# STAFF REPORT

**Report To:** Board of Supervisors **Meeting Date:** February 4, 2016

**Staff Contact:** Nicki Aaker (naaker@carson.org)

**Agenda Title:** For Possible Action: To grant permission for Carson City Health and Human Services to apply for the U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services Center for Medicare & Medicaid Innovation: Accountable Health Communities Grant.

**Staff Summary:** The Accountable Health Communities (AHC) Model is a five-year test to learn whether systematically identifying and addressing beneficiaries' health-related social needs through referral and community navigation services can improve care delivery; enhance quality of care; and reduce their total cost of care and inpatient and outpatient health care utilization. The AHC Model aims to identify and address beneficiaries' health-related social needs in the following core areas: housing instability and quality, food insecurity, utility needs, interpersonal violence, and transportation needs beyond medical transportation.

**Agenda Action:** Formal Action/Motion **Time Requested:** 10 minutes

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## Proposed Motion

I move to grant permission for Carson City Health and Human Services to apply for the U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services Center for Medicare & Medicaid Innovation: Accountable Health Communities Grant.

## Board's Strategic Goal

N/A

## Previous Action

N/A

## Background/Issues & Analysis

Grant funds would be used to test the Accountable Health Communities Model as an evaluation of the effectiveness of addressing high-risk beneficiaries' health-related social needs through referral and community navigation services and the resulting impact on health care costs, health care utilization, and quality of care. The model includes three tracks with interventions of varying intensity that link beneficiaries with community services. No fiscal match is required.

## Applicable Statute, Code, Policy, Rule or Regulation

N/A

## Financial Information

Is there a fiscal impact? ☐ Yes ☒ No

If yes, account name/number:

Is it currently budgeted? ☐ Yes ☐ No

Explanation of Fiscal Impact: N/A

**Alternatives**

To deny Carson City Health and Human Services permission to apply for the U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services Center for Medicare & Medicaid Innovation: Accountable Health Communitiies Grant

**Board Action Taken:**

Motion: _____ 1) _____ Aye/Nay

2) _____ _____

_____

_____

_____

_____

(Vote Recorded By)

CMS.gov (http://www.cms.gov/)
Centers for Medicare & Medicaid Services



# Accountable Health Communities Model - Frequently Asked Questions

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## Funding Opportunity Descriptions

**What is the Accountable Health Communities Model?**

The Accountable Health Communities (AHC) Model is a new model under the U.S. Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS) Innovation Center that examines whether systematically identifying and attempting to address health-related social needs of Medicare and Medicaid beneficiaries through referral and community navigation services can impact health care costs, reduce inpatient and outpatient health care utilization, and improve health care quality and delivery.

**What is the purpose of the model?**

The AHC Model is a five-year test to learn whether systematically identifying and addressing beneficiaries' health-related social needs through referral and community navigation services can improve care delivery; enhance quality of care; and reduce their total cost of care and impatient and outpatient health care utilization. The AHC Model aims to identify and address beneficiaries' health-related social needs in the following core areas:

Housing instability and quality,
Food insecurity,
Utility needs,
Interpersonal violence, and
Transportation needs beyond medical transportation.

**Under what authority will the AHC Model operate?**

The AHC Model is authorized under Section 1115A of the Social Security Act (added by section 3021 of the Affordable Care Act), which established the Center for Medicare and Medicaid Innovation (the CMS Innovation Center) to test innovative payment and service delivery models that have the potential to reduce Medicare, Medicaid, and Children's Health Insurance Program expenditures while maintaining or enhancing the quality of beneficiaries' care.

**Where can I find additional information on the funding announcement?**
Please review the Funding Opportunity Announcement on grants.gov (http://www.grants.gov/view-opportunity.html?oppId=280812) for additional information.

**How can I serve as a reviewer for this Funding Opportunity Announcement?**
Please send an email with your name and contact information as well as a current resume/CV to accountablehealthcommunities@cms.hhs.gov (mailto:accountablehealthcommunities@cms.hhs.gov). Should your services be needed, CMS will contact you.

**How can organizations assist outreach efforts to potential applicants?**
We need your help reaching eligible applicants, community service providers, state Medicaid agencies and clinical delivery sites as the application deadline of March 31th is right around the corner. We would greatly appreciate if you would be willing to alert your networks to this opportunity to participate through the following ways:

