CENTER OF
Excellence
to Align Health and Social Care

USAging | Aging and Disability BUSINESS INSTITUTE

Request for Proposal (RFP)

Through a Cooperative Agreement

between the

Administration for Community Living (ACL)

and the

Center of Excellence to Align Health and Social Care at USAging

to

Improve Access to Long-Term Services and Supports and Address Health-Related Social Needs through Aging and Disability Network Community Care Hubs

The Center of Excellence to Align Health and Social Care (COE), part of the Aging and Disability Business Institute (Business Institute) at USAging, is supported by the Administration for Community Living (ACL), U.S. Department of Health and Human Services (HHS) through a cooperative agreement totaling approximately $12 million over a three-year period with 100 percent funding by ACL/HHS.

The purpose of the COE is to develop, expand, connect and support sustainable, high functioning aging and disability CCHs – and the networks of downstream providers that they lead – throughout the country through infrastructure funding and technical assistance.

RFP Release date: February 13, 2024

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EXECUTIVE SUMMARY

The Center of Excellence to Align Health and Social Care at USAging (COE) will award grants to support innovation and infrastructure costs for up to 20 community care hubs (CCHs)[i]. This funding opportunity is provided by the COE in partial fulfillment of a cooperative agreement between the Administration for Community Living (ACL) and USAging.

The overall goals of the COE are to develop, expand, connect, and support sustainable, high-functioning aging and disability CCHs and their network of social care program and service providers (Hub Network) through infrastructure funding, technical assistance, and multi-level capacity building efforts that promote whole-person care through the alignment of health, public health, and social care systems. This core funding opportunity will be referred to herein as the COE Infrastructure Funding Opportunity Grant (COE Grant) and all awardees will be required to participate in the related COE Grant implementation evaluation as described elsewhere in this funding opportunity.

Additionally, this effort will include a supplemental funding opportunity for a limited number of COE Grantees that are actively engaged in the delivery of hospital-to-home care transition services. This enhanced participation level will include a site-specific evaluation process and additional funding over and above the core funding noted above. This supplemental opportunity is referred to as the Care Transitions Focus Opportunity and Evaluation (CT Evaluation).

The intent of these awards is to provide infrastructure funding directly to selected CCHs to support their contracting efforts with relevant health care and public health organizations (e.g., accountable care organizations, health plans, health systems, state Medicaid agencies, Medicare, employers, and more) for coordinated access to and delivery of social care programs and services (including support for hospital-to-home care transition programs) that assess and/or address health-related social needs (HRSNs) and improve health equity and inclusion for individuals, families, and/or caregivers. These efforts should enhance state No Wrong Door (NWD) access systems and coordinate with local and/or state public health departments.

Grant funds may be supplemented through blending and braiding initiatives with other funding sources to support and enhance the CCH's work.

Purpose of the Funding Opportunity

This RFP aims to support existing and emerging CCHs that serve older adults and people with disabilities with an emphasis on those in geographic areas without current CCH capacity and those serving underserved populations to improve capabilities, increase capacity, and support infrastructure costs associated with aligning health and social care services to address HRSNs.

Successful CCH applicants will have contracts with a robust network of participating CBOs. This "Hub Network" should be administratively organized by the CCH to deliver consistent, high quality social care programs and services to address the HRSNs of populations

traditionally served by the aging and disability networks and other target populations, and do so across larger regions, statewide, or across multiple states. CCHs should also have active relationships with public health departments, perform access functions as part of a broader state No Wrong Door (NWD) system, and demonstrate the capacity to successfully engage in health care contracting. Please see Appendix A for a list of NWD access functions.

The COE is interested in understanding the applicant's experience and capacity to serve populations beyond the target populations and how the CCH will use this opportunity to support and enhance the NWD system within their state. Successful applicants are expected to have an active relationship with a local and/or state public health department to ensure coordination with the public health needs assessment as well as integration of services typically delivered by public health departments (i.e. diabetes prevention programs, food security policy, community health workers, certain clinical services, data collection, etc.). COE Grants are also expected to actively participate in a program evaluation.

Background, Relevance, and Need

There has long been a disconnect between the health, public health, and social care sectors, with these "worlds" having different funding and payment mechanisms, goals, metrics and reporting systems, and terminology. Over the past decade, there has been a drive toward alignment of these sectors to address social risk factors and better meet the holistic health-related needs of older adults, people with disabilities, and other populations with complex care needs. This movement has been catalyzed by technology developments, new payment and delivery system models, a drive toward health equity, and an increasing recognition by the health care sector that upstream, community-level social determinants of health (SDOH) (i.e., food deserts, lack of affordable housing and transportation, etc.) and downstream individual-level HRSNs (i.e., food insecurity, housing instability, etc.) have tremendous impact on a person's health, quality of life, and mortality risks. These determinants and risks also negatively impact the cost of health care and the ability of at-risk individuals to remain at home where studies show they overwhelmingly prefer to be. Research synthesized by the Assistant Secretary for Planning and Evaluation in 2022 demonstrates that clinical care affects only 20 percent of county-level variation in health outcomes, but SDOH impact as much as 50 percent.

This recognition has yielded increasing attention to screening and referrals for services and interventions related to HRSNs. Health care providers, health plans, hospitals, Accountable Care Organizations (ACOs), public health departments, and other types of health care organizations (collectively, "health care organizations") are now being measured on their efforts to screen for HRSNs across the populations they serve. Beginning in 2024, the Centers for Medicare & Medicaid Services (CMS) is requiring hospitals to report two new SDOH measures – screening for SDOH (i.e., food, housing, utilities, transportation, and safety needs) and screening positive for SDOH. CMS also issued new guidance in early 2023 to address HRSNs through Medicaid 1115 demonstration waivers and In Lieu of Services (ILOS) under Medicaid. In an effort to reduce health disparities, the Joint Commission now requires health care organizations seeking accreditation related to health equity to screen patients for HRSNs and provide information about community supports. Similarly, the National Committee for Quality Assurance (NCQA) has added a new social need screening

and intervention measure to the Healthcare Effectiveness Data and Information Set (HEDIS), with the goal of identifying and addressing members' food, housing, and transportation needs.

These changes are bringing increased demand for the services offered by Area Agencies on Aging (AAAs), Centers for Independent Living (CILs), and other community-based organizations (CBOs). However, without consistent data standards, information systems, or a defined payment system, the effectiveness of these efforts is often lacking, adding burden and complexity to AAAs and CBOs receiving requests for services and adding stress to the social care system that often experiences long waiting lists for services due to inadequate funding and, increasingly, incomplete or inaccurate referral data.

Ideally, as social care experts, AAAs and CBOs should be included as an essential voice on the care team for individuals experiencing HRSN gaps in order to meet the holistic, person-centered needs of these individuals, their families, and their caregivers. The recognition of CBOs' important role is increasing as contracting between health care entities, AAAs, and CBOs continues to grow. USAging's Aging and Disability Business Institute (Business Institute) CBO-Health Care Contracting Survey showed that, between 2017 and 2021, contracting between CBOs and health care payers and providers grew by nearly 16 percent. In addition, the proportion of contracting CBOs that reported contracting as part of a network of CBOs doubled from 20 percent to 40 percent. These community-organized and led networks offer centralized contracting for health care partners and provide benefits for Hub Network participating CBOs (Network CBOs) such as administrative efficiencies, IT systems and capabilities, broader geographic and population reach, methods to support identification of best practices, and quality improvement initiatives, as well as a stronger, focused operational and contracting infrastructure.

CBO networks are increasingly led, organized, and supported by CCHs, which provide an administrative and operational infrastructure to support member CBOs and serve as what ACL calls the "connective tissue" within communities to provide contractual linking between health, public health, and social care organizations for equitable access to services for individuals, families, and caregivers, including linkages to their state's NWD access system.

Additionally, according to a 2023 report from the Partnership to Align Social Care, "[a]cross the healthcare and social care landscapes, there is common recognition of the importance of addressing HRSNs, such as food insecurity, housing instability, and lack of transportation, and the role that social inequality plays in health disparities. To better align social care delivery with healthcare delivery and payment, health plans and systems are partnering with CBOs to coordinate and deliver whole-person care that address HRSNs. Recent trends indicate a growing number of health plans contracting with CBOs, particularly through CCHs and the community care networks they organize. The evolution of the CCH reflects an administrative approach aimed at achieving economies of scale and offering a broad range of services over a larger geography than provided by a single CBO. The CCH also provides an efficient means of creating advanced financial, technical, and operational infrastructure required by healthcare partners on behalf of multiple agencies in an organized network delivery model. This has the benefit of 'leveling the playing field' to enable smaller CBOs with close ties to their local community but lacking organizational capacity and resources to work directly with healthcare organizations to participate in contracting opportunities. There

are many challenges in this work, including the differences in language, culture, practices, and regulations between the healthcare, public health, and the social care sectors. [CCHs] are an efficient solution to bridge these gaps and connect healthcare organizations with social care CBOs to better align, coordinate, and deliver person-centered services to historically and/or currently marginalized communities and populations."

Payment opportunities for social care assessments and navigation services are also anticipated to experience a significant increase beginning in 2024 as a result of CMS' adoption of new physician codes and payments for Community Health Integration Services, Principal Illness Navigation, Caregiver Training and Support, and SDOH Risk Assessments. These changes will impact future Medicare (and potentially Medicaid) quality ratings as well as payments to health care entities. They will also likely drive increased demand for solutions from organizations prepared to support these requirements through trained and experienced social care experts, such as those routinely present in AAAs, CILs, and other CBOs across the aging and disability networks.

These health care system changes are driving the need for organized infrastructures with the capacity to coordinate and efficiently scale solutions for HRSN screenings and assessments, social care planning and service coordination, delivery of home and community-based services (HCBS), and transitions care management. Beyond these eminent opportunities, the advent of required screening as noted above will provide documented evidence of the need to integrate social care program and service delivery (and associated funding) to support health care needs across increasing numbers of identified individuals.

The Centers for Disease Control and Prevention (CDC) has been a key federal partner in supporting the expansion of CCHs across the country. In line with the vision of Public Health 3.0, public health departments have long supported SDOH activities in their jurisdiction, including conducting community health assessments, integrating available data at the community level, convening and fostering multisector partnerships, and building and improving linkages between community and clinical sectors. With the emergence of CCH models, new opportunities to utilize these existing leadership capacities exist. Additionally, public health departments are also service providers. They often offer evidence-based programs, such as the National Diabetes Prevention Program and the Healthy Brain Initiative Road Map Series, as well as other prevention programs addressing nutrition, falls, physical activity, and chronic disease self-management. These are important resources to address HRSNs. Thus, there is an opportunity to engage public health in a Hub Network.

This RFP is part of a wide-ranging effort by ACL to ensure alignment between health and social care benefits for all individuals in need. A partial list of those efforts can be found on ACL's website. Specifically, this RFP seeks to bring CCH-level scale and coordination of social care services through infrastructure funding and technical assistance as a catalyst to align health and social care between the social care experts at CBOs with health care organizations as part of the ACL No Wrong Door philosophy and vision which rests on four key functions:

- State Governance and Administration
- Public Outreach and Coordination with Key Referral Sources
- Person-Centered Counseling; and

- Streamlined Eligibility to Public Programs

The NWD System is designed to serve all populations who may need long-term services and supports (LTSS), regardless of health care funding source. This includes people who represent a variety of ages, incomes, nationalities, citizenship statuses, cultures, gender identities and expressions, sexual orientations, languages, or disabilities. At its core, a state NWD System is a network of CBOs comprised of community-based social care professionals, such as information and assistance specialists, person-centered counselors, etc., that manage access functions and processes to support individuals with independent living in the community. CBOs have unmatched expertise in understanding local culture and needs, service coordination and delivery, and securing benefits, services, and supports that maximize independence and well-being. In addition, the breadth of community-based social care professionals residing in a state's NWD system are best positioned to understand a person's preferences for community living; these preferences may differ depending on an individual's age, race, culture, social and family support, as well as which applicable services and supports are important *to* a person and *for* a person. For additional NWD system information, see Appendix A.

Supporting the maturation of CCHs across the nation is the next logical step for NWD systems to streamline access to services and supports. By supporting CCH-health care partnerships, including contracting and rigorous evaluation of service delivery, the connections between health care providers, payers, and CBOs can be strengthened to help realize the ultimate goal of fully coordinated, person-centered care.

Profile of a Successful CCH

In response to the increasing demand for well-coordinated, efficient, and high-quality home- and community-based services (HCBS) delivered across large geographies, CCHs began forming organically more than a decade ago to meet market needs and provide programs and services in the NWD spirit to a growing number of individuals in need of social care programs, services, and supports. These early adopter CCHs are supporting and maximizing the value of the CBOs in their Hub Network while evolving to become competitive enterprises in response to market demand for HCBS. Leading CCHs are shaped by local market forces and are supporting CBOs in their Hub Networks through continuous internal improvements to their business processes, enhanced infrastructures, implementation of quality standards, and best practices to drive value and person-centered outcomes.

Through prior work of the Aging and Disability Business Institute, the Partnership to Align Social Care, and others, the core business functions of a CCH are well established. While each CCH is unique in how it builds and sustains its network, there are foundational business processes and functions that leading CCHs are consistently performing. A profile is emerging of successful CCHs, characterized by their ability to achieve valuable health and wellbeing outcomes for the populations they serve through multi-year contracting with multiple health care organizations. This profile, developed by the Partnership to Align Social Care, includes well-established business processes and best practices as observed in the field and in alignment with long recognized business and management practices across six domains and functional areas:

1. Leadership and Governance
2. Strategic Business Development
3. Network Recruitment, Engagement, and Support
4. Contract Administration and Compliance
5. Operations
6. Information Technology and Security

Established CCHs provide their Network CBOs capacity to:

- Deliver a broad scope of social care services
- Reach more diverse consumers and traditionally hard-to-reach populations
- Build stronger administrative infrastructures
- Capitalize on efficiencies through economies of scale, especially as it relates to infrastructure spending on capital intensive IT systems and related information and data management functions
- Offer one-stop contracting for multiple services with different payers; and
- Identify and adopt best practices and expand quality improvement initiatives and successes quickly and efficiently across the entire network

Additionally, successful CCHs provide expanded geographic coverage and cross-agency coordination at various levels that may include regional (within a state), statewide (throughout an entire state), and multi-state alignments.[ii] [iii]

Common Challenges to CCH Success

When considering the growth and advancement of CCHs, there are common challenges among CCHs, including:

- Lack of experience in health care systems architecture and regulatory performance requirements and incentives
- Lack of expertise in health care claims (billing and payment) management
- Inadequate infrastructure capital
- Difficulties in capacity to develop and implement business development plans
- Lack of experience in marketing and contracting
- Lack of access to expensive and complex information technology to support data management, security, outcomes reporting, and interoperability requirements common in health care
- Underdeveloped pricing and cost accounting systems
- Lack of service provider readiness for the rigors of health care contracting

- Narrow service provider geographical boundaries
- Need to expand populations served and to prepare for the need to scale programs

State Support

States have an opportunity to strengthen and are encouraged to assist with the development and evolution of CCHs and Hub Networks as part of the state's strategy and mission to deliver high quality, coordinated aging and disability network programs and services in an increasingly value-based, integrated care environment. It is especially important for states to consider how they can support CCHs to enhance and leverage the value of their existing programs and services as well as supporting future aging and disability network organizations through structural features in the state's traditional social care programs, Medicaid waivers, and health information exchange (HIE) systems to promote partnerships and contracting between health systems, health plans, managed care organizations, and CCH-led Hub Networks. The Administration for Community Living's recently promulgated final rule on the Older Americans Act (OAA) makes clear that states should develop processes related to health care contracting that are "flexible and streamlined" with the intent to "promote and expand the ability of the aging network to engage in business activities."

In addition, with the active support and leadership of state Medicaid agencies, NWD Systems, and related state aging and disability agencies, CCHs represent a critical tool states should promote as they seek to leverage their historic and future public investments in social care services delivery infrastructure. State support will ensure maximum utility of those investments and encourage a culture where CBOs play a vital role in facilitating alignment across health and social care systems for the citizens of that state.

