Task Force on
Accountable Care Communities

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Meeting Summary

May 31, 2018

10:00 am – 3:00 pm

North Carolina Institute of Medicine

630 Davis Drive

Morrisville, NC 27560

Attendees:

- *Co-Chairs:* Miles Atkins, Reuben Blackwell, Sec. Mandy Cohen, Ron Paulus
- *Steering Committee:* Jason Baisden, Allison Owen, Melanie Phelps, Jeff Spade; *Via phone:* Shelisa Howard-Martinez
- *Task Force Members*: Donna Albertone, Paula Swepson Avery, Blair Barton-Percival, Tristan Bruner, Debbie Collins, Kathy Colville, Satana Deberry, Howard Eisenson, Robert Feikema, Shauna Guthrie, Mark Gwynne, Robby Hall, Nicole Johnson, Dee Jones, Lisa Macon Harrison, Nicolle Miller, Kevin Moore, Barbara Morales Burke, Sharon Nelson, Brendan Riley, Kim Schwartz, Linda Shaw, Pam Silberman, Tish Singletary, Anne Thomas, Sheree Vodicka, Mary Warren, Ciara Zachary; *Via phone*: Kim Green, Hannah Randall

Introductions:

Task Force Co-Chair Ron Paulus opened the meeting and asked Task Force members to introduce themselves. Steering committee members, Task Force members, and guests introduced themselves, including their position and the organization they represent.

A Typology of Potential Financing Structures for Accountable Care Communities
Stacy Becker, Vice President, Programs, ReThink Health

Ms. Becker's presentation described the spectrum of financing mechanisms that can be used for population health programs (ReThink Health's Typology of Financing Structures for Population Health). She stated that we need to change our spending patterns with the money that is already available. Current population health partnerships and programs rely heavily on grants and in-kind support, which is not sustainable. However, there is not one overarching sustainable financing source for health as there is for other areas, like housing.

Ms. Becker clarified that the typology of financing structures describes funding mechanisms, not funding sources. The typology lists mechanisms on a spectrum of sustainability, with grants being the least sustainable and more sustainable mechanisms being health care payment models, reinvestment, anchor institutions, public revenue, appropriations, mandates, and private market.

The group was asked to split into pairs to discuss an intervention to fund, identify a funding structure, and work through questions provided on a handout. The group discussed the ideas they had or examples of previous work.

Questions/Discussion:
Question: There have been challenges providing a diabetes prevention program through a community organization. Discussed social impact bonds, but legal ramifications are complicated. Maybe looking into health care payment models?
Answer: Social Impact Bonds are very difficult, need a broader source that stakeholders can look to. There is a lot of evidence on solid outcomes for prevention programs. Other mechanisms to explore: tax credits, loan/equity models, and referred to research and blog posts on ReThink Health website to identify ROI models. There is a ton of evidence about what works in pop. health and actual cost/benefits. Recommended WISSIP research and information on Results First.

Becker presentation here.

Financial Partnerships
Peter Skillern, Executive Director, Reinvestment Partners

Mr. Skillern discussed the siloed levels of expertise between health care, community development, and finance, which makes it difficult to communicate across sectors that use different language for similar issues. There is a need to understand the language of multiple sectors to engage all stakeholders.

Conversations around social determinants of health are often very local, but these problems are broad and programs need to be scalable and replicable. Also looking at what the outcomes of a program really are, is it “moving the needle” on the outcome you are looking for? May be that it positively impacts something unintended (public safety), but doesn’t fully meet the intended need (access to fresh, healthy food).

When asking if an intervention works for payor, provider, patient - ask if it’s measurable, scalable, replicable, and does it get cost savings. He gave an example of Bull City Bucks program, where SNAP beneficiaries are eligible, enrolled electronically by health care providers, get $40 at beginning of month for fruits and veggies from Food Lion. Now being expanded to 8 more counties.

Key elements of scalability include: payors being on board, administration to set up the program, commitment from distributors, method for enrollment, and capacity for evaluation.

Questions/Discussion:

Question: How did you get Food Lion to invest?
Answer: They have invested in technology for start-up, but not dollars directly to the food prices.

Question: What are organizational issues? HIPAA issues, etc. What are necessary risks to take in order to get to the desired improved health outcomes? What are tensions between different community values?
Answer: Confidentiality is key. Participants sign consent forms to agree to share info. All these issues have to be navigated in order to partner meaningfully with other agencies. We also have lessened burden on health care providers.

Comment: There are very few people in the state who understand both community economic development and public health. We have access to a vast group of people, but there isn't enough communication. We need to figure out a way to talk together to address these needs, because the service providers (from all sectors) are working with the same people. Who can hold these conversations locally?

Skillern presentation here.

Multi-Sector Approach to Investing in Community Partnerships: Cabarrus Health Alliance
William Pilkington, CEO and Director of Public Health, Cabarrus Health Alliance

Dr. Pilkington described the creation of the Cabarrus Health Alliance, formerly Cabarrus County Health Department. Because health crosses boundaries, they got rid of notion that they only serve Cabarrus County. The county has a good number of financial resources that have helped support a research campus, cooking programs, beautiful facility, etc. for the Cabarrus Health Alliance.

The key to their success in developing and funding community partnerships and programs has been relationships. They have people interested in filling the needs of the community and they have the resources to do so.