> An email blast, listservs, newsletters, or other timely outreach methods during the months of January, February and March. Attached is a resource you can share with your networks. You can also include the brief description below in upcoming e-communications. The Accountable Health Communities Model is currently accepting applications through March 31, 2016. The Model addresses a critical gap between clinical care and community services in the current health care delivery system by testing a systematic approach to identifying and addressing health-related social needs of Medicare & Medicaid beneficiaries. The Model awards cooperative agreements to organizations chosen to participate in the model test. Visit our website to access the Letter of Intent and Request for Applications. You can email us at accountablehealthcommunities@cms.hhs.gov (mailto:accountablehealthcommunities@cms.hhs.gov) to get your questions answered.
>
> Help us with social media outreach during the coming month. Please follow us @CMSinnovates to help amplify our sign-up effort by "retweeting" and "liking" our posts. You can also post any of the following approved messages:
>
> New @CMSInnovates program will invest $157m to help providers screen for and address health-related social needs http://1.usa.gov/1PKUzQF
>
> .@CMSInnovates explains new $157m program focused on health-related social needs in @NEJM http://goo.gl/SzClv7
>
> Please spread the word! CMS accepting apps until 3/31 http://1.usa.gov/1PKUzQF #AHCInnovates
>
> Reminder: Applications for Accountable Health Communities Model due 3/31. LOIs due 2/8. #AHCinnovates

## Letter of Intent (LOI) Information

**For the LOI, what information is requested for the State Medicaid Contact?**

If available, please enter the name and contact information for an individual who works at the State Medicaid office. This individual should be a person that can facilitate the sharing of data necessary for the evaluation of the model and with whom the applicant has an existing relationship. Note that this is not a required field for submission of the LOI.

**How do I submit a letter of intent (LOI)?**

Applicants are highly encouraged to submit a non-binding letter of intent to http://innovationgov.force.com/ahcExternal Link Policy by February 8, 2016. Applicants will receive a confirmation email after the submission of their LOI. Applicants should include their LOI confirmation number on the cover page of their application.

## Program Requirements

**What will the AHC Model test?**

The AHC Model test is an evaluation of the effectiveness of addressing high-risk beneficiaries' health-related social needs through referral and community navigation services and the resulting impact on health care costs, health care utilization, and quality of care. The model includes three tracks with interventions of varying intensity that link beneficiaries with community services. Each track has a specific question which the interventions seeks to answer:

**Track 1:** Will increasing beneficiary *awareness* of available community services through information dissemination and referral impact total health care costs, inpatient and outpatient health care utilization, and health and quality of care?
**Track 2:** Will providing community service navigation to *assist* high-risk beneficiaries with accessing community services to address identified health-related social needs impact their total health care costs, inpatient and outpatient health care utilization, and health and quality of care?
**Track 3:** Will a combination of community service navigation (at the individual beneficiary level) and partner *alignment* at the community level impact total health care costs, inpatient and outpatient health care utilization, and health and quality of care?

**How is this model different from existing CMS Innovation Center models?**

The AHC Model is the first Innovation Center model designed specifically to test building community capacity to address the health-related social needs of beneficiaries at the local level. Key innovations in the AHC Model include:

Testing the impact of building community capacity to address the health-related social needs of a local, geographically-defined population of beneficiaries
Systematically screening Medicare and Medicaid beneficiaries to identify unmet health-related social needs;
Testing the impact of using targeted community service referrals to increase beneficiary awareness and utilization of community services; and
Testing the impact of community service navigation to provide assistance to beneficiaries in accessing community services.

**What is the responsibility of the bridge organization?**

Bridge organizations are responsible for:

Making arrangements with clinical delivery sites that provide clinical health care to provide the required AHC intervention services to community-dwelling beneficiaries in a manner that meets the track specific requirements and milestones
Using a standardized screening tool for health-related social needs populated with questions developed by CMS.
Developing and maintaining a comprehensive database, updated at least every six months, that contains information on community service providers that may be able to address the health-related social needs that are screened for in the screening tool
Developing and submitting standard operating procedures
Collecting and sharing, or otherwise explaining how it will ensure that its consortium members collect and share, with CMS any identifiable beneficiary-level data for purposes of model monitoring and evaluation.
Ensuring that CMS funding for this model does not duplicate services already made available through other programs
Certifying in the application that it has financial and accounting systems that are fully auditable and able to document all AHC-related savings, revenues, and expenditures.
Demonstrating that it already has, or has the capacity to develop, active relationships with community service providers.

**Who are the expected model participants for a bridge organization?**

Bridge organizations are expected to partner with:

At least one state Medicaid agency
Clinical delivery sites including at least one of each of the following types:

Hospital
Provider or practice that furnishes primary care services
Provider of behavioral health services

Community service providers capable of addressing core or supplemental health-related social needs identified through the screening tool.

**Should applicants engage prospective model partners during or after the application process?**

Applicants are expected to describe existing and new relationships with model partners in their application. It is expected that applicants will engage with model partners during the application process. Moreover, each applicant must include with its application a memorandum of understanding with at least one state Medicaid agency and each clinical delivery site.

**Does the clinical delivery site or community service provider need to be physically based in the geographic target area that the bridge organization serves?**

The clinical delivery sites or community service providers that are partnering with the bridge organization must serve beneficiaries who reside in the geographic target area specified in the application.

