U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Resources and Services Administration

Federal Office of Rural Health Policy
Hospital State Division

Medicare Rural Hospital Flexibility Grant Program

Announcement Type: Initial: New, Competing Continuation
Funding Opportunity Number: HRSA-15-038

Catalog of Federal Domestic Assistance (CFDA) No. 93.241

FUNDING OPPORTUNITY ANNOUNCEMENT

Fiscal Year 2015

Application Due Date: April 6, 2015

Ensure SAM.gov and Grants.gov registrations and passwords are current immediately!
Deadline extensions are not granted for lack of registration.
Registration in all systems, including SAM.gov and Grants.gov, may take up to one month to complete.

Release Date: February 3 2015

Issuance Date: February 3, 2015

Kevin Chaney
Flex Program Coordinator, Hospital State Division, Federal Office of Rural Health Policy, HRSA
E-mail: KChaney@hrsa.gov
Telephone: (301) 945-0851
Fax: (301) 443-2803

Authority: Title XVIII, §1820(g)(1) and (2) of the Social Security Act (42 U.S.C. 1395i-4), as amended; Consolidated and Further Continuing Appropriations Act, 2015 (P.L. 113-235).

EXECUTIVE SUMMARY

The Health Resources and Services Administration (HRSA), Federal Office of Rural Health Policy (FORHP) is accepting applications for fiscal year (FY) 2015 Medicare Rural Hospital Flexibility Grant Program. The purpose of this grant program is to assist Critical Access Hospitals (CAHs) by providing funding to state governments to encourage quality and performance improvement activities including: stabilizing rural hospital finance; integrating emergency medical services (EMS) into their health care systems; incorporating population health; and fostering innovative models of health care. State Flex Programs will act as a resource and focal point for these activities.

Funding Opportunity Title:	Medicare Rural Hospital Flexibility Grant Program
Funding Opportunity Number:	HRSA-15-038
Due Date for Applications:	04/06/2015
Anticipated Total Annual Available Funding:	$22,540,000
Estimated Number and Type of Award(s):	Up to 45 grants
Estimated Award Amount:	Varies by state
Cost Sharing/Match Required:	No
Project Period:	09/01/2015 through 08/31/2018 (3 years)
Eligible Applicants:	States with certified Critical Access Hospitals [See Section III-1 of this funding opportunity announcement (FOA) for complete eligibility information.]

Application Guide:

All applicants are responsible for reading and complying with the instructions included in HRSA's *SF-424 Application Guide*, available online at http://www.hrsa.gov/grants/apply/applicationguide/sf424guide.pdf, except where instructed in this funding opportunity announcement to do otherwise. A short video for applicants explaining the new *Application Guide* is available at http://www.hrsa.gov/grants/apply/applicationguide/.

Technical Assistance:

FFORHP will provide a TA teleconference on Thursday, February 12, 2015, beginning at 04:00 PM ET and concluding at 05:00 PM ET. To attend, please dial: 800-369-1817, passcode: 9815846. This teleconference will be recorded and the phone recording can be accessed 24 hours after the event and accessed by dialing: 800-391-9851; Passcode: 4115. The Instant Replay will be available until Sunday, April 12, 2015 at 11:59 PM CT.

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I. Funding Opportunity Description

1. Purpose

This announcement solicits applications for the Medicare Rural Hospital Flexibility Grant Program. The purpose of the Medicare Rural Hospital Flexibility Grant (Flex) Program is providing support for critical access hospitals for quality improvement, quality reporting, performance improvements, and benchmarking; designating facilities as critical access hospitals; and the provision of rural emergency medical services.

Through these activities the Flex Program ensure residents in rural communities have access to high quality health care services.

State Flex funding for this three-year project period will act as a resource and focal point for strategic planning in the following program areas with an emphasis and priority on quality and financial and operational improvement:

1. Quality Improvement (required)
2. Financial and Operational Improvement (required)
3. Population Health Management and Emergency Medical Services Integration (optional)
4. Designation of CAHs in the State (required if requested)
5. Integration of Innovative Health Care Models (optional)

Program area three and five are optional paths to achieve quality and financial and operational improvement via other activities beyond the required program areas.
The overall goals of the Flex program are to:

- Improve the quality of care provided by CAHs.
- Improve the financial and operational outcomes of CAHs.
- Understand the Community Health and EMS Needs of CAHs.
- Enhance the health of rural communities through community/population health improvement.
- Improve identification and management of Time Critical Diagnoses and engage EMS capacity and performance in Rural Communities.
- Support the financial and operational transition to value based models and health care transformation models in the health care system.

States will use Flex resources to address identified needs for CAHs within the state and to achieve improved and measurable outcomes in each selected program area. FORHP understands that each state will have varied resources to address those needs; therefore, Flex grantees can determine the best activity or group of activities to improve on key outcomes within each selected program area. FORHP recognizes that the grant funding provided through Flex is not sufficient to meet all needs of CAHs within each state, so grantees are expected to assess the needs of CAHs within their state and prioritize which needs are to be addressed over this project period cycle. In order to maximize Flex funding, grantees are encouraged to look at funding cohorts of CAHs with similar challenges.

While working on program activities, states are encouraged to work with, in addition to State Hospital Associations: Quality Improvement Organizations (QIOs), Quality Innovation

Networks (QINs), Health Information Exchanges (HIEs), Hospital Engagement Networks (HENs), State Rural Health Associations, and others concerned with the future of rural health care.

This project period guidance reflects the continued push towards funding activities that can provide clear outcomes and demonstrated improvements. A broad goal is establishing and measuring outcomes consistently across the program nationally in order to show the impact of Flex investments. Furthermore, these Flex activities will better align rural health providers and CAHs with the current healthcare landscape as it evolves. More specifically, through the Medicare Beneficiary Quality Improvement Project (MBQIP) within the Quality Improvement program area, many CAHs signed on to voluntarily participate in quality reporting and improvement initiatives. With this iteration of the program to align with the focus on quality measurement and outcomes across health care payment systems, CAHs that wish to participate in any Flex activity will be required to participate in reporting MBQIP core quality measures.

2. Background

This program is authorized by Title XVIII, § 1820(g)(1-2) of the Social Security Act (42 U.S.C. 1395i-4), as amended. The Health Resources and Services Administration's Federal Office of Rural Health Policy (FORHP) is the focal point for rural health activities within the U.S. Department of Health and Human Services. FORHP is statutorily required in Title VII (Section 711) of the Social Security Act to advise the Secretary on the effects of current policies and regulatory changes in the programs established under titles XVIII (Medicare) and XIX (Medicaid) on the financial viability of small rural hospitals, the ability of rural areas to attract and retain physicians and other health professionals and access to (and the quality of) health care in rural areas. The Social Security Act also requires FORHP to coordinate activities within HHS that relate to rural health care and provide relevant information to the Secretary and others in the Department.

The Medicare Rural Hospital Flexibility Grant Program was authorized by Section 4201 of the Balanced Budget Act of 1997, (Public Law 105-33) and was reauthorized by Section 121 of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110−275).

Since its inception, the Flex Program has provided a framework for states to strengthen rural health care via a variety of activities. To ensure the program aligns with the changing healthcare landscape and is meeting the needs of rural health, FORHP works with technical assistance and evaluation partners. For several years these partners, Technical Assistance and Services Center (TASC) and the Flex Monitoring Team (FMT), assess Flex activities and document evidence-based best practices in the field in addition to providing programmatic reviews and technical assistance to support achievement of Flex program goals at the state level. As a result, the Flex program has a robust understanding of gaps and challenges, in addition to best practices that bring measurable value to rural health. To inform Flex program guidance overall in future years, as well as state guidance, participants are expected to work with TASC and FMT.

Faced with a rapidly changing landscape that is geared toward quality improvement and population health initiatives, FORHP has engaged several key partners in the field, including Flex coordinators and workgroups, for how to best target Flex Programs that can demonstrate value and prepare rural health for the changes and expectations ahead. The project period allows grantees to develop, implement and measure impact and improvement within the key program

areas of the grant, but is short enough that given the changing health care environment, FORHP can adapt the program to better align, as needed, for the next grant cycle.

II. Award Information

1. Type of Application and Award

Types of applications sought: New, Competing Continuation

Funding will be provided in the form of a grant.

2. Summary of Funding

This program will provide funding during Federal fiscal years 2015 – 2017. Approximately $22,540,000 is expected to be available annually to fund an estimated forty-five (45) awardees. New Applicants may request up to $750,000. Competing Continuation applicants should apply *requesting only up to their FY2010 award amount.* The project period is three (3) years. Funding beyond the first year is dependent on the availability of appropriated funds for the Medicare Rural Hospital Flexibility Grant Program in subsequent fiscal years, satisfactory awardee performance, and a decision that continued funding is in the best interest of the Federal Government.

Indirect costs: Administrative (indirect) expenses are limited to the lesser of 15 percent of the award or the State's Federally negotiated indirect rate for administering the award.

Effective December 26, 2014, all administrative and audit requirements and the cost principles that govern Federal monies associated with this award are superseded by the Uniform Guidance 2 CFR 200 as codified by HHS at 45 CFR 75.

