VT Health Care Innovation Project - Payment Model Design and Implementation Work Group Meeting Agenda
Monday, January 4, 2016 1:00 PM – 3:00 PM.
DVHA Large Conference Room, 312 Hurricane Lane, Williston
Call in option: 1-877-273-4202 Conference Room: 2252454

Item #	Time Frame	Topic	Presenter	Decision Needed?	Relevant Attachments
1	1:00 – 1:10	Welcome and Introductions Approve meeting minutes	Cathy Fulton Andrew Garland	Y – Approve minutes	Attachment 1: December Meeting Minutes
2	1:10-1:30	2015 In review	Georgia Maheras	N	Attachment 2: Presentation
3	1:30-2:10	Population Health Financing	Jim Hester	N	Attachment 3a: Report Attachment 3b: Presentation
4	2:10-2:50	APM Update		N	http://www.leg.state.vt.us/jfo/healthcare/Health%20Reform%20Oversight%20Committee/2015_11_13/GMCB%20-%20COSTA%20-%20All%20Payer%20Model%20Update%20HROC%2011-13-2015.pdf
5	2:50-2:55	Public Comment		N	
6	2:55-3:00	Next Steps and Action Items		N	Next Meeting: Monday, February 1th, 2016 1-3PM EXE - 4th Floor Conf Room, Pavilion Building 109 State Street, Montpelier

Attachment 1: December Meeting Minutes

Vermont Health Care Innovation Project
Payment Model Design and Implementation Work Group Meeting Minutes

Pending Work Group Approval

Date of meeting: Monday, December 14, 2015, 1:00-3:00pm, 4th Floor Conference Room, Pavilion Building, 109 State Street, Montpelier.

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions; Approve Meeting Minutes	Andrew Garland called the meeting to order at 1:01pm. A roll call attendance was taken and a quorum was present. Susan Aranoff moved to approve the November meeting minutes by exception. Diane Cummings seconded. The minutes were approved unanimously with no abstentions. Catherine Fulton announced that Spenser Weppler is leaving the Green Mountain Care Board to work for OneCare Vermont, and noted that the former Payment Models and Quality and Performance Measures Work Groups owe him gratitude for all of his work in support of this project.	
2. ACO Analysis Update	Alicia Cooper presented an analysis of Year 1 savings in the Medicaid Shared Savings Program (SSP). Alicia noted that a more comprehensive written report will be available in the coming weeks, pending review. The group discussed the following: • Is DVHA surprised by the number of people eligible but not attributed? Yes, somewhat. DVHA thinks this is a combination of patients with primary care relationships that would have linked them to Accountable Care Collaborative of the Green Mountains (Health*first*) if they were participating, and others with PCPs not linked to any ACO. • How do these analyses take into account people who were formally commercially insured but since shifted to Medicaid coverage? Alicia responded that DVHA considered past enrollment and eligibility. • DVHA did not look at VHAP specifically. Alicia noted that DVHA may have a chance to do additional analyses before reports are finalized, and welcomed stakeholder input. • Population with Medicaid Expansion eligibility in 2014 is relatively evenly attributed across OneCare, CHAC, and Other (eligible for attribution but unattributed). Alicia noted that beneficiaries with at least 10	**Alicia's slides will be shared once the accompany report is finalized.** **Email Alicia Cooper (Alicia.Cooper@vermont.gov) with recommendations for additional analyses.**

Agenda Item	Discussion	Next Steps
	months of eligibility in the year are eligible for attribution through primary care utilization or PCP of record (claims data takes predominance if claims and PCP of record conflict). • Expansion populations who are attributed through claims have higher costs than other populations attributed through claims; however, expansion populations who were attributed through PCP of record have lower costs than other populations attributed through PCP of record. • Alicia cautioned against making generalizations about each ACO's performance from these analyses, noting that each has its own model and clinical priorities. • There are significant differences between CHAC and OneCare on per capita spending. Jim Westrich clarified that OneCare has a greater proportion of children; in addition, adjustments for acuity can make a difference. These numbers are risk adjusted.	
3. Medicaid Expenditure Analysis	Suzanne Santarcangelo from Pacific Health Policy Group presented on the Medicaid Expenditure Analysis (Attachment 3). The group discussed the following: • Individuals receiving specialized services represent 25% of Medicaid recipients, and 72% of Medicaid spend (including specialized and traditional Medicaid services). Gabe Epstein noted that many of these individuals are dually eligible for Medicaid and Medicare, so Medicare funds are also being expended. • What percentage of our Medicaid spend is part of the ACO Total Cost of Care calculations? Alicia commented that DVHA could look into this. • Are people receiving long-term care services being attributed to the VMSSP? Alicia commented that people receiving long-term care services could be attributed if they receive primary care services or have a PCP of record. • What does "non-disability-related 65 and over" mean? Suzanne clarified that recipients can come into Medicaid through income or categorical eligibility (Aged, Blind, and Disabled/ABD, for example). This analysis looks at claims data associated with various programs. • The breakdown of populations in this analysis doesn't cleanly follow the line between financially needy and medically needy; similarly, the breakdown of services doesn't cleanly follow the breakdown between mandatory and non-mandatory Medicaid services. • Dual eligibles are attributed to Medicare ACOs, not Medicaid. If many duals' services are predominantly from Home Health Agencies, how are duals attributed? How does the Medicare shared savings model distribute savings to HHAs? Richard Slusky commented that it's up to the ACO under Medicare SSP rules. • Suzanne noted that it is challenging to compare Medicaid programs across states. • Vermont has more robust home- and community-based services than most other states in the country, and has been a leader in this area for decades. • Specific rates for long-term care services are not under discussion as part of All-Payer Model planning, though there is an intended shift toward increased primary care spending/decreased hospital spending. • Do these analyses indicate that a significant portion of the Medicaid spend would be outside of the All-	

Agenda Item	Discussion	Next Steps
	Payer Model? Richard noted that CMMI has expressed interest in incorporating a broader scope of services at a future date, but conversations are ongoing, and it's not yet clear whether it would be "at risk" money or not for ACOs. There is no dispute that these services are valuable in constraining costs and cost growth in the system. Richard noted that recent spending costs have largely been in specialty growth since Medicaid expansion. Mike Hall noted that specialized/LTC services have been flat funded/underfunded much more than other service categories. Richard suggested that reimbursement for these services is a Medicaid question – how to blend this into a statewide approach? Mike commented that this is an opportunity to start thinking about that solution. • Case management and care coordination are not included in the ACO's total cost of care. Suzanne noted that targeted case management is a very targeted service category under our Medicaid State Plan. • Andrew welcomed ideas about how to move additional services into payment reforms over the coming year, though this group does not have decision-making authority, it can certainly have discussions and make recommendations. • Heidi Klein commented that the Population Health Work Group is also talking about other payment reform ideas that include a broader scope of services and activities, and some of them will be included in the Population Health Plan. Jim Hester will be presenting on financing models for population health improvement at the January meeting. Mike added that the current definition of services does not allow for payment for some things that could impact outcomes and population health. • Dale Hackett emphasized that care models need to be supported by payment models, not the other way around. • Richard raised a conundrum related to flexible funding for services that are otherwise not reimbursable – investments may not give adequate returns to the organizations that must make the investments, and could have financial impacts on other provider types/parts of the system. Bard Hill commented that there are opportunities for flexibility in some areas in the current system.	
4. Public Comment	There was no additional public comment.	
5. Next Steps, and Action Items	For next meeting: • Lila Richardson requested an update on the EOC program in our next meeting. • Maura Graff requested an update on the all-payer model. **Next Meeting:** Monday, January 4, 2015, 1:00-3:00pm, DVHA Large Conference Room, 312 Hurricane Lane, Williston.	

VHCIP Payment Model Design and Inplementation Work Group Member List

Sue 1° Diane 2° unanimous no abstentions

Monday, December 14, 2015

Member		Member Alternate			
First Name	Last Name	First Name	Last Name	Minutes	Organization
Melissa	Bailey ✓	Shannon	Thompson ✓		AHS - DMH
		Jaskanwar	Batra		AHS - DMH
		Kathleen	Hentcy ✓		AHS - DMH
		Frank	Reed		AHS - DMH
Jill Berry	Bowen	Stephanie	Breault		Northwestern Medical Center
		Jane	Catton		Northwestern Medical Center
		Diane	Leach		Northwestern Medical Center
		Don	Shook		Northwestern Medical Center
		Ted	Sirotta		Northwestern Medical Center
Michael	Counter				VNA & Hospice of VT & NH
Diane	Cummings ✓	Shawn	Skafelstad		AHS - Central Office
Mike	DelTrecco	Bea	Grause		Vermont Association of Hospital and Health Systems
Tracy	Dolan	Heidi	Klein ✓		AHS - VDH
		Cindy	Thomas ✓		AHS - VDH
		Julie	Arel ✓		AHS - VDH
Rick	Dooley ✓	Susan	Ridzon		HealthFirst
	Joined late	Paul	Reiss		HealthFirst
Kim	Fitzgerald	Stefani	Hartsfield ✓		Cathedral Square and SASH Program
		Molly	Dugan ✓		Cathedral Square and SASH Program
Aaron	French	Erin	Carmichael ✓		AHS - DVHA
		Nancy	Hogue ✓		AHS - DVHA
		Megan	Mitchell ✓		AHS - DVHA
Catherine	Fulton ✓				Vermont Program for Quality in Health Care

VHCIP Payment Model Design and Inplementation Work Group Member List

Monday, December 14, 2015

Member		Member Alternate			
First Name	Last Name	First Name	Last Name	Minutes	Organization
~~Larry~~	~~Gootschius~~	Beverly	Boget		VNAs of Vermont
Peter	Cobb ✓				
Steve	Gordon	Mark	Burke		Brattleboro Memorial Hopsital
Maura	Graff ✓	Heather	Bushey		Planned Parenthood of Northern New England
Dale	Hackett ✓				Consumer Representative
Mike	Hall ✓	Sandy	Conrad		Champlain Valley Area Agency on Aging / COVE
		Angela	Smith-Dieng		V4A
Paul	Harrington ✓				Vermont Medical Society
Karen	Hein				University of Vermont
Bard	Hill ✓	Patricia	Cummings ✓		AHS - DAIL
		Susan	Aranoff ✓		AHS - DAIL
		Gabe	Epstein ✓		AHS - DAIL
Jeanne	Hutchins ✓				UVM Center on Aging
Kelly	Lange ✓	Teresa	Voci ✓		Blue Cross Blue Shield of Vermont
Ted	Mable	Kim	McClellan ✓		DA - Northwest Counseling and Support Services
		Amy	Putnam		DA - Northwest Counseling and Support Services
David	Martini ✓				AOA - DFR
Lou	McLaren ✓				MVP Health Care
MaryKate	Mohlman ✓	Jenney	Samuelson		AHS - DVHA - Blueprint
Ed	Paquin				Disability Rights Vermont
Lila	Richardson ✓	Kaili	Kuiper		VLA/Health Care Advocate Project

VHCIP Payment Model Design and Inplementation Work Group Member List

Monday, December 14, 2015					
Member		**Member Alternate**			
First Name	**Last Name**	**First Name**	**Last Name**	**Minutes**	**Organization**
Greg	Robinson	Miriam	Sheehey ✓		OneCare Vermont
		Abe	Berman ✓		OneCare Vermont
		Vicki	Loner		OneCare Vermont
Laural	Ruggles				Northeastern Vermont Regional Hospital
Julia	Shaw ✓	Rachel	Seelig		VLA/Health Care Advocate Project
Kate	Simmons	Kendall	West		Bi-State Primary Care/CHAC
		Patricia	Launer ✓		Bi-State Primary Care
		Melissa	Miles		Bi-State Primary Care
		Heather	Skeels		Bi-State Primary Care
Richard	Slusky ✓	Pat	Jones ✓		GMCB
		Spenser	Weppler ✓		GMCB
Julie	Tessler				VCP - Vermont Council of Developmental and Mental Health Services
		Sandy	McGuire ✓		VCP - Howard Center
			Joined late.		
	32		45		