**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)?**

CMS funds may ***not*** be used to pay directly or indirectly for any community services (e.g., housing, food, violence intervention programs, utility assistance, and transportation) received by beneficiaries as a result of their participation in any of the three Tracks. Rather, successful applicants will receive funds to develop a community referral inventory, implement health-related social needs screening and referral in all tracks, and offer community navigation services in Tracks 2 and 3.

**Can I apply to multiple tracks?**

Applicants may apply to up to two tracks, but successful applicants will be selected to participate in only a single track.

**Are there special populations that can be considered "community-dwelling beneficiaries" (i.e. prison population, those living in halfway houses)?**

Individuals eligible for AHC services must be Medicare and/or Medicaid enrolled (or presumptively eligible, as applicable), must seek health care at a participating clinical delivery site and must be community-dwelling at time of care.

**How will applications be reviewed?**

An objective review panel will be convened to determine the merits of each application and the extent to which the proposed intervention is structured to further the purpose of the AHC model.

**What constitutes a "state Medicaid agency"?**

The state Medicaid agency is the Medicaid agency that would be expected to pay for Medicaid-covered services furnished to its community-dwelling Medicaid beneficiaries at the applicant's participating clinical delivery site. Where such participating clinical delivery sites would be expected to furnish Medicaid-covered services to community-dwelling Medicaid beneficiaries from more than one state, the applicant is expected to secure, at a minimum, assurances from such agencies as may be needed to ensure participation by those State Medicaid agencies that collectively pay for the majority of such services furnished at such sites. All such assurances must document the agency's willingness to participate in the applicant's implementation of this model, and acknowledge that, as a model participant, it will be subject to 42 CFR §403.1110 (providing for model participants' production of such data to CMS or its contractors, including protected health information (PHI), as may be required to monitor and assess the model). Potential applicants should refer to the Funding Opportunity Announcement (FOA) for application requirements related to the participation of state Medicaid agencies in the AHC program.

**What is the definition of a clinical delivery site? What type of care settings can qualify as this?**

For the purposes of the AHC funding opportunity, a bridge organizations must establish relationships with at least three types of clinical delivery sites: (1) a hospital; (2) a healthcare provider or practice that furnishes primary care services; and (3) a behavioral health service provider. A single entity may qualify as more than one type. The types listed above are required for each application. Additional clinical delivery sites (other than the types listed above) that meet the requirements of the FOA would also be eligible to participate.

**Can a beneficiary complete the health-related social needs assessment more than once per year?**

The health-related social needs assessment may be completed by the same community dwelling beneficiary more than once per year. Community-dwelling beneficiaries may be offered screening each time they present at a clinical delivery site participating in AHC. The data collection system will risk stratify and randomize all community-dwelling beneficiaries as demonstrated in the track specific evaluation diagrams. The data collection system will also maintain the number of times the community-dwelling beneficiary has completed the health-related social needs screening, community-dwelling beneficiary responses to the health-related social needs screening, and whether or not the community-dwelling beneficiary received a tailored community referral summary and/or community navigation services.

**Can the navigation intervention be repeated for a beneficiary?**

The navigation intervention may be repeated annually if the high risk community-dwelling beneficiary screens as having any health-related social need at least 12 months after previously being offered community service navigation services.

**Can a beneficiary screened in year 1 and therefore counted towards year 1 screening figures also be screened and counted towards year 2 screening figures?**

Yes. Annual beneficiary figures counted towards milestones do not require that the beneficiaries be unique from year to year. However, the requirements included in the FOA on offering services to a beneficiary must be met each time the services are offered.

**Will CMMI prioritize the participation of beneficiaries in fee-for-service plans over those in managed care plans? Can beneficiaries in Medicare Advantage plans participate as beneficiaries in the Accountable Health Communities funding opportunity?**

The Accountable Health Communities (AHC) model addresses a gap in the current delivery system by funding interventions that connect community-dwelling Medicare and/or Medicaid beneficiaries with community services. For the purposes of the AHC model, a community-dwelling beneficiary is a Medicare and/or Medicaid beneficiary, regardless of age, functional status, and cultural or linguistic diversity, who is not residing in a correctional facility or long-term care institution (e.g., nursing facility), who seeks health care at a participating clinical delivery site and who lives within the geographic target area specified by the applicant. This definition also includes Medicare and/or Medicaid beneficiaries enrolled in managed care.

