>> Moderator: Greetings and welcome to today’s Dialogue4Health web forum on Accountable Health Communities. My name is Dave Clark. I'll be your host for today's event. There are just a couple things that I'd like to you know about. First real time captioning is available for today's web forum provided by home team captions. It's located on the right side of your screen. If you're on a Mac you'll see that on the bottom right of your screen. If you would like to use captioning you will easy -- you will see a link. If you click both of the links you'll be able to see the captioning more easily. If the captioning window disappears click that media view icon that I mentioned to bring it back again.

Now, today's web forum will not include any kind of live Q&A session but we do encourage you to submit questions and those questions will help inform the official frequently asked questions published regularly on Accountable Health Communities website. You can type your questions at any time in the Q&A panel. It's also located on the right side of your screen and it can be toggled on and off. If you're on a Mac you'll see the icon on the bottom right of the screen. In the Q&A panel make sure that all panelists is selected. And by the way, you can also use the Q&A panel to communicate with me and my colleague, Laura Burr if you're having any technical problems including audio issues, let us know and we'll help you out.

Do engage with us if you have any questions. We'll read each and every one of them, I promise. In fact, let's engage right now. Let's bring your voice into the web forum right now. We thought that you might be interested in seeing who you're attending this event with today. So we'll bring up a quick poll so you can tell us whether you're attending alone or whether you're in a group. You'll see that poll appear on the right side of your screen. You'll be able to select from one of the four choices. When you made your selection you can click the submit button. Are you attending by yourself, individually, in a group of 2 to 5 people, maybe in a larger group of 6 to 10 people or perhaps you've invited all of your colleagues to a big giant conference room today, more than ten people. Let us know.

Who are you attending today's web forum with? Let's look at the results. If you're not seeing the results appear right away, give them a few moments to tabulate and if you made a choice and didn't click the submit button you'll see an option right now to submit your answer so go ahead and do that. I can tell you that not surprisingly a good percentage of you are attending alone or whether you're in a group. You'll see that poll appear on the right side of your screen. You'll be able to select from one of the four choices. When you made your selection you can click the submit button. Are you attending by yourself, individually, in a group of 2 to 5 people, maybe in a larger group of 6 to 10 people or perhaps you've invited all of your colleagues to a big giant conference room today, more than ten people. Let us know.

Who are you attending today's web forum with? Let's look at the results. If you're not seeing the results appear right away, give them a few moments to tabulate and if you made a choice and didn't click the submit button you'll see an option right now to submit your answer so go ahead and do that. I can tell you that not surprisingly a good percentage of you are attending alone today, about 88%. Looks like a little over 10% of you are attending in a relatively small group of 2 to 5 people. And it doesn't look like we have anyone attending in groups of larger than five people.

Thanks for engaging with us and thanks for helping us bring your voice into this web forum today. Let's go ahead and get started with today’s presentation on Accountable Health Communities. Our moderator today is Adam Lustig, senior manager of Health Systems Transformation. Adam works closely with members, funders, and partner organizations to implement the Bridging Portfolio. He provides content expertise and contributes to strategies
related to improving health care systems, alternative payment models, and supporting people-centered health systems. Adam will be leading us through the rest of today's event so Adam, over to you.

>> Adam Lustig: Thanks, Dave. As Dave mentioned my name is Adam Lustig and I'm pleased to welcome all of you to the webinar. I'd like to share information about all the individuals that registered and are attending today's webinar. A little about our audience, we have a total of over 1400 individuals registered for this webinar. And as you can see here there's strong interest in the AHC model from stakeholders in all 50 states with those being displayed on the screen having 20 or more registrants for this webinar. Before I introduce the panel presenters today I would like to acknowledge the team behind the scenes, Laura Burr and Dave Clark. We are fortunate to have knowledgeable leaders. The full bios for all of our panelists will be available. With that I'm happy to introduce the three speakers.

Alex Billioux, Simeon Niles and Louise Amburgey. Alex Billioux is a Senior Advisor to the Director and Deputy Directors at the Center for Medicare and Medicaid Innovation and Acting Director of the Division of Population Health Incentives and Infrastructure in the Preventive and Population Health Care Models Group. He is an internal medicine physician focused on improving the health of vulnerable communities by increasing access to comprehensive primary care and developing cross-sector public health policy.

Simeon Niles joined the Division of Population Health Incentives and Infrastructure in PPHG in December 2014, and as of July 2016 is the Model Lead for the Accountable Health Communities Model. Prior to joining CMMI he was a Federal Consultant in Deloitte's Strategy and Operations practice where he provided legal, analytic and project management support to clients by monitoring the development of federal and state legislation and regulations; and supporting process improvement activities including workflow enhancement of Federal clearance processes.