There is a time-sensitive window of opportunity to directly address health equity in this country by addressing both 1) *equitable access* to programs and services that address HRSN through a culturally competent and coordinated statewide access system in concert with the state's existing NWD System; and 2) *equitable distribution* of these programs and services, including in rural and underserved settings. Building, enhancing, and expanding CCHs and Hub Networks can increase the availability and delivery of HRSN-focused programs and services efficiently and effectively to support alignment and coordination of public resources.

FUNDING OPPORTUNITY OVERVIEW

Use of Funds

The development and enhancement of CCHs provides a unified and consistent approach to address challenges and enhance program delivery across a geographic area, including management of critical business operations, administrative oversight, and establishment of governance responsibilities. To build and strengthen the operations, infrastructure, and sustainability of CCHs for delivery of services that address HRSNs through contracts with health care entities, funds available through this funding opportunity can be used to:

1. Assess business requirements to operate as a CCH in the applicant's state, including insurance liability requirements and gaps in liability coverage that may hinder health care

contracting efforts.

2. Staffing / Leadership / Governance
    a. Assess competencies of key staff performing access functions of the CCH
        i. Provide relevant training in cultural competency, person-centered counseling, social service coordination, etc.
    b. Develop mechanisms for managing staff training across Hub Network partner organizations to ensure service excellence and a culture of quality improvement.
    c. Assess CCH partner organizations representing underserved populations as defined by the *Executive Order on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government.*[iv]
    d. Develop mechanisms to curate and evolve CCH partner organizations to meet the needs of populations over time related to nutrition, housing, transportation, behavioral health, etc.
    e. Develop and implement mechanisms for managing sub-contractual relationships as well as administrative infrastructure needed to pay partner organizations.
3. Financial Modeling
    a. Assess network financial and legal liability for managing risk relevant to participation in contracting.
    b. Conduct cost benefit assessments to determine the financial costs and risk to the network in contracting.

        Develop or enhance processes for blending and braiding funds from available public resources and health care contracts (enabled by the CCH and supported across the Hub Network). For example, state-level benefits and Medicaid reimbursement (e.g., reimbursement for SDOH assessment, social care coordination, state-funded nutrition and transportation assistance, etc.) can be factored into a blending and braiding process.
4. Information Technology (IT) Infrastructure
    a. Assess the health IT requirements for contract performance, including hardware, software, business processes, and privacy and security requirements.
    b. Assess ability of Hub Network partner organizations to file claims electronically.
    c. Assess requirements and opportunities for shared IT services that are needed to function as a CCH but obtained through a collaboration across CCHs.
5. Quality Assurance and Service Delivery Compliance
    a. Determine flow of contracting requirements, metrics, and performance evaluation of CCH partner organizations.
    b. Conduct readiness assessments and regular report cards.
    c. Conduct process mapping and workflows for service activation and relevant follow-up to ascertain service delivery outcome.

Funding Opportunity Components

All COE Grantees will participate in the core COE Infrastructure Funding Opportunity (COE Grant). Additionally, a subset of COE Grantees with active care transitions programs will be selected to participate in a second area of opportunity, the Care Transitions Focus Opportunity and Evaluation (CT Evaluation). Care Transitions Focus Opportunity and Evaluation selections will occur subsequent to COE Grantee award announcements for the core COE Grant and will come with additional funding to support the effort.

All COE Grantees are required to participate in an evaluation of their CCH. As noted above, this funding opportunity, including the evaluation component, consists of two parts: 1) COE Infrastructure Funding Opportunity: All COE Grantees funded through this announcement will participate in an implementation evaluation of CCHs as part of the core COE Grant, and 2) CT Evaluation: COE Grantees will also be evaluated for inclusion in a care transitions program evaluation process. A small group of these COE Grantees will be invited to participate in a site-specific care transitions evaluation that will examine the impact of CCHs on health outcomes for Medicare and Medicaid beneficiaries receiving care transitions services. Selections for the CT Evaluation will be based on programmatic and funding considerations, including but not limited to the specifics of each CCH's care transitions-related programs, services, population and geography served, etc. Additional supplemental funding may be available for COE Grantees participating in the CT Evaluation component. Details on the two funding opportunity components include:

- **COE Infrastructure Funding Opportunity (COE Grant):** The COE Grant is this RFP's core funding opportunity. It is designed to support the overall CCH infrastructure goals described earlier. It includes an implementation evaluation to help the COE and ACL understand how CCHs operate and identify relevant keys to success. All COE Grantees will participate in an implementation evaluation as part of this core COE Grant.
- **Care Transitions Focus Opportunity and Evaluation (CT Evaluation):** Participation in the CT Evaluation will be by invitation-only among the COE Grantees. The CT Evaluation will include a site-specific focus on awarded COE Grantees with experience providing hospital-to-home care transitions.

  The site-specific evaluation intends to assess the extent to which CCHs affect client-level health and social outcomes through hospital-to-home care transitions programs. Three required components include: 1) HRSN screening/assessment, information, and referral/linkage; 2) transition-related case management/service coordination and coaching; and 3) follow-up post-discharge.

  No applicant will be awarded participation in the supplemental CT Evaluation without first being awarded a COE Grant under the COE Infrastructure Funding Grant Opportunity.

  More information on the design and requirements of both components of this supplemental CT Evaluation are outlined in the Evaluation section of this RFP.

Additional details will be provided to COE Grantees invited to participate in the CT Evaluation after the COE Grantee awards are announced.

COE GRANTEE EVALUATIONS

Evaluations Overview

Evaluations will be conducted by ACL with support from ACL's external evaluator, Mission Analytics Group (Mission), in coordination with the COE. Together, they are referred to herein as the "Evaluation Team." All COE Grantees will be required to fully support and engage in these evaluation methods and tools and submit data as required to achieve the program goals and objectives. Details include:

1) **COE Grant:** Data for the implementation evaluation will come from a variety of sources, including existing data that CCHs already collect (e.g., administrative), and new data collection (e.g., surveys, interviews/focus groups) to be carried out with the Evaluation Team. All awardees will complete a CCH capacity assessment no more than three times over the course of the grant period. The Evaluation Team will seek opportunities to limit COE Grantee burden, to the extent possible, and collect the necessary data through regular reporting and interim check-ins with COE Grantees.

2) **CT Evaluation:** In addition to the core COE Grantee evaluation, CCHs participating in the CT Evaluation will also participate in a robust site-specific evaluation. For this purpose, CT Evaluation grantees will be expected to provide individual-level data (e.g., Medicare and/or Medicaid beneficiary identification number, birthdate, etc.) to ensure ACL can independently confirm and access claims data for individuals served by the grantee's care transitions programs. However, CCHs participating in the CT Evaluation will not be responsible for submitting claims data to ACL and its evaluation team. Data sharing opt-ins from the individuals involved, as well as coordination and data sharing agreements with relevant health care organizations, may be necessary. Approvals from those individuals and organizations are not required at the time of application.

Core COE Grantees that are invited and agree to participate in the site-specific CT Evaluation must have an existing hospital-to-home care transitions program operated by the CCH or among its Network CBOs. At a minimum, this care transitions program must serve individuals transitioning from hospital-to-home (including the home of a relative, friend, caregiver, etc.) and will, preferably, include all of the following components:

- **HRSN screening/assessment, information, and referral/linkage**
  - Complete a HRSN screening/assessment for individuals served as part of their care transitions program. This HRSN screening/assessment should include at least the following domains related to the individual's needs during the transition period: food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety. This HRSN screening/assessment can be conducted by the CCH, its Network CBO(s), or its hospital partner(s) as long as

the CT Evaluation grantee has access to the data and can share the results with the Evaluation Team.
- CT Evaluation grantees and their Network CBOs should have a process in place to take action(s) based on HRSN screening/assessment results, including facilitating a person-centered process with the individual (and caregivers/family members, if applicable) pre-discharge. This process should identify goals, discuss available options, and determine preferences for community services during the care transition period post discharge.

- **Transition-related case management/service coordination and coaching**
  - CT Evaluation grantees and their Network CBOs should collaborate with the hospital discharge team to ensure consistent and adequate communications with the individual and their caregivers/family members (if applicable). The goal of this coordination is to ensure the individual and family are well-informed and a smooth transition to the community is achieved, including activation of social care services related to any needs identified by the HRSN screening/assessment and any contractual requirements with the CT Evaluation grantee's transition program funder(s). The scope of these services may be limited to addressing the individual's specific needs around the transition.
- **Follow-up post-discharge**
  - CT Evaluation grantees and their Network CBOs should coordinate the client's transition needs with the individual's primary care provider(s) post discharge to ensure the individual's medical needs and HRSNs are being met and the primary care provider is informed of these activities for further action and care plan documentation.
  - CT Evaluation grantees and their Network CBOs should follow up with the individual (including caregivers and family as warranted) to reassess HRSNs and ensure transition-related HRSNs are met post-discharge (e.g., by readministering the HRSN screening/assessment or other consistent and demonstrable means).

Applicants that provide some, but not all, of the care transitions components listed above may be invited to participate in the site-specific CT Evaluation and, if awarded, will be required to add the remaining components to their care transitions program as a condition of any additional funding award for participation in the site-specific CT Evaluation.

Evaluation Methods

For applicants awarded as COE Grantees, the COE will utilize the following methods and tools as part of the project evaluation:

- Submission of all required project updates and reports on a timely, accurate, and complete basis.
- Completion of ACL's organizational capacity assessment no more than three times over the course of the grant period. The Evaluation Team will seek opportunities to limit COE

Grantee burden, to the extent possible, through regular reporting and interim check-ins with awardees.

- COE Grantees will be expected to address the following in the applicant's proposal and work plan and prepared to provide progress reporting on a quarterly basis:
  - Progress towards and completion of milestones each CCH identifies in its approved application's Strategic Plan and Work Plan under the six CCH function domains: Leadership and Governance; Strategic Business Development; Network Recruitment, Engagement and Support; Contract Administration and Compliance; Operations; and Information Technology and Security. Each milestone will be informed and updated during the grant period to align with the COE Grantee's organizational capacity assessment results and work plan progress. Projects, goals, and initiatives funded under this grant should be designed to support the CCH's maturation and success securing and sustaining multi-year contracts with multiple health sector partners.
  - Proposed milestones should be outlined in the applicant's proposal and reflect the needs of the CCH as well as the expectations outlined herein.
  - Existing health care contracts, including type of health care payor, funding source(s) (e.g., Medicaid Managed LTSS waiver, Medicare Advantage plan, ACO, etc.), a basic outline of the programs or services provided, the basic geographical coverage area (e.g., counties, entire state, zip codes, etc.), approximate number of individuals served over the prior twelve months through the program or services, contract payment model(s), and the number of individuals projected to be served through the program or service over the next 12 months.
  - Additional project evaluation criteria will include, but are not limited to, the following and, unless otherwise identified, each shall be included in the COE Grantee's initial report, in the final report, and significant changes included in required periodic reports:
    1. Number of individuals served through health care contracts, including a breakdown by program or service type.
    2. Number and type of health care organizations engaged, including state agencies, health care providers and systems, managed care plans, employers, and other partners.
    3. Number and types of CBOs contracted in the CCH's Hub Network, including a breakdown by programs and services offered by each (individual identification is not required).
  - Completed (deidentified) closed loop referrals, including referral systems utilized, numbers of referrals, sources and needs identified in the incoming data, as well as needs subsequently identified by the CCH or its Hub Network provider(s), resultant service(s) provided, needs filled, and social care gaps closed. Where health care outcomes data is provided by the referring source, that should also be tracked and reported.
  - Other proposed expectations, initiatives, and anticipated outcomes as specified in the applicant's proposal, workplan, or as required by Evaluation Team.

- For the COE Infrastructure Funding Opportunity evaluation, required report data will be accepted in a deidentified format.
- The COE will conduct post-event evaluation surveys for webinars and other TA offerings to gauge effectiveness of the offering as well as growth in learning among COE Grantees. All COE Grantees are expected to participate in relevant TA offerings and associated evaluation surveys.
- Some elements of the Care Transitions Focus Opportunity and Evaluation site-specific data collection and submission requirements remain under development and will be outlined by the Evaluation Team as part of the invitation process following the initial COE Grantee award notice. At a minimum, reporting will require individual identifiers to allow ACL to perform outcomes evaluations from available claims data.

The Evaluation Team will limit new data collection requirements as much as possible to minimize burden on COE Grantees.

COE GRANTEE AWARD AND APPLICATION DETAILS

Number of Awards, Award Limits, and Project Term

Applicants may request a total budget that reflects the parameters outlined below. Funds will be allocated on a quarterly reporting basis over a two-year project period. Awards will be subject to the availability of federal funds, COE Grantee responsiveness to the COE and ACL, Evaluation Team requirements, and satisfactory work plan progress as determined by the COE and ACL.

Expected Maximum Number of COE Infrastructure Funding Opportunity Grantee Awards: **20**

Individual COE Infrastructure Funding Opportunity Grantee Award Ceilings:

Year 1: **$ 223,300**

Year 2: **$ 245,500**

Total Award Maximum: $ 468,800

Expected Number of COE Infrastructure Funding Grantees invited to participate in the CT Evaluation: **3**

Anticipated Supplemental COE Grantee funding through the CT Evaluation:

Year 1: **$ 30,000**

Year 2: **$ 30,000**

Anticipated Total Supplemental Award: $ 60,000

Anticipated Combined Maximum Award Over the Two-Year Period: $ 528,800

Final supplemental awards for participation in the CT Evaluation will be determined by the COE in consultation with the Evaluation Team and communicated to invitees as part of a CT Evaluation invitation process. Additional funding may also become available.

Projected Grant Period: May 1, 2024 through April 30, 2026

Projected Award Announcement: Prior to May 15, 2024

All dates are subject to change. Final project period dates will be finalized following award.

Note: Year 2 funding is subject to the availability of federal funds and ALL funding is subject to satisfactory COE Grantee responsiveness and work plan progress.

Information Call

An informational video call will be held on February 26, 2024 from noon-1:00 pm ET

Information Call Registration is Required. Click here to register.

The information call can also be accessed via phone call. Call in numbers will be provided in the registration confirmation email.

A recording will be available within 48 hours of the call's end at coe.aginganddisabilitybusinessinstitute.org.

GRANT AGREEMENT TERMS

Overview of Terms

These awards will all be new grant agreements with the COE. The COE will be substantially involved in the technical assistance, monitoring, and evaluation efforts in cooperation with ACL and ACL's external evaluator.

All COE Grantees must fully budget for all project work, deliverables, staffing, travel, reporting, evaluation, etc. necessary to complete all grant deliverables.

An overview of the general terms and conditions of the agreement are provided below and will be included in the grantee agreement, acceptance of which is a required condition of the award.

COE Responsibilities

The COE will carry out the following activities specifically in support of the awarded COE Grantee agreements noted above and in alignment with the above stated objectives:

- Perform the day-to-day responsibilities of managing the COE's role under the grant initiative and work with each COE Grantee to monitor progress and provide basic, non-technical support to ensure that the COE Grantee remains on track to meet all necessary grant deliverables.
- Assist the COE Grantee project leadership in understanding the COE's expectations and

priorities through scheduled, periodic briefings and ongoing COE Grantee consultations, as needed.

- Work cooperatively with each COE Grantee to clarify the COE's programmatic and budgetary expectations under the grant. If issues are identified, work with the COE Grantee to discuss potential draft revisions to the project work plan. However, the COE Grantee will be solely responsible for detailing the status of major activities, proposing any potential revisions to the project work plan, and ensuring the grant deliverables are completed in a timely manner. Any requests for work plan modifications shall be subject to COE approval.
- Provide technical assistance to COE Grantees to support activities and tasks related to fulfillment of the goals and objectives of this grant, including technical assistance to support COE Grantee development and work plan progress. Technical assistance will be provided by a network of national, state, and CCH/CBO subject matter experts utilizing a variety of methods, including webinars/office hours, mentorship, resource materials, and an online CCH portal.
- Provide consultation to the COE Grantee in identifying emerging issues as they relate to the goals and objectives of this grant program.
- Work with the COE Grantee on the development and implementation of evaluation and quality assurance systems to ensure that performance is measured, and continuous improvement occurs.

