Comparison of Key Aspects of CMMI AHC and CACHI

On January 22, 2016, Community Partners, with support from The California Endowment, Blue Shield of California Foundation and Kaiser Permanente, released the ***California Accountable Communities for Health Initiative,*** to support up to six new population health models. Just two weeks earlier, the Centers for Medicare and Medicaid Services released a $157 million funding opportunity for ***Accountable Health Communities (AHC)***, which seek to connect health care delivery systems with health-related community and social services.

Because of the similarity in the names of the initiatives and overlapping timeframes for developing and submitting proposals, we are providing this side-by-side comparison of the two initiatives.

Topic	CA Accountable Communities for Health Initiative (CACHI)	CMMI Accountable Health Communities (AHC)	Implications/ Analysis
Goals and Philosophy	• CACHI will assess the feasibility, effectiveness, and potential value of a more expansive, connected and prevention-oriented health system. • An ACH aims to 1) improve community-wide health outcomes and reduce disparities with regard to identified health needs; 2) reduce costs associated with the health care and, potentially, non-health sectors; and, 3) develop financing mechanisms through a self-sustaining Wellness Fund, to sustain the ACH and provide ongoing investments in prevention and system-wide efforts to improve population health.	• The Accountable Health Communities (AHC) model addresses a gap in the current delivery system by funding interventions that connect community-dwelling Medicaid and Medicare beneficiaries with community services. • The AHC Model is a five-year test to learn whether systematically identifying and addressing beneficiaries' health-related social needs through referral and community navigation services can improve care delivery; enhance quality of care; and reduce their total cost of care and impatient and outpatient health care utilization.	• The goals and philosophy of CACHI and AHC are aligned in that they both recognize that the medical care system alone is insufficient for achieving the desired health outcomes and that a critical step is to connect the health care delivery system to community programs and social services
Core Elements	• Shared vision and goals: A common set of goals and vision, based on a shared understanding of the problem. • Partnerships: Meaningful collaboration among the health care, social services, and various community agencies and sectors dedicated to achieving the vision and goals.	• Track 1 Awareness: (1) systematic health-related social needs screenings for certain beneficiaries, (2) identification of community-dwelling beneficiaries with 2 or more ED visits, (3) random assignment of community-dwelling beneficiaries with 2 or more ED visits and those with less than 2 ED visits to intervention and control groups, (4)	• The core elements of CACHI and CMMI AHC are complementary although there are many differences.

	• Leadership: At least one, but ideally several, champions at both an individual and organizational level among the core entities of an ACH. • Backbone: An agreed upon entity that will serve as the collaborative facilitator and convener. • Data analytics and capacity: The infrastructure, capacity and agreements for collecting, analyzing and sharing financial, community and population-level data across a variety of providers and organizations. • Wellness fund: a vehicle for attracting resources from a variety of organizations and sectors to support the goals, priorities and strategies developed by the ACH. • Portfolio of interventions: A set of coherent mutually-supportive interventions that address a particular issue or conditions across five key domains: clinical care, community programs and social services, community-clinical linkages, environment, and public policy and systems.	provision of usual care to all community-dwelling beneficiaries assigned to control group, and (5) usual care, along with an offer of a review and distribution of a tailored community referral summary for all community-dwelling beneficiaries assigned to intervention group. • Track 2 Assistance: 1) 1-3 above; 2) risk stratification of community-dwelling beneficiaries based on number of ED visits, 3) random assignment to intervention and control groups for all community-dwelling beneficiaries with 2 or more ED visits, 4) offer of a review and distribution of tailored community referral summary for all community-dwelling beneficiaries with unmet health-related social needs who are not assigned to intervention group (along with usual care), and (5) offer of a review and distribution of tailored community referral summary and navigation services for all high-risk community-dwelling beneficiaries with unmet health-related social needs who are assigned to intervention group (along with usual care). • Track 3 Alignment: (1) the first through fifth core elements in track two, and (2) continuous quality improvement and gap analysis for community and clinical resource alignment.	• CACHI focuses on developing and sustaining, through a Wellness Fund, the required relationships, organizational structures and portfolio approach to achieve population level improvements. • The Accountable Health Communities (AHC) model is based on emerging evidence that addressing health-related social needs through enhanced clinical-community linkages can improve health outcomes and reduce costs.
Target Population	• All residents in a targeted community/geography with focus on equity • No prescribed geographic size, but similar initiatives are between 100,000 and 200,000. The geography should: include sufficient partners and services to reach the majority of the population; include areas of significant disparities with respect	• Medicaid and/or Medicare beneficiaries living in a particular community. • Must be able to screen at least 75,000 community-dwelling beneficiaries (defined as Medicare and Medicaid beneficiaries who live in a particular geographic target area per year.	• CACHI takes a broad population health improvement approach in a defined geography, while the CMMI AHC is focused on Medicare and Medicaid beneficiaries within a

