# Accountable Health Communities

*Model Overview and Track 1 Requirements*

*Presenters*

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# Agenda

- Accountable Health Communities (AHC) Model Design
  - Model Overview & Structure
  - Track 2 & 3 Updates

- Track 1
  - Overview
  - Requirements

- Application Process
  - Eligibility Criteria
  - Application Requirements
  - Selection Criteria

- Grants Management Process

# CMS Aims

**Better Care:** We have an opportunity to realign the practice of medicine with the ideals of the profession—keeping the focus on patient health and the best care possible.

**Smarter Spending:** Health care costs consume a significant portion of state, federal, family, and business budgets, and we can find ways to spend those dollars more wisely.

**Healthier People:** Giving providers the opportunity to focus on patient-centered care and to be accountable for quality and cost means keeping people healthier for longer.

# CMS Quality Strategy – Goal 5

Successful efforts to improve social determinants of health and access to appropriate healthcare rely on deploying evidence-based interventions through strong partnerships between local healthcare providers, public health professionals, community and social service agencies, and individuals.*

– CMS Quality Strategy, 2015

* https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/CMS-Quality-Strategy.html

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# **Accountable Health Communities Model Overview & Structure**

# Why the Accountable Health Communities Model?

- Many of the largest drivers of health care costs fall outside the clinical care environment.

- Social and economic determinants, health behaviors and the physical environment significantly drive utilization and costs.

- There is emerging evidence that addressing health-related social needs through enhanced clinical-community linkages can improve health outcomes and impact costs.

- The AHC model seeks to address current gaps between health care delivery and community services.

# The Vision for Enhanced Clinical and Community Linkages

| Care Process | Today's Care | Future Care |
|---|---|---|
| **Identification of health-related social need** | Ad hoc, depending on whether patient raises concern in clinical encounter | Systematic screening of all Medicare and Medicaid beneficiaries |
| **Provider response to health-related social need** | Ad hoc, depending on whether provider is aware of resources in the community | Systematic connection to community services through referral or community service navigation |
| **Availability of support to help patient resolve health-related social need** | Ad hoc, depending on whether case manager is available and has capacity given case load and care coordination responsibilities | Community service navigation designed to help high-risk beneficiaries overcome barriers to accessing services |
| **Availability of community services to address health-related social needs** | Dependent on fragmented community service system not aligned with beneficiary needs, often resulting in wait lists or difficulty accessing services | Aligned community services, data-driven continuous quality improvement and community collaborations to assess and build service capacity |

# What Does the Accountable Health Communities Model Test?

The Accountable Health Communities Model is a 5-year model that tests whether systematically identifying and addressing the health-related social needs of community-dwelling Medicare and Medicaid beneficiaries impacts total health care costs and utilization.

# Key Innovations

- **Systematic screening** of all Medicare and Medicaid beneficiaries to identify unmet health-related social needs

- Testing the **effectiveness of referrals** to increase beneficiary awareness of community services using a rigorous mixed method evaluative approach

- Testing **the effectiveness of community services navigation** to provide assistance to beneficiaries in accessing services using a rigorous mixed-method evaluative approach

- **Partner alignment** at the community level and implementation of a quality improvement approach to address beneficiary needs

# Key Definitions for Purposes of AHC Model

- **Community-Dwelling Beneficiary –** a Medicare or Medicaid beneficiary, regardless of age, functional status, and cultural or linguistic diversity, who is not residing in a correctional facility or long-term care institution (e.g., nursing facility) when accessing care at a participating clinical delivery site

- **Community Services –** a range of public health and social service supports that aim to address health-related social needs, and include many home and community-based services

# Key Definitions for Purposes of AHC Model

- **Health-Related Social Need** – refers to community services need that can be linked to health care, including the cost of care and inpatient and outpatient utilization of care

- **Usual Care** – describes the routinely provided clinical care received by patients for the prevention or treatment of disease or injury

# Health-Related Social Needs

| Core Needs | *Supplemental Needs |
|---|---|
| Housing Instability | Family & Social Supports |
| Utility Needs | Education |
| Food Insecurity | Employment & Income |
| Interpersonal Violence | Health Behaviors |
| Transportation | |

* This list is not inclusive

# Model Structure

- The AHC model will fund award recipients, called bridge organizations, to serve as "hubs".

- These bridge organizations will be responsible for coordinating AHC efforts to:
  - Identify and partner with clinical delivery sites
  - Conduct systematic health-related social needs screenings and make referrals
  - Coordinate and connect community-dwelling beneficiaries who screen positive for certain unmet health-related social needs to community service providers that might be able to address those needs
  - Align model partners to optimize community capacity to address health-related social needs

