Dialogue4Health Web Forum
Community Prevention and Multi-Sector Stakeholder Web Forum Series – Advancing Accountable
Health Communities: A New Funding Opportunity to Spur Clinical and Community Partnerships
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>> Hello and welcome to Advancing Accountable Health Communities: A New Funding Opportunity to Spur Clinical And Community Partnerships. My name is Star Tiffany and I will be running today's web forum. Closed captioning will be available throughout today's web forum. Regina with Home Team Captions will be providing real-time captioning. The closed captioning text will be available in the media panel viewer. The media viewer panel can be accessed by clicking on an icon that looks like a small circle with a film strip running through it. This can be found in the top right hand corner. And on a Mac, bottom right hand corner of your screen. On the bottom right hand corner, you'll see the show/hide header text. Please click on this in order to see more of the live captioning. During the web forum, another window may cause the media viewer panel to collapse. But don't worry, you can always reopen the media viewer window by clicking on that circle with the film strip running through it.

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Once the web forum ends today, survey evaluation will open in a new window. Please take a moment to complete the evaluation as we need your feedback. The recording and presentation slides will be posted on our web site at Dialogue4Health.org. We are encouraging you to ask questions throughout today's presentation. To do so, simply click the question mark icon, type your question in and hit send. Please send your question to all panelists. We will be addressing questions both throughout and at the end of the presentation. We will also be using the polling feature. Tonya, please bring up poll number one. Please select your answer from the available choices and click the submit button. I am attending this web forum individually, in a group of 2 to 5 people, in a group of 6 to 10 people, in a group of more than 10 people. Once you've chosen answer, be sure to click submit.

Again, once you are done taking the poll, bring up that media viewer panel, click on the circle with the film strip running through it. It is my pleasure to introduce our moderator. Richard Hamburg, MPA. He is Interim President and CEO at Trust for America's Health or TFAH. He oversees public policy initiative, advocacy campaigns and internal operations and has more than 25 years of experience as a leading health policy advocate. He helped lead TFAH's efforts and has been instrumental in TFAH's work on obesity prevention, building national pandemic flu and public health emergency response capabilities, and increasing support for public health programs. Rich, please go ahead.

>> Richard Hamburg, MPA: Thanks a lot, Star. Glad to be here today. Pleased to welcome you to this second installment of our new community prevention and multi sector Stakeholder webinar series. Today's series is brought to you by a series of co-sponsoring organizations. American Public Health Association, Public Health Institute, Prevention Institute and a collaboration of a number of co-sponsoring organizations. Too numerous to list right now. But you see them on the slide.

The goal of the series is to highlight the unique partnerships between public healthcare and multi-sector Stakeholders. We're delighted to have a range of sponsors for this series. It enables new funding opportunities and emerging models and best practices. The third webinar will take place on January 27th. You can go to Dialogue4Health.org for more information and to register.

On to today's topic, Accountable Health Communities, we're fortunate to have with us two great panelists. Chisara Asomugha, MD from Centers for Medicare and Medicaid Services, former executive director, Jeffrey Levi, PhD.

We'll hear about the funding opportunity including CMS's aims and also about the structure requirements for the effort. We'll then hear from Jeff who will share reflections and opportunities as this new effort emerges. And then we'll have time for questions. Please remember to submit questions using the Q and A feature during the web forum as we'll have time at the end to answer as many as possible.

So before we start, this is a good time to ask our participants -- and here's the general agenda. Now's a good time to ask participants to respond to a second poll question. How familiar are you with the goals and aims of Accountable Health Communities? We'll briefly share results and move on with our agenda.

>> This is Star. I would continue. It's going to take a little bit for that to end.

>> Richard Hamburg, MPA: All right. Let's move along here. We'll get the results in just a while. On behalf of Trust for America's Health, we're excited to be part of today's discussion. Including in the social determinacy of health. This funding opportunity provides the opportunity to demonstrate that meeting patient's social needs improves health outcomes and reduces cost in Medicare and Medicaid. We're excited about the chance to demonstrate the effectiveness of multi-sector coalitions to identify and address service gaps, specifically track three of this demonstration/funding opportunity.

Community level quality improvement is what public and now population health is all about. We look forward to hearing more from Chisara about how CMS will support partnerships, data and community level improvement. Dr. Chisara Asomugha, MD has spent her career working to improve the health of vulnerable populations. She's director for the population health incentives and infrastructure in the innovation center at the Centers for Medicare and Medicaid Services. Thank you for joining us today and willingness to review the application details. Let me turn it over to you to hear more about this new $157 million opportunity. We also appreciate your willingness to take questions later in the forum.

>> Chisara Asomugha, MD: Good morning and good afternoon, everyone. It is a pleasure to be with you today to discuss the Accountable Health Community model that was announced a few weeks ago from the Center for Medicare and Medicaid Innovation at CMS. I'd like to go

over a few things with you guys about the model including what Rich has said. Some of the thinking behind where this model came from and what we hope to see happen as it goes live.

To begin, I want to discuss three aims of CMS. Many of you have heard. The three part aim or triple aim. Better care, smarter spending, and healthier people. These three aims of CMS provide the foundation by which models are created and executed within the innovation center. Having the opportunity to realign the practice of medicine for better care. Realizing that healthcare costs consume a significant portion of state, federal, family, business and community budgets. And then also realizing that giving providers the opportunity to focus on patient-centered care and be accountable for the quality and cost means keeping people healthier and longer over the life spectrum.

So what is the Accountable Health Community model? I will come back to this slide. I want to get right into the meat of it. Many of the largest drives of healthcare costs fall outside of the clinical care environment. I recognize and understand that many of you know this. Especially, if you are working within the communities outside of the clinical care environment. We also recognize that social and economic determinants drive utilization and costs. And emerging evidence as well as decades of work to address health-related social needs through enhanced clinical-community link ans that can improve health outcomes and impact costs. This new model coming out, seeks to address current gaps between the healthcare delivery system and community services.