COE Grantee Responsibilities

COE Grantees will develop and execute a workplan reflecting their grant-related responsibilities including those listed below:

- Fulfill all requirements of the subgrant agreement as outlined in this program announcement, as well as carry out project activities outlined in the COE Grantee's proposal and workplan as reviewed, approved, and awarded.
- Participate in ACL and COE education and communication activities (including teleconferences and webinars) provided that ACL or the COE provides reasonable notice of the subject, date, and time of the teleconference.
- Attend an in-person meeting at USAging's annual conferences in 2024 (Tampa) and 2025 (Chicago). Funding for travel to these in-person meetings should be included in the applicant's budget.
- Complete ACL's organizational capacity assessment (or complete a reassessment if the tool has been previously completed) within the initial 45 days of the grant period to evaluate the capacity and readiness of COE Grantees and identify areas for CCH and Hub Network improvement to be included in the COE Grantee's work plan and deliverables.
- Complete additional evaluation tasks as identified by the COE and ACL evaluation team over the two-year grant period.
- Develop and/or update a business plan, to include a health and social service market

assessment and a gap or SWOT analysis to guide activities and monitor progress.

- Determine a process for blending and braiding funds from available public resources and health care contracts (enabled by the CCH and supported across its Hub Network).
- Comply with all other reporting requirements and deliverables expectations, as outlined elsewhere in this Funding Opportunity and the Notice of Award.

Eligibility Information

Domestic public or private non-profit entities including state and local governments, Indian tribal governments and organizations (American Indian/Alaskan Native/Native American), existing CCHs, faith-based organizations, community-based organizations, and institutions of higher education.

APPLICATION SUBMISSION AND SCREENING EXPECTATIONS AND CRITERIA

Application Submission Expectations

Applicants are required to utilize the Submittable online system to submit their application. Applications will be screened to ensure a level playing field for all applicants. Applications that fail to meet the three initial screening criteria described below will not be reviewed and will receive no further consideration.

a. **Submittable:** In order for an application to be reviewed, it must be submitted electronically via the Submittable process as briefly outlined elsewhere herein. Additional details will be provided by the COE to all interested parties during the information call and via the project webpage noted above. Any application submitted or received using any delivery method other than the USAging Submittable online platform, including email, fax, post, courier, hand-delivery, or any other form of submission will not be accepted.

b. **Timeliness:** Applications received after the deadline will be disqualified and not reviewed or considered, regardless of the proposal's merit.

c. **Completeness:** Missing information will be considered as non-responsive. Missing required information will be considered negatively in the overall application quality portion of the application review and scoring process. Missing or non-responsive answers to "scored" questions in the application will receive zero points. The Project Work Plan, Budget, Letters of Commitment, and Resume/Curriculum Vitae of Key Project Personnel will each receive a quality score based on the quality, accuracy, thoroughness, and responsiveness of that portion of the application submission.

Notice of Intent to Apply

Applicants are requested, but not required, to provide a Notice of Intent to apply for this funding opportunity to assist the COE in planning for the application review process. The purpose of this Notice of Intent is to allow our staff to estimate the number of independent

reviewers needed and to avoid potential conflicts of interest in the review process.

Applicants should submit their Notice of Intent through Submittable.

Notices of Intent are requested to be submitted no later than March 8, 2024.

To create your Submittable account and submit your Notice of Intent, please see the "Application Submission Process and Platform" beginning on page 26.

Submission Guidelines

Proposals from successful applicants will demonstrate a strong foundational knowledge of CCHs and social care services. Additionally, quality applications will thoughtfully and thoroughly address each aspect of this funding announcement through the submission process.

Strong consideration and time should be given to developing a well-designed narrative about the applicant organization and how/why it serves or will serve as the CCH and identifying its strengths, experiences, and capabilities as well as those of participating CBOs that comprise CCH's Hub Network. It may be helpful, but is not required, to include a network organizational chart as an uploaded appendix to your application.

To assist reviewers in scoring your application, applicants will submit their responses to each section through a question and response process in the Submittable tool. Additional information and an Applicant Preparation Tool will be made available by the COE following the information call. Applicants are also strongly encouraged to take advantage of Submittable applicant tutorials provided on their website and referenced elsewhere herein.

APPLICATION ELEMENTS

Project Abstract

This section should include a brief and clear description of the proposed project, including goal(s), objectives, and outcomes.

Project Relevance and Current Need

Applicants will be asked to briefly describe each of the following:

- The current CCH structure and governance, notable existing infrastructure, and a high-level scan of the state of health and social care alignment within your state or region.
- Information on contracts or partnerships with state NWD system lead agencies, state and local public health departments, Medicaid agencies, and other state or federal partners.
- The geographic area that your Hub Network serves across all products and services.
- The CCH's and Network CBOs' products, programs, services and populations served.
- The applicant's existing contracts, operational experience, and capacity to deliver these programs and services including current volumes and capacity to scale as well as any

variations in geographic area(s) served by those products and services, if any. These should be organized by funder and program. For example, approximate numbers of individuals served who are Medicare only, Medicaid only, and Medicare-Medicaid (dually eligible) beneficiaries.

- On average, how many discrete individuals (across all services and all service areas) does your CCH network serve annually?
- How the CCH's network reflects and serves diversity in their communities.
- Existing partnerships with health plans, health systems, and other payers as well as prior partnerships and current/planned outreach efforts.
- The degree to which your organization is performing access functions as part of a broader NWD System in your state (see Appendix A for a list of access functions) and how this grant, if awarded, may assist your agency to enhance your performance of these functions.
- Briefly describe any barriers or challenges that exist with respect to a fully operational and accessible Hub Network in your target geography, and how the proposed project would address those barriers and challenges. Include specific information regarding the initiatives you propose to undertake, if awarded.
- For applicants with existing care transitions programs that wish to be considered for the CT Evaluation, describe your care transitions program including, but not limited to, the questions listed below:
  - Are care transitions services being delivered through CCH contracts or through separate agreements with one or more of the CBOs in your Hub Network? If through separate Network CBO agreements, please name those CBOs.
  - Please describe each component of your care transitions program (e.g., in-hospital planning, medication reconciliation, adherence to follow-up medical appointments and communications with providers, follow up home visit(s) and phone check-in calls, etc.).
  - What is your care transitions workflow?
  - Provide an overview of how the process ensures efficient, ongoing coordination of transition services, including clear designations regarding the role and responsibilities of CBO staff and health care staff. Please address data sharing and outcomes/performance evaluation.
  - If your program maintains fidelity to a specific, evidence-based care transitions model, please identify and describe any variations or additions made in the applicant's model as well as briefly describing any variations required by any health care partners.
  - How are your Hub network's care transitions services funded (e.g., contracts with health plans or hospitals, foundations, government programs, etc.)?
  - Related to each of these funding sources, what is the geographic scope of each contract?
  - In total, approximately how many individuals does your care transitions program(s) serve annually?

- Among those served, please identify what percentage are covered by Medicare only, Medicaid only, or both (dual eligibles).
- What criteria are used to determine if an individual is eligible for your care transitions program (e.g., specific conditions, co-morbidities, age, medications, etc.)? Do these criteria vary by health care partner/contract?

Approach

This section should describe:

- The CCH's measurable, outcomes-based quantitative and qualitative goals and major objectives.
- How the CCH would maximize the opportunity to deliver a broad scope of social care programs and services for older adults and people with disabilities, if funded. Specify the services to be delivered, infrastructure to be secured, skills and expertise to be developed, and/or capacity to be built or enhanced.
- How your proposed activities through this funding opportunity will address any unmet needs with respect to CCH or Hub Network infrastructure development and/or expansion of geographic coverage, populations served, staffing capacity across a variety of roles (e.g., access functions, care coordination, transitional care services, community health/social workers/navigators, etc.) to ensure the CCH and Hub Network social care providers have the expertise and capacity to fully coordinate and oversee service delivery, information technology, etc.
- How this funding, if awarded, will help the CCH and its Hub Network's social care providers engage network partners, including public health agencies, to reach diverse consumers, geographic areas without current CCH capacity, and traditionally underserved populations (as defined by Executive Order on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government) as well as attract the CBOs focused on serving these populations.

Outcomes and Internal Evaluation

Outcomes

- This section must clearly identify the outcomes that will result from your comprehensive strategy to implement this project. Any proposed outcomes should:
  - address the goals of this funding opportunity
  - be quantifiable, measurable, and likely to be achieved during the project period; and
  - further the goals of the state NWD system and support cooperation with state/local public health agencies.
- List measurable outcomes in the Work Plan grid under "Measurable Outcomes," in addition to any discussion included in the narrative.

Internal Evaluation

- This section should describe the internal method(s), techniques, and tools that the COE Grantee will use to:
  - determine whether the proposed intervention achieved its anticipated outcome(s); and
  - document the "lessons learned" – both positive and negative – from the project that will be useful to people interested in replicating the intervention if it proves successful.

NOTE: The Internal Evaluation is not to be confused with the ACL Evaluation for the overall project. It is not the intention of the COE that COE Grantees hire a separate independent evaluator. The expectation is that each COE Grantee demonstrate a thoughtful method through which the CCH measures outcomes of their programs and services and ensures that the proposed intervention is included in that process and will be shared with the COE during the project period and as part of an end of project reflections and lessons-learned report.

Dissemination

In addition to participating in and supporting the COE and/or ACL's efforts to promote and disseminate the results and findings of the evaluation, describe in this section how the CCH will:

- disseminate the project's methods, results, and findings in a timely manner and in easily understandable formats, to parties who might be interested in using the results to inform practice, service delivery, program development, and/or policymaking, including those parties who would be interested in replicating the project and method(s) utilized.
- participate in conferences, webinars, and other presentation formats to share project-relevant information with interested parties.

Organizational Capacity

In this section, describe:

- how the applicant's CCH is organized, including governance structure. Include the nature and scope of its work to date and the capabilities it possesses, including under contract if applicable.
- the CCH's experience delivering and/or facilitating streamlined access to services/programs that address HRSNs, including for underserved populations and SDOH in underserved communities.
- the CCH governance and project management functions, including the roles and responsibilities of project staff, board, consultants, including:
  - a description of the qualifications and experience of key personnel to be assigned to this proposed project, including for the Project Director. Applicants must include resumes or CVs (upload all resumes/CVs as one attachment through Submittable) and

clearly indicate the role assumed for each person.

- who will have day-to-day responsibility for key tasks such as: leadership of project, monitoring the project's on-going progress, preparation of reports, and communications with other partners and the COE.

Letters of Commitment from Key Participating Organizations

CCHs are expected to work with multiple partners in the communities served. Letters of commitment and support are strongly encouraged to demonstrate the depth and breadth of your organizational community relationships and capacity to execute on your CCH's proposed work plan.

- Include confirmation of the commitments to the project (should it be funded) made by key collaborating organizations and agencies (including Network CBOs, proposed health care partners, and public health departments). Any organization that is specifically named to have a significant role in carrying out the project should be considered an essential collaborator with a letter of commitment to document their agreement to the proposal.
- The quality of the letter content (i.e., specificity with respect to the role of that partner) is more important than the quantity of letters submitted with your application. Signed letters of commitment should be scanned and included as indicated in the Submittable tool. Letters of commitment must be uploaded as part of the applicant package – hard copies will not be accepted. Electronic signatures (e.g., scanned or "DocuSigned" signatures) are acceptable.
- It is highly encouraged that applicants demonstrate strong connections with state, territory, and tribal organizations, including public health departments, the state unit on aging (SUA), statewide independent living council (SILC), NWD systems, state Medicaid agency, and/or state intellectual/developmental (I/DD) disabilities agency by including letters affirming their support for your proposed project (appropriate state agency is dependent upon the nature of the applicant organization and composition of the Hub Network).

  If a state agency is supportive and declines to provide a letter because of a standing practice against doing so, please include documentation to address this (e.g., an email from the agency stating that letters of commitment are not being provided).

  - You can locate the applicable SUA information using the search feature at https://eldercare.acl.gov/Public/Index.aspx.
  - You can locate applicable state, territory, and tribal public health departments using the search feature at https://www.cdc.gov/publichealthgateway/healthdirectories/index.html.
  - You can locate the applicable SILC information using the search feature at https://www.ilru.org/projects/silc-net/silc-directory.
  - You can locate the applicable state I/DD agency information using the search feature at https://www.nasddds.org/state-agencies/.

- It is expected that relevant regional or local Area Agencies on Aging (AAAs), Centers for Independent Living (CILs), and public health departments will also provide letters affirming their commitment to participate in the CCH's Hub Network and/or support for the project. Include such letters from local AAAs, CILs, and public health departments from across your targeted geographic areas. If your CCH is unable to secure participation and support from these local organizations, please address the reasons why.
    - If you are an aging-specific applicant from a Single State Authority state (Alaska, Delaware, Nevada, New Hampshire, North Dakota, Rhode Island, South Dakota, Washington DC, and Wyoming) the applicant may satisfy this requirement by substituting letters of commitment from other leading aging and disability social care organizations in the community(ies) served by the CCH.
    - You can locate the applicable AAA information using the search feature at https://eldercare.acl.gov/Public/Index.aspx.
    - You can locate the applicable local public health department using the search feature at https://www.cdc.gov/publichealthgateway/healthdirectories/index.html.
    - You can locate the applicable CIL information using the search feature at https://www.ilru.org/projects/cil-net/cil-center-and-association-directory.

Budget Narrative/Justification

- Applicants are required to provide a detailed Budget Narrative/Justification. Your budget should be aligned with the proposed activities in your Project Narrative and Work Plan.
- The Applicant's proposed budget should be provided using the format included in the documentation posted on the COE website. Applicants are encouraged to pay particular attention to this document, which provides an example of the level of detail sought.
- If funds from the award are intended to be used for travel and other related costs to attend the two required in-person meetings at USAging's annual conferences in 2024 (Tampa) and 2025 (Chicago), please include these projected costs in your proposed budget.
- Applicants must submit the following:
    - Budget Narrative/Justification for Year 1
    - Budget Narrative/Justification for Year 2; and
    - Combined Year 1 and Year 2 budget

Work Plan

- Provide a project Work Plan that covers both Years 1 and 2. This work plan should reflect and be consistent with the goals outlined in this RFP as well as the applicant's Project Narrative, Budget, and related responses in their Submittable application.
- This Work Plan should be specific and clear. It should identify the project's overall goals, anticipated outcomes, key objectives, and major tasks/action steps that will be pursued to achieve the results-based goals and outcomes.

- It should also include tasks/action steps that will be taken to evaluate progress toward goals and outcomes and the effectiveness of relevant strategies for quality improvement.
- Applicants should identify timeframes involved (including start- and end-dates) and the lead person responsible for completing the task.
- Include a brief narrative to explain the Plan and outline any known risks to success on work plan deliverables and how your project proposes to address those risks.
- The Work Plan should be uploaded using the Submittable application system.

RELEVANT APPLICATION SUBMISSION DATES, TIMES, AND EXPECTATIONS

Dates, Times, and Applicant Responsibilities

Interested Parties Conference Call: February 26, 2024 @ noon Eastern

Notice of Intent to Apply (preferred, but not required): March 08, 2024

Application submission due date/time: April 05, 2024 @ 5:00 pm Eastern

Application submittal responsibilities: Potential applicants are solely responsible for ensuring their application is complete, accurate, responsive, and submitted by the stated deadline. Applications submitted after the application due date/time, as well as those not in compliance with the requirements set forth herein, will not be reviewed and will receive no further consideration except as otherwise provided herein.

Potential applicants are strongly encouraged to submit their application a minimum of 3-5 days prior to the application closing date. Do not wait until the last day in the event you encounter technical difficulties. Each applicant is solely responsible for ensuring successful application submission. USAging is not responsible for any technical or other difficulties that may arise, regardless of source of the error. Should the applicant experience technical difficulties with Submittable, the applicant should contact Submittable using their online self-help resources and instructions (see "Application Submission Process and Platform" instructions below).