# Accountable Health Communities Model Structure
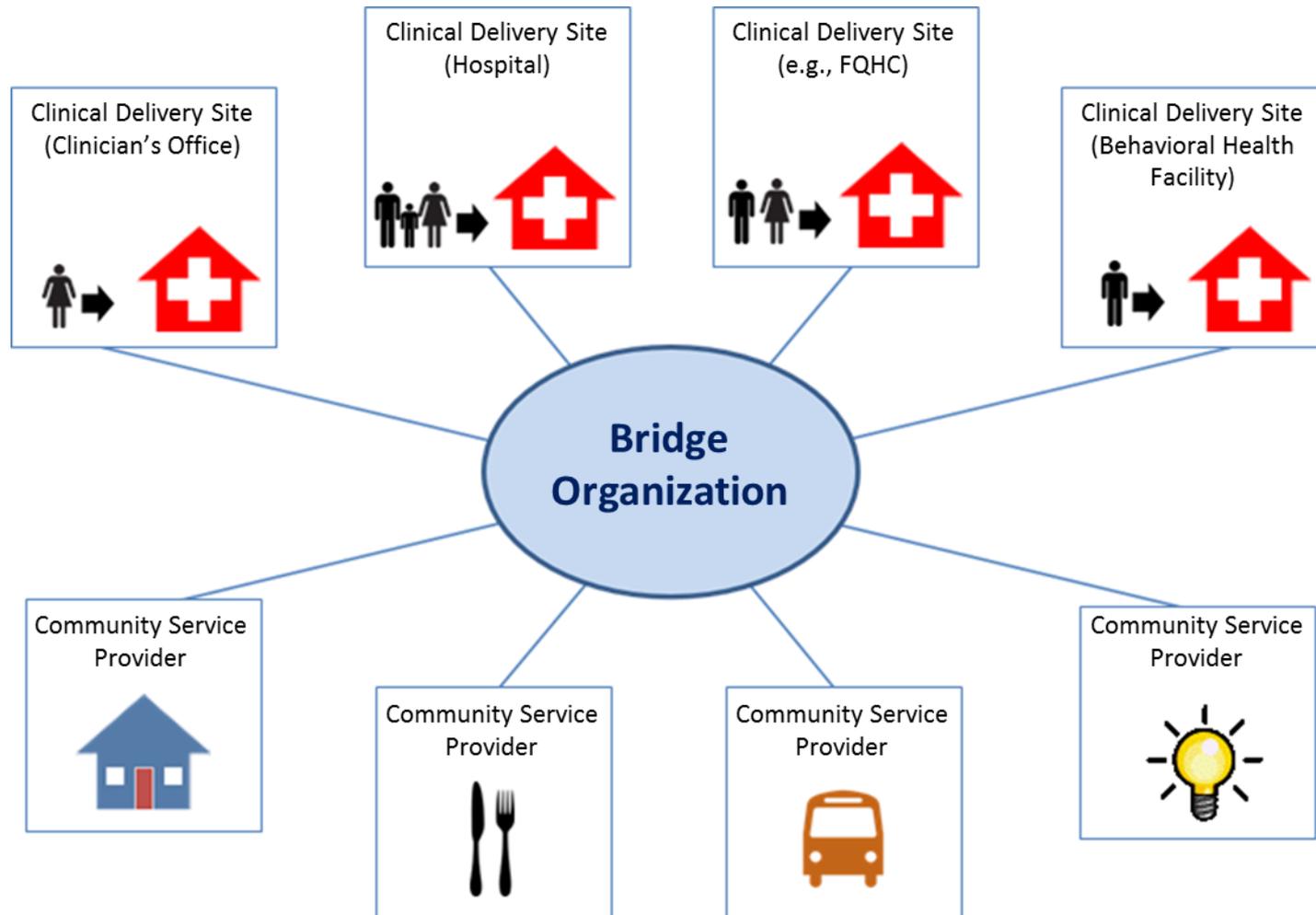
# Accountable Health Communities Model Intervention Approaches:
# Summary of the Three Tracks
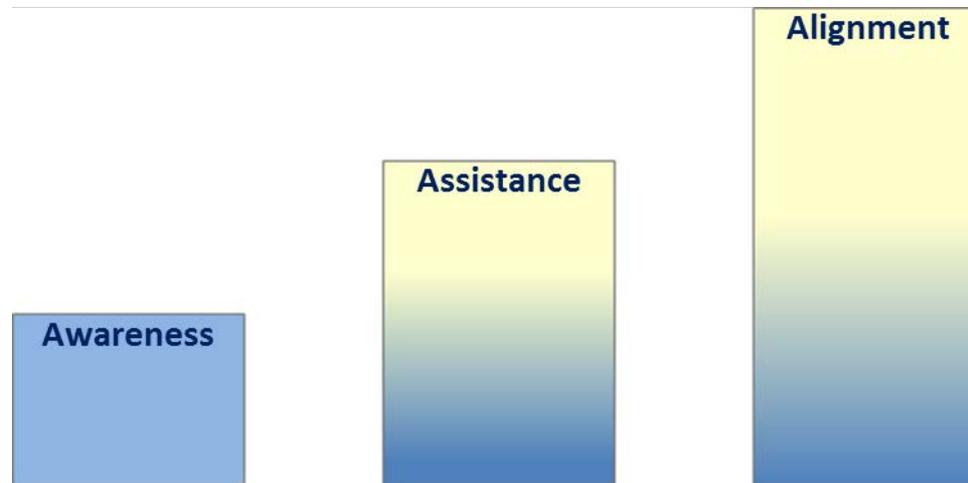


- **Track 1: Awareness** – Increase beneficiary *awareness* of available community services through information dissemination and referral

- **Track 2: Assistance** – Provide community service navigation services to *assist* high-risk beneficiaries with accessing services

- **Track 3: Alignment** – Encourage partner *alignment* to ensure that community services are available and responsive to the needs of beneficiaries

# Track 2 & 3 Updates

- The initial application period for Tracks 1, 2, and 3 closed in May 2016.

