INITIATIVE TO REDUCE HOSPITALIZATIONS AMONG NURSING FACILITY RESIDENTS

(Funding Opportunity number: CMS-1E1-12-002, CFDA Number: 93.621)
The funding opportunity announcement and other information can be found at
http://innovation.cms.gov/initiatives/rahnfr/

FREQUENTLY ASKED QUESTIONS (FAQ)

(Updated May 30, 2012 with questions 14-30)

1. **The funding opportunity announcement states that the proposals must include staff that maintains a physical presence at the partnering nursing facilities. Is there a specific number of hours that is required to be on site?**
2. **"My organization is owned by a company whose primary line of business is the delivery of skilled nursing facility/ nursing facility services. Would my organization be eligible to serve as an enhanced care and coordination provider?"**
3. **"My organization or my parent company owns nursing facilities, but the delivery of nursing facility services is not their primary line of business. Would my organization be eligible to serve as an enhance care and coordination provider?"**
4. **If an entity is still unsure about their eligibility, what factors can also be considered to perform a self-assessment?**
5. **Are other Federal contractors, such as Quality Improvement Organizations (QIOs), eligible to participate in this Initiative?**
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16. **Can an applicant partner with assisted living or independent living facilities to fully or partially satisfy the requirement to partner with at least 15 nursing facilities to implement a proposed intervention?**
17. **Can a nursing facility be listed on more than one application?**
18. **Can an applicant use subgrantees or subcontractors to implement their proposed intervention?**
19. **Are clinical staff funded through this Initiative permitted to bill Medicare or Medicaid for services delivered to nursing facility residents in partnering nursing facilities?**
20. **“We would like to use the residents’ current attending or primary care provider(s) to act as the clinical staff who will maintain a physical presence in the nursing facilities. Would this staffing model meet CMS’ requirements under this Initiative?”**
21. **Can clinical staff hired by the enhanced care & coordination provider provide bedside care to nursing facility residents participating in this Initiative?**
22. **Can the medical director of a nursing facility also serve as the medical director for the ECCP?**
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24. **If a state agency declines a request to provide a letter of support to any or all organization(s), can an organization still be eligible for this Initiative?**
25. **Are applicants required to obtain and submit the Memorandum of Understanding (MOU) signed by the directors of the State agencies with their application?**
26. **Can you give us more information about how to apply the indirect cost rate?**
27. **Shall the Monthly Financial Plan be included in the application narrative or the appendices?**
28. **To whom should the letters of support from State Medicaid director and State survey and certification director be addressed?**
29. **How do applicants complete the columns requesting information on staff hours per resident per day in Table 2 of Appendix C?**
30. **Do the appendices included in the application need to be double-spaced?**

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1. **Q: The funding opportunity announcement states that the proposals must include staff who maintain a physical presence at the partnering nursing facilities. Is there a specific number of hours that staff are required to be onsite?**

   A: CMS is not prescribing the number of hours that the applicant's staff needs to spend at the participating nursing facilities. Rather, applicants shall describe the organizational structure and staffing needed to achieve the objectives of the Initiative. The following items should be included in proposals:

   - The qualifications of staff involved in the day-to-day work with nursing facility residents;
   - Staffing levels and ratios;
   - The hours during the week when staff will be onsite and accessible to each nursing facility;
   - The roles and responsibilities of each staff member; and
   - How staff will work in cooperation with nursing facility residents, nursing facility staff, hospital staff (including attending physicians), residents' primary care physicians, pharmacists, and residents' families and how communication will be improved among these individuals.

   Applications should also include the proposed responsibilities and the percentage of time that key personnel would dedicate to the project. Required personnel include clinical staff who will maintain a physical presence in nursing facilities, a project director, and a medical director. See I.4 Program Requirements and IV.2.B.iv.1.2 Staffing of the Intervention Model in the funding opportunity announcement for more information.