If more than one application is submitted on behalf of any organization, only the last application submitted will be reviewed and considered, regardless of the reason for multiple applications.

Application Submission Process and Platform

All applications must be submitted through USAging's online application platform on Submittable.

To submit a Notice of Intent to Apply and start an application, applicants will need to create a Submittable account. To create a Submittable applicant account, follow Submittable's Getting Started instructions. Applicants may also wish to review Submittable's Product Demo for Submitters and the Submittable applicant FAQs page.

The USAging Submittable platform landing page can be accessed by following this link.

While the Notice of Intent to Apply form is available at this time, the COE staff are currently building out the remaining elements of the application on the Submittable system. As a result, some aspects and forms that will be part of the application process are not currently available on the date of the RFP release.

More information will be provided on the project webpage – coe.aginganddisabilitybusinessinstitute.org – and during the information call noted above.

An Applicant Assistance Tool is being created to make the application process clear and straightforward in a step-by-step format. All aspects that will be required in the Submittable application process are reflected in this RFP. The tool will be available no later than February 26, 2024, the date of the information call for interested parties.

However, the first step in submitting an application is to complete the Notice of Intent to Apply and we encourage all organizations intending to apply to register and complete this Notice on the Submittable platform. Once the remaining forms are ready for review and completion, an email notice will be shared with organizations that have submitted a Notice of Intent to Apply in the Submittable system and during the Information Call.

If you are experiencing problems setting up your Submittable account or for other common applicant questions related to Submittable, please see the Submittable Help for Applicants page.

If for any reason multiple application packages are submitted on behalf of an applicant organization, the **COE will accept only the final electronic application package submitted prior to the application due date** regardless of the completeness of that last-submitted application package or the intent of the organization. The Submittable system does allow applicants to work on their application over time in the Submittable system. As a result, it is not necessary to complete the entire application in one session. However, do not submit partial applications. Submit all portions of the application as a single package. If an applicant does submit an incomplete application or needs to correct or amend any aspect of the application after submission, a process is available in the Submittable system for application withdrawal and resubmission as long as those changes and resubmission occur before the due date/time.

Information on what to expect from Submittable after you electronically submit your application can be found here.

Appealing Application Denial for Late Submissions

We will not consider an application for review if you failed to fully register and submit a complete application to Submittable before the application deadline or the applicant experiences technical problems not specifically caused by a technical failure of the Submittable system (e.g., the Submittable application system experiences a technical, internal failure and is not available). Examples of unacceptable excuses include, but are not limited to, an applicant misread or forgot the application deadline; or experiences a power outage, internet problems, or computer problems. Failure on the applicant's part to learn, understand, and operate the Submittable application process is not the responsibility of USAging. It is solely the responsibility of the applicant to operate the Submittable

application submission system and process and to ensure timely and successful application submission.

As noted above, only technology-related problems that directly caused the submission failure and are directly attributable to a technical failure in the Submittable system will be considered. For an applicant to successfully appeal denial of a late application, the unsuccessful applicant will be required to submit authenticated verification demonstrating the Submittable system failure existed at the time of your submission, was unresolvable through Submittable, and was outside the applicant's control. For example, you will be required to provide a Submittable error notification screenprint, email, or similar objective evidence in order to substantiate missing the submission due date/time. Loss of power, computer malfunctions, loss of internet access, or other technical failures not the responsibility of Submittable will not constitute a successful appeal. If you are prevented from electronically submitting your application by the application deadline because of technical problems with the Submittable system and have exhausted your help options using the Submittable links provided above, please immediately send an email requesting an acceptance denial appeal review request to COE@usaging.org and provide a screenprint (saved as a jpg or pdf) of the error along with a brief written explanation of the technical problem you experienced with Submittable along with any additional relevant supporting documentation. The Subject line should include "Acceptance Denial Appeal Review Request." This email must be received by the COE no later than 48 hours following the application deadline. As noted above, only technical failures regarding the Submittable system will be considered. Applicant errors or omissions related to their application and other personal challenges or barriers do not constitute a technical failure regarding the Submittable system and will not receive consideration. The COE will contact you after a determination is made on whether your application will be accepted. Out of fairness to other applicants, the COE's decision will be made based solely on objective information provided by the applicant and Submittable and the COE's decision is final and not appealable.

We remind all applicants to become familiar with Submittable early and complete your application submission well prior to the deadline.

FUNDING RESTRICTIONS

The following activities are not fundable:

- Construction and/or major rehabilitation of buildings
- Basic research (e.g., scientific or medical experiments)
- Continuation of existing projects without expansion or new and innovative approaches

CRITERIA, REVIEW, AND SCORING

NOTE: Applicants may be awarded either a COE Infrastructure Funding Opportunity Grant (COE Grant) OR a COE Grant <u>and</u> supplemental site-specific Care Transitions Focus Opportunity and Evaluation (CT Evaluation) funding. No applicant will be accepted into the site-specific CT Evaluation without being awarded a core COE Grant.

COE Infrastructure Funding Grant Scoring Overview

All applicant responses are expected to be complete and responsive to the questions. While no specific point structure is noted for certain information requested (e.g., basic applicant information), consideration will be given to the thoughtful and responsive nature of those sections when making final award determinations.

For all applicants, the COE Infrastructure Funding Grant section of the application must include the following information. COE Infrastructure Funding Grant applications are scored by assigning a maximum of 100 points across seven domains as follows (additional details are provided on subsection pages):

1. Project Abstract (Maximum Points: 5)
2. Project Relevance and Current Need (Maximum Points: 17)
3. Approach (Maximum Points: 26)
4. Outcomes, Evaluation, and Dissemination (Maximum Points: 14)
5. Organizational Capacity (Maximum Points: 10)
6. Letters of Commitment or Support from Key Organizations and Health Care Partners (Maximum Points: 10)
7. Budget Narrative/Justification (Maximum Points: 8)
8. Work Plan (Maximum Points: 10)

Applicants must document all of their source material. If any text, language, and/or materials are from another source, the applicant must make it clear the material is being quoted and where the text comes from. The applicant must also cite any sources when they obtain numbers, ideas, or other material that is not their own. If the applicant fails to comply with this requirement, regardless of the severity or frequency of the plagiarism, the reviewers shall reduce their scores accordingly even to the degree of issuing no points at all.

Topics and Information Applicants Must Include

Project Abstract

- Provide a Project Abstract that aligns with the Project Approach and includes a brief description of the proposed project, including clear and measurable goal(s), objectives, and outcomes. (5 points)

Project Relevance and Current Need

- Demonstrate a clear understanding of existing CCH and Hub Network activities within their state/region. (2 points)
- Include information on partnerships (and the relevance of those partnerships) with state NWD System lead agencies, public health departments, and related agencies. (4 points)
- Highlight the degree to which the applicant's organization is performing access functions (directly or through support for their Hub Network participating agencies) as part of a broader NWD System in their state (see Appendix A for list of access functions). (3 points)
- Describe their current role as a CCH. If adequate capacity does not currently exist, indicate why they are well-positioned for this role and how they intend to ensure success. (4 points)
- Describe the barriers/challenges that exist with respect to a fully operational/accessible CCH in their target geography, and how the proposed project would address those barriers/challenges. (4 points)

Approach

- State clearly the project's overall approach and major objectives it will pursue, if funded. (4 points)
- Describe how the CCH will pursue contracts with health care organizations (if funded) to deliver social care programs and services for older adults and people with disabilities, and how the CCH has or intends to secure those contracts and grow the depth and breadth of those contracts. Blending and braiding concepts may be included here. (5 points)
- Describe how the CCH's proposed activities (if funded) will enhance the CCH's capacity in any/all of the following domains: Leadership; Finance; Business Development; Network Development and Support; and Network Administration. (8 points)
- Describe how the applicant's proposed activities will address any unmet needs with respect to CCH and Hub Network infrastructure development and/or expansion (i.e., geographic coverage, populations served, staffing capacity, information technology, etc.). Proposals should clearly describe how the CCH will engage health care organizations to reach diverse consumers and traditionally hard-to-reach populations and underserved communities (as defined by Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government). (9 points)

Outcomes

Identify the outcomes that will result from the comprehensive strategy to implement the project. Proposed outcomes should:

- Address the goals of this funding opportunity; and (3 points)

- Be quantifiable, measurable, and likely to be achieved during the project period and in alignment with the project narrative and work plan. (2 points)

Evaluation

- Describe the method(s), techniques, and tools that will be used to document and evaluate: 1) whether or not the proposed work (if funded) achieves its anticipated outcome(s); and 2) how "lessons learned" – both positive and negative – from the project will be useful to the applicant and other CCHs interested in replicating the intervention, if it proves successful, or avoid pitfalls in the program's design. (4 points)
- Specifically acknowledge and agree to participate fully in the COE and ACL's overall project evaluation. (1 point)

NOTE: This Evaluation component of the application does not replace and should not address the COE and ACL's evaluation process. In this section, the applicant should address how the applicant's organization evaluates the value and success of its programs and services to achieve positive outcomes for the individual's served, its contractors, and the needs of the community. The applicant will also be expected to participate fully in the COE and ACL's evaluation process as described elsewhere.

Dissemination

- Describe the method(s) that will be used to disseminate the project's results and findings in a timely manner and in easily understandable formats, to parties who might be interested in using the results to inform practice, service delivery, program development, and/or policymaking, including and especially those parties who would be interested in replicating the project or engaging in quality improvement efforts by using the lessons learn to improve upon the project in future CCH work. (3 points)
- Affirm the applicant's willingness to participate in conferences, webinars, and other presentation formats to share project-relevant information with interested parties. (1 points)

Organizational Capacity

- Describe how the CCH is organized and governed, the nature and scope of its work, and the capabilities it possesses. (2 points)
- Describe the applicant's experience (including the work of the CCH's Hub Network agencies) delivering and/or facilitating streamlined access to programs and services that address HRSNs, including for underserved populations, especially instances where the CCH and Hub Network agencies have worked or intend to work as part of or collaboratively with NWD systems and public health agencies. (3 points)
- Articulate their role/function as a CCH, as well as identify the partners that currently comprise their Hub Network. (3 points)

- Describe how the project will be managed, including the experience/qualifications, roles, and responsibilities of key project staff. (2 points)

Letters of Commitment or Support from Key Organizations and Health Care Partners

- Include letters of commitment to participate and support the project (should it be funded) from key collaborating organizations and Hub Network participating CBOs and other collaborators (including NWD systems, public health agencies, other applicable state agencies, and any health care organizations). At a minimum, letters of commitment should demonstrate the following:
  - The applicant's Hub Network (of participating CBOs) is sufficiently broad and aligned with the programs and services the CCH intends to offer. (3 points)
  - The applicant has letters of support or commitment from existing or proposed health care organizations to work with the CCH and its Hub Network participating CBOs. (3 points)
  - A letter of support from applicable state unit(s) on aging (SUA), state public health department(s)/agency(ies), state Medicaid agency(ies), statewide independent living council(s) (SILC), and/or state intellectual/developmental (I/DD) disabilities agency(ies). NOTE: If the state agency declines to provide a letter, the applicant should include documentation indicating the request and evidence of why the agency declined. (2 points)
  - Applicable Area Agency(ies) on Aging (AAAs), local public health department(s), or Centers for Independent Living (CILs) that operate in the applicant's targeted geographic areas. NOTE: This requirement is not applicable to aging-specific applicants from a Single State Authority (Alaska, Delaware, Nevada, New Hampshire, North Dakota, Rhode Island, South Dakota, Washington DC, and Wyoming). In these states, the applicant may substitute letters of support/commitment from other relevant aging and disability CBOs. (2 points)

Budget Narrative/Justification

- Provide a detailed Budget Narrative/Justification (using the format provided) that is aligned with the proposed activities in the Project Narrative and Work Plan. (3 points)
- Include detailed budgets consistent with this RFP for each of the following:
  - Project Year 1 (2 points)
  - Project Year 2 (2 points); and
  - A combined Year 1 and Year 2 budget (1 points)

Work Plan

The Work Plan should be uploaded as a PDF file and should address the following:

- Provide a logical, objective, well-designed, and measurable project layout and

progression for Years 1 and 2. It should reflect and be consistent with the applicant's Project Narrative and Budgets. (5 points)

- Include achievable project goals, key objectives, and major tasks/action steps (including task owners) that are consistent with the Project Narrative and the pursuit of achievable, CCH results-based goals, outcomes, and objectives. (5 points)

REVIEW AND SELECTION PROCESS

An independent review panel of at least three individuals will review and evaluate applications that pass an initial eligibility screening and meet the responsiveness criteria. These independent reviewers are experts in their field, and are drawn from academic institutions, non-profit organizations, experienced practitioners and consultants in the field, state and local governments, and federal government agencies. Based on the Application Review Criteria, the reviewers will comment on and score the applications, focusing their comments and scoring decisions on the identified criteria and exclusively on the applicant's response. As a result, references to content outside of the application submission (e.g., references to websites and related hyperlinks) will not be considered by reviewers.

Final award decisions will be made by the Award Team from the COE and ACL. In making these decisions, the Award Team will take into consideration: recommendations of the review panel; reviews for programmatic and grants management compliance; the goal to reach geographic areas without current CCH capacity and those serving underserved populations; the reasonableness of the proposed budget in consideration of available funding and anticipated results; and the likelihood that the proposed project will result in the benefits expected.

Applicants operating some or all aspects of a care transitions program identified in this RFP should indicate their interest in consideration for the supplemental CT Evaluation and related funding. All applicants awarded as COE Grantees who indicate an interest in the supplemental CT Evaluation will be considered based on the information provided by the applicant in the Submittable application process regarding their hospital-to-home care transitions program as outlined elsewhere in this RFP, especially on pages 13, 14, 21 and 22.

One or more COE Grantee may be offered the opportunity to participate in the CT Evaluation even if their current care transitions program does not currently include all care transitions program aspects outlined in this RFP where the COE Grantee demonstrates a willingness to expand their care transitions program to include those remaining program aspects. As a result, all applicants that currently include some but not all care transitions program aspects outlined in this RFP should briefly describe plans for adding any remaining care transitions components to their program, if the applicant is invited to participate in the CT Evaluation. The opportunity to participate in the supplemental CT Evaluation process will be extended to a small number of COE Grantees after the initial COE Grantee awards are announced and may include discussions and additional information requests with specific COE Grantees. If a COE Grantee is offered the opportunity to participate in the supplemental CT Evaluation process and chooses to not accept the offer, that decision will not negatively impact the COE Grantee's award under the core COE Infrastructure Funding Opportunity Grant.

SUBMITTING QUESTIONS

Direct all questions and related RFP Correspondence to: COE@USAging.org. Only questions sent to this email address or posted to the Questions feature during the Zoom information session described elsewhere will be considered submitted and considered for response. Any answers provided to questions submitted will be posted to a publicly-available Frequently Asked Questions (FAQs) document that can be accessed through a link on the COE main webpage, coe.aginganddisabilitybusinessinstitute.org.

NOTE: COE staff reserves the right to determine whether a submitted question is substantive and whether or not it is addressed in publicly available documentation, including this Request for Proposal and may not separately address a question(s) that is determined by the COE staff, in their sole discretion, to be non-substantive or covered elsewhere in publicly available documentation.

ADDITIONAL SOURCES AND INFORMATION

[1] *Social Determinants of Health*. Centers for Disease Control and Prevention, 9 Mar. 2021, http://www.cdc.gov/socialdeterminants/index.htm.

[2] Whitehead, Margaret and Göran Dahlgren. WHO Collaborating Centre for Policy Research on Social Determinants of Health University of Liverpool, 2006, *Levelling up (Part 1): a Discussion Paper on Concepts and Principles for Tackling Social Inequities in Health*.

[3] Blue Cross Blue Shield of Massachusetts Foundation, 2015, *Leveraging the Social Determinants of Health: What Works?*

[4] American Academy of Family Physicians, 2019, *Advancing Health Equity by Addressing the Social Determinants of Health in Family Medicine (Position Paper).*

[5] Community Based Organizations (CBO) may include Area Agencies on Aging, Aging and Disability Resources Centers, Centers for Independent Living or other aging and disability network agencies.

