State Approaches to Addressing Population Health Through Accountable Health Models

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Introduction

Breaking the cycle of intergenerational poverty and the poor health associated with it[1] is a goal shared by many state and federal leaders. Studies show that health disparities are often passed down from socially disadvantaged parents to their children and grandchildren. Poor children begin life on an uneven playing field. They face greater challenges than their healthier, more advantaged classmates, and they often struggle as adults to accumulate wealth to share with—and bequeath to—their children. State and federal health policymakers play a crucial role in breaking this cycle of poverty and inequity so that all can live healthy, prosperous lives.

The administrator of the Centers for Medicare & Medicaid Services (CMS) has spoken about the agency's desire for working-age, non-disabled Medicaid beneficiaries to engage with their communities, achieve economic self-sufficiency, and, ultimately, relinquish their safety net supports.[2] CMS recently launched an initiative to reduce regulatory burden on states and empower people to make informed health decisions,[3] along with other objectives.

Many state policymakers are also advocating innovative strategies to promote community engagement as a means of including low-income, disadvantaged individuals and families in defining community health priorities. Some states are developing accountable health structures[4] that help communities conduct community health needs assessments and identify a wide range of strategies to improve community health. These approaches can include traditional clinical preventive services, innovative patient-oriented interventions such as targeted home asthma-trigger remediation, and community-wide prevention activities.[5]

Support for community-wide prevention activities is based on the shared understanding that health is affected by factors that extend beyond clinical care. Research shows the physical environment of a community and the social and economic context in which people live have a substantial impact on their health.[6] Addressing these factors can reduce health care costs, as evidenced by a study that found that low-income adults who participated in the Supplemental Nutrition Assistance Program spent less on health care than those who did not.[7] Studies also show that safe housing can lower health care costs for some groups experiencing homelessness.[8]

How Accountable Health Models Address Communities' Non-Clinical Health Needs

- Two California Accountable Communities for Health focus on reducing violence and trauma.
- Michigan's Community Health Innovation Regions identified the intersection of housing, homelessness, and health as a priority area. Its goal is to strengthen collaboration between health and housing agencies and develop solutions for Medicaid beneficiaries whose housing needs put their health at risk.
- Oregon Coordinated Care Organizations' global budgets give them flexibility to provide non-medical services to improve health and lower costs, such as supporting home improvements and rental assistance, embedding mental health professionals in school systems, and promoting gym memberships.
- Washington's Accountable Communities of Health are addressing the opioid public health crisis.

For more information, see NASHP's States Share Innovative Approaches to Improve Population Health through Accountable Health Models

In light of this emerging emphasis on health-related social factors across populations, many Medicaid and public health agencies are incorporating accountable health models into their health system transformations. The transformations in which many accountable health entities operate take myriad forms, from multi-payer state innovation models and Medicaid payment and delivery models that reward care quality over quantity, to initiatives connecting care delivery with population-wide health activities. Some are fully operational and others are still in planning phases. To create a cross-state comparison, the National Academy for State Health Policy (NASHP) analyzed accountable health initiatives in various stages of development in 12 states: **California, Colorado, Connecticut, Delaware, Massachusetts, Michigan, Minnesota, New York, Oregon, Rhode Island, Vermont,** and **Washington**. (The Appendix features a matrix summarizing their accountable health structures.)

Accountable health entities are often supported by transformation-oriented state offices, such as the Transformation Center within the Oregon Health Authority and Vermont's Blueprint for Health, or offices implementing State Innovation Model (SIM) projects designed to transform the health system, address non-clinical health needs, and advance health equity. Accountable health models, which are built into these transformation efforts, provide a framework for states seeking to integrate non-clinical population health priorities into their health systems.

State accountable health models generally fall along a continuum. On one end of the spectrum are health care delivery structures that contract with Medicaid to provide services to Medicaid beneficiaries. Even though the accountable health entities at this end of the spectrum grow out of Medicaid transformation initiatives, they build accountability for population health into their clinical care models, often rewarding providers who meet population health quality metrics and connecting Medicaid members to community and social services that address health-related social needs. Colorado's Regional Care Collaborative Organizations (RCCOs) take this approach and seek to connect Medicaid members to providers and help them find community and social services in their area.

On the other end of the spectrum are state models that promote healthy communities primarily through community partnerships, rather than through providing clinical services to individuals. Their focus is to improve the health of designated communities and address root causes of disparities, implement policy and environmental changes that address health-related social needs, and strengthen clinical-community linkages. In these models, community members first identify their needs and choose issues to target. They bring partners and stakeholders to the table and work to develop financing mechanisms. An example of this model is California's Accountable Communities for Health (ACHs). According to a California ACH stakeholder, "The ACHs develop a portfolio of solutions designed to improve health outcomes and provide value so that resources and existing payment systems will invest and sustain both the backbone and the interventions. The interventions grow from community priorities and evidence about what works independently from existing payment systems or quality incentives."

