



# State Levers to Advance Accountable Communities for Health

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## Introduction

In an era of extraordinary health care reform, states are testing a myriad of models that strive to achieve the Triple Aim<sup>1</sup> objectives of improved care, reduced health care costs, and better health. Several state-wide health care delivery and payment system reforms have demonstrated their ability to help slow the growth of health care expenditures and improve methods for delivering health care. However, taken alone they are not enough to fully attain the Triple Aim goals and often fall short of improving the

overall health of populations and significantly reducing costs. To achieve these ambitious aims, many state and federal health policymakers are partnering with communities to implement population health initiatives that engage new community partners to address the social factors influencing health such as housing, food, work, and community life. A growing body of evidence supports this notion, and proves that community-based interventions can be effective at changing behaviors, preventing disease and reducing health care costs and can address behavioral, environmental, and social determinants of health.<sup>2,3</sup> Among the models for implementing community-based interventions, Accountable Communities for Health (ACHs) are surfacing as a promising state strategy to integrate and align state health care delivery system transformation with community-based social services to create communities that promote health and well-being.

At their core, ACHs are locally driven models that unite an array of key partners and stakeholders, each of whom shares a common goal of health improvement, and who, by coordinating and aligning strategies across sectors, can strive to achieve sustainable improvements by addressing multiple contributors of poor health. ACHs take a two-pronged approach to achieve this goal: they focus on improving health care for individuals with existing medical conditions (e.g. coordinating care for individuals with multiple health and social needs) and they facilitate policy and environmental changes that benefit the entire community, enabling community members to pursue healthier lifestyles that can prevent the onset of disease (e.g. ensuring access to healthy foods to prevent obesity and diabetes).

At this time, California, Minnesota, Vermont, and Washington State are all in the process of developing and implementing statewide ACH models as part of their larger health care delivery system transformation strategies. At the federal level, the Center for Medicare & Medicaid Innovation (CMMI) is administering an Accountable Health Community initiative, which funds selected communities to test the impact of identifying health-related social needs and connecting Medicaid beneficiaries to those services. Though the goals and strategies employed under the CMMI initiative bear similarities to some aspects of the

state ACH models, CMMI's model focuses its resources on the communities themselves, carving out only a minor role for states. While communities fundamentally drive ACHs, states can play a critical role in their development, sustainability, and scope. State agencies can bring significant resources to the table, develop a framework for ACH implementation that integrates with other aspects of the delivery system, and support local innovation while enabling models to spread statewide.

This brief identifies state levers that advance ACHs by examining the ACH programs in California, Minnesota, Vermont, and Washington State. Specifically, this brief weighs the roles states and communities have played in establishing core ACH components including governance structures, geographic boundaries, financing mechanisms, priority conditions and target populations. It also considers state-level resources that can be leveraged to support and sustain ACH models going forward.

## About this Report

Many states have taken advantage of opportunities offered by the Affordable Care Act to build stronger partnerships across the public health and health care delivery systems to support community-based interventions.<sup>4</sup> Through a variety of models, states are implementing programs that align the state health care delivery system with community-based social services in an effort to address the health and social needs of individual patients and whole communities. The National Academy for State Health Policy (NASHP) identified three types of models states are implementing to integrate health care, social services, and delivery system reform initiatives through community-based interventions. Though similar in their overarching goals, the models vary in their core strategies and emphasis on individual versus population-wide approaches. Furthermore, each model strikes a new balance in determining state and local roles, some with more clarity than others.

Some states have designed approaches rooted in the health care delivery system; these models are often comprised of community-organized structures that are responsible for health care delivery oversight and financing (e.g. accountable care models). The primary purpose is to create integrated networks of providers who can coordinate care across a range of health care needs of their target populations. In these models, providers assume a new level of accountability for their patients' health and may address social determinants of health through the process of establishing new community-clinical linkages.

Other states have begun developing targeted community-based initiatives that seek to improve health equity by directing resources to communities that experience economic disadvantage and poor health outcomes (e.g. health equity zones). These models place more emphasis on increasing community capacity and coordinating community resources to create community environments that promote health for all residents.

State ACH models are a third approach; they are designed to support community-organized structures that are responsible for community health improvement. They strive to include strategies to improve the health and wellbeing of a whole community through community-wide disease prevention efforts in addition to focusing on integrating care across medical and social service systems for individuals already in need of health care services. ACHs accomplish these goals by convening multi-sector partners to implement projects that target a health-related issue faced by their community. Typically each partner has a role in addressing the particular issue through a specific intervention, and by aligning their roles and responsibilities, they can maximize their impact and achieve sustainable health improvements. For example, an ACH seeking to address a high prevalence of diabetes in their community may partner with

an ACO to deliver care management services for diabetic patients and partner with local government to implement prevention strategies that benefit the entire population, such as changing zoning regulations to increase access to physical activity.

States acknowledge communities need flexibility to develop ACHs that meet their specific needs, and have provided that flexibility to varying degrees across models. However, states also envision ACHs a component of their statewide delivery systems, often encouraging or requiring ACHs to develop strong partnerships with health plans and providers. Furthermore, all four states with an ACH program have included it as a strategy in their payment and delivery system reform plans under the State Innovation Model (SIM) program, and must consider the structure and impact of ACHs in the context of their larger delivery system transformation efforts. This leads to important questions regarding whether the state or local community should take the lead in determining core ACH components, including governance structure, geographic boundaries, financing, and target populations. It also raises key questions such as how will a state determine what a successful ACH looks like in order to maximize resources? How can local communities best leverage state resources? To shed light on these questions, NASHP conducted interviews with state agencies and organizations leading ACH implementation in each state. This brief captures interview findings in a cross-state analysis of the approaches California, Minnesota, Vermont, and Washington State have taken in developing their ACH models. It may also be used to inform other similar models that states are developing to improve population health through community-based interventions.

## State ACH Models

Each state conceived of ACHs as one piece of a comprehensive delivery system reform initiative focused on improving care, reducing costs, and improving health. All ACHs are intended to improve the overall health of communities, and states are selecting initial ACHs based on the ability of communities to meet core standards. Table 1 provides the most common criteria states have used to select or designate ACHs.

**Table 1: Common State Criteria for ACHs**

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| <ul style="list-style-type: none"> <li>• Shared vision and goals among partners</li> <li>• Multi-sector partnerships</li> <li>• Established governance structure or leadership</li> <li>• Population-based prevention activities</li> <li>• Backbone or integrator organization<sup>5</sup></li> <li>• Identified community engagement activities/interventions</li> <li>• Ability to perform basic financial and administrative functions</li> <li>• Sustainability planning</li> </ul> |
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Beyond these common criteria, states have also included a variety of unique requirements for communities applying to become ACHs (e.g. health equity focus, partnerships with an accountable care organization, capacity for data analytics, measurement, and evaluation). All states expect ACHs to engage in some form of sustainability planning, often with additional support from the state. In California, ACHs are expected to establish a Wellness Fund to achieve sustainability. While these states view initial ACH selection criteria as important foundational requirements, they also acknowledge that their ACH initiatives are in a testing phase and will use this opportunity to evaluate the importance of these criteria. Furthermore, states noted they do not view these initial criteria as a final developmental milestone and

expect ACHs will evolve over time.

