets to develop a state-specific Medicare FFS global budget methodology. Any state-designed Medicare FFS global budget methodology will be subject to CMS review and approval. States should submit to CMS their proposed state-designed Medicare FFS global budget methodology, including detailed specifications and supporting data, no later than 18 months before the start of the PY in which the methodology would be implemented. In conducting its review, CMS may ask states for clarification, additional information, and revisions to better meet model goals and alignment with the principles outlined below. If the state-designed methodology is not approved by CMS, the CMS-designed Medicare FFS global budget methodology will apply. If the state-designed methodology is approved by CMS, there will be an ongoing approval process for any modifications to the methodology and a dispute process if the state and CMS are unable to reach agreement on updates to the state-designed methodology. Finally, the award recipient must ensure that this methodology is clearly understood by providers.

In reviewing state-designed Medicare FFS hospital global budget methodologies, CMS will look for alignment with the CMS-designed methodology in the following areas. These principles may also be useful to states as they design their commercial hospital global budget methodology. Alignment principles for Medicaid are in the following appendix.

1. The state-designed methodology must establish annual global budgets for hospital participants that transition hospitals away from existing volume-based reimbursement and incentivize a reduction in unnecessary hospital utilization. Hospital global budgets will include facility services in hospital inpatient, outpatient, and emergency departments, at minimum.
2. The state must make hospital global budgets available to short-term acute care hospitals and critical access hospitals (CAHs), at a minimum.
3. Hospital global budgets must be designed in such a way that enables the state to both meet its annual Medicare FFS TCOC targets and achieve savings by the conclusion of the Performance Years.
 - a. The methodology must include a process by which hospital global budgets can be adjusted in the event the state misses the statewide Medicare FFS TCOC target(s) and is on a Corrective Action Plan.
4. The methodology must consider incentives to recruit and retain hospitals early into the Model, and to facilitate hospital investment in the infrastructure needed to be successful under a hospital global budget construct (e.g., an upward adjustment to hospital global budgets for the first two Performance Years, similar to CMS's Transformation Incentive Adjustment).
5. Hospital global budgets must be adjusted for both medical and social risk for either the beneficiaries the hospital serves or the hospital's geographic service area. The methodology must account for population growth, demographic changes, and other factors influencing the cost of hospital care.
6. The methodology must include a mechanism by which hospital global budgets are adjusted for hospital-level quality performance (similar to CMS's Quality Adjustment described above). This quality adjustment must be based on performance on either the CMS national hospital quality programs themselves or on similar categories of quality

measures to those used for these programs. If the state chooses to select its own quality measures for these purposes, hospital performance on those measures must achieve or surpass the measured results in terms of patient outcomes and cost savings as the CMS national hospital quality programs.

- a. Hospital global budgets must be adjusted for performance on disparities-sensitive quality measures for improving health equity. At minimum, the selected measures must include sufficient data to identify disparities and changes in those disparities, and the selected measures must align with overall model goals.
7. The methodology must hold hospitals accountable for TCOC of a defined beneficiary population via a performance adjustment (e.g., CMS's TCOC Performance Adjustment) or some other mechanism. The CMS-designed methodology will include geographic assignment, but a state-designed methodology may utilize a different approach to assign beneficiaries to hospitals for these purposes.
8. Hospital global budgets should account for changes in service line and unplanned volume shifts, while not incentivizing FFS-oriented utilization.
9. The methodology must account for annual changes, such as inflation.
10. While the methodology may include modifications to account for the unique circumstances of critical access hospitals (as CMS's methodology does), the hospital global budgets for CAHs may not be reconciled back to costs.

Unless there is a previous hospital global budget methodology in place with CMS and the Medicare Administrative Contractors prior to the start of the AHEAD Model, Medicare hospital global budgets will be paid as a bi-weekly lump sum. If there is interest in a different approach to payment, CMS will require appropriate justification and time to implement the approach with the Medicare Administrative Contractors and other infrastructure.

CMS encourages states to make their state-designed Medicare FFS hospital global budget methodologies publicly available to foster transparency and accountability. At a minimum, methodology algorithms must be disclosed to CMS so CMS can replicate and validate the state's hospital global budget calculations.

Appendix VIII. Medicaid Alignment Criteria

Hospital Global Budget Medicaid Alignment

As noted in Section A.4.5, *Hospital Global Budgets*, Medicaid HGBs must be implemented prior to or during PY1. Medicaid HGBs may begin payments at any point prior to or during PY1 so that states can align implementation with their Medicaid rate setting calendar. If a state's rates are usually finalized in Q3 or Q4, CMS will encourage states to consider implementation of Medicaid HGBs during the pre-implementation year prior to PY1. State Medicaid Agencies will develop their own Medicaid hospital global budget methodology in consultation with CMS and subject to CMS final approval. In developing their budget methodology, states should coordinate with applicable plan MCOs and other payer partners.

Medicaid hospital global budgets should provide the same general incentives for hospitals as the Medicare FFS global budgets. However, a Medicaid hospital global budget arrangement in a recipient state or region will likely differ from the AHEAD Medicare global budget methodology based on differences in covered services, member populations, unique revenue sources and payment streams, and/or existing capitation or value-based care arrangements already in place for Medicaid. CMS can provide technical assistance to award recipients on development of the proposed methodology. While CMS believes the incentives of the hospital global budgets are strongest when the vast majority of net patient service revenue is under the global budget, states may request that certain patient populations be excluded from the hospital global budget calculations.

CMS will review the proposed methodologies, as well as any state regulatory changes, federal flexibilities, or waiver authorities required to implement hospital global budgets for Medicaid. In addition to submitting their proposed framework for the authority needed to implement a Medicaid global budget by 18 months prior to the start of PY1, states should submit to CMS their proposed Medicaid hospital global budget methodology with sufficient time for review and CMS approval, no later than 12 months before the start of PY1. Draft methodologies for CMS input may be submitted earlier.

Payments to Participant Hospitals in a Medicaid hospital global budget may be implemented in one of two ways:

1. **Prospective payment:** Under this option, Participant Hospitals would no longer receive payments for fee-for-service claims and managed care plan rates as outlined in current fee schedules and contracts and/or provider participation agreements. Instead, Participant Hospitals will receive a fixed payment amount as calculated in the state's global budget methodology at regular, specified intervals (e.g., biweekly, monthly) over the course of the year. Following each performance year, the state completes a review process as outlined in their financial specifications to adjust future payments for performance, quality, market shifts, and other factors.
2. **Virtual global budget:** Under this option, states/MCOs continue to pay fee-for-service claims for care furnished to enrollees under current arrangements and conduct periodic reconciliation to global budget amounts (e.g., monthly, quarterly, annually). There would

be a defined reconciliation process to true up the claims payments against the prospectively set global budgets.

The award recipient’s proposed Medicaid global budget methodology should adhere to the requirements and suggestions outlined in the table below (note that all elements are required elements of the methodology unless specified as “encouraged” or “suggested”).

