Accountable Health Communities
Track 1 – Awareness Overview
Track 1 Changes

• CMS modified Track 1 application requirements and released a new funding opportunity. The modifications include:
  – Reducing the annual number of beneficiaries applicants are required to screen from 75,000 to 53,000; and
  – Increasing the maximum funding amount per award recipient from $1 million to $1.17 million over 5 years.
• CMS believes these two key modifications to Track 1 will make the program more accessible to a broader set of applicants.
• Applicants that previously applied to Track 1 of the AHC Model under the original FOA must re-apply using this FOA to be considered for the Model.
• CMS anticipates announcing Track 1 cooperative agreement awards in the Summer of 2017.
## Track 1 – Awareness

<table>
<thead>
<tr>
<th>Target Population</th>
<th>Question Being Asked</th>
<th>Partners</th>
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</table>
| Community-dwelling Medicare and Medicaid beneficiaries with unmet health-related social need(s) | Will increasing beneficiary awareness of available community services, through information dissemination and referral, impact total health care costs, inpatient and outpatient health care utilization and quality of care? | • State Medicaid Agencies  
• Clinical delivery sites  
• Community service providers |
Track 1 – Awareness Pathway

1. Beneficiary enters Clinical Delivery Site
2. Screening for health-related social needs
3. If assigned to Awareness
4. Review and distribute Community Referral Summary
Track 1 – Awareness Evaluation Diagram

Beneficiary enters Clinical Delivery Site

Screening for health-related social needs

(+) Screen: Any health-related social need present

Stratified Randomization

Awareness Group

Receives Awareness Intervention and Usual Care

Community Referral Summary

(-) Screen: No health-related social need

Usual Care

Usual Care

 Awareness Intervention Pathway

Comparison Group Pathway

Not included in Track 1 intervention
Track 1 – Stratification Process

Beneficiary has a health-related social need present

- High Risk (≥ 2 ED visits within 12 months)
  - Randomized
    - High-risk Awareness Group
    - High-risk Comparison Group

- Low Risk (< 2 ED visits within 12 months)
  - Randomized
    - Low-risk Awareness Group
    - Low-risk Comparison Group

Primary unit of analysis for evaluation purposes
Performance Metrics

• Healthcare utilization: emergency department visits, inpatient admissions, readmissions and utilization of outpatient services
• Total cost of care
• Provider and beneficiary experience
Accountable Health Communities
Track 1 Requirements
Model Participants

• Bridge organization

• At least one state Medicaid agency

• Clinical delivery sites, including at least one of each of the following types:
  – Hospital
  – Provider of primary care services
  – Provider of behavioral health services

• Community service providers that have the capacity to address the core health-related social needs
Bridge Organizations and Model Participant Requirements

Bridge organizations collaborate with model participants to:

- Develop their application proposals
- Identify existing community resource inventories
- Design and implement an intervention that supports the community service and clinical communities’ commitment to achieving Accountable Health Communities goals
As consortium members, state Medicaid agencies dedicate staff time for Accountable Health Communities-related activities, including:

- Data collection and reporting
- Sustainability planning
- An annual intervention review (to ensure that AHC services are not duplicative)
- An annual review of the Accountable Health Communities Intervention and a Letter of Support
State Medicaid Agency
MOU Requirements

• Statement of status toward meeting ongoing T-MSIS milestones
• Summary of state laws and policies regulating the release of Medicaid claims data for beneficiaries in the model to CMS, and an overview of the process and timeline for obtaining Medicaid claims data
• Supplemental statement outlining a plan for coordinating with CMS to provide required AHC data in the absence of timely T-MSIS data
• Description of roles and responsibilities for the respective tracks
• Commitment of key personnel
• Summary or list of state-run initiatives with the potential for overlap or duplicative services that are operating in the target area
• Verification from state Medicaid agency on clinical delivery sites’ estimates of Medicaid beneficiary ED utilization in the previous 12 months
• Commitment to working with bridge organization to establish a consortium
Bridge Organizations must:

• Include contracts, MOUs or equivalents agreements with clinical delivery sites in their application for participating hospitals, primary care provider or practice, and provider of behavioral health services

• Ensure that their consortium, through their participating clinical delivery sites, will be able to present opportunities to screen at least 53,000 community-dwelling beneficiaries per year
Clinical Delivery Sites
MOU Requirements

• The description of the community-dwelling beneficiary population who have received clinical services in the previous 12 months at the clinical delivery site (specifically address the number of each)