Table 1. Accountable Health Structures that Contract to Provide Medicaid Services

State	Initiative	Medicaid Service Provider?
California	California Accountable Communities for Health Initiative (CACHI)	No
Colorado	Accountable Care Collaborative	Yes
Connecticut	Health Enhancement Communities	No
Delaware	Healthy Neighborhoods	No
Massachusetts	Accountable Care Organizations (ACOs)	Yes
Michigan	Community Health Innovation Region (CHIR)	No
Minnesota	Accountable Communities for Health (ACHs)	Yes
New York	Performing Provider Systems (PPS)	Yes
Oregon	Coordinated Care Organizations (CCOs)	Yes
Rhode Island	Accountable Entities (AEs)	Yes
	Health Equity Zones (HEZs)	No
Vermont	Accountable Communities for Health (ACHs)	No
Washington	Accountable Communities of Health (ACHs)	Yes

It is important to note that distinctions between these models can be fluid. Models that begin by offering traditional clinical care interventions for individuals can evolve to encompass community health approaches as well. (*Note: While the Accountable Health Communities*[9] *model from the Center for Medicare and Medicaid Innovation (CMMI) connects community needs and services with the clinical care system, it is not primarily a state model and will not be addressed in this paper.*)

NASHP recently convened a closed meeting of state health officials representing Medicaid, public health, health transformation, and other agencies from 10 states who had existing or developing accountable health models during its annual state health policy Conference. Participants discussed state strategies for leveraging accountable health structures to advance population health. They also discussed ideas for gauging the impact of accountable health entities on population health, determining their return on investment, and developing sustainable funding approaches. This report documents key ideas that emerged from the meeting, including:

- Use states' policy and contracting levers to address prevention and health-related social needs in payment and delivery reform.
- Align population health goals, agendas and where possible, metrics, across communities, payers, and stakeholders.
- Use data and measurement to raise the bar on performance, and consider financial incentives to address prevention and health-related social needs.

- Work across sectors and agencies to develop a range of financial strategies to support investment in prevention and community health and identify any gaps and duplication in funding streams.
- Learn from other states' value-based payment roadmaps and other lessons learned.

Goals and Policy Levers to Support Accountable Health Structures

Accountable health structures aim to improve population health and health equity and promote cross-sector partnerships and coordination. Many also aim to lower costs and move toward economic sustainability. States use a range of Medicaid and multi-payer policy levers to develop and achieve the goals of accountable health structures. (See the Appendix for more information on states' goals and policy levers.) State policymakers at the meeting made a number of suggestions for using available policy levers to support accountable health structures.

Build on the flexibility available through Medicaid Section 1115 demonstration waivers. States use Section 1115 demonstration waivers in multiple ways to support their accountable health entities. Massachusetts' and Oregon's Section 1115 demonstration waivers allow accountable entities to pay for health-related services using Medicaid dollars. Massachusetts' Accountable Care Organizations, New York's Performing Provider Systems, Rhode Island's Accountable Entities, and Washington's Accountable Communities of Health participate in Delivery System Reform Incentive Payment (DSRIP) programs or other flexible federal funding strategies authorized under Section 1115 demonstration waivers. DSRIP and other flexible programs support a range of projects designed to improve population health by incentivizing providers, health systems, and communities to address prevention and non-clinical health needs. Many programs restructure Medicaid funding into a pay-for-performance arrangement in which providers earn incentive payments outside of capitation rates for meeting certain metrics or milestones based on state-specific goals.[10] Other programs, such as Massachusetts' DSRIP initiative, provide startup[11] and ongoing funding for their accountable health structures to address health-related community needs.

Leverage Medicaid contracting to advance population health. When a state pays a Medicaid contracting entity — such as a managed care organization or an accountable health structure — a set amount per beneficiary for health care services, the contracting entity often has flexibility to invest in services that may not be allowed under fee-for-service Medicaid arrangements. Many states leverage this flexibility by encouraging contracting entities to invest in prevention and population health initiatives, such as housing. States such as Oregon are taking steps to ensure that such investments are encouraged and accounted for in managed care global budgets.

Incorporate population health into value-based payment models. States can guide accountable health structures in moving from volume to value to contain health care costs and/or incorporating social determinants of health by using value-based payment (VBP) models. Massachusetts includes the adoption of VBP as a DSRIP state accountability measure, which puts a percentage of the state's total DSRIP funding at risk based on the rate at which ACOs adopt VBP. States that have already developed VBP roadmaps for other entities such as health plans can also modify their existing roadmaps to include accountable health structures instead of reinventing the wheel. For instance, New York's amended VBP roadmap guides the VBP contracting between health plans and Performing Provider Systems and requires social interventions to be incorporated into contracts. Washington has a roadmap to achieve one of its Section 1115 demonstration waiver goals of having 90 percent of health care payments in VBP

by 2021. Oregon is developing a VBP roadmap and will be exploring ways to foster partnerships with community-based organizations throughout the development process.

