

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

**Adult Medicaid Quality Grants
Measuring and Improving the Quality of Care in Medicaid**

Announcement Type: Initial

**Funding Opportunity Number: CMS-1F1-12-001
CFDA: 93.609**

Date: July 13, 2012

Applicable Dates:

State Voluntary Letter of Intent to Apply Due Date: July 31, 2012

Electronic Grant Application Due Date: August 31, 2012

CMS Anticipated Notice of Award Date: October 31, 2012

Grant Period of Performance: October 31, 2012 – October 30, 2014

Table of Contents

OVERVIEW INFORMATION	4
I. FUNDING OPPORTUNITY DESCRIPTION.....	4
1. Purpose.....	4
2. Authority	6
3. Background	6
4. Program Requirements.....	8
II. AWARD INFORMATION	10
1. Total Funding	10
2. Award Amount.....	10
3. Anticipated Award Date.....	11
4. The Period of Performance	11
5. Number of Awards	11
6. Type of Award	11
III. ELIGIBILITY INFORMATION	11
1. Eligible Applicants.....	11
2. Cost Sharing or Matching	13
3. Foreign and International Organizations.....	13
4. Faith Based Organizations	13
5. Other.....	14
IV. APPLICATION AND SUBMISSION INFORMATION	14
1. Address to Request Application Package.....	14
2. Content and Form of Application Submission.....	18
3. Submission Dates and Times	23
4. Intergovernmental Review	24
5. Funding Restrictions	24
V. APPLICATION REVIEW INFORMATION.....	25
1. Criteria.....	25
2. Review and Selection Process.....	26
3. Anticipated Announcement and Award Date.....	27
VI. AWARD ADMINISTRATION INFORMATION.....	27

1.	Award Notices.....	27
2.	Administrative and National Policy Requirements.....	27
3.	Terms and Conditions	28
4.	Reporting.....	28
VII.	AGENCY CONTACTS.....	32
VIII.	APPENDICES	34
1.	Appendix A: Letter of Intent to Apply.....	34
2.	Appendix B: Application Check-Off Cover Sheet – Adult Medicaid Quality Grant	35
3.	Appendix C: Guidance for Preparing a Budget Request and Narrative in Response to SF 424A.....	36
4.	Appendix D: Initial Core Set of Quality Measures for Medicaid-Eligible Adults.....	44

OVERVIEW INFORMATION

Agency Name: Department of Health and Human Services
Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services

Funding Opportunity Title: Adult Medicaid Quality Grants, Measuring and Improving the Quality of Care in Medicaid

Announcement Type: Initial

Funding Opportunity Number: CMS-1F1-12-001

Catalog of Federal Domestic Assistance (CFDA) Number: 93.609

Key Dates:

Date of Issue: July 13, 2012

Letter of Intent Due Date: July 31, 2012

Application Due Date: August 31, 2012

Anticipated Notice of Award: October 31, 2012

Period of Performance: October 31, 2012 – October 30, 2014. Please note that the period of performance is divided into two fiscal budget periods that last for 12 months each.

Applicant's Teleconference:

Information regarding the date, time (Eastern Daylight Time) and call-in number for an open applicants' teleconference is available on the CMS website at

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-%E2%80%93-Performance-Measurement.html>. Please check the Medicaid.gov website for additional details.

I. FUNDING OPPORTUNITY DESCRIPTION

1. Purpose

The Patient Protection and Affordable Care Act (The Affordable Care Act) will extend coverage to millions of the nation's uninsured population, and includes provisions focused on improving access, affordability and the overall quality of care for all Americans. The overarching goal of this funding opportunity is to support States in developing their capacity for standardized collection and reporting of data on the quality of health care provided to adults covered by Medicaid. It also seeks to strengthen States' analytic capacity to use the data in measuring and improving the quality of care for the approximately 30 million adults currently enrolled in Medicaid.

The Affordable Care Act, Title II, Subtitle I, *Improving the Quality of Medicaid for Patients and Providers*, section 2701, made available \$300 million for Adult Health Quality Measures, of which \$112 million will be used for this funding opportunity. Specifically, up to \$56 million will be awarded each fiscal year (FY) over a 2-year period of performance. A total of 56 grant awards are available in the amount of up to \$1 million for each 12-month budget period (an estimated total of up to \$2 million per Grantee) over the two-year project period. The remainder of any funds appropriated for adult Medicaid quality measurement is intended to fund other adult Medicaid quality measurement activities, including technical assistance to States. Under this funding opportunity, there is no required State match.

Any effort focused on improving the quality of health care must begin with performance measurement. Identification of the initial core set of health care quality measures for Medicaid-eligible adults is an important first step in an overall strategy to encourage and enhance quality improvement. The Centers for Medicare & Medicaid Services (CMS) published this Initial Core Set of Measures via Federal Register Notice on January 4, 2012 (77 FR 286) signifying an important step toward better understanding, at both the State and national-level, the quality of health care delivered to Medicaid covered adults.

<https://www.federalregister.gov/articles/2012/01/04/2011-33756/medicaid-program-initial-core-set-of-health-care-quality>).

As such, this grant opportunity will be open to all 56 State Medicaid agencies to support testing, collecting, and reporting the Initial Core Set Measures to CMS. Additionally, the grant funding will also support States' efforts to use this data for improving the quality of care for adults covered by Medicaid. By "State," we refer to the definition provided under 45 CFR §74.2 as "any of the several States of the U.S., the District of Columbia, the Commonwealth of Puerto Rico, any territory or possession of the U.S., or any agency or instrumentality of a State exclusive of local governments." By "territory or possession" we mean Guam, the U. S. Virgin Islands, American Samoa, and the Commonwealth of the Northern Mariana Islands.

Each participating State Medicaid grantee will be required to implement a grant project with the following three aims:

1. Testing and evaluating methods for collection and reporting of the Initial Core Set Measures (See Appendix D) in varying delivery care settings (e.g. managed care, fee-for-service, long term care settings such as nursing homes and intermediate care facilities). States are encouraged to demonstrate alignment with existing methods and infrastructures for collection and reporting [e.g., Health Information Technology for Economic and Clinical Health (HITECH), Medicaid Management Information Systems (MMIS)];
2. Developing staff capacity to report the data, analyze, and use the data for monitoring and improving access and the quality of care in Medicaid; and

3. Conducting at least two Medicaid quality improvement projects¹ related to the Initial Core Set Measures. States are encouraged to consider alignment with CMS or other Federal quality improvement activities such as the National Quality Strategy, Strong Start Initiative, Partnership for Patients, Million Hearts Initiative, etc.

The information and lessons learned through these grant activities will be used by CMS to provide guidance and best practices to all Medicaid agencies on collecting, reporting, and using the quality measures to drive quality improvement. Further, data collected through this grant will be publically reported by CMS in the same manner as data submitted by States on the Initial Core Set of Children’s Health Care Quality Measures (e.g. annual Secretary’s Reports, Reports to Congress). Included is a detailed description of the funding opportunity, to include eligibility requirements, award information, application and submission information, and the application review criteria.

2. Authority

This grant is being issued under the authority of Affordable Care Act, Section 2701, *Adult Health Quality Measures*, which added section 1139B of the Social Security Act (Act) directing the Secretary of Health and Human Services (HHS) to identify an initial core set of quality measures that could be used to monitor and improve the care provided to adults covered by Medicaid. This authority was established in the same manner as the child health quality measures efforts under section 1139A of the Social Security Act, which provided for quality improvement demonstrations.

3. Background

Recent Federal legislative authorities have focused on improving the quality of care provided to children and adults covered by Medicaid and the Children’s Health Insurance Program (CHIP). In 2009, Title IV of the Children’s Health Insurance Program Reauthorization Act (CHIPRA) created health care quality initiatives for both the CHIP and Medicaid programs. It included provisions directing the Secretary of HHS to identify and publish an initial core set of quality measures for children; establish a pediatric quality measures program, provide technical assistance to States; produce a new model electronic health record (EHR) format for children; implement demonstration projects on quality improvement and health information technology (HIT) for children; and conduct a study to report to Congress on pediatric health and health care quality measures.

The Affordable Care Act, enacted a year later in 2010, builds upon CHIPRA’s efforts to improve health care quality through a variety of provisions focused on improving access, affordability and overall health care quality for all Americans. In particular, Section 2701 of the Affordable Care Act mirrors many of the quality provisions in CHIPRA and underscores the need to improve how health care quality is measured and monitored – this time for adults. This section of the

¹ Examples of approaches to quality improvement projects can be found at: <http://www.ahrq.gov/qual/qualix.htm> and <http://www.healthcare.gov/compare/partnership-for-patients/resources/bibliography.html>

Affordable Care Act creates a broad imperative to improve the quality of care for adults covered by Medicaid that is underpinned by a focus on health care quality measurement. The Affordable Care Act directs the Secretary of HHS to identify and publish an initial core set of quality measures for adults eligible for Medicaid; establish a Medicaid health care quality measures program; report to Congress on adult health care quality measures; and annually report State-specific quality of care measures applied under Medicaid.