Table 3. Medicaid Global Budget Requirements

Medicaid Global Budget Element	Principles	Managed Care vs. FFS Specifications
General Requirements	<ul style="list-style-type: none"> • Implementation Start: <ul style="list-style-type: none"> ○ Must be implemented prior to or no later than the end of PY1 of the applicable Cohort. States are encouraged to implement as early as possible in the calendar year that corresponds to PY1 of their Cohort but may begin Medicaid global budget payments at any point before the end of PY1 if a state needs to align its start date with its managed care rate setting calendar. ○ States must finalize Medicaid global budget methodology and share with hospitals in accordance with Model Milestones timeline.. Later implementation after these dates may result in corrective action (see Appendix XII. <i>Milestones and Potential Corrective Action</i>). • States will establish annual Medicaid global budgets for Participant Hospitals that transition hospitals away from existing volume-based reimbursement and incentivize a reduction in unnecessary Medicaid hospital utilization. Hospital global budgets will include facility services in hospital inpatient, outpatient, and emergency departments, at minimum. • A prospective global budget payment is delivered to hospitals on a regular, periodic basis (e.g., biweekly, monthly), or implemented as a virtual budget (continue current FFS/MCO payments to hospitals and reconcile payments to the global budget). • The methodology considers incentives to recruit and retain hospitals early into the global budget methodology. • CMS encourages hospital global budget methodologies to be public to foster transparency and accountability. 	<ul style="list-style-type: none"> • Early and substantive engagement with managed care plans on proposed changes, with risk analysis for MCOs conducted during the Pre-Implementation Period • Process for contract negotiations and planned contract language developed with MCOs during the Pre-Implementation Period, if applicable • Process for including global budgets in MCO capitated rate development established during the Pre-Implementation Period • HGBs may be allocated to the MCOs by volume (suggested)

Medicaid Global Budget Element	Principles	Managed Care vs. FFS Specifications
Eligible Hospitals	<ul style="list-style-type: none"> • The Medicaid global budget will allow for all short-term acute care hospital and critical access hospital participation at minimum. • A SMA may propose including additional types of hospitals (e.g., psychiatric hospitals, or children’s hospitals). • For critical access hospitals, the Medicaid methodology may include accommodations for their participation, however after the end of a PY, the state may not reconcile Medicaid global budget payments to CAHs back to Medicaid costs. • Long Term Care Hospitals (LTCH) and federally-owned government facilities are not included in the Medicaid global budget. 	
Eligible Hospital Services	<p>The Medicaid hospital global budget will cover hospital inpatient and outpatient services. Additions or other changes must be approved by CMS.</p> <p>Service line inclusion/exclusion:</p> <ul style="list-style-type: none"> • The SMA may propose including or excluding hospital inpatient and outpatient services that differ from the services included in the Medicare global budgets (e.g., hospital-based dental services). However, the SMA must provide a justification including information on how any excluded services are currently paid for (e.g., FFS, capitation, other value-based arrangement), and any additional information requested by CMS. 	<ul style="list-style-type: none"> • Comprehensive analysis of populations and services excluded from managed care and a consideration of how to treat those populations and services in the global budgets for managed care states (e.g., which populations and/or services will remain in FFS, and how feasible is it to calculate HGBs with these populations) • For FFS states, CMS will negotiate with the state on which services and populations may be excluded from HGBs, taking into consideration the impact on hospital revenue
Baseline Setting and Adjustments	<ul style="list-style-type: none"> • CMS suggests using 2-3 years of historical data to calculate Medicaid hospital global budgets, weighting the more recent years more heavily. • The methodology must account for inflation, population growth, demographic changes, and 	<ul style="list-style-type: none"> • If populations and services included in the global budget are split between FFS and managed care, the state may need to develop

Medicaid Global Budget Element	Principles	Managed Care vs. FFS Specifications
	<p>other factors influencing the cost of hospital care.</p> <ul style="list-style-type: none"> • In addition, hospital global budgets must be adjusted for both medical and social risk for either the beneficiaries the hospital serves or the attributed geographic region. • The SMA must identify the Medicaid beneficiary groups to be included in the Medicaid global budget methodology. The SMA must also identify beneficiary groups to be excluded from the Medicaid global budget methodology, along with a rationale for their exclusion. This must be included in the SMA’s proposed Medicaid global budget methodology in accordance with the model milestones. 	<p>global budget methodologies specific to each system. CMS will evaluate each state’s managed care and FFS systems to determine whether separate methodologies are needed.</p>
Quality	<ul style="list-style-type: none"> • Hospital global budgets must be adjusted for performance on quality measures. • Quality performance adjustments must be based on the quality outcomes of an attributed patient population. • CMS suggests relying on state-specific hospital reporting and hospital quality performance programs currently in place for the state’s FFS and/or managed care Medicaid programs (to reduce implementation effort). • Hospital global budgets must be adjusted for performance using disparities-sensitive quality measures aimed at improving health equity. At minimum, the selected measures must provide sufficient data to identify disparities and improvements in health equity, and the measures must align with the overall model goals. 	<ul style="list-style-type: none"> • Quality measures embedded in MCO rates must be identified by the state and cross-referenced with Medicaid global budget quality measures prior to finalizing the Medicaid global budget methodology with any additional quality measures contained within the hospital global budget methodology to prevent any double-counting or conflicts between different measures.
“Supplemental” Payments: UPL, UCC, IME, DSH, DSRIP	<p>CMS will establish guardrails and requirements for each type of supplemental payment and their inclusion in the Medicaid Global Budget methodology where relevant. Where there is flexibility, states will work with CMS to finalize the details of these policies depending on state context and CMS requirements.</p>	

Medicaid Global Budget Element	Principles	Managed Care vs. FFS Specifications
Market shift and service line changes	<p>Hospital global budgets must account for changes in service line and unplanned volume shifts, while continuing to avoid incentivizing FFS-oriented utilization.</p> <p>SMA must clearly define this process for the Medicaid global budget, including identifying these or other circumstances under which this process would occur (e.g., FFS prospective budget payments, hospital service line changes, eligibility updates, other unplanned programmatic changes beyond a certain revenue threshold, etc.). Federal matching dollars will be returned by the state to the federal government should a recoupment be made as a result of this process.</p>	<ul style="list-style-type: none"> • SMA should be aware of how the AHEAD Medicare FFS global budgets account for market shift and service line changes and coordinate timing with Medicaid rate changes as they relate to AHEAD Medicaid global budget implementation and market shifts and service line changes.

Primary Care AHEAD Medicaid Alignment

As stated in the Section A4, *Program Requirements*, states or sub-state regions participating in AHEAD must implement a state Medicaid Primary Care APM or Patient-Centered Medical Home by PY1 and throughout the AHEAD Implementation Period. This program will serve as the basis of alignment for Primary Care AHEAD’s care transformation. State Medicaid Agencies must assist CMS in recruiting healthcare providers and suppliers for Primary Care AHEAD by identifying those who are already participating (or could participate if they are not doing so already) in the Medicaid primary care program. They will also work with CMS in identifying existing care transformation priorities within the Medicaid program that Primary Care AHEAD should align with. Examples may include specific treatment initiatives (diabetes management, behavioral health integration), or overall program improvement goals (industry accreditation or certification).