Louise Amburgey is a Grants Management Officer and Specialist in the Office of Acquisition and Grants Management at CMS. She has over 20 years of grant and cooperative agreement experience, serving primarily within the Department of Health and Human Services. Prior to joining CMS in 2006 she served within the National Institutes of Health. She also served a short stint at the University of Missouri, Columbia, managing clinical trial agreements with pharmaceutical companies for the School of Medicine.

As Dave previously mentioned, while there is a question and answer feature as part of the webinar platform we'll not be having a live Q&A at the end of this webinar however you are encouraged to submit questions via the Q&A function and these will help the frequently asked questions on the Accountable Health Communities website. When submitting your question, provide your e-mail address to receive a response following the web forum. With that I'm happy to hand it over to Alex.

>> Alexander Billioux: Thank you, Adam; and as well to Dave and Laura. And welcome to everybody. It really exciting to see the level of interest and enthusiasm we have received over the last couple of days. And with that Dave, Adam just shared that there's interest in the model spread across the entire nation. As Adam said my name is Alex Billioux. Glad to have you joining us today. Just to give you a sense of the order of our discussion we'll start by talking about an Accountable Health Communities Model and give you an overview, the role of the model, where it fits within the center's work and also the basic structure of the model as well as an update on tracks 2 and 3. And then we'll hear from Simeon about the change in Track 1 and the new Track 1 funding opportunity announcement as well as the application process and then from Louise we'll hear about the grant management process as well.

So the Accountable Health Communities Model fits firmly win CMS’s overall goal of improving better care, smarter spending and healthier people. And more specifically we think it moves forward CMS quality strategy five which is focused on addressing the health as well as increasing access to health care by developing strong partnerships that we try to work with to improve the health of our beneficiaries. So we'll talk about as I said the overall structure. So the motivation for the Accountable
Health Communities Model was really based in the understanding that a little bit over 60% in some cases up to 80% of the determinants of health really fall outside of the direct health measures that our health care system deals with. And specifically the model is focused on the social and economic determinants of health that we know drive high levels of utilization and costs for the care of our beneficiaries. In addition I think the opportunity that we see for the model or that has been seen for the model is there's increasingly evidence to support the idea that addressing these upstream determinants of health and linking our beneficiaries to even existing community services can have a real impact on their health. And that has downstream impacts on their health care utilization and overall cost of health care. The model is situated between the health care system and our community existing services to link our beneficiaries and determine what is the ideal way to do that. We also like to think of the model as bridging between where we see as the current state of our current clinical community linkages and across four core domains.

And then the actual response from the provider to those health related social needs is very much dependent on the training of that provider and their knowledge as well of what the community can bring to bear to help meet those social needs and we would like to see that be more systematic in the future so there's not a lack of awareness or connection. In addition, even that process of linking a patient to or enabling a patient to resolve their health related social needs often takes an extra person or an extra work step and currently that falls on case managers and social workers and other care-based members and clinics but they may not be present in all clinics or clinical locations or the emergency departments but perhaps not in a small primary care center. We would like to evaluate ways to help make those connections and help support meeting health related social needs.

And finally we are also clear that not all health related social needs are currently being addressed by all communities so really developing a system by which we can further develop those systems and fill those gaps is a key driver. What will the Accountable Health Communities test? It's a five year possible that is going to test systemically identifying and addressing the health related social needs of community dwelling Medicare and Medicaid beneficiaries. Key innovations that the model brings are the systematic screening that I just referenced so for all community dwelling Medicare and Medicaid seeking clinical care as well as testing a couple interventions. So the effectiveness for referring for those services when a health related social need is identified, the effectiveness of community service navigators and that strong partner alignment. So I'll go through these at a rather high level.

These slides will be posted so you have access to these definitions but for if purposes of this model when talking about Accountable Health Communities we are talking about Medicare and Medicaid beneficiaries in the community and that are access and care clinical sites participating in the model. The community services themselves can be a broad range of public health and social services. Health related social needs are synonymous with social determinants of health but they have a clear impact and we'll talk about the core health related social needs we call out specifically in this model. And unusual care describes that current state that I spoke to a few slides ago. It's more focused on prevention and treatment of actual disease or injury. So this model is focused on five core domains addressing housing instability, utility needs, food, interpersonal violence answered transportation but also has flexible for individual applicants to propose screening and linking for supplement needs including but not exclusive of others but including family and social support, education, employment and income and health behaviors.