Maximize State Innovation Model investment in population health and cross-sector alignment. All 12 of the states featured in the matrix received SIM design or test grants to plan, design, or test multi-payer health care payment and delivery system reform models in order to improve the quality of care, lower costs, and improve health for the population of their state. These states used the SIM investment to design or advance their innovative accountable health structures.

In addition to identifying the types of levers used to support accountable entities, state officials at the meeting recommended aligning goals and resources across communities and payers, including aligning payment levers and performance measures. For example, Rhode Island's Health Equity Zones (HEZs) were already in their first year of implementation and conducting community needs assessments when the state received a SIM test grant. Rhode Island Department of Health staff who worked on developing the HEZs reached out to SIM stakeholders to make sure that the HEZs were included as part of the SIM health assessment. HEZ stakeholders were also involved in the stakeholder engagement process for the state's Medicaid accountable care organizations, known as Accountable Entities (AEs), to ensure that AEs integrate the population health goals, levers, and priorities that HEZs identified.

Accountable health structures are most effective in reaching their goals when stakeholders across sectors work together toward shared goals. Resources and lessons learned that are applicable across payers and populations would interest more providers to participate. One state official recommended investment in local community capacity and infrastructure change rather than in disconnected projects limited to certain payers or populations.

Demonstrating Performance and Return on Investment: Measurement Strategies

State health policymakers collect, analyze, and report on a range of health data across agencies and programs, from administrative claims data and clinical electronic health records that provide information about patient care to public health data such as vital statistics. However, these vital data tend to be siloed within different agencies. State officials who are rolling out accountable health structures must identify, in conjunction with communities, valid and reliable measures of population health that include public health, health care utilization, and, more recently, social determinants of health such as housing, food security, and other health-related needs. At the same time, they must be mindful of reporting burden on their partners. Standardized implementation of population health measures and aggregation of data across siloes of health care delivery and social determinants remains challenging and complex. The strategies listed below build on information found in the Appendix that documents population health measures across states.

Use multi-sector measurement approaches and measures that address root causes of health. For accountable health models that aim to engage across sectors to improve community health and strengthen community-clinical linkages, it is critical to collect and analyze data across sectors at multiple levels. In addition to health outcomes, state accountable health structures commonly measure preventive services (e.g., chronic disease screening and immunizations), and health services (e.g., avoidable utilization or emergency room visits). They also include measures of community health, such as housing conditions, access to healthy food, and opportunities for physical activity as well as health disparities.

Because this work is driven by community priorities, officials agreed the challenge is to create cross-cutting measures that address root causes and track outcomes. Accountable health structures may need to develop a data-sharing infrastructure that enables data sharing across organizations. State officials suggest working with community partners on data-sharing strategies in a flexible, mutually beneficial way. California, as part of its SIM design project, developed an ACH data-sharing toolkit to help communities assess their current data-sharing maturity along a continuum. In Michigan, local health departments contract with the health care delivery system to exchange data and strengthen clinical-community linkages.

One critical question that arises, according to state officials, is not only what is measured but who is held accountable for impact. Are health care providers, or the accountable health structure more broadly, held accountable for community health improvement? State policymakers suggest that governance of accountable health structures is critical for determining accountability for outcomes, especially for mutually reinforcing activities.

Evaluate the value of accountable health structures in addition to the impact of interventions. The ultimate goal of accountable health structures is to improve the health of communities, and state officials need the tools to determine whether these structures are successful in advancing this goal. Common elements of accountable health evaluations include governance capacity, community engagement and diverse partnerships, effectiveness of interventions, sustainability, and impact on health care spending, quality, and value. States, including Delaware, are assessing commitment to collective impact — a framework developed to address complex social problems and achieve significant and lasting social change. Oregon is evaluating the impact of different types of Coordinated Care Organizations (CCOs) on health, health behaviors, health care utilization, and costs over time to identify successful models. In most cases, these new structures are embedded within a SIM program, and the impact of these new payment and delivery system models are included within the overall SIM evaluation plan.

Table 2. Common Elements of State Accountable Health Evaluation Frameworks

	Governance	Community Engagement and Diverse Partnerships	Effectiveness of Interventions	Sustainability	Impact on Health Care Spending, Quality, and Value
California	x	x			x
Colorado					x
Connecticut*	NA	NA	NA	NA	NA
Delaware		x		x	
Massachusetts	x	x	x	x	x
Michigan		x	x	x	
Minnesota		x			
New York			x		x
Oregon	x	x			x
Rhode Island Health Equity Zones	x				
Vermont*	NA	NA	NA	NA	NA
Washington		x		x	

*Connecticut's and Vermont's programs are in development.

Use measurement and incentive strategies to raise the bar for population health performance. State policymakers are exploring new measurement strategies for accountable health structures, seeking new performance indicators that keep them focused on improving health, and starting conversations about priorities. They are exploring data that can be used to address equity and reward prevention. Some suggest identifying and applying a small, unified, set of metrics that can be used across various systems and can be tied to payment and accountability. These small payment changes can be used to test larger-scale financing changes.