What does the Accountable Health Community model test? Some of you may know, the innovation center is authorized under section 3021 of the Affordable Care Act to test, design and test models that can impact healthcare utilization and cost. So out of the innovation center, we have model tests. And the Accountable Health Community model is tests identifying and addressing the health related social needs of community dwelling Medicare and Medicaid beneficiaries can impact quality, utilization and cost. And what makes the model so unique is it is the first to look at health-related social needs universally across Medicare and Medicaid beneficiaries.

So what are health-related social needs? I'm going to be specific to this model. There's another way of describing this. But within this model, we're talking about health-related social needs that the evidence has shown that we can address that will impact healthcare utilization and cost. Within the model, there are two types of needs separated out if you've read the funding opportunity needs. Core needs and supplemental needs. The core needs housing instability, utility needs, food and security, interpersonal violence and transportation are those we are hoping that all awardees -- or expect that all awardees for funding for this model test will address. Systematically identify and address within their communities.

The supplemental needs fall into the four categories here. Family and social supports, education, employment and income, and health behaviors. Those needs in that column are not inclusive. They, based on the needs of the community, led by the Bridge organization or the hub that would be applying for this, can determine what needs may be an issue within the community based on community needs assessments that may have been done. So there is flexibility in the supplemental needs if a community says this particular thing is an issue we want to address. That is fine. But all awardees are expected to look at the core needs related to the health-related social needs listed there.

Now, what are some of the key innovations of this model test? First of all, like I said before, there's this universal systematic screening of all Medicare and Medicaid beneficiaries to identify health-related social needs. And testing the effectiveness of referrals to increase awareness of commercial services. And then also testing the effectiveness of community service navigation to provide assistance to beneficiaries in accessing services. And the way that we'll assess those is using a mixed-method evaluation approach. And especially in track three but hopefully across all three tracks, the key innovation here from CMS is this partner alignment at the community level. And this being a really community-driven model. And an

implementation of a quality improvement approach to identifying and addressing beneficiary needs.

So what is the structure of the Accountable Health Communities? They serve as the backbone or the hub of the community. And these organizations are responsible for coordinating the Accountable Health Community effort to test three community focused interventions of varying intensity. That's coming up visually on another slide. Where they are partnering with clinical delivery sites to conduct these systematic health-related social needs screenings. They are coordinating community resources for high-risk beneficiaries who are identified to have these health-related social needs. And aligning with partners within the model to optimize community capacity to address those needs.

Here it is. Track one is our awareness. Increasing the awareness of what is happening in the community. And by beneficiary, I'm speaking specifically to Medicare and Medicaid beneficiaries. And then you see there's track two, which in addition to what is taking place with track one, there is the assistance through community navigation services. And then track three which is the alignment to ensure community services are available.

There are three things that we're looking at specifically because of the way the innovation center is designed. One is the healthcare utilization. And then total cost of care. We're also doing a qualitative component. And that's why the evaluation approach is mixed method, which is looking at provider, beneficiary and community experience as this model test goes forward. It helps us to better understand what is working, what doesn't work, what must we tweak as we think into the future in terms of scaling and sustainability.

What are some of the model requirements? So the model requires there be a bridge organization. That's the lead applicant. Person or organization submitting the application. One that is part of that community or serves beneficiaries in that community. The community service providers that have the capacity to address the core health-related social needs I mentioned earlier. And clinical delivery sites. That is, at least one hospital. One provider of primary care services and one provider of behavioral health services. At a bare minimum, these are the groups that should be involved in any test of the Accountable Health Community. So if you're a community looking to apply, one much each of these is necessary in order to be considered meeting the criteria for the application process.

An important note is bridge organizations have to establish a consortium. That's the applicant comes in, they need to be able to demonstrate they have a consortium or able to build a consortium for the purposes of this model. Why the consortium needed? Well, first, it's to facilitate timely data sharing between the state Medicaid agency, the bridge organization and other model partners that are joining in the consortium. What is meant by data broadly is data associated by the health community's model.

And also to support collaboration on continuous quality improvement and sustainability planning. That is required in track three. The members required are the bridge organization and the state Medicaid agency or agencies that administer funds to Medicaid beneficiaries in that geographic target area. Let me pause for a moment. State Medicaid agencies that are involved. For instance, if you are in a community that borders multiple states, if you have a population served by multiple state agencies, the state Medicaid agency that serves the majority of those beneficiaries in your community should be on this consortium.

In addition, you can also have other state Medicaid agencies participate if their population is represented in your community. I will say it again. You can have more than one state Medicaid agency as part of your consortium. Especially, if you are in one of the Border States where it is overlapping. The point is to make sure the one who takes care of the Medicaid beneficiaries in your community is on that consortium. If you'd like to add others, that is up to your digression.

When it comes to geographic target area, some ask what's the ideal geographic target area? That is up to the applicant and the community. We really want this to be community

driven, community led. And that the state involvement will be at the level of the agency to ensure that data is shared appropriately. And understanding how to use data to drive improvement for health.

Delivery sites who are all model participants as I mentioned are also able to be on the consortium. But at least the bridge organization and the state Medicaid agency associated with the Medicaid beneficiaries in the community applying must be in the consortium.

There's also the screening tool that I mentioned. This health-related social screening tool. Bridge organizations will use the screening questions provided by CMS to screen for poor health-related social needs specific to the AHD model. They will choose an appropriate method whether it's paper, electronically, by a trained staff like a counselor or some other designated professional. There is flexibility in that.

Then they will submit this information including beneficiary identifiers received through the screening tool to CMS or contractors. As part of understanding whether the health related social needs that are being identified are being addressed and what is impacts on healthcare utilization and cost.

And also to be able to make the tool available to beneficiaries regardless of language, literacy level or disability status.