**Where can the social needs screening take place?**

Bridge organizations must establish relationships and make arrangements to offer screening for health-related social needs to all community-dwelling beneficiaries who seek care from at least one of each of the following types of clinical delivery sites (a single entity may fulfill more than one of these roles): a hospital, a primary care provider or practice, and a behavioral health services. *Bridge organizations may offer these screenings directly, through administrative or clinical staff under an agreement with the clinical delivery site or through arrangements with a third party.*

**Is there information on the data that community service providers are required to collect?**

Community service providers have four primary responsibilities: (1) supporting the bridge organization in the planning process and development of the community resource inventory; (2) supporting bridge organization/AHC navigator to track AHC participants utilizing community service provider resources and related outcomes (Tracks 2 – Assistance and 3 – Alignment); (3) participating in the advisory board (Track 3 – Alignment); and (4) informing the Gap Analysis and QI efforts (Track 3 – Alignment). Bridge organizations may establish agreements with community service providers to share data if the appropriate arrangements-both legal and model-specific-are put in place.

**How are Medicare/Medicaid beneficiaries identified- via clinical service utilization or a priori?**

Individuals will be identified as Medicare and Medicaid beneficiaries based upon self-identification when seeking care from participating clinical delivery sites. The self-identification will later be verified using CMS claims data.

**Are the milestone figures for screening and receiving intervention services cumulative figures?**

The milestone figures for screening and receiving intervention services are annual figures. That is, each award recipient is expected to screen and provide intervention services to the set numbers of beneficiaries each year.

**Are the screening milestone in years 2, 3, and 4 in Tracks 2 and 3 per site or spread across all award recipients?**

All milestones listed in Tables 3, 4, and 5 of the funding opportunity announcement are per award recipient figures.

**Will award recipients be allowed to use their own screening tool?**

No. The bridge organization must use a standardized screening tool for health-related social needs populated with questions developed by CMS. The screening tool will contain initial threshold questions to determine eligibility for the full screening, screen for core health-related social needs that CMS has defined for the purpose of this model, and may also screen for supplemental health-related social needs supported by the results of a community needs assessment and for which CMS has developed appropriate screening questions.

## Technical Assistance

**Does CMS have any resources the bridge organizations can consult?**

Throughout the implementation of the model, CMS will provide informational webinars. Please check the Accountable Health Communities Model web page (/initiatives/ahcm/index.html) for updates.

# Award Information

**How much funding is available for each track?**

Up to $1 million to each bridge organization in Track 1 – Awareness
Up to $2.57 million to each bridge organization in Track 2 – Assistance
Up to $4.51 million to each bridge organization in Track 3 – Alignment

**When will awards be made and the AHC Model begin?**

CMS anticipates that awards will be made in the fall of 2016 and the period of performance for the model test will begin shortly thereafter.

**What is the performance period for the AHC Model?**

The budget and project period of each cooperative agreement is five years – January 1, 2017 through December 31, 2021. 12-month project and budget periods are anticipated:

Year One: January 1, 2017 to December 31, 2017
Year Two: January 1, 2018 to December 31, 2018
Year Three: January 1, 2019 to December 31, 2019
Year Four: January 1, 2020 to December 31, 2020
Year Five: January 1, 2021 to December 31, 2021

**How many award sites will be supported/funded under this model?**

CMS will support and fund up to 44 award sites:

12 cooperative agreements for Track 1 – Awareness
12 cooperative agreements for Track 2 – Assistance
20 cooperative agreements for Track 3 – Alignment

**Where can I find more information on the types of organizations that are charged the de minimis rate of 10% for indirect costs?**

As noted in 45 CFR 75.414(f), any non-Federal entity that has ***never*** received a negotiated indirect cost rate, *except for those non-Federal entities described in appendix VII to part 75 (D)(1)(b)* may elect to charge a de minimis rate of 10% of modified total direct costs (MTDC) which may be used indefinitely. As described in §75.403, costs must be consistently charged as either indirect or direct costs, but may not be double charged or inconsistently charged as both. If chosen, this methodology once elected must be used consistently for all Federal awards until such time as a non-Federal entity chooses to negotiate for a rate, which the non-Federal entity may apply to do at any time.

The primary applicant must include subrecipients approved federally recognized indirect cost rate negotiated between the subrecipient and the Federal Government or, if no such rate exists, either a rate negotiated between the primary applicant and the subrecipient, or a de minimis indirect cost rate as defined in §75.414(f).

**Can an organization ask for less than the amount listed for a given track (Track 1- up to $1 million, Track 2- up to $2.57 million, Track 3- up to $4.51 million)?**

Organizations may request less than the total listed for the particular track to which they are applying.

**Is the funding listed (Track 1- up to $1 million, Track 2- up to $2.57 million, Track 3- up to $4.51 million) per-year or a total over the five-year period of performance?**

The estimated award amounts listed in the table found in the Executive Summary of the FOA (Track 1- up to $1 million, Track 2- up to $2.57 million, Track 3- up to $4.51 million) are totals for the five-year period of performance. They are not per-year figures.