Appendix IX. Enhanced Primary Care Payment Financial Methodology

As noted in the Program Requirements, Primary Care AHEAD will include a Medicare Enhanced Primary Care Payment (EPCP). This NOFO includes an overview of the EPCP financial methodology for informational purposes; however, the methodology as described below is subject to change at CMS' sole discretion. Detailed financial specifications will be provided by CMS during the AHEAD Pre-Implementation period.

CMS recognizes that several states are moving towards primary care capitation in their Medicaid programs. CMS is evaluating for implementation beginning in 2027 an option for a Medicare primary care capitated track under Primary Care AHEAD for those states that have implemented similar capitated models in their Medicaid program.

Practice Eligibility

Primary care practices, FQHCs and RHCs that are located within a recipient state or sub-state region, are participating in the state's Medicaid Primary Care APM, and are eligible to bill Medicare, are eligible to participate in Primary Care AHEAD and receive EPCPs. Practices that participate in Primary Care First (PCF), Making Care Primary (MCP), or any other CMS model with a no-overlaps policy are ineligible to participate. Practices that participate in Medicare Shared Savings Program or ACO REACH, however, will be eligible to participate.

Eligible practices will be identified at the Tax Identification Number (TIN) level, except system-owned practices, which will also be identified by NPI in addition to TIN. A practice that is owned by a hospital or health system can only participate in Primary Care AHEAD if that hospital is a Participant Hospital under the AHEAD Model global budgets. Hospital or health-system affiliated FQHCs and RHCs are exempted from this requirement.

Payment Methodology

Payment Amount: The anticipated value of the EPCP is \$17 per beneficiary per month (PBPM). This is an average amount that will be adjusted for beneficiary social and medical risk. Within a participating state, the EPCP amount may also be subject to an upward or downward adjustment based on the state's performance on hospital participation goals and state Medicare FFS TCOC cost growth targets. The floor for these adjustments is \$15 average PBPM and the ceiling is \$21 PBPM.

Payment Mechanism: The EPCP is paid prospectively on a quarterly basis to Participant Primary Care Practices, similar to a care management fee. These payments will be made in addition to claim payments from Medicare, including certain fee-for-service payments and all-inclusive rates.

Beneficiary Attribution: CMS will attribute Medicare FFS beneficiaries to Participating Primary Care Practices prior to the start of each quarter during a given Performance Year and this list will be used to calculate the total EPCP that a practice will receive. Beneficiary eligibility for attribution will be assessed quarterly as of a point in time prior to the start of the quarter and attribution to practices will be based on where beneficiaries are expected to receive the plurality of their primary care services in the upcoming quarter. In this way, beneficiaries

will be assigned to Participant Primary Care Practices with which they have established and ongoing care relationships. There is no minimum beneficiary attribution requirement for participation in Primary Care AHEAD.

Medicare FFS Payment Overlap: Certain Medicare FFS care management services may be duplicative of the care transformation activities paid for by the EPCP. Participant Primary Care Practices will receive \$0 payments for these services, identified by HCPCS codes, and instead be required to replace these activities with the more robust care management and consultation activities described in the Program Requirements. The list of HCPCS codes is available upon request and will be made available to Participant Primary Care Practices in advance of joining the model and each PY.

Relationship to Quality Scores: A small portion of the EPCP (5% to start, scaled up over the course of the model to 10% by PY8) will be tied to performance on select quality measures each year. Technical assistance will be available to support practices with limited experience with quality reporting.

Rate Setting and Social Risk Adjustment: The baseline PBPM dollar amount for the EPCP will be adjusted for social and medical risk of attributed beneficiaries to determine the payment amount for each Participant Primary Care Practice. Risk scores will be calculated quarterly and adjusted for inflation on an annual basis. CMS is considering using Hierarchical Condition Category (CMS-HCC) and national and state Area Deprivation Index (ADI) to measure risk, though the specific indices that will be used are subject to change as CMS is also considering adjustments based on Part D Low-Income Subsidy (LIS) eligibility, dual eligible status, and other demographic data.

Appendix X. Quality and Population Health Strategy

The quality and population health strategy in AHEAD is an important mechanism for driving alignment across payers and advancing health equity in AHEAD participating states, through supporting states in identifying disparate outcomes for population subgroups, motivating change, and incentivizing progress in reducing these disparities.

AHEAD’s quality and population health strategy is built on lessons learned from past Innovation Center models. States can use the Model’s Cooperative Agreement funding, as well as policy and regulatory levers, to direct resources toward their quality and population health strategy and to further support health equity initiatives that address the underlying root causes of poor health outcomes.

The overall Model quality strategy includes three sets of quality measures, each with a health equity focus:

1. Statewide measures
2. Primary care measures
3. Hospital quality programs

Each of these quality measure sets are intentionally designed to align with overall Model goals and to be mutually reinforcing. Within each measure set, the Model will use reliable population health measures across four domains (Table 4) that account for performance improvement across sectors, with a specific focus on reducing health disparities among population groups. These measure sets will rely primarily on measures that align with the Medicaid and CHIP Child Core Set, Medicaid Adult Core Set, and CMS Universal Foundation Measure Set.^{22,23} In addition, hospitals and primary care providers participating in AHEAD will collect comprehensive beneficiary level demographic data and submit to CMS. CMS may modify or expand the measure sets as the Model evolves.

Table 4. Quality and Population Health Strategy Goals for the AHEAD Model

Domain Area	Goals
Prevention & Wellness	<ul style="list-style-type: none">• Increase equitable access to preventive services (e.g., recommended cancer screenings).
Population Health	<ul style="list-style-type: none">• Improve chronic conditions by focusing on health care transformation efforts at the community level.• Achieve high-quality, whole-person, equitable care across different population groups.
Behavioral Health	<ul style="list-style-type: none">• Improve behavioral outcomes in alignment with unique needs of state initiatives (e.g., reduce opioid use and

²² Douglas Jacobs, et al. The Universal Foundation. NEJM February 2023, available [here](#).

²³ For more information, see [Medicaid and CHIP Child Core Set](#) and the [Medicaid Adult Core Set](#).

Domain Area	Goals
	dependence, improve management of major depression, improve coordinated care between providers). ²⁴
Health Care Quality and Utilization	<ul style="list-style-type: none"> • Reduce avoidable admissions and readmissions. • Improve patient experience and delivery of whole-person care.

Statewide Quality and Population Health Measures

States or sub-state regions will be accountable for performance and improvement on a set of at least six population-level measures for beneficiaries residing in their state or sub-state region. States will select at least one measure from each of the five core domains listed in Table 5 below and will select at least one additional measure from at least one of the optional domains in Table 6. The state population health needs and goals, as defined in the Health Equity Plan will inform their rationale for selecting their state measures. The state will determine an overall quality target for all beneficiaries for that measure, as well as one or more targets to address observed health disparities for that measures outcome as a sub-target(s). The process and format for measure selection and reporting will be detailed in the Cooperative Agreement Terms & Conditions and more information on the selection process and Health Equity Plan development process will be available upon award. The selected measures and their reporting will be memorialized in the State Agreement.

