Options for Financing Community Prevention Efforts to Improve Health

Post implementation of the Affordable Care Act, the U.S. health care system is rapidly evolving. Many more Americans are insured. New incentives that place higher value on outcomes are gradually becoming the day to day reality of health care business. From denied payments for hospital readmissions to bundled payments and shared savings models, value-, rather than volume-based health care financing models are increasingly common. Nevertheless, health care financing is still focused primarily on payment for clinical care, most often for patients who are already sick.

Community-based initiatives that promote health and prevent disease hold great promise for achieving the Triple Aim, but are generally not tightly connected to, nor financed by, the health care system. These initiatives are often funded by public and private grants, making it difficult to sustain a program over a long period, despite the need for continuity when attempting to create health behavior change and environments that support healthy choices.

This Issue Brief outlines traditional and newer sources of financing for community prevention and is intended for use by program managers seeking to establish, sustain or expand community prevention initiatives and by policy makers who want to invest more in keeping their constituents healthy.

Community Prevention Grant Funding

There are many sources of funding for community health improvement, from private and public (government) sources. The Dashboard developed by the Trust for America's Health (TFAH) is a searchable database that includes many of these public and private funding sources.

The Centers for Disease Control and Prevention at HHS is a central resource for community prevention grant funding. Other federal Health and Human Services agencies directly or indirectly support community prevention, including the Health Resources and Services Administration, the Substance Abuse and Mental Health Agency, the National Institutes of Health and the Centers for Medicare and Medicaid Services. Additional Federal agencies that have grants aimed, at least in part, at health outcomes include Housing and Urban Development (e.g., Healthy Communities Transformation Initiative, Healthy Homes Program), Department of Education (e.g., Carol M. White Physical Education Program, Promise Neighborhoods), United States Department of Agriculture (e.g., Healthy Food Financing Initiative and Children, Youth and Families at Risk Program), and the Environmental Protection Agency (Healthy Communities). In addition, many public and private programs may not appear to fund health directly, but they work to address social determinants that are aligned with those that impact health.

Some foundations make **Program-Related Investments (PRIs)** to support charitable activities that involve the potential for return of capital within an established time frame. PRIs include financing methods commonly associated with banks or other private investors, such as loans, loan guarantees, linked deposits, and even equity investments in charitable organizations or in commercial ventures for charitable purposes. A large portion of PRI dollars support affordable housing and community development. For the recipient, the primary benefit of PRIs is access to capital at lower rates than may

otherwise be available. For the funder, the principal benefit is that the repayment or return of equity can be recycled for another charitable purpose.[1]

Leveraging Resources, Including In-kind Support

Community prevention programs can leverage resources in their communities by soliciting and accepting in-kind donations. An in-kind donation is a gift of goods and services that your organization would have to otherwise buy if they hadn't been donated. The value of the donated supplies or services may be recorded as the amount that your organization would have to pay for similar items. For example, a local company might donate the use of their conference space for meetings or events. A local printing company might donate their printing services to produce a brochure, annual report or event program.

Not for Profit Hospital Community Benefit Requirements

The Internal Revenue Service (IRS) requires non-profit hospitals to meet certain requirements to retain their non-profit status and some states have additional requirements. Hospitals must conduct programs or activities to address community need and meet at least one of the following community benefit objectives:

- Improve access to health care services
- Enhance the health of the community
- Advance medical or health care knowledge
- Relieves or reduces government burden

Non-profit hospitals meet their obligations by providing financial assistance to patients; writing off the unpaid costs of care provided to patients enrolled in government-sponsored insurance, and through community benefit services, which include:

- Community Health Services
- Health Professional Education
- Subsidized Health Services
- Research
- Financial Contributions
- Community Building Activities (defined as support for physical improvement and housing, economic development, community support, environmental improvements, leadership development and training for community members, coalition building, community health improvement advocacy and workforce development)[2]

