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Lessons from Accountable Health Communities Model Participants: Preparing for Future Innovation

Collaboratives in Action

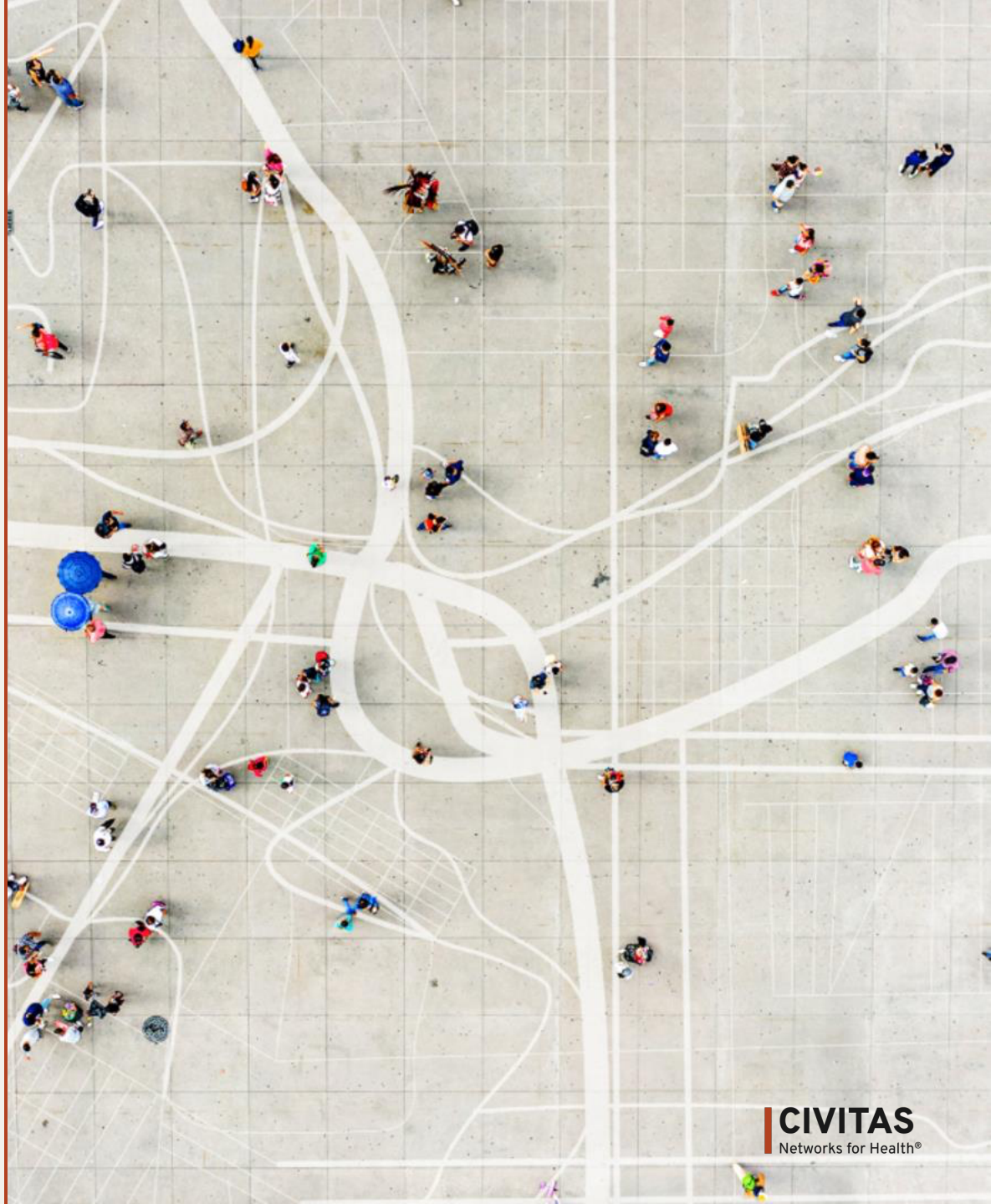
August 25, 2026

Agenda

- Welcome, Civitas Updates, & Introducing the Accountable Health Communities (AHC) Model Evaluation Report
  - Jolie Ritzo, CEO, Civitas Networks for Health®
- Lessons from AHC Model Participants: Preparing for Future Innovation
  - Ashley Humienny, Senior Director, Digital Systems & Solutions, Camden Coalition
  - Audrey Hendricks, Senior Operations Manager, Camden Coalition
  - Marisol Caban, Associate Director, Community Engagement and Capacity Building, Camden Coalition
  - David Kendrick, Senior Advisor & Consultant, University of Oklahoma & Civitas Networks for Health®
  - Karen Ostrowski, Director, Health Policy and Partnerships, Civitas Networks for Health®
- Discussion and Q&A

Housekeeping Reminders

- This is a webinar where all participants are automatically muted and your video is not displayed.
- If you would like to ask a question, please use the Q&A function on the right-side taskbar.
- This webinar is being recorded, and the recording will be shared after today's event.
- For questions following the webinar, please reach out to contact@civitasforhealth.org.



About Civitas Networks for Health®

Who we are, who we serve, and about what we do

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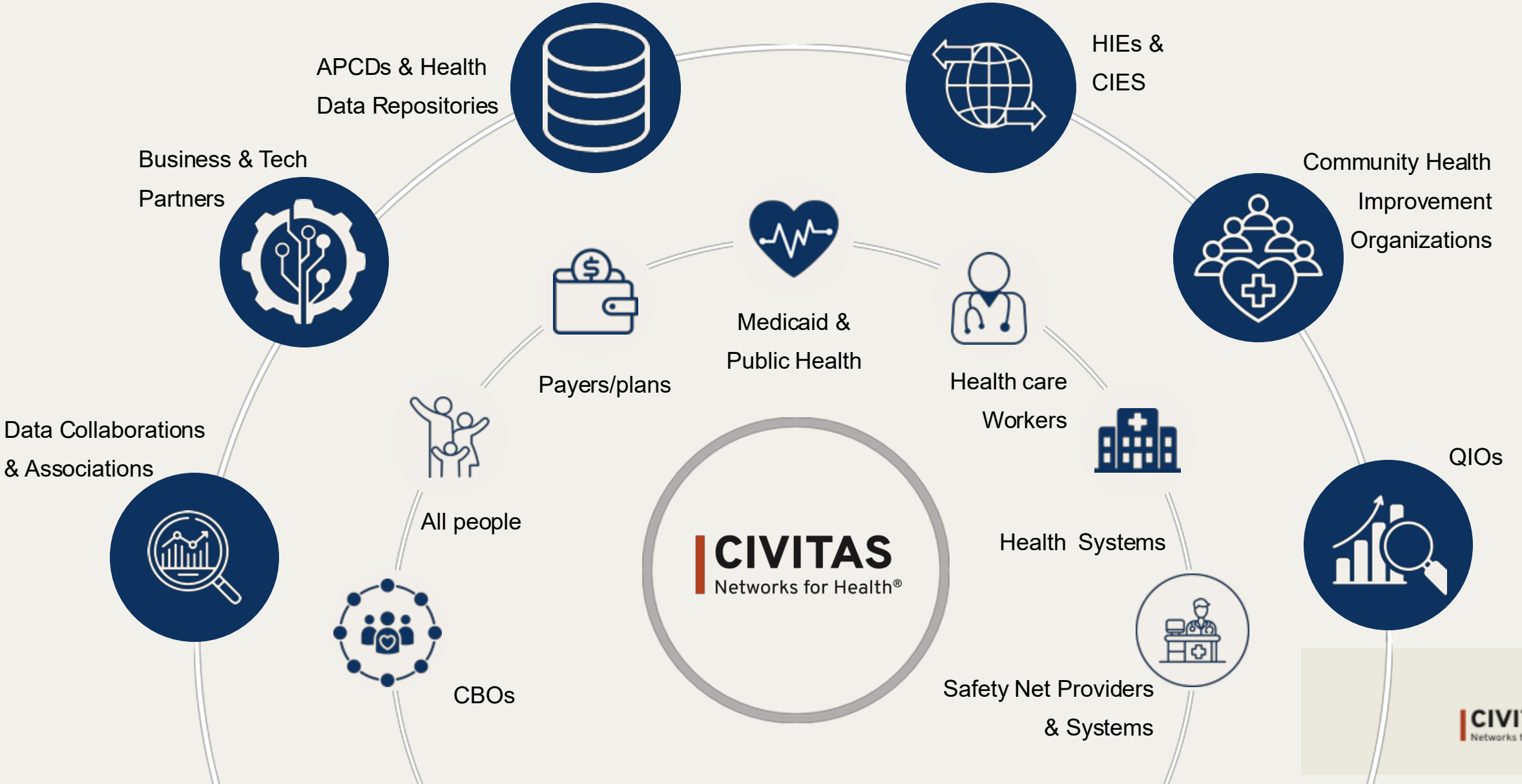
Who We Serve



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Expert Convenors

- Civitas provides a unique platform that connects collaborators working on health improvement across the U.S.
- We believe that local communities should lead and influence national progress on health.
- We offer forums for shared learning, education, networking, and advocacy, and have proven our ability to help our members navigate the ever-changing health landscape.
- We create opportunities and pathways for aligned groups to work together on key priorities, overcoming barriers and developing health solutions, so others don’t have to start from scratch.

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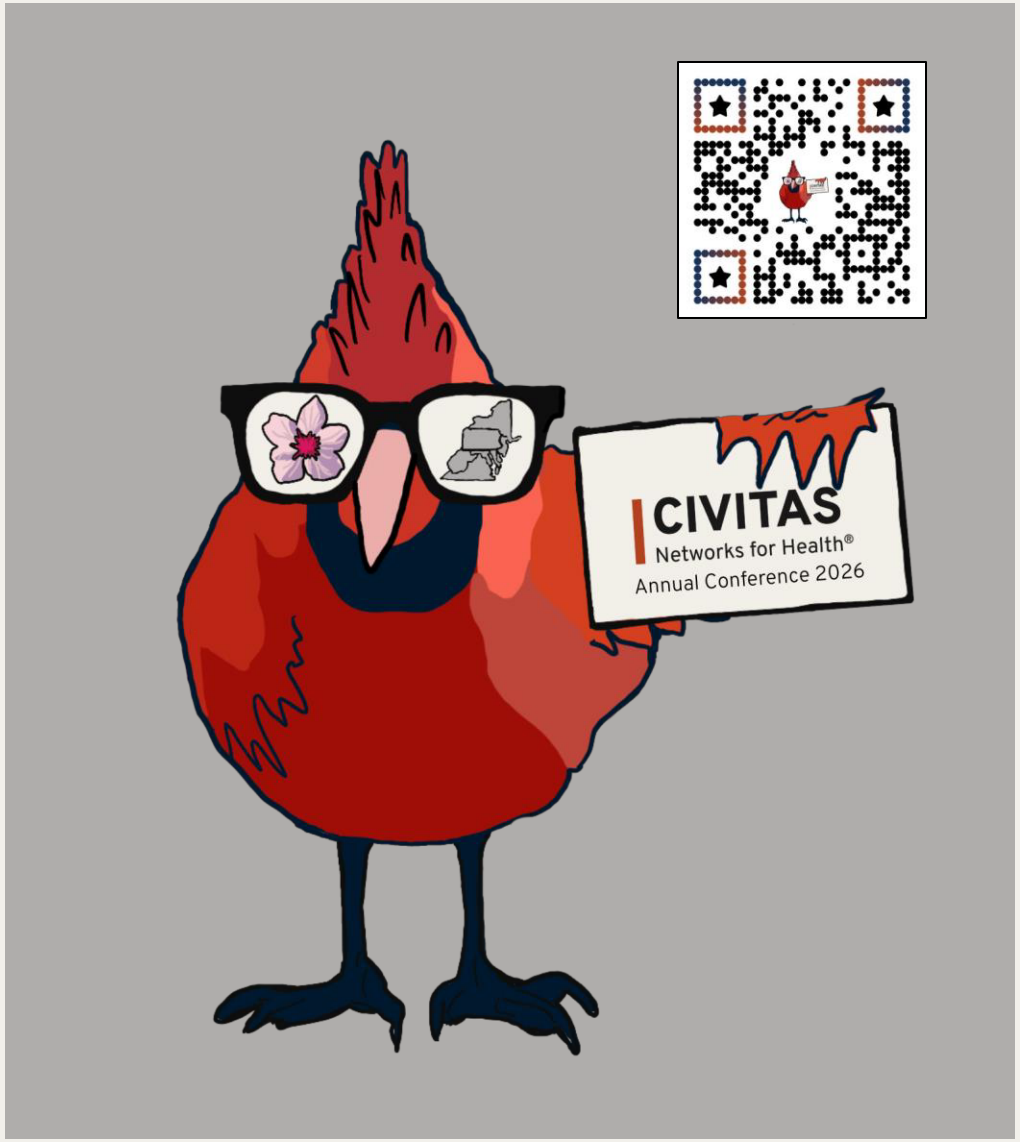
Join Us at the Civitas 2026 Annual Conference!

Join 750+ leaders from across the health data and improvement ecosystem. Hosted in collaboration with our Mid-Atlantic Host Committee, just minutes from Washington, D.C. in Arlington, VA.

- Registration is open – secure your spot today!
- Plan early and save with discounted hotel and flight options.
- Get your Civitas merchandise before the conference – 100% of proceeds go to Doorways for Women and Families Virginia.
- Interested in sponsoring? We still have a select few opportunities available for you to get in front of a national audience shaping interoperability, data exchange, and health transformation. Review the Sponsorship Prospectus and email contact@civitasforhealth.org if you're interested in learning more.