The ACHs are designed to implement prevention programs that address the needs of both individuals and whole populations, including, but not limited to, a focus on coordinating services and establishing formalized community partnerships that link clinical care with social services. With these goals in mind, the states conceptualize the range of interventions differently, along a continuum of prevention activities that focus on clinical preventive services to population-wide policy and environmental change.

California and Vermont, for example, lay out a framework for ACH population health strategies along a continuum (See Table 2).

**Table 2: State Framework for ACH Interventions in California and Vermont**

<p>California's Five Domains for ACH Intervention<sup>6</sup></p> <ul style="list-style-type: none"> <li>• Clinical services</li> <li>• Community programs, social services</li> <li>• Community-clinical linkages</li> <li>• Public policy and system change</li> <li>• Environments</li> </ul>	<p>Vermont's Three Buckets of Prevention for ACH Intervention<sup>7</sup></p> <ul style="list-style-type: none"> <li>• Traditional clinical preventive interventions (focused on individual health improvement)</li> <li>• Innovative clinical prevention (linking individuals to community services)</li> <li>• Total population or community-wide prevention (focused on improving the health of populations)</li> </ul>
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ACH programs in each state build on a strong foundation, and connect multiple ongoing payment and delivery system initiatives with community-based interventions to improve the health of communities. Importantly, each state supported planning and/or implementation for its ACH initiative with funding provided through the Center for Medicare and Medicaid Innovation (CMMI's) State Innovation Model (SIM) initiative to accelerate the design and testing of health care payment and service delivery reforms. Given that each state developed its ACH model in the context of various health care reform initiatives, each features unique origins, goals, and visions for transforming health.

## California

The ACH concept in California emerged from the work of the Let's Get Healthy California Task Force, a multi stakeholder workgroup convened by the Governor in 2012 to develop a 10-year plan to make California the healthiest state in the nation. In its final report, the Task Force identified the creation of healthy communities as one of six core goals for healthcare reform in California.<sup>8</sup> Using the Task Force report as a foundation, California then applied for, and received, a SIM design grant from CMMI to develop a plan for reforming its health care delivery and payment systems. SIM workgroups identified ACHs as one of four core initiatives the state could implement with a SIM testing grant from CMMI. Although the state was unsuccessful in its SIM testing grant application, it did receive a second SIM design grant that, combined with private foundation funding, enabled it to launch many of the initiatives identified in its SIM testing proposal, including ACHs. In continuing partnership with the state, three private funders are leading ACH implementation under the California ACH Initiative (CACHI).<sup>9</sup> CACHI is engaging health care providers, social service providers, community agencies, foundations, and other stakeholders in implementing six initial ACHs that will strive to improve the health of communities with an explicit focus on prevention strategies. ACHs are expected to coordinate a portfolio of aligned and mutually reinforcing interventions that span the five key domains listed in Table 2. Unique to the California model is the requirement for ACHs to establish wellness funds to sustain ACHs by braiding available public and private sector funding.

## Minnesota

Minnesota's ACH program is a core component of the state's Accountable Health Model supported by a SIM testing grant. The ACH initiative is linked to one of the model's five key drivers that are necessary for success: provider organizations partner with communities and engage consumers, to identify health and cost goals, and take on accountability for population health. The state has dedicated \$5.6 million of SIM funding to launch 15 ACHs throughout the state. Through ACHs, Minnesota is evaluating various community-based approaches to improving health and lowering costs for targeted communities with significant health and social needs. As such, the geographic scope, target populations, and strategies employed by ACHs vary widely across the state. Minnesota's ACH program builds largely on the success of community care teams, locally-based teams that coordinate health and social services for Medicaid beneficiaries. ACHs expand the work of community care teams by serving additional populations and coordinating with new partners to provide preventive services and holistic care that address health and health-related needs. A key feature of the Minnesota ACH model is its unique alignment with the health care delivery system; the state requires each ACH to partner with an accountable care organization (ACO). Minnesota will further test and evaluate whether investments in ACHs improve health outcomes and reduce costs when ACOs adopt community care team and ACH models to support integrating health care and non-medical services compared to ACOs that do not adopt these elements.

### State Example: Minnesota ACH Addresses Diabetes

The Southern Prairie Community Care ACH in Minnesota is developing a community-wide approach to delaying and preventing type 2 diabetes for at-risk individuals in 12 counties in southwestern Minnesota. The ACH target population includes 185,000 at-risk residents with a focus on Latino and East African populations and individuals who are low-income, at least 60 years of age, or receiving services from a mental health center. The Southern Prairie Community Care ACO is leading the ACH initiative in partnership with local health and human services agencies, mental health centers, and several community-based service providers. After identifying at-risk individuals through the ACO's claims data, a member of the ACO's community care team contacts individuals to offer them an ACH diabetes risk assessment. The ACH then offers services (e.g. care coordination, diabetes prevention classes) to individuals considered to be at high risk for developing type 2 diabetes. The ACH is training staff at several local mental health centers to conduct diabetes screenings and facilitate prevention classes to sustain the program once SIM funding expires.

## Vermont

Using funds from its SIM testing grant, Vermont is currently administering a year-long Peer Learning Lab that will gauge the readiness of communities across the state to launch ACHs and inform the need for additional reforms in state level policy and practice to support ACHs. The ACH initiative falls under the payment model design and implementation focus area of Vermont's SIM grant, reflecting the state's intent to incorporate ACHs in the larger delivery and payment system.<sup>10</sup> ACHs in Vermont will connect many state and local health innovations already underway to develop a coordinated, locally driven strategy for delivering health and social services within communities. Vermont envisions its Unified Community Collaboratives (UCCs) will serve as the essential building blocks for many ACHs. The UCC program uses SIM funds to integrate statewide health care delivery system initiatives at the local level to improve care for targeted patient populations. UCCs strive to integrate medical home and community health team implementation with Vermont's ACOs. Vermont has structured UCCs to align with its 14

health services areas (HSAs) and required them to use a shared governance structure that includes a specific set of local leaders from ACOs, medical homes, and other community organizations such as housing. While UCCs currently emphasize developing community-clinical linkages and implementing strategies to prevent the progression of chronic disease, Vermont envisions that any ACHs that evolve would incorporate strategies and policies that can promote health and prevent the onset of disease within entire communities as opposed to specific individuals. At this time, the state has not prescribed many requirements for governance structure, financing, or other specific ACH features in an effort to provide communities with enough flexibility to develop programs that best meet their needs.

## Washington

ACHs are a key strategy of Healthier Washington, the payment and delivery system reform initiative Washington is supporting through funding from a SIM testing award. Washington's ACH program aims to improve the health of communities across the state by creating a partnership between the state and community-based, cross-sector coalitions that work to improve health within their respective regions. The initiative builds on existing community partnerships, collaboration, and expressed interest from regional health improvement groups to be partners in system transformation. The ACH model in Washington emphasizes aligning resources from public and private sector partners to improve health for all residents of the state, regardless of their insurance coverage. ACHs are locally driven and each ACH is responsible for establishing its own governance structure and priorities within broad state guidelines. There are nine ACHs in Washington, covering the entire state and aligning geographic boundaries with the state's Medicaid regional service areas. All nine ACHs have received official designation from the state, indicating that they have each achieved multi-sector representation, launched community engagement activities, identified initial regional health needs, demonstrated the ability to perform basic administrative and financial functions, and established an initial budget with a plan for continued funding.