22 ✓

VHCIP Payment Model Design and Inplementation Work Group

Attendance Sheet 12/14/2015

	First Name	Last Name		Organization	Payment Model Design and Implementation
1	Peter	Albert		Blue Cross Blue Shield of Vermont	X
2	Susan	Aranoff	here	AHS - DAIL	MA
3	Julie	Arel	phone	AHS - VDH	MA
4	Bill	Ashe		Upper Valley Services	X
5	Lori	Augustyniak		Center for Health and Learning	X
6	Debbie	Austin		AHS - DVHA	X
7	Ena	Backus		GMCB	X
8	Melissa	Bailey	here	Vermont Care Partners	M
9	Michael	Bailit		SOV Consultant - Bailit-Health Purchasing	X
10	Susan	Barrett		GMCB	X
11	Jaskanwar	Batra		AHS - DMH	MA
12	Abe	Berman	phone	OneCare Vermont	MA
13	Bob	Bick		DA - HowardCenter for Mental Health	X
14	Mary Alice	Bisbee	here	Consumer Representative	X
15	Charlie	Biss		AHS - Central Office - IFS / Rep for AHS - DM	X
16	Beverly	Boget		VNAs of Vermont	MA
17	Mary Lou	Bolt		Rutland Regional Medical Center	X
18	Jill Berry	Bowen		Northwestern Medical Center	M
19	Stephanie	Breault		Northwestern Medical Center	MA
20	Martha	Buck		Vermont Association of Hospital and Health	A
21	Mark	Burke		Brattleboro Memorial Hopsital	MA
22	Donna	Burkett		Planned Parenthood of Northern New Engl	X
23	Catherine	Burns		DA - HowardCenter for Mental Health	X
24	Heather	Bushey		Planned Parenthood of Northern New Engl	MA
25	Gisele	Carbonneau		HealthFirst	A
26	Erin	Carmichael		AHS - DVHA	MA
27	Jan	Carney		University of Vermont	X
28	Denise	Carpenter		Specialized Community Care	X

29	Jane	Catton		Northwestern Medical Center	MA
30	Alysia	Chapman		DA - HowardCenter for Mental Health	X
31	Joshua	Cheney		VITL	A
32	Joy	Chilton		Home Health and Hospice	X
33	Amanda	Ciecior		AHS - DVHA	S
34	Barbara	Cimaglio		AHS - VDH	X
35	Daljit	Clark		AHS - DVHA	X
36	Sarah	Clark		AHS - CO	X
37	Peter	Cobb		VNAs of Vermont	X
38	Judy	Cohen		University of Vermont	X
39	Lori	Collins		AHS - DVHA	X
40	Connie	Colman		Central Vermont Home Health and Hospice	X
41	Sandy	Conrad		V4A	MA
42	Amy	Coonradt		AHS - DVHA	S
43	Alicia	Cooper		AHS - DVHA	S
44	Janet	Corrigan		Dartmouth-Hitchcock	X
45	Brian	Costello			X
46	Michael	Counter		VNA & Hospice of VT & NH	M
47	Mark	Craig			X
48	Diane	Cummings		AHS - Central Office	M
49	Patricia	Cummings		AHS - DAIL	MA
50	Michael	Curtis		Washington County Mental Health Services	X
51	Jude	Daye		Blue Cross Blue Shield of Vermont	A
52	Jesse	de la Rosa		Consumer Representative	X
53	Danielle	Delong		AHS - DVHA	X
54	Mike	DelTrecco		Vermont Association of Hospital and Health	M
55	Yvonne	DePalma		Planned Parenthood of Northern New Engla	X
56	Trey	Dobson		Dartmouth-Hitchcock	X
57	Tracy	Dolan		AHS - VDH	M
58	Michael	Donofrio		GMCB	X
59	Kevin	Donovan		Mt. Ascutney Hospital and Health Center	X
60	Rick	Dooley		HealthFirst	M
61	Molly	Dugan		Cathedral Square and SASH Program	MA
62	Lisa	Dulsky Watkins			X
63	Robin	Edelman		AHS - VDH	X
64	Jennifer	Egelhof		AHS - DVHA	MA

65	Suratha	Elango		RWJF - Clinical Scholar	X
66	Gabe	Epstein	here	AHS - DAIL	S/MA
67	Jamie	Fisher		GMCB	A
68	KIm	Fitzgerald		Cathedral Square and SASH Program	M
69	Katie	Fitzpatrick		Bi-State Primary Care	A
70	Patrick	Flood		CHAC	X
71	Erin	Flynn		AHS - DVHA	S
72	LaRae	Francis		Blue Cross Blue Shield of Vermont	X
73	Judith	Franz		VITL	X
74	Mary	Fredette		The Gathering Place	X
75	Aaron	French		AHS - DVHA	M
76	Catherine	Fulton	here	Vermont Program for Quality in Health Care	C
77	Joyce	Gallimore		Bi-State Primary Care/CHAC	X
78	Lucie	Garand		Downs Rachlin Martin PLLC	X
79	Andrew	Garland	here	MVP Health Care	M
80	Christine	Geiler		GMCB	S
81	Carrie	Germaine		AHS - DVHA	X
82	Al	Gobeille		GMCB	X
83	Larry	Goetschius		Home Health and Hospice	M
84	Steve	Gordon	phone	Brattleboro Memorial Hopsital	M
85	Don	Grabowski		The Health Center	X
86	Maura	Graff	phone	Planned Parenthood of Northern New Engla	M
87	Wendy	Grant		Blue Cross Blue Shield of Vermont	A
88	Bea	Grause		Vermont Association of Hospital and Health	MA
89	Lynn	Guillett		Dartmouth Hitchcock	X
90	Dale	Hackett	here	Consumer Representative	M
91	Mike	Hall	phone / here	Champlain Valley Area Agency on Aging / C	M
92	Thomas	Hall		Consumer Representative	X
93	Catherine	Hamilton		Blue Cross Blue Shield of Vermont	X
94	Paul	Harrington	phone	Vermont Medical Society	M
95	Stefani	Hartsfield		Cathedral Square	MA
96	Carrie	Hathaway		AHS - DVHA	X
97	Carolynn	Hatin		AHS - Central Office - IFS	S
98	Karen	Hein		University of Vermont	M
99	Kathleen	Hentcy	phone	AHS - DMH	MA
100	Jim	Hester		SOV Consultant	S

101	Selina	Hickman		AHS - DVHA	X
102	Bard	Hill		AHS - DAIL	M
103	Con	Hogan		GMCB	X
104	Nancy	Hogue		AHS - DVHA	M
105	Jeanne	Hutchins		UVM Center on Aging	M
106	Penrose	Jackson		UVM Medical Center	X
107	Craig	Jones		AHS - DVHA - Blueprint	X
108	Pat	Jones		GMCB	MA
109	Margaret	Joyal		Washington County Mental Health Services	X
110	Joelle	Judge		UMASS	S
111	Kevin	Kelley		CHSLV	X
112	Melissa	Kelly		MVP Health Care	X
113	Trinka	Kerr		VLA/Health Care Advocate Project	X
114	Sarah	King		Rutland Area Visiting Nurse Association & H	X
115	Sarah	Kinsler		AHS - DVHA	S
116	Heidi	Klein		AHS - VDH	MA
117	Tony	Kramer		AHS - DVHA	X
118	Peter	Kriff		PDI Creative	X
119	Kaili	Kuiper		VLA/Health Care Advocate Project	MA
120	Norma	LaBounty		OneCare Vermont	A
121	Kelly	Lange		Blue Cross Blue Shield of Vermont	M
122	Dion	LaShay		Consumer Representative	X
123	Patricia	Launer		Bi-State Primary Care	MA
124	Diane	Leach		Northwestern Medical Center	MA
125	Mark	Levine		University of Vermont	X
126	Lyne	Limoges		Orleans/Essex VNA and Hospice, Inc.	X
127	Deborah	Lisi-Baker		SOV - Consultant	X
128	Sam	Liss		Statewide Independent Living Council	X
129	Vicki	Loner		OneCare Vermont	MA
130	Nicole	Lukas		AHS - VDH	X
131	Ted	Mable		DA - Northwest Counseling and Support Ser	M
132	Carole	Magoffin		AHS - DVHA	S
133	Georgia	Maheras		AOA	S
134	Jackie	Majoros		VLA/LTC Ombudsman Project	X
135	Carol	Maloney		AHS	X
136	Carol	Maroni		Community Health Services of Lamoille Vall	X

137	David	Martini	here	AOA - DFR	M
138	Mike	Maslack			X
139	John	Matulis			X
140	James	Mauro		Blue Cross Blue Shield of Vermont	X
141	Lisa	Maynes		Vermont Family Network	X
142	Kim	McClellan	phone	DA - Northwest Counseling and Support Ser	MA
143	Sandy	McGuire	here	VCP - HowardCenter for Mental Health	M
144	Jill	McKenzie			X
145	Lou	McLaren	phone	MVP Health Care	M
146	Darcy	McPherson		AHS - DVHA	X
147	~~Jessica~~	~~Mendizabal~~		AHS - DVHA	S
148	Anneke	Merritt		Northwestern Medical Center	X
149	Melissa	Miles		Bi-State Primary Care	MA
150	Robin	Miller		AHS - VDH	X
151	Megan	Mitchell	phone	AHS - DVHA	MA
152	MaryKate	Mohlman	here	AHS - DVHA - Blueprint	M
153	Madeleine	Mongan		Vermont Medical Society	X
154	Kirsten	Murphy		AHS - Central Office - DDC	X
155	Chuck	Myers		Northeast Family Institute	X
156	Floyd	Nease		AHS - Central Office	X
157	Nick	Nichols		AHS - DMH	X
158	Mike	Nix	phone	Jeffords Institute for Quality, FAHC	X
159	Miki	Olszewski		AHS - DVHA - Blueprint	X
160	Jessica	Oski		Vermont Chiropractic Association	X
161	Ed	Paquin		Disability Rights Vermont	M
162	Annie	Paumgarten	here	GMCB	S
163	Laura	Pelosi		Vermont Health Care Association	X
164	Eileen	Peltier		Central Vermont Community Land Trust	X
165	John	Pierce			X
166	Tom	Pitts		Northern Counties Health Care	X
167	Luann	Poirer		AHS - DVHA	S
168	Sherry	Pontbriand		NMC	X
169	Alex	Potter		Center for Health and Learning	X
170	Amy	Putnam		DA - Northwest Counseling and Support Ser	MA
171	Betty	Rambur		GMCB	X
172	Allan	Ramsay		GMCB	X

173	Frank	Reed		AHS - DMH	MA
174	Paul	Reiss		HealthFirst/Accountable Care Coalition of tl	MA
175	Virginia	Renfrew		Zatz & Renfrew Consulting	X
176	Lila	Richardson	here	VLA/Health Care Advocate Project	M
177	Susan	Ridzon		HealthFirst	MA
178	Carley	Riley			X
179	Laurie	Riley-Hayes		OneCare Vermont	A
180	Greg	Robinson		OneCare Vermont	M
181	Brita	Roy			X
182	Laural	Ruggles		Northeastern Vermont Regional Hospital	M
183	Jenney	Samuelson		AHS - DVHA - Blueprint	MA
184	Howard	Schapiro		University of Vermont Medical Group Pract	X
185	seashre@msn	seashre@msn.com		House Health Committee	X
186	Rachel	Seelig		VLA/Senior Citizens Law Project	MA
187	Susan	Shane		OneCare Vermont	X
188	Julia	Shaw	phone	VLA/Health Care Advocate Project	M
189	Melanie	Sheehan	~~ph~~ phone	Mt. Ascutney Hospital and Health Center	X
190	Miriam	Sheehey		OneCare Vermont	MA
191	Don	Shook		Northwestern Medical Center	MA
192	Kate	Simmons		Bi-State Primary Care/CHAC	M
193	Colleen	Sinon		Northeastern Vermont Regional Hospital	X
194	Ted	Sirotta		Northwestern Medical Center	MA
195	Shawn	Skafelstad	here	AHS - Central Office	MA
196	Heather	Skeels		Bi-State Primary Care	MA
197	Richard	Slusky	here	GMCB	M
198	Chris	Smith		MVP Health Care	X
199	Angela	Smith-Dieng		V4A	MA
200	Jeremy	Ste. Marie		Vermont Chiropractic Association	X
201	Jennifer	Stratton		Lamoille County Mental Health Services	X
202	Beth	Tanzman		AHS - DVHA - Blueprint	X
203	JoEllen	Tarallo-Falk		Center for Health and Learning	X
204	Julie	Tessler		VCP - Vermont Council of Developmental ar	M
205	Cindy	Thomas	phone	AHS - VDH	MA
206	Shannon	Thompson	phone	AHS - DMH	MA
207	Bob	Thorn		DA - Counseling Services of Addison County	X
208	Win	Turner			X