Submit a Community Excellence Award Nomination by August 31

The Civitas 2026 Community Excellence Awards recognize outstanding Civitas member organizations and individuals advancing community health through innovation, leadership, and partnership. These awards highlight impactful contributions in areas such as data use, quality improvement, governance, and mentorship. Please browse this year's award categories below and submit a Civitas member organization or one of your peers that you think exemplifies the award description.

Thank you in advance for helping us recognize the amazing organizations across our networks!

Learn more and submit a nomination by August 31 to be considered.

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Register to Attend the Remaining Virtual Preconference Sessions (Open to the Public!)

Join us for virtual preconference sessions designed to deepen learning and spark meaningful discussion ahead of the Civitas Annual Conference. Register to attend:

- **September 10, 3-4:30 p.m. ET** – From Data to Impact: Using APCD Analytics to Shape Policy and Improve Population Health
- **September 16, 2-3:30 p.m. ET** – Co-Designing Trusted CIEs: Privacy, Coordination, and Data Systems for Whole Person Health

Thank you to our returning virtual preconference sponsor, J2 Interactive!

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Conference Keynotes to Look Forward To

- **Tuesday, September 22** –
  - *Bridging Federal and State Policy with Local Implementation for Transformation*, featuring Dr. Ayanna Bennett (DC Department of Health), Dr. B. Cameron Webb (Virginia Department of Health), and Dr. Joseph Kanter (Association for State and Territorial Health Officials; Panel Moderator)
  - *Driving the Next Wave of Value-Based Care Through CMMI*, featuring Abe Sutton (CMMI; CMS) and Theresa Dreyer (Health Care Transformation Task Force)
- **Wednesday, September 23** – *Real World Considerations for Deploying AI in High-Stakes Environments*, a fireside chat hosted by Civitas CEO Jolie Ritzo with Dr. S. Craig Watkins (IC^2 Institute at the University of Texas at Austin).
- **Thursday, September 24** –
  - *Putting Patients at the Heart of Health Care and Health Technology*, featuring Anthony Polizzi (Chief Patient Experience & Innovation Officer, CMS), Regina Holliday (Resident, Art Teacher, Artist, Muralist, Patient Rights Arts Advocate, & Founder, Walking Gallery & the Medical Advocacy Mural Project), Sarah DeSilvey (Terminology Director, Gravity Project), and Jessica Little (Chief Operating and Programs Officer, Civitas; Moderator)
  - As part of our *Public Policy Briefing*, sponsored and hosted in partnership with Troutman Strategies, there will be a fireside chat featuring Dr. Tom Keane (National Coordinator for Health IT) and Craig Behm (President & CEO of CRISP - Chesapeake Regional Information System for our Patients and Chair of the Civitas Government Relations and Advocacy Committee (GRAC))

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Thank You to Our Civitas 2026 Annual Conference Upgrade Sponsors

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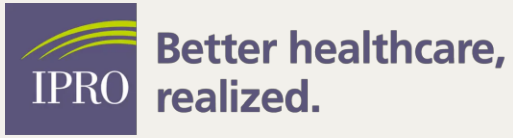
...And Thank You to Our Civitas 2026 Annual Conference Silver & Host Committee Sponsors



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Strengthening Civitas' Salesforce Capabilities with J2 Interactive

Through our partnership with J2 Interactive, Civitas is enhancing Salesforce to better support our operations, member engagement, and organizational growth.

- **System Integration**: Connecting Salesforce with essential third-party platforms to improve data flow and operational efficiency
- **Workflow Optimization**: Configuring and automating workflows to streamline key business processes
- **Reports and Dashboards**: Developing customized tools that provide clearer, more actionable insights
- **Ongoing Support**: Providing Salesforce administration, testing, deployment, consultation, and staff training
- **Greater Member Value**: Building a stronger foundation for tracking engagement, managing organizational information, and helping Civitas maximize the value of its data

J2 INTERACTIVE

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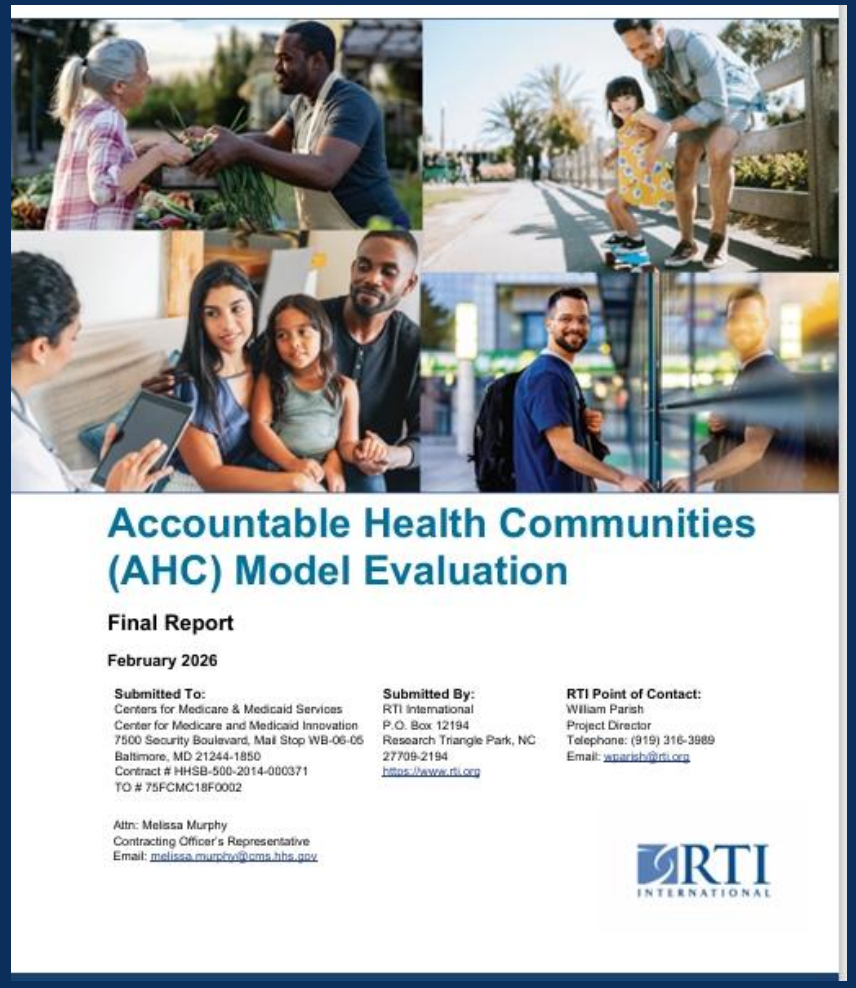
CMS AHC Model Evaluation Report

Key Findings from the Report:

- Total Savings: The model saved over $200 million by screening and connecting patients to vital community resources.
- Medicaid Impact: Nearly 80% of total savings came from Medicaid-only beneficiaries, who made up about 70% of all participants in the model.
- Utilization Reductions: The initiative led to a 3% reduction in overall hospitalizations and avoidable emergency department visits for connected beneficiaries.
- Core Needs Addressed: Programs focused on five main social determinants of health: housing instability, food insecurity, transportation problems, utility difficulties, and interpersonal violence.



Today's Presentation: Lessons from Accountable Health Communities Model Participants: Preparing for Future Innovation

Audrey Hendricks, Marisol Caban, and Ashley Humienny, Camden Coalition

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Who we are

The Camden Coalition is a multidisciplinary, community-based nonprofit working to improve care for people with complex health and social needs in the city of Camden, across New Jersey, and around the country.

Designated as NJ Regional Health Hub, the model functions through legislation:

- Convene stakeholders around state Medicaid priorities.
- Operate and use a Health Information Exchange (HIE).
- Serve Medicaid and other state departments as a local expert, strategic planning partner and program implementer.
- Run pilots and demonstrations to innovate on population and clinical health interventions
- Perform quality improvement activities based on population-level data.

Camden Coalition was the bridge organization for South Jersey's AHC model

33,395
Total SDOH screens

7,202
Beneficiaries navigated

40
Screening sites

- ✓ Convened clinical and community partners around screening and navigation services
- ✓ Developed and maintained community resource inventory (My Resource Pal, hosted by Findhelp)
- ✓ Deployed our HIE data & capabilities to support workflows
- ✓ Monitoring interventions at clinical delivery sites
- ✓ Data collection and reporting

Keys to success: unique implementation approach

No Cookie-Cutter Approach

Every site location required a unique strategy tailored to its staff and patient population

Frontline Staff Engagement

Engaging frontline staff early rather than relying solely on leadership led to significantly better program translation and by-in across sites.

Staff on the ground understood patient dynamics & could adapt screening workflows to fit clinical conditions.

Tailored Site Protocols

Customized screening protocols for each location adjusting frequency, timing, and staff models to match site capacity.

Identified on-site champions and developed tailored scripts to engage patients in screening conversations.

Keys to success: depth of relationships

Regional coordination

Partnerships carried the work across organizations

Frontline staff

Staff shaped how the work actually ran: “buy-in" mattered more than tech and tools

Navigation = the difference maker

Navigators were consistent points of contact and went beyond addressing specific resource needs

Camden Coalition

Keys to success: data & systems

Pivoting for COVID-19

Existing HIE infrastructure enhanced our outreach process once we moved telephonically

Focusing on health equity within larger AHC model

HIE let us target screening and navigation activities within the AHC workflow, allowing us to respond to the ever-changing health and social needs from patients

Improving triage & coordination

Data integrations boosted triage and coordination — closing gaps with members who fell out of contact and reducing duplication across care programs

Our Regional Health Hub status is the infrastructure to scale

Regional infrastructure as an intervention itself

RHHs are the connective tissue that links healthcare, public health, Medicaid, CBOs, and state agencies across the region.

Dedicated governance and implementation capacity

Formal governance and dedicated capacity ensure accountability, alignment, and effective implementation at the regional level.

HIE-enabled regional data coordination

HIE-enabled data sharing and regional data coordination increase visibility, inform decisions, and drive measurable impact.

Flexibility for regional variation within statewide alignment

RHHs allow for regional approaches that reflect local needs and resources while aligning with statewide goals and priorities.

Ongoing support for Medicaid transformation

RHHs provide ongoing technical assistance, resources, and support to advance and sustain Medicaid transformation efforts.

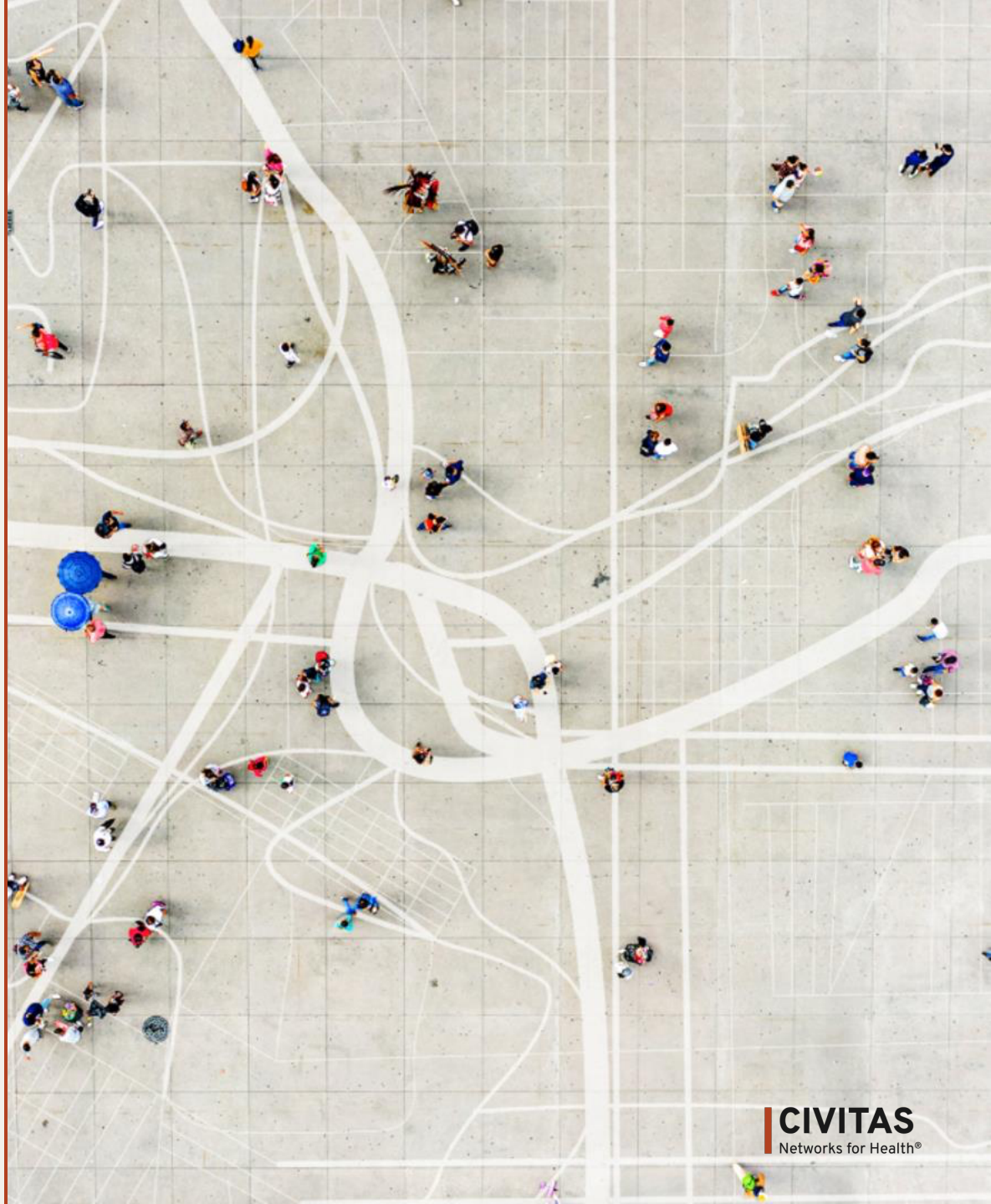
The RHH model operationalizes AHC lessons at scale by creating infrastructure, governance, and regional capacity needed to sustain cross-sector collaboration and improve outcomes.

