Support for Demonstration Ombudsman Programs Serving Beneficiaries of Financial Alignment Models for Medicare-Medicaid Enrollees

---

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

Initial Announcement

Funding Opportunity Number: CMS-1J1-13-001
Competition ID: CMS-1J1-13-001-018232
CFDA: 93.634

Applicable Dates:
Application Due Date: August 5, 2013 (1st round); October 3, 2013 (2nd round); and January 14, 2014 (3rd round)
Anticipated Notice of Award: September 13, 2013 (1st round)
Anticipated Period of Performance: Three years from date of award

OVERVIEW INFORMATION

Agency Name: U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
Medicare-Medicaid Coordination Office
Center for Medicare & Medicaid Innovation

Funding Opportunity Announcement (FOA) Title: Support for Demonstration Ombudsman Programs Serving Beneficiaries of Financial Alignment Models for Medicare-Medicaid Enrollees
Announcement Type: Initial
Funding Opportunity Number: CMS-1J1-13-001
Catalog of Federal Domestic Assistance (CFDA) Number: 93.634

Key Dates:
Application Due Date: August 5, 2013; October 3, 2013, and January 14, 2014
Anticipated Notice of Award (first round): September 13, 2013
Anticipated Notice of Award (future rounds): Approximately 45 business days after each application date.
Anticipated Period of Performance: Three years from date of award

Table of Contents

I. Funding Opportunity Description

1. Purpose

Under the Centers for Medicare & Medicaid Services (CMS), the Center for Medicare & Medicaid Innovation (the Innovation Center) is authorized to test innovative payment and service delivery models to reduce program expenditures under Medicare, Medicaid and the Children's Health Insurance Program (CHIP) while preserving or enhancing the quality of care furnished to individuals under such programs. The Federal Coordinated Health Care Office (Medicare-Medicaid Coordination Office) is charged with more effectively integrating and ensuring access to benefits under the Medicare and Medicaid programs and improving the coordination between the Federal government and States. In July 2011, CMS released a letter to state Medicaid Directors which discussed two models for integrating care and aligning financial incentives for Medicare and Medicaid as part of CMS' Financial Alignment Initiative, a joint initiative of the Innovation Center and the Medicare-Medicaid Coordination Office, under which States and CMS will collaborate to integrate care and financing for individuals who are dually eligible to receive services through both Medicare and Medicaid (referred to in this proposal as beneficiaries).

The Financial Alignment Initiative is a unique Federal-State partnership to test aligning the service delivery and financing of the Medicare and Medicaid programs to better serve these beneficiaries. As part of this effort, there is a need for strong beneficiary support, education and outreach in each State that is implementing a Financial Alignment model, including ombudsman services for beneficiaries. States are well situated to select an entity which is able to meet the principles described below (Section I.4.1) in each State. In so doing, States may choose to build upon and leverage existing infrastructure or develop a consortium of entities to provide Demonstration ombudsman services (see Section I.4).

Before receiving an award under this Funding Opportunity Announcement, States must have signed a Memorandum of Understanding (MOU) with CMS to implement the Financial Alignment Initiative. This Funding Opportunity will provide financial assistance over a three-year period to States to plan, develop and provide Demonstration Ombudsman Program services to individuals who participate in the Financial Alignment model. In providing an Ombudsman Program, States will ensure that individual beneficiaries have access to person-centered assistance in resolving problems related to the Demonstration. In addition, a Demonstration Ombudsman Program will inform States, Plans, CMS, and other stakeholders regarding beneficiary experience with the Plans and will recommend areas of improvement in States' Financial Alignment Initiatives.

2. Statutory Authority

This solicitation is being issued under section 1115A of the Social Security Act (added by section 3021 of the Patient Protection and Affordable Care Act (P.L. 111-148)), which authorizes the Innovation Center to test innovative payment and service delivery models to reduce program expenditures under Medicare, Medicaid, and the Children's Health Insurance Program while preserving or enhancing the quality of care.

3. Background

As discussed above, the Innovation Center is authorized to test innovative service and payment delivery models. The Center's mission is threefold:

- **Better health care** by improving all aspects of patient care;
- **Better health** by encouraging healthier lifestyles in the entire population; and
- **Lower costs through improvement** by promoting preventative medicine, improved coordination of health care services, and by reducing waste and inefficiencies.

The Medicare-Medicaid Coordination Office works with the Medicaid and Medicare programs, across Federal agencies, States and stakeholders to align and coordinate benefits between the two programs effectively and efficiently. It partners with States to develop new care models and improve the way Medicare-Medicaid enrollees receive health care.

In April 2011, the Medicare-Medicaid Coordination Office awarded design contracts to 15 States to design State Demonstrations to Integrate Care for Medicare-Medicaid Individuals. The overall goal of this initiative is to develop, test and validate fully integrated delivery system and care coordination models. Early work with these States confirmed that a key component of such initiatives will be testing new payment and financing models to promote better care and align the incentives for improving care and lowering costs between Medicare and Medicaid.

In July 2011, CMS released a letter to state Medicaid Directors providing guidance on two financial alignment models that CMS is seeking to test with States. Through the Innovation Center, CMS will be testing these models across the country, over a three-year period, in programs that collectively serve up to 2 million Medicare-Medicaid individuals.

The Financial Alignment models will address a longstanding barrier to coordinating care for individuals who are dually eligible for Medicare and Medicaid, which is the financial misalignment between Medicare and Medicaid. To begin to address this issue, CMS will test two models for States to better align the financing of these two programs and integrate primary, acute, and behavioral health services, long term services and supports (LTSS) and prescription drugs for these beneficiaries. These two models include:

- **Capitated Model:** A State, CMS, and a health plan enter into a three-way contract, and the plan receives a prospective blended payment to provide comprehensive, coordinated care.
- **Managed Fee-for-Service Model:** A State and CMS enter into an agreement by which the State would be eligible to benefit from savings resulting from initiatives designed to improve quality and reduce costs for both Medicare and Medicaid.

CMS is presenting this Funding Opportunity Announcement (FOA) to ensure that the beneficiaries of these models – as well as their caregivers and authorized representatives – have access to person-centered assistance in resolving problems related to the Demonstration. A Demonstration Ombudsman Program will:

- work to empower beneficiaries and support their engagement in resolving problems they have with their health care, behavioral health care, and long-term services and supports;
- investigate and work to resolve beneficiary problems with Plans, and
- provide systems-level analysis and recommendations.

CMS will provide for support to States and designated entities in their planning, technical assistance, reporting, and training needs related to development and operation of the Demonstration Ombudsman Program.

4. Program Requirements

Through this cooperative agreement, CMS seeks to fund activities necessary to plan for, develop and implement Demonstration Ombudsman Program services to beneficiaries and their families, as appropriate. CMS may award up to one cooperative agreement per State. Any State government agency, with a signed MOU with CMS to implement the Financial Alignment Initiative, may apply for this funding in order to provide such service directly or by contract or other arrangement to a public or private non-profit entity or entities (referred to in this document as "designated entity"). The state agency or designated entity must meet the following principles and capabilities.

4.1. General Program Requirements

4.1.a Demonstration Ombudsman Program Principles and Capabilities

<u>Credibility with beneficiaries</u>

The Demonstration Ombudsman Program shall:

- Serve as a problem-resolver – providing resolution of beneficiary problems when a Medicare-Medicaid Plan (Plan) has not been able to successfully address the issue.

- Be free of conflicts of interest – neither an individual serving as an ombudsman nor the organizational placement of the Demonstration Ombudsman Program should have a conflict with the beneficiaries' interests. The entity should not be co-located with the Plan, service providers of the Plan, an entity funding or administering the Plan, or an entity making eligibility or enrollment decisions for beneficiaries.
- Be knowledgeable in areas relevant to beneficiary service – about beneficiary rights under Medicaid and Medicare programs, long-term services and supports, health and behavioral health services, and person-centered planning and service approaches.
- Be confidential – the identity of the individual at issue and the complainant (if other than the individual at issue) and information provided to the ombudsman shall not be revealed without consent of the beneficiary. Individuals who contact an ombudsman should be protected from retaliation.
- Be skilled in negotiation – experienced in alternative dispute resolution techniques; sufficiently independent to have access to negotiate; access to Plans, Plan service providers, state policy-makers, and others with authority to resolve the problem.

