Accountable Communities for Health: A Promising Solution for Addressing Social Determinants of Health
Meeting Summary Highlights

November, 2018

Within the context of health system transformation, including value based payment and population health initiatives, communities and policymakers at the federal, state and local level are focused increasingly on social determinants of health (SDOH). Accountable Communities for Health (ACH) have emerged as one promising model to address social needs. The ACH multisector partnerships allow delivery of holistic care, integrating clinical treatment with community and social services that address upstream SDOH or focusing on upstream prevention approaches at the community level. Specifically, ACHs may provide assistance with housing, food, employment, transportation, and other needs, which may help to improve health behaviors, socioeconomic factors, and the physical environment.

Accountable Communities for Health are multi-faceted, multi-stakeholder interventions seeking to improve the health of communities they serve by addressing unmet health and social needs. By fostering unique partnerships and targeting both the upstream and downstream factors that impact an individual's and community's health, ACHs seek to improve health outcomes and reduce health care costs.

On November 1, 2018, the Funders Forum on Accountable Health, sponsored a full-day convening to discuss the challenges and "lessons learned" regarding ACH partnerships and financial sustainability.

Meeting participants included health officials and ACH representatives from four states: California, Washington, Oregon, and Colorado. Representatives from sponsoring foundations and federal health officials from the Centers for Medicare and Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) attended as well. A full list of participants is attached as Appendix 1.

The timing for the meeting was purposeful as federal, state, and local officials are making key decisions about the evaluation and expansion of the ACH model. Building upon the *Accountable Health Communities Model* awards in 2017, CMS has announced two new ACH models—*Integrated Care for Kids (InCK)* and *Maternal Opioid Model (MOM)*—that will tackle Substance Use Disorder (SUD) and other conditions. The formal funding opportunity announcement for both models are expected to be released in January 2019. These models underscore federal interest and commitment to addressing SDOH, both through model design and outcomes of interest. For example,

CMS' announcement described out-of-home placement for children, such as foster home placement, as one potential outcome of interest for *InCK*.

Even as states determine whether to apply for these newer awards, many health officials have or will be considering longer-term strategies for existing ACHs, namely identifying the policies and investments needed to ensure sustainability.

This memo describes key issues that must be addressed to enable and support full expansion of the ACH model.

Policy Issues

An increasing number of communities and policymakers are working to strengthen implementation and sustainability of the ACH model. Two key issues include partnership development and long-term financial support:

Building sustainable partnerships

Fundamental to any ACH is the need to bring diverse partners to the table and to keep them there and engaged in pursuing an aligned vision. Challenges range from setting a table that is truly equitable, to encouraging partners to consider community-wide needs rather than focusing solely on their own institutional concerns, to "cementing" the partnerships to enable meaningful health system transformation that promotes health and well-being.

The discussion on partnership development focused on the following questions:

- What have we learned about building and sustaining partnerships?
- How do we know if partnerships are moving in the right direction?
- What can be done to assure this?

The goal for partnership is authentic engagement, or as stated by one participant, "to move beyond community input to relationships, which are honored and respected." Meeting participants identified numerous factors that influence the strength and durability of ACH partnerships.

- **Time.** Fundamental to developing partnerships is trust, which takes time to develop. Partners must believe, reinforced by demonstrated actions, that they are united around a common vision for a healthy community and all partners will support the activities needed to achieve such vision.

- **Mutual benefit.** All ACH partners recognize and acknowledge the societal benefits of healthier communities. However, monetary considerations are important as well. For example, participating health systems and providers may benefit from enhanced reimbursement, expanded membership, and increased visibility. Participating community groups could benefit from increased funding, potentially from wellness funds and grant programs.

- **Capacity.** The strength of an ACH often reflects the "community readiness" or capacity to engage. Prior federal investments, including *Community Transformation Grants* and *Communities Putting Prevention to Work*, have increased community readiness by facilitating new or solidifying existing relationships, and providing opportunities to "test" these working relationships through collaboration on local initiatives.