In late 2012, CMS will launch a national technical assistance and analytic support program similar in design to the technical assistance program available for States collecting and reporting the Initial Core Set of Children's Health Care Quality Measures.² The adult core measures technical assistance program will be available for all States regardless of whether they are grantees of this funding opportunity. The technical assistance program will be centered around providing guidance to all States in order to increase the feasibility of voluntary reporting on the Initial Core Set Measures. The technical assistance and analytic support will be provided through a variety of vehicles, including a technical assistance mailbox for specific Initial Core Set Measure questions; one-on-one assistance to States; and technical assistance tools (e.g., technical specification manuals, webinars, issue briefs). The technical assistance will help CMS and States to identify strategies for more efficient and effective performance measurement within and across Medicaid programs at the State-level.

Using the resources and authorities afforded to CMS through the Affordable Care Act, CMS is committed to working with States to improve health care quality for all adults in Medicaid and to better measure how that health care is provided.

Medicaid Quality of Care -What We Know Today

System-wide improvements in health care quality require standardized quality data that provide a comprehensive picture about the performance of the health system in the provision of health care for adults in Medicaid. National standardized data on the quality of health care provided by States to adults in Medicaid programs does not currently exist.

In 2008, CMS contracted with the National Committee for Quality Assurance (NCQA) to provide CMS, State Medicaid agencies and other stakeholders with an analysis of quality measures and a set of standardized and validated performance benchmarks. The project augmented NCQA's Quality Compass® database of health plan Healthcare Effectiveness Data and Information Set (HEDIS®) information with additional compatible data from States. Quality Compass data are annually submitted by health plans through NCQA's standard HEDIS data submission process. Although the study included an analysis of the quality of care delivered by only Medicaid managed care plans, it identified significant differences in regional performance results, and assessed regional performance against national benchmarks over three years of data.

² Information about CMS' Technical Assistance and Analytic Support Program for the Initial Core Set of Children's Health Care Quality Measures can be found at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/CHIPRA-Initial-Core-Set-of-Childrens-Health-Care-Quality-Measures.html>.

Key findings:

- Variations in States' methodological approaches to collecting HEDIS measure data decreases the ability to analyze data across States.
- Since States maintain the authority to decide which performance measures Medicaid health plans report, there are often variations in what is collected and reported on an annual basis.
- While HEDIS reporting captures the quality of care in managed care, it may leave out the segments of the Medicaid population covered by other care delivery mechanisms.
- States range in the availability of resources and expertise to effectively collect quality measures and use them for quality improvement purposes.

More recently, the experience of the two years of voluntary reporting for the Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP revealed some of the challenges States face in collecting, reporting, and using quality measures to monitor and improve care. These challenges include budgetary constraints and limited staff capacity to collect, report, and analyze the Initial Core Set of Children's Measures. This experience supports the need for a more systematic and focused effort to support States as CMS extends voluntary standardized quality measurement reporting to adults covered by Medicaid.

Through these grant funds, CMS will help make available (e.g. through public reports such as the annual Secretary's report required by the Affordable Care Act) for the first time more robust health care quality data than ever before. Further, CMS will be better able to understand the value and potential uses of the Initial Core Set Measures, as Grantee States will test and evaluate the collection and reporting of these measures and share that information with CMS. Using quality measurement as a starting point, data collected through each State's grant activities will be used to identify opportunities to improve health care quality for particular segments of the adult population enrolled in Medicaid (e.g., adults with mental health problems, adults with chronic conditions such as diabetes) and to drive changes in care practices and delivery accordingly. Further, States receiving grants under this funding opportunity will be encouraged to align identified quality improvement activities and goals that support use of the Initial Core Set Measures with the National Quality Strategy priorities and/or CMS led quality improvement initiatives.³

4. Program Requirements

All State Medicaid Agencies are eligible to apply for this grant opportunity. Through this grant opportunity, States will focus on collecting and reporting the Core Measures and using this data to make tangible improvements in health care quality for adults covered by Medicaid. As part of

³ Report to Congress: National Strategy for Quality Improvement in Health Care, April 2012. Accessible: <http://www.ahrq.gov/workingforquality/nqs/nqs2012annlrpt.pdf>

this grant opportunity, States will be required to work with their partners, including hospitals, other providers, Departments of Public Health, and other relevant stakeholders to obtain the necessary data and to develop the infrastructure needed to meet the following three aims of the grant over the course of the two year grant project:

1. Test and evaluate methods for collection and reporting of the Initial Core Set Measures (See Appendix D) in varying delivery care settings (e.g. managed care, fee-for-service, long term care settings such as nursing homes and intermediate care facilities). States are encouraged to demonstrate alignment with existing methods and infrastructures for collection and reporting (e.g., HITECH, MMIS);
2. Develop staff capacity to report the data, analyze, and use the data for monitoring and improving access and the quality of care in Medicaid; and
3. Conduct at least two Medicaid quality improvement projects related to Initial Core Set Measures. Since several of the Initial Core Set Measures align with other CMS and Federal quality improvement initiatives (e.g., the National Quality Strategy, Strong Start Initiative, Partnership for Patients, and Million Hearts Initiative), States are encouraged to use this grant opportunity to further support their participation in these activities.

Potential grantees are asked to submit an actionable, detailed operational plan for collecting the Initial Core Set of Measures, developing the infrastructure and staff resources to implement this work, and strategies for using the data to drive quality improvement. The operational plan must include timelines for collecting and analyzing the measures, and a detailed approach to the quality improvement projects, including baseline information. Additionally, as States develop the operational plan and carry out the three aims of the grant they will need to consider the following:

- States may use grant funds to improve data validation methods/initiatives, evaluate data sources and measures, and train and educate providers in collecting and reporting the Initial Core Set Measures.
- States may use funds for staff training in the use of tools for collecting and analysis of data from claims, surveys, medical records, or encounter records.
- States may use the grant funding to develop a plan to sustain collection of the Initial Core Set Measures beyond the grant period.
- States must design and implement at least two Medicaid quality improvement projects related to Initial Core Set Measures in the first 12 months. States are required to maintain implementation of the quality improvement projects over the entire two-year grant period.
- States must collect and report to CMS at least 15 of the Initial Core Set Measures in the second year of the grant. Grantees are asked to demonstrate how they plan to use data collected through these measures to drive quality improvement.

- States must, over both years, begin developing their capacity to collect individual data and begin testing their ability to stratify at a minimum three of the following four measures by at least two of the following demographic categories: race/ethnicity, gender, language, urban/rural, and disability status. States will stratify, at a minimum, three of the following measures to evaluate disparities:
 - Comprehensive Diabetes Care: Hemoglobin A1c Testing
 - Prenatal and Postpartum Care: Postpartum Care Rate
 - Controlling High Blood Pressure
 - Cervical Cancer Screening

Proposed timeline of reporting for Grantees (dates are tentative):

1st Year of Grant Award

Period of Performance: October 31, 2012 to October 30, 2013

- Semi-annual progress report due May 30, 2013
- Annual progress report due November 30, 2013

2nd Year of Grant Award

Period of Performance: October 31, 2013 to October 30, 2014

- January 2014 - Performance measurement data submitted to CMS on least 15 Initial Core Measures
- Semi-annual progress report due May 30, 2014
- Final report addressing the entire two year grant period (October 31, 2012 to October 30, 2014) is due January 30, 2015

II. AWARD INFORMATION

1. Total Funding

In total, \$112 million has been designated for this funding opportunity. Grants will be awarded with consideration to: (1) available funding; and (2) the quality of each application and the applicants' demonstrated ability to meet the goals of the project. Awardees may not receive the total award requested and may be asked to revise the work plan and budget to reflect the award.

2. Award Amount

Approximately \$56 million could be awarded each fiscal year over the two-year period of performance (2012 through 2014) to implement this grant program. A total of up to 56 grants

could be awarded to States, the District of Columbia, and the US Territories. Grant awards may be up to \$1 million for each 12-month budget period, with an estimated total of up to \$2 million per Grantee over the two-year project period.

3. Anticipated Award Date

The anticipated award date is October 31, 2012.