- Applications for Tracks 2 & 3 are currently under review.

- CMS anticipates awards will be announced in Spring 2017.

- All applicants, including those who applied to Tracks 1, 2 or 3 in the previous Funding Opportunity Announcement (FOA), are eligible to apply to this FOA.

- Successful applicants will be selected to participate in a single track only.

# Accountable Health Communities
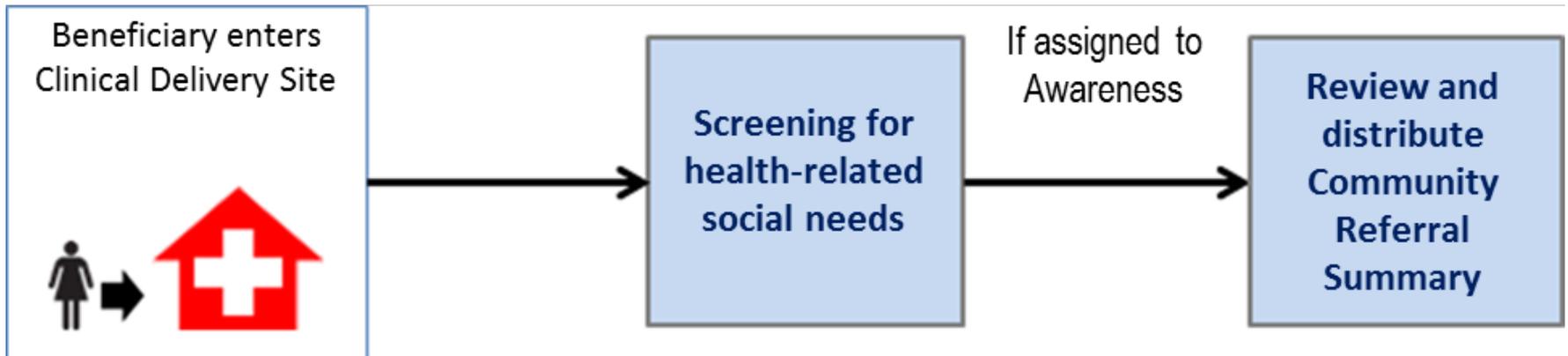# Track 1 – Awareness
# Overview

# Track 1 Changes

- CMS modified Track 1 application requirements and released a new funding opportunity. The modifications include:

  - Reducing the annual number of beneficiaries applicants are required to screen from 75,000 to **53,000**; and

  - Increasing the maximum funding amount per award recipient from $1 million to **$1.17 million** over 5 years.

- CMS believes these two key modifications to Track 1 will make the program more accessible to a broader set of applicants.

- Applicants that previously applied to Track 1 of the AHC Model under the original FOA must **re-apply** using this FOA to be considered for the Model.

- CMS anticipates announcing Track 1 cooperative agreement awards in the Summer of 2017.

# Track 1 – Awareness

| Target Population | Question Being Asked | Partners |
|---|---|---|
| Community-dwelling Medicare and Medicaid beneficiaries with unmet health-related social need(s) | Will increasing beneficiary awareness of available community services, through information dissemination and referral, impact total health care costs, inpatient and outpatient health care utilization and quality of care? | • State Medicaid Agencies<br>• Clinical delivery sites<br>• Community service providers |