Accessible to beneficiaries

The services of the Demonstration Ombudsman Program shall be:

- Free of charge to beneficiaries and applicants.
- Accessible by phone, web, and e-mail.
- Able to provide in-person access when necessary (e.g., this may require in-person visits to homes or facilities, depending on the functional limitations of the beneficiary).
- Able to provide culturally and linguistically competent services – including, but not limited to, competency to serve individuals of varying ethnicities and functional and cognitive abilities and of limited English proficiency (For more information about culturally and linguistically competent services, go to: http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=11).

Authorized to access information needed to investigate complaints

The Demonstration Ombudsman Program shall be:

- Provided with access to records of the Plan, Medicaid/Medicare, service providers and regulatory agencies, needed to investigate and resolve beneficiary complaints, with the beneficiary's approval.
- Required to comply with HIPAA Privacy Rule and other relevant privacy laws and regulations.

Coordinated with other entities in order to resolve beneficiary problems

The Demonstration Ombudsman Program shall:

- Coordinate its services and develop referral protocols with other entities, including, but not limited to:
    - State Health Insurance Assistance Programs (SHIPs), State Protection and Advocacy Programs, Aging and Disability Resource Centers (ADRCs), Medicaid certified application counselors and health care marketplace navigators – in order to make appropriate pre-enrollment, benefits counseling, and options counseling referrals;
    - Relevant licensing and regulatory agencies – in order to make appropriate regulatory referrals;
    - State consumer protection programs specifically designed to help consumers resolve problems with health insurance plans and products, including programs that have received funding under the Affordable Care Act for Consumer Assistance Programs; and,
    - Civil legal services providers (including services for low-income individuals, individuals with disabilities and older Americans, such as those funded by the Legal Services Corporation or the Administration for Community Living) – in order to make appropriate referrals for legal representation and counsel of beneficiaries.
- Regularly communicate with representatives of the Plan, service providers under the Plan, and enrollment brokers – in order to negotiate on behalf of beneficiaries and make appropriate referrals related to enrollment and disenrollment processes.

Capable of identifying trends and emerging issues

The Demonstration Ombudsman Program shall:

- Collect data on complaints received and outcomes of efforts to resolve complaints.
- Provide reports on identified systemic trends to policy-makers, stakeholders, CMS contract management team, and plans.
- Provide recommendations to improve the Financial Alignment Initiative and Medicaid or Medicare-covered services to beneficiaries.

Capacity of State administrative agency or entity

The State shall select an entity consistent with the principles and capabilities indicated above (Section 4.1) and, if services are provided through a designated entity, develop any

needed contracts or other agreements to carry out the program. In selecting the State agency or designated entity to host the Demonstration Ombudsman Program, the State shall consider:

- The capacity of the State or designated entity to be prepared to provide services to beneficiaries no later than six months after the award date.
- Existing entities that it may be able to leverage in order to promote efficient delivery of services to beneficiaries. States may wish to consider the capacity of entities (or a collection of entities) to expand their scope of work to provide services to these additional populations. Such existing entities could include, but not be limited to, the protection and advocacy network, the entity hosting the Office of the state Long-Term Care Ombudsman, the state's enrollment broker, state-authorized health or behavioral health ombudsman programs, and State agencies or programs specifically designed to help consumers resolve problems with health insurance programs or plans, including Consumer Assistance Programs that have been funded by CMS under the Affordable Care Act.
- How to avoid compromising the capacity of the State or designated entity to provide current services to its existing service populations.

4.1.b State Assurances to CMS

The State must provide assurance to CMS that, in implementing the Demonstration Ombudsman Program, the State will:

- Not divert resources from or diminish the capacity of existing consumer protection services.
- Provide any needed legal authority to the Demonstration Ombudsman Program in order to ensure that:
    - Demonstration Ombudsman Program representatives have access to beneficiaries (including in their places of residence) and access to records needed for investigations;
    - The identity of beneficiaries and complainants served by the Demonstration Ombudsman Program is protected; and
    - The information provided to the Demonstration Ombudsman Program from beneficiaries and complainants is protected.
- Operate the Demonstration Ombudsman Program in alignment with the principles and capabilities indicated above.
- Coordinate its efforts with the State Medicaid program. If the State agency applying for the cooperative agreement is not the State Medicaid agency, the cooperative agreement applications must include a letter from the state Medicaid director expressing support for the application.

- Establish procedures for systematically using the analysis and recommendations produced by the Demonstration Ombudsman Program to improve the performance of the Financial Alignment Model to better serve its beneficiaries.
- Ensure that federal funding under this Financial Alignment Initiative project will not be used by the Demonstration Ombudsman Program as match for Medicaid funding.

4.1.c State Plans for Sustainability

The project period for the cooperative agreement is three years from the date of award or the end of the Demonstration, whichever is sooner. The State shall include in its application, its plans for sustaining ombudsman services (as described in section I.4.4.b, below) beyond the period of this cooperative agreement as long as the State continues to operate a Financial Alignment Model.

4.2 Awardee Activities in General

Awardee activities through this funding announcement will encompass:

- Project Management and Oversight
- Phase I – Planning Phase Activities
- Phase II – Implementation Activities
- Reporting

4.2.a Project Management and Oversight

Within 10 calendar days of the cooperative agreement start date, each awardee shall conduct a kick-off teleconference with CMS and its partners. The kick-off teleconference is the first meeting with project team members to discuss the cooperative agreement project work that will be completed. At that time, the awardee must identify to CMS the key State staff (and may also indicate designated entity staff if known) to serve as the main points of contact for the cooperative agreement.

States will participate in periodic teleconferences as requested by CMS and its technical assistance support in order to keep CMS informed of the progress of the cooperative agreement project work. States will also participate in up to two, 2-day grantee meetings per year convened by CMS and its partners in the Baltimore/Washington DC area.

4.2.b Phase I – Planning Phase Activities

The first four to six months of the three-year project period of this Cooperative Agreement will consist of working with CMS, its partners and the other grantees to refine its detailed strategies,

updating work plan charts, developing reporting elements and systems, and where applicable, initiating the contract or other arrangement needed to engage a designated entity to provide ombudsman services.

During the Planning Phase, States – and where appropriate its designated entity – will begin to solicit input from stakeholders to inform the refinement and on-going operations of the Demonstration Ombudsman Program.
At a minimum, the State shall request the input of:

- Relevant state agencies focused on health, behavioral health and long-term services and supports, and consumer protection in the health insurance marketplace;
- the state Long-Term Care Ombudsman;
- any other ombudsman programs in the State which has within its jurisdiction service to Medicare and/or Medicaid beneficiaries;
- the state's protection and advocacy network;
- the state's Developmental Disabilities Council;
- State Health Insurance Assistance Program (SHIP);
- state Insurance Commissioner;
- state consumer protection programs specifically designed to help consumers resolve problems with health insurance plans and products, including programs that have received funding under the Affordable Care Act for Consumer Assistance Programs;
- state health care marketplaces;
- state enrollment broker;
- Aging and Disability Resource Centers (ADRCs);
- Senior Medicare Patrol (SMP) programs;
- the Statewide Independent Living Council and Centers for Independent Living;
- state agencies providing aging services, behavioral health services, and disability services;
- Area Agencies on Aging;
- legal services providers (including those supported by Legal Services Corporation and Title IIIB of the Older Americans Act);
- state self-advocacy organizations;
- State University Center(s) for Excellence in Developmental Disabilities; and
- advocacy organizations focused on health and behavioral health care consumers, individuals with disabilities, and/or older adults.

<u>During the Planning Phase, States – and where appropriate its designated entity – will also begin work on:</u>

- Reporting system development: The State and/or designated entity shall participate with CMS, its technical assistance provider, and peers from other Demonstration States in the development of a reporting system, including methodologies for reporting, that will be used by the State, CMS and its partners to monitor program performance and outcomes.
- Sharing resources across States: The State and/or designated entity shall work with CMS, its technical assistance provider(s), and peers from other Demonstration States in order to leverage opportunities for cross-state synergies in addressing common needs (e.g. the development of standardized information, training, and tools that could be used by Demonstration Ombudsman Programs in all States).
- Training: Provide access to orientation and professional development training for all relevant staff as provided by CMS or its technical assistance provider.
- Refining its strategies and updating work plans: Based on the States work with CMS and its technical assistance provider, as well as peers from other Demonstration States, the State will have the opportunity to refine its strategies and work plan charts.
    - The work plan charts submitted with the State's application should be created in a chart/matrix format and must contain the following elements: Goals, Measurable Outcomes, Major Objectives, Key Tasks, Lead Person assigned, Timeframe (Start and End Dates).
    - The work plan charts should describe the specific mechanisms that the State will employ/utilize to ensure that the Demonstration Ombudsman Programs fulfills all of the principles and capabilities set forth in Section 4.1.a, above.
    - Other elements may be added to the work plan chart during the initial planning phase.