209	Karen	Vastine		AHS-DCF	X
210	Teresa	Voci	phone	Blue Cross Blue Shield of Vermont	MA
211	Nathaniel	Waite		VDH	X
212	Beth	Waldman		SOV Consultant - Bailit-Health Purchasing	X
213	Marlys	Waller		DA - Vermont Council of Developmental an	X
214	Nancy	Warner		COVE	X
215	Julie	Wasserman	here	AHS - Central Office	S
216	Monica	Weeber		AHS - DOC	X
217	Spenser	Weppler		GMCB	MA
218	Kendall	West		Bi-State Primary Care/CHAC	MA
219	James	Westrich	here	AHS - DVHA	S
220	Robert	Wheeler		Blue Cross Blue Shield of Vermont	X
221	Bradley	Wilhelm		AHS - DVHA	S
222	Jason	Williams		UVM Medical Center	X
223	Sharon	Winn		Bi-State Primary Care	X
224	Stephanie	Winters		Vermont Medical Society	X
225	Mary	Woodruff			X
226	Cecelia	Wu		AHS - DVHA	S
227	Erin	Zink		MVP Health Care	X
228	Marie	Zura		DA - HowardCenter for Mental Health	X
229	Joshua	Plavin		Blue Cross Blue Shield of Vermont	X
230	Sarah	Relk			X
231	Hillary	Wolfley			X
					231

Suzanne Santarchangelo - PHPG

Attachment 2: Presentation

Vermont Health Care Innovation Project 2015: Year in Review

January 2016

Successes: Payment Model Design and Implementation

- Medicaid and Commercial **Shared Savings Programs** (SSPs): Year 2 program implementation; Year 1 savings analyses and distribution; State Plan Amendments approved for Years 1 and 2 of Medicaid SSP; continued provider capacity development.
- Analyses to select and develop **Medicaid Episodes of Care**.
- Continued implementation of Blueprint for Health and Hub & Spoke programs.
- Research to explore and define **Accountable Communities for Health**.
- Collaboration to support development of new payment models for DLTSS providers, including a **Prospective Payment System for Home Health Agencies** and **Medicaid Value-Based Purchasing for Mental Health and Substance Abuse providers**.

Spotlight on: PMDI: Counting our Beneficiaries

- Summer 2015 – Stakeholders and CMMI requested we develop unduplicated counts of Vermonters in alternatives to fee-for-service (FFS).
- VHCIP staff worked with payers and other State staff to identify this new number, and to develop a denominator of Vermonters eligible to participate in payment reforms.*
- Total number of Vermonters in an alternative to FFS: 317,922 or 55% of all eligible Vermonters (no duplicates across programs).

* Non-eligible: Medicare Advantage enrollees, Military personnel, uninsured individuals, incarcerated individuals

Successes: Practice Transformation

- **Integrated Communities Care Management Learning Collaborative** continued first cohort and launched second cohort.
- **Disability Awareness Briefs** developed.
- Continued implementation of **Regional Collaboratives**.
- Continued implementation of **Sub-Grant Program**, including two well-attended symposiums.
- **Care Management Inventory** finalized.
- Contractor selected to perform **Workforce Demand Modeling** work.
- **Workforce Supply Data Collection and Analysis** is ongoing.

Spotlight on Practice Transformation: Integrated Communities Care Management Learning Collaborative

- Learning Collaborative is now statewide – expanded to 8 additional communities (11 total).
- Communities are developing processes and tools to better serve at-risk individuals, and engaging in continuous quality improvement.
- Key lessons learned identified:
  - Some of most complex individuals do not have a case manager.
  - Lead case manager may change as individual's needs change.
  - Some individuals have many community partners working with them without realizing this.
- Communities are reporting positive anecdotal results and starting to explore more formal evaluation.

Successes: Health Data Infrastructure

- **Gap Analyses** for ACO and DLTSS providers completed.
- **Gap Remediation** begun for ACO member organizations and Designated Mental Health and Specialized Service Agencies.
- **ACO Gateways** for OneCare and CHAC completed.
- **Data Quality** improvement efforts launched for ACO providers and Designated Agencies.
- **Telehealth Strategic Plan** finalized; RFP for **Telehealth Pilots** released and bidders selected.
- **EMRs acquired** for five Specialized Services Agencies (SSAs) and for the Dept. of Mental Health/State Psychiatric Hospital.
- Contract executed for **Vermont Care Network Data Repository**.
- Business and technical requirements developed for **Universal Transfer Protocol** and **Shared Care Plan** solutions.
- **Event Notification System** contractor selected.
- **Health Data Inventory** completed.

Spotlight on HDI: Shared Care Plans

- Business requirements gathering through the Shared Care Plan/Universal Transfer Protocol project uncovered significant community enthusiasm for a solution:
  - Says one team member: “It not only turned up the pressure on the team to provide a useful tool but really energized us to deliver a high performing solution that would change the way health care was being delivered in those communities.”
- The project completed initial requirement-gathering (both business requirements and technical requirements) and is currently developing a proposal for a solution, to be piloted in 2016.

Successes: Evaluation and Project Management

Evaluation

- **Self-Evaluation Plan** draft submitted to CMMI.
- New **Self-Evaluation Contractor** selected based on revised self-evaluation scope.

Project Management and Reporting

- Launched **Outreach and Communication** activities, including work toward website redesign.
- Successfully overhauled **Project Governance** structure to support robust stakeholder engagement and expedited decision-making.

Challenges

- Delayed Year 2 budget approval.
- Shift to new governance structure.

Looking Ahead: 2016!

- **Payment Model Design and Implementation:**
  - Final year of Shared Savings Programs.
  - Launch of 3 Medicaid Episodes of Care.
  - Peer learning opportunity to develop Accountable Communities for Health.
  - Continued work to launch new payment models for Home Health Agencies and mental health/substance abuse providers.
- **Practice Transformation:**
  - Core Competency Trainings focused on general care management skills and DLTSS-specific competencies.
  - Wrap up Integrated Communities Care Management Learning Collaboratives.
  - Wrap up Sub-Grant program.
  - Workforce Demand Modeling, Supply Data Collection and Analysis.

Looking Ahead: 2016! (Continued)

- **Health Data Infrastructure**:
  - Continue Data Quality efforts for ACO providers and DAs.
  - Launch Telehealth pilots.
  - Continue work on DA/SSA Data Warehousing solution, and begin to implement cohesive strategy for developing data systems to support analytics.
  - Launch Shared Care Plan solution pilot, launch Universal Transfer Protocol solution.

- **Evaluation**:
  - Launch of new self-evaluation contract.
  - Implementation of Self-Evaluation Plan.

Looking Ahead: 2016! (Continued)

- Also:
  - **Population Health Plan** development.
  - **Sustainability Planning**.
  - Launch of final **suite of HDI projects** that could include additional gap remediation (all pending Core Team approval).
  - Gathering **lessons learned** from across the project.

Attachment 3a: Population Health Financing Report

Sustainable Financing for Population Health in Vermont

Population Health Work Group
Jim Hester
November 2015

DRAFT 3

The opinions expressed in the paper are those of the author and have not been endorsed by the Vermont Population Health Work Group or VHCIP. They are intended to stimulate discussion and the development of policy options.

Sustainable Financing for Population Health in Vermont

I. **Introduction**

The biggest single barrier to improving the health of Vermont's population is the lack of a sustainable financial model which supports and rewards improvements in population health. To clarify, financing vehicles are the sources of funds, as opposed to payment models which are how funds are disbursed to providers for services. In the past, population health interventions have been financed primarily by grants and limited term awards which resulted in the termination of successful programs when their funding ended. A conceptual model for sustainable financing includes the following elements (Hester et al, "Towards Sustainable improvements in Population Health: Overview of Community Integration Structures and Emerging Innovations in Financing" CDC Health Policy Series #2, 2015):

1. Diverse financing vehicles: One of the encouraging developments has been the emergence of a diverse set of financing vehicles and sources of funds for population health interventions.
2. Balanced portfolio of interventions: meeting the needs of a community requires implementing a combination of different programs which are balanced in terms of their time horizon for producing results, their risk of failure, their scale and their financing vehicle.
3. Integrator or backbone organization: the integrator brings together key community stakeholders to assess needs and build a consensus of priorities. It then builds the balanced portfolio over time, matching each intervention with an appropriate financing vehicle and an implementer organization.
4. Reinvestment of savings: one of the basic principles of long term sustainability is capturing a portion of the savings of each intervention and returning it to the community for reinvestment. A community wellness fund is a useful repository for these captured savings.

One of the three themes of the Population Health Workgroup charter focused on the third element or integrator organizations, which have been given the name Accountable Community for Health. The report of the Prevention Institute clarified the functional capabilities of the ACH, reviewed the experience of national exemplars, identified six Vermont communities which have laid the foundation for an ACH and recommended how to move these communities to the next level (Prevention Institute, "Accountable Communities for Health: Opportunities and Recommendations", 2015). The report confirmed that several Vermont communities have been quite successful in doing the front end work of building a community coalition and prioritizing needs. However, translating those plans into

sustained action has been hampered by the issue of sustainable financing. This memo will address two of the other components of the model by reviewing the innovative financing vehicles currently available for inclusion in a balanced portfolio, and the prospects for reinvesting savings. This memo complements the work of the Center for Health Care Strategies which is reviewing innovative public models for program support (reference) and the three new payment models being tested in the Vermont Health Care Improvement Project (VHCIP).

The mix and potential sources of financing evolve with the stage of development of the integrator: start up, initial implementation, and mature. The two earlier stages will have a greater dependence on grants and donations as they build core infrastructure and begin developing their portfolio. More mature organizations will have a track record which lets them access a wider range of financing vehicles.

II. **Overview of Financing Vehicles**

We know that social determinants, including behavior and environmental exposures, play a greater role in population health than do clinical services. However, the time frames for some upstream health interventions often stretch over years, if not decades, and thus require different financing vehicles than payment models for clinical services. One of the more exciting developments in population health is the emergence of new financing vehicles for population health. (Hester et al, CDC policy series # 2, 2015) The following financing vehicles will be reviewed in this paper:

1. global budgets
2. non profit hospital community benefit
3. community development financial institutions
4. engagement with private sector
5. social impact bonds/pay for performance
6. community wellness fund

The rest of this paper will briefly describe each vehicle and comment on the experience within Vermont, interactions with other components of Vermont health reform and the prospects for reinvestment.

Global budgets: an entity, usually a health care system, is paid a global budget to provide a comprehensive bundle of services to a defined population. The budget can be population based eg capitation paying an amount for each person per month, or an aggregate budget which is adjusted each year for inflation and system changes such as demographics, technology etc. The level of risk accepted if the global budget is exceeded can vary from nothing for 'one sided' shared savings programs to 100%

for pure capitation. The global budget is an effective means of capturing short term savings and provides strong incentives to reduce the volume of services. To ensure that those incentives are not abused, global budget programs include a strong set of quality measures to ensure that patients have good access and are not denied appropriate care

Vermont health care systems have extensive experience with this vehicle, including

- risk sharing programs with commercial insurers (The Vermont Health Plan sponsored by Blue Cross of Vermont and MVP's program with three Vermont PHO's)
- ACO savings sharing programs for commercial insured, Medicaid and Medicare
- Rutland Regional Medical Center proposal for a pilot global budget program.