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2. **Q: "My organization is owned by a company whose primary line of business is the delivery of skilled nursing facility/ nursing facility services. Would my organization be eligible to serve as an enhanced care and coordination provider?"**

   A: Organizations whose parent company's primary line of business is the delivery of skilled nursing / nursing facility services would be ineligible to serve as enhanced care and coordination providers.

   Note: CMS will not provide individual confirmation of an organization's eligibility until after submission of a full application.

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3. **Q: "My organization or my parent company owns nursing facilities, but the delivery of nursing facility services is not its primary line of business. Would my organization be eligible to serve as an enhanced care and coordination provider?"**

   A: The entity identified in this question is considered to be under common ownership of nursing facilities. Examples of these types of organizations include (but are not limited to) the following:

   - Integrated delivery networks or health systems which are often comprised of multiple hospitals, nursing facilities, primary care, and other health care providers.
   - Assisted living or continuing care retirement communities (CCRCs).

   These entities may be eligible for this opportunity provided that they meet all other eligibility and program requirements, *and* they partner with a minimum of 15 unaffiliated nursing facilities that are not under common ownership, management, or other operations.

   Note: CMS will not provide individual confirmation of an organization's eligibility until after submission of a full application.

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4. **Nursing facilities, entities controlled by nursing facilities, or entities for which the primary line of business is the delivery of skilled nursing facility/ nursing facility services are excluded from serving as enhanced care and coordination providers under this cooperative agreement.**

   Q: If, after considering the above exclusion, an entity is still unsure about its eligibility, which factors can also be considered to perform a self-assessment?

   A: Applicants should consider whether they can demonstrate that they are not any of the excluded organizations and can also clearly demonstrate the following:

   - The proposed intervention is additive to the core skilled nursing facility/nursing facility services (e.g., services, staff, etc.) and can be tracked separately;
   - The unique impact of the intervention can be measured and attributed to the intervention; and
   - The applicant and/or the proposed intervention does not give the appearance that nursing facilities are being directly funded for functions that could be reasonably interpreted as services currently available to beneficiaries.

   In addition to the above factors, applicants will need to meet all other requirements set forth in the funding opportunity announcement.

   Note: Entities that own, manage, or operate nursing facilities, but whose primary line of business is NOT the delivery of skilled nursing facility/nursing facility services (e.g., integrated delivery networks or health systems), may be eligible for this opportunity

provided that they meet all other eligibility and program requirements, *and* they partner with a minimum of 15 unaffiliated nursing facilities that are not under common ownership, management, or other operations.

CMS will not provide individual confirmation of an organization's eligibility until after submission of a full application.

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5. Q: Are other Federal contractors, such as Quality Improvement Organizations (QIOs), eligible to participate in this Initiative?

A: The funding opportunity announcement does not explicitly exclude Quality Improvement Organizations or other types of Federal contractors from being eligible to participate in this Initiative. However, these organizations should review their existing Federal contracts and adhere to any policies that may be listed in those agreements or any restrictions that might exist under Federal statutes or regulations. QIOs, for example, can only participate in this Initiative under a contract that is separate from their current contracts with CMS under the QIO statute. In addition, QIOs must ensure that their participation will not create a conflict of interest or potential conflict, will not duplicate their current activities, and that being involved in the Initiative will not interfere with their obligation to make their QIO work primary to all other interests and activities.

For some kinds of contractors these policies include submitting information and seeking approval from an administrator of an existing contract, within a given time-frame, prior to being eligible to receive another award. As with all applicants, organizations with current CMS contracts need to explain how the proposed intervention differs from existing practices and services provided in proposed nursing facility partners.

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6. Q: Why is there a requirement for the nursing facilities included on an application to have an average size of 100 residents and how is it applied?

A: This requirement in the funding opportunity announcement helps to ensure that we have a statistically robust pool of data to evaluate the Initiative's impact (I.4.1 Intervention Requirements, Nursing Facility Partnerships in the funding opportunity announcement). Note: This is the average number of all residents (long-stay and short-stay) across all 15+ nursing facility partners (total residents/total facilities); we are not requiring that each of the 15+ nursing facility partners have 100 or more residents.

