| **Health Care Innovations Awards- Round Two (HCIA)**  **Executive Overview**  Please complete all fields unless directed otherwise. | | | | | | | | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
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| **Organization Contact Information** | | | | | | | | | | | | | | | | |
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| **Letter of Intent Confirmation Number** | | | | | | | | | | | | | | |  | |
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| **Organization Name** | |  | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| **Street Address** | |  | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| **City** | |  | | | | **State** | | | |  | | | **Zip Code** | | |  |
|  | | | | | | | | | | | | | | | | |
| **Organization TIN** | |  | | | | **Organization NPI Number** | | | | | | |  | | | |
|  | | | | | | | | | (if applicable) | | | | | | | |
| **Primary Contact Information** | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| **First Name** | |  | | | | | **Last Name** | | | | |  | | | | |
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| **Bus. Phone** | |  | | | | | **Bus. Email** | | | | |  | | | | |
|  | | | | | | | | | | | | | | | | |
| **Primary TIN** | |  | | | | **NPI Number** | | | | | |  | | | | |
|  | (if applicable) |  | | | | | (if applicable) | | | | |  | | | | |
| **Backup Contact Information** | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| **First Name** | |  | | | | | **Last Name** | | | | |  | | | | |
|  | | | | | | | | | | | | | | | | |
| **Bus. Phone** | |  | | | | | **Bus. Email** | | | | |  | | | | |
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| **Organization General Information** | | | | | | | | | | | | | | | | |
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| **Type of Organization** | | |  | | | | | | | | | | | | | |
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|  | | |  | | | | | | | | Other | | |  | | |
| **Organization Status** | | |  | | | | | | | |  | | | | | |
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| **Year Established/ Incorporated** | | |  | |  | | | **Revenue** | | |  | | | | | |
|  | | | | (YYYY) | | | | | | | (Most Recent Fiscal Year) | | | | | |
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| **Project Information** | | | | |
| --- | --- | --- | --- | --- |
| Project Title should reflect the design of your model. Please do not propose a generic-sounding title such as "Health Care Innovation Project". (Max 150 characters) | | | | |
| **Project Title** | | Click here to enter text. | | |
|  | | | |
| **Primary Clinical Condition to be Addressed** | | |  |
|  | | | |
| Other or Additional Conditions or Objectives | | |  |
|  | | | | |
| **Primary Innovation Category Type** | | |  | |
| **Additional Innovation Category Type(s)**  Please mark an ‘**X**’ next to additional Categories your proposal will address, **excluding** Primary Category above.) | | | | |
|  | Models that are designed to rapidly reduce Medicare, Medicaid, and/or CHIP costs in outpatient and/or post-acute settings. | | | |
|  | Models that improve care for populations with specialized needs. | | | |
|  | Models that test approaches for specific types of providers to transform their financial and clinical models. | | | |
|  | Models that improve the health of populations – defined geographically (health of a community), clinically (health of those with specific diseases), or by socioeconomic class – through activities focused on engaging beneficiaries, prevention (for example, a diabetes prevention program or a hypertension prevention program), wellness, and comprehensive care that extend beyond the clinical service delivery setting. | | | |

| **Priority Areas to be Addressed Within the Innovation Categories**  (as referenced in Funding Opportunity Announcement (FOA))  (Please mark an ‘**X**’ next to any areas that apply.) | | | | | |
| --- | --- | --- | --- | --- | --- |
|  | Category 1: diagnostic services | | |  | Category 1: outpatient radiology |
|  | Category 1: high-cost physician-administered drugs | | |  | Category 1: home based services |
|  | Category 1: therapeutic services | | |  | Category 1: post-acute services |
|  | Category 2: high-cost pediatric populations | | |  | Category 2: children in foster care |
|  | Category 2: children at high risk for dental disease | | |  | Category 2: adolescents in crisis |
|  | Category 2: persons with Alzheimer’s disease | | |  | Category 2: persons living with HIV/AIDS (in particular, efforts to link and retain patients in care and improve medication adherence that lead to viral suppression) |
|  | Category 2: persons requiring long-term support and services | | |  | Category 2: persons with serious behavioral health needs |
|  | Category 3: models designed for physician specialties and subspecialties (for example, oncology and cardiology) | | |  | Category 3: models designed for pediatric providers who provide services to children with complex medical issues (including but not limited to care for children with multiple medical conditions, behavioral health issues, congenital disease, chronic respiratory disease, and complex social issues) |
|  | Category 4: models that promote behaviors that reduce risk for chronic disease, including increased physical activity and improved nutrition | | |  | Category 4: models that lead to better prevention and control of cardiovascular disease, hypertension, diabetes, chronic obstructive pulmonary disease, asthma, and HIV/AIDS |
|  | Category 4: models that prevent falls among older adults | | |  | Category 4: models that promote medication adherence and self-management skills |
|  | Category 4: broader models that link clinical care with community-based interventions | | |  |  |
|  | Other | Enter text here. |  |  |  |