States will be subject to reporting requirements, including baseline and at least annual updates for each selected measure on a Medicare FFS and all-payer basis where feasible (e.g., obesity may only be available for a geographically-defined population in the Behavioral Risk Factor Surveillance System (BRFSS)). Each reported measure must be stratified by routinely collected data including race, ethnicity, dual status, and geography where statistically feasible. CMS also recommends that states collect and stratify by additional factors relevant to equity, such as sexual orientation, gender, language, and disability status.

CMS may assist states in analyzing Medicare FFS data to adhere to measure reporting requirements. CMS will continue to work with states as part of the ongoing Medicaid Adult Core Set and Medicaid Child Core Set reporting. States should work with commercial payers for quality reporting and measurement, either individually or through an all-payer claims database or other health information exchanges/networks, for reporting on these measures for all payers when possible.

States will be held accountable for performance on selected core measures over time and, per the State Agreement, will be required to monitor performance on addressing disparities identified at baseline over the course of the Model. States not meeting the targets outlined in their State Agreement may be at risk of a Performance Improvement Plan (PIP), Corrective Action Plan (CAP), restriction of Cooperative Agreement funding, or termination from participation in the Model. The aim is for participating states to identify existing disparities at baseline and for CMS

²⁴ States will be required to report the behavioral health measures part of the Medicaid Adult Core Set beginning in 2024.

to then assess state progress in closing identified gaps and work to improve outcomes across the state. Participant Hospitals and primary care provider payments will not be tied to state-wide performance on these measures; however, performance measures will aid in targeting improvement strategies to address population health.

Table 5. Core Statewide Measures

Domain	Measure	Identifier	Steward	Payer Alignment	Data Sources
Population Health	CDC HRQOL– 4 Healthy Days Core Module	_____	_____	_____	BRFSS
Prevention & Wellness <i>Choose at least 1</i>	*^Colorectal Cancer Screening (CCS-AD)	CBE 0034 CMIT 139	NCQA	Medicaid Adult Core Set; Medicare; Marketplace; Commercial	Claims or EHR data
	*^Breast Cancer Screening: Mammography (BCS-AD)	CBE 2372 CMIT 93	NCQA	Medicaid Adult Core Set; Medicare; Marketplace; Commercial	Claims or EHR data
Chronic Conditions <i>Choose at least 1</i>	*^Controlling High Blood Pressure (CBP-AD)	CBE 0018 CMIT 167	NCQA	Medicaid Adult Core Set; Medicare; Marketplace; Commercial	Claims, hybrid, or EHR
	*^Hemoglobin A1c Control for Patients with Diabetes (HBD-AD)	CBE 0059/0575 CMIT 204/147	NCQA	Medicaid Adult Core Set; Medicare; Marketplace	Claims, hybrid, or EHR
Behavioral Health <i>Choose at least 1</i>	Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)	CBE 3400 CMIT 750	CMS	Medicaid Adult Core Set	Claims
	^Antidepressant Medication Management (AMM-AD)	CBE 0105 CMIT 63	NCQA	Medicaid Adult Core Set; Commercial	Claims or EHR

Domain	Measure	Identifier	Steward	Payer Alignment	Data Sources
	+^Follow-Up After Hospitalization for Mental Illness (FUH-AD)	CBE 0576 CMIT 268	NCQA	Medicaid Adult Core Set; Medicaid and CHIP Child Core Set; Medicare Shared Savings; Commercial	Claims
	Follow-up after ED Visit for Substance Use	CBE 3488 CMIT 264	CMS	Medicaid Adult Core Set;	Claims
Health Care Quality and Utilization	*^Plan All-Cause Unplanned Readmission (PCR-AD)	CBE 1768 CMIT 561	NCQA	Medicaid Adult Core Set; Medicare Part C; Marketplace; Commercial	Claims

* Included in CMS Universal Foundation

+ Aligned with CMCS Health Equity Set

^ Aligned with Medicare Advantage

CBE = Consensus-based Entity (previously National Quality Forum/NQF)

CMIT = [Centers for Medicare & Medicaid Services Measures Inventory Tool](#)

Table 6. Statewide Optional Measures

Domain	Measure	Identifier	Steward	Payer Alignment	Data Sources
Maternal Health Outcomes <i>Choose at least 1</i>	+Live Births Weighing Less than 2500 grams (LBW-CH)	CBE 1382 CMIT 413	CDC/NCHS	Medicaid and CHIP Child Core Set	State vital records
	+Prenatal and Postpartum Care: Postpartum Care (PPC-AD)	CBE 1517 CMIT 581	NCQA	Medicaid Adult Core Set; Marketplace	Claims or hybrid
Prevention Measures <i>Choose at least 1</i>	*Adult Immunization Status	CBE 3620 CMIT 26	NCQA	Commercial	Claims, Electronic Health Data, EHR, Enrollment Data,

Domain	Measure	Identifier	Steward	Payer Alignment	Data Sources
					Management Data, Registry Data
	Prevalence of Obesity	—		—	BRFSS
	Medical Assistance with Smoking and Tobacco Use Cessation (MSC)	CBE 0027 CMI 432	NCQA	Medicaid Adult Core Set	Survey
	ED Visits for Alcohol and Substance Use Disorders [#]	Under Development by CMMI	CMS	Not Available Yet	Claims
Social Drivers of Health <i>Choose at least 1</i>	Food Insecurity	—		—	USDA Current Population Survey or equivalent
	Housing Quality	—		—	American Housing Survey; Census Bureau or equivalent

* Included in CMS Universal Foundation
+ Aligned with CMCS Health Equity Set
Measure in development by CMMI with Yale CORE

Primary Care AHEAD Quality Measures

Primary Care AHEAD will test the Model’s investment in primary care while aligning with each state’s goals and initiatives in primary care under Medicaid and other payers. Participant Primary Care Practices will be accountable, through the EPCP, for performance on a set of 5 measures outlined in Table 7 below. Participant Primary Care Practices are expected to participate in primary care transformation activities that fall into three categories:

- behavioral health as a function of primary care,
- care management, and
- addressing health-related social needs.

The corresponding quality measures fall into the broad categories of behavioral health, prevention and wellness, chronic conditions, and utilization.

Should an award recipient wish to propose an alternative measure to align with other ongoing state efforts, CMS will consider potential measure replacements, so long as the alternative measure aligns to a domain below or to Model goals broadly. This process and format will be outlined in the State Agreement and primary care participation agreements. CMS will assess proposals for alternative measures on an individual basis to ensure that they align with Model goals, facilitate improvement over time, further the overall provision of advanced primary care services, and are feasible to implement. CMS may modify or expand the measure set for the EPCP (Table 7) as the Model develops. More information on health IT requirements for quality reporting under Primary Care AHEAD is available upon request.