In terms of state Medicaid agency consortium requirements, the next two slides are focused on the state Medicaid agency's requirement as being partner with the bridge organization. One, they should facilitate the reporting of Medicaid claims data. They should support data sharing across clinical delivery sites and community service providers consistent with federal state and local law and ensure alignment with existing Medicaid policy, waivers and any state plan amendment so we can achieve sustain ability if the model is successful. And then also be a point of contact for data collection and reporting. I can't stress enough how much data is important for us to understand what's taking place on the ground and whether the interventions or the practices are actually helping us move in the right direction.

Now, I mentioned earlier the community resource inventory. By we, I'm saying we collectively. What is available in terms of community services and community service providers. Bridge organizations will have to create a community resource inventory. If one already exists, at least be able to show it is useful for the community and update this inventory every six months. The inventory should include basic information that anybody trying to even do a Google search on housing services might be able to find like contact information. Addresses, hours of operation and other information that may be relevant to the beneficiary.

Another important aspect of the Accountable Health Communities model is the learning system. Within the innovation center, the spread and diffusion of best practices is a priority. Very important and we have it included in all of our models. The Accountable Health Community model is no different. Because of its unique nature to CMS and history in terms of innovation center models, this learning system is critical. All awardees who participate in the Accountable Health Community model will and must participate in the learning system to help spread best practices, not only with peers but with CMS and across the country to help us understand what is taking place when it comes to facilitating strong linkages between the clinical services environment and community services.

So this learning system will support shared learning and continuous quality improvement. And timely, accurate and relevant information to allow bridge organizations and partners to share promising practices and also learn from peers about the Accountable Health Community activity.

Bridge organizations and their model partners will work with the learning systems as a framework to guide and align design and implementation activities. Align data driven decisions with outcomes sought by the model which I mentioned earlier. Those healthcare metrics. Participating in the learning system's events whether in person or virtually. And engaging state Medicaid agencies as necessary to achieve model goals.

So let's turn over to some of the eligibility criteria related to the Accountable Health Community model. Lots of questions about eligible applicants. Who is eligible? Here in this list, if you fall into these categories you are eligible. Community-based organization, individual and group provider practice. Providing specialty care. Hospitals and health systems. Institutions of higher education. Local government entities. And tribal organizations. Applicants from all 50 states are eligible to apply.

Letters of intent and application submission requirements. On this slide, take note. Tomorrow we will be doing a webinar, much longer webinar through CMS related to the Accountable Health Communities and be talking about the application process. In the meantime, we are strongly encouraging that letters of intent be submitted prior to the application submission using the web site that is listed here. If you have not been able to see the application, visit grants.gov where you cannot only upload the funding opportunity announcement but can submit it electronically too.

And any questions that you may have, if your questions aren't answered today, can be directed to the CMS mail box listed.

We are posting every week responses to questions that can be asked via that email box. If you send an email, you will get a reminder or an up data letter saying your question has been answered in this week's FAQs and to go to that. You can imagine with the amount of interest we have had in this model that we are overflowing with questions and comments and items. So please feel free to do that to send your email to that mail box.

I'm going to go back to a slide that I had previously slid over. Just to make sure we're clear and everybody has the dates. The funding opportunity announcement was posted January 5th. The Letter of Intent is due February 8th. And the application is due March 31st of this year. We hope to award in December of 2016 and the expected performance period will be in January. As I said, we will be having another webinar tomorrow. We will reiterate a lot of this information and go into some significant detail about the application process.

With that, I want to conclude my part of this discussion. Thank you.
>> Richard Hamburg, MPA: Clearly, the agency is --
>> Hi, Rich, you are still muted.
>> Richard Hamburg, MPA: Okay. Sorry, I was being muted and unmuted. Pardon us. Thanks so much for that. That was terrific. A lot of questions coming in. We'll try to address as many as we can after Jeffrey Levi, PhD.

That was a thoughtful presentation. The specifics. We'll take some time for everyone to get through. But very helpful. Before I introduce Jeff, I want to ask our webinar participants one additional polling question. Are you planning to apply or join the Accountable Health Communities application? Take a minute to complete this and we'll share later on in this webinar.

Okay. Now I have the pleasure of introducing my long-time colleague and good friend Dr. Jeffrey Levi, PhD. Currently at the Milken Institute School of Public Health and work focuses on public health, healthcare system and multi-sector collaborations required to improve health. So glad you could join us today. Look forward to hearing your reflections on this new opportunity with this effort as the work moves forward. Jeff?
>> Jeffrey Levi, PhD: Well, thank you, Rich. I am delighted to be on this call. And to really -- this is such an important culmination on the part of so many organizations to make this new experiment and new things happen.

Part by so many of us in the public health community to think about how healthcare can be moving upstream. This FOA from CMS is really an incredibly important policy statement by CMS. Really important in achieving the health outcomes and cost containment so central to improving our health system. So this is an incredible opportunity to evaluate how well the different systematic approaches out there work. And to build on the theory, the practice and policy work of so many of us on the call today, as I said. Also builds on research and evidence

based developed over a significant period of time. But this is a chance to see how we can spread and scale some of these important concepts.

What's important for many of us in the public health community and part of this Dialogue4Health series is the notion of population health in this funding opportunity announcement really moves us beyond thinking about one patient at a time in a healthcare setting to really addressing the needs of beneficiaries in the Medicare and Medicaid system by harnessing community's assets. Population health is being addressed -- can be addressed through a combination of healthcare services, public health, community, policy systems, and environmental change. And also individual provision of social services. This FOA takes into account two of the four factors. The delivery of healthcare services and the provision of social services.

But there's also the potential in track three of bridging and aligning all four. And to give you something of a visual context for this. This very busy slide comes out of one of the TFAH convening back in 2012 where we're trying to think where does prevention happen in this reform and going changing healthcare system. And the system starts rewarding health outcomes rather than volume.