“

People do not experience their lives in silos.
Our systems should not operate in silos either.

Experience with the AHC Model

David Kendrick, University of Oklahoma & Civitas



Accountable Health Communities

Route 66 Consortium

2016-2024

Contact
David-Kendrick@ou.edu

MyHealth Access Network

MyHealth ACCESS NETWORK

Oklahoma's State Designated HIE/HDU

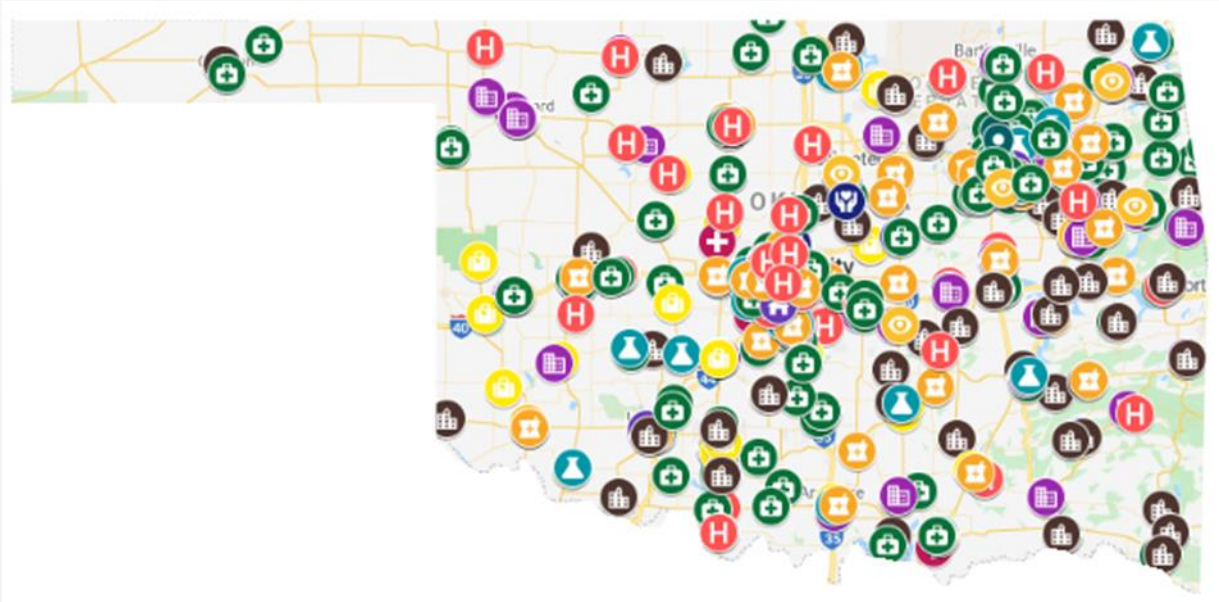
Link medical providers	Exchange timely information	Improve delivery of local healthcare

Health Information Exchange that seeks to deliver the right information to the right doctor, at the right time, to care for patients

MyHealth Access Network

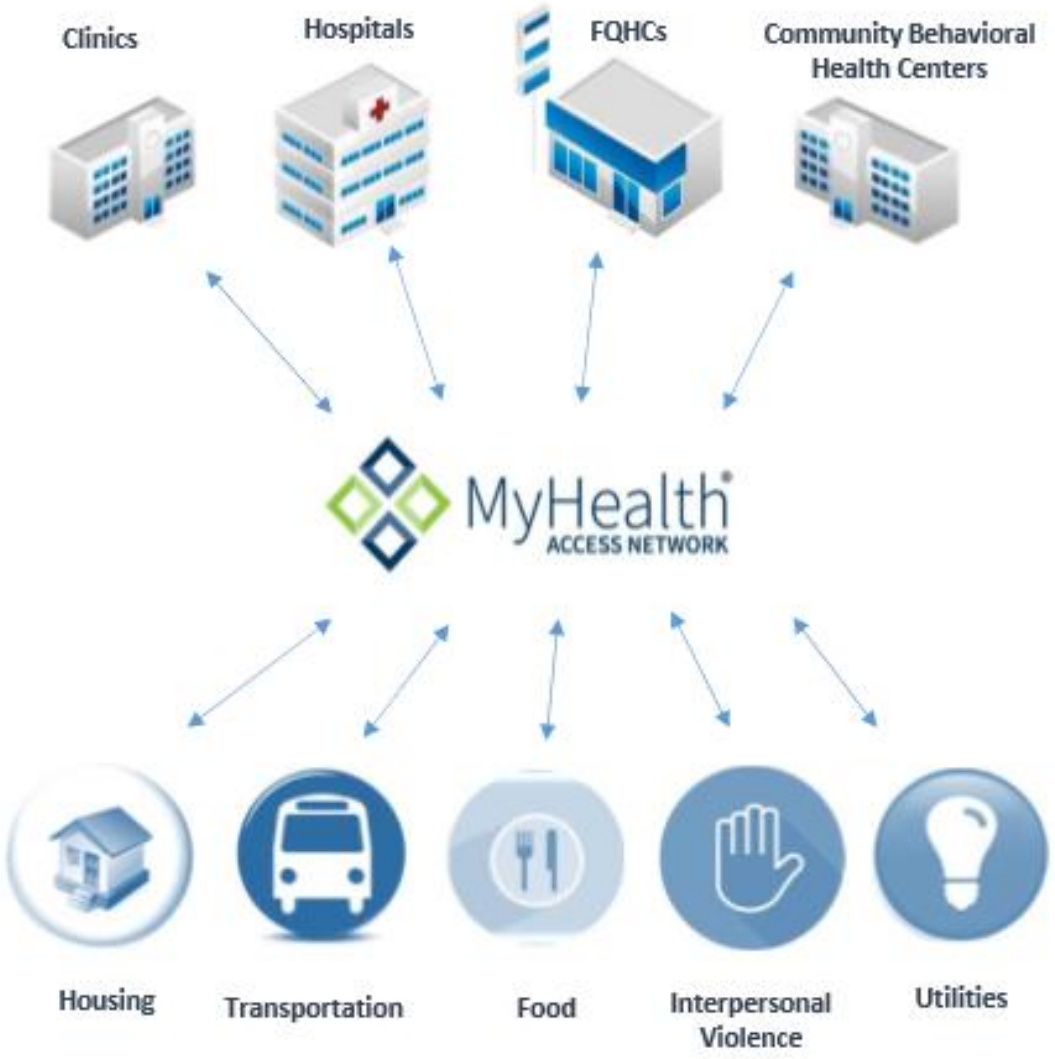
MyHealth Access Network is a non-profit health information exchange created by a coalition of health care industry stakeholders across Oklahoma. Through this coalition, members securely share electronic health records to achieve better, safer, and lower cost care for all.

- Over 15 years of experience exchanging health information across Oklahoma
- Handles more than 130K clinical encounters a day from more than 600 members with more than 2,200 sites of care
- Provides 24-7 access to a comprehensive health record for more than 3 million patients in Oklahoma
- Currently receives real-time ADT information for >90% of Oklahoma hospital activity



Bridge Organization Responsibilities

- Provide screening for patients to assess social needs
- Minimize burden of screening for clinics
- Use standardized screening tool to measure study outcomes
- Provide individualized Community Resource Summary to patients with identified social needs
- Refer high-risk patients for navigation services
  - *Provided by Tulsa and Oklahoma City Health Departments*
- Build relationships with community resource agencies to ensure quality referral processes



Accountable Health Communities: 2016-2024

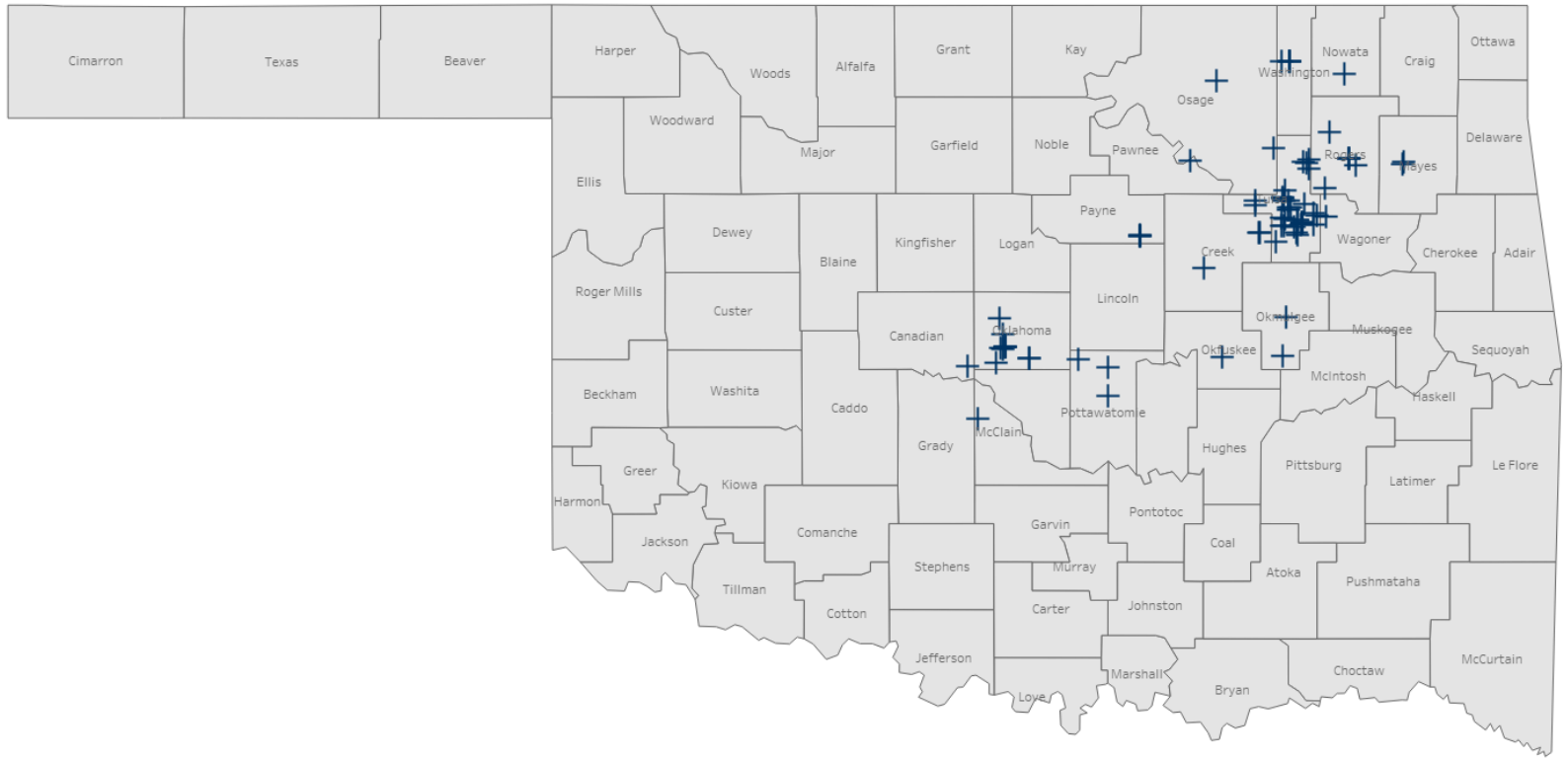
MyHealth ACCESS NETWORK

Staffing

- Principal Investigator: David Kendrick
- Project Director: Jennifer Faries
- Program Lead & Quality Improvement Specialist: Charlie Clegg
- Training & Implementation Specialist: Candice Holley
- Navigators on contract:
  - Tulsa Health Department [6 on staff]
  - Oklahoma Health Department [5 on staff]