Table 7. Primary Care Measure Set

Domain	Measure	Identifier	Steward	Data Source	Payer and Program Alignment
Behavioral Health (30%) <i>Measure is Required</i>	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	‡CBE 0418e; CMIT 672	CMS	eCQM	Medicaid Adult Core Set; Commercial; Making Care Primary; CPC; UDS
Prevention & Wellness (15%) <i>Choose at least 1</i>	*Colorectal Cancer Screening (COL-AD)	CBE 0034 CMIT 139	NCQA	eCQM	Medicaid Adult Core Set; Commercial; Making Care Primary; Primary Care First; CPC+; CPC; UDS
	*Breast Cancer Screening: Mammography (BCS-AD)	CBE 2372 CMIT 93	NCQA	eCQM	Medicaid Adult Core Set; Medicare; Marketplace; Commercial; CPC+; CPC; UDS
Chronic Conditions (15%) <i>Choose at least 1</i>	*+^Controlling High Blood Pressure (CBP-AD)	CBE 0018 CMIT 167	NCQA	eCQM	Medicaid Adult Core Set; Medicare; Marketplace; Commercial; Making Care Primary; Primary Care First; CPC+; CPC; UDS
	*+^ Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%)	CBE 0059 CMIT 204	NCQA	eCQM	Medicaid Adult Core Set; Medicare;

Domain	Measure	Identifier	Steward	Data Source	Payer and Program Alignment
					Marketplace; Making Care Primary; Primary Care First; CPC+; CPC; UDS
Health Care Utilization (40%) <i>Both measures are required</i>	Emergency Department Utilization (EDU)	N/A	NCQA	Claims	Commercial; Making Care Primary; CPC+
	Acute Hospital Utilization (AHU)	N/A	NCQA	Claims	Commercial; Primary Care First; CPC+

CBE = Consensus-based Entity (previously National Quality Forum/NQF)

CMIT = [Centers for Medicare & Medicaid Services Measures Inventory Tool](#)

UDS = Health Resources and Services Administration (HRSA) Uniform Data System measures

*Included in CMS Universal Foundation

+ Aligned with CMCS Health Equity Set

‡ = Measure is no longer endorsed by the CBE

^Aligned with Medicare Advantage

Hospital Measures

PPS hospitals participating in hospital global budgets in AHEAD will continue to report through the following national hospital quality programs and promoting interoperability programs:

- Hospital Inpatient Quality Reporting (IQR),
- Hospital Outpatient Quality Reporting (OQR),
- Hospital Value-Based Purchasing Program (VBP),
- Hospital Readmissions Reduction Program (HRRP),
- Hospital-Acquired Condition Reduction Program (HACRP), and
- Medicare Promoting Interoperability Program.

No reporting aspects of the CMS national hospital quality programs and promoting interoperability programs will be waived for Participant Hospitals; however, AHEAD would continue to waive applicable requirements for those states that have been operating a state-based hospital quality program pursuant to a waiver under a current state model. Hospitals will be accountable for performance in these programs via adjustments to their hospital global budget payments (based on their scoring on the CMS hospital quality programs or a state-based program).

For participating CAHs, the hospital global budget methodology under AHEAD will include an upside-only quality adjustment based on scoring in a CAH specific quality program. The CAH specific quality program will begin as pay-for-reporting and advance to pay-for-performance over the Model lifecycle. The CAH measure set (Table 8) aligns with existing measures used to assess rural health care quality. CMS may modify or expand the CAH measure set as Model evaluation policy develops.

Table 8. CAH Measure Set

Domain	Measure	Identifier	Steward	Data Source	CMS Program Alignment
Health Care Quality and Utilization	Hybrid Hospital-Wide All-Cause Unplanned Readmission Measure	CBE 2879e CMIT 356	CMS	Claims and Electronic Health Data	HIQR
Health Care Quality and Utilization	Emergency Transfer Communication Measure	CBE 0291	University of Minnesota	Claims, Electronic Health Data, Paper Medical Records	N/A (Medicare Beneficiary Quality Improvement Program)
Health Care Associated Infections	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital onset Clostridium difficile Infection (CDI) Outcome Measure	CBE 1717 CMIT 462	CDC	Electronic Health Data, Other, Paper Medical Records	HACRP
Health Care Associated Infections	National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure	CBE 0138 CMIT 459	CDC	Electronic Health Data, Other, Paper Medical Records	HACRP
Patient Experience	Hospital Consumer Assessment of Healthcare Providers and Systems	CBE 0166 (0228) CMIT 338	CMS	Instrument-Based Data	HIQR; HVBP

Domain	Measure	Identifier	Steward	Data Source	CMS Program Alignment
Patient Safety	Safe Use of Opioids – Concurrent Prescribing	CBE 3316e CMIT 669	CMS	Electronic Health Data (eCQM)	HIQR; Promoting Interoperability Program
Patient Safety	Venous Thromboembolism Prophylaxis	CBE 0371 CMIT 758	Joint Commission	Electronic Health Data (eCQM)	HIQR; Promoting Interoperability Program

In addition to quality-based adjustments to the hospital global budgets, the AHEAD hospital global budget methodology includes a Health Equity Improvement Bonus (HEIB), which is an upward adjustment based on hospital performance on select health equity-focused measures. Table 9 lists examples of the potential measures that may be used to assess hospital performance for purposes of the HEIB.

- The Hybrid Hospital-Wide All-Cause Unplanned Readmissions (Hybrid HWR) measure aligns with the overall statewide quality strategy.
- The Prevention Quality Indicators (PQI)-92 is a composite of potentially preventable admissions for chronic conditions that aligns with the statewide quality strategy emphasis on control of chronic conditions. Per population potentially avoidable hospitalization rates will be determined based on a hospital’s beneficiary population as described in Appendix VII. *Medicare FFS Hospital Global Budget Financial Methodology*.

The HEIB measures will be stratified to evaluate differences in care across populations (see Enhanced Demographic Data Collection). More on the HEIB can also be found in Appendix VII. *Medicare FFS Hospital Global Budget Financial Methodology*.

Table 9. Example Health Equity Improvement Bonus Measures for Participant Hospitals

Domain				
Health Care Quality and Utilization	Hybrid Hospital-Wide All-Cause Unplanned Readmissions	CBE 2879e CMIT 356	CMS	Claims and Electronic Health Data
Health Care Quality and Utilization	Prevention Quality Indicators (PQI)-92 Chronic Conditions Composite	CMIT 593	AHRQ	Claims and Administrative data (non-claims)

Appendix XI. Medicare FFS Total Cost of Care (TCOC) Expenditure Target

Medicare FFS TCOC Expenditure Targets

This appendix includes an overview of the Medicare FFS TCOC expenditure target for informational purposes; however, the methodology as described below is subject to change at CMS' sole discretion. This methodology will be detailed further by CMS prior to the start of the Pre-Implementation period, negotiated between CMS and the state during the Pre-Implementation period, and finalized in each State Agreement. The components of the Expenditure Targets open to negotiation include: savings component, weighting of the base years, and, for award recipients that have engaged in prior CMMI models involving TCOC growth targets and infrastructure investment to reduce TCOC, recipients may negotiate non-consecutive baseline years to reflect past investment to reduce TCOC growth.