If more than six months is needed for Phase I planning activities, the applicant should send a request to extend this period for CMS consideration.

4.4 Phase II – Ombudsman Program Implementation Activities

This phase will involve States or designated entities providing individual assistance to beneficiaries and their families or other representatives and complainants.

4.4.a State activities

The State shall be responsible for the implementation of this cooperative agreement. If the Demonstration Ombudsman Program is housed within a designated entity, the State will have an

additional responsibility to monitor the quality and compliance of the designated entity with the terms and conditions of the contract or other arrangement under which this service is provided.

4.4.b Demonstration Ombudsman Program activities
General description

In general, the Demonstration Ombudsman Program shall investigate and resolve complaints with or on behalf of Medicare-Medicaid beneficiaries participating in (or enrolling in) the Financial Alignment Initiative. Like any ombudsman program,[1] the Demonstration Ombudsman Program is designed to be a safe place to which individuals may complain without fear of retaliation. Ombudsman complaints generally relate to access to a needed service, the quality of the service, and individuals' rights or allegations of unfair treatment.

The Ombudsman helps even the playing field for the individual who may well be overwhelmed by an entity that may be large, bureaucratic or complex in the following ways:

- **Empowering individuals** – Upon receiving a complaint, an Ombudsman focuses on educating and empowering the individual and/or their family as appropriate, with information needed to resolve the problem.
- **Complaint investigation and resolution** – If an individual needs further assistance to resolve the issue, an Ombudsman investigates and negotiates in order to assist in resolution of the issue. While Ombudsman programs typically coordinate with relevant regulatory agencies, the Ombudsman is usually able to resolve individuals' complaints informally, thereby avoiding initiation of more expensive and often-prolonged regulatory processes.
- **Systems analysis and recommendations** – An Ombudsman program tracks complaint trends and makes recommendations which inform policy makers about an entity's impact on the individuals that the entity is designed to serve.

Demonstration Ombudsman Program Services

1. Empowering beneficiaries
    a. Providing one-on-one education to individual beneficiaries (and their caregivers and representatives) relating to beneficiary rights to Medicare and/or Medicaid benefits and the quality of services provided to the individual by such benefits.
    b. Providing education to groups of beneficiaries or other stakeholders, relating to beneficiary rights to Medicare and/or Medicaid benefits and the quality of services provided to the individual by such benefits.

[1] For a description of Ombudsman models and minimum standards, see American Bar Association, *Standards for the Establishment and Operation of Ombuds Offices* (February, 2004).

2. Conducting outreach
    a. Implementation of the outreach plan to help beneficiaries (and their caregivers and representatives) know of the service availability.

3. Complaint investigation and resolution
    a. Complaint intake – Accepting complaints relating to beneficiary rights to Medicare and/or Medicaid benefits and the quality of services provided. Complaints may be received from any source.
    b. Investigation of complaints – Investigation is for the purpose of determining whether there is sufficient merit to the complaint to pursue resolution (but does not need to provide sufficient evidence to substantiate the claim for purposes of any legal proceeding).
    c. Resolving the complaint – Implementing strategies to resolve the complaint, including, but not limited to, negotiating with involved parties (e.g., service provider, the Plan, the Medicaid agency, other relevant state agencies), assisting the beneficiary to file appeals, and making referrals to appropriate regulatory or licensing entities.
    d. Representing the interest of the beneficiary – Throughout the complaint resolution process, the ombudsman should represent the beneficiary's interest, for example:
        i. Requesting consent of the beneficiary prior to investigating the complaint. Complaints should not be investigated by the ombudsman when a beneficiary has indicated that he/she does not want the ombudsman to investigate on his/her behalf. If a beneficiary is unable to provide informed consent, the ombudsman may receive consent from a beneficiary representative.
        ii. Working with the beneficiary (or representative if beneficiary is unable to do so) to develop the strategy for resolution of the complaint.

NOTE: States are not prohibited from using funds under this cooperative agreement to support outside services that would assist beneficiaries in appeals of Plan, service provider, or Medicaid determinations. However, in designing the Demonstration Ombudsman Program sustainability plan (for after the completion of the award) the State should be aware that CMS will not provide funding for outside services in such appeals or legal services for beneficiaries. There should be mechanisms in place to avoid supplantation or duplication in funding or overlapping of identical services between operation of the Demonstration ombudsman program and other existing programs.

4. Systems analysis and recommendations
    a. Collection and reporting of complaint data – Data must be submitted to CMS or its technical assistance provider on a quarterly basis through the Reporting

System that is to be designed with State and designated entity involvement during Phase I of this cooperative agreement.

   i. Identifying information of individual beneficiaries or complainants shall not be included in the data transmitted by the Demonstration Ombudsman Program to any other entity.

b. Analysis of complaint trends.
c. Coordination with stakeholders and other agencies involved in Medicaid and Medicare benefits, and other third-party health insurance as applicable.
d. Inform and make recommendations to the CMS contract management team, the State, the Plan, and other stakeholders of systemic analysis findings.

4.5 Cooperative Agreement Reporting

The State shall be responsible for providing ongoing ad hoc status updates at the request of CMS as well as formal semi-annual progress reports to CMS to summarize progress against the milestones identified in the implementation plan. The semi-annual progress report shall provide an analysis of challenges, discuss best practices or key lessons, and provide mitigation strategies for addressing barriers during implementation. The report shall also detail how cooperative agreement funds were used for each six-month period. This information shall be provided to CMS using the SF-424A form. CMS will use this information to monitor operations. This report shall be submitted within 30 calendar days of the end of each six-month period.

Within 90 calendar days of the end of the three-year cooperative agreement, the awardee shall submit a final report to CMS. The report will summarize federal and state expenditures for implementation activities, review lessons learned, and inform CMS about implementation needs to replicate successful Financial Alignment Initiative projects in other States or make potential future Medicare and Medicaid policy changes.

The Demonstration Ombudsman Program will be evaluated as a part of the overall evaluation of each State's Financial Alignment Initiative. With respect to the Financial Alignment Initiative project evaluation, States and designated entities are required to cooperate, and shall require any other individuals or entities performing functions or services related to Financial Alignment Initiative activities to cooperate with CMS and its designee(s). CMS will contract with an independent evaluator who will assess the impact of the States' Financial Alignment Initiative projects. States must provide data needed to assess the impact of the Ombudsman program to the independent evaluator. CMS shall have full rights to use such data to disseminate successful complaint resolution techniques, including factors associated with performance, to other providers and suppliers and the public and to evaluate the Financial Alignment Initiative. States and designated entities shall cooperate, and shall require any other individuals or entities performing functions or services related to Financial Alignment Initiative activities to cooperate,

in any site visits conducted by CMS or its designee(s). CMS or its designee(s) shall schedule the site visit with the awardee no less than 15 days in advance for purposes of evaluation, learning, and documenting best practices.

II. AWARD INFORMATION

1. Total Funding

The total amount of federal funds available is anticipated to be up to $12,170,000 over three years. In determining amount of the awards, CMS will consider requests as follows:

- base funding requests of up to $125,000 per State the first year and up to $75,000 for each of the second and third years of the cooperative agreement, in order to plan, develop and establish a program; and
- additional funding to carry out program activities, considering factors related to the enrollee population of each State (e.g., number of estimated enrollees, geographic distribution of enrollees).

2. Award Amount

CMS expects to make total awards to States ranging from $275,000 to $3 million to each State over a period of three years. States may not use this funding to supplant or duplicate funding from other funding sources, including from the Implementation Support Funding Opportunity Announcement (CMS-1I1-13-001) and the CMS funded Consumer Assistance Program. States that received an award under the Implementation Support Funding Opportunity Announcement or the CMS Consumer Assistance Program may be required to submit additional documentation to CMS to ensure those funds are not being used for purposes identical to those that will be funded or are being funded under this Demonstration Ombudsman Program FOA. If a State has received such an award, it should indicate clearly how it plans to use funds under this current funding opportunity in a manner that avoids supplantation or duplication of funds for the same services. Award funds may not be used as match under the Implementation Support Funding Opportunity or to match any other federal funds. However, funding may be requested to expand service capacity or to extend the duration of the Demonstration Ombudsman Program.