4. The Period of Performance

Upon notification of the grant award, States will receive an initial award for the first year or 12-months of program implementation to pursue the goals and objectives of the grant program. Non-competing continuation awards will be granted for the second year of the grant program contingent upon availability of funding, Grantee performance, and demonstrated implementation of at least two Medicaid quality improvement projects related to Initial Core Set Measures in the first year of the grant. If the State receives a second year of grant funding, it will be required to report on at least 15 of the Initial Core Set Measures to CMS in the second year of the grant, provide results of the stratification and an assessment of disparities using three of the four measures identified by CMS, and continue implementing at least two quality improvement projects. In the absence of funding, CMS is under no obligation to make additional awards under this program. The anticipated period of performance for the 2-year project period is October 31, 2012 through October 30, 2014.

5. Number of Awards

A maximum of 56 awards will be made.

6. Type of Award

These awards are structured as grants. CMS will periodically evaluate each Grantee's performance and ability to show demonstrated progress toward all three aims of the grant including collecting, reporting, and using the Initial Core Set Measures to drive quality improvement and identify health care disparities. **If a Grantee fails to meet the mutually agreed upon annual progress, CMS may rescind the grant award including all un-obligated balances.**

III. ELIGIBILITY INFORMATION

1. Eligible Applicants

Eligible applicants for this funding opportunity are limited to the 56 State Medicaid Agencies. The single State Medicaid Agency will lead the project. Only one application can be submitted for a given State. By "State," we refer to the definition provided under 45 CFR §74.2 as "any of the several States of the U.S., the District of Columbia, the Commonwealth of Puerto Rico, any territory or possession of the U.S., or any agency or instrumentality of a State exclusive of local governments." By "territory or possession" we mean Guam, the U. S. Virgin Islands, American Samoa, and the Commonwealth of the Northern Mariana Islands.

CMS expects that grant-funded activities would align with and not duplicate similarly-focused efforts, such as enhancements to the Medicaid Management Information System and associated data systems, health information exchange, and any meaningful use quality measure collection infrastructure developed for the administration of the Medicaid Electronic Health Record Incentive Program. As appropriate, there is an expectation that the State will coordinate with its Department of Public Health, other State agencies, and health care providers⁴ and hospitals, as necessary to ensure accurate and reliable data collection.

A letter or memorandum of agreement from any major partner that is not the lead agency is encouraged. An applicant should include all such letters as part of its application package as instructed in this solicitation (please see Section IV.2, Content and Form of Application Submission). CMS will disregard any letter received outside of the submitted application. Letters should be included as a PDF file as instructed in the requirements of the application submission.

Only one grant application can be submitted for a given State.

Eligibility Threshold Criteria:

- Application deadline: Applications not received electronically through www.grants.gov by the application deadline of August 31, 2012 will not be reviewed.
- Application requirements: Applications will be considered for funding only if the application meets the requirements as outlined in, Section III, Eligibility Information and, Section IV, Application and Submission Information.
- Page limit: The application must not be more than 40 pages in length, including the project narrative and the budget narrative (30 pages) and any supporting materials (10 pages available, if needed). The Standard Forms, Cover Letter, and Project Abstract are not included in the page limit. For more information, see Section IV.2, Content and Form of Application Submission.
- Dollar limit: Applications will be considered for funding only if the preliminary budget proposed is within the range presented in Section II. Award Information.

⁴ These providers may include primary, secondary and tertiary health providers (including Federally Qualified Health Centers and Rural Health Clinics, maternal and child health clinics, hospitals (including Medicaid disproportionate share hospitals); other primary and specialized care professionals (including members of the allied health professions); Tribal providers, behavioral health professionals; Medicaid managed care plans, primary care case management providers (PCCMs), medical groups, independent physician associations and quality improvement collaborative that include these providers.

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

Legal Status: All applicants must have a valid Employer Identification Number (EIN) assigned by the Internal Revenue Service.

Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS number): All applicants must have a Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number in order to apply. The DUNS number is a nine-digit identification number that uniquely identifies business entities. Obtaining a DUNS number is easy and free. To obtain a DUNS number, access the following website: www.dunandbradstreet.com or call 1-866-705-5711. See Section IV, Application and Submission Information, for more information on obtaining a DUNS number.

Central Contractor Registration (CCR) Requirement: All awardees must provide DUNS and EIN numbers in order to be able to register in the Central Contractor Registration (CCR) database at www.ccr.gov. Applicants must successfully register with CCR prior to submitting an application or registering in the Federal Funding Accountability and Transparency Act Subaward Reporting System (FSRS) as a prime awardee user. See Section IV, Application and Submission Information, for more guidance on CCR registration. Prime awardees must maintain a current registration with the CCR database, and **may make subawards only to entities that have DUNS numbers**. Organizations must report executive compensation as part of the registration profile at www.ccr.gov by the end of the month following the month in which this award is made, and annually thereafter (based on the reporting requirements of the Federal Funding Accountability and Transparency Act (FFATA) of 2006 (Pub. L. 109-282), as amended by section 6202 of Public Law 110-252 and implemented by 2 CFR Part 170)). See Section VI, Award Administration Information, for more information on FFATA.

The Grants Management Specialist assigned to monitor the sub-award and executive compensation reporting requirements is Iris Grady, who can be reached at [division of grantsmanagement@cms.hhs.gov](mailto:division_of_grantsmanagement@cms.hhs.gov).

2. Cost Sharing or Matching

Grantees are not required to make a State match contribution.

3. Foreign and International Organizations

Foreign and international organizations are not eligible to apply for this funding opportunity.

4. Faith Based Organizations

Faith based organizations are not eligible to apply for this funding opportunity.

5. Other

Letter of Intent to Apply

Applicants are encouraged to submit a non-binding Letter of Intent to Apply. Letters of Intent to Apply are not required and their submission or failure to submit a letter has no bearing on the scoring of proposals received. Receipt of such notices enables CMS to better plan for the application review process. These may be submitted in any format; however, a sample is included in Section VIII, Appendices, Appendix A. Letters of Intent to Apply are due July 31, 2012, and should be emailed to Mark Smith at mark.smith@cms.hhs.gov.

IV. APPLICATION AND SUBMISSION INFORMATION

1. Address to Request Application Package

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

It is recommended that a Letter of Intent be submitted by 11:59 pm on July 31, 2012. The purpose of the Letter of Intent is to estimate the number of applications and enable CMS to plan its review process. The signed Letter of Intent must be submitted via e-mail to Mark Smith at mark.smith@cms.hhs.gov.

Application materials will be available for download at <http://www.grants.gov>. Please note that HHS requires applications for all announcements to be submitted electronically through <http://www.grants.gov>. For assistance with [grants.gov](http://www.grants.gov), contact support@grants.gov or call 1-800-518-4726. At <http://www.grants.gov>, applicants will be able to download a copy of the application packet, complete it off-line, and then upload and submit the application via the Grants.gov website. The Funding Opportunity Announcement can also be viewed on HHS's website at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-%E2%80%93-Performance-Measurement.html>.

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

- You can access the electronic application for this project at <http://www.grants.gov>. You must search the downloadable application page by the CFDA number **93.609**.
- At the <http://www.grants.gov> website, you will find information about submitting an application electronically through the site, including the hours of operation. HHS strongly recommends that you do not wait until the application due date to begin the application process through <http://www.grants.gov> because of the time needed to complete the required registration steps.
- All applicants under this announcement must have an Employer Identification Number (EIN) to apply. **Please note, the time needed to complete the EIN registration process is substantial, and applicants should therefore begin the process of obtaining an EIN**

immediately upon posting of this FOA to ensure this information is received in advance of application deadlines.

- All applicants, as well as sub-recipients, must have a Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number at the time of application in order to be considered for a grant or cooperative agreement. A DUNS number is required whether an applicant is submitting a paper application (only applicable if a waiver is granted) or using the Government-wide electronic portal, www.Grants.gov. The DUNS number is a nine-digit identification number that uniquely identifies business entities. Obtaining a DUNS number is easy and free. To obtain a DUNS number, access the following website: www.dunandbradstreet.com or call 1-866-705-5711. This number should be entered in the block with the applicant's name and address on the cover page of the application (Item 8c on the Form SF 424, Application for Federal Assistance). The name and address in the application should be exactly as given for the DUNS number. **Applicants should obtain this DUNS number as soon as possible after the announcement is posted to ensure all registration steps are completed in time.**
- The applicant must also register in the Central Contractor Registration (CCR) database in order to be able to submit the application. Applicants are encouraged to register early and must have their DUNS and EIN numbers in order to do so. Information about CCR is available at <http://www.ccr.gov>. The Central Contractor Registration process is a separate process from submitting an application. **You should allow a minimum of five business days to complete CCR registration; however, in some cases, the registration process can take approximately two weeks or longer to be completed. Therefore, applicants should begin the CCR registration process as soon as possible after the announcement is posted to ensure that it does not impair your ability to meet required submission deadlines.**
- Authorized Organizational Representative: The Authorized Organizational Representative (AOR) who will officially submit an application on behalf of the organization must register with Grants.gov for a username and password. AORs must complete a profile with Grants.gov using their organization's DUNS Number to obtain their username and password at http://grants.gov/applicants/get_registered.jsp. AORs must wait one business day after successful registration in CCR before entering their profiles in Grants.gov. **Applicants should complete this process as soon as possible after successful registration in CCR 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 POC will receive an email notification. The email address provided in the profile will be the email used to send the notification from Grants.gov to the E-Biz POC with the AOR copied on the correspondence.
- The E-Biz POC must then login to Grants.gov (using the organization's DUNS number for the username and the special password called "M-PIN") and approve the AOR, thereby providing permission to submit applications.