Both Vermont state government and several health care systems have long been interested in moving to a global budget and a waiver to create an all payer global budget program is being designed for submission to CMS. This waiver would be similar to that granted to Maryland, but would be broader in scope of services covered and be more comprehensive that just hospital care. At the request of the St. Johnsbury community, Senate Finance Committee passed language in S 135 for an implementation plan for an Accountable Care Community including a community wide budget with one option being a global budget. The language was eventually withdrawn, but it led to a feasibility study which is currently underway with an initial focus on integrating key social and mental health services.

Hospital Community Benefit and Investments: The Affordable Care Act (ACA) strengthened the requirement for non profit hospitals to provide community benefit by requiring the preparation of a Community Health Needs Assessment, together with an implementation plan. The ACA strengthened this IRS requirement at the same time that expanded insurance coverage is expected to reduce the need for charity care. Therefore, there was an expectation that healthcare systems would target freed-up funds toward true prevention and wellness efforts—efforts aimed to keep people healthy and out of the clinical care system. The Green Mountain Care Board has required Vermont hospitals to include their assessment and plan as part of their annual budget submission. While in the past, community benefit funds have been used largely for free care and to cover Medicaid discounts, the Prevention Institute report documented that Vermont hospitals have been receptive to playing a lead role in convening and supporting a wide range of community health initiatives.

A new trend that is developing is for hospitals to tap their endowments and investment portfolios to provide low cost capital loans for community investments. Two examples are Dignity Health's $200 million fund for partnering with Community Development Financing Institutions (CDFI's) and in Vermont, UVM Medical Center recently supported the creation and operation of Harbor Place in Shelburne, which provides short-term/transitional housing for patients who don't need a hospital but need more care/support than they can get "on the street." . Community Benefit awards are an important source of funding for piloting programs and building capacity during startup or initial development, but they do not provide a way to share in savings or sustainable financing.

Community Development Financial Institutions: Some financial institutions have a similar requirement to reinvest in their community, per the Community Reinvestment Act, which they have delegated to a nationwide network of Community Development Financial Institutions (CDFI's). CDFI's, with the encouragement of the Federal Reserve, have recently expanded their traditional focus on economic development and housing to health. Because many of these CDFI's are sophisticated financial organizations managing large, diverse portfolios, they bring advanced modeling and analytic capabilities. We are already beginning to see innovative partnerships developing outside of Vermont between healthcare systems, public health entities, and these private sector institutions, and to see coordination across those partnerships so that portfolios, investments, and interventions are aligned (for example, the Alignment for Health Equity and Development initiative, AHEAD).

While Vermont health care reform has partnered with community development and housing organizations such as the SASH program with Cathedral Square Corporation, we are not aware of any joint initiatives with local or regional CDFI's. However, three Vermont communities recently participated in a joint workshop with CDFI's hosted by the Boston Federal Reserve. This has created connections with CDFI's and stimulated interest in developing joint projects with them.

Engagement of Private Sector: The private sector is becoming increasingly involved in public health in a number of ways. Some businesses are recognizing that they have multiple reasons for helping improve community health include improving employee productivity, controlling employee health care costs, improving recruitment and retention of workforce. Channeling corporate philanthropy can also serve a dual role, contributing to healthier community and improving community relations, goodwill, or branding, and creating public and private partnerships that can become the foundation for cooperation and

community-based problem solving for many other issues. Self-insured employers, who now account for a majority of the commercially insured population, are adopting triple aims objectives for their employee benefit programs, working with new advisors such as Vermont's Marathon Health. These employers have recognized the multiple benefits of having a healthier workforce and are becoming much more proactive in designing their benefits and interventions to explicitly target improvements in health. Many of these companies are more nimble than public payers and willing to experiment with innovative programs and policies to improve health. For example, several Vermont employers are supporting the ReThink Health community in the upper Connecticut River valley by making a per employee contribution.

Social Impact Bonds: Social Impact Bonds (SIBs) represent a potentially powerful tool to leverage new capital for initiating targeted upstream health innovations. However, SIBs are only suitable for a select type of social problem and intervention. They provide project-specific (versus system-wide) financing typically lasting from 4-6 years, and are most appropriate for use in building community-based health care and social services programs necessary to reduce the need for more expensive hospital-based services. To reduce investor risk, SIBs are not used to test new strategies, but rather to grow previously proven interventions with a high likelihood of social impact and adequate ROI. SIBs should be viewed as a funding source that can be part of a portfolio of financing solutions that together bolster both short and long-term improvements to a community's health and health care systems.

SIBs use funds pooled from investors to scale evidence-based interventions that decrease the demand for costly avoidable health services, promoting savings across a range of payers. Investors, often backed by philanthropic organizations, bear the financial risk of program success; principal and a financial return on their investment (ROI) is only paid if agreed upon outcomes are achieved. Since successful SIB implementation requires cooperation among numerous stakeholders, they are ideally suited for environments where collaborative partnerships are pre-existing or where durable linkages could easily be developed. While in the near term health-related SIBs will tend to focus on issues generating significant and immediate savings, the hope is that SIBs will be adapted to fund long-term population-based health interventions. They are a potential vehicle for capturing cross sector impacts and sharing in savings for reinvestment.

To date, there are no examples of SIBs in Vermont. Cathedral Square did a feasibility study with an investment partner for a SIB to finance the Support and Services at

Home program (SASH), but the state was not interested in pursuing the model at the time.

Community Wellness Fund: Funding pools raised and set aside specifically to finance prevention and wellness interventions aimed to improve the health outcomes of specific populations. As wellness trusts strategically allocate funds to coordinate prevention efforts, they have the potential to enable collective impact in wellness investment. Wellness trusts are managed by multi-stakeholder governing bodies, focus on the development of a coordinated portfolio of improvement projects, and pool sustainable funds for community level health improvement.

In 2008 Vermont created a Health Care Information Trust Fund to support a state wide health information exchange and help finance electronic medical records for primary care physicians. The fund was financed by a small assessment on all medical claims which recaptured some of the projected savings to insurers. It provides an example of a potential state level wellness trust. The Upper Connecticut River Valley initiative is exploring the possibility of a community level wellness fund.

III. **Next Steps**

The Prevention Institute documented that a number of Vermont communities have laid the groundwork for an ACH and need a path to sustainable funding to move to the next level. A number of national projects are explicitly exploring the issue of sustainable funding including Moving Health Care Upstream, the 100 million lives campaign and the ReThink Health initiative. VHCIP should monitor these projects and encourage Vermont sites to participate in them and in new ones as they emerge.

Some of the more promising financing options which should be explored by the work group include

- community global budget: this model offers the greatest potential for reinvestment of shared savings and evolution over time to a Total Accountable Care Organization. The all payer waiver being designed should include the option to test the findings of the St. Johnsbury feasibility study on reducing the barriers to integration and access to a broad spectrum of services and to paying the global budget to an ACH
- Health care systems investments:. Systems can leverage their community benefit funds by partnering with other organizations such as CDFI's, bulding

community centered programs into their operating budgets, and adding strategic community loans to their investment portfolio.

- Partnerships with CDFI's: Partnerships between Vermont health systems, ACH and CDFI's should be explored, including both local CDFI's and regional CDFI's who may be attracted to the vibrant population health initiatives in the state.
- Vermont Community Wellness Fund: Develop a proposal for a statewide fund which could be used to match community support for local initiatives.
- Value added support for community integrator infrastructure: make the business case for the added value to employers, the equivalent of developers fees for housing projects and other bases for adding value.

All of these options require developing stronger evidence and bridging the cultures of health care, public health and financing: The new financing vehicles offer the promise of major sources of capital to fund programs and infrastructure targeted at upstream determinants of health, but they also impose new requirements for better evidence on financial impacts and better tools for projecting long term consequences. Much of the traditional evidence for public health interventions stops at risk factors and does not go the next step to document savings and costs. The development of convincing business cases which tap new sources of capital will require new types of evidence. This includes modeling the outcomes of interventions assess feasibility, likelihood of success and Return on Investment, both in terms of improving health and moderating costs.

Attachment 3b: Presentation

Financial Model For A Sustainable Community Health System

Payment Models Workgroup
January 4, 2016

Jim Hester
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Population Health WG Charter

Three tasks, including

"How to pay for population health through modifications to proposed health reform payment mechanisms, and identification of promising new financing vehicles that promote financial investment in population health interventions."

Questions

- How to support a community health system and reward improvements in population health and well being?
  - Financing for infrastructure
  - Funding for interventions
- How to capture part of savings for reinvestment?
- How to align payments for services to support improvements in population health?

Outline

- Context: Population health and delivery system reform
- Components of financial model
  - Overview of financial vehicles: sources
  - Balanced portfolio
- Options for VT agenda for paying for population health

Disclaimer: my thoughts and interpretation, not a PHWG or VHCIP proposal

I. Population Heath and Delivery System Payment Reform

Measures of Success

Better health care:	Improving patients' experience of care within the Institute of Medicine's 6 domains of quality: *Safety, Effectiveness, Patient-Centeredness, Timeliness, Efficiency,* and *Equity.*
Better health:	Keeping patients well so they can do what they want to do. Increasing the overall health of populations: address behavioral risk factors and focus on preventive care.
Lower costs through Improvement:	Lowering the total cost of care while improving quality, resulting in reduced expenditures for Medicare, Medicaid, and CHIP beneficiaries.

US Health Care Delivery System Evolution

Acute Care System 1.0

Episodic Non-Integrated Care

- Episodic health care
- Lack integrated care networks
- Lack quality & cost performance transparency
- Poorly coordinated chronic care management

Coordinated Seamless Healthcare System 2.0

Outcome Accountable Care

- Patient/person centered
- Transparent cost and quality performance
- Accountable provider networks designed around the patient
- Shared financial risk
- HIT integrated
- Focus on care management and preventive care

Community Integrated Healthcare System 3.0

Community Integrated Healthcare

- Healthy population centered
- Population health focused strategies
- Integrated networks linked to community resources capable of addressing psycho social/economic needs
- Population-based reimbursement
- Learning organization: capable of rapid deployment of best practices
- Community health integrated
- E-health and telehealth capable

Halfon N. et al, Health Affairs November 2014

Status: Growing Opportunity

- Broad diffusion of language supporting better health for populations
- New payment models being tested at scale
- Signs of payers aligning in initial regional markets, e.g., Comprehensive Primary Care Initiative
- **BUT**, delivery system evolution lags rhetoric, with broad distribution across Halfon's scale
  - A very few exploring path to 3.0

Challenges for Population Health Financial Models

- Other dimensions of value have a long history in payment models
  - Interventions better understood
  - Measures and instruments developed
  - Accountability more clear cut
- Tasks of transforming to manage total cost and patient experience are all consuming
- Population health business case is complex and involves impacts from multiple sectors over extended times
- Confusion between quality of care and population health

