



Accountable Health Communities Model

*State Medicaid Agency Partner Engagement
Track 1 of the AHC Model*

*Alexander Billioux, MD, DPhil
Center for Medicare and Medicaid Innovation*

*Jessica Kahn, MPH
Center for Medicaid & CHIP Services*

Agenda

Purpose

To define state Medicaid agencies' role as a Track 1 model partner and outline the responsibilities of state Medicaid agencies in the Accountable Health Communities (AHC) model.

Discussion Topics

- AHC Model Overview
- AHC Structure & Track 1 Changes
- State Medicaid Agency (SMA) Partner Role
- Application Requirements



AHC Model Overview

Why the Accountable Health Communities Model?

- Many of the largest drivers of health care costs fall outside the clinical care environment.
- Social and economic determinants, health behaviors and the physical environment significantly drive utilization and costs.
- There is emerging evidence that addressing health-related social needs through enhanced clinical-community linkages can improve health outcomes and impact costs.
- The AHC model seeks to address current gaps between health care delivery and community services.

The Vision for Enhanced Clinical and Community Linkages

Care Process	Today's Care	Future Care
Identification of health-related social need	Ad hoc, depending on whether patient raises concern in clinical encounter	Systematic screening of all Medicare and Medicaid beneficiaries
Provider response to health-related social need	Ad hoc, depending on whether provider is aware of resources in the community	Systematic connection to community services through referral or community service navigation
Availability of support to help patient resolve health-related social need	Ad hoc, depending on whether case manager is available and has capacity given case load and care coordination responsibilities	Community service navigation designed to help high-risk beneficiaries overcome barriers to accessing services
Availability of community services to address health-related social needs	Dependent on fragmented community service system not aligned with beneficiary needs, often resulting in wait lists or difficulty accessing services	Aligned community services, data-driven continuous quality improvement and community collaborations to assess and build service capacity

What Does the Accountable Health Communities Model Test?

The Accountable Health Communities Model is a 5-year model that will test whether systematically identifying and addressing the health-related social needs of community-dwelling Medicare and Medicaid beneficiaries impacts health care costs and utilization.

Health-Related Social Needs

Core Needs	*Supplemental Needs
Housing Instability	Family & Social Supports
Utility Needs	Education
Food Insecurity	Employment & Income
Interpersonal Violence	Health Behaviors
Transportation	

* This list is not inclusive

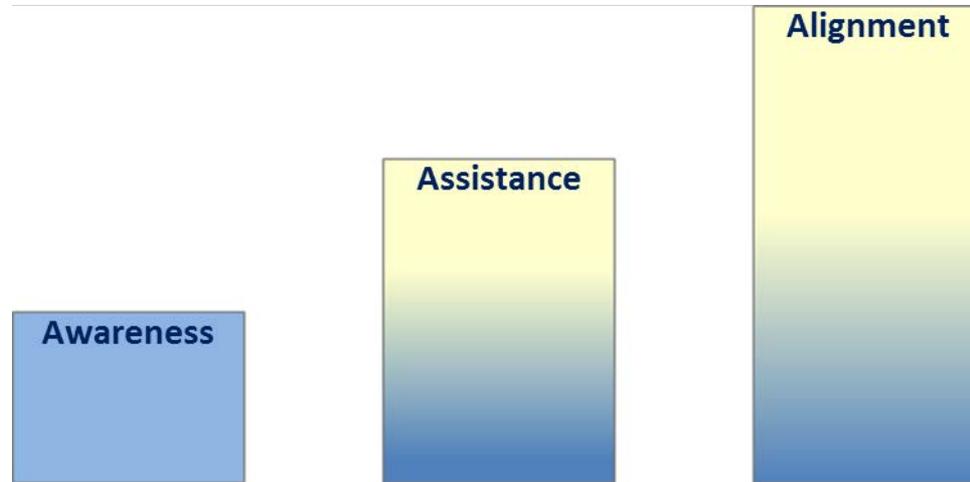
Targeted Outcomes

- Increased beneficiary awareness of community resources
- Increased beneficiary access to community resources
- Optimized community capacity to address health-related social needs
- Reduced inpatient and outpatient health care utilization and total cost of health care



AHC Model Structure

Model Intervention Approaches: Summary of the Three Tracks



- **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

Model Participants

- Bridge organization
- State Medicaid Agency
- Community service providers that have the capacity to address the core health-related social needs
- Clinical delivery sites, including at least one of each of the following types:
 - Hospital
 - Provider of primary care services
 - Provider of behavioral health services

Consortium (1 of 2)

- Applicants may consist of either a consortium, composed of collaborators led by a bridge organization, or a bridge organization that intends to form a consortium.
 - Consortiums must either be formalized at the time of application *or* within 12 months of award.
 - A consortium must include at a minimum a bridge organization and a state Medicaid agency, and may also include any other participants in the model.
 - Being a part of the consortium will allow state Medicaid agencies to support community efforts at a local level.

Consortium (2 of 2)

- State Medicaid agencies cannot serve as the bridge organization; in all cases, the bridge organization must serve as the lead award recipient.
- CMS will not fund proposals that do not submit a contract, MOU, or equivalent from the appropriate number of state Medicaid agency(ies) that would be expected to pay for Medicaid-covered services furnished to beneficiaries participating in the model.

Track 1 Changes

- The initial application period for Tracks 1, 2, and 3 closed in May 2016. Applications for Tracks 2 & 3 are currently under review and awards will be announced in Spring 2017.
- 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.