- **Any files uploaded or attached to the Grants.Gov application must be PDF file format and must contain a valid file format extension in the filename. Even though Grants.gov allows applicants to attach any file format as part of their application, CMS restricts this practice and only accepts PDF file formats. Any file submitted as part of the Grants.gov application that is not in a PDF file format, or contains password protection, will not be accepted for processing and will be excluded from the application during the review process. In addition, the use of compressed file formats such as ZIP, RAR, or Adobe Portfolio will not be accepted. The application must be submitted in a file format that can easily be copied and read by reviewers. It is recommended that scanned copies not be submitted through Grants.gov unless the applicant confirms the clarity of the documents. Pages cannot be reduced in size, resulting in multiple pages on a single sheet, to avoid exceeding the page limitation. All documents that do not conform to the above constraints will be excluded from the application materials during the review process.**
- After you electronically submit your application, you will receive an automatic email from <http://www.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. Rather, this email is only an acknowledgement of receipt of the application by Grants.gov.** All applications 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 the application is not accepted, then the applicant will receive a subsequent notice from Grants.gov indicating that the application submission has been rejected. **Applicants should not wait until the application deadline to apply because notification by Grants.gov that the application is incomplete may not be received until close to or after the application deadline, eliminating the opportunity to correct errors and resubmit the application. Applications submitted after the deadline because the original submission failed validation and is therefore rejected by Grants.gov, as a result of errors on the part of the applicant, will not be accepted by CMS and/or granted a waiver.** For this reason, CMS recommends that applicants apply in advance of the application due date and time.
- After HHS retrieves your application package from Grants.gov, a return receipt will be emailed to the applicant contact. This will be in addition to the validation number provided by Grants.gov.
- Each year organizations and entities registered to apply for Federal grants through <http://www.grants.gov> will need to renew their registration with the Central Contractor Registration (CCR). You can register with the CCR online; registration will take about 30 minutes to complete (<http://www.ccr.gov>). **Failure to renew CCR registration prior to application submission will prevent an applicant from successfully applying.**

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

All grant applications must be submitted electronically and be received through <http://www.grants.gov> by 5:00 pm Eastern Daylight Time on August 31, 2012.

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

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 Central Contractor Registration (CCR), registering as an Authorized Organizational Representative (AOR), obtaining an Employer Identification Number (EIN), completing Grants.gov registration, as well as requested 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:

- Search for the application package in Grants.gov by entering the CFDA number. This number is located on the first page of this announcement.
- Paper applications are not the preferred method for submitting applications. However, if you experience technical challenges while submitting your application electronically, please contact Grants.gov Support directly at: www.grants.gov/customer-support or (800) 518-4726. Customer Support is available to address questions 24 hours a day, 7 days a week (except on Federal holidays).
- Upon contacting Grants.gov, obtain a tracking number as proof of contact. The tracking number is helpful if there are technical issues that cannot be resolved and a waiver from the agency must be obtained.
- If it is determined that a waiver is needed, you must submit a request in writing (emails are acceptable) to Michelle.Feagins@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 should be sent directly to the Division of Grants Management Division and received by the application due date.

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

A. 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.
- The narrative portions of the application must be **DOUBLE-SPACED**.
- The project abstract is restricted to a one-page summary which should be single-spaced.
- Applications must not be more than 40 pages in length including the project narrative and the budget narrative (30 pages) and any supporting materials (10 pages available, if needed). Standard forms, the Cover Letter, and the Project Abstract are not included in the page limit. The total size of all uploaded files may not exceed a total file size of 10 MB.

B. Overview of Grant Application Structure and Content

i. Standard Forms

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

- SF 424: Official Application for Federal Assistance (see note below)
- SF 424A: Budget Information Non-Construction
- SF 424B: Assurances-Non-Construction Programs

SF LLL: Disclosure of Lobbying Activities
Project Site Location Form(s)

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

- Item 15 “Descriptive Title of Applicant’s Project.” Please indicate in this section the name of this grant: Adult Medicaid Quality Grant
- Check “No” to item 19c, as Review by State Executive Order 12372 does not apply to these grants.

ii. Cover Letter

A letter from the State Medicaid Director identifying the Medicaid agency applicant as the lead organization, indicating the title of the project, the principal contact person, amount of funding requested, and the name of the division within the State Medicaid agency that will administer the grant and all major partners, departments, divisions, services, and organizations actively collaborating in the project is required.

This letter should be addressed to:

Michelle Feagins
Grants Management Officer
Centers for Medicare and Medicaid Services
Office of Acquisition and Grants Management
200 Independence Ave., S.W.
Room 733H-02
Washington, DC 20201

iii. Project Abstract (maximum of one page)

The one-page abstract (single-spaced) should serve as a succinct description of the proposed project and should include the goals of the project, the total budget, and a description of how the grant will be used. The abstract is often distributed to provide information to the public and Congress, so please write the abstract so that it is clear, accurate, concise, and without reference to other parts of the application. Personal identifying information should be excluded from the abstract.

iv. Project Narrative

The application is expected to address how the State will (1) test and evaluate methods for collection and reporting of the Initial Core Set Measures in varying delivery care settings (e.g. managed care, fee-for-service, long term care settings such as nursing homes and intermediate care facilities); (2) develop staff capacity to report the data, analyze, and use the data for monitoring and improving access and the quality of care in Medicaid; and (3) conduct at least two Medicaid quality improvement projects related to the Initial Core Set Measures. In the development of these quality improvement activities, States are encouraged to consider alignment with CMS or other Federal quality improvement activities such as the National Quality Strategy, Strong Start Initiative, Partnership for Patients, Million Hearts Initiative, etc.

The required elements (sections) of the project narrative are outlined below. Also, provided is a brief description of the type of information that is required to be addressed within each specific section.

- Organization and Administration – The application must include a description of the organizational and structural administrations that will be in place to implement, monitor, and operate the grant program. The tasks to be conducted by each administrative component must also be described. The application should document the State’s ability to successfully implement the proposed program. The application should describe State activity related to the grant including a description of other HHS grant funding the applicant has received that is related to quality measurement (e.g., Electronic Health Record Incentive Program, CHIPRA Quality Demonstration Grants). It should document how the proposed activities will complement, not duplicate, activities currently funded by prior CMS grants, other grants, and/or cooperative agreements and how the grant activities will interact with other legislative efforts. Applicants must also include an organizational chart for the entity that is responsible for the management of this grant. Describe the relationship between that entity and all other departments, agencies, and service systems that will play a role in collecting information or data related to the measurement and evaluation of care and services under the grant program.

- Narrative Staffing Plan –
 - The number, title, and, if known, the names of staff that will be dedicated to the grant program.
 - Percentage of time each individual/position is dedicated to the grant.
 - Brief description of roles/responsibilities of each position
 - For each position, the percentage of that individual’s work that represents in-kind support.
 - Number of contracted individuals supporting the grant.
 - A resume of the proposed Project Manager.

- Operational Plan –
 - Document current information about quality measurement within the State and anticipated impact of this project.
 - Implementation Plan: Describes specific grant objectives and activities, defines specific milestones, and includes start and end dates. Assigns all tasks to a task owner or party accountable for accomplishing the task, and addresses his/her qualifications to perform the task. Management Plan: Describes how the overall project will be managed, including a plan for communication among task leaders. Monitoring: Identifies quantifiable interim steps toward achieving goals that will serve as the basis for measuring progress.
 - Stakeholder involvement in the proposal and program – The application must list the consumer/advocacy groups conferred with while developing the proposal and describe the State’s method for involving stakeholders in the implementation of the grant program, and its method for continuing involvement throughout the life of the program.