### State Example: Washington State ACH Focuses on Youth Behavioral Health

Cascade Pacific Action Alliance (CPAA) is an ACH made up of multi-sector partners from seven counties in central western Washington State, supported by CHOICE Regional Health Network. As one of the two pilot ACHs in Washington State, CPAA received funding designated from the legislature in January 2015 to support staff for its first year of planning activities, and will continue to receive funding through the state's SIM grant in future years. CPAA's pilot project, Youth Behavioral Health Coordination Project, aims to identify children with behavioral health challenges in the school and healthcare settings and connect them with community-based treatment services and interventions. The pilot project was launched in 2015 and in January 2016 was implemented in four pilot schools across both rural and urban areas in the region. This partnership brings together stakeholders from behavioral health providers, community-based social service organizations, educational service districts, Medicaid MCOs, pediatricians and primary care providers, public health, and schools. CPAA plans to evaluate the project before scaling up to other school districts. Initial outcomes are promising. At one early adopter school, school attendance of students served by the pilot program has increased by 59% and behavior incidents requiring disciplinary action have dropped by 52% since inception of the program.

**Table 3: Fast Facts on State ACH Models**

State	Number of ACHs Planned	State Entities Leading ACH Initiative	Funding Allocated to Each ACH*	Relevant State Delivery System Reform Levers
California	6	<ul style="list-style-type: none"> <li>California Health and Human Services</li> <li>Private foundations including: Community Partners, The California Endowment, Blue Shield Foundation of California, and Kaiser Permanente</li> </ul>	<ul style="list-style-type: none"> <li>\$250,000 for Year 1 (2016-17)</li> <li>\$300,000 per year for Years 2-3 (2017-19)</li> </ul>	<ul style="list-style-type: none"> <li>Two SIM Design Initiatives</li> </ul>
Minnesota	15	<ul style="list-style-type: none"> <li>Minnesota Department of Health</li> <li>Minnesota Department of Human Services</li> </ul>	<ul style="list-style-type: none"> <li>\$370,000 total for 2 years (2015-16)</li> </ul>	<ul style="list-style-type: none"> <li>SIM Testing Initiative</li> </ul>
Vermont	Up to 14	<ul style="list-style-type: none"> <li>Vermont Department of Health</li> <li>Vermont Health Care Innovation Project Team (SIM)</li> </ul>	<ul style="list-style-type: none"> <li>\$230,000 total dedicated to the Peer Learning Lab for 12-14 months (not to individual ACHs)</li> </ul>	<ul style="list-style-type: none"> <li>SIM Testing Initiative</li> </ul>
Washington	9	<ul style="list-style-type: none"> <li>Washington State Healthcare Authority</li> <li>Washington State Department of Health</li> <li>Washington State Department of Social and Health Services</li> </ul>	<ul style="list-style-type: none"> <li>\$150,000 allocated through state legislation over 1 year (2015) for 2 Pilot ACHs</li> <li>\$100,000 from SIM award over one year (2015) for 7 Design ACHs</li> <li>\$810,000 from SIM award for remainder of SIM (2016-2019) for 9 ACHs Post-Designation</li> </ul>	<ul style="list-style-type: none"> <li>SIM Testing Initiative</li> <li>State Legislation**</li> <li>Pending Medicaid 1115 Demonstration</li> </ul>

\*Except in California, funding source for ACHs at this early stage is through SIM. In California funding for ACHs is through three private foundations.

\*\* In 2014, Washington State passed legislation that allocated \$150,000 in funding for each of two pilot ACHs.<sup>11</sup>

## State Role in Determining Key ACH Components

The state role in prescribing components of ACH models varies across the states; California, Minnesota, Vermont and Washington State allow the individual ACHs some flexibility in designing several key components of their models including governance structure, geographic boundaries, targeted populations or priority conditions, and the ACHs' financing model. In some areas, the state takes a more prescriptive role in the development of ACHs.

### Governance

Each of the four states allows ACHs to determine their own governance structure based on the needs of the community, although they stipulate some requirements and offer some guidance. In Minnesota

and California, communities must identify their governance structure when responding to a request for proposal (RFP), so an established structure must be in place before the ACH can receive funding. Similarly in Vermont, communities outlined their ACH governance structure when they applied for the state's Peer Learning Lab. While Vermont gives communities the flexibility to design their own ACH governance structure within broad guidelines, the state envisions ACHs building on existing UCCs for which there is a state recommended governance structure. Washington State also gave ACHs the flexibility to design their own governance structure, yet awarded ACH designation based on a state benchmark that included a governance structure that reflects balanced multi-sector engagement.

All states require that ACHs have a backbone organization or integrator entity to guide ACH activity and convene key partners, yet they give ACHs flexibility when determining the organization that is best suited to fill this role. The backbone organization can be a local health department, community organization, community care team, hospital, or, in the case of Washington State, a non-profit organization that doubles as the ACH itself. While not a requirement, Vermont anticipates that hospitals, which are all nonprofits in Vermont and have a history of engagement and investment in community health initiatives, including specified community health improvement offices, may fill the role of the backbone organization in many regions.

All four states require multi-sector partnership within the governing body that reflects the needs and resources of each specific community, although these partners may vary among ACHs within key parameters. Such potential partners include medical providers, health plans, hospitals, behavioral health representatives, and dental providers; local health and human service agencies and public health departments; community and social service representatives such as education partners, transportation agencies, and food systems; local business; and tribal agencies. Minnesota specifically calls out the potential for local public health partners to bring expertise in providing community assessment information and convening partners. The RFP notes that there may be barriers to local public health participation on leadership teams, and requires a letter of support that describes their involvement, or lack thereof, in the ACH. As Washington State noted, the challenge for each ACH is to strike a balance between being inclusive in its decision-making structure and process and remaining functional and nimble.

ACHs have defined relationships with health plans in each state. Minnesota requires that ACHs partner with ACOs in an effort to measure the ability of ACHs to improve health outcomes and reduce costs. In Washington State, managed care organizations (MCOs) are active participants in ACHs and some have contributed funding and other resources in particular regions. In California, MCOs are expected to be partners at the local level. Given that ACHs in Vermont are likely to evolve from the existing UCCs, which feature partnerships between ACOs, medical homes, and community health teams, Vermont envisions many ACHs will also include ACO partnership.

## Geographic Boundaries

Across the four states, the state's role varies in establishing the geographic boundaries of each ACH. In Minnesota and California, communities identified ACH boundaries when responding to the RFP, allowing flexibility in determining geographic boundaries and the population served. Because Vermont envisions the communities participating in the ACH Peer Learning Lab building on UCCs, it is therefore likely that ACH boundaries in Vermont will naturally align with the state-defined Health Service Areas (HSAs) that serve as the base for UCCs. However, the state does allow communities applying for the state's Peer Learning Lab flexibility when defining their own boundaries. For example, Vermont reports



that one region that responded to the state's RFP bridges multiple HSAs. Washington State's model is the only one of these four in which the ACH boundaries were defined by the state. As a result, it is also the only initiative that serves the entire state, with ACH boundaries aligning with the state's nine Medicaid regional service areas for Medicaid purchasing. Because of the flexibility for communities in California and Minnesota to design their boundaries, these initiatives do not cover the entire state and also have potential to overlap geographically.

## Priority Conditions and Target Populations

In all four of these models, states allow ACHs flexibility when choosing priority conditions or target populations to serve as the focus for their interventions, although they expect them to be in alignment with the state's system transformation plan. ACHs often turn to community health needs assessments, state health improvement plans, or SIM population health plan goals when choosing priority conditions and target populations as the focus of their work.

ACHs in California, Vermont, and Washington State are all intended to serve a geographic population regardless of insurer, or insurance status. Washington State emphasizes a whole-person and whole-population approach, while leveraging related Medicaid transformation efforts. Minnesota's ACHs, in contrast, can be designed to serve a population in either a defined geographic area or with significant identified health and social needs.

While the ACHs select priority conditions, the states may provide input into the ACH intervention strategies, recommending prevention strategies ranging from clinically focused to community policy or environmental change. For example, as is stated in Table 2, the RFP in California specifies that proposed interventions should span at least three of the five listed domains. The rationale for having five domains is to embed a focus on system change within a broad vision of community health, with the understanding that achieving population health requires a multitude of mutually reinforcing activities of sufficient reach and strength. Vermont outlines three strategies for improving population health, and the state will help communities participating in the ACH Peer Learning Lab learn how to address priority conditions through these strategies. These strategies may be influenced by funding sources and the need to show return on investment as well as recommendations from the state, as described below.

## Financing

Given the nascent nature of ACH models, all four states leverage funding from SIM grants to aid in initial ACH development. Minnesota and Washington State both directly provided ACHs with funding for two and four years, respectively, through the states' SIM grants. In contrast, because California received a SIM design grant, rather than a testing grant, SIM funds are not available to fund implementation of the ACHs. Although lack of SIM testing funding for ACHs could have presented a significant challenge in California, SIM design funding has been designated to develop an evaluation framework and identify data sharing needs for ACHs, and private foundations stepped in to provide the seed funding for ACHs themselves. This alternative funding source provides increased flexibility for ACH interventions, because ACHs are not bound by the need to show a return on investment within the short timeframe of the SIM awards. Vermont will use SIM funds to launch the state's Peer Learning Lab; however no SIM funds will be given directly to the ACHs to aid in their development. Vermont envisions that because ACHs will be building on existing infrastructure, they will be able to leverage existing funds.

States expect ACHs to develop a plan to achieve financial sustainability. In California, ACHs are required to establish a wellness fund to support ACH infrastructure and future interventions. These wellness funds may braid<sup>12</sup> or blend<sup>13</sup> funding from several sectors and organizations within the community, and will allow ACHs to reinvest any savings from successful community interventions for future use. While no other states outline the use of wellness funds, Minnesota, Vermont, and Washington State expect that ACHs will develop a plan for financial sustainability that incorporates funding from a variety of federal, state, or local sources (e.g. grants, hospital community benefits investments, health plan contributions, social impact bonds) and reinvests savings that the ACHs help generate in health care or other areas. Washington sees the state as a key partner in sustainability planning, recognizing ACHs are a key component of Healthier Washington, including the sustainability of a value-based health system. All states acknowledge that there are key questions to resolve, including where savings accrue and how they become dedicated to reinvestment in communities.

Several states envision support for some ACH strategies by integrating them with delivery and payment system reforms. Vermont envisions ACHs continuing to be a part of the conversation as they develop a more integrated payment structure. Minnesota, which requires ACHs to partner with ACOs, anticipates that ACHs will create interventions that payers will want to support based on health improvement results. Washington State has submitted an application for a Section 1115 Medicaid demonstration waiver that would provide funding to ACHs to implement transformation projects that focus on building health systems capacity (e.g. workforce development), redesigning care delivery (e.g. primary care and behavioral health integration), and improving population health (e.g. prevention activities).<sup>14</sup> While a Medicaid waiver demonstration in Washington State would provide ACHs with an identified funding source, it might also limit the scope of ACH projects that are funded through this mechanism. Medicaid funding would be tied to outcomes within the defined five-year period of the waiver, which would limit projects to those that can demonstrate a return on investment (ROI) within that time. For population health approaches that often require a longer-term intervention, this source of funding could be limiting, although planners point out that this funding would not be the ACH's only source and provides an opportunity for a portfolio of linked strategies.

**Table 4: State Role in Determining Key ACH Components**

State	Governance	Financing Model	Geographic boundaries	Targeted priority conditions and populations
<b>California*</b>	State allows communities to design governance structure when applying for RFP.	Start-up funding from private organizations, long term funding through Wellness Funds.	State allows communities to designate boundaries when applying for RFP, ACHs cover select communities.	State allows communities flexibility when choosing priority conditions and populations.
<b>Minnesota</b>	State allows communities to design governance structure when applying for RFP.	State gave start-up funding to ACHs through SIM testing grant.	State allows communities to designate boundaries when applying for RFP, ACHs cover select communities.	State allows communities flexibility when choosing priority conditions and populations.
<b>Vermont</b>	State allows communities to design governance structure when applying for Peer Learning Lab.	State funding Peer Learning Lab through SIM testing grant, no funding direct to ACHs.	State allows communities to designate boundaries when applying for Peer Learning Lab, but boundaries are influenced by state Health Service Areas. ACHs may or may not cover entire state.	State allows communities flexibility when choosing priority conditions and populations.
<b>Washington</b>	Community designed, state assigns designation upon completion.	State gave start-up funding to ACHs through state legislation and the SIM testing grant.	State designed boundaries align with Medicaid regional service areas. ACHs cover the entire state.	State allows communities flexibility when choosing priority conditions and populations.

*\*In the case of California, the “state role” refers to a partnership between the state and CACHI.*

## State Resources to Support Local Initiatives

Beyond laying the foundation for ACHs by making strategic decisions about their relationship with broader system transformation, providing seed funding, and linking to infrastructure such as medical homes and community health teams, states can play an important role in supporting the ongoing development and evolution of ACH models. State agencies in California, Minnesota, Vermont, and Washington State all serve a crucial role in ACH implementation by ensuring ACHs receive technical assistance and by serving as a central resource to collect and disseminate best practices through learning collaboratives and evaluations. Minnesota has designated a portion of SIM funding for an ACH learning community grant to provide technical assistance on ACH leadership, community-clinical care partnerships, care coordination models and systems and sustainability plans.<sup>15</sup> In California, a nonprofit, Community Partners, is designated as the entity to deliver technical assistance and run a learning community for ACH awardees. Vermont’s Peer Learning Lab, funded through SIM, will enable the state to assess the ability of communities to launch ACHs and identify additional resources required by communities. Washington State’s technical assistance vendor emphasizes shared learning opportunities across ACHs and currently hosts quarterly ACH convenings. Washington’s technical assistance effort builds upon the

formative evaluation effort. The state anticipates two-way sharing of information to inform innovation; the state expects to call on ACHs to provide state agencies with advice and recommendations that will inform state programs, including providing feedback on the design and operation of the Medicaid program and how it might be improved from a local perspective.

All states are using some SIM funds to conduct evaluations that will measure ACH progress and identify best practices. Given most ACHs are still in their infancy, evaluations at this time will focus more on capacity building and infrastructure as opposed to improvements in health outcomes. Minnesota's evaluation in particular will allow the state to compare considerably different ACH models to identify a set of best practices that can inform a future, potentially more prescribed model for ACHs. In addition to its SIM evaluation, California is also investing in research to determine how to capture the return on investment of long-term interventions, such as asthma interventions that result not only in health care cost savings but also fewer missed school and work days. Washington's formative evaluation is built upon a chain-of-impact approach that looks at process, health improvement strategies, and long-term health outcomes. This evaluation approach also aligns evaluation feedback with ACH development milestones for real-time improvements. While such state-led evaluations will reveal important strategies that inform local policies and programs, states have also expressed an interest in using input from communities to improve state policies.

Local-level data sharing is a crucial aspect to delivering coordinated care to individuals and enabling communities to identify community-wide needs, and therefore an important goal as ACHs continue to mature. As states focus on adopting enhanced health information technology to facilitate electronic data sharing between health care providers, this is another key area where states can offer their expertise and resources to support ACHs. California is using a portion of its SIM funding to develop a toolkit with strategies for ACHs to increase local data sharing capacity. Increasing data sharing is a key goal of the Minnesota and Washington State SIM plans. Washington State is currently implementing a regional data dashboard for ACHs and plans to develop a system that will integrate data from insurers, clinical and behavioral health providers, and social service providers (e.g. housing) to inform both state and community policies. Vermont, a national leader in health information technology, identified the ability to use data and indicators as a core ACH element and expects ACHs to encourage data sharing among partners to inform ACH activities and measure progress. Vermont envisions ACHs with the capacity to compare trends in disease with social patterns and attribute causality with such analyses to improve community health. For example, partners within an ACH could compare the number of healthy food vendors in communities and data on the prevalence of type 2 diabetes to develop policies that increase access to healthy foods in high-need communities.<sup>16</sup>

Statewide payment and delivery system reform initiatives will continue to serve as important resources that communities can leverage to advance local innovations. Beyond the capacity for demonstration waivers in Washington to sustain ACH initiatives as described above, they can promote strategies for services such as care coordination that can enhance ACH capacity. State plan amendments could also support ACHs by enabling states to reimburse for care coordination or preventive services through new methods.<sup>17, 18</sup> As states continue to explore such innovative financing strategies, they will need to determine how to best reinvest savings and some have expressed an interest in collaborating with health plans and federal policymakers to develop strategies for investing those savings in communities. Multi-sector partnerships among state agencies can maximize resources available to support ACHs. While all states implementing ACHs engage Medicaid and public health agencies, partnerships that

include state social service and human welfare agencies can amplify state capacity to support ACHs. For example, while Washington State's Medicaid agency, the lead for SIM implementation, also leads ACH implementation, the Department of Health contributes its expertise in population health activities, the Department of Social and Health Services provides guidance on long-term services and supports as well as high end mental health services, the Department of Commerce assists with housing initiatives, and the Department of Corrections advises on policies affecting justice-involved populations.

## Lessons and Themes from State ACH Models

As states continue to test community-based health improvement models that strive to meet the Triple Aim goals, it will be important to consider lessons learned from early state ACH experiences. The following key themes emerged from an analysis of the ACH models in California, Minnesota, Vermont, and Washington:

- State models for ACHs are emerging; they are in the early stages of planning and development. Each state that is rolling out an ACH model emphasized that they are testing various approaches to identify success factors. Once states have identified success factors, they may become more prescriptive in their approaches.
- States are designing ACH models with flexibility for communities to determine their governance, financing, and highest priorities. All four states:
  - Provide flexibility for communities to determine their own governance structures based on community needs, yet each requires multi-sector engagement.
  - Expect ACHs to undertake sustainability planning
  - Allow ACHs flexibility to choose priority conditions or target populations based on community health needs assessments, state health improvement plans, or SIM priorities.
- Although ACH models are designed to allow flexibility for communities to determine and address their needs, states play an important role in supporting the ongoing development and evolution of ACH models. They are aligning ACHs with existing policy, providing seed funding, linking to delivery system infrastructure, convening ACHs to provide technical assistance and disseminate best practices, and supporting sustainability planning.
- State ACH models are designed to address a spectrum of prevention strategies ranging from clinical to community-based interventions. All ACH models include some focus on community health improvement, including strategies to improve the health and wellbeing of a population, along with efforts to integrate care across systems for individuals.
- State ACH models vary state to state and are designed to complement and align with unique delivery system reforms. The models fall along a continuum of integration with health care payment and delivery systems reforms. ACHs are designed to inform, and be informed by, state policy.
- States have yet to identify sustainable financing strategies for ACHs. States shared a variety of possible funding sources and approaches that could include wellness funds, health plans, federal, state, and local grants, Medicaid demonstrations, social impact bonds, and hospital community benefit programs among others. States suggested ACHs will rely on a combination

of funding streams to sustain a variety of interventions after SIM funding expires.

- Integral to state ACH models is the ability to capture and reinvest savings from interventions that improve health and reduce costs. There is keen interest in exploring mechanisms to identify where savings accrue and how best to capture and reinvest them in population health.
- Aligning ACHs with new delivery and payment models, such as risk-based systems that could conceivably reinvest shared savings in prevention activities, could provide an opportunity for sustainable funding streams, yet this strategy also could influence intervention strategies. There is an inherent tension between focusing on clinical strategies that have an earlier return on investment and social determinants that affect health and wellbeing but have a longer return on investment.
- Given the early stage of the state ACH initiatives, state leads are focused on, and likely to measure ACHs on, capacity building, infrastructure, and partnerships rather than interventions and health outcomes.

## Conclusion

State policymakers and their partners in California, Minnesota, Vermont, and Washington State conceived of ACHs as one piece of a comprehensive delivery system reform initiative focused on improving care, reducing costs, and improving health. In each state, ACHs are intended to complement transformations in the payment and delivery system by improving the overall health of communities. Given that each state has its own unique innovation plan, each state ACH model is slightly different. Rolling out ACHs as a component of a broader statewide strategy provides the opportunity to maximize state funding streams, test models to identify critical success factors, provide technical assistance and peer learning opportunities, and spread models. As ACHs emerge, evaluation will be critical, as the models could have implications for other aspects of delivery and payment reform implementation. The evolution of ACHs in these four early states is likely to inform ACH models in other states seeking to address the health and social needs of individual patients and whole communities.

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## Appendix A - California

### Overview

California chose to pursue an Accountable Communities for Health (ACH) model as one of four initiatives of its State Health Care Innovation Plan designed to achieve the Triple Aim. This plan stemmed from the 2012 Let's Get Healthy California Task Force, designed to improve health and achieve greater health equity. The California Health and Human Services Agency (CHHS) received funding to design this model through two State Innovation Model (SIM) Design Grants. A multi-sector work group of stakeholders developed recommendations for an ACH model. The work group outlined five key domains that the participating ACHs will focus on: clinical services, community programs, clinical-community linkages, public policy and system change, and environments. Subsequent to the CHHS-sponsored design process, a group of California funders built on the recommendations of the work group to develop to the California Accountable Communities for Health Initiative (CACHI). As part of CACHI, Community Partners, the lead implementation entity, with support from the funders – The California Endowment, Blue Shield Foundation of California, and Kaiser Permanente – have released a Request for Proposals (RFP) to support up to six ACHs in California in carrying out interventions across these five domains.