CMS reserves the right to award less or more depending on the scope and nature of the individual applications received. Awardees may not receive the total award amount requested and may be asked to revise the work plan to reflect the funding that CMS will award.

3. Anticipated Award Date

CMS anticipates making cooperative agreement awards by September 13, 2013. Thereafter, it is approximately 45 days after each application due date.

4. Period of Performance

The anticipated cooperative agreement period of performance for the program is three years. Funding will be awarded in 12-month budget periods. Continuation awards following the 12-

month base period are contingent on the progress in meeting the goals of the previous award. CMS is under no obligation to make additional awards under this program. To receive continued funding in the second or third year, cooperative agreements will be awarded through a non-competitive process contingent upon the progress of the State towards meeting the benchmarks set forth in the State's draft implementation plan and detailed in the Terms and Conditions.

5. Number of Awards

The number of estimated awards is based on the number of States that have signed MOUs with CMS to implement a financial alignment model at the time of award.

6. Type of Award

Awards will be made through cooperative agreements. CMS will be substantially involved in award activities. This will include collaboration and participation by the awarding staff as well as monitoring the cooperative agreements and their resulting recipient responsibilities.

While awardees are expected to cooperate with and facilitate the role of the awarding office and work of the technical assistance support contractor and evaluation contractor, it is not necessary to budget for these activities beyond allowance for staff time for interactions and data reporting. For example, the awardee is not expected to provide working space for federal participants, etc. Applications should propose plans and budgets without any assumption of operational programmatic support from the awarding office. For example, the awarding office will not make facilities or other resources available beyond the cooperative agreement award amount. Applications that would require such additional support will be considered non-responsive and will be eliminated from consideration. Applications that require data from CMS should specify this need.

7. Termination of Award

Continued funding to an awardee is dependent on satisfactory performance against goals and performance expectations delineated in the cooperative agreement's terms and conditions. CMS reserves the right to terminate the cooperative agreement if it is determined to be in the Government's best interests. Projects will be funded subject to meeting terms and conditions specified and may be suspended or terminated if these are not met [see 1115A [42 USC 1315 a](b)(3)(B)].

III. ELIGIBILITY INFORMATION

1. Eligible Applicants

Funding under this Announcement is only available to States that have signed an MOU with CMS to implement an approved Financial Alignment model at the time of award. A list of States that have signed MOUs for the Financial Alignment Initiative at the time of the release of the FOA can be found at: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html.

Eligible applicants from the CMS-approved Financial Alignment States include any state government agency. Regardless of which agency applies, CMS recommends that the state unit on aging, state disability agency, state protection and advocacy agency, state developmental disabilities council, state behavioral health agency, and state Medicaid agency should be involved in the planning, development and implementation of the State's Demonstration Ombudsman Program under this funding opportunity. Only one application can be submitted for approval from each eligible State.

Application Eligibility Threshold Criteria

Applications not meeting threshold criteria will not be reviewed. Threshold criteria include:

- Application deadline: Applications must be received in Grants.gov by the application deadline.
- Applications shall include the required letter expressing support from state Medicaid Director. The letter of support should be addressed to:

Penny Williams, Grants Management Specialist
Centers for Medicare & Medicaid Services
Office of Acquisitions and Grants Management
7500 Security Boulevard
Mail Stop: B3-30-03
Phone: 410-786-2237 or email: Penny.Williams@cms.hhs.gov

More information can be found in Section IV Application and Submission Information. Applicants are strongly encouraged to use the review criteria information, provided in Section V Application Review Information, to help ensure that the application adequately addresses all the criteria that will be used in evaluating the applications.

2. Cost Sharing or Matching

No cost-sharing or matching payments are required.

3. Foreign and International Organizations

Foreign and international organizations are ineligible to apply.

4. Faith-Based Organizations

Faith-based organizations are eligible to serve as the designated entity if selected by the State.

IV. APPLICATION AND SUBMISSION INFORMATION

1. Application Materials

This FOA contains all of the instructions for a potential applicant to apply.

Application materials will be available for download at http://www.grants.gov/. Please note that U.S. Department of Health and Human Services (HHS) requires applications for all announcements to be submitted electronically through http://www.grants.gov/. For assistance with http://www.grants.gov/, contact support@grants.gov or call 1-800-518-4726. Below are specific instructions for applications submitted via http://www.grants.gov/

- You can access the electronic application for this FOA at http://www.grants.gov/. Search for the funding opportunity by using the CFDA Number or the Funding Opportunity Number shown on the cover page of this announcement.
- At the http://www.grants.gov/ website, you will find information about submitting an application electronically through the site, including the hours of operation. HHS strongly recommends that you do not wait until the application due date to begin the application process through http://www.grants.gov/.
- All applicants under this announcement must have an Employer Identification Number (EIN), otherwise known as a Taxpayer Identification Number (TIN), to apply. Please note, the time needed to complete the EIN/TIN registration process is substantial, and applicants should therefore begin the process of obtaining an EIN/TIN immediately to ensure this information is received in advance of application deadlines.
- All applicants must have a Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number. The DUNS number is a nine-digit identification number that uniquely identifies business entities. To obtain a DUNS number, access the following website: http://www.dnb.com/ or call 1-866-705-5711. This number should be entered in the block 8c (on the Form SF-424, Application for Federal Assistance). The organization name and address entered in block 8a and 8e should be exactly as given for the DUNS number.

Applicants should obtain this DUNS number immediately to ensure all registration steps are completed in time.

- The applicant must also register in the System for Award Management (SAM) database in order to be able to submit the application. Information about SAM is available at https://www.sam.gov/portal/public/SAM/. Registering an account with SAM is a separate process from submitting an application. Applicants are encouraged to register early. Therefore, registration should be completed in sufficient time to ensure that it does not impair your ability to meet required submission deadlines**.** Applicants must have their DUNS and EIN/TIN numbers in order to do so. Information about SAM is available at https://www.sam.gov/portal/public/SAM/.
    - Applicants were previously required to register with the CCR. However, SAM has integrated the CCR and 7 other Federal procurement systems into a new, streamlined system. If an applicant has an active record in CCR, there will be an active record in SAM. Nothing more is needed unless a change in the business circumstances requires updates to the Entity record(s) in order for the applicant to be paid, receive an award, or to renew the Entity prior to expiration. Please consult the SAM website listed above for additional information.
- Authorized Organizational Representative: The Authorized Organizational Representative (AOR) who will officially submit an application on behalf of the organization must register with Grants.gov for a username and password. AORs must complete a profile with Grants.gov using their organization's DUNS Number to obtain their username and password http://grants.gov/applicants/get_registered.jsp. AORs must wait at least one business day after registration in SAM before entering their profiles in Grants.gov**. Applicants should complete this process as soon as possible after successful registration in SAM to ensure this step is completed in time to apply before application deadlines.**
    - When an AOR registers with Grants.gov to submit applications on behalf of an organization, that organization's E-Biz point-of-contact will receive an email notification. The email address provided in the profile will be the email used to send the notification from Grants.gov to the E-Biz point of contact (E-Biz POC) with the AOR copied on the correspondence.
    - The E-Biz POC must then login to Grants.gov (using the organization's DUNS number for the username and the special password called "M-PIN") and approve the AOR, thereby providing permission to submit applications.
    - The AOR and the DUNS must match. If your organization has more than one DUNS number, be sure you have the correct AOR for your application.
- **Any files uploaded or attached to the Grants.gov application must be PDF file format and must contain a valid file format extension in the filename.** Even though Grants.gov allows applicants to attach any file format as part of their application, CMS restricts this practice and only accepts PDF file format. **Any file submitted as part of**

the Grants.gov application that is not in a PDF file format, or contains password protection, will not be accepted for processing and will be excluded from the application during the review process. In addition, the use of compressed file formats such as ZIP, RAR or Adobe Portfolio will not be accepted. The application must be submitted in a file format that can easily be copied and read by reviewers. It is recommended that scanned copies not be submitted through Grants.gov unless the applicant confirms the clarity of the documents. Pages cannot be reduced resulting in multiple pages on a single sheet to avoid exceeding the page limitation. All documents that do not conform to the above will be excluded from the application during the review process.