- Reporting and Evaluation –
 - The application must include a description of the State’s plan for collecting, reporting, and otherwise producing the data, information, and analysis required to be provided to CMS.
 - The application must include detailed information on the State’s evaluation plan, if any, including evaluation design for process assessment and outcome evaluation, variables, and data sources.
 - The tentative deadline for reporting of the adult quality new measures is listed below. CMS will provide information on the reporting format during 2012.
 - January 2014 Initial Core Measures reporting deadline

v. Budget and Budget Narrative

a. Budget SF424A

All applicants must submit a SF424A. For the budget recorded on form SF 424A, the instructions outlined below should be followed, in addition to reviewing the general instructions provided for the SF424A.

Section A – Budget Summary

Grant Program Function or Activity (column a) = Enter “Adult Medicaid Quality Grant” in row 1.

New or Revised Budget, Federal (column e) = Enter the Total Federal Budget Requested for the 2-year project period in rows 1 and 5.

New or Revised Budget, Non-Federal (column f) = Enter Total Amount of any Non-Federal Funds Contributed (if applicable) in rows 1 and 5.

New or Revised Budget, Total (column g) = Enter Total Budget Proposed in rows 1 and 5, reflecting the sum of the amount for the Federal and Non-Federal Totals.

Section B – Budget Categories

Enter the total costs requested for each Object Class Category (Section B, number 6) for each year of the 2-year project period.

Column (1) = Enter the heading for this column as Year 1. Enter Year 1 costs for each line item (rows a-h), including the sum of the total direct charges (a-h) in row i. Indirect charges should be reflected in row j. The total for direct and indirect charges for all year 1 line items should be entered in column 1, row k (sum of row i and j).

Column (2) = Enter the heading for this column as Year 2. Enter Year 2 costs for each line item (rows a-h), including the sum of the total direct charges (a-h) in row i. Indirect charges should

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

Column 5 = Enter total costs for all years of the project period for each line item (rows a-h), direct total costs (row i), and indirect costs (row j). The total costs for all line items for the two years should be entered in row k (sum of row i and j). The total in column 5, row k should match the total provided in Section A - Budget Summary, New or Revised Budget, column g, row 5.

b. Budget Narrative

The Budget Narrative must include a yearly breakdown of costs for the 2-year project period. Specifically, the Budget Narrative should provide a detailed cost breakdown for each line item outlined in the SF424A by grant year, including a breakdown of costs for each activity/cost within the line item. The proportion of grant funding designated for each grant activity should be clearly outlined and justify the State's readiness to receive funding through 2014 including complete explanations and justifications for the proposed grant activities. The budget must separate out funding that is administered directly by the lead agency from funding that will be used by any entity other than the lead agency.

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

- Personnel
- Fringe benefits
- Contractual costs, including subcontract contracts
- Equipment
- Supplies
- Travel
- Indirect charges, in compliance with the Code of Federal Regulations. If requesting indirect costs in the budget, a copy of the indirect cost rate agreement is required.
- Other costs (can include infrastructure, data collection, and data analysis costs)

Submissions must identify a Project Manager responsible for the overall project. It is recommended that each grantee either dedicate a full-time Project Manager whose salary will be 100% paid through grant funds by either hiring or voluntarily utilizing a Staff employee to dedicate time as a Project Manager through an in-kind contribution. This grant award will not reimburse costs of a Project Manager if that Project manager is an independent contractor or is hired and/or paid through an independent contractor.

The Budget Narrative should also outline the strategies and activities of the grant program, the cost of a full-time Project Manager should the State choose to hire one, and cost breakdowns for any contracts that will be implemented to achieve the anticipated outcomes.

The Budget Narrative should clearly distinguish the funding source of any given activity/cost, as either Federal or Non-Federal. Applicants should pinpoint those costs funded through in-kind contributions. Applicants must include detailed salary and fringe benefit costs for State staff dedicated to this project through an in-kind contribution. Applicants must also include yearly salary costs and the percentage of time dedicated to this project (for any given year). For example, if a State employee regularly makes \$75,000 a year and will dedicate 50% of his/her time to this project for Year 1 (as an in-kind contribution) then the Budget Narrative should include a formula to indicate this, such as $(\$75,000 \times 50\%) = \$37,500$.

Completion of the Budget Form SF424A remains a requirement for consideration of your application. This Estimated Budget and Budget Narrative are an important part of your proposal and will be reviewed carefully by HHS staff.

c. Additional Cost Considerations

All grantees will be required to budget for two representatives from the grantee team to attend an annual Medicaid/CHIP quality conference in the Washington, DC or Baltimore, MD area sponsored by CMS. Therefore, applicants' budgets must include travel funds for two people to attend this annual CMS-sponsored conference in the Washington, DC or Baltimore, MD area.

vi. Letter(s) or Memorandum of Agreement(s) – Optional

All grantees are encouraged to submit a letter or memorandum of agreement from any major partner that is not the lead agency. An applicant should include all such letters as part of its application package as instructed in this solicitation. CMS will disregard any letter received outside of the submitted application. Letters should be included as a PDF file as instructed in the requirements of the application submission.

3. Submission Dates and Times

Letter of Intent to Apply

Voluntary Letters of Intent to Apply are due by July 31, 2012 and should be e-mailed to Mark Smith, Project Officer at mark.smith@cms.hhs.gov. It is not mandatory for an applicant to submit a Letter of Intent to Apply; however, such submissions help CMS plan its review process, including its review panels. Submission of a Letter of Intent to Apply does not bind the applicant to apply; nor will it cause a proposal to be reviewed more favorably. The sample Letter of Intent to Apply is located in Section VIII, Appendices, Appendix A.

Grant Applications

All grant applications are due by August 31, 2012. Applications submitted through <http://www.grants.gov> by 5:00 p.m. Eastern Daylight time on August 31, 2012 will be

considered “on time.” All applications will receive an automatic time stamp upon submission and applicants will receive an e-mail reply acknowledging the application’s receipt.

All grant awards have an anticipated award date of October 31, 2012. All grants will have an initial budget period of 12 months.

4. Intergovernmental Review

Applications for these grants 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 grants.

5. Funding Restrictions

Indirect Costs

If requesting indirect costs, a currently effective 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.

Direct Services

Grant funds may not be used to furnish direct services to Medicaid service recipients. Please note, however, that direct services do not include:

- Expenses budgeted for provider and/or consumer task force member conferences; and
- Attendance at technical assistance conferences sponsored by CMS; or
- National technical assistance provided for the benefit of all States.

Reimbursement of Pre-Award Costs

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

Prohibited Uses of Grant Funds

1. To match any other Federal funds.

2. To provide services, equipment, or support 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.
3. To provide infrastructure for which Federal Medicaid matching funds are available at the 90 / 10 matching rate, such as certain information systems projects.
4. To supplant existing Federal, State, local, or private funding of infrastructure or services, such as staff salaries, etc.

V. APPLICATION REVIEW INFORMATION

In order to receive a grant under this funding opportunity announcement, applicants must submit an application, in the required format, no later than the deadline dates.

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 grant.

As indicated in Section IV, *Application and Submission Information*, all applicants must submit the following:

1. Standard Forms
2. Cover Letter
3. Project Abstract
4. Project Narrative
5. Budget and Budget Narrative

1. Criteria

This section fully describes the evaluation criteria for this grant program. 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, of this solicitation. The following criteria will be used to evaluate applications received in response to this solicitation. Applications will be scored with a total of 100 points available.

A. Design of Grant Program (30 points)

The proposed grant program is well-designed and likely to succeed in: (1) testing and evaluating the collection, reporting and using of the Initial Core Set of Quality Measures for Medicaid-eligible adults; (2) developing staff capacity to report, analyze, and use the data for monitoring and improving access and the quality of care in Medicaid; and (3) conducting at least two Medicaid quality improvement efforts related to the Initial Core Set Measures. Further, the proposal effectively demonstrates how the State will enhance the related data infrastructure

activities; partner with organizational entities (e.g., Department of Public Health, hospitals, health care providers, other publicly financed health programs) needed to collect and report the Initial Core Set Measures to CMS by January 2014; and conduct related quality improvement activities. The proposal also outlines a plan for collecting and reporting information needed for an analysis of data on disparities (e.g., race/ethnicity, language). The proposal shall be comprehensive, feasible and define specific milestones.

B. Administration and Organization (25 points)

The proposed grant program demonstrates plans for effective administration of the grant program and coordination with other relevant State initiatives. The State has a documented ability to successfully implement the proposed program as determined by legislative support and system readiness. The State also has effectively demonstrated how it will partner closely with its Department of Public Health, provider groups, managed care entities and others as necessary to collect and report the Initial Core Measures. The grant program partners should also have administrative ability to carry out the grant program. Tasks for implementation, the organizations accountable for accomplishing each task, and each organization's ability to perform the task are fully described and explained.