- **Measures of Success.** Developing genuine ACH partnerships can be an extensive process, without tangible deliverables. Successful partnership development should be reframed and measured as an outcome by evaluators, health officials, payors, and other stakeholders.

- **Federal/state policy influence.** In some instances, ACH partnerships are encouraged or mandated by elected leadership at the federal or state level. These "shot gun weddings" can be critical in bringing (and keeping) non-traditional allies to the table, particularly in the early stages of ACH implementation.

- **Community advocacy.** Grass roots advocacy efforts can help to identify and give voice to the priorities of ACH community partners. Such advocacy is particularly helpful when selected priorities are politically unpalatable or perceived to be difficult to address. Social justice and racism are two examples of controversial priorities that have been pushed by community partners.

- **Data.** State and local level data may help to galvanize stakeholders to take action together through an ACH. In addition, data can help to justify the need for the ACH, and clarify the roles and potential contributions of the various participants.

- **Shared priorities.** ACH partnerships often form in response to a shared community priority, such as a disease condition. Once strong relationships and trust are established, the ACH is often empowered to tackle additional community priorities.

- **Shared ethos.** The meeting attendees believed that the most critical factor for building partnerships is a shared ethos. Specifically, ACH participants must commit to prioritizing community needs ahead of the desires and preferences of their own institutions.

Ensuring financial sustainability

Most ACH initiatives have been launched with seed funding that allowed experimentation and infrastructure development. Sustainability of these ACHs requires an understanding of long-term resource needs, access to new and durable sources of

funding, and potentially, new financing mechanisms that will provide flexibility in use of existing funds to address upstream SDOH.

The discussion on financial sustainability was framed by the following questions:

- What approaches are you testing or considering?
- What opportunities and challenges have you encountered as you have begun to address sustainability?
- Who are the partners you need to achieve sustainability?

Sources of funding

States have leveraged a variety of sources of funding to implement ACHs. Notably, the financing arrangements supporting the initial stages of ACH implementation often evolve as ACHs become more mature and a "customary" way of providing community care.

Potential or actual sources of ACH funding include the following:

- Medicaid, including DSRIP, section 1115 waivers, and managed care contracts
- CMMI awards, including State Innovation Model (SIM) and Accountable Health Community awards
- Wellness trusts
- Nonprofit hospital community benefit funds
- Foundation grant support
- Community Development Financial Institution (CDFI) and other social impact funds
- State "incentive dollars" and other "special funds"

> "Wellness trusts are funds raised or allocated (by governments or private sources) to support primary prevention interventions in community settings to improve population health." Georgia Health Policy Center/Robert Wood Johnson Foundation, 2016)

Of these sources, Medicaid funding has been especially critical for many ACH initiatives, highlighting the importance of including health care systems and providers for purposes of "drawing down" matching federal funds. However, aside from DSRIP and waivers, Medicaid support for ACH structure and function can be limited.

As a practical matter, meeting participants note that long-term financial sustainability will require conversion of one-time or short-term financing to longer-term or mandatory financing streams that may provide predictability and potentially, a higher level of resources. One Medicaid-related option could be to require managed care contracts to support ACH structure and function. Although the ACH may not receive direct state funding, the state's authority could be leveraged to require investment in an ACH.

Another priority for meeting participants concerns the need for flexibility in financing arrangements, particularly to allow braiding and blending of categorical and other funds. Wellness trust and other social impact models could potentially help with this function at the local level.

Newer financing models or concepts that are being explored include social enterprise models, such as social contracting similar to 211 models and "social PPOs." Developing a "social loss ratio" could be another consideration, which is similar in concept to a medical loss ratio that requires most insurance companies covering individuals and small businesses to spend at least 80 percent of their premium income on health care claims and quality improvement,.

Regardless of financing mechanism, there is a need to quantify the cost of creating and maintaining an ACH. Generally, meeting participants believed that ACH infrastructure costs are not high; however, the portfolios of interventions (POIs) can be costly depending on the mix and breadth of the activities.