## Governance

ACHs selected through the RFP will be responsible for assembling their own governance structures comprised of partners from health care, health and social services, and community organizations. Each ACH is required to engage certain key partners including health plans, hospitals, medical providers serving the ACH population, local health and human services agencies, public health departments, and community and social services organizations that work on the ACH's selected health issue. Each ACH can choose a health need, chronic condition, community or set of related

health conditions to focus its efforts on. Examples of additional potential partners include housing agencies, food systems, behavioral health providers, schools, transportation agencies, and dental providers. Each ACH is required to establish a leadership team that includes representation at both the individual and organizational level, and develop a process for collaborative decision-making. Finally, each ACH must feature an organization to convene partners, guide the development of goals, facilitate and coordinate activities, manage the budget, and evaluate overall outcomes of the work.

### California ACH Fast Facts

**Number of ACH demonstration sites:** up to 6

**Funding allocated to each ACH:**

Year 1: \$250,000

Years 2-3: \$300,000

**Implementation Dates:** Grants start July 1, 2016

## Targeted Populations and Conditions

Communities responding to CACHI's RFP are encouraged to choose a health issue on which to focus their interventions. The only criteria for the selection of such health issues is they must have broad support within the community, be amenable to evidence-based interventions across the five domains listed above, and any intervention must target a wide variety of populations and stages of the health condition (e.g. already present, at risk, not yet developed), not just the high need and high cost population.

## Financing Model

Successful ACH applicants will receive a grant of up to \$250,000 for one year, with an optional 6-month extension period to achieve program milestones. ACHs that meet year one milestones will then be eligible to receive an additional \$300,000 per year for two years, amounting to a maximum of \$850,000 per ACH in grant funding through CACHI. This grant funding is largely intended to support start-up activities such as staffing the collaborative and governance structure, coordinating community systems to identify or refer intervention participants, and developing plans for sustainability and data sharing. Beyond grant funding, ACHs are required to implement a wellness fund that may braid and/or blend funding from a variety of other sectors and community organizations. Wellness funds will support essential ACH infrastructure and finance certain priority ACH interventions that have no other available funding sources. Wellness funds are an important vehicle for ACH sustainability; the work group envisions savings that ACH initiatives generate from cost avoidance being reinvested in wellness funds to support ACHs long-term.

## Resources offered to ACHs

CACHI has committed to providing technical assistance to the grantees to aid in the development of a governance structure, data analytics and sharing mechanisms, the development of a plan for financial sustainability including wellness funds, and the alignment of various ACH interventions. In addition to this technical assistance, CACHI also plans to sponsor a learning community for grantees to share successes, challenges, and best practices. This will involve annual convenings of all grantees, as well as smaller meetings with specific stakeholders from each ACH. Additionally, the SIM design grant is

funding the development of an ACH evaluation framework, the identification of data sharing needs and the development of a toolkit for ACH partner organizations.

## Next Steps

Selected grantees will have a list of milestones to accomplish in their first year in order to ensure that ACH activities in the second and third years are successful. These include the creation of the ACH's infrastructure and governance model; agreement on the selected health issues for intervention focus and alignment of interventions to at least three of the five key domains; demonstration of capacity for data sharing among members of an ACH; coordination with the evaluator to identify key outcomes, indicators, and baseline data to track; and progress towards a plan for achieving financial sustainability.

# Appendix B - Minnesota

## Overview

Minnesota's Accountable Communities for Health (ACH) initiative seeks to improve the overall health of communities across the state through the delivery of person-centered, coordinated care that addresses the clinical and social needs of a defined population. To accomplish this goal, ACHs are responsible for fostering community-clinical linkages that improve patient care and developing a population-based prevention plan specific to their communities. The ACH model is a core component of the three-year State Innovation Model (SIM) Testing grant Minnesota received in 2013. Under SIM, Minnesota is testing the effectiveness of its Accountable Health Model in improving health, providing better care, and reducing health care costs for Minnesota residents. The Minnesota Department of Health (MDH) and the Minnesota Department of Human Services (DHS) jointly lead the state's SIM initiative with support from the governor's office. Of the \$45 million Minnesota received to implement the Accountable Health Model under SIM, the state has allocated approximately \$5.6 million to support 15 ACH projects that currently engage 180 clinical and social service providers.

The ACH program builds on the success of multiple payment and delivery system reform initiatives in Minnesota including health care homes, community care teams, and accountable care organizations (ACOs). Community care teams, locally based teams responsible for coordinating multiple health and social services for patients, are considered to be the foundation for ACHs. The three original community care teams Minnesota implemented in 2011 were the first communities to receive ACH funding in late 2014. Minnesota's ACOs are also closely aligned with the ACH initiative, as the state requires each ACH to partner with an ACO. Through this partnership, the state is assessing the ability of ACHs to improve health outcomes and reduce costs for an ACO by coordinating support systems and integrating health-related services for its patients.

## Governance

ACHs have developed diverse governance bodies corresponding with the state's intent for the ACH decision-making entity to reflect key partners and its target population. Rather than prescribing a specific governance structure for ACHs, the state has established a set of broad guidelines. ACH leadership must be locally based and include an array of providers and community partners in addition to members of the community and population served. Minnesota required ACH leadership structures to be in place prior to applying for funding and charged leadership with the responsibilities of identifying ACH priorities and developing coordinated strategies to address the needs of ACH target populations.



Beyond requirements for ACHs to partner with an ACO, it is largely at the discretion of the ACH to select appropriate partners that meet the health and social needs of the target population. Examples of additional ACH partners include primary and acute care providers, behavioral health providers, local public health departments, long-term care services, community services organizations, and social services such as employment, food, and housing.

## Targeted Populations/Conditions

Minnesota's ACH model is fundamentally driven at the local level. Priority conditions are identified by the state, but communities are responsible for proposing ACH target populations with significant health and social needs. ACHs can be designed to serve a population in either a defined geographic area or a specific community with an identified need. For example, one of Minnesota's ACHs serves Medicaid beneficiaries and uninsured, low-income residents in three specific counties while another targets patients with developmental and intellectual disabilities served by a particular ACO. As such, ACHs may not reach the entire state but can also have overlapping geographic boundaries.

## Financing Model

After a competitive application process, Minnesota disbursed grants in the amount of \$370,000 to 12 ACH applicants in addition to 3 pre-existing community care teams, accounting for 15 total ACHs. The grant money is intended to support the costs of developing ACH infrastructure, organizing leadership team activities, and coordinating care across community partners. Start-up grant funding expires at the conclusion of the SIM testing grant period, in December 2016. ACHs are responsible for developing sustainability plans that can incorporate funding from a variety of federal, state, and local resources.

## State Resources offered to ACHs

In addition to initial grant funding, Minnesota offers training and technical assistance to support certain ACH activities including sustainability planning, leadership development, care coordination, and establishing community-clinical linkages. MDH and DHS are facilitating a mandatory ACH learning community to disseminate best practices and supply expert resources. Finally, the state anticipates many medical service providers partnering with ACHs will be able to contribute data on quality measures available through the Statewide Quality Reporting and Measurement System in order to guide quality improvement efforts.