**Will selected applicants receive payments for particular activities (i.e. screening, referral, navigation services)?**

Initial funds will be disbursed to award recipients based on the evaluation of applications. An objective review panel will be convened to determine the merits of each application and the extent to which the proposed intervention is structured to further the purpose of the AHC model. Subsequent funds will be disbursed to award recipients based on meeting the milestones outlined in the Funding Opportunity Announcement in Tables 3, 4 and 5. Payments will not be made for particular activities (screenings, referrals, and navigation services).

**How often are continuation funds disbursed?**

The period of performance consists of five 1-year (12 months) budget periods renewable based on satisfactory progress and the availability of funds. Award recipients must meet reporting and certification deadlines to be eligible throughout the initial 12 month budget period and to remain eligible for a non-competing continuation award for subsequent budget periods. In addition, grantees would need to demonstrate strong performance during the previous funding cycle(s) before additional year funding is awarded. Additionally, in subsequent funding cycles, grantees could receive decreased funding or their grant could be terminated due to poor performance. **(See Continued Eligibility in FOA)**

**If an organization meets milestones and funds are available, can an organization expect the same funding each year?**

The period of performance consists of five 1-year budget periods renewable based on satisfactory progress and the availability of funds. Award recipients must meet reporting and certification deadlines to be eligible throughout the initial 12 month budget period and to remain eligible for a non-competing continuation award for subsequent budget periods. In addition, grantees would need to demonstrate strong performance during the previous funding cycle(s) before additional year funding is awarded. Grantees could, however,receive decreased funding or their grant could be terminated due to poor performance.

# Eligibility Information

**What is a community-dwelling beneficiary?**

For the purposes of the AHC model, a community-dwelling beneficiary is a Medicare and/or Medicaid beneficiary, regardless of age, functional status, and cultural or linguistic diversity, who is not residing in a correctional facility or long-term care institution (e.g., nursing facility), who seeks health care at a participating clinical delivery site and who lives within the geographic target area specified by the applicant. This definition includes children and adults covered under Medicaid through presumptive eligibility, and all community-dwelling beneficiaries that are dually eligible.

**What types of organizations are eligible applicants?**

CMS invites community-based organizations, individual and group healthcare practices, hospitals and health systems, institutions of higher education (IHE), local government entities, tribal organizations and for-profit and not-for-profit local and national entities with the capacity to develop and maintain relationships with clinical delivery sites and community service providers to apply. Applicants from all 50 states, United States territories (American Samoa, Guam, Northern Mariana Islands, Puerto Rico, and the Virgin Islands), and the District of Columbia may apply to become bridge organizations.

**What is a community-based organization?**

The term community-based organization refers to a nonprofit organization that demonstrates effectiveness in: (A) representing a community or significant segment of a community: and (B) providing educational or related services to individuals in the community.

**What is a community service provider?**

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

**Can a Quality Innovation Network - Quality Improvement Organization apply to become an Accountable Health Communities award recipient?**

If a Quality Innovation Network - Quality Improvement Organizations (QIN-QIOs) meets the criteria of an eligible organization, then they are eligible to apply. CMS contracted QIN-QIO services may not duplicate services provided through the AHC model intervention.

**Can a Skilled Nursing Facility serve as a bridge organization?**

Yes. CMS invites community-based organizations, individual and group healthcare practices, hospitals and health systems, institutions of higher education (IHE), local government entities, tribal organizations and for-profit and not-for-profit local and national entities with the capacity to develop and maintain relationships with clinical delivery sites and community service providers to apply.

**Can an Accountable Care Organization (ACO) serve as a bridge organization?**

Yes. CMS invites community-based organizations, individual and group healthcare practices, hospitals and health systems, institutions of higher education (IHE), local government entities, tribal organizations and for-profit and not-for-profit local and national entities with the capacity to develop and maintain relationships with clinical delivery sites and community service providers to apply.

**Can a single organization receive an award as a bridge organization and also serve as a model participant on another award?**

Yes. However, CMS will consider the geographic diversity of all applications when making cooperative agreement award selections. No more than one cooperative agreement will be awarded within a single geographic target area, if two or more applications identify the same or overlapping areas.

**How do I apply for the model?**

Application instructions are included in the FOA on grants.gov (https://www.grantsolutions.gov/gs/preaward/previewPublicAnnouncement.do?id=55237) (//www.cms.gov/About-CMS/Agency-Information/Aboutwebsite/External-Link-Disclaimer.html).

**What is the deadline for applications?**

Applications must be submitted electronically through www.grants.gov by the application deadline of **1:00 p.m. EST on March 31, 2016**. Applications will require a confirmation number from the submission of the letter of intent. Applications will only be considered for funding if they are submitted by the deadline and the application meets the requirements as outlined in the Funding Opportunity Announcement (FOA).