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7. Q: Are all hospital-based nursing facilities excluded from this Initiative?

A: CMS has revised the requirement regarding hospital-based facilities. Hospital-based facilities with a resident profile made up of less than 50% of beneficiaries with Medicaid as their primary payer are excluded from this Initiative.

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8. Q: Facilities in which more than 25% of the residents are enrolled in Medicare managed care are excluded from participating as nursing facility partners. Does the 25% apply to all residents in the nursing facility?

A: The 25% threshold applies only to those residents in nursing facilities who are 'long-stay' residents. This Initiative defines 'long-stay' residents as those who have resided in a nursing facility for 100 days or more or are identified on the Minimum Data Set assessment as residents expected to remain in the facility. Medicare managed care includes Medicare Advantage plans and any plan where capitation payments cover inpatient and other Medicare Parts A and B services. For purposes of this calculation, beneficiaries in stand-alone prescription drug plans do not count towards the 25% criterion. Please note that the 25% criterion does not apply to Medicaid managed care.

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9. Q: How can we assess whether we are positioned to implement the Initiative despite the presence of another existing Federal initiative (e.g., Accountable Care Organization, Community-based Care Transitions Program, Bundled Payments for Care Improvement)?

A: CMS will accept applications from entities participating in other Federal initiatives or entities operating in the same geographic area as other Federal initiatives. For more information on the geographic locations of other Federal initiatives (e.g., demonstrations, Accountable Care Organizations, etc.), please see http://www.innovations.cms.gov/. However, the applicant must inform CMS of its participation or the participation of any partnering nursing facilities in other Federal initiatives and also describe how participation in this Initiative will complement and support other health reforms, without leading to duplicative funding or circumstances where an organization already has an arrangement to share in Medicare savings for the same individuals served through this Initiative. Additionally, the applicant must describe how the CMS evaluation of its intervention would measure the intervention's unique impact (including the unique impact on Federal and State costs), above and beyond existing initiatives. If selected by CMS for participation in this Initiative, the enhanced care & coordination providers shall inform CMS on an ongoing basis of its participation in any other Federal initiatives. Please see I.4.1 Intervention Requirements, Restrictions/Limitations in the funding opportunity announcement.

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10. Q: Can an organization propose to implement the Initiative in the same State as a Financial Alignment Demonstration to coordinate care for Medicare-Medicaid enrollees?

A: In a separate project, CMS has contracted with 15 States to design new integrated care programs for Medicare-Medicaid enrollees, which could include initiatives for individuals in nursing facilities. In addition to these 15 States, other States are interested in integrating care for their Medicare-Medicaid enrollees. The list of States that submitted letters of intent and are pursuing Financial Alignment Demonstrations can be found at: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html.

CMS will accept applications from entities proposing to operate in States pursuing a Financial Alignment Demonstration. However, the applicant will need to present a compelling case that the activities funded through this Initiative would work in synergy and not diminish the value to CMS from funding both initiatives in the same State. Please see I.4.1 Program Requirements, Restrictions / Limitations of the funding opportunity announcement.

For States that are applying to participate in the Capitated Financial Alignment Demonstration, potential applicants should consider how that demonstration might change the extent to which long-stay Medicare-Medicaid enrollees residing in nursing facilities receive their care through a Medicare fee-for-service program versus a Medicare managed care program.

For States that are applying to participate in the Managed Fee-for-Service Financial Alignment Demonstration, applicants should consider the extent to which the Financial Alignment Demonstration and this Initiative may duplicate the services provided to long-stay Medicare-Medicaid enrollees residing in nursing facilities.

Please note that the Financial Alignment models vary by State in their target geographic reach, beneficiary population, and timing for implementation. These proposals will all require CMS approval.

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11. Q: Can enhanced care and coordination providers make payments to nursing facility partners?