So the overall structure of the model is that the applicant is applying as a bridge organization which will serve as the hub between the clinical delivery sites and the community provider systems. They will be responsible for identifying and partnering clinical delivery sights. They will suggest a systematic social needs screening and make referrals, and then help coordinate and connect those community dwelling beneficiaries who screen positive for unmet health related social needs to seek services within community service providers that they're also partnered with. And finally in parts of the model the bridge organization will also align with partners across the community to align an optimize community services available to meet those health related social needs.
So this is a graphical depiction of what I just said in words and you can see that bridge organization is the hub at the center of those spokes with each of these spokes being critical. Community service providers at the bottom meeting those five social needs and at the top you see examples of clinical delivery sites. There needs to be at least a partnership with a hospital, a behavioral or mental health facility and a primary care facility in each application.

The model is broken up in three tracks testing slightly different aspects of this overall hypothesis. In Track 1 the evaluation is focused on whether improving the awareness of our beneficiaries to have health related social needs of community services that meet those needs can impact their accessing and their overall care from accessing those services. In Track 2 we build on that and add a community service navigation seeking services from those community service providers. And Track 3 partners are more deliberately aligned and come together in a gap analysis to look at where unmet needs are still existing in their communities and to develop plans to address them. So before we talk about Track 1 which is the main focus I want to give a little update because we have a robust group of people calling in about tracks 2 and 3. The initial period for tracks 1, 2 and 3 closed in May, 2016. All applicants including applicants who applied to track 1, 2 or 3 in the previous funding opportunity announcement are eligible to apply to this funding opportunity announcement but any one applicant or any one awardee would only be awarded to a single track.

>> Simeon Niles: Thank you, Alex. I would like to echo that we are very excited to have so many folks who are interested in a Track 1 awareness so I'll continue by providing an overview of the Track 1 awareness which includes group discussion of the changes to the Track 1 FOA to the previous FOA as well as describing the requirements under the Track 1 FOA. Changes to the Track 1 FOA. CMS modified Track 1 application requirements and released a new funding opportunity announcement. The modifications are we reduced the number of beneficiaries’ applicants from 75,000 to 53,000 and we also increased the maximum funding amount per award recipient from 1 million to 1.17 million. We believe these two key modifications will make the program more accessible and as Alex stated applicants that previously applied to Track 1 or track 2 or 3 under the previous FOA can apply for this FOA and to be considered you must apply to this FOA.

Track 1 awareness, the target population is community dwelling Medicare and Medicaid beneficiaries with unmet health related social needs. Our primary resource question will be will increasing beneficiary awareness of available community services through information dissemination and referral impact total health costs inpatient and outpatient health care utilization and quality of care. Partnerships with community service providers are encouraged but they're not required.

In Track 1 awareness because we are testing the effectiveness of information dissemination and referral, those in the intervention pathway if they are assigned to the awareness track will receive a community referral summary. Very briefly the reevaluation strategy for Track 1 is depicted in this diagram such that beneficiaries enter clinical delivery site and screened for health related social needs. They undergo a process of stratified randomization whereby those in the first stratified by risk such that those who have two or more EE visits are deemed high risk and those with fewer than two EE visits are deemed lower risk. And those in the high risk category are randomized into a control and intervention group. Those in the intervention group receive the community referral summary.

This describes stratification process for Track 1. Key performance metrics for the model are health care utilization that include emergency department visit, inpatient admissions, readmissions and utilization of outpatient services. Also looking at total cost of care and will be assessing provider experience for the model. Requirements for Track 1 under the Accountable Health Communities Model. Key model participants for Track 1 are the bridge organization, at least one state Medicaid agency and that's an agency that covers a population that lives or resides in the geographic target area that the bridge organization or applicant will propose. Clinical delivery sites to include at least one of each of the following times, those include hospitals, providers of primary care services and providers of behavioral health services. Community service providers are also encouraged as model participants and we encourage applications to propose community service providers to have the capacity to address the core health needs in the model.
Bridge organizations in Track 1 are required to collaborate with model participates, develop application proposals, identify existing community resource inventories and designed an implement and intervention to achieving AHC goals. As consortium comments state Medicaid agencies dedicate staff time for Accountable Health Communities related actives including data collection and reporting, sustainability planning, as well as an annual review of the AAC invention and providing a letter of support. The state Medicaid agency must also provide or the applicant must also provide an MOU or an MOU equivalent with the state Medicaid agency and the requirements for that MOU include a statement of the status towards meeting on going T-MSIS milestones, the ability to release Medicaid data, supplement statements outlining a plan for coordinating with CMS to provide data, a description of the roles and responsibilities of the state personnel, a summary and list of state run initiatives with the potential to overlap or provide due -- duplicative services. And a commitment to work with the bridge organizations to establish that consortium.