C. Staffing and Budget (20 points)

The staff proposed to lead the grant program has the skills and experience needed to assure smooth and effective implementation. The proposed budget is carefully developed, with plans for an efficient use of funds.

D. Plans for Data Collection (25 points)

The proposal includes plans for implementing the changes needed to ensure measurement collection processes, analyses, and tracking of related quality improvement outcomes. The Medicaid program will report clinical and quality data needed to support the analyses for Reports to the Secretary and Congress on improving the care for Medicaid beneficiaries. The proposal includes plans to track and report on data from the grant program on such issues as grant program participation, and effects of the grant program on utilization and outcomes.

2. Review and Selection Process

A team consisting of staff from HHS will review all applications. The review process will include the following:

- A. Applications will be screened to determine eligibility for further review using the criteria detailed in this solicitation. Applications received late or that fail to meet the eligibility requirements as detailed in the solicitation or do not include the required forms will not be reviewed.
- B. The results of the objective review of the applications by quality experts 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; reviews for programmatic and

grants management compliance; the reasonableness of the estimated cost to the government and anticipated results; and the likelihood that the proposed project will result in the benefits expected.

The Department reserves the right to conduct pre-award Budget Negotiations with potential awardees.

C. Successful applicants will receive one grant award issued under this solicitation.

3. Anticipated Announcement and Award Date

The anticipated award date is October 31, 2012.

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. The NoA is the document authorizing the grant award and will be sent through electronic mail to the applicant organization as listed on its SF 424. Any communication between CMS and applicants prior to issuance of the NoA is not an authorization to begin performance of a project.

Unsuccessful applicants are notified within 30 days of the final funding decision and will receive a disapproval letter via the U.S. Postal Service or electronic mail.

Federal Funding Accountability and Transparency Act (FFATA) subaward Reporting

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

2. Administrative and National Policy Requirements

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

- A. Specific cost principles and administrative requirements, as outlined in 2 CFR Part 225 and 45 CFR Part 92, apply to grants awarded under this announcement.
- B. All States receiving awards under this grant 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, and

- iv. 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 applicant's original grant application or agreed upon subsequently with HHS, and may not be used for any prohibited uses.
- D. Consumers and other stakeholders must have meaningful input into the planning, implementation, and evaluation of the project. All grant budgets must include some funding to facilitate participation on the part of individuals who have a disability or long-term illness and their families. Appropriate budget justification to support the request for these funds must be included.

3. Terms and Conditions

Grants issued under this FOA are subject to the *Health and Human Services Grants Policy Statement (HHS GPS)* at <http://www.hhs.gov/grantsnet/adminis/gpd/>. Standard terms and special terms of award will accompany the Notice of Award. Potential applicants should be aware that special requirements could apply to grant awards based on the particular circumstances of the effort to be supported and/or deficiencies identified in the application by the HHS review panel. The general terms and conditions that are outlined in Section II of the HHS GPS will apply as indicated unless there are statutory, regulatory, or award-specific requirements to the contrary (as specified in the Notice of Award).

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

4. Reporting

States are required to submit two semi-annual progress reports, an annual progress report, performance measurement data on at least 15 Initial Core Measures, and a final report to the CMS Project Officer. The semi-annual, annual, and final reports are to be submitted to CMS via e-mail. Content of the reports will be detailed in the Standard and Special Terms and Conditions, but will at a minimum include information such as:

- A. Semi-Annual Progress Reports (May 2013 and May 2014). The semi-annual progress reports should include information such as:
 - An assessment of overall project implementation, including lessons learned and best practices (May 2013 and 2014 semi-annual progress reports).

- Updates on progress towards collection, reporting, and analyses of data on the Initial Core Set Measures (May 2013 semi-annual progress report).
- Updates on progress towards analyses of data on the Initial Core Set Measures (May 2014 semi-annual progress report).
- Updates on progress towards stratifying at least three of the Initial Core Measures in order to identify and analyze disparities (May 2013 semi-annual progress reports).
- Updates on implementation, outcomes, and lessons learned from quality improvement projects (May 2013 and 2014 semi-annual progress reports).
- Identification of barriers to implementing the grant project (i.e., what were the barriers encountered and how were they addressed?) (May 2013 and 2014 semi-annual progress report).

B. Annual Progress Report (November 2013). The report should include information such as:

- The specific use(s) of the grant funds.
- Estimates of cost savings resulting from the grant-funded activities.
- To what degree did the grant achieve its purposes, aims, goals, objectives, and quantified targets related to the overall aims of the grant in the first year?
- What specific lessons were learned as a result of the first year of the grant program? What would you recommend to other States which may be interested in implementing a similar approach?
- Recommendations to CMS for using the Initial Core measures to drive quality improvement including: accuracy and usability of measurement specifications and methodologies provided by CMS as well as plans for quality improvement based on measurement results.
- Analyses of two (or more) quality improvement projects including effectiveness of the interventions used as well as baseline and measurement results. The report should also include information about reaching the quality improvement goal; challenges and lessons learned; sustainability of project; impact on clinical outcomes of Medicaid beneficiaries, and the potential for replicating the projects in other States. Technical assistance will be available to States interested in developing evaluation plans.
- Accomplishments of the first year of the grant project, overall lessons learned, challenges encountered in collecting and using the Initial Core Set Measures to improve the quality for adults in Medicaid.
- Assessment of progress in stratifying measures to identify disparities using, at a minimum, three of the four measures identified by CMS (listed below). The State is required to report on its progress with this activity including successes and challenges with producing stratification data on at least two of the following categories: race/ethnicity, gender, language, urban/rural, disability status.
 - Comprehensive Diabetes Care: Hemoglobin A1c Testing
 - Prenatal and Postpartum Care: Postpartum Care Rate

- Controlling High Blood Pressure
- Cervical Cancer Screening

C. Performance Measurement Data on Initial Core Measures (January 2014)

- Submit performance measurement data for at least 15 of the Initial Core Measures. States will provide CMS performance measurement data at a State-aggregated level through a CMS-specified reporting template which will be made available by November 2013. As part of this reporting requirement, States will adhere to the technical specifications as outlined in the CMS technical specifications manual that will be available to States by December 2012.

D. Final Report (January 2015). The reports should include information such as:

- The specific use(s) of the grant funds.
- Estimates of cost savings resulting from the grant-funded activities.
- To what degree did the grant achieve its purposes, aims, goals, objectives, and quantified targets related to the overall aims of the grant?
- What lessons were learned as a result of the grant program? What would you recommend to other States which may be interested in implementing a similar approach?
- Recommendations to CMS for using the Initial Core measures to drive quality improvement including: accuracy and usability of measurement specifications and methodologies provided by CMS as well as plans for quality improvement based on measurement results.
- Final analyses of two (or more) quality improvement projects including effectiveness of interventions used as well as baseline and final measurement results. The report should also include information about reaching the quality improvement goal; challenges and lessons learned; sustainability of project; impact on clinical outcomes of Medicaid beneficiaries, and the potential for replicating the projects in other States.
 - Accomplishments of the grant project during the two-year grant period, overall lessons learned, challenges encountered in collecting, reporting, and using the Initial Core Set Measures to improve the quality for adults in Medicaid.
 - Results of the stratification and an assessment of disparities using, at a minimum, three of the four measures identified by CMS (listed below). State is required to report stratification data on at least two of the following categories: race/ethnicity, gender, language, urban/rural, etc. States must evaluate and determine if disparities by their two demographic characteristics are static, widening or narrowing.
 - Comprehensive Diabetes Care: Hemoglobin A1c Testing
 - Prenatal and Postpartum Care: Postpartum Care Rate
 - Controlling High Blood Pressure
 - Cervical Cancer Screening

Proposed timeline of reporting for Grantees (dates are tentative):

1st Year of Grant Award

Period of Performance: October 31, 2012 to October 30, 2013

- Semi-annual progress report due May 30, 2013
- Annual progress report due November 30, 2013

2nd Year of Grant Award

Period of Performance: October 31, 2013 to October 30, 2014

- January 2014 - Performance measurement data submitted to CMS on least 15 Initial Core Measures
- Semi-annual progress report due May 30, 2014
- Final report addressing the entire two year grant period (October 31, 2012 to October 30, 2014) is due January 30, 2015

E. Federal Financial Report (FFR)

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

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

www.dpm.psc.gov/grant_recipient/guides_forms/ffr_quick_reference.aspx.