A: Applicants may propose to include funds for nursing facility partners in their proposed budgets for this Initiative, subject to the requirements of the funding opportunity announcement and any applicable laws. Applicants shall clearly describe how all funds requested will be used, including funds requested for nursing facilities partners. Please note that award dollars cannot be used for any of the restricted uses outlined in I.4.9 Restriction on Awards of the funding opportunity announcement and that any financial arrangement between an awardee and its partnering facilities must comply

with applicable fraud and abuse laws in Titles XI, XVIII, and XIX of the Social Security Act.

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12. Q: What data are available to assist with preparation of submitting a proposal?

A: Upon receipt of applications for the Initiative, CMS will assess and give preference to applications that propose to implement interventions in geographic locations with high Medicare costs, high hospital readmission rates, and where Medicare-Medicaid enrollees account for a high percentage of nursing facility residents. As you construct your application, it may be helpful to review the data using the resources listed in 4.1 Intervention Requirements, Restrictions / Limitations of the funding opportunity announcement. These resources include:

- https://www.cms.gov/Insight-Briefs/downloads/PAHInsightBrief.pdf: CMS has analyzed the prevalence and cost of potentially avoidable hospitalizations for individuals who are eligible for both Medicare and full Medicaid benefits. Using data from 2005, this CMS report provides data on potentially avoidable hospitalizations for Medicare-Medicaid enrollees by source and State.

- http://ltcfocus.org/default.aspx: This website is a product of the Shaping Long-Term Care in America Project at the Brown University Center for Gerontology and Healthcare Research and supported by the National Institute on Aging. The website contains data on the characteristics of nursing facilities and the residents they serve, including re-hospitalization rates by nursing facility and the percent of residents enrolled in Medicare and Medicaid.

- http://www.healthindicators.gov/: The Health Indicators Warehouse is a collaboration of many agencies and offices within the U.S. Department of Health and Human Services, and is maintained by the Center for Disease Control's National Center for Health Statistics. The website contains data on demographic, cost, utilization, and quality indicators for all hospital referral regions and States. For more information regarding hospital referral regions and how to determine which hospital referral region a nursing facility corresponds to, see http://www.dartmouthatlas.org/downloads/methods/geogappdx.pdf.

- http://www.cms.gov/DemoProjectsEvalRpts/downloads/CCTP_FourthQuartileHospsbyState.pdf: The CMS Community-based Care Transitions Program (CCTP) has developed a list of "high readmission hospitals," which provides 30-day Medicare hospital readmission rates for acute myocardial infarction, heart failure, and pneumonia by State and city. While this document was developed to determine eligibility for CCTP, it may be helpful in identifying geographical locations with high hospital readmission rates.

In addition to the resources provided within the funding opportunity announcement, potential applicants may also want to explore http://www.data.gov/, which provides a collection of useful Medicare and Medicaid data and additional data as it relates to health care utilization, cost, coverage, access, population health, and health determinants. The website also makes available other data pulled from a variety of Federal government agencies and links to additional data resource sites.

Finally, organizations may also want to access the Medicare.gov Nursing Home Compare website (http://www.medicare.gov/NHCompare), which contains information on Medicare and Medicaid certified facilities such as location, size, and census.

Please note that CMS does not plan to provide additional data to applicants for purposes of preparing applications for this Initiative.

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13. Q: How will CMS evaluate this Initiative?

A: CMS will contract with an independent evaluator to assess the effect of each of the proposed interventions on the program's objectives, including:

(1) Reduction in the frequency of avoidable hospital admissions and readmissions;
(2) Improvement in nursing facility resident health outcomes;
(3) Improvement in the transition process between inpatient hospitals and nursing facilities; and
(4) Reduction in overall health care spending, without restricting access to care or choice of providers.

To do this, the independent evaluator will identify a broad set of evaluation measures for the Initiative, and also may develop measures for specific interventions. The evaluator will have access to nursing facility resident assessment data and data on nursing facility surveys and complaint surveys. Medicare and Medicaid claims data will be used to measure impact on combined Medicare and Medicaid expenditures. In addition, qualitative and quantitative data specific to the project will be collected by the evaluator.