[6] Hopson, Chris. "Health and Social Care Integration: How Do We Make It Work?" *The Guardian*, 18 Sept. 2013.

[7] According to the Centers for Disease Control and Prevention, a community health worker (CHW) is a frontline public health worker who is a trusted member or has a particularly good understanding of the community served. A CHW serves as a liaison between health and social services and the community to facilitate access to services and to improve the quality and cultural competence of service delivery.

[8] The Office of the Assistant Secretary for Planning and Evaluation (ASPE) and the Administration for Community Living (ACL) at the U.S. Department of Health & Human Services. *Community Care Hubs: A Promising Model for Health and Social Care Coordination*, November 2023. https://aspe.hhs.gov/reports/community-care-hubs

[9] *Call to Action: Addressing Health-Related Social Needs in Communities Across the Nation.* U.S. Department of Health and Human Services. https://aspe.hhs.gov/reports/hhs-call-action

[10] *Community Care Hubs: A Promising Model for Health and Social Care Coordination.* ASPE. https://aspe.hhs.gov/sites/default/files/documents/5b8cba1351a99e904589f67648c5832f/health-social-care-coordination.pdf

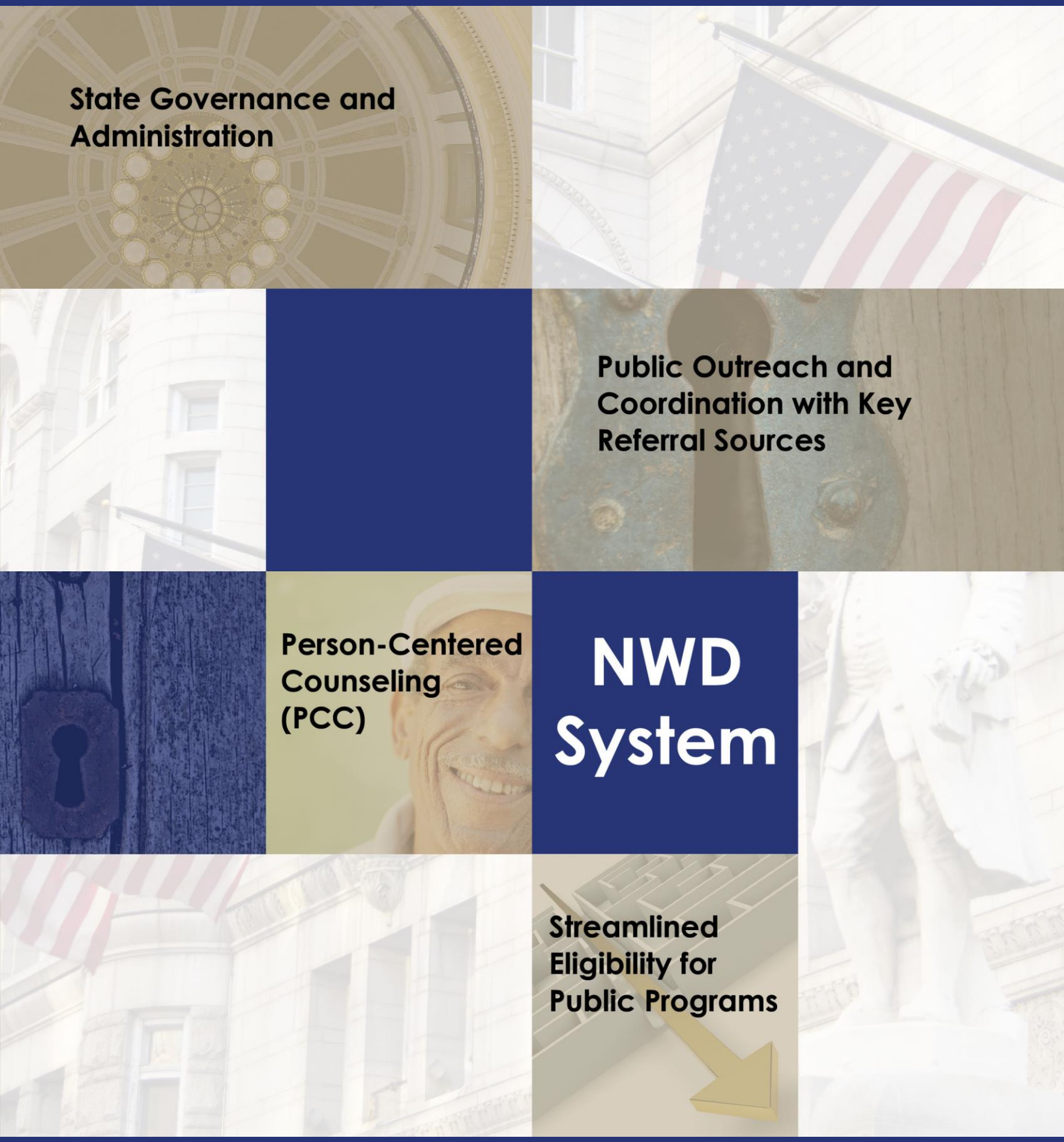
[11] *Social Determinants of Health.* ASPE. https://aspe.hhs.gov/topics/health-health-care/social-determinants-health

[i] **Community Care Hub (CCH)**: A CCH (formerly referred to as a "Network Lead Entity") serves as a community-focused, regional, statewide, or multi-state umbrella organization that coordinates administrative services and supports for a network of social care providers (e.g., multiple area agencies on aging, "AAAs" and/or other community-based organizations, "CBOs") -- providing social care programs and services to address health-related social needs (HRSNs) under funding arrangements with health care organizations, public health departments, Medicare, Medicaid, etc. A CCH may also offer its programs and services directly to consumers through a variety of payment arrangements and may hold contracts with government agencies to coordinate administration of programs and services across a region or state. The CCH centralizes and scales administrative functions and operational infrastructure to enhance efficiencies, standardization, compliance, performance, and quality on behalf of its Hub Network of social care providers.

[ii] **Health Affairs blog:** https://www.healthaffairs.org/content/forefront/improving-health-and-well-being-through-community-care-hubs

[iii] **ASPE report:** https://aspe.hhs.gov/sites/default/files/documents/5b8cba1351a99e904589f67648c5832f/health-social-care-coordination.pdf

[iv] **Executive Order on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government:** https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/


State Governance and Administration
Public Outreach and Coordination with Key Referral Sources
Person-Centered Counseling (PCC)
NWD System
Streamlined Eligibility for Public Programs

Key Elements of a NWD System of Access to LTSS for All Populations and Payers

Introduction

Finding and accessing the right long term services and supports (LTSS) presents a daunting task for many individuals and their families. The current LTSS system involves numerous funding streams administered by multiple federal, state and local agencies. These agencies use different, often fragmented, and sometimes duplicative processes and requirements involving screening, intake, needs assessment, service planning, and eligibility determination. Consequently, individuals trying to access LTSS frequently find themselves confronted with a bewildering maze of organizations and bureaucratic requirements at a time of vulnerability or crisis which can result in people making decisions based on incomplete, and sometimes inaccurate, information about their options. This can include decisions to purchase and/or use more expensive options than necessary, such as institutional care, that can quickly exhaust an individual's personal resources and result in their spending down to Medicaid.

The Administration for Community Living (ACL), the Centers for Medicare and Medicaid Services (CMS), and the Veterans Health Administration (VHA) have partnered for several years to support states' efforts to develop coordinated systems of access to make it easier for consumers to learn about and access LTSS. These efforts have been supported by a variety of programs, including the Aging and Disability Resource Center (ADRC) program, Real Choice Systems Change grants, the Balancing Incentive Program, Money Follows the Person (MFP), and Veteran Directed Home and Community-Based Services (VD-HCBS). The Elements in this document reflect the cumulative experience and learnings from these investments and are designed to provide all states with a framework for developing "high performing" No Wrong Door Systems (NWD Systems) that can enhance consumer choice and control and can help states create more consumer-driven, more efficient, and more cost-effective LTSS systems.

The Elements are characteristics or attributes that shape a single statewide system available to all populations who need or may at some point need LTSS and all payers who help to finance LTSS. For purposes of these elements, "all payers" includes all state programs, including federally supported programs such as Medicaid, that pay for LTSS, as well as all individuals who pay for LTSS using their own personal resources. The Elements embody a "No Wrong Door" model, recognizing that multiple agencies and organizations at the state and local level need to be formally involved in the operation of a NWD System in order for it to have the capacity to serve all populations and all payers. Thus, there is a leadership role states must play in developing and implementing NWD Systems and a meaningful involvement of key stakeholders, especially consumers and their families, in the design, implementation and ongoing administration and evaluation of a NWD System.

The four primary functions of a NWD System that are reflected in these Elements include:

1. State Governance and Administration;
2. Public Outreach and Coordination with Key Referral Sources;
3. Person-Centered Counseling (PCC); and
4. Streamlined Eligibility for Public Programs.

The Elements are designed to help states in providing the leadership that is necessary to effectively develop and implement a NWD System of access to all populations and all payers. These Elements include guidance and indicators that states can use to assess their progress in transforming their multiple LTSS access programs and functions into a single statewide NWD System. The Elements will help all the agencies and organizations involved in a NWD System to understand their role in the system and to improve their capacity to carry out NWD functions. The Elements should also help consumers and their advocates to better understand the nature of a NWD System and the essential role it can play in optimizing consumer choice and control and in making a state's overall LTSS system more consumer-driven.

The specific goals of these Elements include:

- Establishing a uniform set of national guidelines and expectations for NWD Systems;
- Improving the consistency and quality of NWD Systems across the states;
- Helping states to create a vision for their NWD Systems and multi-year strategies for advancing their vision within their states.
- Helping states to strategically leverage existing resources, programs, functions and organizational entities to support the development of their NWD System;
- Providing a basis for states to establish meaningful outcome and process measures and a method for continually evaluating and improving the performance of their NWD Systems;
- Establishing clear expectations about the roles and responsibilities of NWD staff doing Person-Centered Counseling, especially with respect to their use of person-centered planning skills and practices to empower individuals to make informed decisions, to exercise control over their LTSS, and to achieve their personal goals and preferences; and,
- Helping states to meet projected increases in consumer demand as a growing aging and disability population seeks assistance in navigating the LTSS System.

Each Key Element includes:

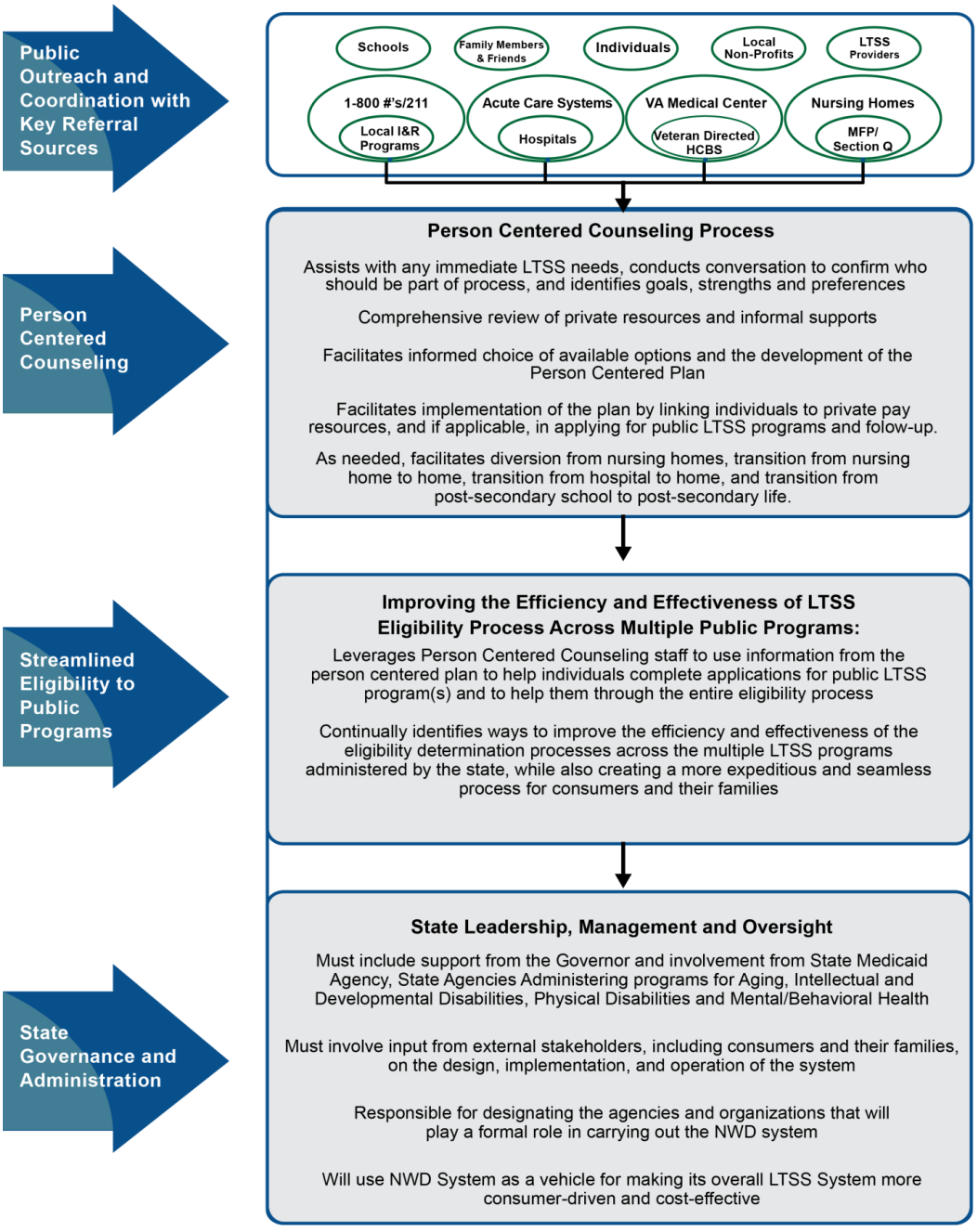
1. A brief description;
2. "Guidance" on implementation of that Key Element; and
3. "Scorecard Measures" related to that Key Element that were used in the survey to states to help provide information for AARP's State 2017 *Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers.*[1]