Policymakers also emphasize the importance of incorporating health-related social factors into measurement and making sure performance metrics assess community outcomes as well as provider outcomes. Rhode Island's statewide Health Equity Zone measures, for example, include high school graduation rates and households with at least one parent with full employment as equity indicators. State officials reported there is ongoing discussion about the degree of direct causality between HEZs and these measures. Washington's ACHs identify health disparities and social risk factors, such as adverse childhood experiences and rates of homelessness and arrests. Its Demonstration Project Toolkit embeds these and other performance measures into its evaluation criteria for payment based on reporting and performance.

Oregon includes social determinants within its Medicaid value-based payments. Oregon conducted an annual assessment of CCO performance using 17 measures with a quality pool paid to CCOs for performance, equal to 4.25 percent of CCOs' global budget in 2017. Initially, CCO incentive measures focused on process measures and clinical settings, but the state introduced incentive measures that focused on population health, including effective contraceptive use among women at risk of unintended pregnancy, cigarette smoking prevalence, and childhood obesity. The state is now exploring future measurement approaches that include such social determinants as kindergarten readiness and food insecurity.

Keep advancing population health efforts despite challenges in demonstrating a return on investment. In a health care environment in which cost reduction is a key driver, demonstrating return on investment (ROI) is critical. There is great interest in capturing and reinvesting any savings from interventions that improve health and reduce costs into population health initiatives.[12] Some states are investing targeted resources to identify analytical approaches to analyze ROI. In an effort to improve the predictive accuracy of financial risk models, Colorado is developing a risk adjustment model that incorporates social determinants of health and can be used to extrapolate ROI of interventions that affect the social determinants of health.

> "Not everything that can be counted counts, and not everything that counts can be counted."
> – Attributed to William Bruce Cameron.

However, state policymakers acknowledge that a three-year ROI for strategies to address health-related social needs is unrealistic and especially difficult given the need for comprehensive, mutually reinforcing activities. They note that the burden of proof required to demonstrate the value of population health strategies is higher than for medical procedures. For example, one policymaker noted that state officials do not apply the same expectations for ROI to new technologies. So how do state policymakers measure social welfare ROI? Do they measure its impact on the quality of life?

"The ROI question is, which of this blizzard of strategies is worth starting with?" observed a state official. One state Medicaid official provided an alternative approach to addressing this question. Instead of relying on state-specific ROI analyses, the agency relies on research demonstrating a correlation between health outcomes and a higher ratio of social-to-health spending to make the case to invest in

social determinants.[13] As a result, the state Medicaid program is now holding Medicaid managed care plans accountable for kindergarten readiness.

Developing Sustainable Structures for Long-Term Reinvestment in the Social Determinants of Health

State health policymakers use a range of strategies to fund investments in health-related social needs, but developing sustainable funding streams that endure beyond a given grant or budget cycle remains a challenge. Many states designed and implemented their accountable health entities with time-limited federal funds, such as those from SIM[14] initiatives. While these finite grants are important to states, Medicaid and public health officials alike recognize the importance of building sustainable funding models to support shared goals long after individual grants come to an end. Medicaid and public health agencies each use their own tools and policies to craft sustainable funding strategies, such as Medicaid's managed care contracting and public health's alignment of grant priorities.

Increasingly, state health policymakers are exploring the potential for aligning and maximizing resources across agencies and sectors to build in long-term funding for accountable health goals. Braiding and blending funding across state housing, education, and social services agencies to meet health-related goals is one example. Drawing on private funding sources, such as tax-exempt hospitals or philanthropic investment, to support pay-for-success initiatives is another. Below are some state strategies for sustaining funding to address health-related social needs.

Leverage Medicaid waiver authority and managed care contracting to support population health goals. Medicaid Section 1115 demonstration waivers are an important source of funding for state accountable health entities and other efforts to address upstream prevention and population health. As noted, Medicaid managed care contracting has been an important source of funding for state Medicaid efforts to connect beneficiaries to safe housing, nutritious food, and other health-related resources.

Align public health funding streams to address state health priorities. State public health agencies have long depended on federal grants for much of their funding. Public health investments in prevention and community health often rely on funding from federal entities such as the U.S. Centers for Disease Control and Prevention (CDC), the Health Resources and Services Administration (HRSA), and the Substance Abuse and Mental Health Services Administration (SAMHSA),[15] with many grants focusing on a particular disease or condition and requiring their own deliverables and accountability.

Despite the specific focus and time-limited nature of many grants, some state public health agencies are working to ensure that their activities and resources align with their priorities. For example, the Rhode Island Department of Health is working to disinvest from activities not aligned with its priorities and instead use that funding to reinvest in community and population health goals and support its accountable health work. For some state public health agencies, this may involve disinvesting from clinical services and investing instead in community services and capacity building. Oregon's public health division reorganized its staff and activities to address factors underlying chronic health conditions, and integrated multiple grant funding streams to align with that goal, which is shared by the state's Coordinated Care Organizations.