# Track 1 – Awareness Pathway

# Track 1 – Awareness Evaluation Diagram
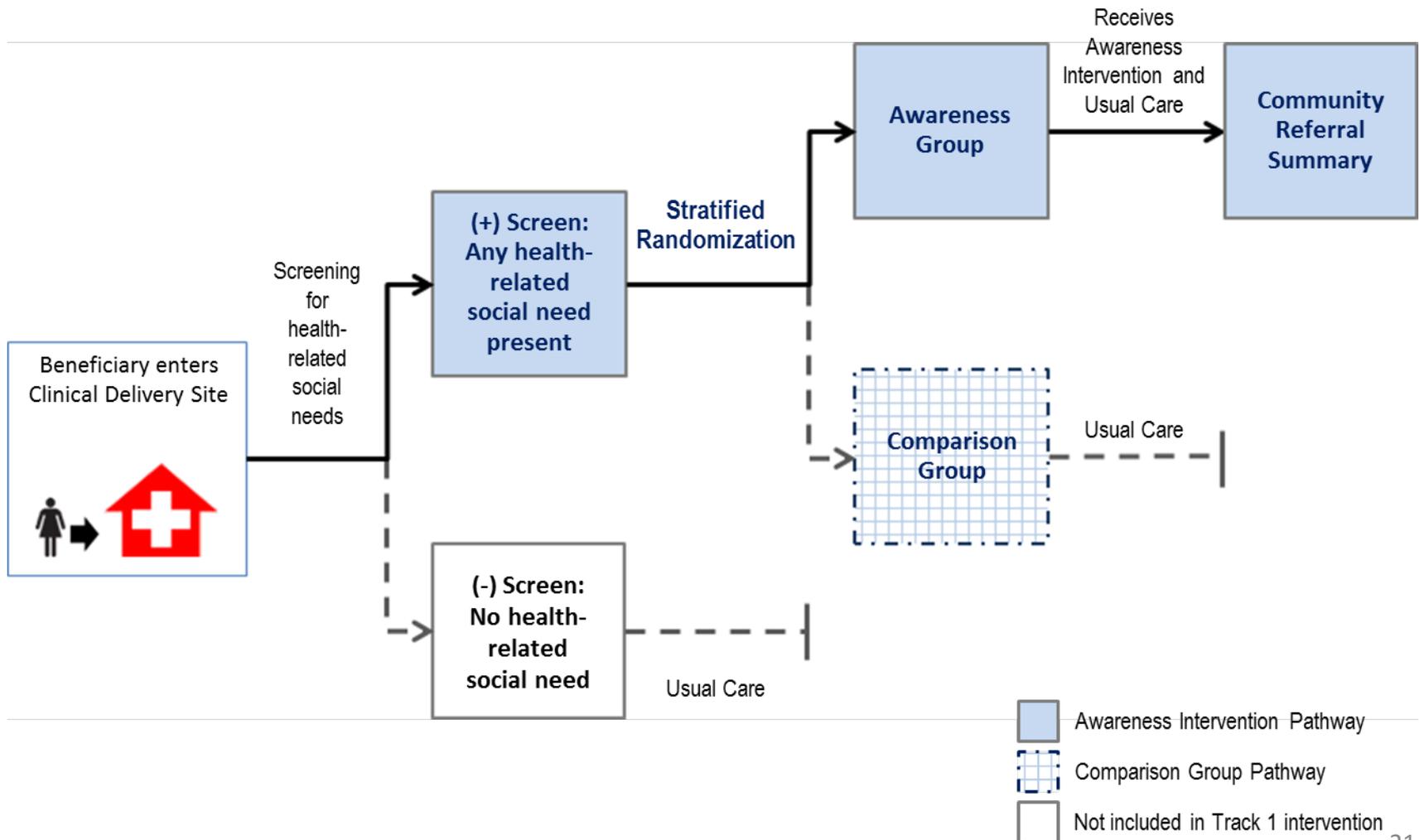
# Track 1 – Stratification Process



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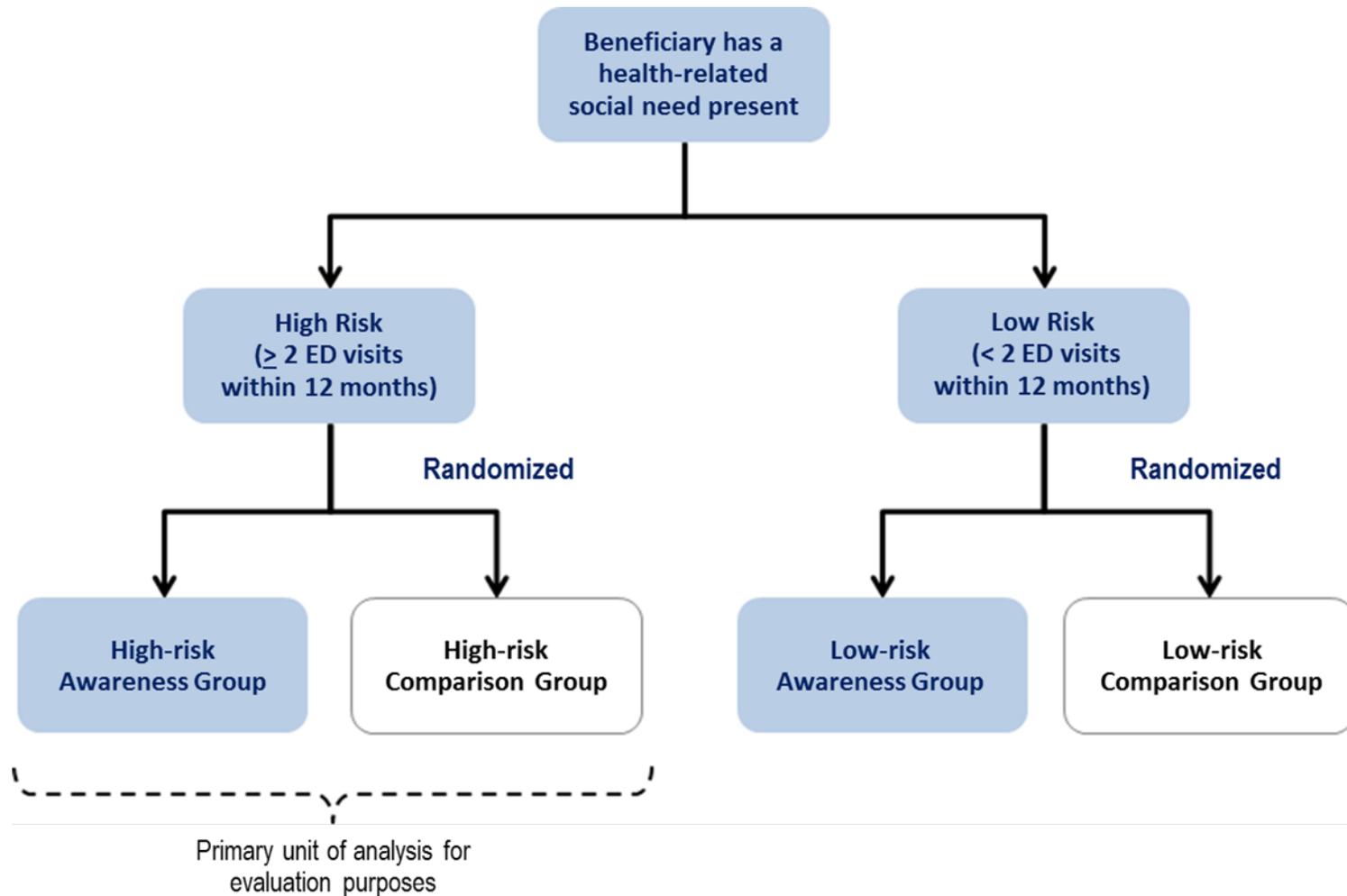
# Performance Metrics