Each state will be accountable for meeting a Medicare FFS TCOC expenditure target annually. This will be structured as an expenditure target for resident Medicare FFS beneficiaries on a per beneficiary per year annual basis. The annual state Medicare FFS TCOC expenditure target will be informed by (1) the state's historic expenditures; (2) risk adjustment for changes to the states' population over time; and (3) a growth factor that represents a prospective trend factor with a retrospective guardrail (see retrospective reconciliation of the trend factor in *Guardrails* below) minus a savings component that CMS will negotiate with the state. The following terms are referenced in this section.

- **Historical benchmark:** Equal to annual per beneficiary Medicare Parts A and B spending for beneficiaries residing in the participant state or sub-state region over three weighted baseline years (BYs). The term "baseline" refers to a year of expenditure data that is used to construct the historical benchmark.
- **Risk adjustment:** Risk normalization of the PBPY Medicare data to an HCC score of 1.0
- **Trend factor:** Compound annual growth rate, which is the weighted average of an empirical national growth rate, such as the USPPC, and an administrative benchmark. The trend factor is designed to match the expected TCOC growth in the absence of model participation.
- **Savings component:** A value subtracted from the trend factor to produce savings over time compared to the expected TCOC growth in the absence of AHEAD.
- **Growth factor:** The trend factor for the relevant PY minus the savings component, which is compounded. The growth factor is applied to each baseline year before the three baseline years are weighted to construct the historical benchmark.
- **Statewide or sub-state Medicare FFS TCOC Expenditure Target, or "Expenditure Target":** The final PBPY value to which CMS will compare annual Medicare Parts A and B spending for beneficiaries residing in the recipient state or sub-state region.

(1) Historical benchmark construction. The Medicare FFS TCOC expenditure target is based on a historical spending benchmark, a per-beneficiary-per-year (PBPY) amount calculated using Medicare Part A and B spending for three baseline years, weighted as described below in *Constructing the final TCOC expenditure target*. All Medicare Part A and B spending for beneficiaries residing in the state or sub-state region, regardless of the location where services

were provided, will be included in the actual spend calculation unless specifically excluded. This spending includes claims and non-claims-based payments, including those payments made for participation in shared savings programs and other CMMI models.

The three baseline years remain fixed throughout the Implementation Period, with some exceptions as noted below. For award recipients in Cohort 1, CMS will use 2022, 2023 and 2024 as the baseline years for calculating the expenditure target in PY1, but may consider using 2023, 2024, and 2025 as the baseline years for calculating the expenditure target for Cohort 1 beginning in PY2 and subsequent years if CMS determines this is warranted due to residual effects of the pandemic (exogenous event) in 2022. This change would be subject to agreement between the award recipient and CMS. For award recipients in Cohorts 2 and 3, the BYs will be 2023, 2024, and 2025. There will be no overlap between performance years and baseline years. CMS may consider changes to the baseline years in the event of exogenous events (such as a pandemic or a recession) during pre-implementation.

(2) Risk adjustment. Before trending each BY forward, CMS will use CMS Hierarchical Condition Categories (HCC) risk scores to standardize historical spending to a 1.0 risk score basis. Risk standardizing historical spending will account for differences in beneficiary demographics and health conditions of the award recipient's resident beneficiaries. For each of the three baseline years, CMS will divide the state or sub-state region's Medicare FFS Part A and B expenditures for the baseline year by the state's average HCC score for that baseline year.

(3) Growth factor. The compounded growth factor will be comprised of the negotiated savings component subtracted from the trend factor. The trend factor represents a mechanism to update baseline period expenditures to PY expenditure targets. It is constructed as a weighted average of (1) compound annual nationwide Medicare FFS historical growth rates, such as the USPCC, and (2) an administratively set prospective growth rate closely based on the Accountable Care Prospective Trend (ACPT) from the Medicare Shared Savings Program to reflect changes in prices, practices and technologies. For any award recipients with statewide all-payer rate setting authority, the award recipient will have the option to use only the USPCC without ACPT blend. In any given year, the compounded trend factor will include terms for both past years (that is, years between the Baseline Year and the upcoming Performance Year) and for the current Performance Year. In determining the compounded trend factor for the upcoming Performance Year, the USPCC projection (that is, a prospective estimate of the growth rate for the upcoming year) will be included for the current Performance Year's component of the growth factor, and the USPCC actual historical (observed) rate will be included for growth factor components pertaining to past Performance Years. The ACPT is an administrative factor, prospectively set every five years. For PY1, the (1) Medicare FFS historical growth rate will represent 90% of the weight while the (2) ACPT will represent 10%. In each successive year, the (1) Medicare FFS historical growth rate share will be decreased by 4% while the (2) ACPT share will be increased by 4% until the (1) Medicare FFS historical growth rate share is 58% and the (2) ACPT share is 42% in PY9 as indicated in Table 10 below.

CMS may adjust the weighting of the ACPT used in calculating the expenditure target in order to better align with the Medicare Shared Savings Program and Innovation Center models if growth

rates deviate substantially from the ACPT as a result of a pandemic, economic recession, or other exogenous factor.

Table 10: Blended Trend Factor Approach

Annual growth factor applied to:	% of Trend Factor USPCC (national Medicare growth rate)	% of Trend Factor ACPT
PY1	90%	10%
PY2	86%	14%
PY3	82%	18%
PY4	78%	22%
PY5	74%	26%
PY6	70%	30%
PY7	66%	34%
PY8	62%	38%
PY9	58%	42%

The savings component will be negotiated by CMS and the state and will be subtracted from the trend factor to determine the growth factor that is applied to baseline expenditure data to create the TCOC expenditure target. The savings component must demonstrate savings relative to projected state expenditure growth, at minimum, and, based on prior CMMI model experience, will likely range from 0.2 percentage points below national growth rate for states with historical expenditures below national average, to 0.5 percentage points below national for states with historical expenditures above national average.

The growth factor will be applied to the historical baseline using a blend of dollar-based approach (1/3 weight) and percentage-based approach (2/3 weight) to control for regression to the mean. The dollar-based approach involves increasing the historical baseline by the year-over-year change in national average FFS spending, measured in dollars per-beneficiary per-year (PBPY). Growth allowed by the dollar-based approach does not depend on the level of the award recipient’s historical baseline. The percentage-based approach involves increasing the historical baseline at the same rate of growth as national average spending growth PBPY.

