Innovations in Population Health Financing
January 10, 2018
Jim Hester PhD, Principal, Population Health Systems
Web Discussion Objectives

• Provide background context on the Accountable Communities for Health Model
• Overview existing and emerging innovations in financing population health initiatives
• Provide an orientation to the balanced portfolio action framework
• Summarize highlights of Vermont’s population health components of all payer model and ACH initiative
• Opportunity for questions and dialogue.
The health care system is in the early stages of a major transformation to deliver Triple Aims outcomes, particularly improved population health.

The determinants of health imply that improving population health requires integrating clinical services with public health and community based interventions targeted on upstream determinants.

The proposed financial model for improving health has a community integrator managing a balanced portfolio of interventions financed by diverse funding vehicles.

A wide variety of experiments creating community integrators and linking health and community development are underway.
I. Population Heath and Delivery System 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. |
What determines population health?

US Health Care Delivery System Evolution

Health Delivery System Transformation Critical Path

- 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: Patient/Person centered
  - 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: Healthy population centered
  - 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
Building a Community Health System

‘Every system is perfectly designed to obtain the results it achieves.’

Approach

➢ System redesign at multiple levels
  • Primary care practice level: Enhanced medical homes
  • Community level: Accountable Health Community
  • State/regional infrastructure and support e.g. Health IT, multi-payer payment reform
  • National: Medicare participation, SIMs

➢ Start in pilot communities with early adopters
Structure of an Accountable Health Community

The AHC is made up of

- Backbone organization for governance structure and key functions
- Intervention partners to implement specific short, intermediate, and long term health-related interventions
- Financing partners who fund specific transactions
Key Functions of an AHC

A community centered entity responsible for improving the health of a defined population in a geographic area by integrating clinical services, public health and community services

- Convene diverse stakeholders and create common vision
- Prioritize needs building on community health needs assessment
- Build and manage portfolio of interventions
- Monitor outcomes and implement rapid cycle improvements
- Support transition to value based payment and global budgets
- Facilitate filling gaps in community based services
Backbone Organization’s Aggregation and Alignment of Investments and Reinvestments

Community Financial Commitment → Backbone organization → Wellness Fund

Grant Funding

Balanced portfolio of interventions funded via:
- social capital
- performance contracts
- existing payment for services

Social Determinants of Health Interventions

Risk Behavior Management Interventions

Medical/Social Services Coordination Interventions

Return on Investment + % of Partner Incentives Reinvested + Capture Savings and Reinvest
II. Key Components of Sustainable Financial Model

✓ Theory of action
✓ Inventory of financing vehicles
✓ Building a balanced portfolio
Theory of Action

- Multiple levels of action: practice, community, region/state, federal
- Integration at community level of clinical, public health and community based 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

➢ Public financing:
   - Single sector
   - Multi-sector programs: braided, blended

➢ Value based payment for clinical services
   - Global Budget: eg Hennepin Health, Vermont
     • Shared savings
     • Capitation
Inventory of Financing Vehicles

Public Financing from single sector programs

- **Housing and community development**: HUD (about $30 billion) e.g. Community Development Block Grants, Choice Neighborhoods

- **Public safety**: DOJ ($630 million) in state, local law enforcement e.g. Community-Oriented Policing Services (COPS)

- **Transportation**: DOT and EPA (more than $20 billion) e.g. Sustainable Communities Grants

- **Education**: Department of Education, USDA, HHS (about $30 billion) e.g. School meals programs, Head Start, Race to the Top,
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

Payment mechanism: how does it work?

- 3000 tax exempt hospitals/systems must file an annual report (schedule H) of their “community benefit” with IRS.
- $15-20B federal/state tax exemption benefits
- Heavy funding of ER charity care/Medicaid losses

Time frame: Annual –linked at IRS reporting on community health needs assessment

Risk profile: Low/Medium

Status: As ACA coverage for current uninsured decreases, charity care should increase, reducing resources for non-clinical investments
Payment mechanism: how does it work?
- Tied to banks’ Community Reinvestment Act compliance
- Helps create 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 (5-20 years)

Risk profile: CDFI functions to reduce financial risk for projects

Status: ~1,000 nationwide, weighted toward urban areas
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 business 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