  - Applicants are limited to using the following UTF-8 characters in all attachment file names: A-Z, a-z, 0-9, underscore (_), hyphen (-), space, period. If applicants use any other characters when naming their attachment files their applications will be rejected.
  - Prior to application submission, Microsoft Vista and Office 2007 users should review the Grants.gov compatibility information and submission instructions provided at http://www.grants.gov/. Click on "Vista and Microsoft Office 2007 Compatibility Information."

- After you electronically submit your application, you will receive an automatic email notification from Grants.gov that contains a Grants.gov tracking number. **Please be aware that this notice does not guarantee that the application will be accepted by Grants.gov. It is only an acknowledgement of receipt.** All applications that are successfully submitted must be validated by Grants.gov before they will be accepted. Please note applicants may incur a time delay before they receive acknowledgement that the application has been validated and accepted by the Grants.gov system. In some cases, the validation process could take up to 48 hours. If for some reason your application is not accepted, then you will receive a subsequent notice from Grants.gov citing that the application submission has been rejected. **Applicants should not wait until the application deadline (date and time) to apply because notification by Grants.gov that the application fails validation and is rejected may not be received until close to or after the application deadline, eliminating the opportunity to correct errors and resubmit the application. Applications that fail validation and are rejected by Grants.gov after the deadline will not be accepted and/or granted a waiver.** For this reason CMS recommends submission of applications prior to the due date and time.
- The most common reasons why an application fails the validation process and is rejected by Grants.gov are:
  - SAM registration cannot be located and validated
  - SAM registration has expired

- The AOR is not authorized by the E-Biz POC to submit an application on behalf of the organization
- File attachments do not comply with the Grants.gov file attachment requirements

- **HHS retrieves applications from Grants.gov only after Grants.gov validates and accepts the applications. Applications that fail validations and are rejected by Grants.gov are not retrieved by HHS, and HHS will not have access to rejected applications.**

- After HHS retrieves your application from Grants.gov, you will receive an email notification from Grants.gov stating that the agency has received your application and once receipt is processed, you will receive another email notification from Grants.gov citing the Agency Tracking Number that has been assigned to your application. It is important for the applicant to keep these notifications and know the Grants.gov Tracking Number and Agency Tracking Number associated with their application submission.

- Each year organizations and entities registered to apply for Federal grants and cooperative agreements through Grants.gov will need to renew their registration with the System for Award Management (SAM). You can register with the SAM online at; https://www.sam.gov/portal/public/SAM. **Failure to renew SAM registration prior to application submission will prevent an applicant from successfully applying.**

Full applications can only be accepted through http://www.grants.gov/. Applications cannot be accepted through any email address. Full applications cannot be received via paper mail, courier, or delivery service, unless a waiver is granted per the instructions below.

For the first round of funding, all applications must be submitted electronically and be received through Grants.gov by 3:00 p.m. Eastern Time (Baltimore, MD) on **August 5, 2013**. All applications will receive an automatic time stamp upon submission and applicants will receive an automatic e-mail reply acknowledging the application's receipt.

- If you experience technical challenges while submitting your application electronically, please contact Grants.gov Support directly at: support@grants.gov or (800) 518-4726. Customer Support is available to address questions 24 hours a day, 7 days a week (except on federal holidays). CMS encourages applicants not to wait until close to the due date to submit the application.
- Upon contacting Grants.gov, obtain a helpdesk tracking number as proof of contact. The tracking number is helpful if there are technical issues that cannot be resolved and a waiver from the agency must be obtained.

The applicant must seek a waiver **at least** ten days prior to the application deadline if the applicant wishes to submit a paper application. Applicants that receive a waiver to submit paper application documents must follow the rules and timelines that are noted below.

- In order to be considered for a waiver application, an applicant must have adhered to the timelines for obtaining a DUNS number, registering with the System for Award Management (SAM), registering as an Authorized Organizational Representative (AOR), obtaining an Employer/Taxpayer Identification Number (EIN/TIN), completing Grants.gov registration, as well as requesting timely assistance with technical problems. **Applicants that do not adhere to timelines and/or do not demonstrate timely action with regards to these steps will not be considered for waivers based on the inability to receive this information in advance of application deadlines.** Please be aware of the following: If it is determined that a waiver is needed from the requirement to submit your application electronically, you must submit a request in writing (emails are acceptable) to Penny.Williams@cms.hhs.gov with a clear justification for the need to deviate from our standard electronic submission process.
- If the waiver is approved, the application must be received in the Office of Acquisition and Grants Management, Division of Grants Management by the application due date and time.
- 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 applicants or only those applicants 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.

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

2. Content and Form of Application Submission

2.1 Form of Application Submission

Each application must include all contents described below, in the order indicated, and in conformance with the following specifications:

- Use 8.5” x 11” letter-size pages (one side only) with 1” margins (top, bottom, and sides). Other paper sizes will not be accepted. This is particularly important because it is often not possible to reproduce copies in a size other than 8.5” x 11”.
- All pages of the project narrative must be paginated in a single sequence.
- Font size must be no smaller than 12-point with an average character density no greater than 14 characters per inch.
- All narrative portions of the application (project and budget) must be DOUBLE-SPACED with the exception of charts and tables, which may be single-spaced (but must still meet the font requirements above).
- The project abstract is restricted to a one-page summary which may be single-spaced.
- The application with the appendices shall not exceed 40 pages in length.
- The Project Narrative shall include (not exceeding 20 pages in length):
    - Proposed Approach
    - Organizational Capacity and Management Plan Evaluation and Reporting
    - Budget and Budget Narrative
- The Appendices shall include (not exceeding 20 pages in length):
    1. Letter of support and commitment from the state Medicaid Director
    2. Draft implementation work plan
    3. Brief resumes from designated entity staff (if applicable)

Other required materials NOT included in page limits are:

- Abstract
- Standard forms (see Overview of Cooperative Agreement Application Structure and Content)
- Indirect Cost Rate Agreements or Cost Allocation Plans (CAP)

2.2 Overview of Cooperative Agreement Application Structure and Content

2.2.a Standard Forms

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

a) SF-424: Official Application for Federal Assistance (see note below)
b) SF-424A: Budget Information Non-Construction
c) SF-424B: Assurances-Non-Construction Programs
d) SF-LLL: Disclosure of Lobbying Activities
e) Project/Performance Site Location(s) form

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

a) On Item 15 “Descriptive Title of Applicant’s Project,” state the specific cooperative agreement opportunity for which you are applying: State Demonstration to Improve Care for Medicare-Medicaid Enrollees Implementation Support.
b) Check “C” to item 19, as Review by State Executive Order 12372 does not apply to these grants.
c) Item 18 “Estimated Funding,” shall contain the amount of federal funding requested for the FIRST FUNDING PERIOD (12 months) of the project only

2.2.b Applications shall include the required cover letter expressing support from state Medicaid Director. If applicable, this letter shall express support for the State designated entity to apply for and administer the cooperative agreement and describe the role of the state Medicaid agency in the Demonstration Ombudsman Program. The cover letter should be included as a PDF and uploaded into the application. The letter should be addressed to:

Penny Williams, Grants Management Specialist
Centers for Medicare & Medicaid Services
Office of Acquisitions and Grants Management
7500 Security Boulevard
Mail Stop: B3-30-03
Phone: 410-786-2237 or email: Penny.Williams@cms.hhs.gov

2.2.c Project Abstract and Profile (one page)

The one-page abstract (single-spaced) shall serve as a succinct description of the proposed Demonstration Ombudsman Program and how it will support the goals of the Financial Alignment Initiative, including the total budget, and the projected size of the target population and geographic location of the service. It shall also include a brief description of the capacity of the State, and, if applicable, the designated entity to perform the activities for which funds are being requested. 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. Information specific to an individual should be excluded from the abstract.

2.2.d Project Narrative

The application is expected to address how the applicant will implement the cooperative agreement program in support of the goals of the Financial Alignment Initiative. The required sections of the application are listed below. Also provided is a brief description of the type of information that is required to be addressed within each specific section. The application must be organized by these headings, noted as the operations element sections, outlined below.

A. Proposed Approach

Strategy – The application shall clearly summarize a comprehensive description of the Phase I development and Phase II implementation strategy for providing ombudsman services to beneficiaries, including an anticipated timeline. The applicant shall only propose activities that are necessary and appropriate to implement ombudsman services for individuals served under the Financial Alignment Initiative and that meet the principles and capabilities described in Section I.4.1.