- Healthcare utilization: emergency department visits, inpatient admissions, readmissions and utilization of outpatient services

- Total cost of care

- Provider and beneficiary experience

# Accountable Health Communities Track 1 Requirements

# Model Participants

- Bridge organization

- At least one state Medicaid agency

- Clinical delivery sites, including at least one of each of the following types:
  - Hospital
  - Provider of primary care services
  - Provider of behavioral health services

- Community service providers that have the capacity to address the core health-related social needs

# Bridge Organizations and Model Participant Requirements

**Bridge organizations collaborate with model participants to:**

- Develop their application proposals

- Identify existing community resource inventories

- Design and implement an intervention that supports the community service and clinical communities' commitment to achieving Accountable Health Communities goals

# State Medicaid Agency Requirements

**As consortium members, state Medicaid agencies dedicate staff time for Accountable Health Communities-related activities, including:**

- Data collection and reporting

- Sustainability planning

- An annual intervention review (to ensure that AHC services are not duplicative)

- An annual review of the Accountable Health Communities Intervention and a Letter of Support

# State Medicaid Agency
# MOU Requirements

- Statement of status toward meeting ongoing T-MSIS milestones
- Summary of state laws and policies regulating the release of Medicaid claims data for beneficiaries in the model to CMS, and an overview of the process and timeline for obtaining Medicaid claims data
- Supplemental statement outlining a plan for coordinating with CMS to provide required AHC data in the absence of timely T-MSIS data
- Description of roles and responsibilities for the respective tracks
- Commitment of key personnel
- Summary or list of state-run initiatives with the potential for overlap or duplicative services that are operating in the target area
- Verification from state Medicaid agency on clinical delivery sites' estimates of Medicaid beneficiary ED utilization in the previous 12 months
- Commitment to working with bridge organization to establish a consortium

# Clinical Delivery Sites

**Bridge Organizations must:**

- Include contracts, MOUs or equivalents agreements with clinical delivery sites in their application for participating hospitals, primary care provider or practice, and provider of behavioral health services

- Ensure that their consortium, through their participating clinical delivery sites, will be able to present opportunities to screen at least **53,000** community-dwelling beneficiaries per year

# Clinical Delivery Sites
# MOU Requirements

- The description of the community-dwelling beneficiary population who have received clinical services in the previous 12 months at the clinical delivery site (specifically address the number of each)

- Where possible, the number of community-dwelling beneficiaries who utilized the ED two or more times in the previous 12 months

- The NPI, TIN and any other relevant provider identifiers for providers who will participate in the model

- Commitments to have the bridge organization screen all community-dwelling beneficiaries seeking health care services at their site

- Commitment to submit required AHC data to the bridge organization and CMS

- Description of planned protocols for allowing screening of community-dwelling beneficiaries

# Community Service Providers

**A community service provider is defined as any independent, for-profit, non-profit, state, territorial, or local agency capable of addressing core or supplemental health-related social needs identified through the screening tool**

- Community service providers will receive referrals

- A contract, MOU or MOU equivalent from each intended community service provider is optional, but recommended

# Screening Tool

**Bridge organizations will:**

- Use the screening questions provided by CMS to screen for core health-related social needs

- Choose an appropriate method to administer the screening tool

- Systematically submit all information, including beneficiary identifiers, received through this screening tool to CMS or its contractors

- Make the tool available to all beneficiaries regardless of language, literacy level, or disability status

# Community Resource Inventory

**Bridge organizations will:**

- Create a **Community Resource Inventory** of available community services and community service providers to address each of the domains included in the screening tool

- Update this inventory every six (6) months

**The inventory will include:**

- Contact information, addresses, hours of operation, and other relevant information that a beneficiary would need to access the resources of an organization

# Learning System

**The learning system will:**

- Support shared learning and continuous quality improvement between bridge organizations, their partners and CMS