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Target population</th>
<th>Implementation partners</th>
<th>Financing vehicle</th>
<th>Time frame</th>
<th>Risk/evidence</th>
<th>Savings sharing vehicle</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intensive care coordination</td>
<td>Dual eligible high utilizers</td>
<td>Accountable care organizations</td>
<td>Shared savings</td>
<td>Short</td>
<td>Low risk</td>
<td>Community benefit</td>
</tr>
<tr>
<td>Integrated housing-based services</td>
<td>Medicaid eligible, multiple chronic illness</td>
<td>Medicaid managed care plan, housing corporation</td>
<td>Capitation</td>
<td>Short</td>
<td>Low risk</td>
<td>Performance contract</td>
</tr>
<tr>
<td>Innovative use of remote monitoring</td>
<td>Medicare eligible, multiple chronic illness</td>
<td>Medicare Advantage Plan, private foundation</td>
<td>Grant</td>
<td>Short</td>
<td>High risk</td>
<td>None</td>
</tr>
<tr>
<td>YMCA diabetes prevention program</td>
<td>Commercial insured and self insured</td>
<td>Commercial health plan, self-insured employers</td>
<td>Shared savings</td>
<td>Medium</td>
<td>Medium</td>
<td>Performance contact</td>
</tr>
<tr>
<td>Community walking trails</td>
<td>Community</td>
<td>Nonprofit hospital</td>
<td>Community benefit</td>
<td>Long</td>
<td>Medium</td>
<td></td>
</tr>
</tbody>
</table>

Status: Period of Experimentation

Creating:

➢ 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
Challenges

- Timeframe: lengthen time for outcomes
- Tap shared savings from medical and other sectors
- Create community Integrator:
  - Easing transition to implementation
  - Developing financial role
- Health sector adding value to innovative financing sectors eg CDFI’s
- CDFI’s aware of the community’s balanced portfolio
Building a High-Performing Health System for Vermont

**Big Goal:** Integrated Health System able to achieve the Triple Aim

**All-Payer Model** (Next Gen-type ACO):
- Way to pursue goal of integrated system for certain services and providers.
- Enables Medicare, Medicaid, and Commercial payers to align value-based payments for health care.

**Medicaid Pathway:**
- Way to pursue goal of integrated system for services and providers outside of All-Payer Model.
- Enables Medicaid to align value-based payment models with All-Payer and ACO design.

**Complementary Delivery System Reform and Care Delivery Transformation Efforts, including...**
- Blueprint for Health (multi-payer patient-centered medical homes)
- Community Health Teams (CHTs)
- CHT Extensions – Hub & Spoke, Support and Services at Home (SASH)
- Regional Governance (Unified Community Collaboratives)
- Provider Learning Collaboratives
- **Accountable Communities for Health**
Vermont SIM Grant

Population Health Workgroup

**Charge:** resource for the other working groups: payment models, performance reporting, service coordination
  - ways to incorporate population health principles
  - how to improve the health of Vermonters

**Priorities:**
- Measures of population health eg ACO payment
- Identify innovative financing options for paying for population health and prevention
- Identify and support exemplars of effective community-focused interventions. Accountable Health Communities (Prevention Institute)
VT CMS All Payer Waiver

- Creates aligned global budget payment models for Medicare, Medicaid and commercial payers based on Next Gen ACO models
- Providers organized into an ACO network
- Builds on Blueprint for Health and encourages connections to community resources ($51 million CMS investment)
- Creates explicit incentives for improving population health
Integrating Health Into Payment

➢ Three tiered measures and goals
  • Total population
  • Attributed population for ACO
  • Interim processes

➢ Based on VDH Statewide Health Improvement Plan
  • Substance abuse disorder
  • Suicide
  • Prevalence of chronic disease: COPD, diabetes and hypertension
  • Access to primary care
Consequences

➢ Explicit, defined measures and targets
➢ Regular monitoring of performance
➢ Warning notice, corrective action plan
➢ Performance included in payment model benchmarks and risk sharing
VT Accountable Health Community Initiative

Phase I (Prevention Institute)

- Created template for assessing national and Vermont based initiatives
- Identified national exemplars and lessons learned
- Identified potential ACH sites within VT

Phase II: peer learning ACH program for 2016, 2017
Resource

“Towards Sustainable Improvements in Population Health: Overview of Community Integration Structures and Emerging Innovations in Financing”

Hester JA, Stange PV, Seeff LC, Davis JB, Craft CA

CDC Health Policy Series, January 2015