And so here what you see is that healthcare system and community prevention and social service providers need to come together in order to achieve this improved goal -- this goal of improved health outcomes at lower costs.

So that, I think, you can look at this in more detail later. But to a large degree, this is what the FOA is promoting.

This obviously is building on prior work and on-going related work. There isn't enough time on this call to mention so many in the community who have been doing so much. Earlier models going way, way back to the 70s of the social Health Maintenance Organizations. That was another experiment about thinking how -- what were then financing administration beneficiaries could be linked to social services. But the coordinated care organizations, the care communities and health leads, goes on and on and on.

A lot of the policy work that has been happening around this did emerge from some of the discussions that TFAH sponsored. And there's a link here to some of the earlier descriptions of the models that were really foundational to bringing this concept forward. Certainly, there are similar efforts now happening in the SIM states with Accountable Health Community and RFT that is coming out is another example of a different take on this. More of a broad community geographic community focus rather than Medicare and Medicaid beneficiaries. But certainly complimentary to that. And the efforts of moving healthcare upstream and bringing a lot of providers together to think about creating that link to the community is yet another example. So lots of precedence here. A lot of parallel work happening that can, I think, help people see and benefit from -- can help add to the knowledge base that will support the Accountable Health Communities CMS will be funding.

This is all about building partnerships. In each of these examples I mentioned and particularly in this funding opportunity announcement, it's about creating new types of partnerships across sectors. We've done this before. And, in fact, the federal government has supported this before in different ways. The most -- given my background in HIV, the Ryan White program is a perfect example of recognizing we can't improve healthcare if we're not also addressing social service's needs. The needs assessments required in the program, the planning Councils that serve as bridge organizations, the legal recognition of the role of social services are similar to what we're seeing in this funding taunt announcement. And certainly, in the context of community prevention whether it was in communities putting prevention to work, the transportation grants or the new build grants out there supported by foundations. All of these, again, are the notion of supporting a bridge organization. Bringing the right players to the table to solve a problem.

So what's going to be really important in this is not just that we learn from this FOA and this incredible investment being made but also that we learn for future efforts and we learn from the parallel efforts that are occurring. And these are just a handful of questions that I have come up with that I hope will be looked at. Some of them are certainly going to be built into the evaluation of the Accountable Health Communities. But others, we as a community are going to have to come together and better define looking at the multiple experiments that are taking place. Who must be at the table for a successful consortium among health systems, community and social service providers? So what is the magic number or who are the critical players that need to be there?

What are the attributes of different organizations? How are data and IT going to work well in bridging these various types of services? And how much investment will that take? We all know there may be some social service gaps that are identified in this process. And yet the funding does not allow CMS dollars to use to fill those gaps. But maybe when the table is set right and all of the players come together and identify these gaps, other resources can be found. That's a critical question to be looked at. And quite frankly, even if we see improved health outcomes in savings by helping people get more social services. What is the impact on the overall budget of a state or a locality in terms of health and social services if we're increasing by the same amount, is that going to be -- what does that mean for the future of this kind of an effort? Or by doing a better job of coordinating these two types of services are we actually having a win-win on both sides of the ledger.

And finally, when the Accountable Health Communities are operating in other health initiatives, does that improve outcomes? There are a lot of communities investing in broad based community prevention activities. And we need to be able to look at those evaluators will look at externalities.

Those are a few ideas how we need to be assessing this. That's probably getting ahead of the game. We need people to be apply and be funded. And the main purpose of this is really to make sure that we get your questions answered and get really strong applications in. And so again, thanks to the folks at CMS who develop this funding opportunity and thanks to so many of you on the call part of this partnership in moving the policy environment forward to generate this funding opportunity announcement, I will turn this back over to Rich.
>> Richard Hamburg, MPA: Thanks a lot, Jeff.
>> Hi, Rich, you are muted again.
>> Richard Hamburg, MPA: Okay, sorry. Before poll question 4, thanks, Jeff, for terrific comments. We see a lot of promise and opportunity as this work is getting underway. I do have answers to some of the questions whether or not individuals on the call were planning to apply. We had 81 individuals said yes. 132 said maybe. We know there's a lot of interest here for sure. Poll question 4. What would be helpful to you as you think about engaging in this work? You'll see the five categories. Background papers, examples of current efforts, additional web forums, understanding of capabilities, or other and you can certainly ask additional questions in the Q and A. Let me give you a minute to respond to that.

So now, it's time for your questions. There are a lot of them. We've left significant time to feel those questions. I'll tell you ahead of time we won't be able to answer all of the questions.

In the meantime, during the webinar, we've been compiling them throughout the forum. Attempted to categorize them into themes, eligibility, requirements. I'll take a couple questions in each category and return time permitting.

I think many, if not most of these will be aimed at Chisara. So get ready for a lot of activity here.

First, let's look at overriding question. I apologize in advance, I've been going back and forth whether any of these have been answered. So let me ask a question. Will this be a planning or implementation grant?

>> Chisara Asomugha, MD: Yeah, so not sure about the question but it's neither. It's a cooperative agreement. First you have to meet eligibility criteria and then be accepted or notified as a bridge organization. And then you will participate in the model. And if you are achieving milestones which are set in the funding opportunity announcement, then you are eligible to receive the following years' funding. So you can think of it as a cooperative agreement for one year times 5 years. As long as you are meeting the milestones, you continue to get funding. But it's not planning or implementation grant.

>> Richard Hamburg, MPA: Okay. Thanks for that clarification. A couple questions along the lines going to ask. Can you clarify, can CMS clarify whether applicants must screen for all social determinants or the ones they've selected.

>> Chisara Asomugha, MD: The short answer is we expect as delineated in the funding opportunity announcement that all awardees are screening for the core ones. The food and security. And based on community needs assessments or other data that they can use to show these are other issues that we're experiencing and we have the means to begin to address those effectively to add those to the screening as well.