Bridge organizations must are in into contracts and use MOU equivalents within their application. These are the clinical sites that agree to participate in the AC model. As I said before they must be one of each of a type of clinical delivery sites. Bridge organizations must insure that they're consortium will be able to present opportunities to screen at least 53,000 community dwelling beneficiaries per year. The MOU requirements for clinical delivery sites are that they must include inscription, they must provide NPI and TIN numbers important providers who participate in the model, they must also detail commitments to have the bridge organizations screen all those community dwelling beneficiaries who seek care at those sites as well as commitments, submit the required data to the bridge organization and CMS and a description of planned protocols for allowing screening of those beneficiaries at the clinical delivery sites. A community service provider is defined as an independent for-profit nonprofit state territorial or local agency capable of addressing core or supplement health related social needs. Community service providers will receive the referrals, and we are -- applicants are encouraged to enter into a contract or get a MOU or MOU equivalent signed with the community service providers and again that's optional but highly recommended. Bridge organizations will use a screening tool to screen beneficiaries for their health related social needs. The screening tool will consist of screening questions provided by CMS and they will outline core and supplemental health related social needs questions. The applicant must choose an appropriate method to administer the screening tool and must keep in mind they must systemically submit all screening information including beneficiary identifiers received to CMS and its contractors. Applicants must also make the tool available to all beneficiaries regardless of language or disability status.

Bridge organizations will be required to create a community resource inventory of available community services and community service providers to address each of the domains in the screening tool and they must update this tool every six months. The inventory should include contact information, addresses, hours of operation and other information the beneficiary would need to access the resources. CMS would provide a robust learning system and support shared learning. The shift will support shared learning and continuous quality improvement between the bridge organization and facilitate the movement of timely and accurate relevant information to allow you and allow you to learn from your peers. You will be required to create a driver diagram as a framework to guide and align intervention design and implementation activities. You will participate in learning system events in person and visually. You will also be allowed to engage state Medicaid agencies as necessary to achieve the model goal. Brief overview of the application process includes that the eligible applicants include community based organizations, health care practices, health care systems, and for profit or nonprofit local and national entities. It's open to applicants from all 50 states, U.S. territories and the District of Columbia. The application package includes a project narrative which outlines the design, the implementation plan as well as the assessment of program duplication and all standard forms as required and must be submitted by the application. The application package must include Memoranda of Understanding. They're not required for Track 1. The application package must also include a budget narrative. Application content requirements. Applicants will provide within their project narrative the intervention design, the background, geographic target area, your process for risk
stratification as well as how you plan or providing the community resource inventory and referral.

You should also describe your process for stakeholder engagement including your state Medicaid agency consortium and community service providers. Criteria that would make you ineligible are funds that will not pay directly or indirectly for provision of community services, state Medicaid agencies are ineligible. There will be only one bridge organization that will be funded for a geographic area and applicant can only be funded to implement one AHC track, funds shall not be used to build or purchase health information technology that exceeds 15% of the total cost of the budget, Medicare advantage plans and program for all-inclusive care for the elderly organizations are ineligible to apply. CMS will not review applications that merely restate the text. CMS will not fund proposals that do not submit a contract, MOU or MOU equivalent from the state Medicaid agency and may deny selection based on information found in the review. The selection criteria for applications will be based on the perspective bridge organization’s ability to meet the eligible application requirements demonstrate commitment, collaboration and engagement of community stakeholders and demonstrate the readiness to implement the intervention.

>> Louise Amburgey: Hi, I'm going to go over the grant award process and give you more of the business aspects of it and an overview of the whole grants management process.

>> It looks like we lost the audio for our presenters. We'll give them just a moment to reconnect.

>> Louise Amburgey: Okay. All right. So our grant award process starts whenever -- congress is going to authorize a program. It is going to go through this whole process. The president requests funds, congress appropriates them. The federal agency which is CMS may develop guidelines; we advertise it which is the process we are in at the moment. Perspective applicants will apply. Applications will come in. They will be reviewed for eligibility. And undergo an objective review process. We conduct negotiations, check for risk assessment. Do all types of budget negotiations and it goes from a birth to death life cycle.