In addition to submitting the quarterly FFR to PMS, Grantees must also provide, on an annual basis, a hard copy FFR to CMS which includes their expenditures and any program income generated in lieu of completing a Financial Status Report (FSR) (SF-269/269A). Expenditures and any program income generated should only be included on the annually submitted FFR, as well as the final FFR. Annual hard-copy FFRs should be mailed and received within 30 calendar days of the applicable year end date. The final FFR should be mailed and received within 90 calendar days of the project period end date.

More details will be outlined in the Notice of Award.

F. Transparency Act Reporting Requirements

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

G. Audit Requirements

Grantees 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.

H. Payment Management Requirements

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

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

VII. AGENCY CONTACTS

A. Programmatic Content

Programmatic questions about the Adult Medicaid Quality Grants should be directed to an e-mail address that multiple people access, so that someone will respond even if others are unexpectedly absent during critical periods. This e-mail address is: MedicaidAdultMeasures@cms.hhs.gov. If immediate assistance is required, inquiries may be directed to:

Health Insurance Specialist, Mark D. Smith
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Phone: 410-786-8015

E-mail: Mark.Smith@cms.hhs.gov

B. Administrative Questions

Administrative questions about the Adult Medicaid Quality Grants may be directed to:

Grants Management Officer, Michelle Feagins

Center for Medicare and Medicaid Services

Office of Acquisition and Grants Management

200 Independence Avenue, S.W.

Room 733H-02

Washington, DC 20201

Phone: 301-492-4312 or Email: Michelle.Feagins@cms.hhs.gov

VIII. APPENDICES

1. Appendix A: Letter of Intent to Apply

E-mail: Mark.smith@cms.hhs.gov

Please complete and return, by, July 31, 2012 to the attention of:

Health Insurance Specialist, Mark Smith
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Mailstop S2-01-16
Baltimore, MD 21244-1850
Phone: 410-786-8015

1. **Name of State:** _____
2. **Applicant Agency/Organization:** _____
3. **Contact Name and Title:** _____
4. **Address:** _____
5. **Phone:** _____ **Fax:** _____
6. **E-mail address:** _____

2. Appendix B: Application Check-Off Cover Sheet – Adult Medicaid Quality Grant

REQUIRED CONTENTS

A complete application consists of the following materials organized in the sequence below. Please ensure that the project narrative is page-numbered. The sequence is:

- Forms/Mandatory Documents (Grants.gov) (with an electronic signature)
 - SF 424: Application for Federal Assistance
 - SF-424A: Budget Information
 - SF-424B: Assurances-Non-Construction Programs
 - SF-LLL: Disclosure of Lobbying Activities
 - Project Site Location Form(s)

- Cover Letter

- Project Abstract

- Project Narrative

- Budget Narrative

- Letter(s) or memorandum of agreement(s) from any major partner that is not the lead agency (optional).

3. Appendix C: Guidance for Preparing a Budget Request and Narrative in Response to SF 424A

INTRODUCTION

This guidance is offered for the preparation of a budget request. Following this guidance will facilitate the review and approval of a requested budget by ensuring that the required or needed information is provided. This is to be done for each 12 month period of the grant project period. Applicants should be careful to only request funding for activities that will be funded by the Adult Medicaid Quality Grants, Measuring and Improving the Quality of Care in Medicaid. Any other grant funding provided by HHS or another source, should not be supplanted by this Adult Medicaid Quality Grant funding. In the budget request, States should distinguish between activities that will be funded under this grant and activities funded with other sources. Other funding sources include other HHS grant programs, and other funding sources as applicable.

Please refer to Section IV of this FOA for more information on the Budget and Budget Narrative.

A. Salaries and Wages

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

***Sample budget
Personnel***

Total \$ _____
 Adult Medicaid Quality Grant \$ _____
 Funding other than Grant \$ _____
 Sources of Funding _____

<i>Position Title and Name</i>	<i>Annual</i>	<i>Time</i>	<i>Months</i>	<i>Amount Requested</i>
<i>Project Coordinator Susan Taylor</i>	<i>\$45,000</i>	<i>100%</i>	<i>12 months</i>	<i>\$45,000</i>
<i>Finance Administrator John Johnson</i>	<i>\$28,500</i>	<i>50%</i>	<i>12 months</i>	<i>\$14,250</i>
<i>Outreach Supervisor (Vacant*)</i>	<i>\$27,000</i>	<i>100%</i>	<i>12 months</i>	<i>\$27,000</i>

Sample Justification

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

Job Description: Project Coordinator - (Name)

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

B. Fringe Benefits

Fringe benefits are usually applicable to direct salaries and wages. Provide information on the rate of fringe benefits used and the basis for their calculation. If a fringe benefit rate is not used, itemize how the fringe benefit amount is computed.

Sample Budget

Fringe Benefits

Total \$ _____
Adult Medicaid Quality Grant \$ _____
Funding other than Grant \$ _____
Sources of Funding _____

25% of Total salaries = Fringe Benefits

If fringe benefits are not computed by using a percentage of salaries, itemize how the amount is determined.

Example: Project Coordinator — Salary \$45,000

<i>Retirement 5% of \$45,000</i>	<i>=</i>	<i>\$2,250</i>
<i>FICA 7.65% of \$45,000</i>	<i>=</i>	<i>3,443</i>
<i>Insurance</i>	<i>=</i>	<i>2,000</i>
<i>Workers' Compensation</i>	<i>=</i>	<i>_____</i>
<i>Total:</i>		

C. Consultant Costs

This category is appropriate when hiring an individual to give professional advice or services (e.g., training, expert consultant, etc.) for a fee but not as an employee of the grantee organization. Hiring a consultant requires submission of the following information to HHS (see **Required Reporting Information for Consultant Hiring later in this Appendix**):

1. Name of Consultant;
2. Organizational Affiliation (if applicable);

3. Nature of Services to be Rendered;
4. Relevance of Service to the Project;
5. The Number of Days of Consultation (basis for fee); and
6. The Expected Rate of Compensation (travel, per diem, other related expenses)—list a subtotal for each consultant in this category.

If the above information is unknown for any consultant at the time the application is submitted, the information may be submitted at a later date as a revision to the budget. In the body of the budget request, a summary should be provided of the proposed consultants and amounts for each.

D. Equipment

Provide justification for the use of each item and relate it to specific program objectives. Maintenance or rental fees for equipment should be shown in the “Other” category. All Information Technology equipment should be uniquely identified. As an example, we should not see a single line item for “software.” Show the unit cost of each item, number needed, and total amount.

***Sample Budget
Equipment***

Total \$ _____
 Adult Medicaid Quality Grant \$ _____
 Funding other than Grant \$ _____
 Sources of Funding _____

<u>Item Requested</u>	<u>How Many</u>	<u>Unit Cost</u>	<u>Amount</u>
Computer Workstation	2 ea.	\$2,500	\$5,000
Fax Machine	1 ea.	600	600
		Total	\$5,600

Sample Justification

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

E. Supplies

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

Sample Budget
Supplies

Total \$ _____
Adult Medicaid Quality Grant \$ _____
Funding other than Grant \$ _____
Sources of Funding _____

General office supplies (pens, pencils, paper, etc.) 12 months x \$240/year x 10 staff	= \$2,400
Educational Pamphlets (3,000 copies @) \$1 each	= \$3,000
Educational Videos (10 copies @ \$150 each)	= \$1,500
Word Processing Software (@ \$400—specify type)	= \$ 400

Sample Justification

General office supplies will be used by staff members to carry out daily activities of the program. The education pamphlets and videos will be purchased from XXX and used to illustrate and promote safe and healthy activities. Word Processing Software will be used to document program activities, process progress reports, etc.

F. Travel

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

In-State Travel—Provide a narrative justification describing the travel staff members will perform. List where travel will be undertaken, number of trips planned, who will be making the trip, and approximate dates. If mileage is to be paid, provide the number of miles and the cost per mile. If travel is by air, provide the estimated cost of airfare. If per diem/lodging is to be paid, indicate the number of days and amount of daily per diem as well as the number of nights and estimated cost of lodging. Include the cost of ground transportation when applicable.

Out-of-State Travel—Provide a narrative justification describing the same information requested above. Include HHS meetings, conferences, and workshops, if required by HHS. Itemize out-of-state travel in the format described above.

Sample Budget

Travel (in-State and out-of-State)

Total \$ _____
Adult Medicaid Quality Grant \$ _____

Funding other than Grant \$ _____
Sources of Funding _____

In-State Travel:

1 trip x 2 people x 500 miles r/t x .27/mile = \$ 270
 2 days per diem x \$37/day x 2 people = 148
 1 nights lodging x \$67/night x 2 people = 134
 25 trips x 1 person x 300 miles avg. x .27/mile = 2,025

Total \$ 2,577

Sample Justification

The Project Coordinator and the Outreach Supervisor will travel to (location) to attend an eligibility conference. The Project Coordinator will make an estimated 25 trips to local outreach sites to monitor program implementation.