## Next Steps

To ensure ACH activities endure after SIM, ACHs are developing sustainability plans that align with Minnesota's Accountable Health Model. ACHs are working to identify viable financing mechanisms and measurement strategies to assess ACH progress. The state is supporting ACHs in these endeavors and encouraging ACHs to consider aligning with emerging opportunities such as the Accountable Health Community initiative from the Center for Medicare and Medicaid Innovation or the Community Transformation Grant program from the Centers for Disease Control and Prevention.

### Minnesota ACH Fast Facts

**Number of ACH demonstration sites:** 15

**Funding allocated to each ACH:** \$370,000 total for 2 years

**Implementation Dates:**

February 2015 – December 2016

## Appendix C - Vermont

### Overview

Vermont is currently in the planning stages for a statewide Accountable Communities for Health (ACH) initiative that will build off existing state and local health innovations. The state is pursuing its ACH initiative as part of the Vermont Health Care Innovation Project (VHCIP), its State Innovation Model (SIM) Testing Grant. In 2013, Vermont received \$45 million in SIM funding to work towards achieving the goals of the Triple Aim by integrating health care delivery and payment system reforms with advanced health information technology. Vermont is currently using a portion of SIM funds to implement a 12-month Peer Learning Lab that will gauge the readiness of communities to launch ACHs and identify resources necessary to support this initiative.

ACHs in Vermont will build off the Unified Community Collaborative (UCC) initiative, a Blueprint for Health/VHCIP project with the goal of connecting statewide delivery transformations at the local level to improve care for targeted patient populations. UCCs specifically strive to integrate the work occurring under the Blueprint for Health, primarily medical home and community health team implementation, with Vermont's accountable care organizations (ACOs). Vermont structured the UCCs to align with its 14 Health Services Areas (HSAs) and required them to use a shared governance structure that includes local leaders from ACOs, the Blueprint for Health, and other community organizations such as housing. While UCCs currently emphasize developing community-clinical linkages to integrate services for individuals, Vermont envisions potential ACHs as evolving from UCCs to incorporate community-wide prevention strategies and policies to promote health and wellness for the whole population in addition to integrated services for specific individuals.

### Governance

While Vermont recommended a specific governance structure for UCCs (a maximum of 11 members representing certain organizations, agencies, and providers), the communities participating in the ACH Peer Learning Lab will have greater flexibility in building a leadership body that addresses the needs of the communities they serve. As Vermont intends for UCCs to serve as building blocks for ACHs, the governance structure of each community participating in the ACH Peer Learning Lab will likely reflect existing partnerships forming under the UCC initiative. Applicants for the ACH Peer Learning Lab were encouraged to include UCC participants such as ACOs, Blueprint for Health partners, and hospitals in addition to at least four leaders with decision-making authority from within their organizations, an array of community leaders, and other partners focused on community disease prevention such as district health departments and community prevention coalitions.

Similar to other states, all communities participating in ACH Peer Learning Labs in Vermont will have a backbone organization to convene partners and guide activities. A variety of organizations may serve in this position, however Vermont anticipates that the role may often be filled by hospitals, as they are well suited to take on this role for several reasons. First, all Vermont hospitals are non-profits that have historically demonstrated a strong commitment to community health improvement initiatives, even prior to the hospital

#### Vermont ACH Fast Facts

**Number of possible ACH demonstration sites:**  
up to 14

**ACH Peer Learning Lab Timeframe:**  
February 2016-February 2017

community benefit program. Additionally, hospitals in Vermont have divided service areas that generally align well with district health departments and HSAs, meaning they are well positioned to align with ACH Peer Learning Lab service areas.

## Targeted Populations and Conditions

Communities participating in the ACH Peer Learning Lab will propose their own focus areas by evaluating existing data sources to identify the greatest community needs and areas where an ACH can have the greatest impact. These communities will be able to review data from a number of sources such as regional HSA profiles developed through the Blueprint for Health, community profiles generated by the Department of Health, hospital community health needs assessments, and data collected through ACOs. Once the community selects a topic, they will work with the state to identify evidence-based strategies in three domains: traditional clinical approaches, innovative patient centered care and/or community linkages, and community-wide strategies. Given that ACHs focus on the entire population in a defined geographic area, they will place a greater emphasis on implementing community-wide strategies that promote overall population health and reduce disparities. Some examples of community activities may include promoting access to physical activity and healthy foods through new zoning regulations, banning the sale of alcohol and tobacco products near schools, or expanding affordable housing options.

## Financing Model

Vermont is currently using funding from SIM to support both the UCC initiative and ACH Peer Learning Lab, until SIM funding expires in June 2017.

## State Resources offered to Communities in the ACH Peer Learning Lab

As part of the Peer Learning Lab, the state will provide training, technical assistance and facilitative support during the project year. Communities will be able to leverage certain resources and supports from existing initiatives such as the Blueprint for Health, ACOs and the broad range of evidence-based activities supported through the state's public health agencies. Vermont will determine additional resources as the ACH initiative rolls out.

## Next Steps

Vermont is currently exploring sustainable funding mechanisms including a waiver for an all-payer model that contains strategies to improve population health. Ideally, the state envisions developing a payment and delivery system that can sustain ACHs through re-invested savings from health care costs.

# Appendix D - Washington

## Overview

Washington State developed the Accountable Communities of Health (ACH) model in an effort to bring better health, higher quality care, and lower costs to communities across the state. The state recognizes that health improvement requires local collaboration between health system partners and other community organizations. This model aims to create a partnership between the state and community based, cross-sector coalitions that work to improve health within their respective regions. Primary support for Washington's ACHs, a component of the state's Healthier Washington initiative, comes from the Washington State Healthcare Authority (HCA) in partnership with the Department of Health (DOH)

and the Department of Social and Health Services (DSHS). Washington received a Round Two State Innovation Model (SIM) Model Test Award in December 2014, and is using this federal funding to launch Healthier Washington. There are nine ACHs in Washington, covering the entire state and aligning geographic boundaries with the state's Medicaid regional service areas. Beginning with the two pilot ACHs, Cascade Pacific Action Alliance and North Sound, all nine ACHs received designation between July 2015 and January 2016. Designation is a state benchmark indicating that the ACH has achieved multi-sector representation, launched community engagement activities, identified initial regional health needs, performed basic administrative and financial functions, and established an initial budget with a plan for continued funding.

### Washington ACH Fast Facts

**Number of ACH demonstration sites:** 9

**Funding allocated to each ACH:**

2 Pilot ACHs: \$150,000

7 Design ACHs: \$100,000

9 ACHs Post-Designation: \$810,000 total

**Implementation Dates:**

July 2015 – February 2019

## Governance

While there are general guidelines outlined in the state's funding criteria, ACHs in Washington are self-governed and partners are responsible for designing a governance structure that works best for that specific region. The HCA and the agency's evaluation partner, the Center for Community Health and Evaluation, provide formative feedback to guide ongoing development and adjustment. Across the nine ACHs, governing bodies range from 15-44 participants and vary in decision-making approaches including voting or group consensus. Additionally, depending on the geography and population of the ACH, some have additional groups or committees at the regional or local level that do not have decision-making power but provide input to the governing body. Each also relies on administrative support; these support organizations also vary among the nine ACHs. The role of the support organization is filled by a local public health agency in four of the ACHs, a community-based organization in three, and a single non-profit organization that doubles as the ACH itself in the remaining two. In keeping with the ACHs' goal of multi-sector collaboration, all nine currently involve local public health, multiple health system partners including managed care organizations, and social services or human services organizations. Most ACHs also include education partners, either from school districts or college systems, and over half of the ACHs involve local businesses and local government representatives. Many ACHs are also working to engage tribes, tribal organizations, and consumer representatives, although many of these spaces have not yet been filled.