Enrollment

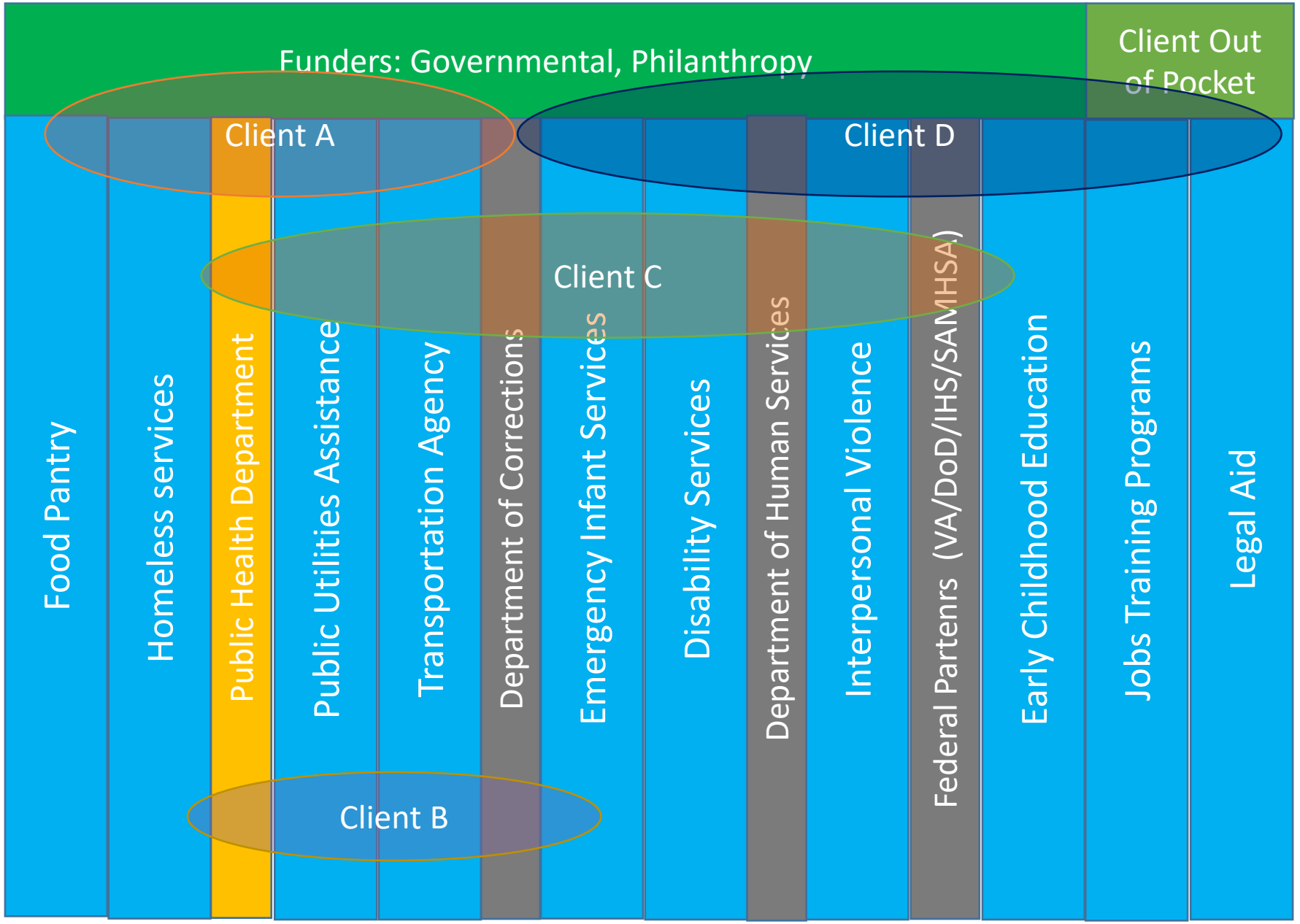
- Total active CDS
  - 5 Health Systems
    - 96 Clinics
    - 11 ERs
    - 7 Urgent Cares
  - 3 Care Coordination Groups



Operational Challenge:

- Goal: 100% of Beneficiaries screened upon registration
- T&M Study showed:
  - Screening: 12-15min per patient
  - Referral for Needs: 20 min per patient
- Health systems, practices, & ERs willing to participate:
  - ZERO

Non-medical drivers of health



SDOH Mobile Screening & Referral

MyHealth ACCESS NETWORK

1
Clinical Encounter

Patient checks into clinic.

2
SDoH Screening

SDoH Screening text from MyHealth is triggered to patient's cell phone while they are in the waiting room.

3
Process Results

MyHealth processes the results to determine social needs reported.

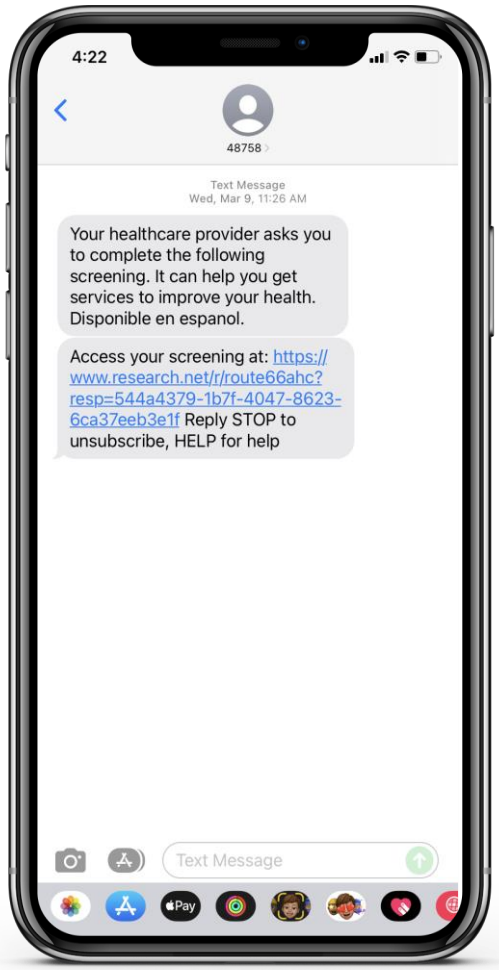
4
CRS Returned

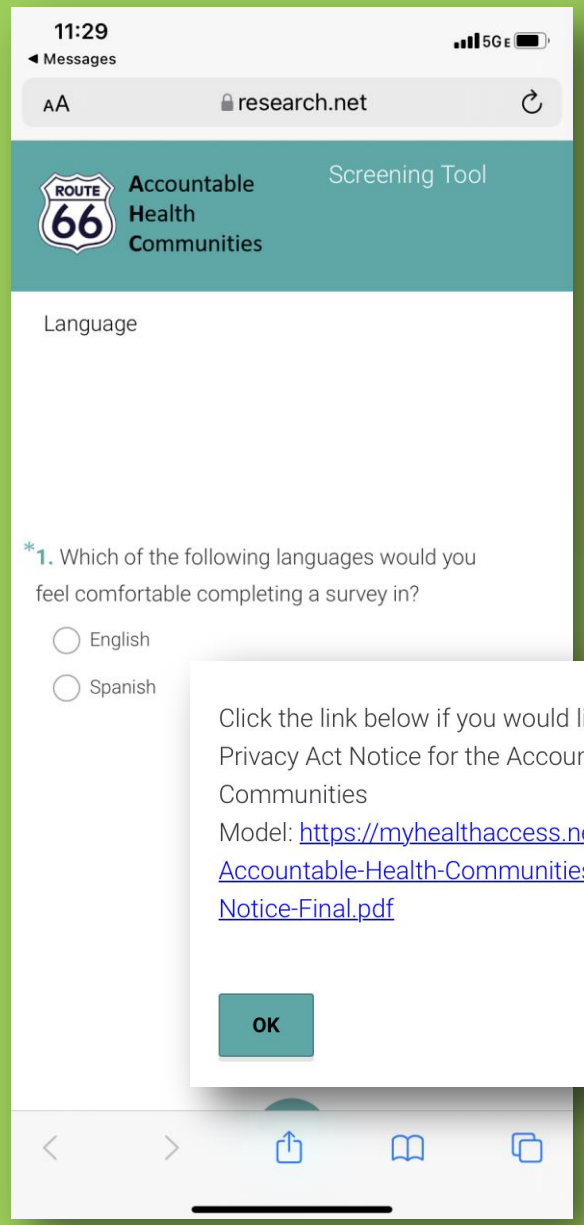
If a need is reported, a community resource summary is returned via text with information for 3 resources per need identified.

5
Navigation Program

>1 ED visit per year referred to Navigators at local city-county health departments (CHWs)

Mobile Screening





Click the link below if you would like to view the Privacy Act Notice for the Accountable Health Communities Model: https://myhealthaccess.net/MyHealth-Accountable-Health-Communities-Screening-Privacy-Notice-Final.pdf

OK

7. Within the past 12 months, you worried that your food would run out before you got money to buy more.

- Often true
- Sometimes true
- Never true

9. In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting to things needed for daily living?

- Yes
- No

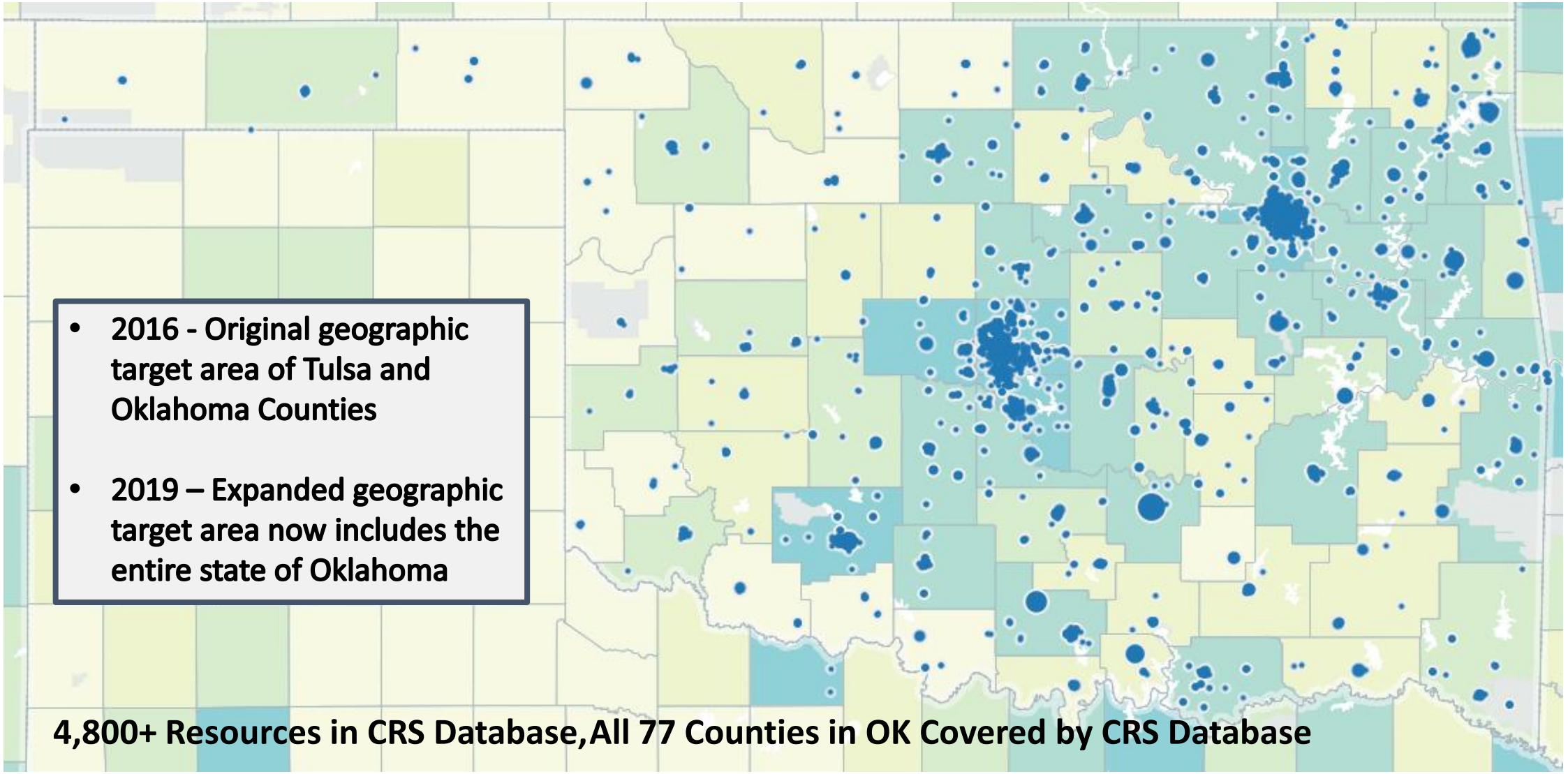
ROUTE 66 Accountable Health Communities — Screening Tool

Thank you for completing our survey! Based on your survey results you may receive an additional text message with a link to help connect you to services in your community that may improve your health. Many of these services are low cost or free of charge.