Constructing the final TCOC expenditure target. After the growth factor is applied to the PBPY Medicare Part A and Part B baseline expenditure data for each of the three BYs, CMS will take the weighted average of the trended values to calculate the risk standardized TCOC expenditure target. BY3 (the most recent BY) will receive the highest weight of 0.6, BY2 will receive a weight of 0.3, and BY1 will receive a weight of 0.1, unless the state has negotiated a different weighting with CMS. CMS will multiply the risk standardized, trended PBPY TCOC target by the participant state’s or sub-state region’s average HCC score for the applicable performance year to determine the final Medicare FFS TCOC expenditure target. For each PY, the state’s Medicare FFS TCOC (Part A expenditures per resident with Part A + Part B expenditures per resident with Part B using average monthly enrollment during the 12 months of the model year) must not exceed the final Medicare FFS TCOC expenditure target for that PY.

For illustration of the compounding mechanism and its application to the benchmark data, below is a sample calculation for an award recipient in AHEAD PY5.

TF = Trend Factor

SC = Savings Component

PY = Performance Year

BY = Baseline Year

The compounded growth factor for each BY is as follows:

- Compounded Growth Factor BY1 = (TF PY5 – SC PY5)*(TF PY4 – SC PY4)* ... *(TF PY1 – SC PY1)*(TF BY3)* (TF BY2)
- Compounded Growth Factor BY2 = (TF PY5 – SC PY5)*(TF PY4 – SC PY4)* ... *(TF PY1 – SC PY1)*(TF BY3)
- Compounded Growth Factor BY3 = (TF PY5 – SC PY5)*(TF PY4 – SC PY4)* ... *(TF PY1 – SC PY1)

Final Medicare TCOC expenditure target =

$[(0.1 * \text{HCC risk standardized BY1} * (\text{Compounded Growth Factor BY1}) + (0.3 * \text{HCC risk standardized BY2} * (\text{Compounded Growth Factor BY2}) + (0.6 * \text{HCC risk standardized BY3} * (\text{Compounded Growth Factor BY3})) * [\text{Average state or sub-state region HCC score for the applicable PY}]$

Guardrails

Retrospective adjustment of the trend factor. To mitigate downside risk exposure for both the state and CMS, CMS will compare the actual Medicare FFS national annual growth rate to the projected value for each Performance Year. If the actual Medicare FFS national annual growth rate deviates from the projected Medicare FFS national annual growth rate by more than 1 percentage point, CMS will add half of the difference between the actual and projected annual growth rates beyond one percentage point to the projected Medicare FFS annual growth rate. Note that this only applies to the component of the Trend Factor that is derived from the annual nationwide Medicare FFS historical growth rate, such as the USPPCC, because the ACPT is administratively set every 5 years. This adjusted compound annual nationwide Medicare FFS historical growth rate will be weighted with the ACPT to calculate the trend factor as described previously for that PY.

State migration patterns. CMS will consider guardrails around out-of-state or sub-state regional expenditures to mitigate the impact of state migration patterns on TCOC performance.

Exclusions

For PY1-3, CMS will exclude the EPCP from the Medicare FFS and all-payer TCOC expenditure performance calculations; the EPCP will subsequently be part of the all-payer TCOC expenditure performance calculations beginning in PY4. However, where the award recipient has a pre-existing analogous Medicare primary care program, such as Maryland's MDPCP, the Medicare FFS and all-payer TCOC expenditure performance calculations will include the

Medicare Part B expenditures for that program as an expenditure for TCOC expenditure performance purposes beginning in PY1. CMS will also exclude the Transformation Incentive Adjustment in the hospital global budget from the Medicare FFS and all-payer TCOC expenditure performance calculations.

Outcome-Based Credits

For award recipients that already participate in outcome-based credits for improvement on certain population health measures under an existing agreement with CMS (e.g., the Maryland Total Cost of Care Model), these will be allowed to continue under AHEAD with credits reducing the total Medicare FFS TCOC expenditures in the state for the year in which the credit is verified by CMS. This will allow ongoing statewide efforts to address select population health outcomes to continue during the Implementation Period.

Modification and Enforcement

If the award recipient fails to meet targets as outlined in the State Agreement, CMS may take corrective action to ensure that the award recipient is able to meet subsequent annual targets. This corrective action may include submission of a corrective action plan, modification of CMS-designed hospital global budget methodology, required changes to the state-designed hospital global budget methodology, reduction of the EPCP, and/or termination of the Cooperative Agreement award.

If the award recipient fails to meet all-payer cost growth targets, CMS may request a corrective action plan, which may include public reporting on commercial cost growth in aggregate and by payer, among other actions to be taken by the state. Under a potential corrective action plan, CMS may consider holding states harmless for Medicaid cost growth if that growth is due to increased access to care, additional uptake of or reimbursement for preventive services, or other factors that align with the AHEAD model goals.

Appendix XII. Milestones and Potential Corrective Action

The following milestones will be included in the Cooperative Agreement Terms and Conditions, and to the extent applicable, will also be included in the State Agreement. These milestones are shared to provide applicants an understanding of the requirements for award recipients, however, these milestones and deadlines may be subject to change by CMS. Award recipients will not be held accountable if they miss milestones due to the actions of CMS (e.g., CMS delays in approval of authorities and methodologies), assuming the state has demonstrated readiness to meet the milestone by the deadline(s) described in the Cooperative Agreement Terms and Conditions and/or State Agreement.

Milestone: State Agreement Negotiation and Signature

Interim Milestones	Deadline	If not met
Final negotiation completed	7-8 months prior to the start of PY1	Work with CMS on remediation ²⁵
Provide regular updates on execution to Model team	Ongoing	Work with CMS on remediation
Final Milestone	Deadline	If not met
Execution of State Agreement ²⁶	6 months prior to the start of PY1	If original deadline is missed, CMS will issue letter with updated deadline for signature within 30 days. If after 30 days, the State Agreement is not signed, CMS will move to terminate Cooperative Agreement.

Milestone: Implementation of Medicaid Primary Care APM*

Interim Milestones	Deadline	If not met
Submission of Medicaid Primary Care APM regulatory change proposal to CMS	18 months prior to the start of PY1	Work with CMS on remediation
CMS approval for regulatory process and Medicaid primary care APM	9 months prior to the start of PY1	Work with CMS on remediation

²⁵ Specific remediation activities and corrective action are up to CMS discretion. These activities may include, but are not limited to, more frequent engagement with and updates to CMS, reprioritization of activities to address identified challenges, developing a corrective action plan, restricting funds already awarded and/or withholding funds not yet awarded.

²⁶ If a Cohort 1 recipient misses this milestone, CMS may change milestone dates/deadlines to align with Cohort 2 and their Implementation Period will be scheduled to begin a year later (2027), pending an executed State Agreement six months before the new Implementation Period start. The period of performance would remain the same (i.e., in this instance the Cohort 1 recipient would have one less year for implementation).

Interim Milestones	Deadline	If not met
Demonstration of readiness for Medicaid Primary Care APM Implementation, as evidenced by finalized APM payment methodology development, provider recruitment, and provider commitments to participate in the Medicaid Primary Care APM	90 days prior to the start of PY1	Work with CMS on remediation
Submission of Medicaid Primary Care APM provider list for the upcoming PY	90 days prior to the start of PY1 and subsequent PYs.	Work with CMS on remediation
Final Milestone	Deadline	If not met
Implementation of Medicaid Primary Care APM with participation from primary care practices	By the beginning of PY1	If Medicaid Primary Care APM is not implemented by PY2, CMS will take steps up to and including termination of the Cooperative Agreement and State Agreement to address this performance miss.