Return on investment

A top priority for all meeting participants was defining the return on investment (ROI) or the "value-add" for an ACH. Participants have been asked to explain what would happen in the absence of an ACH as part of the financial justification for ACH investment.

Participants noted ROI encompasses the financial, more "traditional" ROI, as well as a "social" ROI. ROI calculations for ACHs include savings, whether to the government, health care systems, or other partners. Having a healthier population generates positive dividends for all sectors—from having healthier employees (increased productivity, reduced sick days) for the business sector, to healthier children in schools (reduced absenteeism) for the education sector, and healthier patients (improved performance on population health metrics) for providers participating in alternative payment models. However, other "social" factors for ACHs might include oversight of and accountability for community investments, avoidance of duplication of effort, and ability to engage in upstream work, in part through having strong relationships and "boots on the ground" in the local community. Health plans and providers could grow their membership through expanded relationships and visibility that ACH participation would allow.

Additional policy considerations

Beyond partnership and financial sustainability, the meeting participants reported numerous other ACH-related priority issues. One critical priority is the need to engage and maximize partnerships with leading national and local social service providers, particularly on financial sustainability, as ACHs expand and evolve.

A second leading priority concerns data policy across the following areas of focus:

- Public health surveillance at the national and local level, to identify community health needs and track outcomes of community health interventions
- Integration of health and social services data, including "closing the loop" after referrals have been made

- Privacy, particularly given the public charge rule and other national proposals
- Capacity to perform data analytics, particularly in the social service sector
- Racial, ethnic and other demographic data, which is needed to assess health equity
- Governance, namely who "owns" the data and how it can be shared appropriately and securely across stakeholder groups
- Quality metric extraction for performance reporting for payors, particularly with respect to SDOH and substance use
- Encounter-level data for ACHs, which is critical for reimbursement concerns
- Data matching, within and across state agencies that are responsible for various social and health care services

From the health system perspective, another priority issue concerns clarifying how ACHs "fit" into value based payment models, including its role and contributions, across Medicare, Medicaid, and commercial insurance. Such understanding could help to justify ACHs and quantify ROI. Related, meeting participants expressed the desire to better understand if and how an ACH can be leveraged to drive culture change in the delivery of health care that can lead to increased focus on upstream SDOHs. One participant noted some health systems may perceive increased social service screening as encouraging the "wrong type of patient."

From the vantage of public health, closer collaboration with ACHs would be valuable on many fronts. Many of the goals for ACHs originated from public health, and some participants believed it would benefit ACHs to "understand and leverage intersections" with public health agencies such as CDC and HRSA. Participants queried how public health funding could be augmented with funding from non-traditional health partners in order to achieve a "virtual" block grant, which would avoid the risk of funding cuts, as has been the case historically when block grants have been created. Examples of proposals included establishment of a mechanism for CDC to braid and blend its funding and allow it to go to directly to an ACH. Another suggestion was for CDC and other public health agencies (such as HRSA and SAMHSA) to score applications higher if an ACH was involved in the proposed activity.

Finally, although acknowledging the diversity of ACH models, meeting participants stated the need for an objective, "third party validation" of the core ACH model that could be shared with policy-makers and decision-makers. Guidance on how to develop policies that can bridge across various ACH models would be similarly useful.

Next Steps

The Funders Forum [Convening of Western States] provided an excellent opportunity for federal and state health officials and other stakeholders to learn about diverse approaches to ACH implementation, including shared priorities and experiences to date. The Forum will support more focused, "deeper" dives on many of the identified challenges, including partnership and financial sustainability, to identify policy solutions and develop resources for technical assistance. In addition, the Forum will consider

ways to continue this dialogue and support a “community of practice” among the meeting participants and potentially other states. Finally, the insights and expertise shared at the convening will be shared with CMS and other entities seeking to expand the ACH model as part of health system transformational efforts.