| **Project Summaries** |
| --- |
| **Provide a brief summary of the population(s) and their needs that you propose to address in your project. Be sure to include a description of the problem and/or gap in care being addressed, the size of the population, and the opportunities to improve care and/or health and to lower cost.** (300 word / 2500char max) |
| Click here to enter text. |
|  |
| **Provide a brief summary of your proposed intervention. Be sure to describe how it will address and/or improve the problem and/or gap in care for the population identified above. Briefly summarize the evidence which suggests your intervention has a likelihood of success.** (300 word / 2500char max) |
| Click here to enter text. |
|  |
| **Provide a brief summary of the improvements you expect from this project, and the measures that will quantify improved health/care and lower costs in the proposed model. Quantify the improvement opportunities and quantify the cost drivers that will be different as the result of the intervention described above.** (300 word / 2500char max) |
| Click here to enter text. |
|  |
| **Provide a brief summary of the proposed payment model that will support your project. Please be sure to address how the model will be sustained.** (300 word / 2500char max) |
| Click here to enter text. |

| **Payment Model Information** | | | | | | |
| --- | --- | --- | --- | --- | --- | --- |
| All applicants must submit, as part of their application, the design of a payment model that is consistent with the new service delivery model funded by this second round of Health Care Innovation Awards. Alternatively, applicants may choose to submit, as part of their application, a detailed and fully developed payment model as well as a list of payers interested in testing the new payment and service delivery model.  If they have not already done so as part of the application, awardees must deliver, during or by the conclusion of the cooperative agreement period, a detailed and fully developed version of the payment model required above, as well as a list of payers interested in testing the payment and service delivery model. | | | | | | |
| **Does the application include a *detailed*****and*****fully developed* payment model?** | | | | | |  |
|  | | | | | | |
| If **Yes** above, when will the payment model be ready for launch? | | | | | | MM/YY |
| (Note: While CMS encourages awardees to implement new payment models within the award period, CMS is not obligated to implement payment policy changes during or after the award period.) | | | | | |  |
|  | | | | | | |
| **Do you currently have commitment / interest from payers (other than Medicare, Medicaid, and CHIP) to participate in the payment model?** | | | | | |  |
|  | | | | | | |
| If **Yes** above**,** please list any payers committed to testing the model in the table below. | | | | | | |
| **Payer Name** | | | | | **Commitment?** | |
| Click here to enter text. | | | | |  | |
| Click here to enter text. | | | | |  | |
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| **Net Savings Projection- for CMS Beneficiaries after Deducting In-Kind Costs**  (From financial plan) | | | |
|  | | | |
| **Year 1** |  | $0 |  |
|  | | | |
| **Year 2** |  | $0 |  |
|  | | | |
| **Year 3** |  | $0 |  |
|  | | | |
| **Total** |  | $0 |  |
|  | | | |

| **Partner Organization Information** | | | | |
| --- | --- | --- | --- | --- |
| **Please list all Partner Organizations below applying with Applicant**  Include any participating payer organizations. | | | | |
| **Partner Organization Name** |  | **Partner Organization Type** |  | **Partner Role** |
| Click here to enter text. |  |  |  |  |
| Click here to enter text. |  |  |  |  |
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| **If more space is needed to add partner organizations, please use the space below to list each organization, organization type, and role.**  Ex. Partner Organization Name, Partner Organization Type, Partner Role | | | | |
| Click here to enter text. | | | | |