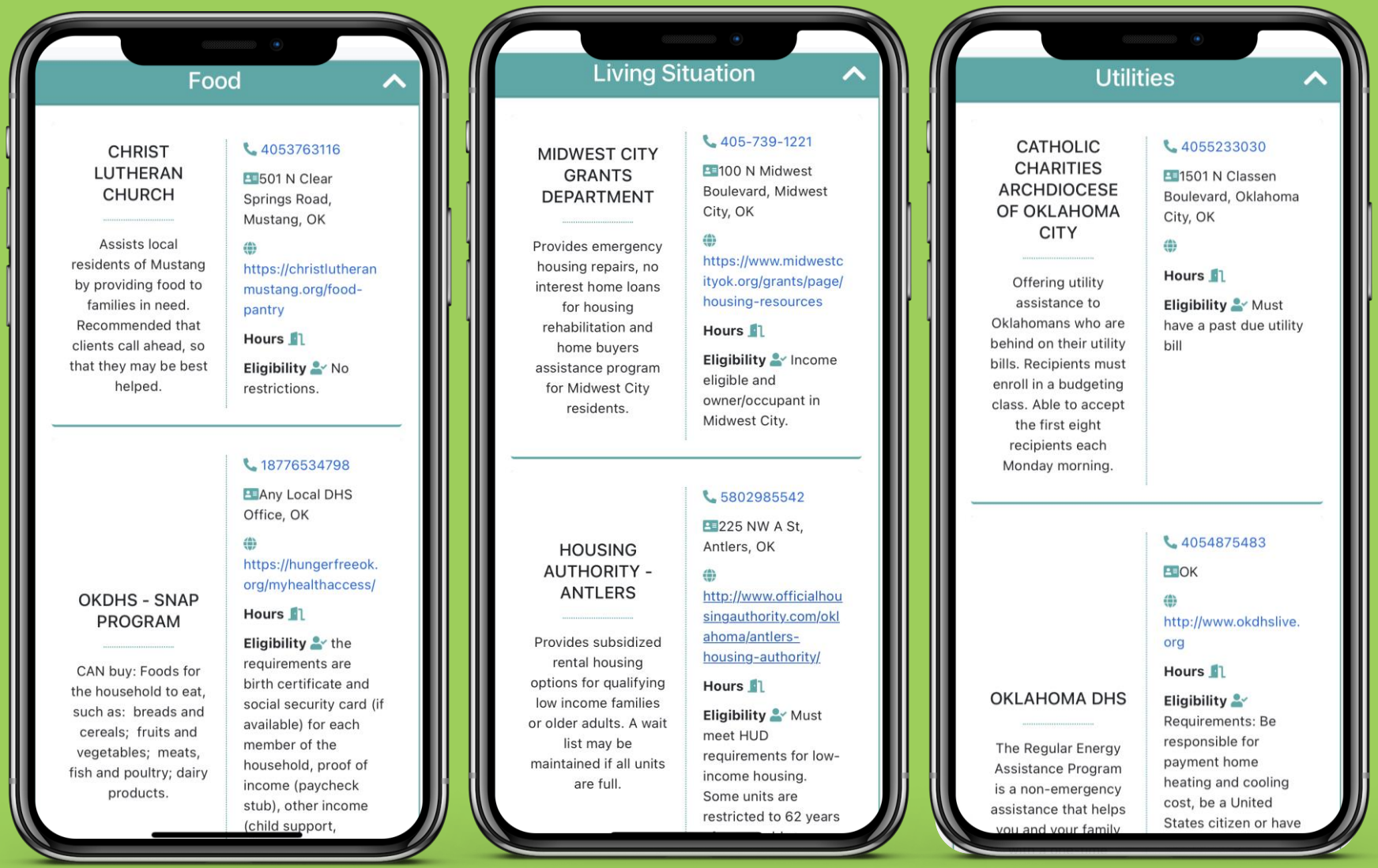
DONE

MyHealth® ACCESS NETWORK

Community Resources in Oklahoma



Community Resource Inventory



Every community resource summary includes information for 211

Community Resource Summary

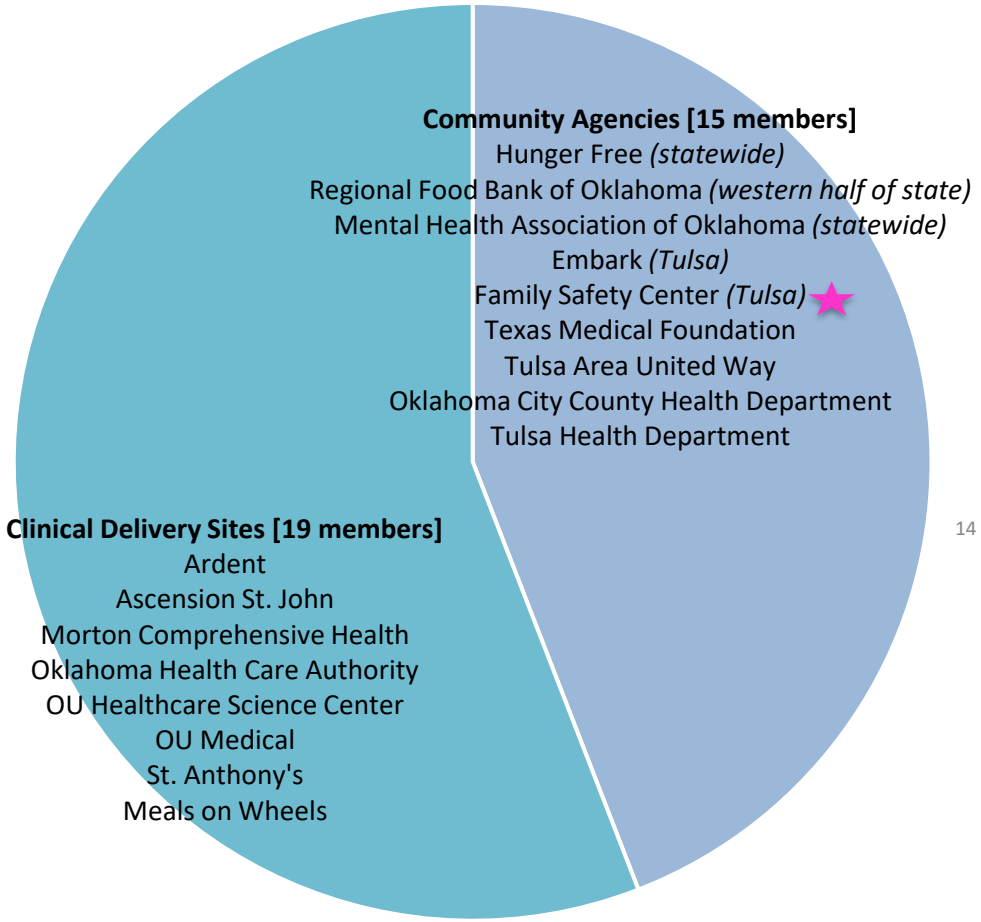
Texted back to patient after completion of the screening

MyHealth® ACCESS NETWORK

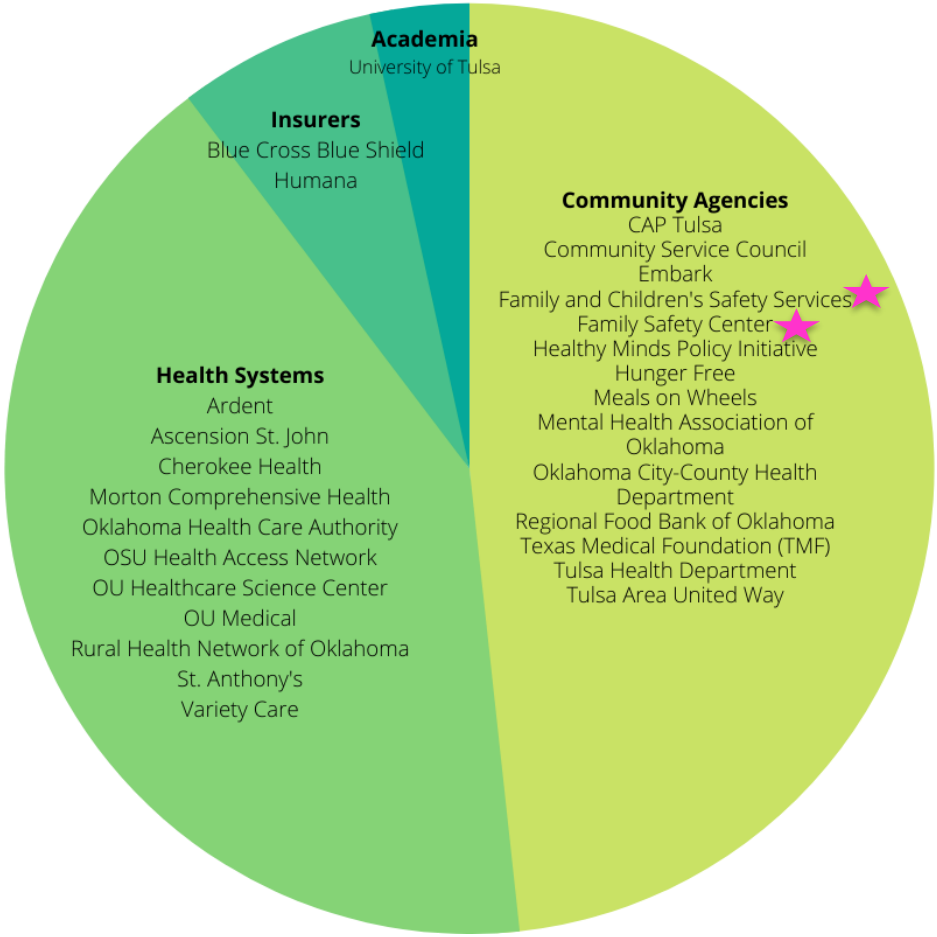
AHC Governance: Board and Committee Members

Increase the representation of community service providers on the AHC Advisory Board and Operations Committee, focusing first on the area of safety

Operations Committee

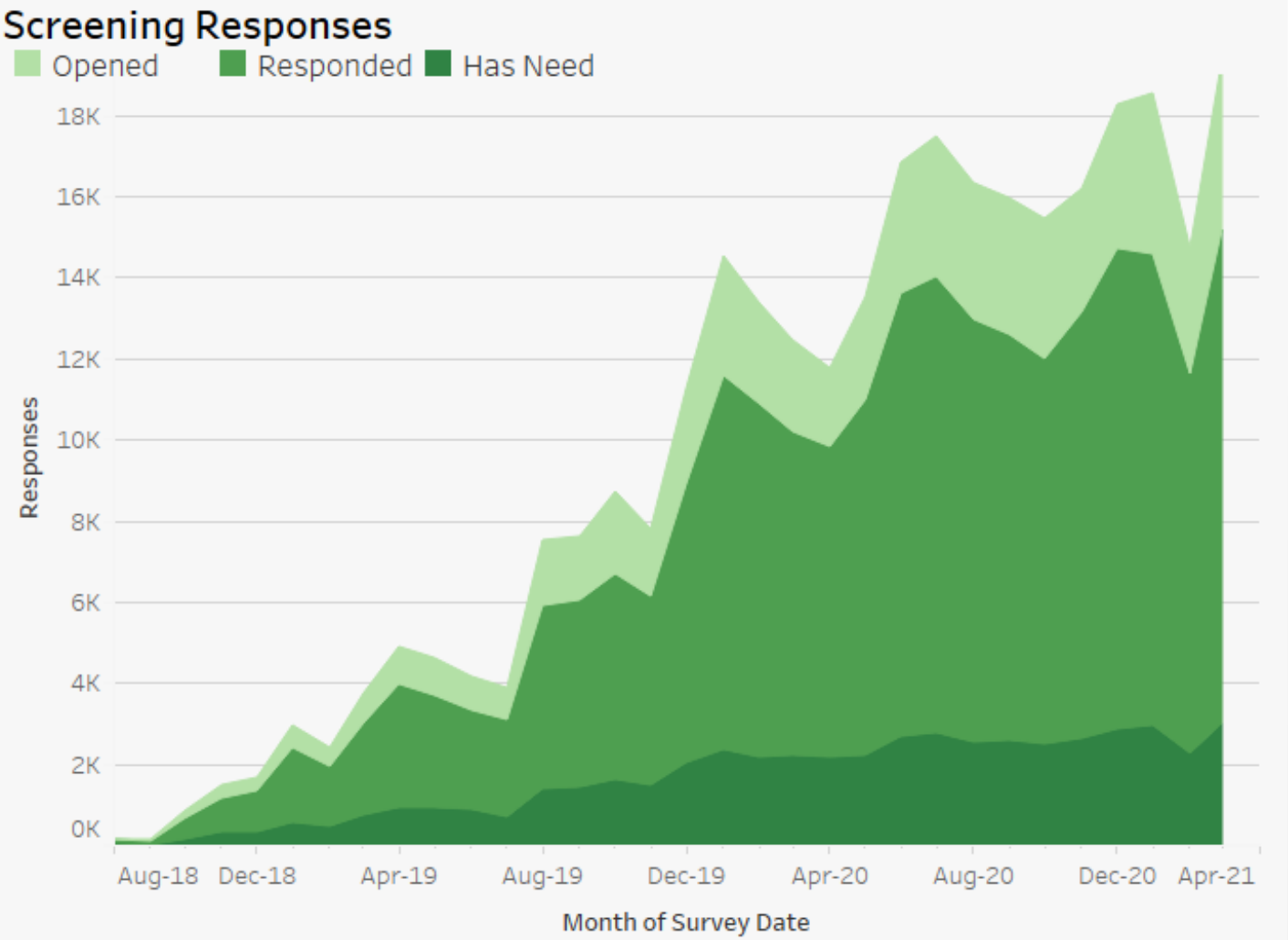


Advisory Board



AHC by the Numbers

August 2018 – April 2021



1,638,000+ Offers to Screen

253,000+ Responses

52,000+ Responses with a Need

85,000+ Individual Needs Reported

6,000+ Eligible Navigation Cases

Medicare and Medicaid Only

6,600+ Navigation Needs Resolved

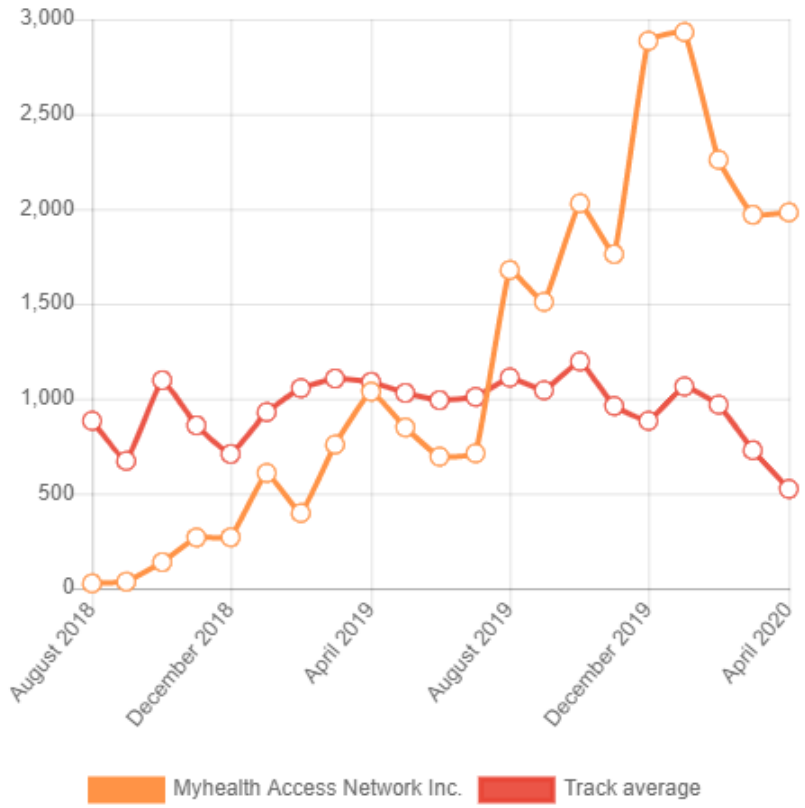
Medicare and Medicaid Only

Note: These patients include Medicare, Medicaid, uninsured and commercially insured patients.