• Where possible, the number of community-dwelling beneficiaries who utilized the ED two or more times in the previous 12 months

• The NPI, TIN and any other relevant provider identifiers for providers who will participate in the model

• Commitments to have the bridge organization screen all community-dwelling beneficiaries seeking health care services at their site

• Commitment to submit required AHC data to the bridge organization and CMS

• Description of planned protocols for allowing screening of community-dwelling beneficiaries
Community Service Providers

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

- Community service providers will receive referrals.
- A contract, MOU or MOU equivalent from each intended community service provider is optional, but recommended.
Screening Tool

Bridge organizations will:

• Use the screening questions provided by CMS to screen for core health-related social needs

• Choose an appropriate method to administer the screening tool

• Systematically submit all information, including beneficiary identifiers, received through this screening tool to CMS or its contractors

• Make the tool available to all beneficiaries regardless of language, literacy level, or disability status
Bridge organizations will:

• Create a **Community Resource Inventory** of available community services and community service providers to address each of the domains included in the screening tool

• Update this inventory every six (6) months

The inventory will include:

• Contact information, addresses, hours of operation, and other relevant information that a beneficiary would need to access the resources of an organization
The learning system will:

• Support shared learning and continuous quality improvement between bridge organizations, their partners and CMS

• Facilitate movement of timely, accurate, and relevant information to allow bridge organizations and partners to share promising practices and learn from their peers about Accountable Health Communities activities
Bridge organizations and their model partners will work with the learning system to:

- Create a driver diagram as a framework to guide and align intervention design and implementation activities.
- Provide data and feedback to CMS at regular intervals on quality improvement efforts, activities, and measures.
- Align data-driven decisions with the successful outcomes sought by the model.
- Participate in learning system events in person and virtually (i.e., web series, online seminars, and teleconferences).
- Engage state Medicaid agencies as necessary to achieve model goals.
Accountable Health Communities
Application Process
Eligible Applicants

Eligible applicants include:

- Community-based organizations
- Health care practices
- Hospitals and health systems
- Institutions of higher education
- Local government entities
- Tribal organizations
- For-profit and not-for-profit local and national entities

Applicants from all 50 states, U.S. territories, and the District of Columbia will be accepted.
Application Package Components

• **Project Narrative**
  – Intervention Design – Core Elements
  – Bridge Organization
  – Stakeholder Engagement

• **Implementation Plan**
  – Health Resource Equity Statement
  – Assessment of Program Duplication

• **All standard forms** are required and must be submitted with the application (see slide 52 for list of forms)
Applicants must also submit:

- Memoranda of Understanding (MOU) with:
  - State Medicaid Agency(ies)
  - Clinical Delivery Sites (hospital, primary care provider, behavioral health treatment facility)
- Budget Narrative
Applications must provide within their project narrative:

- **Intervention Design** to include:
  - Background
  - Geographic Target Area
  - Systematic Screenings for Health-Related Social Needs
  - Risk Stratification
  - Tailored Community Resource Inventory and Referrals Summary

- **Bridge Organization**
  - Description of capacity to carry out core elements and a description of the process for data collection and reporting for internal quality control and CMS monitoring and evaluation

- **Stakeholder Engagement**
  - State Medicaid Agency Consortium
  - Clinical Delivery Sites
Ineligibility Criteria

- Funds will not pay directly or indirectly for provision of community services.
- State Medicaid Agencies are ineligible as lead applicant.
- Only one bridge organization will be funded for a given geographic area.
- An applicant can only be funded to implement one AHC track.
- Funds shall not be used to build or purchase health information technology that exceeds more than 15 percent of the total costs of the applicant’s proposed budget.
- Medicare Advantage plans and Program of All-Inclusive Care for the Elderly (PACE) organizations are ineligible to apply.
- CMS will not review applications that merely restate the text within the FOA.
- CMS will not fund proposals that do not submit a contract, MOU or equivalent agreement from the appropriate state Medicaid agencies.
- CMS may deny selection based on information found during a program integrity review.
The selection criteria for applications will be based on the prospective bridge organization’s ability to:

- Meet eligibility and application requirements for the track chosen by the applicant organization
- Demonstrate commitment, collaboration, and engagement of community stakeholders
- Provide required social needs data and Medicare and Medicaid claims data on beneficiaries in the model to CMS and its contractors
- Demonstrate readiness to implement the intervention