- Facilitate movement of timely, accurate, and relevant information to allow bridge organizations and partners to share promising practices and learn from their peers about Accountable Health Communities activities

# Learning System

**Bridge organizations and their model partners will work with the learning system to:**

- Create a driver diagram as a framework to guide and align intervention design and implementation activities

- Provide data and feedback to CMS at regular intervals on quality improvement efforts, activities, and measures

- Align data-driven decisions with the successful outcomes sought by the model

- Participate in learning system events in person and virtually (i.e., web series, online seminars, and teleconferences)

- Engage state Medicaid agencies as necessary to achieve model goals

# Accountable Health Communities Application Process

# Eligible Applicants

**Eligible applicants include:**

- Community-based organizations

- Health care practices

- Hospitals and health systems

- Institutions of higher education

- Local government entities

- Tribal organizations

- For-profit and not-for-profit local and national entities

Applicants from all 50 states, U.S. territories, and the District of Columbia will be accepted.

# Application Package Components

- **Project Narrative**
  - Intervention Design – Core Elements
  - Bridge Organization
  - Stakeholder Engagement

- **Implementation Plan**
  - Health Resource Equity Statement
  - Assessment of Program Duplication

- **All standard forms** are required and must be submitted with the application (see slide 52 for list of forms)

# Application Package Additional Documents

**Applicants must also submit:**

- Memoranda of Understanding (MOU) with:
  - State Medicaid Agency(ies)
  - Clinical Delivery Sites (hospital, primary care provider, behavioral health treatment facility)

- Budget Narrative

# Application Content Requirements

**Applicants must provide within their project narrative:**

- **Intervention Design** to include:
  - Background
  - Geographic Target Area
  - Systematic Screenings for Health-Related Social Needs
  - Risk Stratification
  - Tailored Community Resource Inventory and Referrals Summary

- **Bridge Organization**
  - Description of capacity to carry out core elements and a description of the process for data collection and reporting for internal quality control and CMS monitoring and evaluation

- **Stakeholder Engagement**
  - State Medicaid Agency Consortium
  - Clinical Delivery Sites
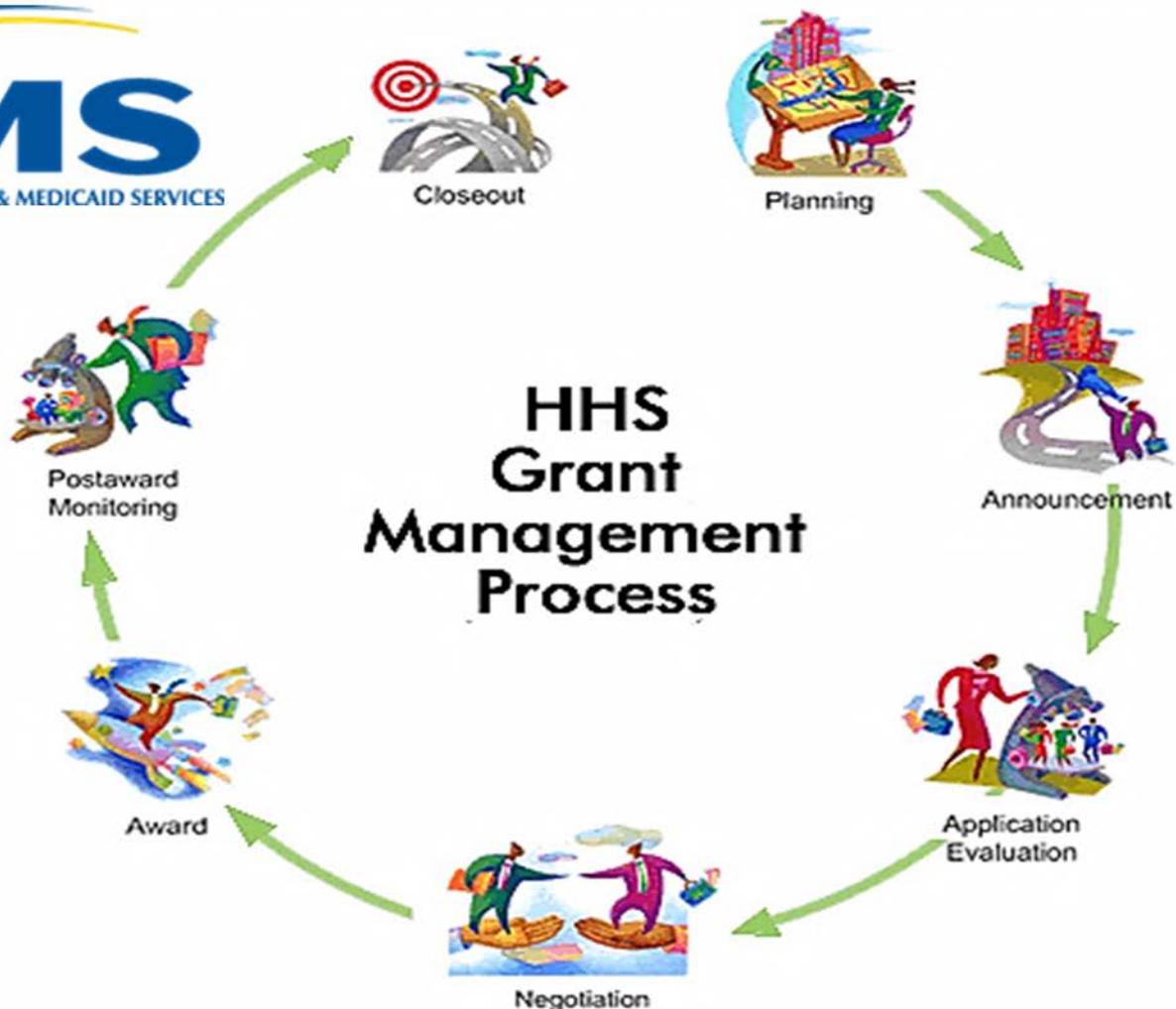  - Community Service Providers