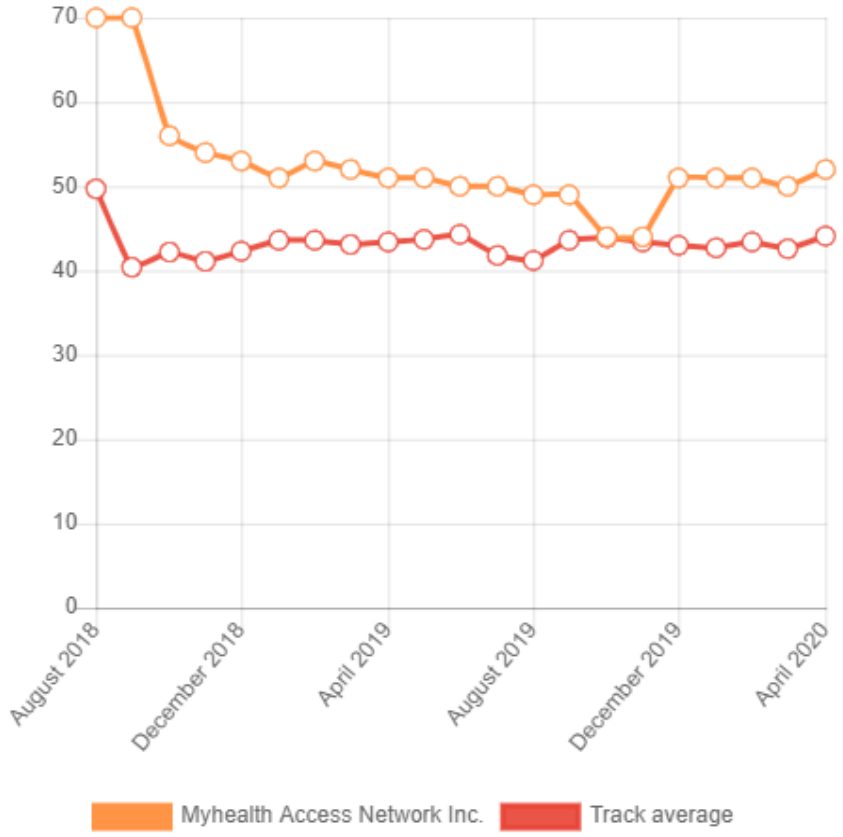
Operational Monitoring Reports:

CMS reported data with comparison to track average

Unique Beneficiaries Registered – Month by Month



Beneficiary Age – Month by Month



SDOH Program Metrics

August 2018– May 30, 2024

By the numbers:

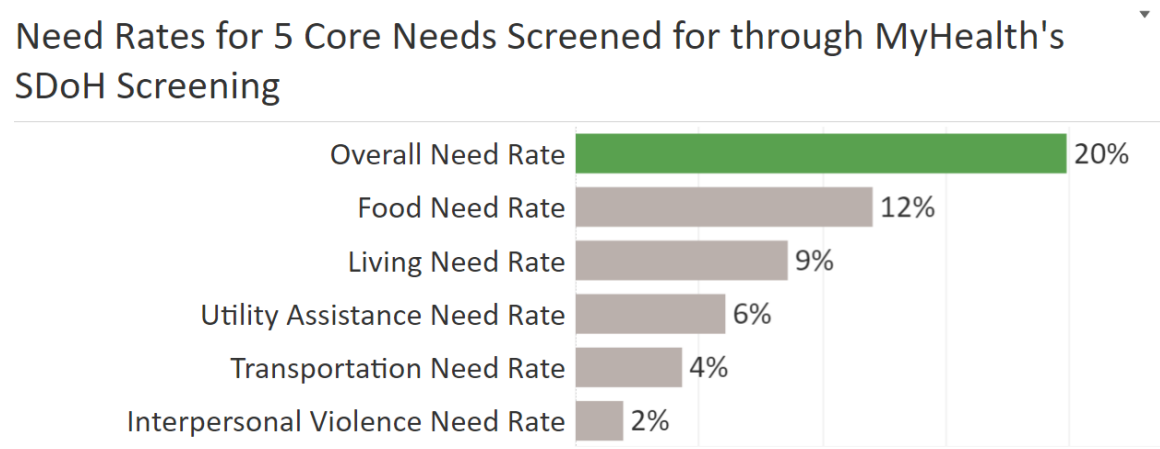
- ✓ **4.6+** million offers to screen
- ✓ **900,000+** responses
- ✓ **300,000+** responses with needs
- ✓ **400,000+** individual needs reported & addressed

Screening Delivery Rate

83%

Screening Response Rate

21%



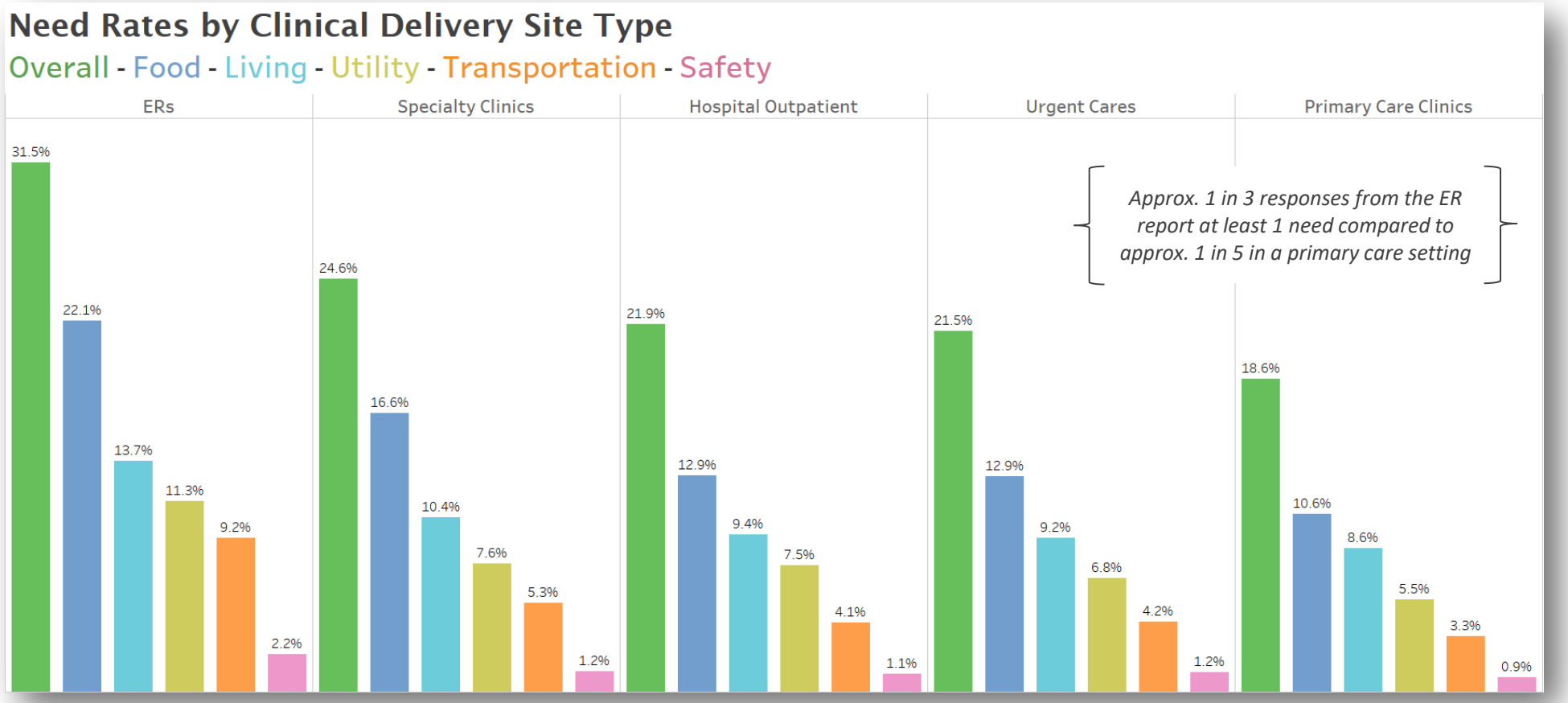
24% of responses report 2+ needs

average of **1.7** needs are reported per need positive screening

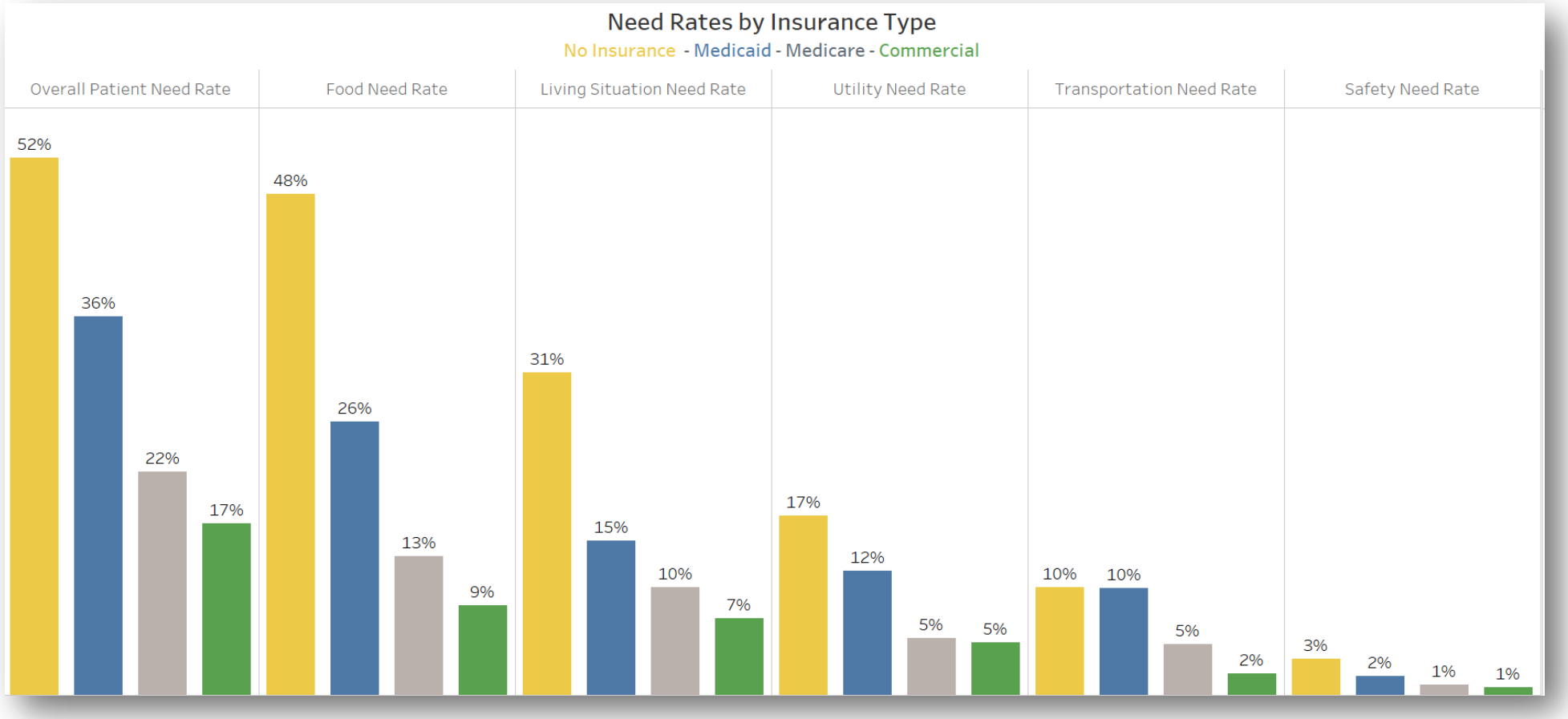
85% of responses with a living need is due to living conditions* rather having a place to stay

**Living condition issues include lack of heating, lead paint or pipes, mold, oven or stove not working, pests, missing or not working smoke detectors, and water leaks*

MyHealth AHC Need Rates by Clinical Site Type



MyHealth AHC Need Rates by Insurance Type



PRELIMINARY AHC OUTCOMES

Outcomes reported by CMS evaluation team

Medicaid Beneficiaries

Medicare Beneficiaries

TOTAL EXPENDITURE

INPATIENT ADMISSIONS

READMISSIONS

ED VISITS

Burden Reduction: CMMI's Accountable Health Communities Model MyHealth HIE Mobile SDoH Screenings & Referrals

	Time	Hourly Rate
Time & Motion Study of Manual Screening & Referral Process		
Provider Administration of AHC Screening (minutes)	12	$30.00
Provider Generation of Tailored Resource Referral for Needs (minutes)	20	$30.00
Total Number of Screenings offered	3,700,000	$30.00
Total Number of Screenings completed	850,000	$30.00
Total Number of Screenings with at least 1 need	250,000	$30.00
Total Human Screener Time Saved (hours)	170,000	$5,100,000
Total Human Tailored Resource Referral Time Saved (hours)	83,333	$2,500,000
Total Cost of MyHealth HIE SDoH Screening and Referral	0	$3,145,000
Net Savings Based on Staff Time and Cost Alone (hours)	253,333	$4,455,000

Health Plan/Employer-Focused Program

- Health Plans/Employers can subscribe to a package of screenings
  - e.g. Quarterly HRSN assessments of the entire population
  - Ensures that encounter-triggered and enrollment-triggered screenings are not duplicative and patient “dosing” is not overwhelming
- Response rates actually higher than the encounter-based offering in many cases
- Impact on total costs not yet shared but the subscriptions persist

Oklahoma AHC Conclusions

- As always, *workflow* is king

- CHWs are an incredible asset for this work
  - High engagement rates
  - Expand beyond patient to family and household and beyond

- HRSNs are more vital sign than diagnosis: needs evolve over time
  - Repeated screening critical to addressing them
  - Lessens dependency on “closing loops” which is very expensive

- Patients can make good choices
  - Give them options
  - Give them agency
  - No visit required- can provide access at all times and between visits

- Do well by doing good: Win (patient) + Win (provider) + Win (payer)

What's Next?