	to the selected health issue; be large enough to demonstrate impact; and, small enough to ensure that the scale of the interventions proposed can address the identified issue(s).	• Track 3: Must be capable of reaching 51 percent of community-dwelling beneficiaries in the geographic target area.	defined community.
Partner-ships	• The ACH collaborative must include: Health plans, hospitals, private providers or medical groups and community clinics serving the geographic area; government health and human services agency/public health department; grassroots, community and social services organizations that include authentic and diverse representation of residents, particularly from underserved communities. • It is desirable to include broad representation such as: County and/or city government leadership, including elected officials; Behavioral health providers; housing agencies; food systems; employers and other business representatives; labor organizations; Faith-based organizations; schools and educational institutions; parks and recreational organizations and agencies; transportation and land use planning agencies; dental providers; local advocacy, grassroots organizations or policy-focused organizations	• Required partners include a bridge organization, the state Medicaid agency, clinical delivery sites including at least one of each of the following types: hospital primary care practice, behavioral health provider; and • Community service providers capable of addressing core or supplemental health-related social needs identified through the screening tool.	• Local health care partner requirements are similarly defined. • In addition, CACHI also includes partners involved in policy, systems and environmental change activities, while AHC requires state-level partnership requirements.
Preferred Target Conditions	• Communities are encouraged to select a health need, chronic condition, set of related conditions, or community condition that has broad support among collaborative partners and residents and with which members already have experience. Communities often characterize their chosen priority in different ways - the examples below are one approach: o A health need priority: tobacco use, obesity o A chronic condition priority: asthma,	• All community-dwelling beneficiaries who screen positive for one or more health-related social needs will be stratified based on their ED utilization history during the previous 12-month period and randomized to an intervention or control group. All community-dwelling beneficiaries who are randomized to the intervention group will be offered both usual care and the intervention. All community-dwelling beneficiaries in the control group will be offered	• Target conditions differ between CACHI and AHC. • CACHI is a population approach that focuses on a particular health need as it applies to the population as a whole. • The AHC is an individual

	diabetes, depression ○ A community condition: family and community violence, lead ○ A set of related conditions: cardiovascular + diabetes; air quality + asthma; diabetes + depression • Suggested criteria for selecting any selected issue should include being: ○ Amenable to having interventions, which are evidence-based to the greatest extent possible, across the five domains, and ○ Inclusive of a variety of populations within a community, not just high need, high cost populations.	only usual care. • Screening must include the following core health-related social needs: ○ Housing instability (e.g., homelessness, inability to pay mortgage/rent, housing quality); ○ Utility needs (e.g., difficulty paying utility bills); ○ Food insecurity; ○ Interpersonal violence (e.g., intimate partner violence, elder abuse, child abuse, etc.); and ○ Transportation needs (beyond medical transportation). • Supplemental health-related social needs include but are not limited to the following: ○ Family and social supports (e.g., prenatal support services, child care, social isolation, respite services, caregiver support); ○ Education (e.g., ESL, GED, certificate programs); ○ Employment and income; and ○ Health behaviors (e.g., tobacco use, alcohol and substance use, physical activity).	service approach that seeks to address a variety of social needs for Medicare and Medicaid beneficiaries who present for care within a geographic area.
Required Interven-tions	• Explicit in the design of the ACH is the coordination of a portfolio of aligned and mutually reinforcing interventions that span five key domains: ○ clinical ○ community ○ clinical-community linkages ○ policy and systems and ○ environment	• Three tracks all of which focus on community-clinical linkage domain 1) Referral only: Inventory of local community services responsive to community needs assessment; Universal screening of all community-dwelling beneficiaries who seek care from participating clinical delivery sites Referral to community services of community-dwelling beneficiaries with certain identified unmet health-related needs.	• The AHC requires individual screens, referral and tracking, which are consistent with the clinical-community linkages domain of the CACHI. • The CACHI includes interventions in two

		2) Community service navigation: all elements above + intensive community service navigation (in-depth assessment, planning and follow-up until needs are resolved or determined to be unresolvable) of high-risk community-dwelling beneficiaries with certain identified unmet health-related needs in the intervention group 3) Navigation and partner alignment: all elements above + 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	additional domains: policy and systems change, and the environment.
Structure and Governance	• Requires Backbone, Wellness fund and ACH collaborative body. • Applicants must specify governance structure and relationships between different partners as well as decision making process. • Lead agency could be the Backbone organization or a different entity	• Bridge organization is applicant and must hold MOUs with clinical and social service partners in a hub/spoke model. • Track 3 requires advisory body. A narrative and diagram of the proposed organizational structure detailing relationships with model participants (i.e., state Medicaid agency, clinical delivery sites, and community service providers) and the flow of funds, data, and communications	• Similar governance structures between AHC and CACHI • AHC model does not include a Wellness Fund or other sustainability vehicle
Backbone/ Bridge organiza-tions	Backbone organization functions: • Guiding development of a common vision, goals and strategy safeguards • Ensuring the engagement of community residents in the process • Facilitating development of agreements across collaborative partners • Coordinating and supporting implementation of aligned activities • Managing the budget of the backbone • Serving as convener, including facilitating conflict	Bridge organizations are responsible for: • Making arrangements with clinical delivery sites to provide the required AHC intervention services to community-dwelling beneficiaries • Using a standardized screening tool for health-related social needs populated with questions developed by CMS. • Developing and maintaining a comprehensive database, updated at least every six months, that contains information on community service	• Significant overlap in roles and functions of Backbone and Bridge organizations

