Summary of CMMI Accountable Health Communities Model

*Overview*: On Jan. 5, 2016, the Center for Medicare & Medicaid Innovation (CMMI) announced the Accountable Health Communities Model (AHC). Given that many of the biggest drivers of healthcare costs and outcomes are unmet health-related social needs, the model seeks to test whether or not integrating social supports into the delivery system will have a positive impact on health outcomes and expenditures. Therefore, CMMI is making 44 grants available to hospitals and other community entities.

*Purpose*: The model aims to identify and address beneficiaries' health-related social needs in at least the following core areas:

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

Over a five-year performance period, CMS will implement and test a three-track model based on promising service delivery approaches (see Appendix I for additional details on AHC model structure):

- Track 1 – Awareness: Increase beneficiary *awareness* of available community services through information dissemination and referral
- Track 2 – Assistance: Provide community service navigation services to *assist* high-risk beneficiaries with accessing services
- Track 3 – Alignment: Encourage partner *alignment* to ensure that community services are available and responsive to the needs of beneficiaries

Each of the tracks requires the award recipient to serve as a hub responsible for coordinating efforts to:

- Identify and partner with clinical delivery sites (e.g., clinics, hospitals)
- Conduct systematic health-related social needs screenings and make referrals for all eligible Medicare and Medicaid beneficiaries
- Coordinate and connect community-dwelling beneficiaries who screen positive for certain unmet health-related social needs and who are randomized to the intervention group to community service providers that might be able to address those needs
- Align model partners to optimize community capacity to address health-related social needs (Track 3 only).

*Funding*: CMS will award a total of 44 cooperative agreements ranging from $1 million (per Track 1 site) to $4.5 million (per Track 3 site) to successful applicants to implement the AHC model. Applicants will partner with state Medicaid agencies, clinical delivery sites, and community service providers and are responsible for coordinating community efforts to improve linkage between clinical care and community services.

*Limitations on Funding Usage*: CMS funds for this model cannot pay directly or indirectly for any community services (e.g., housing, food, violence intervention programs, and transportation) received by community-dwelling beneficiaries as a result of their participation in any of the three intervention tracks. Award recipients, however, must use their award monies to fund interventions intended to connect community-dwelling beneficiaries with those offering such community services.

*Eligibility/Application Process*: Eligible applicants are community-based organizations, healthcare provider practices, hospitals and health systems, institutions of higher education, local government entities, tribal organizations and for-profit and not-for-profit local and national entities with the capacity to develop and maintain a referral network with clinical delivery sites and community service providers.

Applicants from all 50 states, U.S. territories, and the District of Columbia may apply.
CMS will award, through a competitive process, renewable one-year cooperative agreements to successful applicants (award recipients). Applicants may apply to participate in one or two tracks, but successful applicants will be selected to participate in a single track only. Each track will run for a five-year period.

Parameters for each AHC model track are described in the Funding Opportunity Announcement (FOA). CMS encourages potential applicants to understand and apply the criteria information in the Application Review Information section of the FOA. To submit an application go to www.grants.gov. CMS is accepting applications until March 31, 2016.

Interested applicants may submit a non-binding Letter of Intent (LOI) until Feb. 8, 2016, at http://innovationgov.force.com/ahc. Applicants will receive a confirmation email after the submission of their LOI. Applicants must include their LOI confirmation number on the cover page of their application.

*Additional Information*: https://innovation.cms.gov/initiatives/ahcm

**Appendix I:** AHC Model Structure

| | Track 1: Increase Awareness | Track 2: Provide Assistance | Track 3: Align Partners |
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| **Target Population** | Community-dwelling Medicare & Medicaid beneficiaries with unmet health-related social needs | Community-dwelling Medicare & Medicaid beneficiaries with unmet health-related social needs | Community-dwelling Medicare & Medicaid beneficiaries with unmet health-related social needs |
| **Short Description** | Referral only | Community service navigation | Community service navigation and partner alignment |
| **Question Being Tested** | Will increasing beneficiary **awareness** of available community services through information dissemination and referral impact total healthcare costs, inpatient and outpatient healthcare utilization, and health and quality of care? | Will providing community service navigation to **assist** high-risk beneficiaries with accessing community services to address certain identified health-related social needs impact their total healthcare costs, inpatient and outpatient healthcare utilization, and health and quality of care? | Will a combination of community service navigation (at the individual beneficiary level) and partner **alignment** at the community level impact their total healthcare costs, inpatient and outpatient healthcare utilization, and health and quality of care? |
| **Intervention** | **Inventory** of local community services responsive to community needs assessment<br><br>**Universal screening of all Medicare & Medicaid beneficiaries** who seek care from participating clinical delivery sites<br><br>**Referral** to community services for beneficiaries with certain identified unmet health-related needs in intervention group[1] with beneficiaries responsible for completing referral | **Inventory** of local community services responsive to community needs assessment<br><br>**Universal screening of all Medicare & Medicaid beneficiaries** who seek care from participating clinical delivery sites<br><br>**Referral** to community services *and* intensive **community service navigation** (in-depth assessment, planning and follow-up until needs are resolved or determined to be unresolvable) of high-risk | **Inventory** of local community services responsive to community needs assessment<br><br>**Universal screening of all Medicare & Medicaid beneficiaries** who seek care from participating clinical delivery sites<br><br>**Referral** to community services *and* intensive **community service navigation** (in-depth personal interview, planning and follow-up until needs are resolved or determined to be unresolvable) of high-risk |

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| | | beneficiaries with certain identified unmet health-related needs in the intervention group | beneficiaries with certain identified unmet health-related needs in the intervention group<br><br>**Continuous quality improvement** approach including an advisory board that ensures community services are available to address health-related social needs, and data sharing to inform a **gap analysis** and quality improvement plan |
| **Funding Categories** | Start-up funds<br><br>Payments for screening and referral of Medicare/Medicaid beneficiaries who seek care from participating clinical delivery sites | Start-up funds<br><br>Payments for screening and referral of Medicare/Medicaid beneficiaries who seek care from participating clinical delivery sites<br><br>Payments for each high-risk beneficiary in the intervention group that elects to receive community service navigation services | Start-up funds<br><br>Payments for screening and referral of Medicare/Medicaid beneficiaries who seek care from participating clinical delivery sites<br><br>Payments for each high-risk beneficiary in the intervention group that elects to receive community service navigation services<br><br>Annual lump sum payments to support quality improvement activities |
| **Evaluation** | Randomized design | Randomized design | Two matched comparison groups |
| **Number of award recipients** | Up to 12 | Up to 12 | Up to 20 |

[1]Beneficiaries who identify a health-related social need will be stratified based on emergency department utilization history and randomized to an intervention or control group. Beneficiaries assigned to the intervention group will receive a tailored community referral summary. Beneficiaries assigned to the control group will not receive a tailored community referral summary (developed via the AHC model); instead, they will receive usual care.