>> Richard Hamburg, MPA: Great. Thanks. Another question in the program requirement area. Can you further explain and provide a couple examples of a bridge organization?

>> Chisara Asomugha, MD: Not sure exactly whether it makes sense to provide an example like XYZ organization is a beautiful example of a bridge organization. I cannot bias the applicant pool. What I can say is a bridge organization is the kind of organization that has the ability to develop or has strong relationships with community service providers, the clinical community or can get the clinical community on board. You need a hospital, you need a primary care provider or healthcare provider. Having those relationships in place and being able to meet the criteria for what bridge organizations should be doing as outlined in the funding opportunity announcement is a good example what a bridge organization should be. Those who were involved from the beginning or the inception of this model, community is at the heart of it. In so much as communities can drive this sort of change and work with us to help understand what needs to make that happen. That would be good.

>> Richard Hamburg, MPA: Great. I put the Q and A feature back up. I guess I skipped over this. You probably figured it out. Submit questions to Q and A feature and to all panelists.

Let me take a few questions in the eligibility category. Here's one. Does the language of the FOA assure that the community partners can or must be the applicant for type-three applications? And does the initiative have to be statewide or within a region within a state?

>> Chisara Asomugha, MD: You are going to have to repeat that one. I didn't quite understand it.

>> Richard Hamburg, MPA: Two parter. Does the language of the FOA assure the community partners can or must be the applicant for type-three applications? And does the initiative have to be statewide or can it be for a region within a state?

>> Chisara Asomugha, MD: Maybe answering the second question will clarify the first. The bridge organization -- again, community driven. So where the state is involved, the state Medicaid agencies become involved or as we stated in the funding opportunity announcement. There could be local or regional offices or state offices that might want to be partners in this. It is really at the community level. You can define the community as a city, a county or a region. But we're certainly not thinking of states.

If you remember what Jeff was talking about, there are states that are actually looking at some of these things on a state-wide basis. States that have been involved in the SIM model test. So there is that platform there. The Accountable Health Communities is really about communities. Hopefully that clarifies.

>> Richard Hamburg, MPA: That's helpful. And I guess this one will piggy back on that. How would multiple counties apply with a regional approach? Would one county need to be the main contact and coordinator?

>> Chisara Asomugha, MD: There's only one applicant for the funding model. So if that helps in terms of determining how one wants to apply. It is just one applicant. As long as folks are adhering to what the criteria is in the funding opportunity announcement, then great. But when you begin to deviate from that, it becomes an issue.

>> Richard Hamburg, MPA: Okay. Are tribal communities eligible?

>> Chisara Asomugha, MD: Yes.

>> Richard Hamburg, MPA: Easy questions are good. Quick answers. We'll have a couple of those. I'll give you a chance to catch your breath for a minute here.

One more on eligibility. If any of these are duplicates, we'll try to move through them as quickly as possible. Are ACOs eligible as applicants and how would this -- serving Medicare patients in the same area?

>> Chisara Asomugha, MD: So it seems a little conflated. Let me answer the first question. That's the one I can answer. ACOs are eligible to apply as long as they are meeting the requirements of the model or of the funding opportunity announcement. Then that bodes well for them. ACOs are definitely eligible to apply.

For those on the phone listening, if you go to the innovation center web site, there is a link to the Accountable Health Communities. I know there have been questions about ACOs and others and we have them there as well just in case you don't think your question has been answered, we've gone into more depth online.

>> Richard Hamburg, MPA: Great. That's terrific. Here's a program-requirement question that's come up for different opportunities that we've seen in the past. Should applicants engage perspective model partners during or after the application process? Kind of a general question. But does this FOA support the development of partnerships or preference give tone applicants already working together?

>> Chisara Asomugha, MD: So good question about engaging prospective model participants. It's going to be dependent on the community whether those relationships exist or whether they have to create them. And they can Illustrator demonstrate in their application that they are able to meet the milestones in the criteria set out in the funding opportunity. Any potential applicants have to include whether -- and this is also specific to the FOA. A contract MOU or some equivalent with the bare minimum that state Medicaid agency, so the behavioral health organization, the primary care provider. Applicants will be evaluated or reviewed based on their capacity like history, ability, commitment to carry out this described in the funding opportunity announcement and to engage the Stakeholders or partners. We want to make sure they are able to demonstrate their capacity to do that. Partnerships could be developed after the awards are made. The intent on develop and potential for success will be evaluated when those applications come in.

>> Richard Hamburg, MPA: Okay. Great. Thanks. And previously, you said there's one applicant or application. Here's another variation on that question. Somebody posed a question, can the applicant or the bridge organization be one or more organization in essence a collaboration as the applicant?

>> Chisara Asomugha, MD: The same thing. One lead applicant. So if you are a group of organizations, a group is singular. If it's all the organizations, it's plural. One lead applicant and has to meet the criteria of what that lead applicant should be.

>> Richard Hamburg, MPA: Okay. Great. Here's another one. Can the award money be applied to build the availability of community services in a geographic area if those services are weak or resource constrained? For example, using award money to provide housing to beneficiaries?

>> Chisara Asomugha, MD: Yeah. So no part of the funding provided in this can pay directly or indirectly for these community services. We're prohibited from doing that. And such our awardees are prohibited from using our funds to do that. Around systems change and the screening and service navigation. Paying for services whether directly or indirectly would be a

no.

>> Richard Hamburg, MPA: Okay. Here's a time line question that came in the last few minutes. How does the time line and the funding of metrics workout for needs that might take more than a year to alleviate. Will healthcare utilization or total -- I skipped -- all right. I hit the button too much. Hold that thought. My scrolling abilities are to be questioned here.

What is the nature of the partnership with state Medicaid organizations? Is it MOUs, meetings, shared leadership? Any further defining of that?