III. Eligibility Information

1. Eligible Applicants

States with certified Critical Access Hospitals are eligible for this Grant Program. Only one applicant from each state is eligible, based on the designation of the Governor.

2. Cost Sharing/Matching

Cost sharing/matching is not required for this program.

3. Dun and Bradstreet Universal Numbering System Number and System for Award Management (formerly, Central Contractor Registration)

Applicant organizations must obtain a valid DUNS number and provide that number in their application. Applicant must also register with the System for Award Management (SAM) and continue to maintain active SAM registration with current information at all times during which it has an active federal award or an application or plan under consideration by an agency (unless

the applicant is an individual or Federal agency that is exempted from those requirements under 2 CFR 25.110(b) or (c), or has an exception approved by the agency under 2 CFR 25.110(d)).

HRSA may not make an award to an applicant until the applicant has complied with all applicable DUNS and SAM requirements and, if an applicant has not fully complied with the requirements by the time HRSA is ready to make an award, HRSA may determine that the applicant is not qualified to receive an award and use that determination as the basis for making an award to another applicant.

If an applicant/awardee organization has already completed Grants.gov registration for HRSA or another Federal agency, confirm that it is still active and that the Authorized Organization Representative (AOR) has been approved.

The Grants.gov registration process requires information in three separate systems:

- Dun and Bradstreet (http://fedgov.dnb.com/webform/pages/CCRSearch.jsp)
- System for Award Management (SAM) (https://www.sam.gov)
- Grants.gov (http://www.grants.gov/)

For further details, see Section 3.1 of HRSA's *SF-424 Application Guide*.

Applicants that fail to allow ample time to complete registration with SAM or Grants.gov will not be eligible for a deadline extension or waiver of the electronic submission requirement.

4. Other

Applications that exceed the ceiling amount will be considered non-responsive and will not be considered for funding under this announcement.

Any application that fails to satisfy the deadline requirements referenced in *Section IV.3* will be considered non-responsive and will not be considered for funding under this announcement.

NOTE: Multiple applications from an organization are not allowable.

IV. Application and Submission Information

1. Address to Request Application Package

HRSA ***requires*** applicants for this funding opportunity announcement to apply electronically through Grants.gov. Applicants must download the SF-424 application package associated with this funding opportunity following the directions provided at Grants.gov.

2. Content and Form of Application Submission

Section 4 of HRSA's *SF-424 Application Guide* provides instructions for the budget, budget justification, staffing plan and personnel requirements, assurances, certifications, and abstract. You must submit the information outlined in the Application Guide in addition to the program specific information below. All applicants are responsible for reading and complying with the instructions included in HRSA's *SF-424 Application Guide* except where instructed in the funding opportunity announcement to do otherwise.

See Section 8.5 of the *Application Guide* for the Application Completeness Checklist.

Application Page Limit
The total size of all uploaded files may not exceed the equivalent of 80 pages when printed by HRSA. The page limit includes the abstract, project and budget narratives, attachments, and letters of commitment and support required in the *Application Guide* and this FOA. One inch margins, size 12 Times New Roman font are encouraged for the body of the document. Tables and figures can incorporate size 10 font. Standard OMB-approved forms that are included in the application package are NOT included in the page limit. Indirect Cost Rate Agreement and proof of non-profit status (if applicable) will not be counted in the page limit. **We strongly urge you to print your application to ensure it does not exceed the specified page limit.**

Applications must be complete, within the specified page limit, and validated by Grants.gov under the correct funding opportunity number prior to the deadline to be considered under the announcement.

Program-Specific Instructions
In addition to application requirements and instructions in Section 4 of HRSA's *SF-424 Application Guide* (including the budget, budget justification, staffing plan and personnel requirements, assurances, certifications, and abstract), please include the following:

i. Project Abstract
This section provides a summary of the application. Because the abstract is available for public viewing at the HRSA website Hospital State Division (http://www.hrsa.gov/ruralhealth/about/hospitalstate/medicareflexibility_.html) and is often distributed to provide information to the public and Congress, please prepare this so that it is clear, accurate, concise, and without reference to other parts of the application. It must include a brief description of the proposed project including the needs to be addressed, the proposed services, and the population group(s) to be served.

Please place the following at the top of the abstract:
- Project Title
- Applicant Organization Name
- Address
- Project Director Name
- Contact Phone Numbers (Voice, Fax)
- E-Mail Address
- Web Site Address, if applicable
- List all grant program funds requested in the application, if applicable

The project abstract must be single-spaced and limited to one page in length.

ii. Project Narrative

This section provides a comprehensive framework and description of all aspects of the proposed project. It should be succinct, self-explanatory and well organized so that reviewers can understand the proposed project.

Use the following seven section headers to organize the Narrative:

- *INTRODUCTION -- Corresponds to Section V's Review Criterion 1 (Need)*
- This section provides a brief overview of the purpose of the proposed project, the vision of your Flex program, and highlights the goals for the three year project period. Please indicate which program areas you will be addressing with the proposed project.

NEEDS ASSESSMENT -- Corresponds to Section V's Review Criterion 1 (Need)

This section outlines the high-level needs for all the CAHs in your state from a program wide perspective and are meant to help states prioritize needs and guide program activities Therefore, the CAHs' quality, finance and operations, community and population health management needs must be described and documented in this section. This section should help reviewers understand the state's rural hospitals and communities that will be served by proposed state Flex Program activities. Note: The application needs assessment is separate from the assessment activities identified within the Flex Program areas.

The needs assessment should demonstrate understanding of your state's CAH landscape by assessing cohort disparities and trends of CAHs, or individual CAHs with specific challenges. It should also identify stakeholders already engaged with CAHs. Applicants must consult with CAHs and the state hospital association. Other potential stakeholders include; Quality Improvement Organization – Quality Innovation Networks, Hospital Engagement Networks, and Health Information Exchanges. The assessment will inform and set priorities for the grant objectives and activities described within each program area in the methodology and work plan sections. The assessment should answer the following questions:

- What is the environment for CAHs in your state – current status and trends?
    - Include the total number of CAHs in your state and note any newly certified CAHs or CAHs that closed or converted to a different facility type within the past year.
- Where are the challenges that impact the ability of CAHs to provide high quality care to communities?
- What other stakeholders are engaged in supporting CAH efforts?
- What additional stakeholders could be sought out and engaged in your state?
- What are the gaps in data related to CAHs?
- What is the population health need(s) challenging your state?

Clearly identify data sources and associated dates to show that the needs assessment is based on the most recent information available. It is understood that available data may be several years old in some cases, but can be utilized to establish trends or baseline targets. Applicants may also use data from other sources to supplement the Required Data,

including but not limited to data from networks, data from hospitals, health department data, and focus groups or surveys with hospital CEOs/CFOs/quality staff.

Required Data for Needs Assessment

Applicants are required to use Flex Monitoring Team (FMT) data including Quality Reports, Financial Reports, and Community Benefit Reports when preparing the Needs Assessment: http://www.flexmonitoring.org/data/state-level-data/.

Quality Improvement Assessment:
Applicants must include data from MBQIP in this assessment, now that it is required. MBQIP reports are provided from FORHP to flex coordinators on a quarterly basis. The Flex Monitoring Team produces an MBQIP report with regional and state data comparisons as well as annual state quality reports using Hospital Compare data. The state reports include data reported by CAHs on some of the new 2015-2018 MBQIP outpatient and patient safety measures. Applicants should describe the quality improvement needs identified through MBQIP and Hospital Compare Data for CAHs in your state, as well as any additional quality improvement needs as identified through other state Flex activities can be incorporated. In looking at the MBQIP measures for 2015-2018 (Appendix B – MBQIP Quality Domains), determine where you recognize existing needs, or where there might be need for initial baseline reporting of CAHs on certain measures.

Financial and Operational Assessment:
Applicants must include data from the Hospital Financial Indicator Reports from the Flex Monitoring Team. State-level FMT reports are available at http://www.flexmonitoring.org and hospital-level financial indicator reports are provided to each CAH and each state Flex Coordinator every year (individual financial indicators, trends and peer group comparisons). State Flex Coordinators can download CAH Financial Indicator Reports (CAHFIR) for all hospitals in their state from https://www.shepscenter.unc.edu/cah/ (required username and password are mailed to users or available from CAH.finance@schsr.unc.edu) The CAHFIR includes: six years of data for 22 financial indicators, as well as peer group, state, and national comparative data. The CAHFIR also includes a benchmark report, an outpatient report and a community report that are useful to state Flex Coordinators in the assessment of CAH financial performance. Applicants who have equally robust but more recent data than that available in FMT reports may use these data (identifying the source and justification for use), but must discuss the FMT trends and peer group comparisons.

Population Health Management Assessment:
The FMT Community Benefits state reports provide state trends on community benefit for CAHs within each state, from November 2012. Flex coordinators may have newer information to provide from hospital Community Health Needs Assessments conducted since the last FMT report. Based on the FMT report and other information gathered from the hospitals describe common health needs in CAH communities across your state as well as challenges hospitals face in meeting those needs.

- *METHODOLOGY -- Corresponds to Section V's Review Criterion 2 (Response)*
  Thoroughly describe proposed methods used to support the need(s) of CAHs and meet the program requirements listed in Appendix A (Detailed Instructions for Flex Program

Activities) for the duration of the three-year project period. Develop a clear work plan (see work plan instructions in next section) outlining the use of resources to carry out proposed activities meeting the needs of CAHs for the project period. Use this narrative to explain the components of the work plan, the relationships between them, and the expected measures for demonstrating improvements.

FORHP recognizes that state Flex programs might not have the appropriate expertise for any or all of the Flex activities and contracting to third parties or hospitals is an allowable method for achieving goals. However, state Flex programs should have a strong oversight system in place for sub-contracts and how to measure progress. FORHP also recognizes that the quantity of CAHs per state varies and therefore states may need to prioritize which group(s) of CAHs to work with.

Describe methods for establishing routine communication – electronically and face-to-face, when appropriate – with CAHs and other stakeholders to build cohesive and collaborative relationships. Determining and prioritizing state rural health needs is an allowable objective for the Flex Program, if you have identified and discussed gaps in the needs assessment of this application. In this case applicants should provide ongoing checks throughout the project period to ensure progress is being met and challenges and new gaps are identified.

The Methodology narrative should explain how the activities are targeted to meet the greatest collective needs (link to Needs Assessment) of CAHs and used to implement evidence-based approaches. Given limited amount of funding compared to all the needs within CAHs, grantees are encouraged to maximize impact of Flex funds by funding cohorts of CAHs in improvement activities, however, projects targeting improvement in individual hospital(s) can be justified.

The narrative should describe any state, regional or Federal programs (e.g., Small Rural Hospital Improvement Program – SHIP) that complement the Flex program, to ensure efforts are complementary and not duplicative in nature.

- *WORK PLAN -- Corresponds to Section V's Review Criteria 2 (Response) and 4 (Impact)* The work plan is the succinct overview of the grant objectives, goals, activities, and projected outcomes in table format. It is not a narrative but should refer to the narrative text for elaboration and to explain the relationship between needs, activities, objectives, and goals. The work plan should clearly identify the goals and objectives of the project and depict how program activities will achieve outcomes. The work plan should clearly delineate year one activities and goals and how they transition for the remaining project period (years two and three).

  The work plan should include all activities proposed for the entire three-year project period and make clear the planned duration of each activity. FORHP expects year one to be as detailed as possible while subsequent years may not be as fully described. Goals, objectives, and related activities and outputs should be clearly identified.

  Work Plan Sections:
  - Goal (e.g. Flex Program Area): High-level statements that outline the ultimate purpose of a program; this is the end towards which program efforts are directed

- Objective: Statements describing what a program's activities must achieve in order to reach the program's goals
- Activities: Actions developed to achieve objectives for goal attainment
- Budget: funds allocated to the activities
- Timeline: include start and end dates and responsible staff or contractors.
- Outputs (Process Measures): The direct products (tangible results) of program activities
- Outcome Measures (Short-term, Long-term): Must include intended and measurable target. Targets for your proposed outcomes are required, unless you still need to collect baseline information. Outcome measures answer the question, what was the change? Short-term outcomes are likely to be changes in skills, attitudes and knowledge. Long-term outcomes may involve changes at the organization or program level. Not all activities will have both short term and long term outcomes.

The work plan should describe the objectives and associated activities in all active program areas of the Flex Grant applicants are working toward. The priority should be to address quality improvement and financial and operational needs. Optional program areas (3 and 5) should only be included if the applicant plans work in those program areas during the three-year project period.

1. Quality Improvement (required)
2. Financial and Operational Improvement (required)
3. Population Health Management and Emergency Medical Services Integration (optional)
4. Designation of CAHs in the State (required if requested)
5. Integration of Innovative Health Care Models (optional)

Refer to Appendix A for a description of required and optional activities in each of the five program areas.

NOTE: The project narrative and work plan should complement and not duplicate each other. The work plan is a concise presentation of the activities and outcomes in each core area for the proposed project period. The narrative provides space to elaborate on these activities and describe how and why they will be undertaken

- *RESOLUTION OF CHALLENGES -- Corresponds to Section V's Review Criterion 2 (Response)*
  Applicants must describe current and potential challenges that are likely to be encountered in designing and implementing the activities described in the Work Plan and Program Assessment Plan, and approaches that will be used to resolve such challenges.

  Applicants are encouraged to include a process for developing and/or updating contingency plans, succession planning, and standard operating procedures related to proposed Flex activities. Such planning can ensure program success and progression in the event of staff turnover.

- *EVALUATION AND TECHNICAL SUPPORT CAPACITY -- Corresponds to Section V's Review Criteria 3 (Evaluative Measures) and 5 (Resources/Capabilities)*
  Applicants must describe the plan for the program performance assessment that will contribute to continuous quality improvement of their state Flex Program. The program

performance assessment should monitor ongoing processes and the progress towards the defined goals and objectives of the project as presented in the work plan for the project period.

Applicants must describe the systems and processes that will support effective tracking of performance outcomes, including a description of how the organization will collect and manage data (e.g., assigned skilled staff, data management software) in a way that allows for accurate and timely reporting and allows them to assess to what extent the project objectives have been met.

Applicants must include a periodic self-assessment, to ensure their assessment plan is aligned with any changes to program activities and that planned activities are on track to meet intended outcomes. This includes assessments for any contracted Flex activities to ensure work plan progress is being met.

- *ORGANIZATIONAL INFORMATION -- Corresponds to Section V's Review Criterion 5 (Resources/Capabilities)*
  Provide information on the applicant organization's current mission and structure, scope of current activities, and provide an organizational chart (Attachment #6) that identifies the State Flex Program within the larger organization. Describe relationships or subcontracts that contribute to the ability of the State Flex Program to conduct program requirements and meet program expectations. This section should show applicant's capacity and planning for effective program management for the duration of the project period.

ADDITIONAL NARRATIVE GUIDANCE

In order to ensure that the Review Criteria are fully addressed, this table provides a bridge between the narrative language and where each section falls within the review criteria.

Narrative Section	**Review Criteria**
Introduction	(1) Need
Needs Assessment	(1) Need
Methodology	(2) Response
Work Plan	(2) Response and (4) Impact
Resolution of Challenges	(2) Response
Evaluation and Technical Support Capacity	(3) Evaluative Measures (5) Resources/Capabilities
Organizational Information	(5) Resources/Capabilities
	(6) Support Requested – the budget section should include sufficient justification to allow reviewers to determine the reasonableness of the support requested.

iii. Budget

Reminder: The Total Project or Program Costs are the total allowable costs (inclusive of direct **and** indirect costs) incurred by the recipient to carry out a grant-supported project or activity. Total project or program costs include costs charged to the award and costs borne by the recipient to satisfy a matching or cost-sharing requirement.

See Section 4.1.iv of HRSA's *SF-424 Application Guide*. The directions in this guide differ from those offered by Grants.gov. Please follow the instructions included in HRSA's *SF-424 Application Guide* and this FOA when completing the project budget forms.

Budget for Multi-Year Grant Award

This announcement is inviting applications for project periods up to three years. Awards will be made for a one year budget period, subject to renewal for up to a maximum of two additional budget years within the project period. Continuation of grants funded under these awards will be based on a noncompetitive process, subject to availability of funds, satisfactory progress of the grantee and a determination that continued funding would be in the best interest of the Federal government.

In addition, the Flex program requires the following:

1. A line item budget and budget justification narrative for the project overall and for each proposed sub-recipient or subcontractor for the primary recipient organization containing the following:
   - **Personnel costs**: Personnel costs should be explained by listing each staff member who will be supported from funds, name (if possible), position title, percentage of full-time equivalency, and annual salary.
   - **Fringe Benefits**: List the components that comprise the fringe benefit rate, for example health insurance, taxes, unemployment insurance, life insurance, retirement plans, and tuition reimbursement. The fringe benefits should be directly proportional to that portion of personnel costs that are allocated for the project. If the FOA notes that the program is subject to the General Provisions of P.L. 113-235, the following applies: If an individual's base salary exceeds the legislative salary cap (i.e., $183,300), adjust fringe proportionally.
   - **Supplies**: List the items that the project will use to implement the proposed project. Separate items into two categories: office supplies (e.g., paper, pencils), and educational supplies (e.g., brochures, videos). Remember, they must be listed separately. Per Subpart D 2 CFR 200.314, Property will be classified as supplies if the acquisition cost is under $5,000. Note that items such as laptops, tablets, and desktop computers are classified as a supply if the value is under the $5,000 equipment threshold.
   - **Contracts:** Provide a clear explanation as to the purpose of each contract, how the costs were estimated, and the specific contract deliverables. Applicants and or grant awardees are responsible for ensuring that their organization and or institution has in place an established and adequate procurement system with fully developed written procedures for awarding and monitoring all contracts. Applicants and or grant awardees must provide a clear explanation as to the purpose of each contract, how the costs were estimated, and the specific contract deliverables. Reminder: recipients must notify potential sub-recipients that entities receiving sub-awards must be registered in SAM and provide the recipient with their DUNS number.

- **Travel**: List travel costs according to local and long distance travel. For local travel, the mileage rate, number of miles, reason for travel and staff member/consumers completing the travel should be outlined. The budget should also reflect the travel expenses (e.g., airfare, lodging, parking, per diem, etc.) for each person and trip associated with participating in meetings and other proposed trainings or workshops. Name the traveler(s) if possible, describe the purpose of the travel, and provide number of trips involved, the destinations, and the number of individuals for whom funds are requested.
    - Whenever staff turnover occurs by personnel directly responsible for executing the duties of the Flex grant, the replacement personnel are required to attend the Flex Workshop in Duluth, MN, within one year of start date.
    - Applicants should budget for one meeting in Washington, DC as well as any other two regional or national meetings that help inform the Flex Program work.
    - Flex Coordinators are encouraged to visit CAHs in their state in order to be familiar with operational needs and other issues and applicants should budget accordingly.

- **Other**: Include all costs that do not fit into any other category into this category and provide an explanation of each cost in this category. In some cases, rent, utilities and insurance fall under this category if they are not included in an approved indirect cost rate.
- **Indirect costs**: Indirect costs are those costs incurred for common or joint objectives which cannot be readily and specifically identified with a particular project or program but are necessary to the operations of the organization, e.g., the cost of operating and maintaining facilities, depreciation, and administrative salaries. For institutions subject to 2 CFR Part 220 (formerly OMB Circular A-21), the term "facilities and administration" is used to denote indirect costs. If an organization does not have an indirect cost rate, the applicant may wish to obtain one through HHS's Division of Cost Allocation (DCA). Visit DCA's website at https://rates.psc.gov/ to learn more about rate agreements, the process for applying for them, and the regional offices which negotiate them. If indirect costs are included in the budget, please attach a copy of the indirect cost rate agreement. If the indirect cost rate agreement is required per the FOA, it will not count toward the page limit.

  Reauthorization legislation (P.P 108-173) limits administrative (indirect) costs are limited to the lesser of 15 percent of the award or the State's Federally negotiated indirect rate for administering the award.

The Consolidated and Further Continuing Appropriations Act, 2015, Division G, § 203, (P.L. 113-235) states, "None of the funds appropriated in this title shall be used to pay the salary of an individual, through a grant or other extramural mechanism, at a rate in excess of Executive Level II." Please see Section 4.1.iv Budget – Salary Limitation of HRSA's *SF-424 Application Guide* for additional information. Note that these or other salary limitations will apply in FY 2016, as required by law.

iv. Budget Justification Narrative

Provide a narrative that explains the amounts requested for each line in the budget. The budget justification should specifically describe how each item will support the achievement of proposed objectives. The budget period is for ONE year. However, the applicant must submit one-year budgets for each of the subsequent project period years at the time of application. Line item information must be provided to explain the costs entered in the SF-424A. The budget justification must clearly describe each cost element and explain how each cost contributes to meeting the project's objectives/goals. Provide specific justification for cost requested in the "other" category. For subsequent budget years, the justification narrative should highlight any specific variances/changes from the year one budget or clearly indicate that there are no substantive budget changes from year to year during the entire project period. The budget justification MUST be concise. Do NOT use the justification to expand the project narrative.

See Section 4.1.v. of HRSA's *SF-424 Application Guide*.

v. Attachments

Please provide the following items in the order specified below to complete the content of the application. Unless otherwise noted, attachments count toward the application page limit. Indirect cost rate agreements and proof of non-profit status (if applicable) will not count toward the page limit. **Each attachment must be clearly labeled**.

Attachment 1: Work Plan

Attach the Work Plan for the project that includes all information detailed in Section IV. ii. Project Narrative.

Attachment 2: Staffing Plan and Job Descriptions for Key Personnel (see Section 4.1. of HRSA's *SF-424 Application Guide)*

Keep each job description to one page in length as much as is possible. Include the roles, responsibilities, and qualifications of proposed project staff.

Attachment 3: Biographical Sketches of Key Personnel

Include biographical sketches for persons occupying the key positions described in Attachment 2, not to exceed two pages in length. In the event that a biographical sketch is included for an identified individual who is not yet hired, please include a letter of commitment from that person with the biographical sketch.

Attachment 4: Letters of Agreement and/or Description(s) of Proposed/Existing Contracts (project specific)

Provide any documents that describe working relationships between the applicant organization and other entities and programs cited in the proposal. Documents that confirm actual or pending contractual agreements should clearly describe the roles of the contractors and any deliverable. Letters of agreement must be dated.

Attachment 5: Project Organizational Chart

Provide a one-page figure that depicts the organizational structure of the project.

Attachment 6: Accomplishment Summary

A well-planned accomplishment summary can be of great value by providing a record of accomplishments. It is an important source of material for HRSA in preparing annual reports, planning programs, and communicating program-specific accomplishments. The accomplishments of competing continuation applicants are carefully considered during the review process; therefore, applicants are advised to include previously stated goals and objectives in their application and emphasize the progress made in attaining these goals and objectives. Because the Accomplishment Summary is considered when applications are reviewed and scored, **competing continuation applicants who do not include an Accomplishment Summary may not receive as high a score as applicants who do.** The Accomplishment Summary will be evaluated as part of Review Criterion 5: Resources/Capabilities.

The accomplishment summary should be a brief presentation of the accomplishments, in relation to the objectives of the program during the current project period. The report should include:

1. The period covered (9/1/2010 – 8/31/2015).
2. Specific Objectives - Briefly summarize the specific objectives of the five-year project as actually funded.
3. Results- Describe the program activities conducted for each objective. Include both positive and negative results or technical problems that may be important. Describe lessons learned from unsuccessful activities and technical problems.
4. Ongoing – Describe program activities that will be ongoing and completed at the end of the project period, as well as contingency plans for completing these activities if not finished.

Attachments 7 - 15: Other Relevant Documents, if applicable

Include here any other documents that are relevant to the application, including letters of support. Letters of support must be dated and specifically indicate a commitment to the project/program (in-kind services, dollars, staff, space, equipment, etc.).

3. Submission Dates and Times

Application Due Date

The due date for applications under this funding opportunity announcement is *APRIL 6, 2015 at 11:59 P.M. Eastern Time*.

See Section 8.2.5 – Summary of e-mails from Grants.gov of HRSA's *SF-424 Application Guide* for additional information.

4. Intergovernmental Review

The Medicare Rural Hospital Flexibility Grant Program is not a program subject to the provisions of Executive Order 12372, as implemented by 45 CFR 100.

See Section 4.1 ii of HRSA's *SF-424 Application Guide* for additional information.

5. Funding Restrictions

Applicants responding to this announcement may request funding for a project period of up to three (3) years, at the previously awarded project period levels. Awards to support projects beyond the first budget year will be contingent upon Congressional appropriation, satisfactory progress in meeting the project's objectives, and a determination that continued funding would be in the best interest of the Federal Government.

The General Provisions in Division G, of the Consolidated and Further Continuing Appropriations Act, 2015 (P.L. 113-235), apply to this program. Please see Section 4.1 of HRSA's *SF-424 Application Guide* for additional information. Note that these or other restrictions will apply in FY 2016, as required by law.

Reauthorization legislation (P.L. 108-173) limits administrative (indirect) expenses to the lesser of 15 percent of the award or the Federally negotiated indirect rate for administering the award.

Costs exceeding 25 percent of total grant funds will generally be considered unreasonable for Program Area 3: Population Health Management and Emergency Medical Services Integration.

All program income generated as a result of awarded grant funds must be used for approved project-related activities.

V. Application Review Information

1. Review Criteria

Procedures for assessing the technical merit of applications have been instituted to provide for an objective review of applications and to assist the applicant in understanding the standards against which each application will be judged. Critical indicators have been developed for each review criterion to assist the applicant in presenting pertinent information related to that criterion and to provide the reviewer with a standard for evaluation. Review criteria are outlined below with specific detail and scoring points.

These criteria are the basis upon which the reviewers will evaluate the application. The entire proposal will be considered during objective review. Applicants that receive a low score may be subject to additional reporting requirements, funding restrictions, or limited project periods.

Review Criteria are used to review and rank applications. The Medicare Rural Hospital Flexibility Grant Program has six (6) review criteria:

Criterion 1: NEED (20 points) – Corresponds to Section IV's Introduction and Needs Assessment
The extent to which the *Introduction:*

- Clearly describes the purpose for the proposed project.
- Clearly articulates which program areas will be addressed.

The extent to which the *Needs Assessment*:

- Thoroughly identifies and describes the collective needs of CAHs, the needs of rural communities, and partners who can help address these needs.
- Identifies and describes potential stakeholders not yet engaged.
- Uses appropriate data to support the discussion of need.
- Uses the required data available from the Flex Monitoring Team to describe needs of CAHs.
- Uses MBQIP data to discuss the needs around quality for CAHs.
- Identifies and explains current information gaps related to the Flex program areas of quality improvement, financial and operational improvement, health system development and population health, and innovative health care models.
- Clearly describes the assessment techniques used to determine and prioritize the collective needs of CAHs to be addressed with grant funds.
- Clearly describes the vision of the proposed Flex program, as informed by the needs assessment(s) and expected outcomes.

Criterion 2: RESPONSE (30 points) – Corresponds to Section IV's Methodology, Work Plan, and Resolution of Challenges

Methodology (15 points)

The extent to which:

- The proposed project clearly responds to the "Purpose" included in the program description.
- The proposed goals and objectives are well described and directly address the applicant's chosen program areas of the Flex Program, as detailed in Appendix A.
- Activities are well-described and demonstrate a clear link and response to the needs identified in the Needs Assessment section.
- Baseline and target goal(s) for improvement are clearly described for each measure.
- The links from goals and objectives to the chosen activities are clearly described and logical.
- The method and rationale for determining which CAHs and eligible hospitals are chosen for specific activities is clear, reasonable, and based on objective data.
- The method for establishing and maintaining routine communication with stakeholders and CAHs is clearly described
- Each phase of multi-year activities is discussed with reference to how progress will be tracked during each budget period.
- The Methodology section provides a sound narrative and explanation for the activities outlined in the Work Plan.

Work Plan (10 points)

The extent to which the work plan:

- Implements a plan that is comprehensive, appropriate, reasonable, and attainable.
- Identifies each phase of multi-year projects.
- Includes and clearly provides specific timelines and completion dates for each major activity.
- Incorporates the required activities detailed in Appendix A.
- Incorporates optional activities that are reasonable and address identified state specific needs.
- Identifies the individual(s) responsible for carrying out each activity.

- Presents a concise picture of the complete proposed project with reference to the Methodology for narrative and explanation.
- Includes reasonable baseline and targets for proposed activities.

Resolution of Challenges (5 points)
The extent to which the applicant:

- Identifies and discusses current and potential challenges that may be encountered in implementing the program activities as well as the approaches that would be used to address such challenges. Identifies a process for developing and/or updating contingency plans succession plans, and standard operating procedures related to proposed Flex activities.

Criterion 3: EVALUATIVE MEASURES (10 points) – Corresponds to Section IV's Evaluation and Technical Support Capacity
The extent to which the applicant:

- Proposes feasible and effective method(s) to monitor and evaluate the project results.
- Proposes evaluative measures that will be able to assess 1) to what extent the program objectives have been met and 2) to what extent these can be attributed to the project.
- Proposes a self-assessment strategy through the course of the project to ensure project alignment with proposed goals.
- Proposes a sub-contract assessment processes if applicable.

Criterion 4: IMPACT (10 points) – Corresponds to Section IV's Work Plan, Project Narrative
The extent to which the applicant:

- Demonstrates that the proposed project will have a measurable impact on state CAHs and other stakeholders.
- Describes why projects were chosen to support individual hospitals versus cohort of hospitals and how multiple CAHs will benefit from the Flex grant work.
- Demonstrates a strong linkage between the proposed activities and the expected outcomes for CAHs, rural communities, and other stakeholders.

Criterion 5: RESOURCES/CAPABILITIES (20 points) – Corresponds to Section IV's Organizational Information and Organizational Chart, Evaluation and Technical Support Capacity, and Accomplishment Summary (Attachment 6)

Organization: The extent to which: (5 points)

- The Organizational Information section clearly describes the ability of the organization to meet grant requirements including financial documentation.
- The Evaluation and Technical Support section demonstrates the ability of the organization to track performance outcomes through data collection and reporting.
- Applicant demonstrates capability to manage their State Flex Program and related projects including effective management of subcontractors and other projects as applicable.
- Applicant demonstrates the capacity and planning for effective program management based on previous work.

Personnel: The extent to which: (5 points)

- The application's Staffing Plan (attachment 2) and Position Descriptions (attachment 2) provide sufficient detail about the role and responsibilities of each grant-supported staff position.
- Project personnel are qualified by training and/or experience to implement and carry out their roles described in the Staffing Plan as evidenced by biographical sketches/resumes that document the education, experience, and skills relevant and necessary for successfully carrying out the proposed project.
- At least one full time equivalent position is dedicated to the Flex program and that person(s) has appropriate skills and qualifications as evidenced by the biographical sketch/resume.

Past Performance: The extent to which the Accomplishment Summary (Attachment 6): (10 points)

- Clearly describes the specific goals and objectives of the previous five-year project period. Clearly summarizes previous project period objectives and associated activities (both ongoing and completed) as well as explains contingency plans for incomplete activities.
- Identifies which goals were or were not met, if those met were within the original proposed time period and the reasons why if not met.
- Identifies lessons learned and uses those lessons to inform planning and activities for the new project period.

Criterion 6: SUPPORT REQUESTED (10 points) – Corresponds to Section IV's Budget and Budget Justification

The extent to which the applicant:

- Demonstrates a realistic, adequately justified budget for each year of the three-year project period consistent with the proposed project work plan.
- Includes costs that are reasonable given the activities proposed in the Work Plan.
- Budgets for adequate staff time and resources to achieve project objectives.
- Budgets for required travel: travel for three required meetings each year (national, state or regional).
- Provides a detailed explanation as to the purpose of each contract or subcontract, how the costs were determined or estimated, and the specific contract deliverables.

2. Review and Selection Process

Please see Section 5.3 of HRSA's *SF-424 Application Guide*. Applicants have the option of providing specific salary rates or amounts for individuals specified in the application budget or the aggregate amount requested for salaries.]

This program does not have any funding priorities, preferences or special considerations.

3. Anticipated Announcement and Award Dates

It is anticipated that awards will be announced prior to the start date of September 1, 2015.

VI. Award Administration Information

1. Award Notices

The Notice of Award will be sent prior to the start date of September 1, 2015. See Section 5.4 of HRSA's *SF-424 Application Guide* for additional information.

2. Administrative and National Policy Requirements

See Section 2 of HRSA's *SF-424 Application Guide* which lists administrative and policy requirements applicable to this grant. Applicants are responsible for familiarizing themselves with the contents of the HRSA *SF-424 Application Guide* and following the listed requirements.

Additional administrative requirements:

- As a part of the support provided by FORHP, the Flex Program Participants are expected to work with Flex Monitoring Team (FMT) and Technical Assistance and Services Center (TASC) and use these federally supported resources to inform their programmatic direction.

3. Reporting

The successful applicant under this funding opportunity announcement must comply with Section 6 of HRSA's *SF-424 Application Guide* **and** the following reporting and review activities:

1) **Progress Report**(s). The awardee must submit a progress report to HRSA on an **annual** basis. Further information will be provided in the award notice.

2) A **Performance Improvement Management System (PIMS) report** is due within 60 days of the budget period end date. The required documentation will be uploaded into the HRSA Electronic Handbooks (EHBs).

3) **Federal Financial Report (FFR)** according to the requirements and schedule in the *SF-424 Application Guide*. FFRs are due January 30th of each project year. Any requests for carryover of unobligated funds must be submitted within 30 days of the submission of the FFR to be considered for program approval.

VII. Agency Contacts

Applicants may obtain additional information regarding business, administrative, or fiscal issues related to this funding opportunity announcement by contacting:

Kimberly Dews, Grants Management Specialist
Attn: Rural Hospital Flexibility Program Grantees
HRSA Division of Grants Management Operations, OFAM
Parklawn Building, Room 10W-07A
5600 Fishers Lane
Rockville, MD 20857
Telephone: (301) 443-0655
Fax: (301) 594-6343
E-mail: kdews@hrsa.gov

Additional information related to the overall program issues and/or technical assistance regarding this funding announcement may be obtained by contacting:

Kevin Chaney
Flex Program Coordinator, Hospital State Division
Attn: Flex Program
Federal Office of Rural Health, HRSA
Parklawn Building, Room 17W-49C
5600 Fishers Lane
Rockville, MD 20857
Telephone: (301) 945-0851
Fax: (301) 443-2803
E-mail: KChaney@hrsa.gov

Applicants may need assistance when working online to submit their application forms electronically. Applicants should always obtain a case number when calling for support. For assistance with submitting the application in Grants.gov, contact Grants.gov 24 hours a day, seven days a week, excluding Federal holidays at:

Grants.gov Contact Center
Telephone: 1-800-518-4726 (International Callers, please dial 606-545-5035)
E-mail: support@grants.gov
iPortal: https://grants-portal.psc.gov/Welcome.aspx?pt=Grants

Successful applicants/awardees may need assistance when working online to submit information and reports electronically through HRSA's Electronic Handbooks (EHBs). For assistance with submitting information in HRSA's EHBs, contact the HRSA Call Center, Monday-Friday, 8:00 a.m. to 8:00 p.m. ET:

HRSA Contact Center
Telephone: (877) 464-4772
TTY: (877) 897-9910
Web: http://www.hrsa.gov/about/contact/ehbhelp.aspx

VIII. Other Information

Applicants are required to incorporate FMT data, which can be found here: http://www.flexmonitoring.org/data/.

Applicants are encouraged to utilize the TASC website for more information: https://www.ruralcenter.org/.