# Ineligibility Criteria

- Funds will not pay directly or indirectly for provision of community services.

- State Medicaid Agencies are ineligible as lead applicant.

- Only one bridge organization will be funded for a given geographic area.

- An applicant can only be funded to implement one AHC track.

- Funds shall not be used to build or purchase health information technology that exceeds more than 15 percent of the total costs of the applicant's proposed budget.

- Medicare Advantage plans and Program of All-Inclusive Care for the Elderly (PACE) organizations are ineligible to apply.

- CMS will not review applications that merely restate the text within the FOA.

- CMS will not fund proposals that do not submit a contract, MOU or  equivalent agreement from the appropriate state Medicaid agencies.

- CMS may deny selection based on information found during a program integrity review.

# Selection Criteria

**The selection criteria for applications will be based on the prospective bridge organization's ability to:**

- Meet eligibility and application requirements for the track chosen by the applicant organization

- Demonstrate commitment, collaboration, and engagement of community stakeholders

- Provide required social needs data and Medicare and Medicaid claims data on beneficiaries in the model to CMS and its contractors

- Demonstrate readiness to implement the intervention

HHS
Grant
Management
Process

Closeout

Planning

Announcement

Application Evaluation

Negotiation

Award

Postaward Monitoring

# Grant Award Process



Congress **authorizes** the program.

President requests funds; Congress **appropriates** them.

Federal agency may develop **program regulations** or **guidelines** to program implementation.

Agency **advertises** availability of funds.

Prospective recipient **applies** for assistance.

Agency **reviews** applications and selects proposals for funding.

Recipient conducts approved project; agency **monitors** award.

Agency **closes out** the award at the end of the project period.

Process may be repeated for **subawards**.

# Funding Mechanism

**What is a grant or cooperative agreement?**

- Grants and cooperative agreements are defined **as a transfer of money, property, services, or anything of value to a recipient in order to accomplish <u>a public purpose</u> through support or stimulation that is authorized by federal statute in 45 CFR Part 75**.

- **Simply:  A grant or cooperative agreement is used when the principal purpose of the award is to provide assistance for the benefit of the public.**

# AHC=Cooperative Agreement

# What Does "Substantial Involvement" in a Cooperative Agreement Mean?

**Some examples of substantial involvement by CMS include:**

- the ability to halt an activity immediately if detailed performance specifications are not met
- requiring the recipient to meet or adhere to specific procedural requirements before subsequent stages of a grant project may continue
- CMS specifying direction or redirection of scope of work due to the Interrelationships with other projects
- CMS collaborating with the recipient by working jointly with a recipient scientist or technician in carrying out the scope of work, by training recipient personnel, or detailing federal personnel to work on the project
- by CMS limiting recipient discretion with respect to scope of work, organizational structure, staffing, mode of operations, and other management processes, coupled with close monitoring or operational involvement during performance

**The following actions do <u>not</u> represent substantial involvement**:

- exercising normal stewardship responsibilities during the project to ensure compliance with regulations, statutory requirements, and the award terms and conditions
- becoming involved in a project solely to correct deficiencies in project or financial performance
- performing a pre-award survey and requiring corrective action to enable the recipient to account for federal funds
- following normal procedures set forth by regulation concerning federal review of grantee procurement standards and sole source procurement

# Roles and Responsibilities

Grants Management Officer  (federal)

Grants Management Specialist (federal)*

Program Authorizing Official (federal)

Project or Program Officer (federal)*

Authorized Organizational Representative
(non-federal)

Principal Investigator/Project Director
(non-federal)

# Grant Policy

- Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards 2 CFR 200

- **45 CFR Subpart 75—UNIFORM ADMINISTRATIVE REQUIREMENTS, COST PRINCIPLES, AND AUDIT REQUIREMENTS FOR HHS AWARDS**

- HHS Grant Policy Statement (2007)

- SAM.gov
  - EPLS
  - CCR (Central Contractor Registration)

- FAPIIS (initiated in January 2016)

# Application and Submission Procedures

- All applicants must have a valid Employer Identification Number (EIN)/Taxpayer Identification Number (TIN).

- All applicants must have a Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number to apply.

- All applicants must register in the System for Award Management (SAM) database to be able to submit an application.  DO THIS IMMEDIATELY!

- The Authorized Organizational Representative  (AOR) who will officially submit an application on behalf of the organization must register with Grants.gov for a username and password.