>> Chisara Asomugha, MD: Yeah. Great question. So again, it's also stated in the funding opportunity announcement. A contract in MOU or MOU equivalency minimum in terms of how that partnership is developed. We want to make sure that for the bridge organization and the community that's involved, there is something that can at least ensure a strong partnership and ensure what is required of the state Medicaid agency can happen. So we're looking at a contract MOU or MOU equivalent.

>> Richard Hamburg, MPA: Okay. Thanks. A couple specific questions. Is there a population minimum you are looking to include such as counties with a population of 200,000 or more? Can any size community apply for the funding?

>> Chisara Asomugha, MD: No, there isn't. As long as folks are meeting -- can meet the milestones or demonstrate they meet the milestones criteria, then great.

>> Richard Hamburg, MPA: Okay. Any kind of limitations on number of applicants per state or just whatever's submitted?

>> Chisara Asomugha, MD: Because the question was asked, let me say in the funding opportunity announcement, we do say that overlaps. So two folks coming from the same area will not both get awarded.

>> Richard Hamburg, MPA: Okay. That's very helpful. Jeff, you are there? Any questions you want to ask yourself?

>> Jeffrey Levi, PhD: [Laughing] No. But I think it is important to note that I can be a little bit more interpretive perhaps than Chisara can be. You obviously -- people are going to have to demonstrate they have partnership. And the strength of those partnerships is probably going to determine the success of this effort. I know there is an additional question about making -- I guess, one related question is will you support more than one applicant in a jurisdiction? And if not, is -- find out who else submitted LOI in their community.

>> Richard Hamburg, MPA: Great. Thanks.

>> Chisara Asomugha, MD: That's a good question. I'll have to take that back to our folks. I would hope though that folks would be talking to each other in the same area and know that, you know, maybe there's somebody out there who is applying. But in the event there isn't, let me go back to our folks and see.

>> Jeffrey Levi, PhD: One practical solution would be a relationship with the state Medicaid agency. Since they have to be a partner with any applicant, the state Medicaid agency is likely to know who the other interested parties are.

>> Chisara Asomugha, MD: Yeah.

>> Richard Hamburg, MPA: Here's one from prior FOAs. After the LOIs are submitted, will there be any kind of list of LOIs submitted? In order to help coordinate and facilitate where we end up seeing some overlap?

>> Chisara Asomugha, MD: Good question that I cannot answer. I would have to ask our management folks about that.

>> Richard Hamburg, MPA: I've seen it done sometime inside the past. It's been helpful, if at all possible.

Let's see what else we have here. Back to some eligibility questions. Authentic community engagement must begin with the community itself. How will residents be engaged at the planning table? How will community leaders actually live and represent the communities be identified or be part of the process?

>> Chisara Asomugha, MD: That's an important question that every community or applicant applying should answer. There is no way that we have a healthcare system without the people who engage the healthcare system itself. The patients, the people, their families, the care givers.

So I would hope -- this is now me talking, not CMS. I would hope those who are applying are considering that population, us, as part of the process.

>> Richard Hamburg, MPA: Yeah. That's an important piece of anyone filing an LOI or an eventual application need to address in a major way.

How might a school district with health services, one that hires school nurses work with partnering agencies? How might a school district be involved with the partnering agencies? Any thoughts?

>> Chisara Asomugha, MD: The how, it's almost like in any way possible. I would love for -- again, this is me talking. If there's a bridge organization in a community and they've identified a need related to the pediatric population and want to get the school district involved. They would find some opportunities to work together to address whatever those health-related social needs might be. I cannot dictate what a school district could do. I could say school district if you are interested in this kind of work, maybe it's talking to the state Medicaid agency about who is applying. Looking to see where the opportunities are within their communities. I wouldn't know who to direct the school district to other than being involved in what is taking place in the community related to health is the first way to go.

>> It looks like Rich was disconnected.

>> Chisara Asomugha, MD: Oh, okay.

>> From the teleconference part.

>> Jeffrey Levi, PhD: While we're getting Rich back, I'll step in with a question or two. I've been seeing some of them arise as well. For a lot of folks who have been doing traditional community prevention work, this notion of doing a randomized control trial may be relatively new. Perhaps you could take a minute or two to describe the logic behind the randomized control trial in the first two tracks and what that would look like.

>> Chisara Asomugha, MD: I don't want to misspeak but it's not a randomized control trial. I will certainly say that. When that has come up before, they have stated this is not a randomized control. What is happening though is that there's randomization in order to ensure that we can demonstrate there's an impact on healthcare utilization and cost. And can you repeat the last part?

>> Jeffrey Levi, PhD: So then describe for folks the randomization procedure. What are people being randomized between? They are being randomized as I understand it between getting some of these enhanced services. I think for some providers, for example, for many health centers, they may feel there's a great deal of similarity between what would be considered the baseline service versus the services that would be provided under the FOA. So how are those two categories being distinguished through this process.

>> Chisara Asomugha, MD: Yeah. That's a good question I'm going to have to get back to you on. In terms of just the baseline care, we understand the standard of care can vary and some sites may have something that might be similar to that. The way the evaluation is set up is to test the added benefit of this systematic process we're trying to do in the AHC model. There are a lot of different approaches that were considered when it came to this patient randomization and looked at what the potential challenges and benefits might have been of that. And basically, figured that if at the beneficiary level, we can say this person gets usual care. And for many, usual care may be what's already happening versus the comparison group which is actually getting the referral or the navigation in track three being part of a community that is aligned towards these efforts. That would help us to at least be able to show there's an impact on cost and total cost of care and healthcare utilization. But with the other forms of evaluation, that kind of stuff that we would not be able to detect that as well. But I can take your

question back and we can put that up with the FAQs that we post weekly.