*If no existing Medicaid Primary Care APM is in place in the state when awarded a Cooperative Agreement

Milestone: Implementation of Medicaid Hospital Global Budget Methodology with Participant Hospitals

Interim Milestones	Deadline	If not met
Submit initial proposal for any regulatory pathway/change needed for Medicaid hospital global budgets to CMS (note that this is a requirement under the AHEAD model and not a requirement for authority application from CMCS)	18 months prior to the start of PY1	Work with CMS on remediation
Submit full, detailed methodology to CMS for review and approval	12 months prior to the start of PY1	Work with CMS on remediation
CMS approval for the regulatory pathway/change needed for Medicaid Hospital Global Budget Implementation	6 months prior to the start of PY1	Work with CMS on remediation
Obtain CMS approval on full, detailed methodology	6 months prior to the start of PY1	Work with CMS on remediation
Demonstrate readiness for Medicaid Hospital Global Budget Implementation, as evidenced by finalized methodology and hospital recruitment	90 days prior to the start of PY1	Work with CMS on remediation

Interim Milestones	Deadline	If not met
Final Milestone		
Implementation of Medicaid Hospital Global Budget(s)	By end of PY1	Corrective Action \$500,000.00 will be restricted in Budget Period 3 until Medicaid hospital global budget is implemented, which cannot be unrestricted until final milestone is met. If Medicaid hospital global budget is not implemented by start of PY2, CMS will take steps up to and including termination of the Cooperative Agreement and State Agreement to address the failure to meet this model milestone.

Milestone: Creation and Implementation of an All-Payer TCOC and Primary Care Investment Target

Interim Milestones	Deadline	If not met
Draft legislation submitted to state legislature or draft Executive Order language circulated	6 months prior to the start of PY1	Work with CMS on remediation
Draft methodology and calculated target identified for All-Payer TCOC and Primary Care Investment Target	120 days prior to the start of PY2	Work with CMS on remediation
Final Milestones	Deadline	If not met
Creation of an All-Payer TCOC and Primary Care Investment Target (or process to determine such a target) via state Executive Order, statute, or regulatory change	90 days prior to the start of PY1	Termination of Cooperative Agreement and State Agreement
Finalization of the all-payer TCOC and primary care investment targets and memorialization in an amended State Agreement at minimum, 90 days before PY2	90 days prior to the start of PY2, or earlier (at minimum, PY2 is the first measurement year)	Corrective Action

Milestone: Execution of hospital Participation Agreement for hospitals such that 10% of Medicare FFS Hospital Net Patient Revenue (NPR) in State or Sub-State Region would be under Medicare FFS hospital global budgets

Interim Milestones	Deadline	If not met
Medicare FFS hospital global budget methodology is provided to CMS for review and approval for any state-designed methodology	18 months prior to the start of PY1	Work with CMS on remediation. If unable to reach agreement with CMS on the state-designed methodology, the CMS-designed Medicare FFS hospital global budget methodology will apply.
Obtain letter(s) of interest from hospitals interested in participating	6 months prior to the start of PY1	Work with CMS on remediation
Provide regular updates on hospital recruiting to Model team	Ongoing	Work with CMS on remediation
Final Milestones	Deadline	If not met
(1) Execution of hospital Participation Agreement for hospitals such that 10% of Medicare FFS NPR would be under Medicare FFS hospital global budgets by PY1 (2) Execution of hospital Participation Agreement for hospitals such that at least 30% of Medicare FFS NPR would be under Medicare FFS hospital global budgets by PY3 and for each subsequent PY	(1) 90 days prior to the start of PY1 (2) 90 days prior to the start of PY4	Termination of Cooperative Agreement and State Agreement

Milestone: Participation of at least one commercial payer in a hospital global budget methodology with Participant Hospitals

Interim Milestones	Deadline	If not met
Sign Memorandum of Understanding (MOU) or other agreement with award recipient to confirm participation	90 days prior to the start of PY2	Work with CMS on remediation
Provide regular updates to Model team on payer recruitment	Ongoing	Work with CMS on remediation
Final Milestone	Deadline	If not met
Participation of at least one commercial payer in hospital global budgets	By the start of PY2	Corrective Action Restriction of \$250,000.00 in Budget Period 4 will be restricted

Interim Milestones	Deadline	If not met
		and will not be unrestricted until final milestone is met.

Appendix XIII. Acronym Guide

Acronym	Definition
AHEAD	States Advancing All-Payer Health Equity Approaches and Development Model
ACO	Accountable Care Organization
AOR	Authorized Organizational Representative
APM	Alternative Payment Model
BP	Budget Period
CAH	Critical Access Hospital
CFR	Code of Regulations
CMCS	CMS Center for Medicaid and CHIP Services
CMMI	Center for Medicare & Medicaid Innovation or Innovation Center
CMS	Centers for Medicare & Medicaid Services
CTR	Care Transformation Requirement
DFAS	Defense Finance and Accounting Service
D-SNP	Dual Eligible Special Needs Plan
EIN	Employer Identification Number
EPCP	Medicare Enhanced Primary Care Payment
FAPIS	Federal Awardee Performance Integrity Information System
F & A	Facility and Administrative
FFS	Medicare Fee-for-Service
FQHC	Federally Qualified Health Centers
FSRS	Federal Funding Accountability and Transparency Act Subaward Reporting System
FTR	Federal Travel Regulation
GME	Graduate Medical Education
GMO	Grants Management Officer
GPS	Grants Policy Statement
GSA	General Services Administration
HCPCS	Healthcare Common Procedure Coding System
HGB	Hospital Global Budget
HHS	Health and Human Services
HRSN	Health-Related Social Needs
IPPS	Inpatient Prospective Payment System
LOI	Letter of Intent
MCO	Medicaid Managed Care Organization
MDTCOC	Maryland Total Cost of Care Model
Medicaid Primary Care APM	Medicaid Advanced Primary Care Program
MTDC	Modified Total Direct Costs
NAHE	Nursing and Allied Health Education
NICRA	Negotiated Indirect Cost Rate Agreement
NoA	Notice of Award
NOFO	Notice of Funding Opportunity

Acronym	Definition
NPR	Net Patient Revenue
OAGM	Office of Acquisition and Grants Management
OIG	Office of Inspector General
OPPS	Outpatient Prospectively Payment System
PARHM	Pennsylvania Rural Health Model
PCMH	Patient-centered Medical Home
PY	Performance Year
QHP	Qualified Health Plan
REH	Rural Emergency Hospitals
RHC	Rural Health Clinic
SAM	System for Award Management
SMA	State Medicaid Agency
State HEP	State HEP
TIN	Taxpayer Identification Number
UEI	Unique Entity Identifier
TCOC	Total Cost of Care
VT APM	Vermont All-Payer ACO Model