# Grants Management GrantSolutions

**The Grants Center of Excellence (grantsolutions.gov)**

- Official Grant File in electronic file format

- Accessible to OAGM/CMMI/Applicant
  - Issue NoA's
  - Grant Notes (internal and correspondence)
  - Amendments (budget reallocations, carryovers, etc.)
  - FFR Reporting module
  - Closeout

# Application and Submission Procedures

- All pages of the project and budget narratives must be paginated in a single sequence.

- Font size must be at least 12-point with an average of 14 characters per inch (CPI).

- The Project Narrative must be double-spaced.

- The Budget Narrative must be single-spaced.

- Tables included within any portion of the application must have a font size of at least 12-point with a 14 CPI and may be single spaced. Tables are counted towards the applicable page limits mentioned in Section 4. Eligibility Information of this funding opportunity announcement.

- The project abstract is restricted to a one-page summary which may be single-spaced.

- The following required application documents are excluded from the page limitations described in Section 4. Eligibility Information of this funding opportunity announcement: Standard Forms, applicant's copy of its Letter of Intent for the AHC model (if previously submitted) and the Project Abstract.

- **<u>Failure to meet formatting requirements can result in the application not being reviewed at all.</u>**

# Application and Submission Procedures

## Standard Mandatory Forms

- SF 424: Official Application for Federal Assistance

- SF 424A: Budget Information Non-Construction

- SF 424B: Assurances – Non-Construction Programs

- SF LLL: Disclosure of Lobbying Activities

## Budget Narrative

- 15-Page Limit

- Refer to Appendix: Sample Budget and Narrative Justifications in FOA for detailed cost tables and breakdown for each SF 424A line item.  Locate Budget Narrative Form in the Grants Application Package www.Grants.gov

# Funding Restrictions

## Direct Costs

- Cooperative agreement funds may not be used to provide individuals with services that are already funded through any other source, including but not limited to Medicare, Medicaid, and CHIP.

- Funds shall not be used to build or purchase health information technology that exceeds more than 15 percent of the total costs of the applicant's proposed budget.

## Reimbursement of Pre-Award Costs

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

# Funding Restrictions

**Prohibited Uses of Cooperative Agreement Funds**

Use of cooperative agreement funds in the following ways will result in termination of the applicant's funding to implement the AHC model:

- To match any other Federal funds.

- To fund the provision of social services.

- To provide services, equipment, or supports that are the legal responsibility of another party under Federal, State, or Tribal law (e.g., vocational rehabilitation or education services) or under any civil rights laws. Such legal responsibilities include, but are not limited to, modifications of a workplace or other reasonable accommodations that are a specific obligation of the employer or other party.

- To provide goods or services not allocable to the approved project.

- To supplant existing State, local, Tribal or private funding of infrastructure or services, such as staff salaries, etc.

- To be used by local entities to satisfy state matching requirements.

- To pay for construction.

- To pay for capital expenditures for improvements to land, buildings, or equipment which materially increase their value or useful life as a direct cost, except with the prior written approval of the Federal awarding agency.

- To pay for the cost of independent research and development, including their proportionate share of indirect costs (unallowable in accordance with 45 CFR 75.476).

- To use as profit to any award recipient even if the award recipient is a commercial organization, (unallowable in accordance with 45 CFR 75.215(b)), except for grants awarded under the Small Business Innovative Research (SBIR) and Small Business Technology Transfer Research (STTR) programs (15 U.S.C. 638). Profit is any amount in excess of allowable direct and indirect costs.

# Application Process, Review, and Award

- Go to **Grants.gov** to view the full funding opportunity announcement and application kit.

- Submit application at Grants.gov no later than **3pm EST, November 3, 2016**.

- Applications downloaded from Grants.gov into GrantSolutions.

- Applicant review process begins.

- Program produces decision memo recommending selected applicants.

- CMS begins budget negotiations with selected applicants based on the submitted SF 424A, budget tables, and narratives.

# Application and Submission Procedures

## Applications

- Search by the CFDA number:  93.650

- Application must be submitted in the required electronic-PDF format at http://www.grants.gov, no later than the established deadline date: November 3, 2016.

- Application deadline: Applications not received electronically through www.grants.gov by the application deadline <span style="color:red">November 3, 2016</span> will not be reviewed.

- Specific instructions for applications can be found at Grants.gov.

# Contact Information

| For **administrative questions** about this cooperative agreement, please contact: | For **programmatic questions** about this cooperative agreement, please contact: |
|---|---|
| Louise M Amburgey<br>U.S. Department of Health and Human Services<br>Centers for Medicare & Medicaid Services<br>E-mail: OAGM-AHC@cms.hhs.gov | Susan Jackson<br>U.S. Department of Health and Human Services<br>Centers for Medicare & Medicaid Services<br>E-mail:<br>accountablehealthcommunities@cms.hhs.gov |

# Important Accountable Health Community Model Web Links

For important updates and more information on

the Accountable Health Communities Model visit:

https://innovation.cms.gov/initiatives/ahcm

For assistance with www.grants.gov,

contact support@grants.gov or 1-800-518-4726