>> Jeffrey Levi, PhD: Okay. So another question is in the track three where the alignment track, there's a requirement -- there's 51% requirement. Can you explain that more? Is it 51% of the beneficiaries? 51% of the population? What exactly does that mean?

>> Chisara Asomugha, MD: Yeah, and I'm going to read directly from the FOA. In order for an area to qualify as geographic target area, the participating clinical delivery sites must have collectively provided healthcare services to 51% of the total population of community dwelling beneficiaries who lived in the geographic target area already been defined and their model participants in the previous 12 month period. So that 51% is about the number of beneficiaries who are living in that geographic target area. Is that the 51% they are referring to in that question?

>> Jeffrey Levi, PhD: I think so. They don't have to be serving all 51%. They need to be in geographic area.

>> Chisara Asomugha, MD: Yes. They must be capable of reaching that percentage in the geographic area. I can direct -- for folks who are looking, page, I think it is page 15 in the document of the funding announcement describes it for track three.

>> Jeffrey Levi, PhD: So as I've read the FOA, the evaluation is being done separately. So the individual sites are not going to be doing the evaluation. What is the relationship between the grantees or the people who are -- I think the people who get cooperative agreement are still calls grantees. The grantees and evaluation process?

>> Chisara Asomugha, MD: That is still being worked out.

>> Jeffrey Levi, PhD: Okay. And I'm assuming, Star, we still won't have Rich back. I would tell my colleagues I am having trouble seeing. I need help in being able to see more so I can see some of the questions.

>> Hi, this is Star. Sorry, I think Rich called in but he didn't call in using his attendee ID number. If you can call in using that. And you find that information by going to the event info tab in the top left hand corner. Everybody has their own attendee ID number. That's why that's not working right now.

And Jeff, do you see chat there on the right-hand side?

>> Jeffrey Levi, PhD: I do but only seeing three or four lines at a time.

>> What you can do is minimize the other ones.

>> Jeffrey Levi, PhD: I have tried that. I am not able to get it bigger.

>> Sue or Sana or Ann, would you like to come on and help Jeff out with that? Okay. I'm going to start. Sue, you are unmuted.

>> Hi, this is Sue. Can folks hear me?

>> Yes.

>> There's a lot of beeping. I apologize. I'm going to help Jeff here with the questions. So for the question, this is a follow up on the school district questions. Is it possible for them to connect with the state school nurse consultants at state Department of Education, health and getting to more applicants stronger community linkages involving schools? Does that make sense?

>> Chisara Asomugha, MD: Not really. Are you asking whether they should reach out to those groups?

>> Yes. It sounds like should they connect? Could they, should they connect with school nurse consultants, state departments of education or health.

>> Chisara Asomugha, MD: Sure. I don't see why not. Yeah.

>> Okay. Are managed medical organizations considered state education agencies? I don't know if you can answer that.

>> Chisara Asomugha, MD: Yeah, I can't answer that. I do not know the answer to that question.

>> Okay. Can we only address needs of Medicaid and Medicare beneficiaries or can we

develop a system that applies to all residents?

>> Chisara Asomugha, MD: As long as you are able to meet the criteria and the needs of the funding opportunity announcement. Certainly, feel free to address the entire population. But again, the model test is focused on Medicare and Medicaid beneficiaries because of the nature of the innovation center in this particular model. This question is a good one because it goes back a little bit to that learning system slide that I mentioned. What we would love to see, we can only be testing for this particular population. If we're seeing things that can actually benefit the overall population, that's great to know as well.

>> Jeffrey Levi, PhD: The financial support, for example, for enhanced navigation can only be paid for from Medicare/Medicaid beneficiaries.

>> Chisara Asomugha, MD: Yes.

>> Jeffrey Levi, PhD: They would have to find other resources to pay for that enhanced navigation for the broader population they are serving.

>> Chisara Asomugha, MD: Yes, exactly.

>> So the next question is a two -- I'm sorry. The next question is a two parter. Is there a requirement to specifically demonstrate adequate social service capacity to respond to increased need? And the second part is is it screening 75,000 beneficiaries a year or over the grant period?

>> Chisara Asomugha, MD: It is per year. So every year in the funding opportunity announcement or every performance period shows what is expected in that particular 12-month period. In terms of the previous question which was --

>> The requirement specifically demonstrate adequate social service capacity to respond to increased needs. Is there a requirement to specifically demonstrate adequate social service capacity to respond to increased need?

>> Chisara Asomugha, MD: All the requirements that are needed for this particular model are described in the funding opportunity announcement. I will say that during the model performance, we would want to be looking at the context in which these bridge organizations are working with the partners and the beneficiaries to understand some of that as well. But within the funding opportunity announcement are all the requirements we're expecting of applicants to provide information on.

>> Thank you, Chisara. If you need a breather, let us know.

>> Chisara Asomugha, MD: I'm good. I have my water.

>> Do grantees need to address all four of the issues mentioned housing, food and security, et cetera. Is it allowable to address issues of chronic disease, cardiovascular disease, et cetera?

>> Jeffrey Levi, PhD: Maybe I can reframe that question differently. Those are really two separate questions. One is I think you have to address -- do you have to address those core services? But then you can identify additional ones. But the second question is can you target people with certain conditions? HIV, heart disease, diabetes or does the intervention have to serve everyone who is a Medicare/Medicaid beneficiary?

>> Chisara Asomugha, MD: Right. The short answer, in terms of the core health related social needs, yes, that must be done. And then the supplemental, that can be determined by the community based on their needs or analysis of the needs in their communities. In terms of whether this test should be universally targeting community dwelling Medicare and Medicaid beneficiaries. The funding opportunity announcement is specific about this being a systematic identification and addressing of these health-related social needs in Medicare and Medicaid beneficiaries. There's no distinction and that is on purpose. The short answer is no, you want to be focused on the community dwelling Medicare and Medicaid beneficiaries when it comes to how the funding is used and the screening and addressing of these screens.