Non-profit hospitals are required to conduct Community Health Needs Assessments every three years (including input from the community and public health) and develop implementation strategies based on identified community needs. Hospitals are increasingly interested in community benefit strategies that address the social determinants of health. For more information, see:

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[1] http://grantspace.org/Tools/Knowledge-Base/Grantmakers/pris

[2] http://preventioninstitute.org/component/jlibrary/article/id-332/127.html

http://www.hilltopinstitute.org/publications/HospitalCommunityBenefitsAfterTheACA-LeveragingPolicyIssueBrief11-June2015.pdf

https://www.chausa.org/communitybenefit/defining-community-benefit;

http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf402124; and

http://www.phi.org/resources/?resource=supporting-alignment-and-accountability-in-community-health-improvement-the-development-and-piloting-of-a-regional-data-sharing-system

Developing Braided and Blended Funding Streams

It is widely recognized that multiple sources of funding are needed to sustain successful community health improvement initiatives and fund continued innovation. Blending is a term used to describe efforts that use separate funding streams in more coordinated and flexible ways. There are several strategies for blending, including:

- **Braiding/Coordination** – A community and program-level strategy for using separate categorical funding streams together to support seamless services. Separate funding streams are wrapped together to support unified services. Each source of funding that is braided retains its separate requirements and restrictions.
- **Pooling** – Flexible pots of money are blended into one funding pool, typically at the state and county levels. In this type of blended funding, expenses cannot always be matched to the original source of funding.
- **Decategorizing** – Removing, reducing or realigning requirements to make funding streams less "categorical" and thus able to be blended, typically done at the state level.[3]

There are a few Federal initiatives designed to encourage braiding and blending of Federal funding streams, such as the Now is the Time, Performance Partnership Pilots for Disconnected Youth, Partnership for Sustainable Communities, Neighborhood Revitalization Initiative, Strong Cities, Strong Communities (SC2) and Promise Zones. In addition, community health improvement initiatives often blend public and private funding sources. For examples, see:
http://www.nemours.org/content/dam/nemours/wwwv2/filebox/about/2013casestudies.pdf
http://healthyamericans.org/health-issues/prevention_story/registry-colorado

Wellness Trusts

Wellness Trusts are funding pools to invest in upstream prevention, based on the assumption that population health will improve and savings will be realized by reducing utilization in the health care system. For example, Massachusetts health plans and large hospital systems pay into a fund administered by the State Department of Public Health. This Trust was established as a component of the State's cost containment strategy. Competitive grants have been awarded for evidence-based community prevention strategies. See http://www.mphaweb.org/documents/PrevandWellnessTrustFund-MPHAFactSheetupdatedOct12.pdf

[3] http://www.financeproject.org/Publications/fp%20blending%20funds%201_24.pdf

http://www.mass.gov/eohhs/gov/departments/dph/programs/community-health/prevention-and-wellness/
http://www.northeastern.edu/iuhrp/wp-content/uploads/2013/12/PreventionTrustFinalReport.pdf

Various Health Care Reimbursement Mechanisms

While health insurance reimbursement for community prevention is not common in either the public or private markets, pockets of innovation exist and are increasing. For example, Medicaid agencies and Medicaid Managed Care Organizations (MCOs) are increasingly reimbursing for non-traditional services (such as home remediation of environmental triggers), provision of services in non-traditional settings (such as schools or the YMCA), and services provided by non-traditional (unlicensed) providers. For more information, see Investing in Best Practices for Asthma: A Business Case, Health Resources in Action and the Best Practice Compendia issued by the Medicaid Health Plans of America's Center for Best Practices.