	resolution and problem solving and maintaining a culture of learning and collaboration • Facilitating data collection, quality assurance, analysis and evaluation • Mobilizing funding through the Wellness Fund • Ensuring transparency of goals, activities and outcomes	providers address the needs identified in the screening tool • Developing and submitting standard operating procedures • Collecting and sharing, ensuring that its consortium members collect and share, with CMS any identifiable beneficiary-level data for model monitoring and evaluation. • Ensuring that CMS funding for this model does not duplicate services already made available through other programs • Certifying in the application that it has financial and accounting systems that are fully auditable and able to document all AHC-related savings, revenues, and expenditures. • Demonstrating that it already has, or has the capacity to develop, active relationships with community service providers.	
Timeframe, Funding, and Match Require-ment	• Up to 3 years • Up to $850K over 3 years • No Match is required	• Five years: January 1, 2017 through December 31, 2021 o Track 1: $1M over five years o Track 2: $2.57 over five years o Track 3: $4.51 over five years. • Funds cannot pay directly or indirectly for any community services (e.g., housing, food, violence intervention programs, and transportation) in any of the three intervention tracks.	• CACHI offers flexible funding to focus on capacity and infrastructure across the system. • AHC funding supports a structured intervention and can also fund some data infrastructure capacity.
Evaluation and Data Collection	• CACHI will sponsor an Initiative-wide evaluation of the six grantee cohort. The California Department of Public Health is developing an evaluation framework for the initiative with funding from the Center for Medicare and Medicaid Innovation State Innovation Model grant. Sites will participate	• The evaluation will test the impact of the Accountable Health Communities interventions on total health care costs and inpatient and outpatient health care utilization, as well as health and quality of care for Medicare and Medicaid beneficiaries. CMS will test whether community	• AHC has a formal evaluation plan developed. • CACHI will develop an evaluation plan based on

	in the development of the final evaluation design. The goal of the evaluation is to document the development and operations of ACHs, assess the impact of implementing a portfolio of interventions to address a particular health need, identify the structural and programmatic elements for success, and strategies for sustainability to spread and scale the ACH model. • A formal local evaluation plan is not required. However, sites will be will be required to participate in the initiative evaluation, including timely data collection. Sites will be responsible for tracking outcomes of their interventions using readily available data. Applicants should consider budgeting up to 3-5% toward participation in the initiative evaluation.	referral, community service navigation, or community service alignment impacts total cost of care, emergency department visits, inpatient hospital admissions, and quality of care for high-risk Medicare and Medicaid beneficiaries. • Specific milestones for each track are delineated ○ Addresses clinical care and community services by testing whether identifying and addressing the health-related social needs impacts total health care costs, improves health, and quality of care. ○ Community service providers have four primary responsibilities: (1) supporting the bridge organization in the planning process and development of the community resource inventory; (2) supporting bridge organization/AHC navigator to track AHC participants utilizing community service provider resources and related outcomes (Tracks 2 – Assistance and 3 – Alignment); (3) participating in the advisory board (Track 3 – Alignment); and (4) informing the Gap Analysis and QI efforts (Track 3 – Alignment). Bridge organizations may establish agreements with community service providers to share data if the appropriate arrangements- both legal and model-specific-are put in place.	the CDPH contractor's evaluation framework and input from grantees.
TA and learning	• The CACHI will provide technical assistance to grantees on key aspects of the initiative, including developing ACH structure and governance; data analytics and sharing; developing a sustainability plan; and aligning interventions, including assessing how various combinations of interventions can complement one another to	• The implementation contractor will support technical assistance including: ○ convening to develop a tool for assessing health-related social needs; ○ developing a system for assigning community-dwelling beneficiaries to the intervention group; ○ creating and facilitating a learning system;	• TA and learning are complementary between CACHI and AHC • The AHC is prescriptive in the tool for assessing patients' needs, whereas

	enhance both the strength and reach—or "dose"—of their efforts (Schwartz et al 2015). • The CACHI will sponsor annual convenings of all grantees as well as small meetings among specific stakeholders within each ACH.	○ assisting in the monitoring of program implementation, including data exchange and potential for payment duplication; and	CACHI leaves it to the grantees to determine interventions in the community-clinical domain.

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