[1] For more information see http://www.longtermscorecard.org/

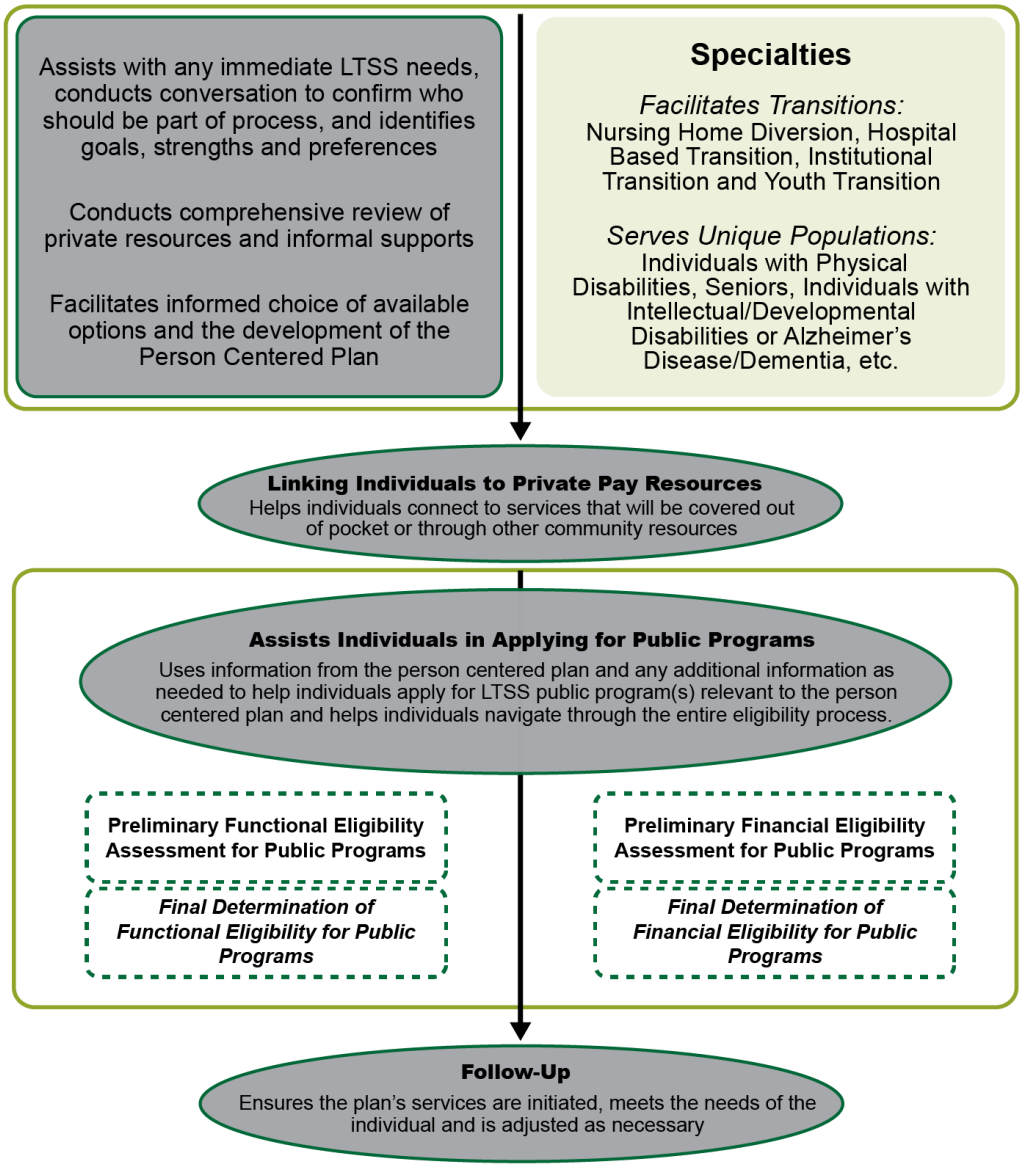
The Elements are not intended to provide a rigid structure by which a state's NWD System must operate. The federal partners recognize that it will take time for states to fully transform their current access programs and functions into a single statewide NWD System consistent with these Elements, and that states will organize and operate their NWD Systems in ways that best meet their unique structures, populations and available resources. The federal partners plan to use these Elements as the basis for receiving broad public input on what will eventually become National Standards for a NWD System of access to LTSS for all populations and all payers.

Finally, different states use different terms to describe their LTSS access programs and systems and they use different job titles for staff working in those programs and systems. In many cases these terms are used for branding purposes and are often grounded in state statutes. Accordingly it is important to note that the terms "No Wrong Door" and "Person-Centered Counseling" used in this document are intended to describe systems structures, functions and job duties; they are not intended to serve as a brand that all states must use in labeling their access functions or job titles. For instance, states are implementing person-centered planning in various ways, including through training programs designed to bolster and upgrade the skills of their existing ADRC Options Counselors and other staff who use different titles. It is expected that many states will continue to use the term "Options Counselor" and other such job titles since a number of states have codified the term in law, as many have with the term "Aging and Disability Resource Center."

No Wrong Door Schematic



Person-Centered Counseling Schematic



Core Competencies: Required of all staff performing Person-Centered Counseling

Specialties: Performed by subsets of Person Centered Counselors who also have specialized knowledge and experience

Streamline Access: Some of these functions can be performed by Person Centered Counselors at the discretion of the state

Examples of Organizations that could be Designated by the State to Perform NWD System Functions

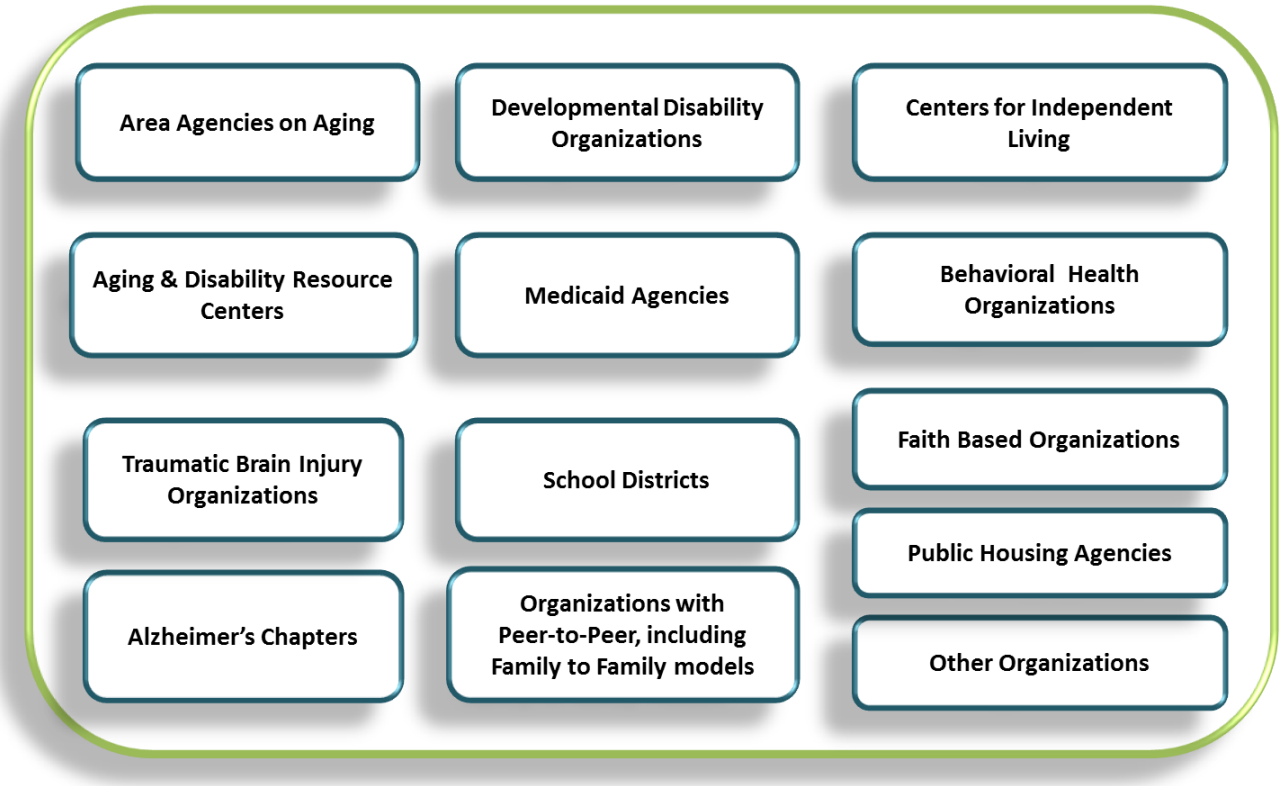


Table of Contents

No Wrong Door Elements

I. State Governance and Administration Function

Among the key learnings from past federal investments in state access systems is the critical importance of the state playing a leadership role in the design, implementation and ongoing administration of a NWD System. This includes having the full support of the Governor and key Cabinet-level officials and the active involvement of the multiple state agencies that have a role in LTSS. Also key is the state's role in setting clear expectations for the multiple organizations outside of state government that will play a formal role in carrying out NWD functions. Finally, it is critical that the state ensures the ongoing and meaningful involvement of key stakeholders, including consumers and their families, in the development, implementation and ongoing evaluation of the NWD System.

Element 1.1: State Leadership and Collaboration

The development, implementation and oversight of a state's NWD System has the support of the Governor and active involvement of the multiple state agencies that administer programs that effect LTSS populations. The Governor designates the state agencies that play a formal role in the development, implementation and oversight of the NWD System, and also designates the state entity that is responsible for coordinating the overall initiative.

Guidance: At a minimum, the following state agencies should be designated by the Governor to be involved in the development and implementation of the state's NWD System: the state Medicaid agency, the state unit on aging, any other state agency that serves or represents the interests of individuals who need LTSS, and any other state agency or entity the Governor chooses to designate. Executive level staff from each of the designated agencies should be formally assigned to oversee their agency's work on the NWD System. The Governor will also designate the state agency or entity that will be responsible for coordinating all of the state's NWD activities. Since different agencies will play different but complimentary roles in the development and implementation of the NWD System, it is essential that the specific roles and responsibilities of each involved state agency are clearly defined and the activities of all involved state agencies are carried out in a coordinated manner. It is also important for the state to identify the federal and state resources currently being used to carry out LTSS access functions across its multiple programs and determine how best to coordinate and deploy these resources to support the ongoing operations of the NWD System.

Measures:

I.1. The State has the Governor's and/or State Legislature's written support for developing a NWD System consistent with the functionality described in "Key Elements of a NWD System of Access to LTSS for All Populations and All Payers."

I.2. The State has a formal multi-state agency body that coordinates the State government's work to develop a single No Wrong Door System for all people needing LTSS, regardless of income, age, or disability, and this body includes the state Medicaid agency, the state unit on aging, the state agencies that serve or represent the interests of individuals with physical disabilities, intellectual and developmental disabilities, and the state authorities administering mental health services.

I. 6. The State uses a variety of state administered funding sources to support the planning, implementation and on-going operation of the state's No Wrong Door System including Medicaid.

I.7. The State coordinates their NWD System with a variety of state and federal administered programs that help beneficiaries understand their health insurance programs (e.g., Senior Health Insurance Program).

VI. 14. The total Medicaid (state and federal) financial investment used to support the ongoing operations of the State's NWD System functions (12 month period).

Element 1.2: Stakeholder Inclusion

The State uses a formal process for ensuring the ongoing and meaningful involvement of key stakeholders, including consumers and their families, in the development and implementation of the NWD System.

Guidance: Stakeholders include older adults, individuals with physical disabilities, individuals with intellectual and developmental disabilities, individuals with mental and/or behavioral health needs, individuals with cognitive impairments and dementia, family members, advocates, Centers for Independent Living (CILs), Area Agencies on Aging (AAA), local Medicaid agencies, Veteran Service Organizations, community-based service providers, and other relevant public and private entities involved in the state's LTSS system.

Measures:

I. 4. Based upon input from consumers and other sources, the state has developed a multi-year plan for implementing a NWD System consistent with the functionality described in the "Key Elements of a NWD System of Access to LTSS for All Populations and All Payers."

I.5. The State has a formal process in place for involving external stakeholders groups and individuals, including older adults, persons with disabilities, (physical, behavioral and ID/DD) and family caregivers in the development and on-going implementation of the NWD System, and it has documented evidence that stakeholder input is influencing the design and ongoing operations of the NWD System.

Element 1.3: Designation of Non-State Government Entities to Perform NWD Functions

The State is responsible for selecting and overseeing the agencies and organizations outside of state government that play a formal role in carrying out NWD functions, including Person-Centered Counseling and Streamlined Eligibility to Public Programs.

Guidance: As noted above, a NWD System requires the involvement of numerous agencies and organizations inside and outside of state government in order for the NWD System to have the capacity to serve all populations and all payers. The state will formally designate, directly or through a delegated entity, the agencies and organizations outside of state government that will be formally involved in carrying out the NWD functions, including the Person-Centered Counseling and/or the Streamlined Eligibility for Public Programs functions. This will involve formal agreements with these entities that describe the performance standards of specific NWD functions they will perform, the populations they will serve, the geographic areas they will cover, their relationship to other NWD entities and reporting requirements they will have to meet. States should build upon and leverage existing entities and networks with a proven record of carrying out functions identical or similar to those required by the NWD system, such as Area Agencies on Aging, Centers for Independent Living, Developmental Disability Management Organizations, local Medicaid Agencies, Behavioral Health Management Organizations, Alzheimer's Chapters, and other entities that serve populations of individuals with disabilities. It is assumed that many of the designated entities will already be receiving federal and/or state funds to carry out the types of functions required for a NWD System. The state will have a communications strategy and process for facilitating communications and ongoing coordination among the many different agencies and organizations playing formal roles in the NWD System at the state and regional/sub-state level so all of these organizations can effectively and efficiently operate as a single statewide NWD System.

Measures:

I. 8. The State uses a formal process and clearly defined criteria to select and oversee the entities outside of state government that play a formal role in carrying out the NWD System function of Person Centered Counseling.

III. 6. The NWD System uses a variety of different organizations to do Person Centered Counseling such as Area Agencies on Aging, Independent Living Centers, etc., to ensure its NWD System has the capacity to serve different LTSS populations.

Element 1.4: Person-Centeredness

The State uses the NWD System to implement person-centered planning statewide as part of a strategy for making its overall LTSS system more consumer-driven. The State ensures that NWD staff doing Person-Centered Counseling for the NWD System have the competencies to do person-centered planning in a way that is consistent with the Elements in Section III of this document, and the State actively promotes the philosophy, values, concepts, and practices of person-centered planning throughout its entire NWD System.

Guidance: The NWD System will be the formal "point of entry" into the State's LTSS system. The State will use its NWD System to fundamentally change the experience of consumers who encounter the LTSS System so it becomes more responsive to the preferences and personal goals of its citizens who need, or may at some point need, LTSS. The Elements in this document are designed to do this by integrating person-centered planning into the NWD Person-Centered Counseling function. The 2014 HCBS Settings Rule establishes clear expectations for person-centered planning that resulted from many years of experimentation and development in states across the country, and recognizes it as foundational for the delivery of effective home and community-based services (HCBS). Through the use of Person-Centered Counseling, the NWD System will empower individuals to make informed choices about their LTSS options consistent with their personal goals, and to successfully navigate the various organizations, agencies, and other resources in their communities that provide LTSS.

Person-centered planning represents the state-of-the art practice for promoting consumer choice and self-determination in our LTSS system, and is fundamentally different from many of the traditional practices that have been, and are still being used, in many parts of our LTSS system to help consumers access LTSS. Accordingly, in addition to ensuring that staff doing Person-Centered Counseling have the competencies to do person-centered planning, the state should also have a strategy for actively educating managers and key staff at all levels within the NWD System on the philosophy, values, concepts, and practices of person-centered planning. This ensures the full embracement within the NWD System, and that the work of the "front line" staff doing Person-Centered Counseling is fully understood and supported by management.

Measures:

I. 15. The State is implementing Person Centered Counseling consistent with Person Centered Planning definition in the HCBS Final Rule.[2]

III. 7. Staff doing Person Centered Counseling in the NWD System have the competencies to conduct person centered planning in a way that is consistent with the Person Centered Planning requirements in the CMS HCBS Settings rule.

[2] Information on the Final Rule can be found at https://www.medicaid.gov/medicaid/hcbs/guidance/index.html.

III. 10. Managers and other key staff throughout the NWD System have an understanding of the philosophy, values, concepts, and practices of person centered planning as part of its strategy to make its LTSS system more consumer-driven.

III. 14. The NWD System has staff doing Person Centered Counseling with skills and expertise required to facilitate the use of self-directed models of LTSS.

Element 1.5: Performance Standards and Continuous Quality Improvement

The State uses clearly defined performance measures and a systematic process for collecting and analyzing the data and information needed by all of the entities in the NWD System to effectively manage, evaluate and continually improve the performance of the NWD System.

Guidance: The State will strategically leverage existing management information systems (MIS) and other data sources to collect and analyze information that will be needed by state and local entities involved in carrying out NWD functions to implement, manage and continually improve the NWD System. A well-managed NWD System will collect and generate timely information, data, and analytics on a wide range of indicators, processes, and outcomes across the programs and entities that make up the NWD System and across populations that are being, or could be served, by the NWD System. This will ensure that informed decision-making can occur at all levels within the System, including state level policy, program and funding decisions.

Person-centered surveys or other information gathering methods will be used to document and measure the experience of individual consumers with the NWD System from their point of entry into the system through follow-up. This includes their views on the system's responsiveness in helping them to realize their personal goals and preferences. This also includes data on the extent of Person-Centered Counseling provided, the types of LTSS services and supports the NWD System was able to help the individual access, and gaps between the services used and the service preferences of the individual. The NWD System will collect individual information when applicable in a way that limits the repeated collection of the same information from an individual while engaged in the LTSS system.

The State will also track the impact of a NWD System on the State's efficiency and effectiveness in administering the multiple LTSS access functions that occur across its LTSS system through the improved coordination and integration of those functions. This will include reductions in duplicative intake, screening, and eligibility determination processes, as well as reductions in the time it takes for individuals to complete applications and eligibility determination for state administered programs. The State will track the number of people placed on waiting lists for services and steps taken staff doing Person-Centered Counseling to help these individuals seek alternative services in the community while on wait lists.

The State will be able to project future demand for NWD functions as the demographics of the state change over time, including projections specific to different populations and to different regional or sub-state geographic areas. The State will also track NWD System costs across NWD functions and geographic areas, as well as statewide cost-savings. At a minimum, this will include cost savings accruing to the Medicaid program as a result of helping Medicaid-eligible individuals use lower-cost LTSS services and helping private-paying individuals avoid the unnecessary use of costly services and subsequent spend down to Medicaid.

The State will collect information from the general public and individuals who use the NWD System on the key aims of the NWD System, including its:

- Visibility - the extent to which the public is aware of the NWD System;
- Trust - on the part of the public in the objectivity, reliability, and comprehensiveness of the assistance available from the NWD System;
- Ease of access - including the amount of time and level of frustration and confusion individuals and their families experience trying to access LTSS;
- Accessibility - of physical locations and accessibility and ADA 508 compliance of all written and web-based materials; and,
- Responsiveness - to the needs, preferences, and unique circumstances of individuals, especially in relation to the NWD System's ability to enable the individual to realize his/her personal goals that were established during the PCC process, and how well the NWD System tracks and responds to complaints and grievances.

Although not required, health information exchange (HIE) can be a key component of a NWD System. Using the term broadly, HIEs encompass systems that share consumer demographic, financial, health and functional data across multiple users, including different programs, providers, individuals and family members. Ideally the HIE will be linked to electronic health records and personal health records to facilitate the exchange of information across entities involved in an individual's health care and LTSS.

Measures:

I.3. The state has conducted a formal assessment of its access programs and functions, including its eligibility determinations processes, across all populations documenting the challenges consumers face when accessing LTSS programs.

I.9. The State has an established process for continually monitoring and improving the performance of its NWD System that allows the state to track its progress over time in implementing a single statewide NWD System consistent with the "Key Elements of a NWD System of Access to LTSS for All Populations and All Payers."

I.10. The State has a documented method for measuring the impact of its NWD System on Medicaid LTSS expenditures.

I. 11. The State uses electronic information technology to support and manage all four functions within its NWD System.

I. 12. The State uses its electronic information technology to facilitate the sharing of client information across some operating organizations in its NWD System and to also exchange client information with entities such as acute care hospitals and long-term care facilities in a way that leverages the use of health IT.[3]

III. 15. The NWD System uses a consumer satisfaction survey that includes consumer outcome measures of autonomy and control.

VI. 1. The total number of unduplicated people that have used the State's NWD System over the last year (12 month period).

VI. 15. Satisfaction: The percent of individuals who contacted the NWD System and reported a high level of satisfaction that they received all the information and/or assistance in learning about and/or accessing LTSS they were looking for.

Element 1.6: Staffing

The State ensures its NWD System has a sufficient number of adequately trained staff to carry out all NWD System functions throughout the state, and deploys a clear strategy to ensure the staffing of its NWD System keeps pace with changing demographics.

Guidance: Although staffing structures and patterns will vary by state, a sufficient number of trained staff to carry out all functions of a NWD System should be in place to meet the needs of state citizens in a timely manner. Two examples of actions the state can take to address staffing adequacy include:

1. *Measuring Capacity and Adequacy:* The State can estimate the total number of persons needing to access LTSS during any given year, both for the general LTSS population as well as for specific LTSS subgroups, and compare these estimates to the numbers of people actually served by its NWD System. States should continually assess staffing capacity against need and develop strategies for closing gaps that may exist. Additionally, states should track and analyze the time needed to provide support to individuals, and the use of technology and other tools that can assist staff and/or complement the work they do for consumers.
2. *Measuring Quality:* The State can establish a minimum threshold for the knowledge, skills and abilities (KSAs) of staff performing various NWD functions and offer training to increase the KSAs of staff. Measurement of individual and system level outcomes outlined under Element 1.5 should include staff performance quality indicators across all functions of the NWD System. These staff quality indicators along with capacity and

[3] "Health information technology (health IT) makes it possible for health care providers to better manage patient care through secure use and sharing of health information. Health IT includes the use of electronic health records (EHRs) instead of paper medical records to maintain people's health information." Available at https://www.healthit.gov/

adequacy indicators can be used by state agencies and stakeholders through ongoing governance and continuous quality improvement of the NWD System.

Measures:

I. 13. The State has a documented method/process to estimate current and future demand for NWD System functions.

I. 14. The State has a strategy in place for ensuring it has the capacity to meet demand for NWD System functions, including the demand across different segments of the state's population.

II. Public Outreach and Coordination with Key Referral Sources

Public outreach and education is key to the NWD System being recognized by the citizens and key referral sources as a trusted source of unbiased and in-depth information and one-on-one counseling. The success of the NWD System is also dependent on having formal relationships with entities where major transitions occur across settings and programs that can dramatically affect the well-being and quality of life for people with chronic impairments.

Measure:

V. 2. Statewide Reach: The NWD System provides Public Outreach in the following areas of the state. (select from list of counties or provide coverage detail).

Element 2.1: Public Outreach and Education

The State proactively engages in public education to ensure its citizens are aware of the NWD System. The NWD System is seen as a visible and trusted source of information and one-on-one personalized counseling that any individual or family can turn to for help in understanding and accessing LTSS. The State's public awareness activities include a website on LTSS options and the NWD System, and a statewide toll-free number that connects individuals to staff doing Person-Centered Counseling.

Guidance: The State has developed and implemented a strategy and plan for informing its citizens about the NWD System and the help it can provide to individuals that need, or at some point will need, LTSS. The NWD System's public education efforts should give special attention to underserved and hard-to-reach populations, including people with hearing and visual impairments and limited English speaking populations.

Measures:

II. 1. The NWD System is implementing an outreach and marketing plan focused on branding the NWD System as a visible and trusted source of information and personalized one-on-one counseling that can help any individual to learn about and access the LTSS options that are available in their communities.

II. 2. The NWD System has a publicly searchable database on a website that is designed to assist older adults, people with disabilities and their family caregivers to learn about and access public and private LTSS options available in their communities which is user friendly and accessible to persons with disabilities.

II. 3. The NWD System has a toll-free number that connects individuals to trained Information and Assistance Specialists to assist people in need of LTSS.

VI. 2. The total number of visits to the State's NWD System website over the last year (12 month period).

VI. 3. The total number of unique visitors who have used the State's NWD System website over the last year (12 month period).

Element 2.2: Information and Referral Entities

The State's NWD public education plan gives special attention to educating key referral sources, including statewide and local information, referral and assistance (I&R/A) programs, statewide toll-free numbers, and 2-1-1 systems so staff and volunteers working for these entities can appropriately and quickly refer individuals to NWD staff doing Person-Centered Counseling.

Guidance: Any agency, organization, website, hotline or other entity that, as part of its normal business, comes into contact with people who may need help in accessing LTSS is a critical referral source for a NWD System. In addition to formal I&R/A programs, other sources may include faith-based and civic organizations, non-profit community organizations that serve older adults and/or people with disabilities, community health centers, homeless shelters, community health centers, Veteran Services Organizations, YM/WCAs, etc.

Measure:

II. 4. The NWD System is conducting ongoing outreach and training targeted at key referral sources, including Information and Referral programs, to inform them about the NWD System and how and when to make referrals to Person Centered Counseling.

Element 2.3: Nursing Facilities and other institutions:

The State uses its NWD System to help individuals, regardless of their income or program eligibility, to avoid unnecessary placement in nursing homes and other institutional facilities as well as to help individuals with LTSS needs who are already residing in these types of facilities to transition back to the community.

Guidance: The research has shown that many people residing in nursing homes and other institutional facilities prefer to live in the community and would be able to do so with appropriate supports. States can and should use their NWD System to implement a two-pronged strategy to address this issue: diversion programs that involve pre-admission screening and other tactics; and transition programs that help individuals who reside in nursing facilities and other institutions to move back to the community. The Money Follows the Person Program has documented that even highly impaired individuals who have resided in institutions for over a year can be

transitioned back to the community with the help of counselors who have specialized skills and experience. Accordingly, the State will ensure that a subset of their NWD staff providing Person-Centered Counseling have the experience and skills required to successfully transition individuals from nursing facilities and other institutions back to the community.

Measures:

II. 5. The State Medicaid agency has designated some of the organizations doing Person Centered Counseling within the NWD System to serve as local contact agencies (LCAs) for individuals who indicate that they wish to return to the community during their MDS 3.0 Section Q assessment.

IV. 5. The NWD System conducts nursing facility pre-admission screening for individuals who are or appear to be eligible for Medicaid LTSS and have the potential to avoid nursing home admission.

IV. 6. The NWD System implements and/or coordinates with the federally mandated Pre-Admission Screening and Resident Review (PASRR) process to help divert individuals with mental illness and I/DD from unnecessary institutionalization.

VI. 6. The total number of individuals who received pre-admission screening and were able to avoid nursing home admission as a result of the NWD System intervention (12 month period).

VI. 7. The total number of individuals who were referred to a NWD System organization as a result of the MDS 3.0 Section Q requirement (12 month period).

VI. 9. The total number of individuals who were transitioned from a nursing home to home with the help of staff in the NWD System (12 month period).

Element 2.4: Hospital Facilities and Other Health Care Settings

The State uses its NWD System to facilitate the successful transition of individuals with LTSS needs from hospitals and other health care settings back to the community.

Guidance: A key function of the NWD System is to serve as a bridge for the health system to the community and to facilitate the transition of individuals with LTSS needs who are being discharged from acute care settings back to their own homes. The NWD System also helps these individuals to arrange for the community services and supports they need to remain at home and avoid unnecessary hospital readmissions. The State will ensure that a subset of NWD staff doing Person-Centered Counseling have the experience and skills required to successfully transition individuals from acute care settings back to the home. The State will also ensure that NWD organizations with this expertise have formal agreements with acute care entities that define the role of the NWD staff in facilitating hospital-to-home transitions for people with LTSS needs.

Measures:

II. 6. The organizations doing Person Centered Counseling in the NWD System have formal agreements (e.g., MOUs, contracts, or written agreements) with hospitals or rehabilitation facilities to facilitate transition to home.

VI. 8. The percent of all acute care hospitals within the State that have a formal agreement with organizations in the NWD System to facilitate discharge planning and transitions as well as to reduce unnecessary hospital readmissions.

VI. 10. The total number of individuals who were transitioned from an acute care hospital or rehabilitation facility to home with the help of staff in the NWD System (12 month period).

Element 2.5: Youth Transition Entities and Systems

The State uses its NWD System to facilitate the transition of youth with significant disabilities who have completed their secondary education or otherwise left school to postsecondary life.

Guidance: This is a critical phase of life for transitioning youth. The options they have and the choices they make during this period of transition can dramatically affect the extent to which they are fully integrated into their communities and the overall quality of their life for decades to come. The State will ensure that a subset of the NWD staff doing Person-Centered Counseling have the skills and expertise required to successfully facilitate these transitions. NWD organizations with this expertise should have formal agreements with secondary educational systems, institutions of higher education, employers, and other entities in their service areas that define the role of these organizations and their staff in working with these youth and their families to facilitate the development of person-centered plans and successful transitions to postsecondary life.

Measures:

II. 7. The organizations doing Person Centered Counseling in the NWD System have formal agreements (e.g., MOUs, contracts, or written agreements) with educational institutions, private employers and other appropriate entities to facilitate the transition of youth with disabilities from secondary education to post-secondary life that include opportunities for competitive integrated employment and/or post-secondary education.

VI. 11. The total number of individuals with intellectual and developmental disabilities who have successfully transitioned from secondary education to post-secondary education with the help of staff in the NWD System (12 month period).

VI. 12. The total number of individuals with intellectual and developmental disabilities who have successfully transitioned from secondary education to competitive integrated employment with the help of staff in the NWD System (12 month period).

Element 2.6: VA Medical Centers

The State encourages NWD organizations to have formal agreements with local Veterans Administration (VA) Medical Centers to assist the VA in implementing the Veteran-Directed Home and Community-Based Services (VD-HCBS) Program and other VA HCBS programs.

Guidance: The NWD System will play a key role in helping the Veterans Administration to expand access to VA funded Home and Community Based Services for Veterans who need LTSS, including Veteran Directed HCBS. The formal agreements with the VA Medical Centers will define the protocols and financial arrangements required for NWD person-centered counselors to work with Veterans and their families deeded by the VA to be eligible for VA funded HCBS to develop person-centered plans, and arrange for the delivery of the services and supports the Veteran identifies. This includes assisting with establishing flexible spending plans and providing financial management services to pay the Veterans' workers in accordance with applicable state and federal laws.

Measures:

II. 8. The organizations doing Person Centered Counseling in the NWD System have formal agreements (i.e., Provider Agreements or Contracts) with VA Medical Centers to provide Veteran-Directed HCBS.

VI. 13. The total number of individuals who received VD-HCBS through the state's NWD System (12 month period).

III. Person-Centered Counseling (PCC)

The Person-Centered Counseling function will serve as the formal "point of entry" into the LTSS system for individuals and their families who need, or may at some point need, LTSS, and will take place in a variety of settings, including: a person's home to help the individual to remain at home; a community residence to help an individual to remain in the community; a nursing facility to help an individual transition back to the community; an acute care hospital to help an individual return home and avoid unnecessary readmissions; a high school to help a teenage child with an intellectual or developmental disability transition successfully to postsecondary life, as well as many other settings. As noted above, the NWD Person-Centered Counseling function embodies person-centered planning and the Elements below are consistent with the 2014 HCBS Rule, which establishes clear expectations for person-centered planning and recognizes it as foundational for the delivery of effective HCBS. The rule resulted from many years of experimentation and development within states across the country.

It is important to note that an individual may not need or require all the Elements of the person-centered counseling process described within this function. A person-centered system recognizes that every individual is unique and the system must be able to respond flexibly to each individual's situation, strengths, needs and preferences. Some individuals contacting the NWD System may only need some detailed information on the LTSS options available in their community. Someone else may have an emergency need that requires a rapid short term response and then no further help. Others may benefit from assistance with development of a full person-centered plan, but are able to fully implement the plan themselves with no further help from the NWD counselor. Others will need help with developing plans and assistance with locating services that they can pay for themselves. Nonetheless, it is essential that every staff person doing Person-Centered Counseling for the NWD System be able to effectively perform every aspect of the person-centered planning and implementation process described in this section.

Measures:

V. 1. Statewide Reach: The NWD System provides Person Centered Counseling in the following areas of the state (select from list of counties or provide coverage detail).

VI. 4. The total number of individuals who have received Person Centered Counseling through the State's NWD System (12 month period).

Element 3.1: Individually-Led

NWD Person-Centered Counseling ensures that the person with LTSS needs directs the PCC process.

Guidance: The person or representative must have control over who is included in the planning process. Person-Centered Counseling may include a representative whom the person has freely chosen, or who is authorized to make personal or health decisions for the person. Person-Centered Counseling must also include family members or legal guardians for non-emancipated

minors, and should involve the individuals receiving care or services to the maximum extent possible even if they are not the legal representative in the planning process.

Measures:

III. 7. Staff doing Person Centered Counseling in the NWD System have the competencies to conduct person centered planning in a way that is consistent with the Person Centered Planning requirements in the CMS HCBS Settings rule.

III. 10. Managers and other key staff throughout the NWD System have an understanding of the philosophy, values, concepts, and practices of person centered planning as part of its strategy to make its LTSS system more consumer-driven.