Planned activities and staffing – The application should include planning, development and implementation tasks, required staffing, appropriateness of the staffing, staffing levels, and key activities by staff. The application shall present a clear and robust strategy explaining how those staff would coordinate with stakeholders. The application shall describe any past, current or planned stakeholder engagement activities related to development of the Demonstration Ombudsman Program.

Resources – The application shall describe the resources needed to support Phase I planning and Phase II implementation tasks, the organizations and individuals who will execute those tasks, and when these resources are needed to support implementation tasks. This description shall identify any existing resources currently available to the State and State contributions to implementation, gaps in existing resources that the cooperative agreement award will address, and any risk to Financial Alignment Initiative implementation in the absence of additional resources.

All States currently have ombudsman services to long-term care facility residents (authorized by the Older Americans Act) and a protection and advocacy system to problem-solve for individuals with disabilities (authorized by the Developmental Disabilities Assistance and Bill of Rights Act and other federal laws). Some States have developed specialized ombudsman and other consumer problem-solving services (e.g., mental health and managed health care ombudsman programs). Most States also have consumer protection agencies and programs specifically designed to help consumers resolve problems and complaints they have with health insurance plans and products, including Consumer Assistance Programs funded by CMS under the Affordable Care Act. The entities providing these services may be among those appropriate for State consideration for delivery of ombudsman services to beneficiaries served by the Financial Alignment Initiative.

The funding in this Cooperative Agreement shall provide for ombudsman services specifically to individuals participating in the Financial Alignment Initiative. States should not assume that existing entities have sufficient capacity or expertise to meet the needs of beneficiaries without additional resources. The applicant shall describe how the services to be provided under this Cooperative Agreement will meet the needs of beneficiaries without endangering the capacity of

the State or designated entity to provide consumer support services to existing service populations.

B. Organization Capacity and Structure

The application shall describe the infrastructure/capacity of the State agency and designated entity, if applicable, to plan and implement the cooperative agreement activities and associated funding. This section shall describe the capacity of the State to manage and oversee execution of the cooperative agreement activities. The State or designated entity, if applicable, is required to maintain sufficient organizational resources, including staff, information technology, and capacity to track data for required quarterly reports, and other resources necessary to implement the project. The applicant must identify key staff for each task.

The application shall include qualifications of relevant staff, roles and responsibilities of each position, and percentage of time that key personnel would dedicate to the project. The application shall describe how the principles and capabilities set forth in Section 4.1.a, above will be met by the State or designated entity hosting the Demonstration Ombudsman Program.

If a State has selected a designated entity to host the Demonstration Ombudsman Program, the application shall describe lines of business, mission statement, total annual revenue, current staffing level, geographic areas of operation, and other factors necessary for CMS to understand the designated entity's organization. It shall describe any relationships, contracts or other arrangements that the designated entity has with the State and its experience providing services on behalf of a state agency, including but not limited to the state Medicaid agency. The application shall describe past performance with activities similar to those proposed under this cooperative agreement.

The application shall include assurances that the State will perform the functions needed to support an effective Demonstration Ombudsman Program, including, but not limited to, the assurances set forth in Section 4.1.b, above.

The application shall include a preliminary draft implementation work plan, which may be submitted as an Appendix, describing how it would organize and manage the project, in what time frames, and what management control and coordination tools would be used to assure the timely and successful implementation of the cooperative agreement activities. The application shall indicate the organizational capacity to effectively conduct this project, track activities and deliverables, and report on its progress throughout the cooperative agreement period of performance.

C. Reporting and Evaluation

The application must describe applicant's plan for two types of reporting:

- The State's semi-annual award progress reporting to CMS
- The State or designated entity's Demonstration Ombudsman Program quarterly program data (to be developed during the Phase I Planning Phase, see Section I.4.2.b, above).

States and the designated entity, if applicable, will also be required to fully cooperate with the CMS operations support, actuarial rate-setting services, and evaluation contractors in reporting data that they may require for the project support and evaluations. Note that CMS nor its contractors nor any other entity shall request identifying information of individual beneficiaries or complainants served by the Demonstration Ombudsman Program.

2.2.e Budget and Budget Narrative

Form SF-424A: Budget Information – Non-Construction Programs and Budget Narrative:
All applicants must submit an SF-424A. Instructions for completing the SF-424A can be found on Grants.gov.

The program is funded in three, 12-month budget periods. On the SF424A Section A– Budget Summary, please use Row 1 for year 1, Row 2 for year 2, and Row 3 for year 3. On the SF424A Section B Budget Categories, please use Column 1 for the first 12-month budget period, Column 2 for the second 12-month budget period, and Column 3 for the third budget period. In Section C Non-Federal Resources, please use one row for each year of the project. Section D should be completed by dividing the year 1 total into the amounts needed in each quarter. Section E should reflect the total federal funds requested for future funding periods. Column B (First) should reflect year 2 and Column C (Second) should reflect year 3.

A. Budget Narrative

In addition, applicants must supplement Budget Form SF-424A with a Budget Narrative. The Budget Narrative must include a yearly breakdown of costs for the three-year cooperative agreement period of performance. Specifically, the Budget Narrative should provide a detailed cost breakdown for each line item outlined in the SF-424A Section B by year including a breakdown of costs for each activity/cost within the line item. The proportion of cooperative agreement funding designated for each activity should be clearly outlined and justify the organization's readiness to receive funding for three 12-month budget periods including complete explanations and justifications for the proposed cooperative agreement activities. The budget must separate out funding that is administered directly by the awardee from any funding that will be subcontracted.

- If the State anticipates that the resources available through the cooperative agreement are less than those needed to fully implement the Demonstration Ombudsman Program, the State shall describe to CMS:
    - what resources would be needed for full implementation; and
    - how it plans to implement services within available resource limits.
        - For example, the State could indicate how the designated entity plans to triage specific types of complaints (e.g., by level of service provided, varying standards of promptness in responding) or to target subpopulations of beneficiaries who may be at greatest risk.

The following budget categories should be addressed (as applicable):

- Personnel
    - NOTE: Consistent with section 203 of the Consolidated Appropriations Act, 2012 (P.L. 112-74) none of the funds appropriated in this law shall be used to pay the salary of an individual, through a grant or other extramural mechanism, at a rate in excess of Executive Level II ($179,700).
- Fringe benefits
- Contractual costs, including subcontracts
- Equipment
- Supplies
- Travel (The budget should reflect that a minimum of one staff person is required to attend up to two 2-day meetings per year in the Washington DC/Baltimore MD area.)
- Indirect charges
- In compliance with appropriate OMB Circulars, if requesting indirect costs in the budget, a copy of the approved indirect cost rate is required.
- Other costs, including those not otherwise associated with training and education.

State personnel and personnel contract costs must include detailed salary and fringe benefit costs clearly delineated for review.

The Budget Narrative shall outline the strategies and activities of the program, and provide cost breakdowns for any subcontracts that will be implemented to achieve anticipated outcomes.

B. Organizational Structure

Applicants must also include with the Budget Narrative an organizational chart for the State agency and designated entity, if applicable, responsible for the management of the cooperative agreement and a Narrative Staffing Plan. The Narrative Staffing Plan shall include:

- The number and titles of staff that will be dedicated to the cooperative agreement;

- Percentage of time and total hours per month each individual/position is dedicated to the cooperative agreement;
- Brief description of roles/responsibilities of each position;
- How the proposed key staff positions have relevant skills and leadership ability to successfully carry out the project; and
- Number of contracted individuals supporting the cooperative agreement.

Note: Rather than duplicate information in their application, applications should refer to the information provided in response to the information specified in Section IV.2.2 Overview of Cooperative Agreement Application Structure and Content when writing this section.

2.3 Submission Dates and Time

The deadline for the submission of applications for the first round of funding under this FOA is **August 5, 2013**. Applications received through http://www.grants.gov by 3:00 p.m. Eastern Standard Time (Baltimore, MD) on due date will be considered "on time." All applications will receive an automatic time stamp upon submission and applicants will receive an automatic e-mail reply acknowledging the application's receipt. This serves as the official date/time that an application is received.