- Add support for routing screening and referral results back into EHR data feeds
  - Take advantage of existing provider workflows for sign off and support risk assessments and targeted care
- Add Closed Loop process to the mobile screening
  - Enable CBOs to prove value and receive funding support
- Expand beyond the AHC screener to other types of medical and social needs screeners
  - Many workflows in the clinical setting benefit from these automations uniquely enabled by connected HIEs
- Payment models for screening, referral and navigation services

The ROI of Social Care Navigation

Final Evaluation, Financial Impacts, and Clinical Outcomes of the **Accountable Health Communities (AHC) Model.**

AHC Final Report Results - RTI

Accountable Health Communities Generated $220M in Net Savings

By directly connecting Medicare and Medicaid beneficiaries to community resources to address five core upstream drivers of health, the AHC model proved that funding social care navigation yields definitive clinical and financial returns.

Financial ROI

$219.6M

Net Federal Savings (across Medicaid and FFS Medicare).

Clinical Impact

Significant, statistically verified reductions in Avoidable Emergency Department (ED) visits and Inpatient Admissions.

The Catalyst

Exponential synergy and multiplier effects when navigation is combined with existing Alternative Payment Models (APMs).

Navigation Infrastructure Drives Exponential Gross Savings

AHC federal funding went exclusively to bridge organization operations and navigation infrastructure. Funds were not used to directly purchase community social services, proving the financial viability of funding the navigation layer itself.

Comparative Diagnostics of Assistance and Alignment Interventions

	Assistance Track	Alignment Track
The Intervention Mechanism	Universal screening + referral + navigation assistance.	All Assistance Track elements + community-level continuous quality improvement.
Total Operating Cost	$24.4M	$82.3M
Medicaid Expenditure Impact	**3% reduction** ($45 PBPM)	**7% reduction** ($105 PBPM)
FFS Medicare Expenditure Impact	**4% reduction** ($111 PBPM)	**5% reduction** (Downward trajectory, smaller sample size limited statistical significance)

Reduced Acute Utilization Drives Total Expenditure Drops

Utilization Heatmap

	Medicaid	FFS Medicare
Inpatient Admissions	↓ **3% drop** in all-cause admissions ↓ **7% drop** in unplanned readmissions	↓ **8% drop** in Ambulatory Care Sensitive Condition (ACSC) admissions ↓ **7% drop** in unplanned readmissions
Emergency Department (ED)	↓ **3% drop** in total ED visits ↓ **3% drop** in avoidable ED visits	↓ **4% drop** in total ED visits ↓ **5% drop** in avoidable ED visits
Ambulatory & Primary Care	↓ **5% drop** in PCP visits	↓ **4% drop** in PCP visits

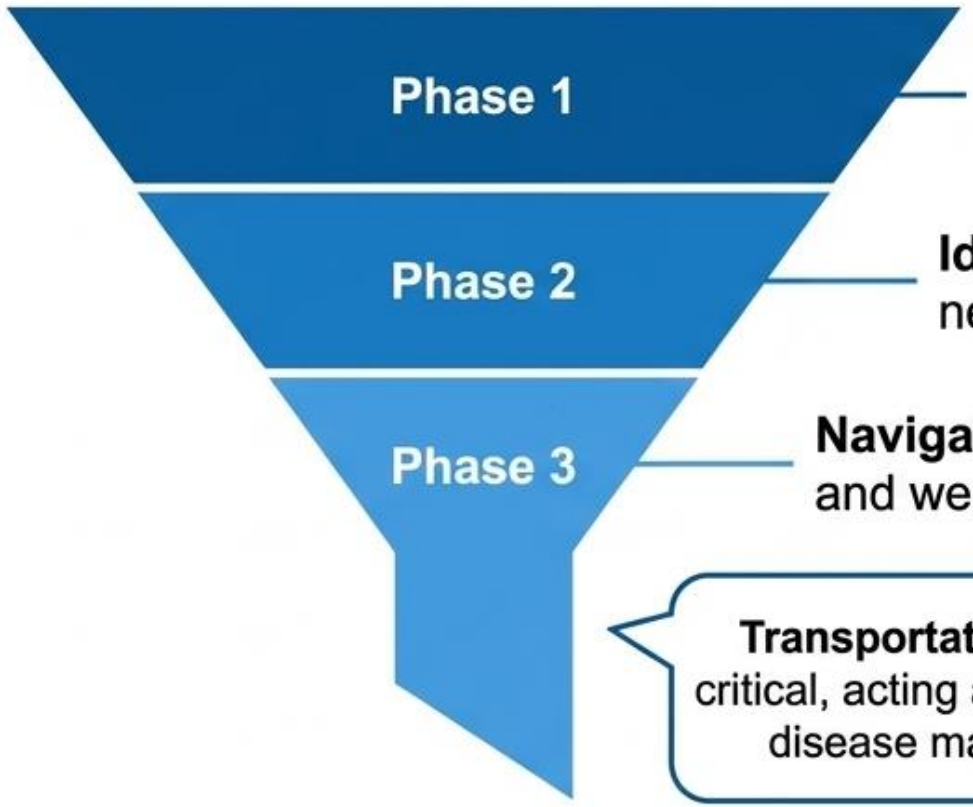
Synthesis Callout

⚠ The uniform reductions across primary care (PCP) visits indicate that successful social care navigation **resolves underlying instability**, reducing the **crisis-driven** need to interact with the broader healthcare system entirely.

Precision Filtering Targets the Highest-Impact Interventions

5

- **Housing instability**
- **Transportation problems**
- **Food insecurity**
- **Utility difficulties**
- **Interpersonal violence**



Universal Screening: 1,114,099 total Medicaid and Medicare beneficiaries screened

Identification: 410,629 (37%) screened positive for 1+ core need

Navigation Eligibility: 204,447 (18%) matched the high-risk criteria and were offered dedicated navigation services

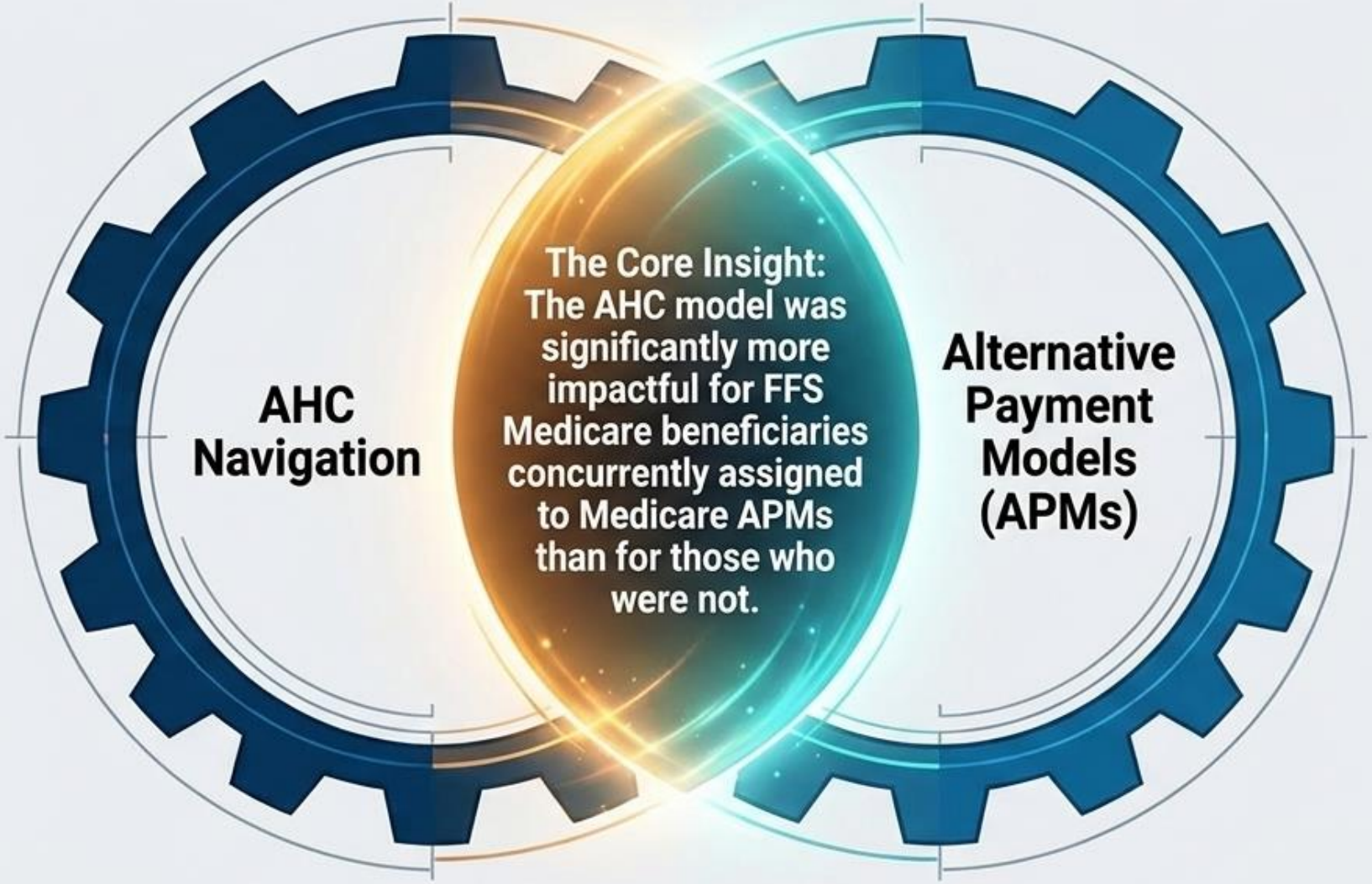
Transportation needs emerged as uniquely critical, acting as the primary enabler for ongoing disease management and clinical access

High-Risk Criteria Definition: Reported 2+ ED visits in the past 12 months

Social Navigation Synergizes with Alternative Payment Models

Data Proof

- Beneficiaries in APMs + AHC Navigation saw significantly deeper reductions in total expenditures, inpatient admissions, and avoidable ED visits compared to their non-APM counterparts.



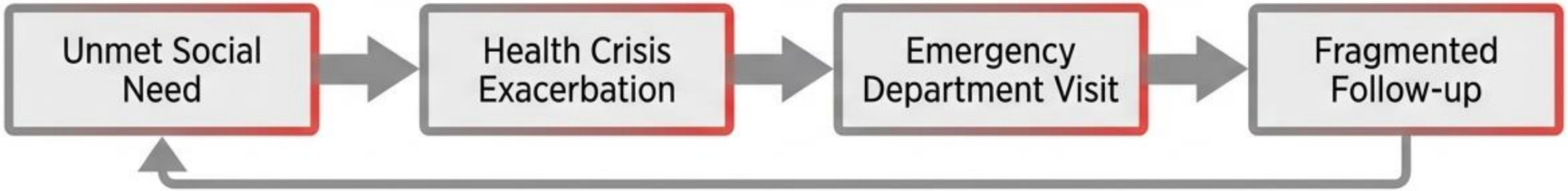
Synthesis

Social care navigation is not a standalone fix. It is a powerful complement to care coordination.

Navigators build trust and close the the logistical, community-level gaps that clinical care managers cannot reach.