If in a community, however, and this is not related to the model. If you are seeing there's something going on with a particular population, there's no reason why a community should not be thinking about how to address in that population and see if that is going to head

back. For the purpose of this model, it is brought on purpose.

>> Jeffrey Levi, PhD: Okay. I think Rich is back.

>> Richard Hamburg, MPA: This is, Rich. Sorry about that. Sometimes technology throws you for a loop here. So first I'm going to attempt to ask the same questions. Pardon me. So here's a question, can the bridge organizational indicate funding to support the technology that enables the clinical delivery sites in community partner?

>> Chisara Asomugha, MD: I believe in the funding, there is -- and it should be -- I believe there is, I don't want to misquote so give me a moment just to make sure. But I believe there is already funding within once an awardee is made or an award is made to go towards some of that work. Let me just make sure. Yes. I believe so. I can verify but I believe so.

>> Richard Hamburg, MPA: Had a series of questions before, tell me if they've been asked about multi state actions. Partnerships that are across state lines. Any possibility of submitting for an opportunity that crosses, like, the delta?

>> Chisara Asomugha, MD: I don't want to preclude anybody from submitting an application. Again, it has to meet first the lead applicant has to meet the criteria established in the funding opportunity announcement. And secondly, the community of partners needs to be able to meet the criteria that are laid out in the FOA.

>> Richard Hamburg, MPA: Okay. Another question's come in. Do you need to address all beneficiaries for a segment? For example, can you have a focus on adults 50 years or older?

>> Chisara Asomugha, MD: That's a good question. Again, it's all community dwelling beneficiaries for this particular model. Whether the person is 50 or 2 and coming into your, say, primarily care clinic or whatnot. They are eligible for that screen.

>> Richard Hamburg, MPA: Okay. And here's a specific one. If we're screening at a pediatric setting, does the screening apply to the parent/child/patient or all in the household? Does that count as one screening or a multiple?

>> Chisara Asomugha, MD: That's a really good question and one we're working out. Primarily the patient. It's focused on the patient. In the pediatric setting, if a child is having housing issues, chances are the parent is too or their caretaker or guardian is too. So again, it's the patient but we might have additional insight on that tomorrow.

>> Richard Hamburg, MPA: Okay. Here's another one. Just curious if greater than 51% of geographic target population are not Medicaid/Medicare recipients. How would this meet the requirements in the FOA?

>> Chisara Asomugha, MD: The requirement inside the FOA are to meet that specific target.

>> Richard Hamburg, MPA: Okay. And a couple more here. We're reaching toward the end. Can you further elaborate on how a healthcare provider will know in real time if a person falls into intervention or control group.

>> Chisara Asomugha, MD: Yeah, sure. So what we are thinking is that within the FOA, we're talking about how bridge organizations are sharing data or the clinical delivery sites are knowing whether the beneficiaries are. Real time through a system that the provide error the healthcare professionals doing the screening will know whether that person is in the comparison group or is going to receive usual care. We expect that would be real time based on the interface we're developing with the model.

>> Richard Hamburg, MPA: Okay. And just a couple more and we'll close things out here. Really appreciate your availability to answer many questions. Given there are 150,000 beneficiaries in our particular community, can the focus be on a subset of the beneficiary population to get to the 75,000 to be addressed?

>> Chisara Asomugha, MD: Again, demonstrate that you can meet the milestones and criteria outlined in the funding opportunity announcement and that will help us in terms of our review. By us, I mean the objective review panel who will be reviewing all the applications.

>> Richard Hamburg, MPA: Okay. Thank you. And one more here. Again, tell me if this was answered. Looking forward toward the end of the process. What are the plans for evaluating

the initiative? Big broad question.

>> Chisara Asomugha, MD: Yes. And with all CMS innovation center models, there is an evaluation component and contractor that works to identify or use the data to determine whether the program was a success or how is it a success or not a success, that kind of thing. So that will also be the case here where an evaluation component has been created for the model and will be done over the course of the model period.

>> Richard Hamburg, MPA: Okay. Great. And one last one here. This is in the category he -- I think it's been asked and answered. Do you have to address all five core health-related social needs or can you address one or more?

>> Chisara Asomugha, MD: Yes. All five core health-related core needs as outlined in the funding announcement.

>> Richard Hamburg, MPA: That was clear. Thank you. So let's wrap it up here. We have another minute or two left. Want to thank our presenters and participants today for this exciting dialogue. As we wrap up today's webinar, we want to remind folks that we have two up-coming CMS events Thursday, tomorrow, 2 to 3:30 eastern and Thursday the 27th, 3 to 4. I don't think Thursday can be the 21st or the 27th. We'll give you help on that.

>> This is Sue. If you can hear me. It's Thursday, January 21st and then Wednesday, January 27th.

>> Richard Hamburg, MPA: Thank you. More information on those, the email.

>> Chisara Asomugha, MD: One thing. No problem. It's just that that has the email on there. I think it might be easier for folks if they want to register not to email the team but to actually go to innovation.cms.gov/initiatives/ahcm. And you will see a link to the webinar registration if you haven't already done so for tomorrow and Wednesday. Thanks, Rich.

>> Richard Hamburg, MPA: Wonderful. Thanks a lot for that clarification. And a reminder our next web forum as part of the community prevention series is scheduled for January 27th at 3 p.m. eastern time. 3 to 4:30. Called stepping up to make a difference. And for that, go to www.Dialogue4Health.org. We hope you can join us. There will be a number of others in the future. Appreciate all the time given today. Thanks to the staff at PHI. My colleagues at TFAH. Despite my ear hitting the off button. And thanks again for co-sponsoring organizations and panelists. And be on the lookout for further discussions in the future. So thanks a lot for participating. Be safe if you are anywhere where the coming storms are on the way and appreciate all your participation.