State Medicaid Agency Role

Benefits of Participation for SMAs

- Opportunity to address population health and upstream non-medical factors that impact the health outcomes of Medicaid beneficiaries
- Awareness of community efforts that address the health-related social needs of Medicaid beneficiaries
- Potential beneficiary utilization and cost reductions due to improved awareness of and linkages to community services for Medicaid beneficiaries
- Community health improvement through collaborations with other consortium participants and through the redress of health-related social needs

Considerations for State Medicaid Agency Participation

- Timely Transformed-Medicaid Statistical Information System (T-MSIS) data — when data submission through T-MSIS does not provide timely data, CMS may consider:
 - Statement of status towards T-MSIS milestones
 - Local, state, and federal laws and policies regulating the release of Medicaid claims data
 - The applicant’s supplemental statement outlining a plan for coordinating with CMS to provide required AHC data
- Requirements of key personnel:
 - Bridge organizations should collaborate with the SMA to structure a relationship that accounts for the SMA’s obligations to the model.
 - Allowable costs may include: personnel, fringe benefits, travel, equipment, supplies, consultant/sub-award recipient/contractual costs, and other expenses not duplicative or used to supplant existing State, local, Tribal or private funding of infrastructure or services, such as staff salaries, etc. (In the FOA, see Appendix 1: Sample Budget and Narrative Justifications.)

State Medicaid Agency Core Responsibilities

State Medicaid agencies that agree to participate in the model will have three core responsibilities:

- Provide required information on utilization outcomes for model participants covered under Medicaid
 - Data submitted by states through T-MSIS will be pulled by CMS to assess total health care costs and inpatient/outpatient utilization of health care services.
 - If timely data is not available through T-MSIS, the evaluation contractor will provide required measures for reporting total health care costs and inpatient/outpatient utilization of health care services.
- Collaborate with the bridge organization on sustainability and scalability planning
- Dedicate staff time for AHG-related activities

State Medicaid Agency Responsibilities (1 of 2)

As consortium members, state Medicaid agencies must confirm willingness to:

- Report or facilitate the reporting of Medicaid claims data to CMS and its contractors for purposes of model monitoring and evaluation (CMS's preference is data submission through T-MSIS)
- Champion appropriate data sharing across clinical delivery sites and community service providers consistent with federal, state, and local law [there may be Federal Financial Payment (FFP) available to support some of these costs]
- Provide a point of contact for data collection and reporting

State Medicaid Agency Responsibilities (2 of 2)

As consortium members, state Medicaid agencies must confirm willingness to:

- Ensure alignment with existing Medicaid policy and, as appropriate, waivers and State Plan Amendments
- Perform an annual review to ensure that CMS funding under the AHC model is not used to duplicate any service that a community-dwelling Medicaid beneficiary would otherwise be eligible to receive under a program administered by that State Medicaid Agency
- Participate in program coordination and review every six months for scalability and sustainability planning

Medicaid Data

- CMS intends to obtain Medicaid data necessary to evaluate Medicaid beneficiaries participating in the model through the T-MSIS.
- A state's status and progress towards using T-MSIS will affect CMS's ability to obtain Medicaid data on beneficiaries participating in the AHC model.
- CMS anticipates that most states will be in some stage of production by the beginning of 2017; thus, making the use of T-MSIS data feasible for the evaluation of the AHC model.
- CMS will consider a supplemental statement outlining a plan for collecting and providing required AHC data if T-MSIS data is not available.

T-MSIS and MMIS Costs

- CMCS will provide CMS Innovation Center with information on applicant states' T-MSIS readiness status, including data quality and completeness.
- Submission of data through T-MSIS for the evaluation of this model avoids additional data reporting requirements for states.
- If the state Medicaid agency needs to enhance its MMIS or eligibility systems in order to facilitate the kind of data sharing needed for this model, those activities may be eligible for the 90/10 enhanced match. CMS encourages states to reach out to their CMS systems point of contact for early discussions prior to Advanced Planning Document (APD) submission.



State Medicaid Agency Application Requirements

SMA-related Application Requirements

- Applicants must include with their application a contract, MOU, or equivalent agreement with the state Medicaid agency(ies) that cover community-dwelling beneficiaries who the applicant believes will seek care at a participating clinical delivery site.
- Where participating clinical delivery sites furnish Medicaid-covered services to beneficiaries from more than one state, the applicant is expected to secure, at a minimum, assurances from such agencies as may be needed to ensure participation by those state Medicaid agencies that collectively pay for the majority of such services furnished at such sites.

Contract, MOU, or MOU equivalent Requirements (1 of 2)

Applicants should ensure that the following information is included in each contract, MOU, or equivalent agreement with the state Medicaid agency:

- Statement of status towards meeting ongoing T-MSIS milestones including continued progress towards current and future goals
- Summary of local, state, and federal laws and policies regulating the release of Medicaid claims data from AHC model participants 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 understood role and responsibilities for Track 1
- Description of key personnel

Contract, MOU, or Equivalent Agreement Requirements (2 of 2)

- Summary or list of state-run initiatives with the potential for overlap or duplicative services operating in the target area
- Concurrence on Assessment of Program Duplication with respect to services that are paid by the state Medicaid agency
- Verification from state Medicaid agency on clinical delivery sites' estimates (or exact counts) of community-dwelling Medicaid beneficiary ED utilization in the previous 12 months
- Commitment to working with bridge organization to establish a consortium within 12 months of notice of award
- The signatures of authorized organizational representatives (AORs) from both the bridge organization and state Medicaid agency

Next Steps

- Establish connections – meet with applicants and other potential model partners to discuss critical factors of model success such as:
 - Data sharing and reporting
 - Consortium participation
 - Community service collaborations
- Conduct an internal assessment of feasibility, ease, and timeliness for data reporting
- Email questions to AccountableHealthCommunities@cms.hhs.gov