Funding Application Submissions and Review Schedule

Application Submission Due	Estimated Review Period	Anticipated Notice of Award Date	Anticipated Funding Period
August 5, 2013 3 p.m. Eastern Daylight Time (EDT)	August 6, 2013- September 12, 2013	September 13, 2013	September 13, 2013- September 12, 2016
October 3, 2013 3 p.m. Eastern Daylight Time (EDT)	October 4, 2013 – November 12, 2013	November 13, 2013	November 13, 2013 – November 12, 2016
January 14, 2014 3 p.m. Eastern Daylight Time (EDT)	January 15, 2013 – February 24, 2014	February 25, 2014	February 25, 2014 – February 24, 2017

2.4 Intergovernmental Review

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

2.5 Funding Restrictions

2.5.a Indirect Costs

If requesting indirect costs, a Federally Negotiated Indirect Cost Rate Agreement will be required. Applicants are required to use the rate agreed to in the Indirect Cost Rate Agreement. However, if there is not an agreed upon rate, the award (if the applicant is selected) may not include an amount for indirect costs unless the organization has never established an indirect cost rate (usually a new recipient) and intends to establish one. In such cases, the award shall include a provisional amount equaling one-half of the amount of indirect costs requested by the applicant, up to a maximum of 10 percent of direct salaries and wages (exclusive of fringe

benefits). If the recipient fails to provide a timely proposal, indirect costs paid in anticipation of establishment of a rate will be disallowed. See the Health and Human Services Grants Policy Statement at http://www.hhs.gov/grantsnet/adminis/gpd/ for more information.

The provisions of 2 CFR Part 225 (previously OMB Circular A-87) govern reimbursement of indirect costs under this solicitation. http://www.whitehouse.gov/omb/circulars.

If a State's indirect costs are determined based on an approved Cost Allocation Plan (CAP) with the Division of Cost Allocation, DHHS, information regarding the CAP will be requested prior to award. Please include a copy of the CAP approval letter along with the application submission.

2.5.b Direct Services

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

2.5.c Reimbursement of Pre-Award Costs

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

2.5.d Prohibited Uses of Cooperative Agreement Funds

- To match any other federal funds.
- Use to substitute for existing state-only or Medicaid funded ombudsman programs or services.
- To provide services, equipment, or supports that are the legal responsibility of another party under federal or state law (e.g., vocational rehabilitation or education services) or under any civil rights laws. Such legal responsibilities include, but are not limited to, modifications of a workplace or other reasonable accommodations that are a specific obligation of the employer or other party.
- To supplant existing state, local, or private funding of infrastructure or services, such as staff salaries, etc.
- To be used by local entities to satisfy state matching requirements.
- To provide infrastructure for which federal Medicaid matching funds are available at the 90 / 10 matching rate, such as certain information systems projects.

- To pay for the use of specific components, devices, equipment, or personnel that are not integrated into the application.
- Construction or alteration and renovation of real property (A&R).
- Any equipment (including information technology equipment) over $5,000 must be approved by CMS.

Promoting Efficient Spending for Conferences and Meetings

It is the Department of Health and Human Services' (HHS) policy that conferences and meetings funded through grants and cooperative agreements: are consistent with legal requirements and HHS' missions, objectives, and policies; represent an efficient and effective use of taxpayer funds; and are able to withstand public scrutiny. CMS must conduct business, including conferences and meetings, consistent with these tenets. As a result, CMS has adopted grant and cooperative agreement practices that promote efficient spending for conferences and meetings.

While grant recipients are always encouraged to provide performance-based solutions to the Government's requirements, the Centers for Medicare and Medicaid (CMS) encourages alternative solutions (i.e. teleconference) as opposed to traditional face-to-face meetings. A "conference" is defined as "[a] meeting, retreat, seminar, symposium or event that involves awardee, subcontractor, or consultant travel."

Please Note: Applicants are prohibited from including any promotional items or food as a part of a conference (defined above) organized with cooperative agreement funds and in furtherance of accomplishing the goals of the cooperative agreement.

Any conferences, with or without travel, that you believe are necessary to accomplish the purposes of this grant must have prior CMS approval. These requests must be priced separately in the budget and include the following information:

(1) a description of its purpose;

(2) the number of participants attending;

(3) a detailed statement of the costs to the grant, including—

(A) the cost of any food or beverages;

(B) the cost of any audio-visual services for a conference;

(C) the cost of employee or contractor travel to and from a conference; and

(D) a discussion of the methodology used to determine which costs relate to a conference.

In addition, funds under this grant may not be used for the purpose of defraying the costs of a conference that is not directly and programmatically related to the purpose for which the grant is awarded (such as a conference held in connection with planning, training, assessment, review, or other routine purposes related to a project funded by the grant).

V. APPLICATION REVIEW INFORMATION

In order to receive an award under this FOA, applicants must submit an application, in the required format, no later than the deadline date and time.

If an applicant does not submit all of the required documents and does not address each of the topics described below, the applicant risks not being awarded a cooperative agreement.

1. Criteria

This section fully describes the evaluation criteria for this cooperative agreement program. In preparing applications, applicants are strongly encouraged to review the programmatic requirements detailed in Section I. Funding Opportunity Description. The application must be organized, as detailed in Section IV Application and Submission Information, and be submitted by an eligible applicant as defined in Section III. Eligibility Information.

Applications received by the due date and time from eligible applicants will be reviewed in the technical review process. If not received by the due date and time, the applicant's submission will not receive further consideration and will not be eligible for award.

Application will be scored with a total of 100 points available. The following criteria will be used to evaluate applications received in response to this FOA.

1.1 Proposed Approach (Overall 30 Points)

The applicant clearly describes the Phase I development and Phase II implementation strategy for providing ombudsman services to beneficiaries, including an anticipated timeline and activities associated with building the infrastructure needed to implement the project. Activities proposed under this cooperative agreement are necessary and appropriate to implement the project and meet the principles and capabilities described in Section I.4 of the FOA.

The application clearly articulates planning, development and implementation tasks to provide ombudsman services to beneficiaries. Consistent with the proposed activities, the applicant describes the required staffing, appropriateness of the staffing, staffing levels, and key activities by staff. The application presents a clear and robust strategy explaining how those staff would

coordinate with stakeholders and describes any past, current or planned stakeholder engagement activities related to the development of the Demonstration Ombudsman Program.

The applicant clearly describes the resources needed to support Phase I planning and Phase II implementation tasks, the organizations and individuals who will execute those tasks, and when these resources are needed to support implementation tasks. This description identifies any existing resources currently available to the State and State contributions to implementation of ombudsman services to beneficiaries, gaps in existing resources that the cooperative agreement award will address, and any risk to Financial Alignment Initiative implementation in the absence of additional resources. The application describes how the services to be provided under this award will meet the needs of beneficiaries without endangering the capacity of the State or designated entity to provide consumer support services to existing service populations.

The application includes a letter expressing support for the application from the State Medicaid director and the role of the State Medicaid agency in the Demonstration Ombudsman Program. If applicable, this letter expresses support for the designated entity to provide Demonstration Ombudsman Services under the cooperative agreement.

The application must also describe how it will coordinate with and leverage existing state programs designed specifically to help consumers resolve complaints with health insurance plans and products, including Consumer Assistance Programs funded by CMS under the Affordable Care Act.

1.2 Organizational Capacity and Management Plan (Overall 25 Points)

The applicant demonstrates sufficient infrastructure and capacity of the State agency and designated entity, if applicable, to plan and implement the cooperative agreement activities and associated funding. The applicant describes sufficient capacity of a) the State to manage and oversee execution of the cooperative agreement activities and b) the State or designated entity, if applicable, in terms of organizational resources, including staff, information technology, and capacity to track data for required quarterly reports, and other resources necessary to implement indicated activities. The applicant must also demonstrate how it will coordinate with and leverage existing state programs designed specifically to help consumer resolve complaints with health insurance plans and products, including Consumer Assistance Programs funded by CMS under the Affordable Care Act.

The applicant adequately describes how the principles and capabilities set forth in Section 4.1.a, above, will be met by the State or designated entity hosting the Demonstration Ombudsman Program. The applicant assures that the State will perform the functions needed to support an

effective Demonstration Ombudsman Program, including, but not limited to, the assurances set forth in Section 4.1.b, above.

If the applicant indicates that it will use a designated entity to host the Demonstration Ombudsman Program, the applicant adequately describes the entity's organizational capacity, including consistent lines of business, mission statement, total annual revenue, current staffing level, and geographic areas of operation. The applicant describes relationships that the designated entity has with the State, the entity's experience providing services on behalf of any state agency, and past performance with activities similar to those proposed under this cooperative agreement.

The applicant clearly articulates its preliminary draft implementation work plan, describing how it would organize and manage the project, in what time frames, and what management control and coordination tools would be used to assure the timely and successful implementation of the cooperative agreement activities.