| **Provider Types Involved with Intervention**  (Please mark an ‘**X**’ next to any areas that apply.) | | | | | | |
| --- | --- | --- | --- | --- | --- | --- |
|  | Emergency Medical Technician (EMT) | |  | | Pharmacist | |
|  | Licensed practical nurse (LPN / LVN) | |  | | Physician, primary care | |
|  | Non-clinical health workers | |  | | Registered Nurse | |
|  | NP,PA, and other advance practice RN | |  | | Physician, specialist (indicate below) | |
|  | Other | Click here to enter text. |  |  | | |
|  | | | | | | |
| **Type of Specialty**  (Please mark an ‘**X**’ next to any areas that apply.) | | | | | | |
|  | Adolescent Medicine | |  | | Allergy and Immunology | |
|  | Anesthesiology | |  | | Cardiology and Vascular Medicine | |
|  | Chiropractic Medicine | |  | | Dentistry | |
|  | Dermatology | |  | | Emergency Medicine | |
|  | Endocrinology | |  | | Family Practice | |
|  | Gastroenterology | |  | | General Practice | |
|  | Geriatric Medicine | |  | | Hematology | |
|  | Hospice and Palliative Care | |  | | Infectious Disease Medicine | |
|  | Medical Toxicology | |  | | Nephrology | |
|  | Neurology | |  | | Obstetrics and Gynecology | |
|  | Oncology | |  | | Ophthalmology | |
|  | Optometry | |  | | Orthopedics | |
|  | Otolaryngology | |  | | Pain Management | |
|  | Pathology | |  | | Pediatrics | |
|  | Physical Medicine and Rehabilitation | |  | | Podiatry | |
|  | Preventative Medicine | |  | | Primary Care, General Practice, and Family Practice | |
|  | Psychiatry | |  | | Pulmonary Medicine | |
|  | Radiology | |  | | Rheumatology | |
|  | Sports Medicine | |  | | Surgery | |
|  | Urology | |  | | Other | Click here to enter text. |

| **Target Population** | | | | | | | | | | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Target Number of Intervention Sites**  (If applicable) | | | | | | **Target Number of Participants**  (Regardless of insurance status) | | | | | | | | | | | | |
|  | | | | | |  | | | | | | | | | | | | |
|  | | | | | | **Year 1**  (by Quarter) | | | **Q1** | **Q2** | | | **Q3** | | **Q4** | |  | |
| **Year 1** |  |  |  | | |  |  | | |  | |  | |  | |
|  | | | | | |  | | | | | | | | | | | | |
| **Year 2** |  |  |  | | | **Year 2**  (Total) | | |  | | | | | | | |  | |
|  | | | | | |  | | | | | | | | | | | | |
| **Year 3** |  |  |  | | | **Year 3**  (Total) | | |  | | | | | | | |  | |
|  | | | | | |  | | | | | | | | | | | | |
| **Total** |  |  |  | | | **Total** | | |  | | | | | | | |  | |
|  | | | | | |  | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| **Targeted Number of Participants by Insurance Status** (Please provide targets by status for each year) | | | | | | | | | | | | | | | | | | |
|  | | | | | | |  | **Year 1** | | |  | **Year 2** | |  | | **Year 3** | | |
| Medicaid\* | | | | | | |  |  | | |  |  | |  | |  | | |
| Children’s Health Insurance Program (CHIP)\* | | | | | | |  |  | | |  |  | |  | |  | | |
| Medicare Fee for Service or Medicare Unspec.\* | | | | | | |  |  | | |  |  | |  | |  | | |
| Medicare Advantage | | | | | | |  |  | | |  |  | |  | |  | | |
| Dually Eligible (Medicare + Medicaid) | | | | | | |  |  | | |  |  | |  | |  | | |
| Private/Commercial Health Ins./Health Plan | | | | | | |  |  | | |  |  | |  | |  | | |
| VA Health System (Veterans of Armed Forces) | | | | | | |  |  | | |  |  | |  | |  | | |
| TRICARE (Armed Forces) | | | | | | |  |  | | |  |  | |  | |  | | |
| Indian Health Service | | | | | | |  |  | | |  |  | |  | |  | | |
| Uninsured | | | | | | |  |  | | |  |  | |  | |  | | |
| Other | | | | | | |  |  | | |  |  | |  | |  | | |
| Unknown | | | | | | |  |  | | |  |  | |  | |  | | |
| \*\***Totals** | | | | | | |  |  | | |  |  | |  | |  | | |
| \*Excludes Dually Eligible | | | | | \*\* Should match Target Number of Participants in table above | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| **Please describe the source data to be used for Participant Recruitment.**  (200 word max) | | | | | | | | | | | | | | | | | |
|  | | | |
| Click here to enter text. | | | | | | | | | | | | | | | | | |