Medicaid Waivers

There are several authorities within Medicaid that can support community prevention, including the following waivers (waivers are mechanisms used by the Federal government to provide states with greater flexibility in the design of their Medicaid programs, since they waive certain requirements or regulations). Section 1115 Research & Demonstration Projects: States can apply for program flexibility to test new or existing approaches to financing and delivering Medicaid and the Children's Health Insurance Program (CHIP). For example, the Texas 1115 waiver sets aside 5% of the annual Medicaid budget for local public health. The New York 1115 waiver reimburses supportive housing service providers via a bundled or case rate payment for services delivered in housing to high-acuity chronically homeless beneficiaries. Waivers must be cost neutral over the demonstration period, which is typically 5 years. For more information, see http://iom.edu/~/media/Files/Perspectives-Files/2014/Discussion-Papers/BPH-TexasInnovation.pdf. For an example of an asthma program with a home-based environmental assessment reimbursed under an 1115 waiver, see the Massachusetts example in A Case Study in Payment Reform to Support Optimal Pediatric Asthma Care (The Brookings Institution) and Sustainable Funding and Business Case for GHHI Home Interventions for Asthma Patients. The Centers for Medicare and Medicaid Services approved an extension of the Massachusetts 1115 waiver to include a pediatric asthma program that is paid at a bundled or global rate which includes the home assessment and other services to support the reduction of environmental triggers in the home.

Integrating Housing in State Medicaid Policy, Center for Supportive Housing

- Delivery System Reform Incentive Payment (DSRIP): In 2010, the Centers for Medicare and Medicaid Services (CMS) launched the DSRIP program, a Section 1115 waiver program whereby states can receive federal financing to support initiatives designed to address the Triple Aim of improving the health of the population, enhancing the experience and outcomes of the patient and reducing the per capita cost of care. To receive federal funding for the DSRIP program, states must identify a source of state dollars that can be used to "match" federal

funding for the DSRIP program.[4] The Texas DSRIP funds comprehensive services in supportive housing to Medicaid and indigent patients in certain areas of the State. The New York DSRIP outlines strategies related to asthma care that include community-based interventions such as medication adherence programs in community settings and asthma home-based self-management programs. For more information on DSRIPs, see: http://www.chcs.org/delivery-system-reform-incentive-payment-program-model-reforming-medicaid/

- Section 1915(b) Managed Care Waivers: States can apply for waivers to provide services through managed care delivery systems or otherwise limit people's choice of providers. 1915(b)(3) waivers, in particular, allow states to use the savings that the state gets from a managed care delivery system to provide additional services.

- Section 1915(c) Home and Community-Based Services Waivers and 1915(i) State Plan Amendment Home and Community-Based Services benefit: States can apply for waivers to provide long-term care services in home and community settings rather than institutional settings. Services can be medical or non-medical, as long as they are designed to transition an individual from an institutional to a home and community-based setting. Many 1915(c) waivers cover housing counseling, assistance, start up and stabilization. Home delivered meals are a common 1915(c) benefit for frail seniors. The Louisiana 1915(i) State Plan Amendment covers supportive housing services for beneficiaries with a significant, long-term disability.

For more in-depth information, see:
Pathways to Reimbursement: Understanding and Expanding Medicaid in Your State, National Center for Healthy Housing
Integrating Housing in State Medicaid Policy, Center for Supportive Housing

Medicaid Fee-for-Service Reimbursement

Medicaid services can be delivered in community settings, including homes and schools. For example, the Asthma Network of West Michigan receives Medicaid fee-for-service reimbursement for home-based environmental assessment services at the standard rate for a skilled nurse visit. For more information, see Health investments that Pay Off: Strategies for Addressing Asthma in Children (National Governors Association) and Asthma Self-Management Education and Environmental Management: Approaches to Enhancing Reimbursement (Centers for Disease Control and Prevention).