## Targeted Populations and Conditions

Each ACH is responsible for developing their initial regional health improvement projects, including one SIM project to advance the Triple Aim. Short-term impact will be assessed using project-specific measures and long-term impact will be assessed using the state's Common Measure Set. The ACHs are identifying regional health priorities that will guide the selection of these projects. Major themes across all nine include access to care; care coordination and care transitions; behavioral health integration; chronic disease prevention and management, specifically diabetes prevention and management; oral health access; and population health improvements such as housing linkages, food security, economic and educational opportunities, and health equity.

## Financing Model

The two pilot ACHs received \$150,000 set aside by the legislature in January 2015. The HCA awarded design funding of \$100,000 to the remaining seven ACHs through Washington SIM grant funding and all nine ACHs received an additional \$150,000 upon designation. For the remaining years of the SIM grant after designation, ACHs will receive a total of \$810,000 with some flexibility regarding spend-down toward sustainability. This funding is supplemented with grants and contributions from other private and public sector organizations. ACHs are currently working with the state to develop plans for financial sustainability that will rely on the value proposition of the ACH, including a model to support the reinvestment of savings that the ACHs are able to generate in their region.

## State Resources offered to ACHs

In addition to funding from the state's SIM grant, Washington is offering other resources to the nine ACHs to achieve their goals. As part of Healthier Washington, HCA and DSHS have submitted a five-year Medicaid Transformation Demonstration Waiver to the Center for Medicare and Medicaid Services (CMS). The first of the three initiatives included in this waiver aims to give ACHs the resources to pursue various delivery system transformation projects, and it is likely that such projects will align and aid the regional health improvement projects outlined by the ACHs. The state has also contracted with the Empire Health Foundation, supported by the Health Philanthropy Partnership, to provide technical assistance to ACHs; the current focus is sustainability planning and shared learning through quarterly convenings of the nine ACHs.

## Next Steps

Going forward, Washington's nine ACHs will be responsible for choosing and implementing their regional health improvement projects and participating in various health transformation activities through 2019 as other initiatives under Healthier Washington launch. HCA and ACHs will also work to sustain the health systems transformation that occurs, including financial sustainability of ACHs based on demonstrated value to their communities and the Healthier Washington initiative.

## Endnotes

1. Donald Berwick, Thomas W. Nolan, and John Whittington, "The Triple Aim: Care, Health, and Cost," *Health Affairs* 27 no.3 (2008): 759-769. Available at: <http://content.healthaffairs.org/content/27/3/759.full>
2. The New York Academy of Medicine. *A Compendium of Proven Community-Based Programs*. New York, NY: New York Academy of Medicine, 2009. Available at: [http://healthyamericans.org/assets/files/NYAM\\_Compendium.pdf](http://healthyamericans.org/assets/files/NYAM_Compendium.pdf)
3. Institute of Medicine. *An Integrated Framework for Assessing the Value of Community-Based Prevention*. Washington, DC: The National Academies, 2012. p.31. Available at: [http://books.nap.edu/openbook.php?record\\_id=13487&page=31](http://books.nap.edu/openbook.php?record_id=13487&page=31)
4. Carla Plaza, Abigail Arons, Jill Rosenthal, and Felicia Heider, *Financing Prevention: How States are Balancing Delivery System & Public Health Roles* (Oakland, CA: Changelab Solutions, 2014). Available at: <http://www.changelabsolutions.org/financing-prevention>
5. A backbone or integrator organization helps carry the vision of the ACH; build trust among collaborative partners; convene meetings; recruit new partners; shepherd the planning, implementation, and improvement efforts of collaborative work; and build responsibility for many of these elements among collaborative members. For more information, please visit: <http://www.preventioninstitute.org/component/jlibrary/article/id-366/127.html>
6. Community Partners. "California Accountable Communities for Health Initiative: Request for Proposals." Available at: <http://www.communitypartners.org/sites/default/files/documents/cachi/rfp/CACHI%20RFPcc20Updated%204-6-16.pdf>
7. John Auerbach. "The 3 Buckets of Prevention," *Journal of Public Health Management & Practice* 22 no.3 (2016): 215-218. Available at: [http://journals.lww.com/jphmp/Citation/2016/05000/The\\_3\\_Buckets\\_of\\_Prevention.1.aspx](http://journals.lww.com/jphmp/Citation/2016/05000/The_3_Buckets_of_Prevention.1.aspx)
8. <http://www.chhs.ca.gov/LGHC/Let%27s%20Get%20Healthy%20California%20Task%20Force%20Final%20Report.pdf>
9. A consortium of funders (The California Endowment, Blue Shield Foundation of California, and Kaiser Permanente), are collaborating to jointly support a three-year, California Accountable Communities for Health Initiative (CACHI). For more information, please visit: <http://www.communitypartners.org/cachi-faq>
10. State of Vermont Agency of Administration Health Care Reform. "Report to the Vermont Legislature Vermont Health Care Innovation Project Quarterly Report." Available at: <http://legislature.vermont.gov/assets/Legislative-Reports/VHCIP-Report-to-the-Legislature-February-2016.pdf>
11. Washington State Health Care Authority. "Washington State Awards \$300,000 in grants to two Accountable Communities for Health." Available at: <http://www.hca.wa.gov/Releases/ACH%20grants%20awarded%201-2-15.pdf>
12. Braided funding occurs when stakeholders coordinate funding from individual sources, with each individual funding source keeping its specific identity.
13. Blended funding occurs when stakeholders merge funding from individual sources into one funding stream, with each individual funding source losing its specific identity.
14. For more information, please visit: [http://www.hca.wa.gov/hw/Pages/mt\\_initiative1.aspx](http://www.hca.wa.gov/hw/Pages/mt_initiative1.aspx)
15. Minnesota Department of Human Services. "Minnesota Accountable Health Model – SIM Minnesota: Learning Collaboratives." Available at: [http://www.dhs.state.mn.us/main/groups/sim/documents/pub/dhs16\\_197632.pdf](http://www.dhs.state.mn.us/main/groups/sim/documents/pub/dhs16_197632.pdf)
16. Leslie Mikkelsen and William Harr, *Accountable Communities for Health: Opportunities and Recommendations* (Oakland, CA: Prevention Institute, 2015). Available at: <http://www.preventioninstitute.org/component/jlibrary/article/id-366/127.html>
17. Centers for Medicare & Medicaid Services. "Health Home Information Resource Center." Available at: <https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/health-home-information-resource-center.html>
18. Through a rule change from the Centers for Medicare & Medicaid Services, state Medicaid agencies are now allowed to reimburse unlicensed practitioners, such as CHWs, for covered services as long as a licensed practitioner recommends the services. For more information on this rule change, visit: <https://www.gpo.gov/fdsys/pkg/FR-2013-07-15/pdf/2013-16271.pdf>

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