Threats

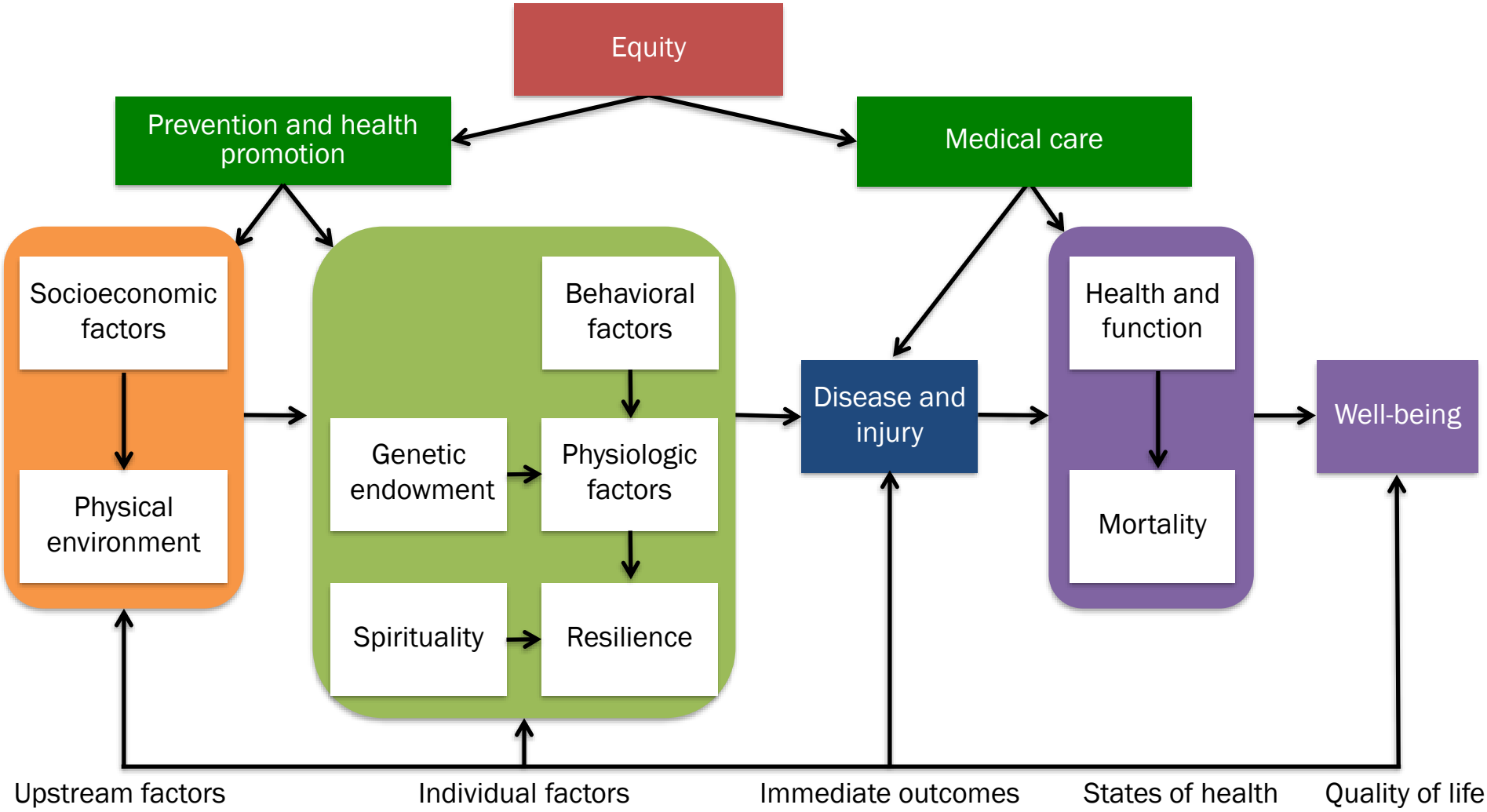
Payment models for population health in early stage

- Population health traditionally funded by grants
- Infrastructure and tools for population health are not well developed.
  - Analytic models for projecting long term impacts
  - Evidence for business case – fundamentally different from impact on risk factors (CMS vs. CDC)
  - Robust measures for learning, accountability and payment
- Risk:
  - new payment models will be established with no meaningful population health component
  - Savings realized without reallocation upstream

II. Key Components of Sustainable Financial Model

- ✓ Theory of action
- ✓ Inventory of financing vehicles
- ✓ Building a balanced portfolio
- ✓ Community level structure: Community Health System

What determines population health?



SOURCE: Adapted from Stiefel M, Nolan KA. Guide to Measuring the Triple Aim: Population Health, Experience of Care, and Per Capita Cost. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2012.

Theory of Action

- Multiple levels of action: practice, community, region/state, federal
- Integration at community level of clinical, public health and community based interventions
- Balanced portfolio of interventions
- Need both operating revenue stream and capital for infrastructure development
- Multi-sector investments and benefits
- Capture portion of savings/benefits for reinvestment for long term sustainability

Inventory of Financing Vehicles

Necessary, but not sufficient building blocks

- Funding for clinical services- (2.0 based)
  - Global Budget: eg Hennepin Health
    - Shared savings
    - Capitation
    - Total Accountable Care Organization (TACO)
- Public financing:
  - single sector
  - Multi-sector programs

Payment Taxonomy Framework

	Category 1: *Fee for Service—No Link to Quality*	Category 2: *Fee for Service—Link to Quality*	Category 3: *Alternative Payment Models Built on Fee-for-Service Architecture*	Category 4: *Population-Based Payment*
Description	*Payments are based on volume of services and not linked to quality or efficiency*	*At least a portion of payments vary based on the quality or efficiency of health care delivery*	*Some payment is linked to the effective management of a population or an episode of care. Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk*	*Payment is not directly triggered by service delivery so volume is not linked to payment. Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g. ≥1 yr)*
Medicare FFS	• Limited in Medicare fee-for-service • Majority of Medicare payments now are linked to quality	• Hospital value-based purchasing • Physician Value-Based Modifier • Readmissions/Hospital Acquired Condition Reduction Program	• Accountable care organizations • Medical homes • Bundled payments • Comprehensive primary care initiative • Comprehensive ESRD • Medicare-Medicaid Financial Alignment Initiative Fee-For-Service Model	• Eligible Pioneer accountable care organizations in years 3 5

Stage 4 Global Budget Model

- System wide population based global budget for
  - Defined population
  - Broad scope of services/core interventions
- Impact: incentives for desired outcomes
  - Scale: impact on total revenue
  - Measures: balanced, robust measures of health
- Aligned payments allocating funds to service providers
  - Inside system
  - Outside system
- Reinvestment of part of savings
- Support for Community Health System
- Operationally feasible
  - Data accuracy/availability

Growing Inventory of Financing Vehicles

Innovative funding sources

- Hospital
  - community benefit
  - Investments: Dignity, Trinity, Dartmouth-Hitchcock
- Community development, e.g., CDFI (AHEAD)
- Social capital, e.g., social impact bonds
- Foundations: Program Related Investments (PRI)
- Employers e.g. subscription, employee benefits
- Prevention/wellness trusts

Issue: fragmentation, lack of coordination

IOM Roundtable on Pop Health 2/2014

Model: Community Development Financial Institutions (CDFI)

- Payment mechanism: how does it work?
  - Tied to banks' Community Reinvestment Act compliance
  - Helps structure subsidized financing to community development corporations and other investors for projects in low income areas
  - Heavy emphasis on affordable housing, but moving to support development of grocery stores, and other "upstream" areas
- Time frame: Longer term (10-30 years)
- Risk profile: CDFI functions to reduce financial risk for projects
- Status: ~1,000 nationwide, weighted toward urban areas

Model: Pay for Success or Social Impact Bond

- Payment mechanism: how does it work?
  - Publicly financed program identified with known interventions and proven returns.
  - Capital needed to scale intervention
  - Create investment model for returns based on performance metrics and private investors deliver capital.
- Time frame: Short term (1-3 years)
- Risk profile: Moderate (with experience). Needs risk mitigation and high financial returns to attract capital.
- Status: Started in UK. Some uptake in USA in social sector/early in health

Building a Balanced Portfolio

No silver bullet – need to

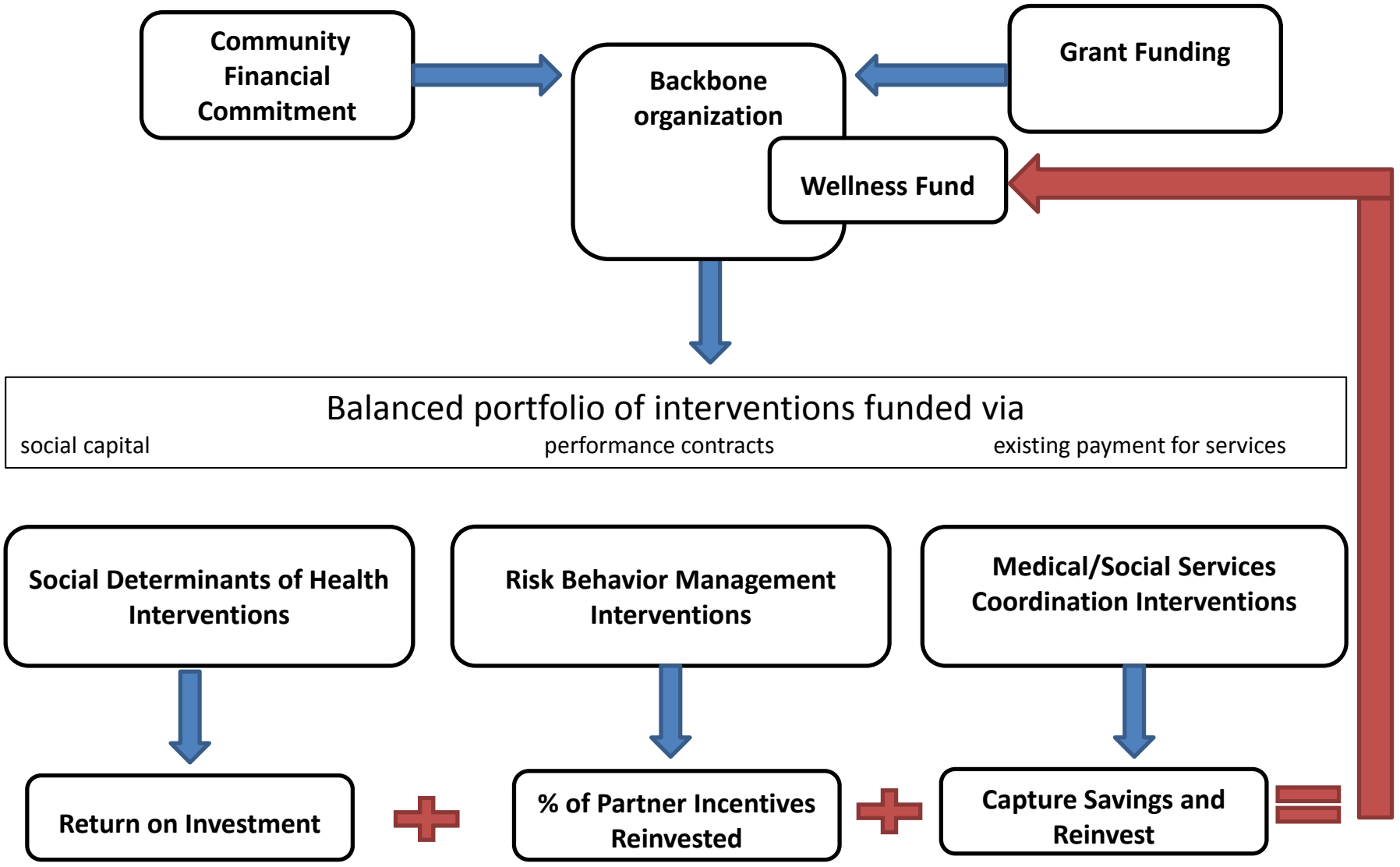
- Balance portfolio in terms of
  - Spectrum of time horizons for impacts
  - Level of evidence/risk: test innovative interventions
  - Scale
- Build case and close on specific transactions
- Aggregate and align financing streams
- Manage and leverage private and public investment to achieve greater impact

TABLE 1 Sample Balanced Portfolio for Community Health System

Intervention	Target population	Implementation partners	Financing vehicle	Time frame	Risk/evidence	Savings sharing vehicle
Intensive care coordination	Dual eligible high utilizers	Accountable care organizations	Shared savings	Short	Low risk	Community benefit
Integrated housing–based services	Medicaid eligible, multiple chronic illness	Medicaid managed care plan, housing corporation	Capitation	Short	Low risk	Performance contract
Innovative use of remote monitoring	Medicare eligible, multiple chronic illness	Medicare Advantage Plan, private foundation	Grant	Short	High risk	None
YMCA diabetes prevention program	Commercial insured and self insured	Commercial health plan, self-insured employers	Shared savings	Medium	Medium	Performance contact
Expand early childhood education	Reduce adverse childhood events	Preschool educators	Pay for Success, Social Impact Bonds	Long	Medium	Investing in Social Impact Bond
Community walking trails	Community	Nonprofit hospital	Community benefit	Long	Medium	

Source: Hester, J.A. and P.V. Stange. 2014. *A sustainable financial model for community health systems*. Discussion Paper, Institute of Medicine, Washington, DC. http://www.iom.edu/Global/Perspectives/2014/SustainableFinancialModel.