1.3 Evaluation and Reporting (Overall 20 Points)

The applicant clearly describes its plan for two types of reporting:

- The State's semi-annual award progress reporting to CMS
- The State or designated entity's Demonstration Ombudsman Program quarterly program data (to be developed during the Phase I Planning Phase, see Section I.4.2.b, above).

The application confirms that the States and designated entity, if applicable, will fully cooperate with CMS operations support, actuarial rate-setting services, and evaluation contractors in reporting data that they may require for the project support and evaluations.

1.4 Budget and Budget Narrative (Overall 25 Points)

The proposed Budget and Budget Narrative are carefully developed and reflect efficient and reasonable use of funds. Overhead and administrative costs are reasonable, with funding focused on services to beneficiaries rather than administration of the Demonstration. The evaluation of applications will consider whether the applicant includes a comprehensive budget reflecting all costs of staffing and implementing the intervention.

If an applicant previously has received an award under the Implementation Support FOA for purposes of establishing and/or operating an ombudsman program, or under the CMS funded Consumer Assistance Program, the application clearly describes how it plans to use funds under this current funding opportunity in a manner that avoids supplantation or duplication of funds for

the same services. Note that funding may be requested to expand service capacity or to extend the duration of the Demonstration Ombudsman Program.

The application does not propose the use of award funds as a match to any other federal funds.

2. Review and Selection Process

The review process will include the following:

- Applications will be screened to determine eligibility for further review. Applications received late or from organizations that are not eligible applicants will not be reviewed and will not be eligible for award.

- A team consisting of staff from HHS and potentially other outside experts will review all applications. A review panel will assess each application to determine the merits of the application and the extent to which the proposed program furthers the purposes of the Financial Alignment Initiative. CMS reserves the option to request that applicants revise or otherwise modify their applications and budget based on the recommendations of the panel.

- The results of the objective review of the applications by a review panel will be used to advise the approving HHS official. Final award decisions will be made by an HHS program official. In making these decisions, the HHS program official will take into consideration: recommendations of the review panel; the extent to which the requested resources directly support planning, development and implementation of a Demonstration Ombudsman Program; any overlap with existing resources that support implementation; the extent to which the State is leveraging state resources to implementation efforts; the reasonableness of the estimated cost to the government and anticipated results; likelihood that the proposed project will result in the benefits expected; and availability of funding.

Successful applicants will receive one cooperative agreement award per application issued under this announcement. See Section II Award Information, Number of Awards for more information. CMS reserves the right to approve or deny any or all applications for funding. Section 1115A(d)(2) of the Social Security Act states that there is no administrative or judicial review of the selection of organizations, sites, or participants to test models under section 1115A.

3. Anticipated Announcement and Award Dates

It is anticipated that decisions for the initial awards under this funding opportunity will be made and awards announced no later than September 13, 2013. Subsequent awards will be made approximately 45 business days after each application date.

VI. AWARD ADMINISTRATION INFORMATION

1. Award Notices

Successful applicants will receive a Notice of Award (NoA) signed and dated by the CMS Grants Management Officer that will set forth the amount of the award and other pertinent information. The award will include standard Terms and Conditions, and may also include additional specific grants terms and conditions.

The NoA is the legal document issued to notify the awardee that an award has been made and that funds may be requested from the HHS Payment Management System. The NoA will be available on the CMS grant award management system and accessible to the awardee. Any communication between CMS and awardees prior to issuance of the NoA is not an authorization to begin implementation of a project.

Unsuccessful applicants are notified within 30 days of the final funding decision for each cooperative agreement and will receive a disapproval letter via e-mail or U.S. mail.

2. Administrative and National Policy Requirements

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

a) Specific administrative and policy requirements of Grantees as outlined in 45 CFR 92, 2 CFR Part 225(previously OMB Circular A-87) and OMB Circulars A-102 and A-133 apply to this cooperative agreement opportunity.

b) All awardees under this project must comply with all applicable Federal statutes relating to nondiscrimination including, but not limited to:

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

ii. Section 504 of the Rehabilitation Act of 1973,

iii. The Age Discrimination Act of 1975,

iv. Hill-Burton Community Service nondiscrimination provisions, and

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

c) All equipment, staff, other budgeted resources, and expenses must be used exclusively for the project identified in the awardee's original cooperative agreement application or agreed upon subsequently with HHS, and may not be used for any prohibited uses.

3. Terms and Conditions

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

Awardees must also agree to respond to requests that are necessary for the evaluation of the overall State Demonstrations to Integrate Care for Dual Eligible Individuals and provide data on key elements of their own cooperative agreement activities. The Ombudsman function will be evaluated as part of the overall evaluation of the Financial Alignment Initiative.

4. Reporting (Frequency and Means of Submission)

4.1 Progress Reports

Awardees are responsible to provide two types of reporting:

- The State's semi-annual award progress reporting to CMS, and
- The State or designated entity's Demonstration Ombudsman Program quarterly program data (to be developed during the Phase I Planning Phase, see Section I.4.2.b, above).

Awardees must agree to cooperate with any federal evaluation of the program and provide required quarterly, semi-annual, and final reports in a form prescribed by CMS. Reports shall be submitted electronically.

Awardees must submit semi-annual Progress Reports that describe their activities, outcomes related to their goals, challenges and lessons learned with final copies of formal funding agreements developed during the grant period attached. The semi-annual Progress Reports shall also detail how cooperative agreements funds were used for each six-month period. This information shall be provided to CMS using the SF-424A form. CMS will use this information to monitor operations.

States and the designated entity, if applicable, will also be required to fully cooperate with the CMS operations support, actuarial rate-setting services, and evaluation contractors in reporting data that they may require for the project support and evaluations. Note that CMS nor its contractors nor any other entity shall request identifying information of individual beneficiaries or complainants served by the Demonstration Ombudsman Program.

4.2 Financial Reporting Requirements

Awardees are required to report their cash transactions on a quarterly basis directly through the Payment Management System using the SF-425 (top portion of the form). The report identifies cash expenditures against the authorized funds for the cooperative agreement. Failure to submit the report may result in the inability to access funds. Awardees are also required to submit overall financial status reports semi-annually, also using the SF-425. Instructions for completing the SF-425 can be found at: http://www.whitehouse.gov/sites/default/files/omb/grants/standard_forms/SF-425_instructions.pdf.

More information regarding submission of the Federal Financial Report (SF-425) will be provided on the Notice of Award.

4.3 Transparency Act Reporting Requirements

Federal Funding Accountability and Transparency (FFATA) Subaward Reporting Requirement: New awards issued under this FOA 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.

Cooperative agreement recipients must report information for each first-tier sub-award of $25,000 or more in federal funds and executive total compensation for the recipient's and sub-recipient's five most highly compensated executives as outlined in Appendix A to 2 CFR Part 170 (available online at www.fsrs.gov).

NOTE: If the State determines a designated entity during Phase I planning, this requirement may be met, with CMS review and approval, prior to the initiation of Phase II activities.

4.4 Audit Requirements

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

4.5 Payment Management Requirements

Grant funds will be distributed to awardees via the Payment Management System. Awardees are required to report their cash transactions on a quarterly basis directly through the Payment

Management System using the SF-425 (top portion of the form). The report identifies cash expenditures against the authorized funds for the cooperative agreement. Failure to submit the report may result in the inability to access funds. Awardees are also required to submit overall financial status reports semi-annually using the SF-425. Instructions for completing the SF-425 can be found at: http://www.whitehouse.gov/sites/default/files/omb/grants/standard_forms/SF-425_instructions.pdf.

More information regarding receipt of grant funds and submission of the Federal Financial Report (SF-425) will be provided on the Notice of Award.

VII. AGENCY CONTACTS

1. Programmatic Contact Information:

All programmatic questions about the cooperative agreements may be directed to:
Latonya Phipps
Centers for Medicare & Medicaid Services
Medicare-Medicaid Coordination Office
7500 Security Boulevard
Mail Stop: S3-13-23
Baltimore, MD 21244-1850
Phone: 410-786-8045 or email: latonya.phipps@cms.hhs.gov

2. Administrative Questions:

Administrative questions about the cooperative agreements may be directed to:
Penny Williams, Grants Management Specialist
Centers for Medicare & Medicaid Services
Office of Acquisitions and Grants Management
7500 Security Boulevard
Mail Stop: B3-30-03
Phone: 410-786-2237 or email: Penny.Williams@cms.hhs.gov