Examples of State Funding Strategies for Health-Related Social Needs

- **Rhode Island** uses cross-sector financial mapping to align funding streams and priorities across sectors. Financial mapping entails first identifying all the funding streams that address health-related programs and services across state agencies — such as housing, social services, education, labor, and transportation — and noting the purposes for which each agency uses its funds. Policymakers can then use the resulting "map" to identify and reduce duplication, streamline the use of federal funds, and identify funding gaps.
- A Medicaid health plan in a **California** county contributes a per-member, per-month (PMPM) payment into a wellness fund to address asthma.
- According to a **New York** state official, venture capital is funding asthma remediation services at zero risk to the health plan and provider network. The contract promises to pay a future value of three-year extended shared savings back to the investor.

Bolster resilience through braiding and blending funding. States health officials are experienced at braiding funds. Public health leaders have long braided funds from multiple federal grants, such as the HRSA Maternal and Child Health block grant and SAMHSA and CDC grants. Braiding funds in this manner generally does not require federal approval because the funding streams retain their own identities and reporting requirements.[16]

Increasingly, states are considering funding structures that braid funding across agencies, such as state permanent supportive housing programs that braid Medicaid funding for services with housing authority funding for rental assistance. These strategies are often aided by Medicaid waivers that support housing-related services, such as those in Washington and New York.[17] Some states have examples of braiding and blending funding that can serve as useful models for states implementing accountable health structures. Virginia, for example, blends — that is, pools funds so they lose their distinct identities — to address nonclinical health needs.[18] To support its home visiting program for high-risk pregnant women, Maryland braids funds from its Medicaid Section 1115 Health Choice demonstration program with federal Maternal, Infant, and Early Childhood Home Visiting program funds from HRSA, as well as matching funds from the local governments participating in the program. States may consider braiding or blending funds to build resiliency into their accountable health initiatives — with braided or blended funding, when one funding stream is interrupted, another may be able to pick up the slack.

Build private-sector support for state health goals. Some state leaders suggest becoming "multi-lingual" to develop a range of financial strategies across sectors. When state Medicaid and public health policymakers share a common vision for community-based health and prevention, they are in a stronger position to seek support from other public agencies, and even entities outside state government. Some states are already incorporating private investment in pay-for-success initiatives or social impact bonds to sustain their accountable health entities or address health-related community needs. For example, although not an accountable health model state, the South Carolina Department of Health and Human Services pooled private philanthropic funds with Medicaid dollars to conduct a pay-for-success intervention through its Nurse-Family Partnership. The state has agreed to make success payments to investors if the program is successful in improving health and reducing preterm births.[19] Similarly, private sources also provided the start-up funding for California's Accountable Communities for Health initiative. The ACHs are required to operate a wellness fund to sustain the initiative and facilitate investment from other sectors and stakeholders.[20] States such as Connecticut and Washington are also exploring ways to incorporate private capital into this work.

Hospital community benefit funds are another source of funding for the work of community-based accountable health entities.[21] Although nonprofit hospitals have long been required to provide some community benefit in order to maintain their tax-exempt status, Section 9007 of the Affordable Care Act included new requirements for nonprofit hospitals to conduct community health needs assessments and develop a strategy to meet the identified needs.[22] Connecticut, Delaware, and Rhode Island are among the states using or exploring the use of hospital community benefit dollars to support accountable health initiatives.

Although each state's circumstances are different, examining the funding strategies states use to leverage Medicaid, public health, and private sector investment in upstream prevention and non-medical social needs may prove useful to states working to improve health and well-being for all state residents.

Next Steps

Additional details about the experiences of these states may prove helpful to state policymakers seeking to use available funding and policy levers to craft sustainable accountable health entities that achieve measurable long-term success in improving population health. NASHP will continue to convene these states, explore and analyze their experiences, and share lessons for other states that may develop accountable health models in the future.