Backbone Organization's Aggregation and Alignment of Investments and Reinvestments



Structure of a Community Health System

The CHS is made up of

- Backbone/integrator organization for governance structure and key functions
- Intervention partners to implement specific short, intermediate, and long term health-related interventions
- Financing partners who engage in specific transactions

Financial sustainability is dependent upon CHS adding value to partners and stakeholders: development fee

Note: AHC is one example of CHS

III. Potential Vermont Agenda

Period of Experimentation to Create

- Working examples of community integrators with enhanced financial competencies
- Successful collaboration with stakeholders with innovative financing vehicles
- Better tools
  - Analytic models for projecting impacts
  - Measures for monitoring, accountability and payment: CMMI project
- Evidence on financial impact across sectors

Opportunities for Developing Working Models

- CMS State Innovation Models:
  - Round 1: 6 testing and 16 design states
  - Round 2: 11 testing and 21 design awards
- Moving Health Care Upstream: Nemours/UCLA/
- AHEAD (Alignment for Health Equity and Development): PHI and The Reinvestment Fund)
- Collaborative Health Network: NRHI
- BUILD Health Challenge: Kresge, RWJ and deBeaumont
- Escape Velocity to a Culture of Health: IHI 100 million people, 1000 communities by 2020
- Way to Wellville contest (HICCup): 5 communities for 5 years

Vermont Financing Vehicles

- Community based global budget option in CMS waiver
  - Population based global budget for AHC
  - Payment for infrastructure and reinvestment
  - Build on UCC structure
  - One element of AHC pilot
- Health care systems investment portfolio
- Partnerships with CDFI's
  - Boston Federal Reserve meeting
- Pilot Social Impact Bond
- Vermont Community Wellness Fund
  - Example of Health IT Fund

Aligning Payment Models With Population Health

Window of Opportunity

- PCP payment: enhanced population health metrics in HSA component of Blueprint model
- Shared Savings Model
  - More robust measures
  - HSA population
- Test enrollment model
  - Commercial: self insured, VT connect
  - Medicaid
  - Medicare: Next Gen ACO
- Align specialty care compensation
  - CMMI Cardiovascular Risk Reduction Program
  - Bundled payments

How to Finance Population Health?

A simple question to ask, but one remarkably difficult to answer

We won’t get the community health system we need until we learn how to answer it.

Additional Materials

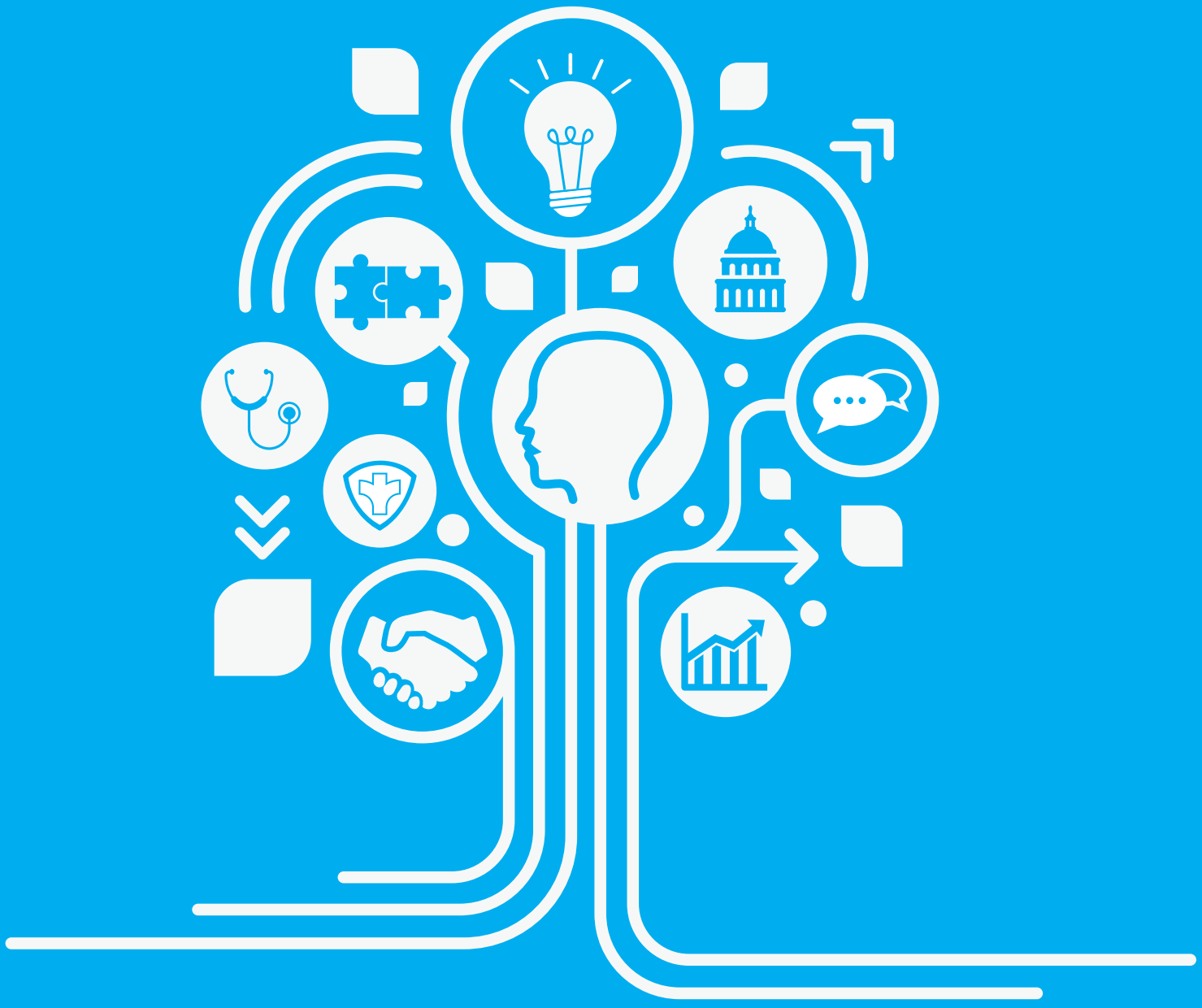
02

CDC HEALTH POLICY SERIES

Towards Sustainable Improvements in Population Health

Overview of Community Integration Structures and Emerging Innovations in Financing

Hester JA,[a] **Stange PV,**[b] **Seeff LC,**[b] **Davis JB,**[c] **Craft CA**[d]



U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

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The American healthcare system is in the midst of unprecedented change, and the Triple Aim®[1,2]—achieving better care for patients, better health for communities, and lower costs through healthcare system improvement—is becoming a widely accepted framework for the desired outcomes of the evolving system.[1,2] Key elements emerging in this transformation include new structures for integrating and coordinating services, a renewed focus on patient engagement and patient-centered care, and new payment models based on the value of population-based health outcomes rather than the volume of services delivered. Private and public payers are testing these payment models in large-scale settings involving thousands of providers and millions of patients. In selected markets, multiple payers are working to align their respective payment models with one another to speed the transformation. This period of change is creating important opportunities to establish effective, more sustainable, community-focused delivery and payment models to improve population health.

Those opportunities—and the accompanying challenges—are discussed in this report. We review evolving community-level population health delivery models; define the key functions, opportunities, and challenges of a community integrator; and introduce the concept of a balanced portfolio as a crucial component in developing a sustainable financial model. We also review emerging financing vehicles that could be used for specific population health interventions.

WHY EMPHASIZE POPULATION HEALTH?

Before going further, it is helpful to define population health and establish why the broader focus on population health is important. The term population health has a range of meanings and uses within the healthcare and public health fields. For this report, we will use Kindig and Stoddart's definition adopted by the Institute of Medicine Roundtable on Population Health Improvement: "the health outcomes of a group of individuals, including the distribution of such outcomes within the group…population health outcomes are the product of many determinants of health, including healthcare, public health, genetics, behavior, social factors, and environmental factors."[3,4]

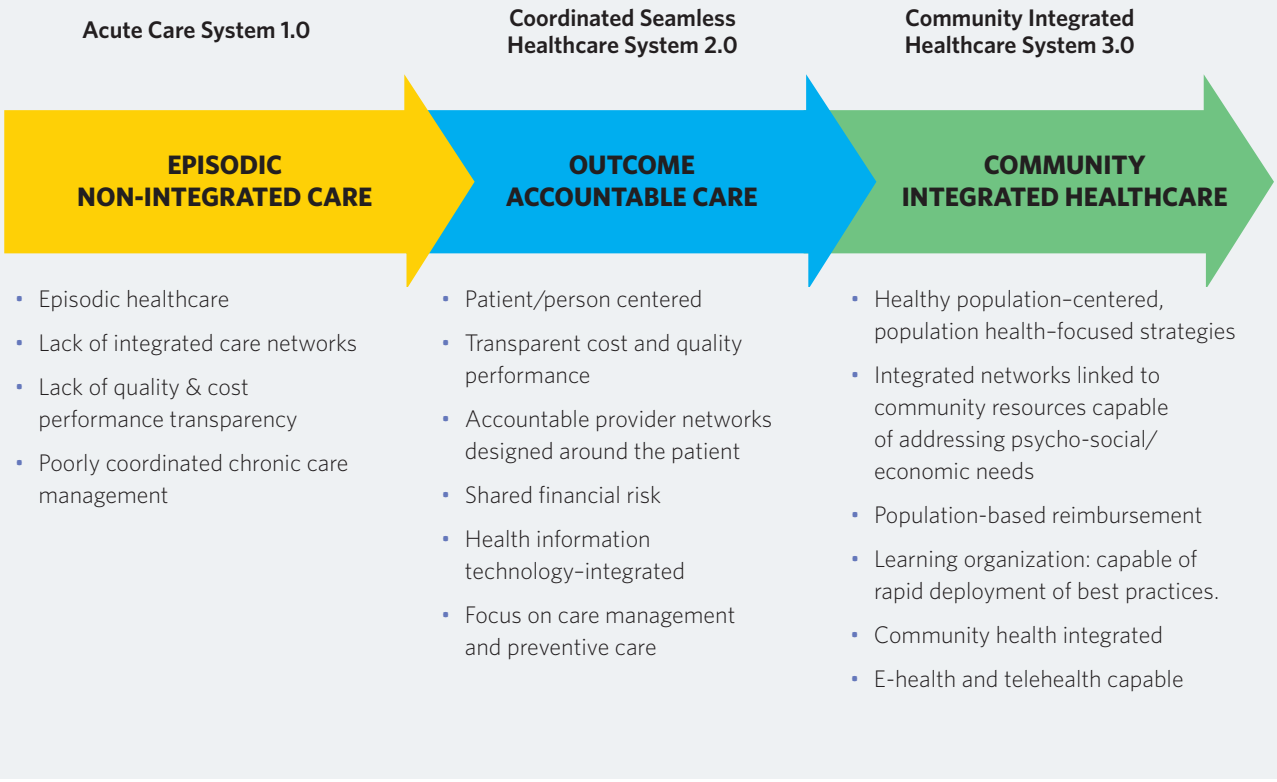
Determinants of health models attribute only a small percentage of a population's health to care received in a clinical setting[5]; however, most healthcare systems and payers continue to focus on improving care delivered to individual patients in a clinical setting with far less attention to the non-medical determinants of health that impact longer-term improvements in the health of individuals and the community. The implication for the current healthcare system seems clear: If the goals of the Triple Aim® are to be realized, this period of innovation must shift the focus beyond the clinical setting to also address other determinants of health for the overall population.