So the funding mechanism that is going to be used for the AHC model is a cooperative agreement. First you will see what the official definition of a grant -- grants and cooperative agreement but simply put a grant or cooperative agreement is used when the principal purpose of the award is to provide assistance for the benefit of the public. The AHC is a cooperative agreement. So with a cooperative agreement the federal government is going to have substantial involvement. What does that mean? I'm not going to read all of the bullets, but it's the ability to hold an activity immediately if the model is not working requiring the recipient to adhere to procedural requirements, maybe the agencies CMS specifying direction or redirection of a scope of work. And you can read the rest of those. Basically what it is not is basically micro managing. We are exercises normal stewardship with responsibilities during the project period so we don't get involved with that. Roles and responsibilities. Through the entire process you might hear or see some of these nomenclatures so our grants management officer and the grants management specialist are federal employees, are usually in the office of grants management. The program authorizing official and program officer are your program office. And the authorized organizational representative or the principal investigator would be applying for the model. Many of the tools that we use for grant and cooperative agreements, we use the uniform administrative requirements cost principals and audit requirements which is implemented under 45 CFR subpart 75. I would encourage all applicants to take a look at these requirements because they give you the allowable costs for your budgets and also gives you guidance on what your internal processes that are needed for being fiscally responsible with federal funds.

So to add on to Simeon's application requirements, all applicants must have a valid employer identification number which is an EIN or TIN number. They have to have a Dunn and Brad Street data universal number which is referred to as a DUNS number. Applicants must register in Sam. Please do it as soon as possible. We have applicants waiting a week before and were deemed ineligible because they were not able to register. Please do this as soon as possible.

And the authorized organizational representative which I mentioned before is the legal -- basically the person at your organization who legally represents your organization. This person must also register with grants.gov. That's where you will be submitting your application. Our grants office also
uses the grants management solutions through the grants center of excellence. So again that issues NoAs, we do amendments, financial reporting and closeout.

So also for your application and submission there are lots of formatting requirements. Again I really would encourage you to follow these. This includes your page limits, font sizes, what each section for example the project narrative must be double spaced. If these requirements are not fulfilled your application will be deemed ineligible and will not be reviewed. Also I just want to again reiterate there will be standard forms, we call a 424 family. Those will be required but do not impact on any of your budget limitations. They also must be included. Your budget narrative has a 15 page limit and I would encourage you to refer to the appendix which offers a sample budget for the funding opportunity announcement.

Funding restrictions. These are in addition to the programmatic funding restrictions for this model. They cannot be used to provide individuals with services that are already funded which just reiterating what was emphasized earlier. They can't be used to build or purchase health information technology that exceeds more than 15% of the total costs of the applicants proposed budget.

Funding restrictions. These prohibited uses of cooperative agreement funds can also be found in the funding opportunity announcement. I'm not going to go over them. Some of them are pretty basic. They can't match any other federal funds. They can't be used to fund the provision of social services so again I encourage you to take a look at those.

So application process review and award. Your solicitation will be available at grants.gov. There you can find a synopsis and the award package. The application deadline to grants.gov is no later than 3:00 p.m. on November 3, 2016. Applications after they are submitted to grants.gov are downloaded into grant solutions which I mentioned before is our official grant database. After applications are received in download we begin the applicant review process. We go through an eligibility based on all of the requirements we have put in the FOA. Programmed and produce decision memo, recommending select applicants after it's been to the objective review and at that point we attend negotiations with selected applicants.

So again at grants.gov you can search by CFDA number which is 93.650. All applications have to be submitted in the required electronic PDF format at grants.gov. The deadline is no later than November 3, 2016. Specific instructions again for the electronic applications are right on grants.gov.

Here you'll see contact information. Here you'll see mine and Susan Jackson's so if you have any questions please feel free to send these to our mailboxes. I want to thank you again today for joining us on our webinar. And look for important updates and more information and the Accountable Health Communities Model and the website is on this slide. Thank you once again for attending this webinar.

>> Adam Lustig: Great. Thank you so much, Louise. And thank you also to Alex and Simeon for providing an overview of Accountable Health Communities Model. I just also wanted to remind you that we have received a lot of questions and we do greatly appreciate you showing interest in the model. However, as we previously mentioned we won't be answering the questions directly on today's web forum. However your questions will inform the official frequently asked questions which will be regularly updated on the Accountable Health Communities website. With that I would like to thank you all for attending the webinar and I'll hand it over to Dave for concluding remarks.

>> Dave Clark: Thanks Adam and to our presenters today, Alex, Simeon and Louise. Thanks to the National Institutes of Health and today's sponsor, Centers for Medicare & Medicaid Services. Now, a recording of today's session as well as the presentation slides will be available shortly at www.dialogue4Health.org. Check your e-mail. It will include a brief survey. We would like to know what topics you would be interested in for future dialogues. We read those comments and that feedback so be sure to take a couple moments, complete that survey. We would like to hear from you. Thanks so much for being with us today. That does conclude today's web forum. Have a great day.

(Webinar concluded)