Appendix: State Accountable Health Models

State	Name of Initiative	Lead Agency	Purpose	Policy Levers	Financing	Geography	Targeted Conditions	Population Health Measurement Areas of Focus	Implementation Date	Status
CA	California Accountable Communities for Health Initiative (CACHI)	Partner collaboration of private foundations, including The California Endowment, Blue Shield of California Foundation, Kaiser Permanente, Sierra Health Foundation, Community Partners, Public Health Institute, and California Health and Human Services	To create an enduring platform for multi-sector collaboration to improve population health and achieve greater health equity.	Exploring connections with state policy initiatives such as the Medicaid Section 1115 demonstration waiver.	Start-up funding from private organizations, Wellness Fund being implemented for long-term sustainability.	Foundation RFP allows communities to designate communities of 100,000 to 200,000 residents in select communities. Six sites have been selected as catalyst sites and nine sites as accelerator sites.	Foundation RFP allows communities flexibility when choosing priority conditions and populations. Conditions that have been chosen include asthma, cardiovascular disease, diabetes and associated depression, trauma, violence prevention, and substance use disorders.	• Increases in percent of clinical providers and community partners addressing target population's clinical and social service needs. • Measures of improved environmental conditions, such as housing conditions, access to healthy food, and opportunities for physical activity to demonstrate improved population health outcomes related to target health issues.	9/1/2016	Second year of three-year grant period.
CO	Accountable Care Collaborative	Colorado Department of Health Care Policy and Financing	To connect Medicaid members to providers and help members find community and social services in their area.	PMPM Medicaid payment/Regional Care Collaborative Organization (RCCO) contracts. Payments will be aligned with SIM, Comprehensive Primary Care Initiative, and other reforms.	Medicaid contracts with RCCOs to create networks of Primary Care Medical Providers (PCMPs). Medicaid provides RCCOs with support for care management and administration, and they in turn seek to ensure care coordination for Medicaid enrollees and better integrate their care with hospitals, specialists, and social services.	Colorado is divided into seven regions; each region has one RCCO. In the next phase of the program, each region will have one new Regional Accountable Entity (RAE) that will be responsible for the duties currently performed by RCCOs and Behavioral Health Organizations (BHOs).	RCCOs currently exclude mental health and SUD services.	2015: • ER visits • Well-child visits ages 3-9 • Postpartum care Additional indicators from evaluation report: • Diabetes testing/ screening • Developmental screening	Phase I: The first clients were enrolled in May 2011. Phase II is expected to be implemented in summer 2018.	The program is being redesigned for system-level integration of administrative entities responsible for physical health and behavioral health. Instead of re-procuring RCCOs, the state is procuring RAEs that will coordinate physical and behavioral health care for clients in the seven regions.
CT	Health Enhancement Communities	Connecticut Department of Public Health in collaboration with the SIM Program Management Office and the state Medicaid agency	To establish Health Enhancement Communities accountable for health, health equity, and related costs for all residents in a geographic area; use data, community engagement, and cross-sector activities to identify and address root causes; and operate in an economic environment that sustainably funds and rewards such activities by capturing the economic value of improved health.	SIM Testing Grant	The state is examining capture and reinvest; low-income housing tax credits; blending and braiding federal, state, and local funds; New Markets Tax Credit; community benefit financial institutions; pay for success/social impact bonds; hospital community benefit; prevention escrow accounts; wellness trusts; captive insurance. It is also examining whether and how existing value-based payment (VBP) models can be modified to reward primary prevention interventions.	State anticipates enabling non-overlapping accountable communities with defined geographic borders.	State intends to create conditions that enable community-directed cross-sector initiatives targeting reduction of root cause risks focused on illness and injuries of their choosing	SIM metrics: State has proposed a range of measures to track statewide and regional progress of population health measures.	Implementation date is per SIM Test Grant.	Several communities have done relevant pre-work including establishing Community Health Collaboratives; completing Community Health Needs Assessments; implementing Community Health Improvement Plans; pursuing National Public Health Department Accreditation; and in two cases, obtaining and implementing CMMI Accountable Health Community grants. Intensive HEC planning with state's Population Health Advisory Council begins January 2018 and concludes July 2018.

State	Name of Initiative	Lead Agency	Purpose	Policy Levers	Financing	Geography	Targeted Conditions	Population Health Measurement Areas of Focus	Implementation Date	Status
DE	Healthy Neighborhoods	Delaware Center for Health Innovation and the Delaware Health Care Commission (HCC)	To meaningfully foster coordination between community organizations, the medical care delivery system, and the public sector across Delaware.	SIM Testing Grant	Potential sources include: - Fund development through grants, stakeholder support, and other sources - In-kind contributions from local organizations - Indirect support from the Division of Public Health for developing community health worker (CHW) roles in Healthy Neighborhoods. - Hospital community benefit funds - Staff support through DPH - SIM funding to support implementation of an accelerated HN mini-grant project	Ten non-overlapping Healthy Neighborhood Communities, each containing between 50,000 and 100,000 residents.	Healthy Neighborhoods target four statewide priority areas: healthy lifestyles; maternal and child health; mental health and addiction; and chronic disease prevention and management.	SIM metrics: • ED visits • Readmissions • Colorectal cancer screening • Screening for clinical depression and follow-up plan • Childhood immunization status • Diabetic nephropathy screening	2016: DCHI implemented 3 HNs 2017-2018: HCC will implement 3-6	DCHI: 3 communities were launched in 2016. 3-5 Healthy Neighborhood Communities to be launched in 2017. HCC: Opened an RFP to support the accelerated HN mini-grant project (estimated start date Oct. 2017).
MA	Accountable Care Organizations (ACOs)	MassHealth	To provide integrated health care to patients with the goals of improving their health and containing costs.	Section 1115 demonstration waiver/ Delivery System Reform Incentive Payment (DSRIP) gives ACOs the latitude to pay for flexible services.	Federal funding and state general funds, including annual $250 million hospital provider assessment (based on private sector charges) in the DSRIP Trust Fund, for the non-federal share.	ACOs do not have geographic boundaries.	ACOs will be able to use DSRIP funds to provide tenancy and nutritional support services and address other health-related social needs, such as services for individuals transitioning from an institution to the community, services to maintain a safe and healthy living environment, and support for individuals who have experienced violence.	Appendix D of DSRIP Protocol: • Prevention and wellness • Behavioral health/ substance abuse • Avoidable utilization	7/1/2017	17 ACOs have been procured.
MI	Community Health Innovation Region (CHIR)	Michigan Department of Health and Human Services (MDHHS)	To improve population health by promoting clinical/community linkages and policy/ environmental conditions that address social determinants of health.	SIM Testing Grant	Each CHIR backbone organization receives a fixed base level of SIM funding to support administrative functions and a health improvement budget that varies based on the number of Medicaid beneficiaries in the region.	While the five pilot CHIRs cover only a portion of the state, final geographic boundaries will be determined after partners have worked together to target investments and impact.	Initial focus areas are addressing ED utilization, assessing community needs, and identifying region-specific health improvement goals.	SIM metrics: • Percent of adults reporting fair or poor health • Premature newborns • Number of mentally unhealthy days in last 30 • Number of physically unhealthy days in last 30 • Rates of excessive alcohol consumption • Adult obesity rate • Childhood immunization • Adult BMI assessment • Lead screening in children • Breast, cervical, colorectal cancer screening • Well-child and adolescent well-care visits	All CHIRs are expected to be fully operational in early 2018.	MDHHS has approved operational plans and budgets for all five CHIR regions.