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| **Provide estimated dates for:** | **Hiring Project Director** (mm/dd/yy) |  |
|  | |
| **Project Launch** (mm/dd/yy) |  |

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| **Claims Data** | | | | | | | | | | |
| Please indicate if you will require CMS data, if awarded, during the course of your projects. While CMS cannot make any commitment to provide this data, we are assessing each award’s requirements.  For operational purposes please consider alternatives that do not rely on receiving this data. Medicaid and CHIP data will not be available due to limited availability of this data at CMS. | | | | | | | | | | |
| *This is a brief initial assessment only. You will be required to provide more detailed paperwork and data use agreements at a later time including a formal written request from your award lead.* | | | | | | | | | | |
|  | | | | | | | | | |
| **Will you need CMS Medicare FFS data for your project?** (Please indicate selection with an ‘**X**’) | | | | | | | | | | |
|  | **Yes** | | Please complete Claims Data section, then proceed to Existing Grants Information. | | | | | | | |
|  | **No** | | Please proceed to Existing Grants Information section. | | | | | | | |
|  | | | | | | | | | | |
| **What is the reason for the data request?** (Please mark an ‘**X**’ next to any areas that apply.) | | | | | | | | | | |
|  | | Cost Analysis for Payment Arrangement | | |  | Sustainability Model | | | | |
|  | | Patient and/or Risk Segmentation for Intervention | | |  | Self-Monitoring and Reporting | | | | |
|  | | Identification of Patients for Intervention | | |  | Other | | | | |
|  | | | | | | | | | | |
| **How soon will data be needed?** | | | |  | | | |  | | |
|  | | | | | | | | | | |
| **Are patient identifiable data required?** | | | |  | | | |  | |
| If you selected **Yes** above, please keep in mind CMS cannot provide identifiable claims data on mental health or substance abuse service for many research grants.  Please explain in the box provided any impact this would have on your project. (max 500 char) | | | | | | | | | | |
| Click here to enter text. | | | | | | | | | | |
|  | | | | | | | | | | |
| **Do you have an alternative plan if CMS data cannot be provided?**  (Note: Medicaid and CHIP data will **not be available** to due limited availability at CMS.) | | | | | | |  | | |
| If you selected **Yes** above, please describe any impact to the project in lieu of data. (max 500 char) | | | | | | | | | | |
| Click here to enter text. | | | | | | | | | | |

| **Data Collection Capability** | | |
| --- | --- | --- |
| **Does your proposal involve the provision of services to participants?** |  | |
| If you selected **Yes** above, please indicate if your organization (and partners) have processes and procedures to capture the following information: | | |
| Provider Tax IDs | |  |
| Practitioner NPIs | |  |
| Medicare Participant HICNs | |  |
| Medicaid Participant IDs | |  |
| CHIP Participant IDs | |  |
| Other Payer IDs | |  |
| Social Security Numbers (if awardee already collects SSN) | |  |
| Participant Name | |  |
| Date of Birth of Participants | |  |
| Home Address of Participants | |  |
| Counts by participant demographic characteristics | |  |
| Service Types | |  |
| Dates of Service | |  |