**Can beneficiaries who are enrolled in another CMS-funded demonstration participate in the AHC funding opportunity?**

Yes. As long as all requirements included in the FOA are met, beneficiaries enrolled in another CMS-funded demonstration may also participate in the AHC funding opportunity. Applicants must conduct a detailed analysis of programs - including but not limited to those funded by Medicare and/or Medicaid, other federal agencies, and state and local governments, which coordinate community services for individuals, navigate these services, or otherwise could overlap with one of the model tracks and submit an Assessment of Program Duplication for each potentially overlapping/ duplicative program. The Assessment of Program Duplication is described more fully in Appendix 7 of the FOA.

**Can I sign up as an individual beneficiary to participate in the model?**

Individuals not meeting eligibility criteria are not eligible to apply for this Funding Opportunity Announcement. Additional information concerning eligibility can be found on grants.gov, Grant Eligibility webpage (http://www.grants.gov/web/grants/learn-grants/grant-eligibility.html).

**Can I sign up as an individual provider to participate in the model?**

CMS invites community-based organizations, individual and group healthcare practices, hospitals and health systems, institutions of higher education (IHE), local government entities, tribal organizations and for-profit and not-for-profit local and national entities with the capacity to develop and maintain relationships with clinical delivery sites and community service providers to apply. Applicants from all 50 states, United States territories (American Samoa, Guam, Northern Mariana Islands, Puerto Rico, and the Virgin Islands), and the District of Columbia may apply to become bridge organizations. Eligible IHEs are limited to college and university health care affiliates delivering clinical services, such as community-based clinics, hospital networks, and health systems. Local government entities include, but are not limited to, local units of state and regional agencies where such classifications exist, local and tribal health departments, local public housing authorities, Indian housing authorities, and local community service agencies. Local government entities exclude state Medicaid agencies.

**Are there limits on the number of applications a single organization may participate in?**

Primary applicants (i.e. bridge organizations) may apply to no more than two AHC tracks. Applicants submitting more than two proposals will not be reviewed for any track.

There is not a limit on the number of applications in which a state Medicaid agency, clinical delivery site or community service provider may participate.

CMS will consider the geographic diversity of all applications when making cooperative agreement award selections. No more than one cooperative agreement will be awarded within a single geographic target area, if two or more applications identify the same or overlapping areas.

There is no limit on the number of applications in which a consultant, sub-award recipient or contractor may participate; such relationships are at the discretion of the applicant. The costs of project activities to be undertaken by a third-party sub-award recipient should be included in the Consultant/Sub-Award Recipient/Contractual Costs, as a single line item charge. Please see 45 CFR Part 75.351 Sub-award recipient and contractor determinations. Award recipients must submit to CMS the required information establishing a third-party sub-award/contract to perform program activities, and a complete itemization of the costs should be attached to the budget. If there is more than one sub-award recipient/contractor, each must be budgeted separately and must have an attached itemization. A consultant is a non-employee who provides advice and expertise in a specific program area. Hiring a consultant requires submission of consultant information to HHS.

**How many applications can be submitted from one institution?**

Applicants may apply to no more than two AHC tracks; however, applicants must complete a separate proposal for each track. Applicants submitting more than two proposals will not be reviewed for any track. Please note that duplicate applications do not count as a submission.

All applicants must have a valid Employer Identification Number (EIN), otherwise known as a Taxpayer Identification Number (TIN), assigned by the Internal Revenue Service. Potential applicants should consider the requirements listed in the Eligibility Information, Application Information and Application Review Information sections of the prior to application submission.

**Can an applicant operate across multiple states?**

Bridge organizations may work in multiple states to test the AHC intervention across multiple clinical delivery sites; however, the applicant will only be considered if their application includes certain written assurance(s) from the state Medicaid agency that would be expected to pay for Medicaid-covered services furnished to its community-dwelling Medicaid beneficiaries at the applicant's participating clinical delivery site. Where such participating clinical delivery sites would be expected to furnish Medicaid-covered services to community-dwelling Medicaid beneficiaries from more than one state, the applicant is expected to secure, at a minimum, assurances from such agencies as may be needed to ensure participation by those State Medicaid agencies that collectively pay for the majority of such services furnished at such sites. All such assurances must document the agency's willingness to participate in the applicant's implementation of this model, and acknowledge that, as a model participant, it will be subject to 42 CFR §403.1110 (providing for model participants' production of such data to CMS or its contractors, including protected health information (PHI), as may be required to monitor and assess the model).

An objective review panel will be convened to determine the merits of each application and the extent to which the proposed intervention is structured to further the purpose of the AHC model.

**Can an organization use funds from this opportunity to offer services that the organization already provides?**

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

Cooperative agreement funds may not be used to supplant existing State, local, Tribal or private funding of infrastructure or services.