III. 15. The NWD System uses a consumer satisfaction survey that includes consumer outcome measures of autonomy and control.

Element 3.2: Personal Interview

The Person-Centered Counseling process begins with a personal conversation that includes elements of screening and assessment to confirm that the person needs LTSS and to determine if they have any needs that require immediate action.

Guidance: The NWD staff doing Person-Centered Counseling will go through an iterative process with the individual, and others as appropriate, to identify his or her personal strengths, values, preferences and goals. The conversation begins in a timely manner and meets the schedule and needs of the individual. Individuals involved in the Person-Centered Counseling process should be oriented to the process in order to ensure their active participation. Necessary information and support provided by the counselor ensures the centrality of the person and/or representative to the process, and their understanding of the information. This includes the provision of auxiliary aids and services when needed for effective communication. The Person-Centered Counseling process must provide meaningful access to participants and/or their representatives with limited English proficiency, including low literacy materials and interpreters. If the person does not have LTSS needs, the counselor will help the individual address his or her immediate needs or seek a referral. In addition to discussing and sharing information about available resources, Person-Centered Counseling assists the person in evaluating various pathways to achieving his or her goals, including the pros/cons of specific options. This process may utilize specific decision support tools, such as motivational interviewing, preferences maps, places maps, mind maps, evaluating options tools, pro-con lists, and shaping outcomes tools, among others.

Measures:

III. 8. The NWD System uses standards that define Person Centered Counseling consistent with the Person Centered Planning requirements in the CMS HCBS Settings Rule (which are

identical to those in the "Key Elements of a NWD System of Access to LTSS for All Populations and All Payers").

Element 3.3: Development of a Person-Centered Plan

The NWD staff doing Person-Centered Counseling record the person's goals, preferred methods for achieving them, and a description of the services and supports needed to successfully achieve the person's goals.

Guidance: Person-Centered Counseling enables and assists people to identify and access a unique mix of paid and non-paid services to meet their needs. Services listed on a plan represent the desires and preferences of the person, but the plan does not guarantee they will be chosen or provided. Preferences may include, but are not limited to, the following quality of life domains:

- Language and health literacy
- Housing
- Family and friends
- Employment
- Community integration
- Behavioral health
- Recreation
- Vocational training
- Relationship building
- Culture (policies and practices should be consistent with the HHS Office on Minority Health Standards National Standards on Culturally and Linguistically Appropriate Services (CLAS))
- Other choices

When a person-centered plan is desired by an individual, the plan should have the following attributes, as applicable:

- Reflects the setting where the person chooses to reside. Settings offered include those that are integrated in and support full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving HCBS.
- Prepared in first-person singular language understandable by the person and/or representative and the individuals supporting him or her. At a minimum, the plan must be written in plain language and in a manner that is accessible to individuals with disabilities and persons with limited English proficiency.
- Considers the positive attributes of the person in order to be strengths-based.

- The plan identifies risks and includes measures available to reduce risks or identify alternate ways to achieve personal goals, while acknowledging the person's right to assume some degree of personal risk.
- Documents goals in the person's and/or representative's own words, with clarity regarding the amount, duration, and scope of HCBS provided to assist the person. Goals will consider the quality of life concepts important to the person.
- Describes the services and supports necessary and specifies the HCBS provided through various resources including natural supports, to meet the goals in the person-centered plan. Natural supports include unpaid supports provided voluntarily to the individual in lieu of the state plan HCBS.
- Documents the specific person or persons, provider agency and/or other entity providing services and supports.
- Assures the health and welfare of the person.
- Documents non-paid supports and items needed to achieve the goals.
- Includes a timeline for review and the signatures of everyone with responsibility for its implementation including the person and/or representative, his or her case manager, and the support broker/agent (when applicable). The plan is discussed with family/friends/caregivers designated by the individual so that they fully understand it and their role(s).
- Any effort to restrict the right of a person to realize preferences or goals is justified by a specific and individualized assessed safety need and documented in the person-centered plan.
- The plan identifies the person(s) and/or entity responsible for monitoring its implementation.
- The plan identifies needed services, and prevents unnecessary or inappropriate services and supports.
- Documents an emergency back-up plan that encompasses a range of circumstances (e.g. weather, housing, and staff).
- Addresses elements of self-direction (e.g. fiscal intermediary, support broker/agent, alternative services) whenever the individual chooses a self-directed service delivery system.
- All persons directly involved in the planning process receive a copy of the plan or portion of the plan, as determined by the participant or representative.
- Outlines mechanisms for solving conflict or disagreement within the process, including clear conflict of interest guidelines.
- Finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation.
- Finally, the person-centered plan is retained by the individual and the counselor and is shared with others as desired, as well as retained in a file or electronically for follow up. The person or representative has the authority to request meetings and revise the plan (and any related budget) whenever necessary.

The Person-Centered Counseling process is centered on the individual and their personal goals and desires, and is much broader in scope than any formal assessment or eligibility determination process tied to a public or private program. However, once completed, the independent person-centered plan informs the formal assessments, service plans and eligibility processes associated with the various publicly administered programs that provide LTSS. The person-centered plan identifies gaps between LTSS needs and preferences identified in the person-centered plan, and services made available through the program and service eligibility processes, along with strategies for achieving the person's goals that cannot be met through public programs.

Measures:

III. 9. The NWD System has established protocols for the development of person-centered plans by staff doing Person Centered Counseling in line with the Person Centered Planning provision of the CMS HCBS Final Rule.

III. 14. The NWD System has staff doing Person Centered Counseling with skills and expertise required to facilitate the use of self-directed models of LTSS.

VI. 5. The total number of individuals who had person centered plans developed through the State's NWD System (12 month period).

Element 3.4: Facilitating Access to Private Sector Services and Supports

Person-Centered Counseling assists the individual in determining how best to pay for and arrange the delivery of services, including helping the individual assess the sufficiency of his or her own personal resources.

Guidance: Most people who need LTSS do not qualify for publicly funded LTSS programs. Accordingly, Person-Centered Counseling includes the critical process of facilitating access to private pay services and community resources, including services that are covered out-of-pocket and/or through other community resources. If individuals are placed on waiting lists for publicly funded programs, NWD staff doing Person-Centered Counseling will assist in accessing non-publicly funded, local community-based LTSS needed to live in the community.

Measures:

III. 17. The NWD System has a process in place to facilitate access to private sector long-term services and supports for individuals who can pay for all or part of their cost of LTSS.

III. 16. The NWD System provides individuals and families with assistance in planning for their future LTSS needs.

Element 3.5: Facilitating Access to Public Programs

Person-Centered Counseling facilitates access to public programs for those who appear eligible for one or more public LTSS options such as Medicaid, Older Americans Act, Independent Living Programs, state revenue programs, and Veterans programs.

Guidance: Person-Centered Counseling assists any individual who appears to be eligible for a state administered or other public program(s) that provides LTSS in navigating the appropriate

processes and requirements that are involved in determining the individual's eligibility for such programs. The NWD staff doing Person-Centered Counseling will work with the individual and use the information collected during the Person-Centered Counseling process to coordinate with the staff responsible for administering the formal procedures and requirements that are involved in assessing needs and determining eligibility to:

- Facilitate the individual's completion and submission of applications and necessary eligibility determination documents;
- Facilitate the individual's input into the development of the program's formal service plan that is required by the program to ensure it is as consistent as possible with the individual's preferences and personal goals as identified in their person-centered plan; and,
- If necessary, help the individual arrange for financial management services (FMS) when s/he chooses self-direction, and/or assist with the choice of a support broker/agent.

This role of the staff doing Person-Centered Counseling is critical to the NWD System being able to create a streamlined and seamless process for individuals trying to access public programs that provide LTSS.

Measures:

III. 14. The NWD System has staff doing Person Centered Counseling with skills and expertise required to facilitate the use of self-directed models of LTSS.

III. 18. Staff doing Person Centered Counseling in the NWD System are able to track individuals' eligibility status throughout the process of eligibility determination and redetermination.

III. 19. There are formal protocols in place to ensure that staff doing Person Centered Counseling in the NWD System are informed when an individual is deemed eligible for LTSS but put on a waitlist so that the NWD Counselor can follow-up with the individual to see if alternative supports can be arranged while the individual is on the wait list.

III. 20. There are established protocols for staff doing Person Centered Counseling to work with individuals in completing their applications for various public programs and for working directly with the staff in the NWD System that make eligibility determinations in a way that helps to expedite and streamline the process for consumers.

Element 3.6: Specialized Person-Centered Counselors

The State has a strategy for ensuring all NWD staff doing Person-Centered Counseling have the requisite skills to do person-centered planning consistent with the Elements in this section. The State also ensures that subsets of their NWD staff doing Person-Centered Counseling have the specialized skills required to work with different LTSS populations and to carry out specialized NWD functions involving transitions from hospitals to home, from nursing homes back to the community, and from secondary education to post-secondary life for youth with intellectual and developmental disabilities.

Guidance: The State needs to ensure all staff doing NWD person-centered planning have the skills necessary to conduct person-centered planning, and it needs to be strategic about the number and distribution of its counselors who have specialized skills in serving different populations and in carrying out specialized functions involving transitions. This strategy should inform the criteria and selection process the state uses to designate the various organizations that will be conducting Person-Centered Counseling for the NWD System.

Measures:

III. 1. The NWD System currently provides Person Centered Counseling which is consistent with the Person Centered Counseling function defined in the "Key Elements of a NWD System of Access to LTSS for All Populations and All Payers to the following populations (Older Adults, Individuals with Physical Disabilities, Individuals with Intellectual/Developmental Disabilities, Individuals with Mental Illness and Behavioral Health Needs, and Family Caregivers.

III. 6. The NWD System uses a variety of different organizations to do Person Centered Counseling such as Area Agencies on Aging, Independent Living Centers, etc., to ensure its NWD System has the capacity to serve different LTSS populations.

III. 11. The NWD System has staff doing Person Centered Counseling with skills and expertise required to successfully transition individuals from long-term care facilities back to the community.

III. 12. The NWD System has staff doing Person Centered Counseling with skills and expertise required to successfully facilitate hospital to home or rehabilitation facility to home transitions.

III. 13. The NWD System has staff doing Person Centered Counseling with skills and expertise required to successfully help youth with disabilities to transition from secondary education to post-secondary life that involves options that can keep them integrated in the community, including competitive employment and/or post-secondary education opportunities.

Element 3.7: Follow-up

Person-Centered Counseling includes the critical function of follow-up.

Guidance: Follow-up involves working with the individual and others as appropriate, including the case manager of relevant public program(s), to help ensure the LTSS identified in the individual's person-centered plan are initiated and meeting the individual's needs. Follow-up also involves being available to assist the individual in making adjustments to their services plan as their personal goals and preferences change.

Measure:

III. 21. There are written protocols for routinely conducting follow-up with individuals who have been assisted by the staff in the NWD System in developing and implementing a Person Centered Plan to determine if they might benefit from further assistance.

IV. Streamlined Eligibility for Public Programs

The NWD Streamlined Eligibility for Public Programs Function optimizes the state's ability to improve the efficiency and effectiveness of the eligibility determination processes associated with LTSS programs, while also creating a more expeditious and seamless process for individuals who are trying to access publicly-supported LTSS.

Measure:

V. 3. Statewide Reach: The NWD System provides Streamlined Eligibility for Public Programs in the following areas of the state. (select from list of counties or provide coverage detail).

Element 4.1: Efficient, Effective and Seamless Eligibility Determinations

The State uses its NWD System to continually improve the efficient and effective administration of its multiple LTSS eligibility processes and requirements to make them seamless for consumers. The State includes all eligibility processes and requirements for any state administered program that provides LTSS in this NWD System function.

Guidance: The NWD System's Streamlined Eligibility for Public Programs Function must include all of the processes and requirements associated with conducting formal assessments and/or determining an individual's eligibility required by any state administered program that provide LTSS, including Medicaid. As part of the development of a NWD System, the State will continually assess how best to coordinate and integrate these various eligibility processes to make them more efficient and effective and more consumer-driven. The State will reduce and/or eliminate duplicative and unnecessarily burdensome processes and requirements and reduce the time and effort for State and local staff and consumers to complete the various processes, requirements and forms.

The NWD Streamlined Eligibility for Public Programs Function ensures:

- Individuals are assessed once via a common or standardized data collection method that captures a core set of individual-level data relevant for determining the range of necessary LTSS, therefore only asking individuals to tell their story once;
- The eligibility determination and enrollment process is as streamlined and timely as possible, even if the person is applying for multiple public programs; and,
- The process leverages data and information collected during the Person-Centered Counseling process to minimize duplication and to ensure that priority attention is given to the individual's personal goals and preferences in the development of program-specific service plans.

Consistent with CMS guidance on NWD System requirements under the Balancing Incentive Program, states are encouraged to use a health information exchange (HIE) to implement and continually improve their NWD Streamlined Eligibility for Public Programs Function. By

reducing the need for phone calls, emails, faxes and letters, an HIE can expedite referrals and enrollment. Individuals are also less likely to "fall through the cracks" and allow multiple parties to rapidly access information that has already been collected from an individual and that is required to conduct assessments, determine eligibility and authorize services. Ideally, the HIE will also facilitate the exchange of information across entities involved in an individual's health care and LTSS.

Measures:

IV. 1. The NWD System is systematically and continually assessing its various state administered LTSS programs to identify and implement more efficient and effective ways to administer the multiple eligibility determination processes across its LTSS programs.

IV. 2. The NWD System has made one or more significant changes in the last two years to the eligibility determination processes associated with its LTSS programs that has made it easier for older adults, people with disabilities and their family caregivers to access those programs (e.g. presumptive eligibility, adopting the use of a common assessment tool, significantly reducing the time from application to a final determination of eligibility etc.).

IV. 3. The NWD System utilizes a formal process or instrument with defined criteria to identify and support individuals at high risk of institutionalization.

IV. 7. The NWD System has written protocols for ensuring that it provides the same type of Person Centered Counseling and Streamlined Access to public programs to anyone in need of LTSS regardless of where they enter the NWD System.

Element 4.2: The Role of Person-Centered Counseling

The State leverages NWD Person-Centered Counseling staff and information to facilitate the NWD Streamlined Eligibility for Public Programs Function.

Guidance: As described in Element 3.5, NWD staff doing Person-Centered Counseling can add significant value to the eligibility determination processes required for state-administered programs. A number of state Medicaid programs in particular have used the information collected during the counseling process and the relationship developed between the staff doing Person-Centered Counseling and the individual to assist with formal assessments and eligibility determinations. The Medicaid agency can train and even designate NWD staff doing Person-Centered Counseling to conduct preliminary Level I assessments and to help with facilitating the financial eligibility process. They can also help individuals gather additional information and documents not already collected.

NWD Staff doing Person-Centered Counseling can help ensure applications are "camera ready" – or completed accurately – when they reach the Medicaid office. Even if the staff is not designated to do preliminary Level I assessments, the data gathered before an individual decides to makes a formal application for Medicaid can be added into the Level I assessment and then automatically transferred into the Level II assessment process. The counselor can also facilitate an individual's completion and submission of applications; help the individual contribute to the development of a program's formal service plan to help ensure it is as consistent as possible with the individual's preferences and personal goals identified in their person-centered plan; and, if necessary, help an individual arrange for financial management services (FMS) when s/he chooses self-direction, including assisting with the choice of a support broker/agent. In doing these tasks, the Person-Centered Counselors can reduce the burden of the application process for both the Medicaid staff and the consumer. They can also ensure applications are processed more efficiently with fewer errors and are more responsive to consumer needs and preferences. This requires the counselor to work in close coordination with the staff responsible for administering the program's formal procedures and requirements involved in assessing needs and determining eligibility.

Measures:

III. 14. The NWD System has staff doing Person Centered Counseling with skills and expertise required to facilitate the use of self-directed models of LTSS.

IV. 4. The NWD System has established protocols to ensure that individuals seeking LTSS do not have to give the same information more than once while they are trying to access LTSS (e.g., the information collected during the Person Centered Counseling process is used in the Medicaid eligibility determination process).