A recent rule change in Medicaid permits states to reimburse for preventive services delivered by a non-licensed provider, when referred by a licensed provider. State Medicaid offices must submit a State Plan Amendment to CMS to implement this change. While this change has not yet been approved in any state, there is potential to fund services of community health workers, health educators and other non-licensed providers who provide preventive services. For more information, see

[4] http://www.manatt.com/ThreeColumn.aspx?pageid=167991&id=652462

Medicaid Reimbursement for Community Prevention Meeting Summary, Trust for America's Health and Nemours

Medicaid Targeted Case Management

Case management consists of services which help beneficiaries gain access to needed medical, social, educational, and other services. "Targeted" case management services are those aimed specifically at special groups of enrollees such as those with developmental disabilities or chronic mental illness.[5] For a chart of Medicaid targeted case management benefits by state, see Kaiser Family Foundation Chart Medicaid Targeted Case Management Benefit by State. For an example of targeted case management support of an asthma program that conducts home assessments, see Sustainable Funding and Business Case for GHHI Home Interventions for Asthma Patients.

Medicaid Managed Care Reimbursement

Managed care organizations (MCOs) typically have the flexibility to support evidence-based community prevention interventions, particularly for those patients/population considered to be high utilizers. As opposed to a fee-for-service Medicaid program, a State Plan Amendment is not required for a MCO to reimburse for non-traditional services, or to reimburse for a service outside of a clinical setting, or provided by a non-licensed provider. States can encourage MCO investment in community prevention by imposing requirements or establishing incentives in the managed care contracting process.

As an example, Medica in Minnesota is conducting a demonstration with beneficiaries who are homeless and managing chronic conditions. Medica pays for supportive housing services, including to Health connection, a non-profit that provides services for supportive housing providers. In Massachusetts, the Massachusetts Behavioral Health Partnership created a Community Support Program benefit for their members who have experienced chronic homelessness. A number of MCOs reimburse for home-based asthma services, and some also cover the costs of products to reduce environmental triggers.

For more information, see:
Integrating Housing in State Medicaid Policy, Center for Supportive Housing
Investing in Best Practices for Asthma: A Business Case, Health Resources in Action
Using Medicaid to Advance Community-Based Childhood Asthma Interventions: A Review of Innovative Medicaid Programs in Massachusetts and Opportunities for Expansion under Medicaid Nationwide, The George Washington University

Medicaid Administrative Claims

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[5] https://www.cms.gov/Regulations-and-Guidance/Legislation/DeficitReductionAct/downloads/CM_Fact_Sheet.pdf and http://www.chcs.org/media/CMS_Medicaid_Targeted_Case_Management_Rule.pdf

Medicaid administrative claims, as opposed to service claims, are a way that states can get federal matching dollars for activities that support the administration of their Medicaid program, such as enrollment and monitoring. In Texas, administrative claiming supports some of the activities of their Childhood Lead Poisoning Prevention Program. For more information, see: Pathways to Reimbursement: Understanding and Expanding Medicaid in Your State, National Center for Healthy Housing, Reimbursement for Healthy Homes Services: A Case Study of Leveraging Existing Medicaid Authority in Texas and see Sustainable Funding and Business Case for GHHI Home Interventions for Asthma Patients.

Various Delivery Mechanisms

Accountable Care Organization (ACO) – An ACO is a model of care that distributes accountability for performance on cost and quality metrics across groups of health care providers, tying shared savings and other financial rewards to maintenance or improvement of care quality.[6] Since an ACO is accountable for a designated population of patients, it stands to gain from preventing illness and reducing health care utilization. An ACO could invest in community prevention to both improve the health of the population and decrease costs. For an example, see http://healthyamericans.org/health-issues/prevention_story/how-a-social-accountable-care-organization-improves-health-and-saves-money-and-lives.