The applicant must submit, as part of the application, a plan that addresses how it will ensure that CMS funding for this model does not duplicate services already made available through other programs. Successful award recipients must only provide community navigation services that are non-duplicative. The assessment for program duplication must address how the applicant will leverage existing provision of services and how duplication of payment for services will be avoided.

**Can an organization use funds from this opportunity to enhance services that the organization already provides?**

Cooperative agreement funds may NOT be used to supplement/improve existing reimbursement rates for services funded through any other source. Funds may be used to pay for additional services that are not currently reimbursed but are ancillary activities that support clinical services that further AHC program goals and objectives.

An objective review panel will be convened to determine the merits of each application and the extent to which the proposed intervention is structured to further the purpose of the AHC model.

The applicant must submit, as part of the application, a plan that addresses how it will ensure that CMS funding for this model does not duplicate services already made available through other programs. Successful award recipients must only provide community navigation services that are non-duplicative. The assessment for program duplication must address how the applicant will leverage existing provision of services and how duplication of payment for services will be avoided.

**Are state government entities eligible to apply?**

CMS invites community-based organizations, individual and group healthcare practices, hospitals and health systems, institutions of higher education (IHE), local government entities, tribal organizations and for-profit and not-for-profit local and national entities with the capacity to develop and maintain relationships with clinical delivery sites and community service providers to apply. Applicants from all 50 states, United States territories (American Samoa, Guam, Northern Mariana Islands, Puerto Rico, and the Virgin Islands), and the District of Columbia may apply to become bridge organizations.

Local government entities include, but are not limited to, local units of state and regional agencies where such classifications exist, local and tribal health departments, local public housing authorities, Indian housing authorities, and local community service agencies. Local government entities exclude state Medicaid agencies. *Other state agencies may be eligible to apply if they are a local unit of state or regional agencies.*

**Are there size restrictions on the population in the area in which an organization works? Are there size restrictions on the population that an organization serves?**

Although there are no minimum numbers required for an application to be reviewed, applicants should detail their approach to achieving program goals, milestones, and benchmarks within their application. This approach to achieving program goals, milestones, and benchmarks, will be evaluated by the objective review panel, to determine the merits of each application and the extent to which the proposed intervention is structured to further the purpose of the AHC model.

CMS will monitor the performance of each award recipient, after awards are made, based on milestones established by this Funding Opportunity Announcement, the Terms and Conditions of Award, and the implementation plan approved by CMS. Only those bridge organizations achieving pre-determined milestones may be recommended for a non-competing continuation award for subsequent budget periods.

**Are the milestone numbers listed in Tables 3, 4 and 5 minimum numbers required for an applicant community? Will an organization be considered if it is unable to screen 75,000 beneficiaries per year?**

Although there are no minimum numbers required for an application to be reviewed, applicants should detail their approach to achieving program goals, milestones, and benchmarks within their application. This approach to achieving program goals, milestones, and benchmarks, will be evaluated by the objective review panel, to determine the merits of each application and the extent to which the proposed intervention is structured to further the purpose of the AHC model.

The number of beneficiaries listed as a milestone is based on the number of beneficiaries who will receive the intervention services (community referral summary in Track 1 and community referral summary and navigation services in Tracks 2 and 3). These numbers will need to be met to allow for sufficient evaluation

of the model. The calculation used to approximate the number of beneficiaries screened from the number of beneficiaries receiving the intervention can be found in Tables 3, 4 and 5 of the Funding Opportunity Announcement in the "Year 1" section.

**Will an organization be required to screen 75,000 beneficiaries per year to receive continued funding?**

The rigorous evaluation of the model depends on particular benchmarks being met. However, the benchmarks are focused on the number of beneficiaries who receive the intervention (referral in Track 1 and navigation services in Tracks 2 and 3). Therefore, the ability to meet milestones related to the number of beneficiaries who are provided the community referral summary (Track 1) and the tailored community referral summary and navigation services (Tracks 2 and 3) will be more important to the evaluation of applications than the number of beneficiaries screened.

**Can an organization participating in other programs funded by Medicare and/or Medicaid participate in the Accountable Health Communities model?**

Organizations that are receiving funding from Medicare and/or Medicaid for other programs (except for Medicare Advantage plans and Program of All-Inclusive Care for the Elderly (PACE) organizations) are eligible to apply as long as all requirements laid out in the FOA are met. However, applicants must conduct a detailed analysis of programs - including but not limited to those funded by Medicare and/or Medicaid, other federal agencies, and state and local governments, which coordinate community services for individuals, navigate these services, or otherwise could overlap with one of the model tracks. Applicants must submit along with their application an Assessment of Program Duplication (see Appendix 7: Assessment of Program Duplication for details) for each program identified as potentially duplicative. Applicants should use the list of potential overlap areas in Appendix 7 to compare existing programs to the AHC requirements and protocols as outlined in the FOA and identify overlaps and gaps.