Sample Budget

Out-of-State Travel:

1 trip x 1 person x \$500 r/t airfare = \$500
 3 days per diem x \$45/day x 1 person = 135
 1 night's lodging x \$88/night x 1 person = 88
 Ground transportation 1 person = 50

Total \$773

Sample Justification

The Project Coordinator will travel to HHS, in Atlanta, GA, to attend the HHS Conference.

G. Other

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

Sample Budget

Other

Total \$ _____
 Adult Medicaid Quality Grant \$ _____
 Funding other than Grant \$ _____
 Sources of Funding _____

Telephone

(\$ ___ per month x ___ months x #staff) = \$ Subtotal

Postage

(\$ ___ per month x ___ months x #staff) = \$ Subtotal

Printing

(\$ ___ per x ___ documents) = \$ Subtotal

Equipment Rental (describe)
 (\$ ___ per month x ___ months) = \$ Subtotal
 Internet Provider Service
 (\$ ___ per month x ___ months) = \$ Subtotal

Sample Justification

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

H. Contractual Costs

Cooperative Agreement recipients must submit to HHS the required information establishing a third-party contract to perform program activities (see **Required Information for Contract Approval later in this Appendix**).

1. Name of Contractor;
2. Method of Selection;
3. Period of Performance;
4. Scope of Work;
5. Method of Accountability; and
6. Itemized Budget and Justification.

If the above information is unknown for any contractor at the time the application is submitted, the information may be submitted at a later date as a revision to the budget. Copies of the actual contracts should not be sent to HHS, unless specifically requested. In the body of the budget request, a summary should be provided of the proposed contracts and amounts for each.

I. Total Direct Costs \$ _____

Show total direct costs by listing totals of each category.

J. Indirect Costs \$ _____

To claim indirect costs, the applicant organization must have a current approved indirect cost rate agreement established with the cognizant Federal agency. A copy of the most recent indirect cost rate agreement must be provided with the application.

Sample Budget

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

Personnel	\$
Fringe	\$
Travel	\$
Supplies	\$

$$\frac{\text{Other \$}}{\text{Total \$}} \times \text{ _____\% } = \text{Total Indirect Costs}$$

If the applicant organization does not have an approved indirect cost rate agreement, costs normally identified as indirect costs (overhead costs) can be budgeted and identified as direct costs.

REQUIRED REPORTING INFORMATION FOR CONSULTANT HIRING

This category is appropriate when hiring an individual who gives professional advice or provides services for a fee and who is not an employee of the grantee organization. Submit the following required information for consultants:

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

REQUIRED INFORMATION FOR CONTRACT APPROVAL

All contracts require reporting the following information to HHS.

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

5. Method of Accountability: How will the contractor be monitored? Describe how the progress and performance of the contractor will be monitored during and on close of the contract period. Identify who will be responsible for supervising the contract.
6. Itemized Budget and Justification: Provide an itemized budget with appropriate justification. If applicable, include any indirect cost paid under the contract and the indirect cost rate used.

4. Appendix D: Initial Core Set of Quality Measures for Medicaid-Eligible Adults

	NQF #†	Measure Steward ‡	Measure Name	Programs in Which the Measure is Currently Used¥
Prevention & Health Promotion	0039	NCQA	Flu Shots for Adults Ages 50-64 (<i>Collected as part of HEDIS CAHPS Supplemental Survey</i>)	HEDIS®, NCQA Accreditation,
	N/A	NCQA	Adult BMI Assessment	HEDIS®, Health Homes Core, Part C
	0031	NCQA	Breast Cancer Screening	MU1, HEDIS®, NCQA Accreditation, , PQRS GPRO, Shared Savings Program, Part C
	0032	NCQA	Cervical Cancer Screening	MU1, HEDIS®, NCQA Accreditation
	0027	NCQA	Medical Assistance With Smoking and Tobacco Use Cessation (<i>Collected as part of HEDIS CAHPS Supplemental Survey</i>)	MU1, HEDIS®, Medicare, NCQA Accreditation, Part C
	0418	CMS	Screening for Clinical Depression and Follow-Up Plan	PQRS, CMS QIP, Health Homes Core, Shared Savings Program
	1768	NCQA	Plan All-Cause Readmission	HEDIS®, Health Homes Core
	0272	AHRQ	PQI 01: Diabetes, Short-term Complications Admission Rate	
	0275	AHRQ	PQI 05: Chronic Obstructive Pulmonary Disease (COPD) Admission Rate	Shared Savings Program
	0277	AHRQ	PQI 08: Congestive Heart Failure Admission Rate	Shared Savings Program
	0283	AHRQ	PQI 15: Adult Asthma Admission Rate	
	0033	NCQA	Chlamydia Screening in Women age 21-24 (<i>same as CHIPRA core measure, however, the State would report on the adult age group</i>)	MU1, HEDIS®, NCQA Accreditation, CHIPRA Core
	Management of Acute Conditions	0576	NCQA	Follow-Up After Hospitalization for Mental Illness
0469		HCA, TJC	PC-01: Elective Delivery	HIP QDRP, TJC's ORYX Performance Measurement Program
0476		Prov/C WISH/N PIC/QA S/TJC	PC-03 Antenatal Steroids	TJC's ORYX Performance Measurement Program
Management of Chronic Conditions	0403	NCQA	Annual HIV/AIDS medical visit	
	0018	NCQA	Controlling High Blood Pressure	MU1, HEDIS®, NCQA Accreditation, PQRS GPRO, Shared Savings Program
	0063	NCQA	Comprehensive Diabetes Care: LDL-C Screening	MU1, HEDIS®, NCQA Accreditation, PQRS
	0057	NCQA	Comprehensive Diabetes Care: Hemoglobin A1c Testing	MU1, HEDIS®, NCQA Accreditation, PQRS

	NQF #†	Measure Steward ‡	Measure Name	Programs in Which the Measure is Currently Used¥
	0105	NCQA	Antidepressant Medication Management	MU1, HEDIS®, NCQA Accreditation
	N/A	CMS-QMHA G	Adherence to Antipsychotics for Individuals with Schizophrenia	VHA
	0021	NCQA	Annual Monitoring for Patients on Persistent Medications	HEDIS®, NCQA Accreditation
Family Experiences of Care	0006 & 0007	AHRQ & NCQA	CAHPS Health Plan Survey v 4.0 - Adult Questionnaire <i>with</i> CAHPS Health Plan Survey v 4.0H - NCQA Supplemental	HEDIS®, NCQA Accreditation, Shared Savings Program (NQF#0006)
Care Coordination	648	AMA-PCPI	Care Transition – Transition Record Transmitted to Health care Professional	Health Homes Core
Availability	0004	NCQA	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	MU1, HEDIS®, Health Homes Core
	1391	NCQA	Prenatal and Postpartum Care: Postpartum Care Rate (<i>second component to CHIPRA core measure “Timeliness of Prenatal Care,” State would now report 2/2 components instead of 1</i>)	HEDIS®

† NQF ID *National Quality Forum* identification numbers are used for measures that are NQF-endorsed; otherwise, NA is used.

‡ Measure Steward

AHRQ – Agency for Healthcare Research and Quality

CMS – Centers for Medicare & Medicaid Services

CMS-QMHAG – Centers for Medicare & Medicaid Services, Quality Measurement and Health Assessment Group

HCA, TJC – Hospital Corporation of America-Women’s and Children’s Clinical Services, The Joint Commission

NCQA –National Committee for Quality Assurance

Prov/CWISH/NPIC/QAS/TJC – Providence St. Vincent Medical Center/Council of Women’s and Infant’s Specialty Hospitals/National Perinatal Information Center/Quality Analytic Services/The Joint Commission

TJC – The Joint Commission

¥ Programs in which Measures are Currently in Use:

CHIPRA Core – Children’s Health Insurance Program Reauthorization Act - Initial Core Set

CMS QIP – CMS Quality Incentive Program

HIP QDRP – Hospital Inpatient Quality Data Reporting Program

Health Homes Core-- CMS Health Homes Core Measures

MU1 – Meaningful Use Stage 1of the Medicare & Medicaid Electronic Health Record Incentive

Payment Programs

PQRS – Physician Quality Reporting Program Group Practice Reporting Option

Shared Savings Program – Medicare Shared Savings Program

VHA – Veterans Health Administration

----- For Administrative Purposes Only -----

Completeness check:

Panel Assignment:

Primary Panel Reviewer: