

The six National DPP grantees offer the program consistent with the CDC's Diabetes Prevention Recognition Program (DPRP) Standards. The National DPP grantees deliver the intervention through an estimated 110 sites. Grantees are responsible for scaling and sustaining the National DPP by:

- Increasing the number of delivery sites,
- developing delivery sites' capacity to obtain and maintain DPRP recognition,
- gaining sustainable support for delivery sites from insurance companies in the form of reimbursement, and
- actively educating employers and insurance companies about the cost effectiveness of including the lifestyle change program as a covered health benefit and reimbursing delivery sites on a pay-for-performance basis.

CDC proposes to assess program implementation among National DPP grantees using Excel data collection spreadsheets. This assessment/spreadsheet process is the formative and summative evaluation of the six grantees, and is just one of the several evaluations of National DPP activities; others include the DPRP Standards' measures and Program and Grants Office (PGO) annual grantee progress reports provided to CDC project officers.

The objective of this formative and summative evaluation of the National DPP is to collect additional information to identify program-level factors leading to successful implementation and best

practices for achieving program sustainability and scalability at the community level. Informing the assessment (*i.e.*, the Excel data collection spreadsheet) is the Reach, Effectiveness, Adoption, Implementation, and Maintenance (RE-AIM) framework that National DPP grantees were provided as part of their funding opportunity announcement in 2012. The RE-AIM framework identifies pertinent questions around process and outcome measures that the Excel data collection spreadsheets are designed to answer.

CDC plans to distribute Excel data collection spreadsheets to all six grantees, who will, in turn, disseminate the spreadsheets to their community-level intervention sites. The estimated annualized number of intervention sites is 120.

Program coordinators at each intervention site will be asked to describe their intervention, identify barriers and facilitators to implementation, and identify resources used to deliver the lifestyle change programs via a site-level spreadsheet. Project directors and managers at the grantee organizations will be asked similar questions about resource use and implementation strategies via a grantee-level spreadsheet, but will also be asked to discuss elements related to the reach of their National DPP programs. CDC will use the information gained from the assessment to discern lessons learned and effective strategies

around (1) expanding the reach and sustainability of the National DPP lifestyle change programs, (2) improving recruitment and retention efforts, (3) increasing referrals, and (4) securing sustained commitment among insurance providers and employers to either reimburse organizations providing the program or providing an employee benefit option for the program so it is accessible to individuals most in need of this intervention. Finally, CDC will use the information to inform the development of data-driven technical assistance for National DPP grantees and their intervention sites.

The estimated time burden per site for completion of a site-level spreadsheet is between 30 and 60 minutes, with an average of 45 minutes per spreadsheet per year. The estimated burden for a grantee is up to 12 hours to complete a grantee-level spreadsheet. This includes coordinating the collection of spreadsheets from their respective sites. Collectively, over the three-year clearance period being requested, the total burden estimate is based on 120 annualized responses from National DPP Intervention Sites (110 + 120 + 130/3) and 6 annualized responses from National DPP Grantees (6 + 6 + 6/3). OMB approval is requested for 3 years. All information will be collected electronically. Participation is voluntary and there are no costs to respondents other than their time.

The total estimated annualized burden hours are 162.

**ESTIMATED ANNUALIZED BURDEN HOURS**

Type of respondents	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hours)
National DPP Intervention Sites .....	Spreadsheet for National DPP Intervention Sites.	120	1	45/60
National DPP Grantees .....	Spreadsheet for National DPP Grantees .....	6	1	12

**Leroy A. Richardson,**  
*Chief, Information Collection Review Office,  
 Office of Scientific Integrity, Office of the  
 Associate Director for Science, Office of the  
 Director, Centers for Disease Control and  
 Prevention.*

[FR Doc. 2015-22672 Filed 9-8-15; 8:45 am]

**BILLING CODE 4163-18-P**

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**Centers for Medicare and Medicaid Services**

**Notification of Single Source Cooperative Agreement Awards**

**AGENCY:** Centers for Medicare and Medicaid Services (CMS), HHS.

**ACTION:** Notice.

**SUMMARY:** The Center for Medicare and Medicaid Innovation (CMMI)/Seamless Care Models Group will issue a single-source, cooperative agreement award to three (3) grantees to test a data

aggregation model that combines data from insurance companies and Medicare in support of an innovative payment and service delivery initiative.

**FOR FURTHER INFORMATION CONTACT:**

Janel Jin, U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, 7500 Security Blvd., Baltimore, MD 21244, Phone: (410) 786-1438.

**SUPPLEMENTARY INFORMATION:** Intended Recipients: Rise Health, The Health Collaborative, and My Health.

*Purpose of Award:* The Centers for Medicare & Medicaid Services (CMS) is authorized to test innovative payment

and service delivery models to reduce program expenditures under Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) while preserving or enhancing the quality of care furnished to individuals under such programs. In October 2012, CMS launched the Comprehensive Primary Care (CPC) initiative as a multi-payer demonstration to test a model that fosters collaboration between public and private health insurance companies ("payers") to strengthen primary care. The program includes 479 participating primary care practices and 38 participating payers across 7 regional areas within the United States. The CMS Innovation Center executed a Memorandum of Understanding (MOU) with each participating payer within the 7 regional areas covered by the program. One of the stated goals in the MOU is improving the flow of cost and utilization data to CPC primary care practices. The test model will aggregate multi-payer data for each primary care practice rather than practices receiving the data individually from each payer.

This single-source cooperative agreement award will allow the inclusion of Medicare data into the CPC multi-payer data model. The awardees will combine Medicare Fee-for-Service (FFS) data with utilization data from participating payers resulting in the creation of uniform and actionable reports to support physicians care coordination and quality improvement efforts.

*Amount of the Award:* There will be three (3) single-source, cooperative agreements awarded in the initial amount of \$200,000–\$450,000 per award for the first budget period. An award for a non-competing continuation at \$200,000–\$450,000 may be awarded for a period of 12 months.

*Justification for Single Source Award:* Commercial payers within the 7 regions have agreed to work together to improve data-sharing to the CPC practices. Each of the awardees currently maintain contracts with all of the CPC payers for data-sharing and have worked with the payers and practices to develop business requirements for the CPC multi-payer claims database system. If CMS were to award another source, the vendor would not be aggregating Medicare claims data with claims data from the regional payers, as each of the payers have selected the three entities of this award to perform this function. Doing so would undermine the CPC practices' ability to improve care and lower costs through care coordination and quality improvement and is counter to CMS's MOU with the payers. In conclusion, the only entities capable of

providing the data aggregation services described are the three entities identified for the single-source awards.

*Project Period:* The anticipated period of performance for each cooperative agreement is 12 months from date of award with one continuation period of up to 12 months.

*Provisions of the Notice:* Title: Testing a Model of Data Aggregation under the Comprehensive Primary Care (CPC) Initiative.

*CFDA Number:* 93.646.

*Estimated Award Date:* September 12, 2015.

CMS has solicited proposal from Rise Health, The Health Collaborative, and My Health to include Medicare data into the multi-payer data model of the CPC initiative.

CMS requested the following to be submitted with each application:

1. Cover Letter
2. Project Abstract Summary
3. Project Narrative to address how the applicant will implement the cooperative agreement program in support of the goals of the Comprehensive Primary Care Initiative.
4. Budget Narrative
5. SF-424: Official Application for Federal Assistance
6. SF-424A: Budget Information Non-Construction
7. SF-424B: Assurances-Non-Construction Programs
8. SF-LLL: Disclosure of Lobbying Activities
9. Project Site Location Form(s) [as applicable]

Applications will be reviewed using the following evaluation criteria:

1. Proposed Approach—describe the development and implementation strategy for collecting and aggregating Medicare data with payer data from across the specified regions, including an anticipated timeline and activities associated with building the infrastructure needed to implement the project.
2. Organizational Capacity and Management Plan—demonstrates sufficient infrastructure and capacity to plan and implement the cooperative agreement activities and associated funding.
3. Evaluation and Reporting—overview of plans for quarterly reporting to CMS on the progress of the data aggregation activities funded under this cooperative agreement.
4. Budget and Budget Narrative—provide a detailed cost breakdown with explanations and justifications for the proposed cooperative agreement activities.

**Authority:** The CMS award is authorized under section 1115A of the Social Security Act, as added by Section 3021 of the Patient Protection and Affordable Care Act (P.L. 111-148) which permits the obligation of funding for CMS to design, implement, and evaluate innovative payment and service delivery models.

Dated: September 1, 2015.

**Daniel F. Kane,**

*Director, Office of Acquisition and Grants Management, Centers for Medicare & Medicaid Services.*

[FR Doc. 2015-22687 Filed 9-8-15; 8:45 am]

**BILLING CODE 4120-01-P**

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Administration for Community Living

#### Announcement of the Intent To Award a Single-Source Cooperative Agreement to the Gerontology Institute, University of Massachusetts Boston

**AGENCY:** Administration for Community Living, HHS.

**ACTION:** Notice.

**SUMMARY:** The Administration for Community Living (ACL) announces the intent to award a single-source cooperative agreement in the amount of \$75,000 to the Gerontology Institute, University of Massachusetts Boston (UMass Boston) to support and stimulate the expansion of work already underway by UMass Boston in providing pension counseling services to residents of the State of Illinois.

**DATES:** The award will be issued for a project period to run concurrently with the existing grantee's budget period of July 1, 2015 through June 30, 2016.

**FOR FURTHER INFORMATION CONTACT:** Valerie Soroka, Office of Elder Justice and Adult Protective Services, Administration on Aging, Administration for Community Living, 1 Massachusetts Avenue NW., Washington, DC 20001. Telephone: 202-357-3531; Email: [valerie.soroka@acl.hhs.gov](mailto:valerie.soroka@acl.hhs.gov)

**SUPPLEMENTARY INFORMATION:** The ACL's Pension Counseling & Information Program consists of six regional pension counseling projects, covering 29 states. The state of Illinois, with 6.4 million workers and a pension participation rate of 42%, is one of the largest states without an ACL-funded pension counseling project. The Pension Action Center at UMass Boston, which conducts ACL's New England Pension Assistance Project, is currently providing pension counseling services