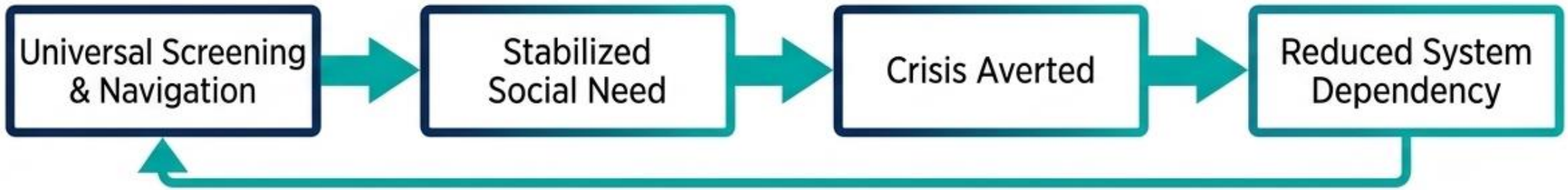
The Crisis-Aversion Cycle: Why Ambulatory Care Dropped

Traditional Fragmented Cycle



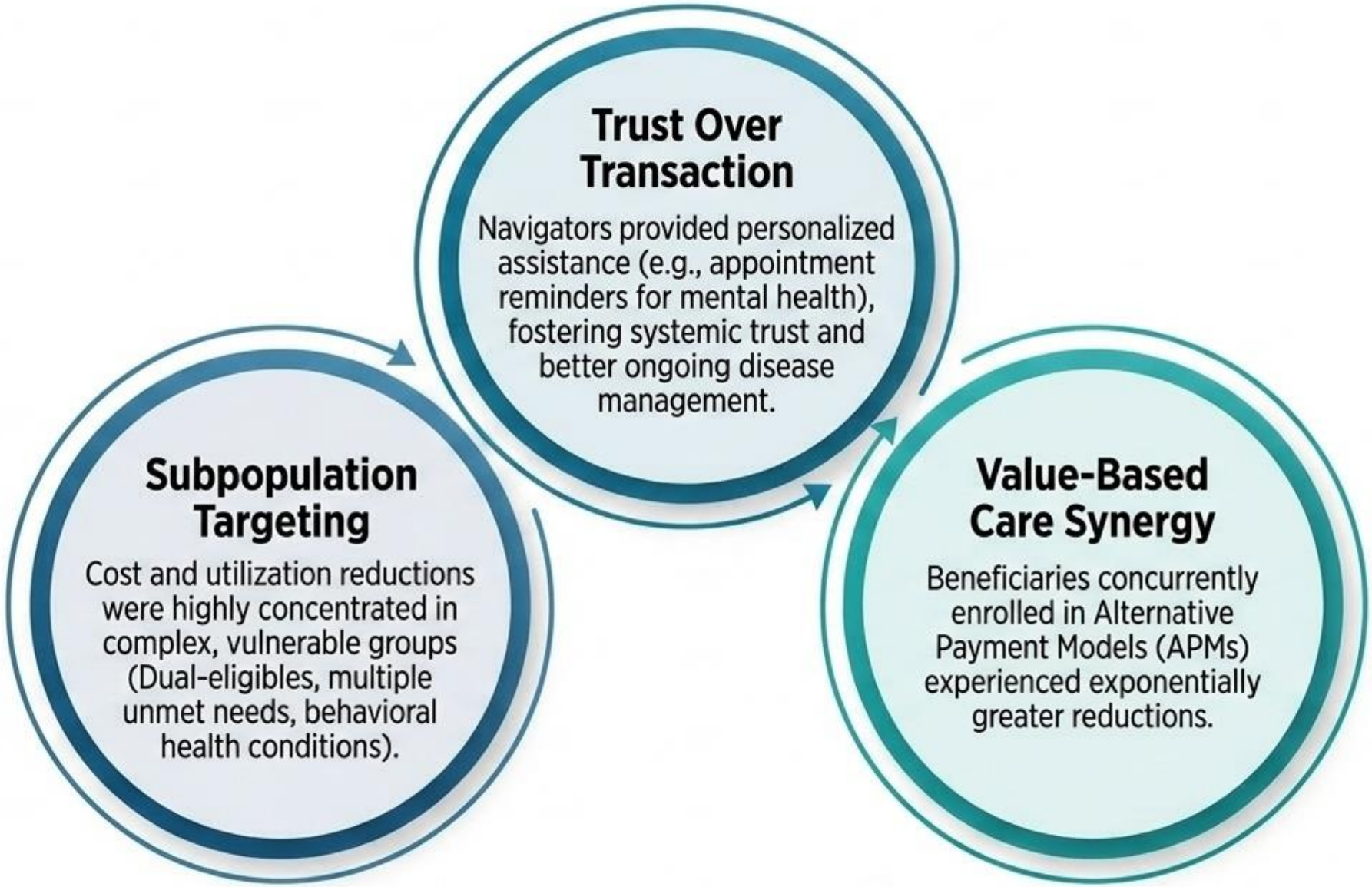
(Drives up both ED and PCP utilization)

The AHC Intervened Cycle



Insight: Navigation reduced the overall crisis-driven need to interact with the healthcare system, explaining why both hospital-based utilization and primary care visits simultaneously declined.

The Mechanics of Impact: Beyond Simple Referrals



Acute Utilization Reductions Concentrate in Complex Vulnerable Groups

In **resource-scarce** environments, universally screening all patients but strictly targeting navigation services to these high-impact groups maximizes ROI.

Dual Eligibles

Beneficiaries qualifying for both Medicare and Medicaid simultaneously.

Compound Vulnerability

Individuals presenting with multiple overlapping unmet social needs.

Clinical Complexity

Beneficiaries burdened with chronic physical conditions or behavioral health conditions.

High Utilizers

Beneficiaries with frequent baseline Emergency Department visits prior to intervention.

The Human Mechanics Behind Need Resolution

Survey data revealed similar overall need resolution rates between intervention and control groups, yet the clinical utilization plummeted for the navigated group. Why?

Step 1: Deep Trust Building

Navigators provided personalized assistance far beyond handing out a referral sheet. Fostering this micro-level trust increased the beneficiary's trust in the macro healthcare system.

Step 2: Proactive Care Management

Navigators stepped directly into logistical care gaps, taking actions like providing appointment reminders for chronic and mental health care, directly supporting ongoing disease management.

Step 3: Partial Need Resolution

Even when complex core needs were only partially resolved, the structured, ongoing support stabilized patients enough to drastically reduce crisis-driven acute care utilization.

The Synthesis: Blueprint for Nationwide Scale

Target Smart

Universally screen to find hidden risks, but strictly limit navigation resources to high-risk profiles (e.g., >2 ED visits, multiple needs, Dual-eligibles).

Integrate with VBC

Do not build isolated social care silos. Embed social navigation directly into existing APMs and clinical care management workflows to trigger the multiplier effect.

Tailor by Population

Precision is required. Prioritize immediate transit solutions for disabled Medicare populations; prioritize comprehensive multi-need Medicaid beneficiaries.

Fund the Destination

Identifying needs is useless if the community cannot fulfill them. Future models must address capacity limits; community-based handle the influx of clinical referrals.

Scalable Impact: As demonstrated, this blueprint can yield over $200 Million in net savings, driven by a 7% reduction in unplanned readmissions and a 5% drop in avoidable ED visits.

The Blueprint for Future Social Care Integration

1

Fund Navigation, Not Just Identification

Identifying unmet needs through screening is

Sustainable clinical ROI requires explicit funding for the human navigation infrastructure required to close the loop.

2

Embed Within Value-Based Care

Do not run social care programs in a silo.

Embed social navigation into existing Alternative Payment Models (APMs) and care-coordination structures to unlock exponential savings.

3

Invest in Community Capacity

Navigation bridge organizations reported that community services frequently overwhelmed. True system alignment requires direct capacity investment into the community-based organizations receiving the clinical referrals.

Questions?

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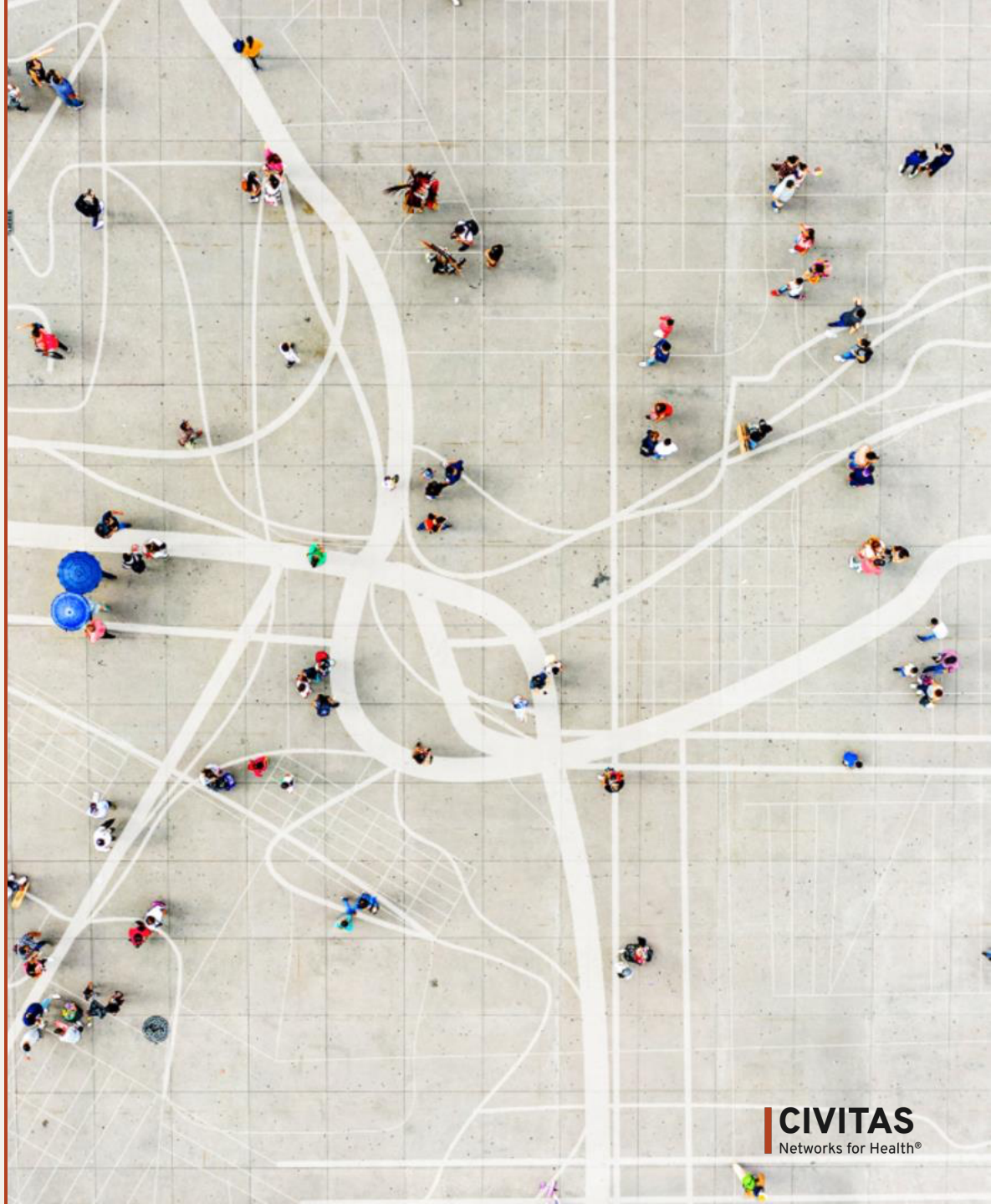
HRSN Value Calculator available upon request!

CMMI Models

Karen Ostrowski, Civitas



CMMI: New Model Blitz

- Within the past year, CMS has created nine new payment models targeting different parts of the system aligned with their vision of building healthier lives through evidence-based prevention, patient empowerment, and greater choice and competition.
- Together the new models + those in the pipeline signal a shift in how CMS designs payment reform: longer, population-level accountability frameworks rather than short-cycle pilots and conditions-specific payments.
- **Central goal:** evaluation findings from completed models directly inform the design of subsequent ones – a principle the AHC model's results and its visibility in new models illustrates directly.

CIVITAS Networks for Health®

Emerging CMMI Models

Each pushes accountability and coordination towards entities that look more like AHC bridge organizations than traditional FFS providers

ACCESS *Advancing Chronic Care with Effective, Scalable Solutions* Population: Medicare FFS, chronic disease AHC results found the most pronounced impacts among beneficiaries with chronic physical or behavioral health conditions, the same population ACCESS targets through technology-supported care.	**LEAD** *Long-term Enhanced ACO Design* Population: Medicare FFS, high-needs, rural, dually eligible AHC found navigation produced larger effects when paired with an accountable payment model. LEAD is built as that kind of model, running as a ten-year ACO REACH successor.
MAHA Elevate *Enhancing Lifestyle and Evaluating Value-based Approaches Through Evidence* Population: Medicare FFS, whole-person needs Structured like AHC's bridge organizations, funding community-based entities through cooperative agreements to deliver non-clinical interventions tied to health outcomes.	**ASPIRE** *Accelerating State Pediatric Innovation Readiness and Effectiveness* Population: Medicaid/CHIP, children with complex needs Serves the same Medicaid/CHIP population that made up 87% of AHC's beneficiaries, using accountable entities that take on cost and quality responsibility much as bridge organizations took on navigation.

Local Infrastructure to Support Implementation

- **HIEs and HDUs:** Technical backbone for cross-sector data exchange between accountable entities and community-based organizations
- **Social Care Networks and Community Care Hubs:** Operational analog to AHC's bridge organizations – many already doing screening, referral, and navigation work
- **Consent and data sharing architecture:** Prerequisite not an add-on especially for ASPIRE's behavioral health and pediatric data sensitivities.
- **Sustainability:** Where AHC infrastructure has persisted, it's because bridge organizations sustained it through ongoing partnerships and funding after the model ended.

Questions for the Panelists

- Which AHC lessons translate into new models?
- What infrastructure already exists?
- What should funders and health plans think about sustaining these capabilities?
- What role does HIEs, HDUs, and community collaboratives play moving forward?

Q&A

Please utilize the Q&A function on the righthand side of the taskbar to ask a question to today's speakers.

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