A critical aim of the evaluation is to identify which interventions best meet the objectives of the Initiative and also understand the factors driving the results.

Please see I.4.4 Monitoring and Evaluation, Evaluation Contractor and VI.4 Reporting of the funding opportunity announcement for more information about the evaluation.

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14. Q: Can an organization's application include different operating partners and/or different target geographic locations for the proposed intervention than those included in the Notice of Intent to Apply (NOIA)?

A: Organizations may submit applications with different operating partners and geographic location(s) for the proposed intervention than the operating partners and geographic locations identified in the NOIA. Note: Operating partners refers to the companies or vendors that the applicant plans to partner with to implement the proposed intervention for this Initiative and does not refer to the 15+ nursing facilities that are required for the application.

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15. Q: "On the list of organizations that have submitted a Notice of Intent to Apply (NOIA) and have approved the posting of their information, we've noticed there are organizations that appear to be ineligible, such as nursing facilities. Is it possible that an ineligible organization appears on this list?"

A: This list is merely a list of organizations that submitted a Notice of Intent to Apply and granted permission to have their contact information listed publicly. The list does not confirm that any organization is eligible, so it is possible for organizations that are not eligible for the Initiative to be included on this list if they submitted a Notice of Intent to Apply. Each application will be evaluated based on the program and eligibility requirements stated in the funding opportunity announcement.

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16. Q: Can an applicant partner with assisted living or independent living facilities to fully or partially satisfy the requirement to partner with at least 15 nursing facilities to implement a proposed intervention?

A: Applicants are required to partner with a minimum of 15 Medicare-Medicaid certified nursing facilities that will agree to implement the proposed intervention described in the application. Assisted living or independent living facilities are not eligible to serve as one or more of the 15 (minimum) nursing facilities with which applicants are required to partner under this Initiative.

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17. Q: Can a nursing facility be listed on more than one application?

A: Nursing facilities can be listed on more than one application. However, they can only participate with one enhanced care & coordination provider once awards have been made. If a facility is listed on two applications, and both of those applications are selected for an award, CMS will address this situation on a case by case basis.

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18. Q: Can an applicant use subgrantees or subcontractors to implement their proposed intervention?

A: Subcontracts for enhanced care & coordination providers are permissible under this opportunity, as long as the subcontractor meets the program eligibility requirements. The subcontractor, therefore, cannot be a nursing facility, an entity controlled by a nursing facility, or an entity for which the primary line of business is the delivery of nursing facility/skilled nursing facility services because these entities are not eligible to be enhanced care & coordination providers.

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19. Q: Are clinical staff funded through this Initiative permitted to bill Medicare or Medicaid for services delivered to nursing facility residents in partnering nursing facilities?

A: Practitioners funded through this cooperative agreement will not be permitted to separately bill Medicare or Medicaid for services delivered to the nursing facility residents at the facilities participating in this Initiative. For example, if a nurse practitioner who is employed by an enhanced care & coordination provider also provides services to nursing facility residents that are not covered by this Initiative, those nurse practitioners cannot also bill Medicare or Medicaid for services rendered to nursing facility residents at the facilities participating in this Initiative. Please see I.4.5 Payment and Restrictions on Billing and also I.4.9 Restriction on Awards in the funding opportunity announcement.

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20. Q: "We would like to use the residents' current attending or primary care provider(s) to act as the clinical staff who will maintain a physical presence in the nursing facilities. Would this staffing model meet CMS' requirements under this Initiative?"

A: This Initiative seeks to fund enhanced care & coordination providers to test interventions that supplement rather than replace existing services. CMS expects enhanced care & coordination providers to hire staff who shall maintain a physical presence at nursing facilities and shall partner with nursing facility staff to implement preventive services and improve recognition, assessment, and management of conditions that commonly cause avoidable hospitalizations. These staff are meant to be additive to staff already serving nursing facility residents and are required to work in cooperation with existing providers, including residents' attending or primary care providers, and are not intended to supplant existing treatment relationships. Additionally, practitioners funded through this cooperative agreement will not be permitted to separately bill Medicare or Medicaid for services delivered to the nursing facility residents at the facilities participating in this Initiative. In their proposals, applicants should describe how their staffing model will meet these and all program requirements described in the

funding opportunity announcement, and how their intervention will achieve the objectives of the Initiative.