Community Health (or Care) Teams – A community care team is a locally defined leadership structure that includes health professionals, local public health staff and community members. The team meets on a regular basis to establish trusting relationships and break down barriers to allow them to coordinate health-related activities, plan for evidence-based prevention and care, coordinate care, develop measurement and evaluation of activities and focus on targeted health goals established by the community's needs. For more information and examples, see http://www.health.state.mn.us/healthreform/homes/legreport/2013hchlegreport.pdf

Medical or Health Homes and Community-Centered Health Homes – Patient-centered medical homes (PCMHs) are rapidly being established to better coordinate the delivery of health care services. Certified PCMHs may receive an additional payment to support chronic disease management, care coordination and health promotion.[7] The Affordable Care Act established a **Medicaid Health Homes** benefit option for states. This option allows states to pay health home providers to coordinate care for Medicaid enrollees with chronic conditions, including primary, acute, behavioral health, and long-term services and supports. For more information, see Medicaid Health Homes: An Overview, CMS.

Some medical homes use a Community Health Team model. The defining attribute of the Community-Centered Health Home (CCHH) is active involvement in community advocacy and systems change. A CCHH not only acknowledges that factors outside the health care system affect patient health outcomes,

[6] http://changelabsolutions.org/sites/default/files/Financing_Prevention-NASHP_FINAL_20140410.pdf

[7] Ibid.

but actively participates in improving them. For more information on Community-centered Health Homes, see http://www.preventioninstitute.org/component/jlibrary/article/id-298/127.html.

Federal Innovation Funds

The Centers for Medicare and Medicaid Innovation at the Centers for Medicare and Medicaid Services in HHS has targeted some of its funds to prevention and population health, particularly focusing on strengthening linkages between health care, public health and community. Two sources with this specific focus are:

- Health Care Innovation Awards
- State Innovation Models – For more information see http://iom.edu/~/media/Files/Perspectives-Files/2013/Discussion-Papers/BPH-OpportnuityKnocks.pdf and http://kff.org/medicaid/fact-sheet/the-state-innovation-models-sim-program-an-overview/

Community Development Funding

Community Economic Development (CED) is a process by which a community uses resources to attract capital and increase physical, commercial, and business development and job opportunities for its residents.[8] Community development helps low-income people and their neighborhoods by providing access to financing and other tools to build affordable housing, launch small businesses, and construct facilities in the community. These investments help to make communities more robust, both economically and socially. The Community Reinvestment Act sets requirements for banks and other financial institutions to help meet the credit needs of the local communities in which they are chartered, particularly low- and moderate-income neighborhoods.[9] Community development funds are often funneled through Community Development Corporations and Community Development Financial Institutions and come in many forms (low-interest loans, tax credits, etc.). For an example, see http://healthyamericans.org/health-issues/prevention_story/purposefully-building-a-community-that-addresses-health-education-and-violence.

For lessons learned on cross-sector community development initiatives to improve health, see: http://www.frbsf.org/community-development/files/wp2013-07.pdf

http://www.hria.org/resources/public-health-toolkits/health-improvement-assessment-resources/community-investment-tax-credit-hia.html

Social Impact Investments

Impact investing places capital in an organization that can create financial returns and achieve a social benefit. Social impact investing takes the form of equity, debt, working capital lines of credit, micro

[8] http://www.acf.hhs.gov/programs/ocs/resource/community-economic-development-definition-of-terms

[9] http://hria.org/uploads/reports/PPReport_r3_011614_pages.pdf

financing and loan guarantees to early-stage companies.[10] Recently, one form of impact investing has gained traction in health -- the **Social Impact Bond**. In a Social Impact Bond (SIB), or Health Impact Bond (HIB), capital is raised from private investors to invest in prevention interventions, capturing the healthcare cost-savings that result from the interventions, and then returning a portion of those savings to the investors as profit.[11]

For an example of a HIB, see:
http://health.citizing.org/data/projects/citizen-solve health/Health%20Capital%20Market%20FINAL%20March%202012.pdf

[10] http://health.citizing.org/data/projects/citizen-solve-health/Health%20Capital%20Market%20FINAL%20March%202012.pdf
[11] http://preventioninstitute.org/component/jlibrary/article/id-332/127.html