State	Name of Initiative	Lead Agency	Purpose	Policy Levers	Financing	Geography	Targeted Conditions	Population Health Measurement Areas of Focus	Implementation Date	Status
MN	Accountable Communities for Health (ACHs)	• Minnesota Department of Health • Minnesota Department of Human Services	To improve health and lower costs in targeted communities with significant health and social needs.	SIM Testing Grant	State gave start-up funding to ACHs through SIM testing grant. Many ACHs have received or are seeking other funding including VBP grant funding from state and non-state sources to sustain their work.	State allows communities to designate boundaries when responding to RFP. ACHs cover select communities.	State allows communities flexibility when choosing priority conditions and populations.	No common measures. ACHs choose measures to track.	Round 1: 2/1/2015 Round 2: 1/1/2017	Round 2 of ACH grant with only six ACHs out of the 15 from round 1. Grant period ended in September 2017.
NY	Performing Provider Systems (PPS)	New York State Department of Health	To help reduce avoidable hospital use and improve the health outcomes of Medicaid beneficiaries.	Section 1115 demonstration waiver/DSRIP	Federal funding through local match created by intergovernmental transfers (IGTs) from major public hospitals and state general revenue funded by Designated State Health Programs (DSHPs) for state share. The state also has funded supplemental DSRIP programs that augment the waiver authorized and funded projects.	Twenty-five PPS are approved to serve selected counties or boroughs. A PPS may be approved to cover multiple counties, and a county may have multiple PPS. Attribution is based on patient connectivity to the approved PPS provider network. Significant incentives were available when providers agreed to form a sole PPS in a given geographic area.	Each PPS implements 9-12 projects from approved project toolkit, at least one of which is a population-wide project that aligns with the state's Prevention Agenda, which includes promoting mental health and reducing premature births, as well as prevention of substance abuse, chronic diseases, and sexually-transmitted diseases.	• Improve health status and reduce health disparities • Promote mental health and prevent substance abuse • Prevent chronic diseases • Prevent HIV and STDs • Promote healthy women, infants, and children	Project plans were approved March 2015 and Year 1 began April 1, 2015.	Year 3 of DSRIP. Mid-point assessment completed. State currently on track to hit waiver goal of 25% reduction in avoidable hospital use.
OR	Coordinated Care Organizations (CCOs)	Oregon Health Authority	To meet the Triple Aim through physical/behavioral/oral health coordination, paying for performance, and incentivizing upstream health promotion.	Section 1115 demonstration waiver gives CCOs the latitude to pay for flexible services and financially incentivizes quality through metrics	Medicaid	CCOs have no designated geographic boundaries; a CCO may cover multiple counties, and a county may have multiple CCOs.	CCOs are local networks of Medicaid providers that are accountable for the health outcomes of the people they serve. CCOs focus on prevention and helping people manage chronic conditions, like diabetes.	Population health incentive measures include: • Effective contraceptive use among women at risk of unintended pregnancy • Cigarette smoking prevalence • Childhood obesity	2012	There are 16 CCOs operating in Oregon.