Halfon has created a helpful framework that defines transitions along three stages in the evolution of the healthcare system that must occur to achieve the Triple Aim® (Figure 1).[6] The first transition moves from the traditional, episodic, acute care–focused stage (Healthcare 1.0) to a more patient-centered stage that coordinates care for a variety of chronic illnesses across a broad range of caregivers and over the lifetime of the patient. This is Healthcare 2.0. Many local and regional healthcare systems throughout the United States are engaged in this transition, implementing new care models such as patient-centered medical homes[2,7] and accountable care organizations (ACOs).[2,8,9] The second transition moves from the 2.0 patient-centered care to a community-based system that addresses the full spectrum of health, including healthcare and the determinants of health, to reduce the prevalence of chronic disease and improve the quality of life. This is Healthcare 3.0, a community integrated healthcare framework.

One likely indicator of a mature 3.0 stage is a shift in accountability from a panel of patients who use a provider or healthcare system to the total population within a geographic area, only a subset of which Healthcare stages 1.0 or 2.0 traditionally serve. Recognizing the significance of the determinants of health within the 3.0 stage requires that the health system 1) expand the scope of interventions beyond clinical services to include a wide range of community-based interventions targeting non-medical determinants of health; and 2) access data that can measure clinical and non-clinical delivery and outcomes for a total geographically defined population.

Although the Triple Aim® is being embraced more widely and incorporated into mission statements and objectives of local, state, and national initiatives, many healthcare systems are reluctant to move away from the familiar fee-for-service payment model. In practice, very few are actually testing a path to Halfon's Healthcare 3.0.[6]

FIGURE 1: U.S. Healthcare Delivery System Evolution: Health Delivery System Transformation Critical Path



Halfon N, Long P, Chang DI, Hester J, Inkelas M, Rodgers A. Applying a 3.0 transformation framework to guide large-scale health system reform. *Health Affairs* 2014;31(11). doi: 10.1377/hlthaff.2014.0485.

EMERGING COMMUNITY-LEVEL INTEGRATION STRUCTURES

Improving population health requires integration of multiple levels within a health system.[8] The first is the primary care practice level—the foundation of integrated care to meet each patient's needs. Such integration requires managing care across multiple settings and supporting patients in making long-term changes in health risk behaviors.

The second is the community or regional health system level, which starts with a local network composed of the community hospital, its primary care practices and specialist physicians, and other key providers in the local area, including those addressing behavioral health.[8] This level must expand to include a spectrum of other public health services, social and behavioral health services, and community-based resources that are vital to facilitate effective disease management for the health of a population.

The third level—the state—provides the enabling infrastructure for the primary care and community health system. That infrastructure includes health information technology support, design and implementation of all-payer payment reforms, and

technical support and training to share best practices and build process improvement.[10] An important current state-based initiative is the State Innovation Model program of the Centers for Medicare and Medicaid Services (CMS).[11] This program will integrate and align state policies in a state transformation plan designed to accelerate delivery system reform.

Finally, an alignment of resources is important for an integrated health system. At the federal level, the transformative policy and payment reforms already occurring in Medicare[12] provide important opportunities for community provider networks to consider. All four levels need to be engaged, but we focus here on the community level.

Community Integrator and a Balanced Portfolio

At the community health system level, one promising approach is the establishment of a community health integrator, accountable for the health of a total population within a geographic area, including reducing health disparities within that population. A number of conceptual models identify the need for an integrator as a central component of a community health system to bring together clinical care, public health, and community services in a coherent strategy to meet the community's needs. This integrator is at the core of models such as the Community Chief Health Strategist,[13,14] Accountable Health Communities,[15] community integrators,[16] community quarterbacks for community development,[17] and the "backbone organization" described in the collective impact movement.[18] For the purposes of this report, we will refer to these models collectively as community integrators. As multiple community integrator models are emerging, the specific term used to describe the integrator is less important than an emphasis on its key structure and functions.

The community integrator is structured as a geographically based organization that identifies appropriate delivery partners for each intervention and selects a financing vehicle to match the time frame and risk profile of each intervention. The community integrator must be a legal, operational entity capable of establishing contractual relationships with delivery partners and have a broad-based and transparent governance. To successfully impact population health, the integrator's geographic boundaries of governance must align with the geographic boundaries of the community it serves. Its credibility and authority will stem from the inclusion of key community stakeholders and its ability to improve the health of the community over time.

The functions of a fully developed community integrator span the planning, implementation, and evaluation cycle. The integrator-led process begins with convening stakeholders and managing their diverse perspectives to establish a shared vision and goals. The integrator facilitates a common assessment of needs for its geographically defined community, defines health priorities, and identifies specific interventions, building on starting points such as the requirement for nonprofit hospitals to conduct community health needs assessments (CHNA).[19] The integrator facilitates development of a coordinated network of medical, behavioral health, and community and social services for its residents. For each intervention prioritized for implementation, the integrator makes the business case for the intervention and identifies a delivery partner and an appropriate financing vehicle.[20]

The resulting network of diverse providers implements a portfolio of interventions that is balanced along a spectrum of three perspectives: 1) time frames, reflecting short- and longer-term intervention effects; 2) level of investment risk,[i] reflecting both the strength of scientific evidence and investment in innovation to help develop the evidence; and 3) scale of return, based on measures for health, financial, and social impact. The balanced portfolio is strategically designed to realize **short-term** opportunities for savings in medical

[i] Investment risk is the likelihood that an investor will recover the principal invested and earn the projected return. It is a measure of the strength of the evidence supporting the use of a given intervention and the experitise of the organization responsible for achieving those results. It is quite different from actuarial risk for the medical expense of a given population, which is used in shared savings or global capitation payment models.

costs, such as providing housing-based services for high-risk Medicaid-eligible individuals[21,22]; to implement **medium-term** interventions to change health risk behaviors, such as the National Diabetes Prevention Program[23]; and to address **longer-term** determinants of health, such as investments in early childhood development. It reflects the assessment and prioritization of community needs aligned to best meet the goals established by the community. An example of a balanced portfolio is given in Table 1.

Balancing the portfolio to optimize returns requires alignment of multiple funding streams, both public and private. Given the need to create more global population-based payment models that align financial incentives with health outcomes, the community integrator might also manage a population health budget, serving as a neutral entity to allocate resources. The integrator additionally facilitates the process of monitoring progress and outcomes and implementing rapid-cycle changes. Early successes offer best practices that can be applied and expanded as new approaches are tested.

Existing integrator models[15-18] could serve as starting points for a fully developed community integrator that includes enhanced financial functions.

TABLE 1: Sample Balanced Portfolio for Community Health Systems

Intervention	Target Population	Implementation Partners	Financing Vehicle	Time Frame*	Investment Risk	Savings-Sharing Vehicle
Intensive care coordination	Dual eligible high utilizers	Accountable care organizations	Shared savings	Short	Low risk	Community benefit
Integrated housing- based services	Medicaid eligible, multiple chronic illnesses	Medicaid managed care plan, housing corporation	Capitation	Short	Low risk	Performance contract
Innovative use of remote monitoring	Medicare eligible, multiple chronic illnesses	Medicare Advantage Plan, private foundation	Grant	Short	High risk	None
YMCA Diabetes Prevention Program	Commercial insured and self-insured	Commercial health plan, self-insured employers	Shared savings	Medium	Medium risk	Performance contract
Asthma medical management	School-aged children	Commercial and Medicaid health plan	Shared savings	Medium	Medium risk	Performance contract
Asthma environmental hot spots	Children with asthma	Public health agency	Social impact bonds	Medium	Medium risk	Investing in social impact bond
Expanded early childhood education	Children at risk for adverse childhood events	Preschool educators	Pay for success, social impact bonds	Long	Medium risk	Investing in social impact bond
Community walking trails	Community	Nonprofit hospital	Community benefit	Long	Medium risk	None
New grocery store	Residents of U.S. Department of Agriculture food deserts	Community development financial institution	Community reinvestment	Long	Medium risk	None

* Time needed to generate financial savings.

Hester JA, Stange PV. A Sustainable Financial Model for Community Health Systems. Discussion Paper, Institute of Medicine, Washington, DC; 2014. Available at http://www.iom.edu/Global/Perspectives/2014/SustainableFinancialModel.

However, few, if any, of the existing models are currently working across the trajectory from planning to implementation and financing.[10]

A SUSTAINABLE PAYMENT MODEL FOR COMMUNITY INTEGRATORS

The elusive "holy grail" for the population health movement has been a payment model that breaks the cycle of dependence on limited-term grants and provides sustainable support for both infrastructure and interventions. Two critical requirements that support sustainable population health improvement are reinvestment of a portion of the savings from interventions back into the community and better alignment of diverse funding sources with interventions in the balanced portfolio.

Capturing a portion of savings for reinvestment is essential for long-term sustainability, and can be achieved in a variety of ways (Table 1). Savings accrued from improved efficiencies gained by restructuring uncoordinated medical and social services may be used to support interventions outside of the acute care setting that improve health and reduce costs. For example, in a short-term initiative using shared-savings payment models for an ACO built around nonprofit hospitals, the integrator could negotiate to receive a percentage of savings for reinvestment into the community. The hospital could classify the money returned to the community for interventions outside the healthcare setting as a community benefit.[19] Even while shared savings are an important potential source of initial funding for the integrator's portfolio, at some point the opportunities to realize savings from reduced medical costs will diminish and financing will need to transition to other, longer-term vehicles. In the early childhood education example in Table 1, for example, the integrator could participate as an investor in the pay-for-success financing, capturing a portion of savings for reinvestment in the community to support future programs.[20]

Viewing community health as a long-term, capital-investment venture will be essential to realize population health improvement. The capital requirements—not unlike those in well-established, rigorously planned regional transportation initiatives throughout the nation[24]—are well beyond the capacity of the health sector alone. Combining and leveraging investment capital from multiple public and private entities will be an important step. Further, as with regional infrastructure development, the necessary planning and investment must be considered on a longer horizon—decades, rather than 3–5 years commonly used in governmental and philanthropic grant-making—as very few interventions yield short-term returns on health or cost outcomes.[24,25]

The mix of financing vehicles in the portfolio will shift with the maturity of the community integrator. At the development and testing phase, integrators require greater grant support, which is more risk tolerant and allows for the time required to develop evidence of new interventions' effectiveness or expand existing initiatives to scale. As a community model matures and begins to achieve early successes, a broader range of financing vehicles may support dissemination of proven interventions and the infrastructure needed for larger-scale implementation. In the mature operation phase, the community integrator has established its balanced portfolio and, ideally, has developed sustainable financing.