Technical Assistance:

FORHP will offer a TA teleconference scheduled for Thursday, February 12, 2015, beginning at 04:00 PM ET and concluding at 05:00 PM ET. This teleconference will be recorded and the phone recording can be accessed 24 hours after here: 800-391-9851; Passcode: 4115. The Instant Replay will be available until Sunday, April 12, 2015 at 11:59 PM CT.

IX. Tips for Writing a Strong Application

Applicants are encouraged to review the TASC Federal Grant Writing Manual at: https://www.ruralcenter.org/tasc/resources/federal-grant-writing-manual.

Also see Section 4.7 of HRSA's *SF-424 Application Guide*.

Appendix A: Detailed Instructions for Flex Core Area Activities

Since its inception, the Flex Program has provided a platform and resources for states to strengthen rural health care by supporting designation of and improvement activities within Critical Access Hospitals (CAHs). The previous project period included core areas of quality improvement; financial and operational improvement; health systems development and emergency medical service integration; and CAH conversion activities. The Flex program has been able to demonstrate its value in many of these areas by improving quality and performance in CAHs; strengthening CAHs and their communities; and ensuring rural communities have access to quality necessary care. Faced with a rapidly changing landscape geared toward quality improvement and population health initiatives; the future of the Flex program will focus on activities that assist CAHs in demonstrating value and prepare rural health organizations for the inevitable changes in our healthcare system. For instance, the program is now composed of five program areas rather than four. Attention toward quality improvement is paramount – the Medicare Beneficiary Quality Improvement Program (MBQIP) is being expanded and is now required as a condition for CAHs to participate in Flex activities. Flex coordinators can utilize up to 25% of their budget on Population Health Management and EMS integration activities in program area three. Lastly, as a new optional initiative, Flex coordinators can propose an Innovative Health Care models that targets a key area of need among CAHs in their state.

The following is a breakdown with more specifics for the five program areas of the Flex Program. Program areas one (1) Quality Improvement and two (2) Financial and Operational Improvement are required to be addressed by all applicants, as they are priority areas for addressing need. Program area three (3) Population Health Management and Emergency Medical Services Integration is optional. However, Activity 3.01(Statewide Population Health Management Needs Assessment) is required if any other Activities within the third program area are selected. Program area four (4) Designation of CAHs in the State, is required *only* if hospitals in the applicant's state seek help in conversion to CAH status. Program area five (5), Integration of Innovative Health Care Models, is a new element of the Flex program designed to allow states to think creatively about transforming rural care across their state given gaps identified through the application development process, initial needs assessment collection and other relevant data. The fifth (5) program area is optional, and allows for states to design a more innovative project that doesn't fit into other program areas, if they have demonstrated that existing needs of CAH in the three required program areas have been addressed.

Key Program Areas:

1. Quality Improvement (required)
2. Financial and Operational Improvement (required)
3. Population Health Management and Emergency Medical Services Integration (optional)
4. Designation of CAHs in the State (required if requested)
5. Integration of Innovative Health Care Models (optional)

Key Definitions for Program Planning and Work Plan:

- **Goals**: High-level statements that outline the ultimate purpose of a program. This is the end toward which program efforts are directed.
- **Objectives**: Concrete statements describing what a program's activities must achieve in order to reach the program's ultimate goals.
- **Activities**: are action(s) that will result in achievement of the objective.

- **Measures**: Ways to quantify the degree of success a program has had in achieving its stated objectives, goals, and activities.
- **Outcomes**: The results of program operations or activities; the effects triggered by the program. Targets for your proposed outcomes are required, unless you still need to collect baseline information.

I. Quality Improvement

This program area, referred to as the Medicare Beneficiary Quality Improvement Project (MBQIP), focuses on work to improve the quality of health care provided by CAHs and other rural health care providers. Other types of health care providers can and should benefit from this work, but the majority of activities must target CAHs.

MBQIP activities are grouped in four different quality domains: Patient Safety, Patient Engagement, Care Transitions, and Outpatient Care. To see a complete list of these quality domain activities with measures please reference Appendix B – MBQIP Quality Domains. FORHP expects all grantees to select Activities 1.01- 1.04, and 1.09 which covers the four quality domains of MBQIP as well as support to CAHs for any needed public reporting assistance.

Building and maintaining the participation of all CAHs in MBQIP through these sets of quality measurement and reporting activities are required. In year 1, it is acceptable to work towards building the capacity for CAHs to participate in these activities and report data if they are not already doing so. For CAHs already engaged in these quality activities, the focus should be on quality improvement. Individual CAHs that do not participate or work towards capacity building, if needed, in all required activities will not be eligible to benefit from Flex grant funds in future years (project period years 2 and 3).

Along with the required set of quality improvement activities, there are additional activities that grantees are encouraged to select based on the needs of the CAHs in their state [Activities 1.05 – 1.08]. These activities do not require participation by all CAHs, but instead should include a cohort(s) of CAHs in the state that need to focus quality improvement efforts on the identified area. It is acceptable to work with an individual hospital, but the need must be clearly justified. While some of the additional activities do have existing measures, some do not yet have a standardized measure set or reporting mechanism. These activities were included to give states an option to work on these national quality priority areas. FORHP will work with grantees in year 1 to determine appropriate outcome measures for those selecting to conduct quality improvement activities for which there is not already a standardized measure set or a national reporting mechanism.

Many of these quality activities have existing quality improvement promising/best practices and resources available for grantees to implement when working with CAHs to improve quality of care. Grantees are encouraged to identify and use existing resources, but there may also be additional innovative projects that grantees can implement, as long as improved quality of care can be shown in the CAHs through use of the identified measures. Potential resources include:

- MBQIP Website (including resources from the Agency on Healthcare Research and Quality (AHRQ): https://www.ruralcenter.org/tasc/mbqip
- Flex Monitoring Team (FMT): http://www.flexmonitoring.org
- Rural Emergency Department Transfer Communications (Stratis Health website): http://www.stratishealth.org/providers/ED_Transfer.html

Specific quality improvement projects can be for 1, 2 or 3 years. Quality outcomes will be assessed for improvement at the state level (for required activities) and cohort level (for optional activities), at the end of each grant year as well as over the course of the 3-year project period. Certain measures and data reporting will be required based on the activity(s) selected.

CAHs already participating in other quality reporting programs outside of the MBQIP program (whether required or optional) should continue with those efforts.

Goal 1: To improve the quality of care provided by CAHs

Objective 1.1: Assist CAHs in implementing quality improvement activities to improve patient outcomes

Activity 1.01(Required): Improve patient safety in CAHs and the community by ensuring all health care providers and eligible patient populations receive their influenza vaccinations.

Activity 1.02 (Required): Improve the patient experience of care through use of the Hospital Consumer Assessment of Healthcare Providers and Systems survey

Activity 1.03 (Required): Improve the transitions of care from the CAH to other healthcare settings in order to improve patient outcomes.

Activity 1.04 (Required): Improve the care provided in CAH outpatient settings in order to improve patient outcomes.

Activity 1.05 (Optional): Improve patient safety and health outcomes in CAHs through other measures.

Specific areas of focus may include:
- Healthcare Acquired Infections (HAI)
- Stroke Care
- Venous Thromboembolism (VTE)
- Pneumonia Care
- Surgical Care
- Perinatal Care

- Falls
- Adverse Drug Events (ADE)
- Reducing Readmissions
- Patient Safety Culture Survey

Activity 1.06 (Optional) Improve care transitions from CAHs to other healthcare settings through improved Discharge Planning.

Activity 1.07 (Optional) Improve care transitions through improved Medication Reconciliation activities.

Activity 1.08 (Optional): Improve the care provided in CAH Outpatient and Emergency Department settings through additional measures.

Measures for all activities you selected (Activity 1.01-1.08): Grantees must provide a baseline and target goal for improvement on measures associated with these activities. For a complete menu set of quality measures to be reported by CAHs, which will be used to determine the baseline and assess quality improvement outcomes, please see Appendix B – MBQIP Quality Domains. Required measures associated with each of the above activities (to be reported by the grantee as statewide totals for required activities, and as cohort totals for additional activities) include: number of CAHs participating in activity, identified baseline quality outcomes, target for quality outcome improvement, actual quality outcomes seen.

Objective 1.2: Assist all CAHs in the state to consistently publicly report data on all required measures.

Grantees should work with CAHs to improve the number of hospitals reporting on the required core measures, including publicly reporting to CMS Hospital Compare. CAHs in need of this assistance should be identified as part of the needs assessment process. Grantees may engage partners to provide the necessary TA around quality reporting with a focus on enhancing CAH capacity (at an organizational level, not only individual staff level) to report quality measures. CAHs are expected to collect and report quality data as a fundamental part of health care operations. Periodic retraining on quality reporting is allowable if challenges are identified during the project period. Quality data must be reported in order to measure and evaluate the outcomes of quality improvement activities conducted under Objective 1.1 activities as well as to conduct needs assessments for determining quality improvement focus areas in years 2 and 3.

Activity 1.09 (Required, if needed) Promote and improve the reporting of quality of care data by CAHs

Measures for Activity 1.09: Grantees must provide a baseline and target goal for improvement on measures associated with this activity. Required measures associated with the above activities: Change in number of CAHs reporting on

required core measures, number of CAHs participating in and reporting on each of the additional quality improvement activities.

II. Financial and Operational Improvement

FORHP expects all grantees to select Activity 2.01 and at least one other activity from areas 2.02-2.04 every year. For the first budget year, FORHP expects that the needs assessment requirement for Financial and Operational Improvement activities will meet the Activity 2.01 requirements. Projects can be for one, two or three years. At the end of each grant year, the grantee is expected to document significant progress, but it is understood that many of these activities cannot be completed in one year. For example, a thorough assessment may be conducted in year 1, the improvement activity (e.g., intensive on-site education and technical assistance) implemented in year two, and a reassessment in year three to determine if the activity was successful. Certain measures and data reporting will be required based on the activity(s) selected. FORHP encourages states to identify new or existing successful financial and operational improvement programs and leverage those to meet the collective needs of CAH in your state to maximize the impact of limited Flex funds. States should minimize consultant expenditures toward individual CAHs for improvement activities and should instead focus on cohorts, unless adequately justified.

Goal 2: To improve the financial and operational outcomes of CAHs.

Objective 2.1: To identify financial and operational strengths and challenges, and to identify statewide and targeted strategies for improvement.

Activity 2.01 (Required)Financial and Operational Assessment

This is a required assessment of statewide CAH financial needs by Flex coordinators using FMT data (22 indicators) or 10 indicators in the Critical Access Hospital Finance 101 Manual, and other hospital financial data, if available in your state. The majority of this information should be on-hand and presented within the needs assessment section of the grant application. Data from CAH Financial Indicator Reports (CAHFIR) produced by the Flex Monitoring Team should be included. Publicly available state-level indicator reports and ancillary resources can be downloaded from http://www.flexmonitoring.org. State Flex Coordinators can download CAHFIRs for all hospitals in their state from https://www.shepscenter.unc.edu/cah/ (required username and password are mailed to users or available from CAH.finance@schsr.unc.edu) The CAHFIR includes: six years of data for 22 financial indicators, as well as peer group, state, and national comparative data. The CAHFIR also includes a benchmark report, an outpatient report and a community report that are useful to state Flex Coordinators in the assessment of CAH financial performance. Applicants who have equally robust but more recent data than that available in FMT reports may use these data (identifying the source and justification for use), but must discuss the FMT trends and peer group comparisons.

Objective 2.2: To identify more in-depth financial and operational strengths and problems based on trends or issues identified through Objective 2.01, and to identify major strategies for improvement for a hospital or cohort of hospitals.

Activity 2.02 (Optional) Financial and Operational In-depth Assessment(s) and Action Planning

Specific areas of focus may include:

- Focus the alignment of health care services with community needs through action planning.
- Prepare the hospital for new payment and care delivery models through strategy development.
- Complete service line level analysis, including: service-level financial and operational efficiency analyses; service market share evaluation; opportunities for new service development and growth of existing services; and discontinuation of services based on market need and/or operational performance.
- Ensure department-level staffing is appropriate relative to benchmarks future community needs.
- Develop action plan with hospital management teams to implement best practice recommendations.
- Develop strategies with leadership to assist the hospital in preparing for the new payment and care delivery models.
- Physician practice management assessment (e.g., physician and mid-level productivity, scheduling, staffing, and billing and collection practices).
- Analysis of reporting practices for Medicare reimbursement.

Measure: Assessments must include an analysis of selected financial indicators (either from the 22 indicators used by the Flex Monitoring Team or the 10 indicators in the Critical Access Hospital Finance 101 Manual).

Objective 2.3: To improve revenue cycle management and to implement activities designed to increase profitability within a hospital or group of hospitals.

Activity 2.03 (Optional) Revenue Cycle Management

Specific areas of focus may include:

- Comprehensive chargemaster review to assess appropriateness of charges and to create a more efficient and compliant pricing mechanism.
- Billing and coding education to improve the understanding of CMS policies, National Correct Coding Initiative, and Current Procedural Terminology (CPT) instructions for reporting and reimbursing services. It can also improve coding accuracy and compliance; identify strategies to capture missed revenue; and increase productivity.
- Implementation of an effective revenue control process
- Use of financial improvement network(s) to share best practices and improve revenue cycle efficiency

- Education and training for hospital personnel and boards to improve revenue management and processes.

Measures for Activity 2.03: Grantees must provide a baseline and target goal for improvement on at least one measure associated with any activity. Required outcome measure(s) associated with the above activities (at least one must be identified): change in days in accounts receivable; change in revenue; or change in number of claims denied.

Objective 2.4: To address areas for improvement (within a hospital or group of hospitals) identified through in-depth operational assessments.

Operational improvement activities may have several areas of focus, including hospital departments, hospital services, and hospital processes. This work can be done through Lean or other process improvement activities, workshops, direct consultations to CAHs or financial improvement networks. Operational improvement activities may also be needed within a hospital in order to build and maintain capacity to report quality data and effectively implement quality improvement activities under MBQIP.

Activity 2.04 (Optional) Operational Improvements

Specific areas of focus can include:

- Hospital departments: Improve operations within specified hospital departments. Support the development and use of productivity benchmarks to improve departmental efficiency.
- Hospital services: Increase a hospital's ability to serve its community by increasing market share and avoiding patient bypass.
- Hospital processes: Improve operations within hospital processes, supply management systems, integration of materials management, billing, purchasing, and patient information systems, work environment, workflow improvement, and pharmacist review of medication orders.

Measures for Activity 2.04: Grantees must provide a baseline and target goal for improvement on at least one measure associated with any activity. Required outcome measure(s): change in revenue, change in staff time, change in patient time, change in market share, percent of all patients in the correct level of care from the time of admission, etc.

III. Population Health Management and Emergency Medical Services Integration

This program area focuses on work to improve the health of rural communities through population health management; communication and collaboration between different health care providers; improving patient experiences when transitioning from one care setting to another; and building EMS capacity to best serve CAHs and their communities.

If grantees select any Activity 3.02-3.06, they must also select Activity 3.01 to inform priorities for other activities funded. Grantees may undertake assessment work during the first year of the grant cycle with development and implementation of targeted activities taking place during years two and three. Projects can be for 1, 2 or 3 years. At the end of each grant year, the grantee is expected to document significant progress against a set target measures, but it is understood that many of these activities cannot be completed in one year. For example, an improvement activity might be planned in year one, conducted in year two, and assessed in year three to determine if the activity was successful.

No more than one quarter of total grant funds can be spent in this core area.

Certain measures and data reporting will be required based on the activity(s) selected.

Goal 3a: To understand the community health and EMS needs of CAHs.

Objective 3.1: Determine collective issues and trends in population health management for CAHs.

This is an assessment of the population health needs from CAHs across your state to understand and determine collective issues and trends. This assessment should include information from the CHNAs required of all not-for-profit hospitals as well as needs assessments from for profit hospitals when available.

Activity 3.01 (Required if this Program Area selected) Statewide CAH Population Health Management Needs Assessment

This assessment should capture the collective population health management needs of CAHs across the state, which can be captured by assessing what CAHs have identified in their own Community Health Needs Assessments.

Objective 3.2: To assist CAHs to identify specific health needs of their communities & implement activities

Activity 3.02 (Optional) Hospital Community Health Needs Assessments and Improvement

These assessments and related projects help specific hospitals or groups of hospitals to identify specific health needs of their communities and programs to identify population health improvement activities, with a focus on building capacity for hospitals and their communities for sustainable and ongoing assessment and improvement initiatives.
These projects could include but are not limited to:

- Promote sharing of findings and best practices among hospitals.
- Provide TA to hospitals to help them conduct Community Health Needs Assessment (building their capacity, but not doing or paying for the work for them).

- Education on health prevention and promotion strategies for population health management.
- Support development of regional population health improvement activities involving multiple CAHs and communities.

Objective 3.03: Improve local/regional EMS capacity and performance in CAH communities. Improve integration of EMS in local/regional systems of care.

Activity 3.03 (Optional) Community-level Rural EMS System Assessment

Use a standard assessment tool to assess EMS capacity and performance. Elements should include: 1) Engage local stakeholders; 2) Conduct assessments; 3) Identify capacity and performance issues; 4) Engage stakeholders in setting priorities; and 5) Identify common priorities by/across communities.

Goal 3b: To enhance the health of rural communities through community/population health improvement.

Objective 3.04: To Assist CAHs to develop strategies for engaging with community partners and targeting specific health needs.

Activity 3.04 (Optional) Population Health Improvement Activity

Measures for Activity 3.04: Chronic disease outcomes (using national metrics to determine outcomes NQF, CDC) diabetes control/COPD/heart disease/mental health

Goal 3c: To improve identification and management of Time Critical Diagnoses and engage EMS capacity and performance in rural communities.

Objective 3.04: To Assist CAHs to develop strategies for engaging with community partners and targeting specific health needs.

Activity 3.05 (Optional) Improve Time Critical Diagnoses EMS System Capacity

Implement strategies to improve local/regional system capacity to identify and manage time critical diagnoses (TCD) (i.e., STEMI, stroke, and trauma). Implement strategies to EMS TCD performance improvement projects could include:

- Engage EMS agencies and local/regional systems of care to develop integrated service systems.
- Improve the capacity of EMS agencies to diagnose and treat TCD episodes of care.

- Expand EMS use of nationally recognized protocols related to TCD and emergency dispatch.

States should think of alternative activities to Leadership Training Academies, unless specific short and long-term measures can be provided to capture Leadership Training activity impact in work towards these TCD performance improvement projects outlined above.

Measures for Activity 3.05: Percent of EMS agencies with operational TCD system PI committees; percent implementing strategies to address resource and work force needs; percent of EMS trained on STEMI, Stroke, and Trauma; percent using AHA Lifeline Guidelines for STEM and stroke; percent using CDC guidelines for field triage of injured patients (trauma) all ages; percent with ED dispatch; percent of systems functioning as integrated systems of emergency care; percent of EMS agencies with improved performance on key TCD measures (e.g., D2B of </= 90 minutes); percent of EMS agencies with improved financial and quality performance; improved EMS systems performance locally and regionally.

Activity 3.06 (Optional) Improve EMS Capacity and Operational Projects

Implement strategies to improve local EMS system capacity issues in CAH communities using data from the EMS assessment process (3.03) and other sources. Activities will target and address issues specific to identified capacity gaps. EMS Capacity projects could include:

- Develop collaborative linkages between CAHs, community providers, and EMS agencies to improve local pre-hospital and emergency care capacity.
- Improve the capacity of EMS agencies to collect and report quality data and use that data for performance improvement.
- Enhance the billing, collection, and financial systems of EMS agencies and their ability to use financial data for performance improvement.

Measures for Activities 3.06: Percent of EMS agencies billing third party payers/patients; percent using patient billing and financial data for PI; percent with quality improvement protocols and processes; percent using quality data; percent of local/regional EMS systems of care in which participants meet regularly to review data on quality and system performance; percent with performance improvement plans; and improved regional/local EMS system capacity.

IV. Designation of CAHs in the State

In accordance with current statute, State Flex Programs are expected to facilitate appropriate conversion of small rural hospitals to CAH status. Flex programs must assist hospitals in evaluating the effects of conversion to CAH status.

This may include assisting with financial feasibility studies for hospitals considering conversion to CAH status as well as feasibility studies for reopening closed rural hospitals or converting CAHs to other types of facilities.

V. Integration of Innovative Health Care Models

This optional program area focuses on developing and integrating innovative health care models around the areas of quality, financial/operations, population health and/or system delivery in rural communities. Ideally, successful models will improve care in rural areas and serve as best practices or strategies for other states. Program Area five (5) is for grantees that have been able to meet the majority of needs of CAHs within their state and have additional capacity to take on an innovative project that isn't captured in the other Program Areas. These innovative projects will be monitored and used to inform Activities included in the next Flex grant project period cycle. Note: Given the intensive nature of Primary Care Medical Home projects which fall outside of the scope of the Flex grant any PCMH activities cannot be included.

Grantees may undertake assessment work during the first year of the grant cycle with development and implementation of targeted activities taking place during years two and three. Projects can be for one, two or three years. At the end of each grant year, the grantee is expected to document significant progress against a set target measure, but it is understood that many of these activities cannot be completed in one year. For example, an improvement activity might be planned in year one, conducted in year two, and assessed in year three to determine if the activity was successful.

Projects proposed must include clear methodology and clear and measurable outcomes.

Goal 5: To support the financial and operational transition to value based models and health care transformation models in the health care system.

Flex funds can be used to assess the impact or support the implementation of health care system changes that will have a substantial effect on quality, financial and operational performance, population health management, or EMS integration of CAHs. A project in this category must include proposed objectives, activities, and desired outcomes.

Objective 5.01: To develop/implement and assess innovative health care models designed to have a positive transformational impact on rural health.

Activity 5.01 Integration of Innovative Health Care Models

Specific areas of focus may include:

- Clinically integrated networks
- Population Health Management
- Projects addressing frequent/high cost users of health care or emergency department
- Care Coordination

Measures for Activity 5.01: Specific outcome measures must be identified so that progress can be measured throughout the project. Applicants must identify proposed projects and measures.

Appendix B: MBQIP Quality Domains

Quality Domain:	***Patient Safety***	***Patient Engagement***	***Care Transitions***	***Outpatient***
Instructions:	Grantees are required to work with all CAHs on all Core Improvement Activities, under each of the four quality domains. There are also Additional Improvement Activities that grantees may select to work on with any cohort of CAHs based on need and relevance (i.e. a Surgical Care initiative would only be relevant for those CAHs who perform inpatient surgeries). *This menu set outlines the quality improvement activities with associated measures that are to be reported by CAHs. Some quality activities are recognized as important areas for quality improvement; however, there are not currently standardized measure specifications or national reporting mechanisms available. These activities are identified as additional quality improvement activities that can be addressed at a state or regional level. States selecting to focus on any such activities will work with FORHP in year 1 to determine a standard set of reporting expectations for future years.* Please remember that these quality improvement and measurement activities are the means to the end goal of improving patient safety, patient engagement, care transitions, and outpatient care in your hospitals.			
Core Improvement Activities	**HCP / OP-27:** Influenza vaccination coverage among healthcare personnel *(Facilities report a single rate for inpatient and outpatient settings)* **Imm-2:** Influenza Immunization	**Hospital Consumer Assessment of Healthcare Providers and Systems** *The HCAHPS survey contains 21 patient perspectives on care and patient rating items that encompass nine key topics:* • *communication with doctors,* • *communication with nurses,* • *responsiveness of hospital staff,* • *pain management,* • *communication about medicines,* • *discharge information,* • *cleanliness of the hospital environment,* • *quietness of the hospital environment,* • *transition of care* *The survey also includes four screener questions and seven demographic items. The survey is 32 questions in length.*	**Emergency Department Transfer Communication (EDTC)***** *7 sub-measures; 27 data elements* **EDTC-1:** Administrative Communication (2 data elements) **EDTC-2:** Patient Information (6 data elements) **EDTC-3**: Vital Signs (6 data elements) **EDTC-4:** Medication Information (3 data elements) **EDTC-5**: Physician or practitioner generated information (2 data elements) **EDTC-6:** Nurse generated information (6 data elements) **EDTC-7:** Procedures and Tests (2 data	**OP-1:** Median time to Fibrinolysis **OP-2:** Fibrinolytic Therapy Received within 30 minutes **OP-3:** Median Time to Transfer to another Facility for Acute Coronary Intervention **OP-5:** Median time to ECG **OP-20:** Door to diagnostic evaluation by a qualified medical professional **OP-21:** Median time to pain management for long bone fracture **OP-22:** Patient left without being seen

			elements) ***Reported to state Flex program and FORHP	
Additional Improvement Activities	**Healthcare Acquired Infections (HAI)** • **CLABSI:** NHSN Central line-associated Bloodstream Infection Outcome Measure (NHSN to IQR) • **CAUTI:** NHSN Catheter-associated Urinary Tract Infection Outcome Measure (NHSN to IQR) • **CDI**: NHSN Facility-wide Inpatient Hospital-onset *Clostridium difficile* Infection Outcome Measure (NHSN to IQR) • **MRSA:** NHSN Facility-wide Inpatient Hospital-onset Methicillin-resistant *Staphlococcus aureus* Bacteremia Outcome Measure (NHSN to IQR) **Stroke** • **Stroke-1:** Venous thromboembolism (VTE) prophylaxis • **Stroke-8:** stroke education • Proportion of patients hospitalized with Stroke – potentially avoidable complications • **OP-23:** ED – Head CT or MRI scan results for Acute Ischemic Stroke or Hemorrhagic Stroke who received Head		**Discharge Planning** *Potential measurement TBD with FORHP* **Medication Reconciliation** *Potential measurement TBD with FORHP*	**ED Throughput** • **ED-1:** Median Time from ED arrival to ED departure for admitted ED patients • **ED-2:** Admit decision time to ED departure time for admitted patients • **OP-18:** Median time from ED arrival to ED departure for discharged ED patients

	CT or MRI scan interpretation within 45 minutes of arrival **Venous thromboembolism (VTE)** • **VTE-1**: venous thromboembolism prophylaxis • **VTE-2**: intensive care unit venous thromboembolism prophylaxis • **VTE-3**: venous thromboembolism patients with anticoagulation therapy **Perinatal Care** • **PC-01**: Elective delivery **Surgery / Surgical Care** • **OP-25**: safe surgery checklist use **Pneumonia** • Proportion of patients hospitalized with Pneumonia – potentially avoidable complications **Falls** Potential measurement around: • Falls with Injury • Patient Fall Rate • Screening for Future Fall Risk **Adverse Drug Events (ADE)** Potential measurement around: • Opioids • Glycemic Control • Anticoagulant Therapy **Reducing Readmissions** *(These measures are calculated for hospitals using Medicare*			

	Administrative Claims Data) **Patient Safety Culture Survey**			