| **Existing Grant Information** | | | | | | |
| --- | --- | --- | --- | --- | --- | --- |
| Please describe any grants or other federal contracts that your organization or partner organizations currently receive or will receive during the period of performance which overlap and/or complement this proposal due to staff and/or subject area similarities.  (If more space is needed to add Existing Grants/Contracts, please submit on a supplemental Word document and attach with the application.) | | | | | | |
|  | | | | | | |
| **Title of Grant/Contract** | **Org / Federal Agency Name** | **Grant/Contract #** | **Award Amt.** | **Dates of Award**  (MM/YY – MM/YY) | **Type of Award**  (CoOp Agreement, Grant, etc.) | **Key Staff Overlap?** |
|  |  |  |  |  |  |  |
| **Brief Summary of Objectives** (Max 500 chars) | | | | | | |
| Click here to enter text. | | | | | | |
|  | | | | | | |
| **Title of Grant/Contract** | **Org / Federal Agency Name** | **Grant/Contract #** | **Award Amt.** | **Dates of Award**  (MM/YY – MM/YY) | **Type of Award**  (CoOp Agreement, Grant, etc.) | **Key Staff Overlap?** |
|  |  |  |  |  |  |  |
| **Brief Summary of Objectives** (Max 500 chars) | | | | | | |
| Click here to enter text. | | | | | | |
|  | | | | | | |
| **Title of Grant/Contract** | **Org / Federal Agency Name** | **Grant/Contract #** | **Award Amt.** | **Dates of Award**  (MM/YY – MM/YY) | **Type of Award**  (CoOp Agreement, Grant, etc.) | **Key Staff Overlap?** |
|  |  |  |  |  |  |  |
| **Brief Summary of Objectives** (Max 500 chars) | | | | | | |
| Click here to enter text. | | | | | | |
|  | | | | | | |
| **Title of Grant/Contract** | **Org / Federal Agency Name** | **Grant/Contract #** | **Award Amt.** | **Dates of Award**  (MM/YY – MM/YY) | **Type of Award**  (CoOp Agreement, Grant, etc.) | **Key Staff Overlap?** |
|  |  |  |  |  |  |  |
| **Brief Summary of Objectives** (Max 500 chars) | | | | | | |
| Click here to enter text. | | | | | | |

| **Additional Partner/Controlling Interest Information** | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Please complete the following tables with full and complete information as to the identity of each person or entity with an ownership or control interest in the applicant, including all officers, directors, and partners. If the applicant is a new entity that has been formed by one or more existing entities, please reflect this in the entity table below.  (If more space is needed to add Existing Grants/Contracts, please submit on a supplemental Word document and attach with the application.) | | | | | | | | |
|  | | | | | | | | |
| **For Persons with ownership or control interests in the applicant:** | | | | | | | | |
| **First Name** | **Last Name** | | **NPI** (if applicable) | | **Address** (City,State,Zip) | **Role** | | **% Ownership**  (If applicable) |
|  |  | |  | |  |  | |  |
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| **For Entities with ownership or control interests in the applicant:** | | | | | | | | |
| **Legal Name** | | **NPI** (if applicable) | | **Address** (City,State,Zip) | | **Relationship** | | **% Ownership**  (If applicable) |
|  | |  | |  | |  | |  |
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| **The applicant must report investigations of, and sanctions, penalties, or corrective action plans imposed against, the applicant and any person or entity with an ownership or control interest in the applicant, including all officers, directors, and partners. Please provide information from the previous three year period.** | | | | | | | | |
| **Person / Entity** | | **Federal or state agency or accrediting body (e.g., DOJ, OIG)** | | **Description of infraction** | | | **Resolution status** | |
|  | |  | |  | | |  | |
|  | |  | |  | | |  | |

| **Additional Information** | | | |
| --- | --- | --- | --- |
|  | | | |
| **Is your organization or partner organization(s) currently participating in a CMS demonstration model or the Medicare Shared Savings Program?** | |  | |
| If you selected **Yes** above, please explain below. (max 500 char) | | | | |
| Click here to enter text. | | | | |
|  | | | |
| **Please describe generally below any financial relationships between or among health care providers and payers and/or patients that may be used in implementing the proposed service delivery and payment models.** | | | |
| Click here to enter text. | | | | |
|  | | | |
| **Do you anticipate the need for IRB approval from your institution for any aspect of your intervention, including but not limited to collecting patient-identifiable data and providing that data to CMS?** | |  | |
| If you selected **Yes** above, please explain below. (max 500 char) | | | | |
| Click here to enter text. | | | | |
|  | | | |
| **If you are a provider organization, does your organization use an Electronic Health Record system?** | |  | |
|  | | | |
| **CMS is sometimes requested by others to provide the name of a contact at our applicants. Does your organization desire to be contacted for information on your HCIA project (if awarded) and/or your HCIA proposal (if not awarded) by other organizations?**  (Please indicate selection with an ‘**X**’) | | | |
|  | Yes, OK to share our contact information with other government agencies. | |
|  | Yes, OK to share our contact information with other HCIA applicants and awardees. | |
|  | No, please do not release our contact information to anyone outside CMS and its contractors for this application (such as evaluators) | |

**Note that CMS may request additional information from you after review of your responses in this Executive Overview and/or in any other submissions you make in connection with your application and proposal.**