EMERGING FINANCING VEHICLES

Currently, governments, insurers, healthcare systems, and other payers and providers are exploring a wide range of financing vehicles that support improved patient and population

TABLE 2: Emerging Financing Vehicles and Payment Mechanisms

Financing Vehicle	Payment Mechanism: How Does It Work?	Time Frame*	Investment Risk Profile	Status
Payment Models for Care Delivery				
Global budget/ capitation	Payment budget set for provider group for expected services (or subset thereof) for a given population. When spending is under budget, providers share the surplus; when spending is over budget, providers are responsible for extra costs. Similar to "capitation" model but more sophisticated means of risk adjustment, and financial results are linked with performance.[25]	Short	Moderate (with experience) two-sided risk.	Population measures are clinical.
Shared savings	Group of providers receive incentive to reduce healthcare spending for expected services (or subset thereof) for a defined patient population. Providers receive a percentage of the net savings. Access to savings often contingent on meeting performance measures for care access, quality, or efficiency.[25]	Short	Low to moderate risk (with experience); range of one- and two-sided risk options.	Implemented widely, but population health measures are clinical.
Care coordination fee	Providers receive payment specifically for care coordination,[26] typically in the form of a per-member-per-month fee for HMO enrollees or the attributed population in a multi-payer advanced primary care practice (aka "medical home").[27]	Short	Low risk.	Implemented with clinical health measures.
Fee for service with pay for performance (P4P)	Combines traditional fee-for-service physician payment system with a financial incentive based on meeting a set of performance or reporting standards over a specified period of time.[25]	Short	Low risk.	Gaining traction, but incentives are small.
Multisector Funds				
Blended: co-mingled	Funds from multiple funding streams are combined into one "pot." Programs and services are financed out of that pot without distinction of where original funding came from.[28]	Varies with funded intervention	Challenge to meet reporting requirements of various funders.	Implemented in early care and education and social services.[29-32]
Braided: coordinated targeting	Funds from multiple funding streams are combined, with careful accounting for how dollars from each funding source are spent.[30]	Varies with funded intervention	Must follow restrictions, reporting requirements for each funding stream.	
Medicaid waiver	States apply for waivers to test new ways to deliver or pay for healthcare services through Medicaid or the Children's Health Insurance Program.[33]	Medium	Loss of waiver or financial penalties for not meeting goals.	>450 waivers across all 50 states and DC.[33]
Innovative Financing Vehicles				
Charitable hospital community benefit	For tax exemption, nonprofit hospitals must file report to IRS of their community benefit.[19] Activities that meet this requirement must improve community health or safety, meet at least one community benefit objective, and respond to a demonstrated community need (determined through health needs assessment conducted every 3 years).	Varies with funded intervention	Low to moderate risk.	As ACA coverage for uninsured rises, charity care should decrease, freeing resources for non-clinical investment.
Pay for success or social impact bond	Government agrees to pay an organization for an intervention if it meets specific, measurable goals in a set time.[34] Organization secures funding from investor(s) to cover program costs and providers. Third-party evaluator assesses outcomes. If intervention achieved goals, government pays the implementing organization, which repays its investors. If not, government does not pay; investors are not repaid with public funds.[35]	Medium	Moderate risk (with experience). To attract capital, organizations must mitigate risks and offer high financial returns.	Several states use social impact bonds; 12 others considering them.[36] Early involvement in health sector.
Community development financial institutions (CDFIs)	CDFIs attract public and private funds—including from the Treasury Department's CDFI Fund—to create economic opportunity for individuals and small businesses, quality affordable housing, and essential community services.[37] All are private sector, market driven, and locally controlled. Closely tied to the Community Reinvestment Act.[38]	Long	CDFIs reduce financial risks for projects.	About 1,000 nationwide, with most focusing in urban areas.
Program-related investments	Foundations invest in charitable activities that involve potential return on capital within a set time.[38] They provide flexible loans, loan guarantees, and equity investments in charitable organizations and in commercial ventures that have a charitable purpose. Capital resulting from the investment is recycled for further charitable investment.	Varies with funded intervention	Foundations use endowments to absorb risks that hinder private investors.	Few hundred U.S. foundations make program-related investments.
Prevention and wellness trusts	State or community raises a pool of money that is set aside for prevention and community health. Funds for trust often come from taxing insurers and hospitals, but can come from pooling foundation resources or redirecting existing government funds.[39]	Varies with funded intervention	Medium risk; mix of innovation and evidence-based interventions.	Model is the philosophy behind Prevention and Public Health Fund.

*Time needed to generate financial savings.

health and have the potential to slow rising healthcare costs.

These vehicles, summarized in Table 2, fall into three broad categories:

1. Payment models for care delivery that reward value-based outcomes instead of volume[26,27];

2. Multisector funds that blend resources into a common pool, such as through some Medicaid Section waivers[28-33]; and

3. Innovative financing vehicles that access new and existing pools of public and private capital.[34-39]

The first category uses incentive-based payment systems for clinical services as a means of achieving better coordinated, accountable healthcare—Healthcare 2.0[6]—and redirecting funds from acute care to upstream determinants. Although Triple Aim® goals have been set in a number of new models, such as ACOs and patient-centered medical homes, the associated population health outcome measures have often been more clinical[40] rather than reflective of the broader measures of health and its determinants. The second category includes a number of evolving examples, some funded through the creative use of Medicaid and Medicare waivers, such as those recently granted to Maryland,[41] New York,[42] and Texas.[43]

Examples in the third category—innovative financing vehicles—include:

- Affordable Care Act (ACA) requirements for nonprofit hospitals to conduct CHNAs and adopt implementation strategies with specific resources to address priority needs[19];

- Recognition of the connection between healthy populations and strong, economically vibrant communities opening the door to access Community Reinvestment Act vehicles, such as Community Development Financial Institutions and Community Development Banks[37];

- The growing social capital movement, implementation of the first pay-for-success agreements (social impact bonds), and creation of new social mission corporate vehicles such as low-profit limited liability companies[34,35];

- Use of program-related investments by philanthropic institutions as a complement to traditional grants[39]; and

- Establishment of health and wellness trusts at the state and local levels, such as the Massachusetts Wellness Trust.[38,44]

While a diversity of financial interests, structures, and objectives is valuable because it increases the likelihood that a given intervention will be financed by an appropriate vehicle, it raises the unintended possibility of fragmentation and conflicting efforts. Simply implementing an uncoordinated series of intervention transactions will likely be neither effective nor sustainable. An important role of the community integrator is to avoid this fragmentation. To do this, it will need to implement a combination of complementary interventions that are tailored to each community's needs, generating a multiplier effect that results in positive community outcomes and achieves the goals of reduced disparities and better quality of life.

CHALLENGES AND CONCLUSIONS

Transitioning from an episode-focused, volume-driven healthcare system to an integrated system that supports population health by attending to both clinical care and the non-medical determinants of health will be challenging. To support change and sustain significant improvements in health at the community level, coordination of programs and policies at the federal level related to healthcare delivery and payment, public health, quality measurement, and financing will be of paramount importance.

The National Prevention Council[45]—created through the Affordable Care Act and composed of 20 federal departments, agencies, and offices, including housing, transportation, education, environment, and defense—is a unifying federal body that can provide leadership, coordination, and support for the kind of long-term integrated planning, prioritization, and financing that will support and sustain change at the community level. Through the *National Prevention Strategy: America's Plan for Better Health and Wellness*,[46] released in 2011, and the 2012 *National Prevention Council Action Plan: Implementing the National Prevention Strategy*,[47] the National Prevention Council continues to prioritize prevention across multiple settings to improve health and save lives. Stronger connections between federal financing and regulatory agencies, including the Department of Treasury and The Federal Reserve, could accelerate important links between health and innovative financing described in this paper. Existing federal initiatives—such as the "Partnership for Sustainable Communities," an interagency partnership between Housing and Urban Development, Department of Transportation, and the Environmental Protection Agency[48]; the Department of Health and Human Services' "Birth to 5: Watch Me Thrive" initiative[49]; and the Department of Defense's "Healthy Base" initiative[50]—could be examined as starting points for building collaboration, with an emphasis on those that already highlight cross-sector partnerships.

A key building block for emerging delivery and financing models is the ability to measure meaningful and timely health, quality, and cost outcomes at a population level across a spectrum of time horizons. Existing measures and datasets are not well developed and are not typically available at a local, census-tract level, limiting the ability to describe community-level health. They also focus more on short-term clinical and cost outcomes and less on non-medical processes and outcomes. Additional measures and analytic models are needed for use at the community level to address intermediate outcomes related to disease burden, patient-reported quality of life, long-term outcomes of quality-adjusted life expectancy, and the non-medical social determinants of health. Such analytic tools would also help to project long-term impacts and provide evidence to make a business case for population health, which is fundamentally different than demonstrating an impact on risk factors or specific conditions.

The business case for population health is complex and requires investments from multiple sectors that accrue over long periods of time. This requires a shift in focus, as population health programs have traditionally been evaluated on the basis of risk factor reduction—that is, whether an intervention changed behavior—rather than on their combined health and financial impact. Current shared savings models, with a focus on medical expenditures on an annual cycle, do not fully capture the longer term benefits of effective population health interventions. Emerging financial mechanisms, including shared savings models and social impact bonds, will likely be more sustainable in the intermediate to long term when both the health and non-health sectors at the community level move closer to an outcome-oriented, population-based global budget. Without these elements, the risk is that new payment models will be established with a limited population health component.[51,52]

Substantial developmental work and conceptual realignment is still needed to understand, prioritize, and finance efforts to improve population health. Broad-based, multi-stakeholder engagement of government entities, the healthcare delivery system, private investors, and communities can accelerate the development and testing of new and emerging models for improving population health. It will be important also to continue to test a broad set of interventions and sustainable financing vehicles for improving health, with successful models scaled up to the national level and lessons learned translated to private healthcare payer systems.

Examples of community-level innovation focusing on improving health and addressing and financing determinants of health are rapidly emerging. The private sector has initiated a number of community-centered programs to identify promising local initiatives, create learning networks, and disseminate best practices. Some examples include "The Way to Wellville," an investor-sponsored contest by HICCup (Health Initiative Coordinating Council)[53]; the "Moving Healthcare Upstream" collaborative funded by the Kresge Foundation[54]; and "Escape Velocity to a Culture of Health,"[55] organized by the Institute on Health Improvement.

Given the focus of public health on geographically defined populations and on community and social service supports, the public health enterprise—including governmental public health departments, non-governmental public health organizations, and academic public health—should play an important role to help accelerate evolution toward a mature and integrated healthcare system. As the infrastructure, delivery, and financing of community and population health evolve, so will the role of the public health enterprise and public health departments.[13,14] Public health and health departments should accelerate

strategic, collaborative partnerships with the changing community health system and with healthcare purchasers, payers, and providers and emerging shared-savings delivery models, building on early successes.[36] Public health has an important opportunity to exercise and strengthen its traditional roles of surveillance and epidemiology, measurement, evaluation, and the convening of key stakeholders, and adapt into critical new roles including policy design and a re-orientation of the health system towards prevention, health promotion, and wellness.[13,56] Alignment of the changing health system and evolving public health role with accreditation of public health departments may also be an important step. One important near-term role for public health is to promote the use of tools to help communities and nonprofit hospitals conduct their 2015 community health needs assessments and implementation plans in a coordinated, collective impact–driven fashion. Such tools are being developed by CDC and will be publicly available in 2015.[57]

While the number of private and public initiatives supporting system-level, integrated population health improvement is encouraging, a number of challenges will need continued attention, including:

As the infrastructure, delivery, and financing of community and population health evolve, so will the role of the public health enterprise and public health departments.

- Wider acceptance of the concept and implementation of a balanced portfolio, particularly support for interventions within the portfolio requiring a longer time horizon to achieve sustained outcomes;
- Better understanding of how to create and sustain a fully realized, credible community integrator that works from planning to implementation to evaluation and manages the financing of a balanced portfolio;
- Improved use of varied data sources, measures, and tools to facilitate the monitoring of complex and evolving community models and their intended short-, medium-, and long-term outcomes; and
- An improved ability for all key stakeholders, including public health, to articulate their individual added value towards true collective impact.

Sustaining attention to the evolving community-based delivery and financing models during this critical window of opportunity will be a challenge for the healthcare and public health fields, particularly in learning to collaborate with the private financial world on the financing innovations they are exploring.[52,58] Ultimately, it will be imperative to align a broad range of financial resources with the needs of each community if we are to fully address the upstream social determinants of health and succeed in substantially improving population health.

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About this Series

The passage of the Affordable Care Act led to changes in the U.S. health care and public health systems. With both now positioned to place greater emphasis on better care, smarter spending, and healthier people, there is a tremendous opportunity to improve population health as more of the population is covered by health insurance. To support this change, the Centers for Disease Control and Prevention, Office of the Associate Director for Policy, in partnership with NORC at the University of Chicago, experts at the Milken Institute School of Public Health at The George Washington University, and Population Health Systems, have produced a series of issue briefs highlighting opportunities for public health to support health system transformation.

Each issue brief is designed to provide practical guidance to state and local public health departments and to health systems, highlighting specific opportunities for public health and health care to engage to improve population health. Additionally, the briefs include success stories to demonstrate how state and local public health practitioners can collaborate with the health system to catalyze health system transformation.

Disclaimer

The findings and conclusions in this report do not necessarily represent the views of the Centers for Disease Control and Prevention.

Suggested Citation

Hester JA, Stange PV, Seeff LC, Davis JB, Craft CA. Toward Sustainable Improvements in Population Health: Overview of Community Integration Structures and Emerging Innovations in Financing. Atlanta, GA: CDC; 2015. CDC Health Policy Series, No. 2.

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