**Are applicants required to have a Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number in order to apply?**

Yes, all applicants must have a Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number in order to apply.

**Does the existence of a mandatory enrollment Managed Long Term Supports and Services (MLTSS) program in the state prevent the award of an AHC program?**

No. The Applicant must submit, as an appendix to the applicant's implementation plan, an Assessment of Program Duplication for each program identified as potentially duplicative and a plan for addressing potential duplication. Successful award recipients must only provide community navigation services that are non-duplicative. The Assessment of Program Duplication will compare existing programs to the AHC requirements and protocols as outlined in the FOA and identify overlaps and gaps. The implementation plan must address how the applicant will leverage existing provision of services and how duplication of payment for services will be avoided.

**Can an applicant propose to focus exclusively on a particular population- for example, only older adults with serious mental illnesses, or only Medicaid beneficiaries?**

No, an applicant may not focus exclusively on a particular population. Bridge organizations are required to systematically offer screening to community-dwelling beneficiaries who seek care at participating clinical delivery sites for health-related social needs in order to determine community-dwelling beneficiaries' AHC intervention eligibility and identify their health-related social needs. Notwithstanding the previous sentences, applicants must submit a Health Resource Equity Statement (HRES) along with their applications. The purpose of the HRES is to assist bridge organizations and other model participants with: (1) identifying and targeting minority and underserved populations (geographic and otherwise) in model participation; (2) assessing their total model in relation to these targeted subpopulations; (3) evaluating the inclusion of subpopulations in the AHC model; and (4) tracking progress on outcomes and engagement of these subpopulations throughout the AHC performance period.

**Is a letter of support from the state required with the application?**

Applicants are required to submit, along with their application, a contract, Memorandum of Understanding (MOU) or MOU equivalent from the state Medicaid agency(ies) (or equivalent organization responsible for operating the Medicaid programs in the geographic region in which the model is to take place). Each contract, MOU or MOU equivalent must address each role and responsibility criteria for consortium participation described in the AHC FOA in Section 2.4.1.1 Model Test Proposal Requirements – All Tracks, Subsection on State Medicaid Agency.

**Whom do I contact for questions regarding the model?**

Information about the AHC Model is available at Accountable Health Communities Model web page (/initiatives/ahcm/index.html).

For programmatic questions about the cooperative agreement, please contact:

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

E-mail: accountablehealthcommunities@cms.hhs.gov (mailto:accountablehealthcommunities@cms.hhs.gov)

For administrative questions about this cooperative agreement please contact:

Louise M. Amgurgey

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

Email: OAGM-AHC@cms.hhs.gov (mailto:OAGM-AHC@cms.hhs.gov)

Where Health Care Innovation is Happening

(/initiatives/map/index.html)
See who's working with CMS to implement new payment and service delivery models.

**Get the Widget (/CMMIMapWidget/index.html)**

*Last updated on: 01/22/2016*

CMS.gov

A federal government website managed by the Centers for Medicare & Medicaid Services
7500 Security Boulevard, Baltimore, MD 21244

(http://www.hhs.g

## CMS & HHS Websites

Medicare.gov (http://www.medicare.gov)

MyMedicare.gov (http://MyMedicare.gov)

StopMedicareFraud.gov (http://www.stopmedicarefraud.gov)

Medicaid.gov (http://Medicaid.gov)

InsureKidsNow.gov (http://www.insurekidsnow.gov)

HealthCare.gov (http://www.HealthCare.gov)

HHS.gov/Open (http://www.hhs.gov/open/)

## Tools

Acronyms (http://www.cms.gov/apps/acronyms)

Contacts (http://www.cms.gov/apps/contacts)

FAQs (https://questions.cms.gov/)

Glossary (http://www.cms.gov/apps/glossary/)

Archive (http://archive-it.org/collections/2744)

## Helpful Links

Web Policies & Important Links (http://www.cms.gov/About-CMS/Agency-Information/Aboutwebsite/index.html)

Privacy Policy (http://www.cms.gov/About-CMS/Agency-Information/Aboutwebsite/Privacy-Policy.html)

Plain Language (http://www.medicare.gov/about-us/plain-writing/plain-writing.html)

Freedom of Information Act (http://www.cms.gov/center/freedom-of-information-act-center.html)

No Fear Act (http://www.cms.gov/About-CMS/Agency-Information/Aboutwebsite/NoFearAct.html)

Nondiscrimination/Accessibility (http://www.cms.gov/About-CMS/Agency-Information/Aboutwebsite/CMSNondiscriminationNotice.html)

HHS.gov (http://www.hhs.gov)

Inspector General (http://oig.hhs.gov)

USA.gov (http://www.usa.gov)

Help with file formats & plug-ins (http://www.cms.gov/About-CMS/Agency-Information/Aboutwebsite/Help.html)

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