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21. Q: Can clinical staff hired by the enhanced care & coordination provider provide bedside care to nursing facility residents participating in this Initiative?

A: CMS is not prescribing any specific clinical model; it is allowing applicants to propose interventions to meet the cooperative agreement's objectives. However, all interventions must meet the requirements outlined in I.4.1 Intervention Requirements of the funding opportunity announcement. These requirements include hiring staff who shall maintain a physical presence at nursing facilities and shall partner with nursing facility staff to implement preventive services and improve recognition, assessment, and management of conditions, such as pneumonia, congestive heart failure, chronic obstructive pulmonary disease and asthma, urinary tract infections, dehydration, skin ulcers, falls, and other common causes of avoidable hospitalizations. An individual's activities as part of this Initiative should be activities they are currently allowed or licensed by the State according to the State's applicable scope of practice laws and regulations. For example, if a certain type of health care professional is licensed to start an IV in a nursing facility, those activities could be included as part of the clinical intervention implemented under this Initiative. For more information on program requirements and staffing, please see I.4 Program Requirements and IV.2.B.vi.1.2 Staffing of the Intervention Model in the funding opportunity announcement.

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22. Q: Can the medical director of a nursing facility also serve as the medical director for the enhanced care & coordination provider?

A: A medical director of a nursing facility may serve as the medical director for an enhanced care & coordination provider provided they meet all other program and eligibility requirements to support the goals of the Initiative. Applicants shall describe how the role of the enhanced care & coordination provider medical director will be additive to the current roles and responsibilities of the facility medical director and how they will track the added activities and associated costs over the cooperative agreement period of performance. Applicants shall also clearly describe how all funds requested will be used, including how the medical director will be funded. Please note that award dollars cannot be used for any of the restricted uses outlined in I.4.9 Restriction on Awards of the funding opportunity announcement and that any financial arrangement between an awardee and its partnering facilities must comply with applicable fraud and abuse laws in Titles XI, XVIII, and XIX of the Social Security Act. Please also see FAQ #11.

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23. Q: What type of data will be requested from States and what level of time and/or resources will be needed to share the data?

A: CMS is not expecting States to collect any new data elements that they are not already collecting. Also, States do not need to manipulate the data as long as the State can provide it to CMS in a usable format. CMS will engage a contractor to clean and analyze these data, minimizing any burden placed on States. CMS will engage States to discuss the most efficient process to share data and does not anticipate this activity will require significant time and/or State resources.

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24. Q: If a State agency declines a request to provide a letter of support to any or all organization(s), can an organization still be eligible for this Initiative?

A: Applicants must include the required letters of support from State Medicaid and State survey and certification directors expressing support for the application and agreeing to engage in a memorandum of understanding (MOU) upon selection. If not, the applicant's submission will not receive further consideration and will not be eligible for award. Applicants may provide one letter with two signatures or two separate letters, and CMS will only review applications that include these letters of support. States may, at their discretion, offer support to multiple applicants or none at all. For more information, see V. Application Review Information, 2. Review and Selection Process in the funding opportunity announcement.

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25. Q: Are applicants required to obtain and submit the Memorandum of Understanding (MOU) signed by the directors of the State agencies with their application?

A: Applicants are not required to obtain and submit the Memorandum of Understanding (MOU) signed by the directors of the State agencies with their application. CMS will facilitate the execution of this agreement with State agencies upon selection of applicants awarded cooperative agreements. For informational purposes only, Appendix B of the funding opportunity announcement includes a draft MOU.

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26. Q: Can you give us more information about how to apply the indirect cost rate?