State	Name of Initiative	Lead Agency	Purpose	Policy Levers	Financing	Geography	Targeted Conditions	Population Health Measurement Areas of Focus	Implementation Date	Status
RI	Accountable Entities (AEs)	Rhode Island Executive Office of Health and Human Services	To improve the quality of care, member experience, and total cost of care for Medicaid beneficiaries enrolled in managed care organizations.	Section 1115 demonstration waiver	Federal funding, DSHP for non-federal share.	AEs have no designated geographic boundaries.	Two types of AEs: - Comprehensive AEs will be accountable for the care furnished to the general Medicaid eligible population, and will focus on the integration of primary care and behavioral health services - Specialized long-term services and supports (LTSS) AEs will be accountable for the care furnished to Medicaid beneficiaries receiving LTSS.	• Preventable admissions • Readmissions • Avoidable ED use • Total cost of care	Health System Transformation Project start date:10/20/2016. Full program performance period for comprehensive AEs begins in CY 2018. Specialized LTSS AE pilot will be implemented in CY 2018.	Comprehensive AE Certification Process is underway. Specialized LTSS AE pilot is being designed.
	Health Equity Zones (HEZs)	Rhode Island Department of Health	To eliminate health disparities using place-based strategies to promote healthy communities.	Aligned with SIM; potentially aligning with existing PCMHs, Health Homes, and AEs.	State braids CDC chronic disease prevention funds for the prevention of obesity, diabetes, heart disease and stroke; CDC preventive health block grant funds; and early childhood wellness funds from SAMHSA.	Ten zones, each with a population of at least 5,000. Community Collaboratives defined their zones' geographic areas.	HEZs support innovative approaches to prevent chronic diseases, improve birth outcomes, and improve the social and environmental conditions of neighborhoods across the state.		2015	Year 3
VT	Accountable Communities for Health (ACHs)	• Vermont Department of Health • Vermont Health Care Innovation Project Team (SIM)	To develop a coordinated, locally driven strategy for delivering health care, social services, and primary prevention within communities.	SIM Testing Grant	State funding ACH Peer Learning Lab through SIM testing grant; no funding direct to ACHs. Post-SIM, existing staff and resources at multiple state agencies have continued peer learning activities.	State allows communities to designate boundaries when applying for Peer Learning Lab, but boundaries are influenced by state Health Service Areas. ACHs may or may not cover entire state.	State allows communities flexibility when choosing priority conditions and populations.		The state began exploring the ACH concept in late 2015.	ACH Peer Learning Lab concluded in February 2017, and a final report was published. Of the 10 ACH sites that participated in the Peer Learning Lab, many have functioning core leadership teams and are ready to implement community-based prevention strategies and address the health of their entire populations.

State	Name of Initiative	Lead Agency	Purpose	Policy Levers	Financing	Geography	Targeted Conditions	Population Health Measurement Areas of Focus	Implementation Date	Status
WA	Accountable Communities of Health (ACHs)	Washington State Health Care Authority in coordination with the Washington State Department of Health and Washington State Department of Social and Health Services	To improve the health of communities across the state by creating a partnership between the state and community-based, cross-sector coalitions that work to improve health within their respective regions.	SIM Testing Grant, State Legislation, Section 1115 demonstration waiver/DSRIP	State gave start-up funding to ACHs through state legislation and the SIM testing grant. ACHs will receive additional support and will direct investments under DSRIP to implement Medicaid transformation projects.	State-designed boundaries align with Medicaid regional service areas. ACHs cover the entire state, and there is no overlap between ACH boundaries.	ACHs are required to implement at least four DSRIP projects, in addition to potential projects outside of DSRIP: 1. Physical and behavioral health integration 2. At least one of the following: community-based care coordination, transitional care, diversion interventions 3. Addressing opioid use 4. At least one of the following: reproductive and maternal/ child health, access to oral health services, chronic disease prevention and control.	• Immunizations • Well child visits • Primary caries prevention for young children • Tobacco use cessation • Breast, cervical, colorectal cancer screening • Chlamydia screening in women • Mental health service penetration • SUD service penetration	All nine ACHs received designation between July 2015 and January 2016.	All nine ACHs have passed Phase 1 and 2 certification as of Sept. 20, 2017. ACHs submitted DSRIP project plans in November 2017, with implementation beginning Q1-Q3 2018. ACHs are currently in award year 3 of 4 under the SIM Testing Grant.

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Acknowledgements:
The authors wish to thank individuals from the following organizations and agencies who participated in the convening and/or reviewed drafts of this document:

California Accountable Communities for Health Initiative
Colorado Department of Health Care Policy and Financing
Connecticut Office of the Lieutenant Governor and State Innovation Model Program Management Office
Delaware Department of Health and Social Services
Maryland Department of Health and Mental Hygiene
Massachusetts Executive Office of Health and Human Services
Michigan Department of Health & Human Services
Minnesota Department of Health
New York State Department of Health
Oregon Health Authority
Rhode Island Department of Health and Executive Office of Health and Human Services
Department of **Vermont** Health Access
Washington State Health Care Authority
California Alliance for Prevention Funding
Centers for Disease Control and Prevention
Georgia Health Policy Center
Robert Wood Johnson Foundation

The authors also thank the Robert Wood Johnson Foundation for its generous support of this project. Any errors or omissions are the authors'.

Support for this work was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.

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