A: **If the organization applying to become an enhanced care & coordination provider already has an indirect cost rate agreement negotiated with a Federal agency:** These organizations should review their negotiated agreement and apply the indirect cost rate to their application as described in the negotiated agreement. The applicant shall include a copy of the approved indirect cost rate agreement in the application for the Initiative. For example, consider a negotiated agreement that stipulates that the indirect cost rate of 15% may only be applied to the Personnel budget

category, exclusive of fringe benefits and contract salaries. In its application for the Initiative, the organization shall apply the 15% indirect cost rate only to the Personnel budget category.

If the organization applying to become an enhanced care & coordination provider does not already have an indirect cost rate agreement with a Federal agency: These organizations may start the process of obtaining an indirect cost rate agreement by contacting their cognizant Federal agency. More information can be obtained from the Division of Cost Allocation, which is within the U.S. Department of Health and Human Services, at: http://rates.psc.gov/. This link includes region maps with contact names and numbers as well as guidance on what an indirect cost rate is and the process for negotiating an indirect cost rate. For purposes of submitting an application for this Initiative, the organization may include an indirect cost rate of up to 10% of direct salaries only (i.e., personnel costs). Within 90 days of cooperative agreement award, the organization must send CMS the approved negotiated indirect cost rate agreement.

If the applicant does not plan to establish an indirect cost rate agreement, it may still include in the proposed budget time spent managing a cooperative agreement. If the cost involves time spent by the applicant's own staff, the applicant would list the costs budgeted for managing the grant under the Personnel budget category. If the cost involves time spent by contractor staff, the applicant would list the costs for managing the grant under the Contractual budget category. The applicant would pro-rate the salary of the staff according to the time spent managing the grant. For example, if the salaried staff earn a salary of $50,000 per year and spend 10% of their time managing the grant, the applicant would include $5,000 in the Personnel budget category. The applicant could also apply the organization's fringe benefit rate to the costs associated with salaried staff managing the cooperative agreement and include them in the Fringe Benefit budget category. For example, if the applicant's fringe benefit rate is 15%, the applicant would include $750 in the Fringe Benefit cost category. The same rules would apply if contractor staff managed the cooperative agreement.

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27. Q: Shall the Monthly Financial Plan be included in the application narrative or the appendices?

A: The Monthly Financial Plan narrative and supporting information explaining the rationale behind all assumptions used to develop the Monthly Financial Plan shall be included in the appendices, which shall not exceed 80 pages in length. Applicants shall also include Tables 4-7 of the Monthly Financial Plan in the appendices.

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28. Q: To whom should the letters of support from State Medicaid director and State survey and certification director, and Letters of Intent from the nursing facilities be addressed?

A: These letters should be addressed to:

Medicare-Medicaid Coordination Office and Innovation Center
Centers for Medicare and Medicaid Services
7500 Security Blvd
Baltimore, MD 21244

All letters (from State agencies, nursing facilities, or other entities) must be uploaded to the application package through the grants.gov website and included as part of the final application. Letters should not be mailed separately to CMS.

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29. Q: How do applicants complete the columns requesting information on staff hours per resident per day in Table 2 of Appendix C?

A: This question is referring to the following columns in Table 2 of Appendix C:

- RN/Director of Nursing Hours Per Resident Day (2011) (3rd column)
- Total Licensed Nursing Hours (RN/DON/LPN) Per Resident Day (2011) (4th column)
- Certified Nurse Aide Hours Per Resident Day (2011) (5th column)

Applicants are no longer required to complete these columns as part of the application (they are optional). Information included in or omitted from these three columns shall not impact the evaluation of an application.

Note: In order to complete these columns, applicants will also need to access total resident census data from the most recently completed Form CMS-672 and combine it with data from the CMS-671.

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30. Q: Do the appendices included in the application need to be double-spaced?

A: While the narrative portion of the application must be double-spaced, the appendices (not to exceed 80 pages in length) may be single- or double-spaced.

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