Questions/Discussion:

Question: What have been some of the difficulties creating partnerships?
Answer: Need to develop strategic plans re: funding and program plans. Most difficult to develop ROI was with school garden - how do you demonstrate impact on kids' nutrition or health? Decided the ROI was community enthusiasm.

Question: Have you done anything with social impact bonds?
Answer: Tried, but it did not work.

Pilkington presentation here.

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Enabling Sustainable Investment in Effective Social Interventions: A Review of Medicaid Managed Care Rate Setting Tools
Jocelyn Guyer, Managing Director, Manatt Health Strategies

Ms. Guyer explained that when focusing on Medicaid, it is often critical to have diversity of funding sources, so some states marry Medicaid funding with grant funding, etc. There is a lot of conversation happening around states looking to use Medicaid system delivery for other approaches – such as paying for value and focusing on social determinants. Medicaid rate setting involves analyses of the claims experience for people that will be covered, how much was spent on them in the past, and what typy of social interventions are covered benefits.

Typically, the Medical Loss Ratio (MLR) is set to at least 85% so that the majority of premium dollars will be spent on medical care. Calculating the MLR: claims + quality improvement expenses + fraud prevention expenses / premiums - taxes + fees. Medicaid Managed Care plans are allowed to cover value-added services, but costs cannot be included in capitation rates, though they can be included in the numerator of the MLR if part of a quality initiative. Also allowed to cover "In-Lieu-Of" Services, the costs of which are accounted for when setting capitation rates and in the numerator of the MLR.

Key questions to consider are: 1) How can the cost of social interventions be built into a plan's capitation rate?; 2) How can the cost of social interventions be considered part of the numerator of a plan's MLR?; 3) What options are available to states to respond to concerns about "premium slide" - the reduction in future managed care rates due to plans successfully utilizing non-clinical interventions to lower medical spending?

Options for dealing with these issues include: 1) Classifying a service as a Medicaid benefit that would be built into the rate setting process (e.g., case managers helping people fill out SNAP paperwork). Requirements around "statewideness" and "comparability" apply. 2) Waiver authority of CMS to waive Medicaid rules to allow states to operate differently from statute. North Carolina is pursuing an 1115 Waiver now. 3) Value-based payment arrangements that reward providers for delivering higher-value care. 4) Pay incentives to plans or hold back some of payment contingent on meeting certain requirements. 5) Mix and match option. 6) Reward plans with effective investments in social interventions with higher rates. 7) Require plans to address social needs as part of care management responsibilities.

Questions/Discussion:

Question: Could you say want each MCO to invest 6% in community, and then they can put that into housing?
Answer: Arizona said that doesn't create a lot of dollars, but it's something. Arizona strategy raises complex incentive issues. Incentive to understate profits? Appealing option but somewhat limited and complex. Pennsylvania is following Arizona's lead.

Guyer presentation here.

Using ABC Alcohol and Substance Use Education Funds to Make a Sustainable Impact in Your Community
Miles Atkins, Mayor, Town of Mooresville

Mayor Atkins described Mooresville as a town of 40,000 residents in Iredell County, which has a total of 170,000 residents. There were 559 drug-related overdoses there in 2016. They connected with the health department to collaborate and brought in schools, law enforcement, nonprofits, elected officials, and courts. The group created the Drug-Alcohol Coalition of Iredell (DACI), which developed a strategic plan and created subcommittees.

State statute enacted in 2004 requires that 7% of gross receipts (after other distribution requirements) go to treatment of alcohol or substance abuse research or education and funds must be spent within one year. The Iredell ABC Board was not in the position to manage these funds and gave them to the town, which then gave them to the police department to use for DARE or other programs. The State ABC Board has begun auditing funds from the grants. The State Board, Town Board, and DACI have an agreement to supply sustainable funding and have been joined by Statesville and Troutman.

DACI now works as intermediary within county, bringing together community members and agencies. Other agencies are bound to limits - treatment, education, prevention, etc. DACI will become clearinghouse for all agencies and providers in this space who want to apply for funds.

Atkins presentation here.

Health System Investments in Community Partnerships: Mission Health
Ronald Paulus, President and CEO, Mission Health

Dr. Paulus explained that Mission Health has two main levers to impact population health: Mission Community Investment, which gives out grants, and Mission Health Partners, the effector arm of all community health activities. He described a bottom-up strategy to drive where community investment dollars go. The most recent priorities determined by the region are behavioral health, substance abuse and its linkage with interpersonal violence, chronic disease, and social determinants of health.

Noting a major domestic violence problem in Buncombe County, Mission worked with Helpmate to educate more than 7,000 people, with 84% of individuals demonstrating increased knowledge of healthy relationships. To create a bigger impact within their community, Mission helped lead a community-wide domestic violence initiative. The initiative created the Integrated Family Justice Center for Buncombe County, where victims can go to one single location and find all services they might need. A similar center was also developed for child victims.

Dr. Paulus noted that anchor organizations have an important role in facilitating collaboration between existing not-for-profits that are otherwise competing.

Other community partners Mission has been involved in include MANNA Food Bank and YMCA of Western North Carolina, who joined together to pilot a referral process for food insecurity in Buncombe and McDowell counties.

Mission has also found great value in donating in-kind performance improvement specialists to community-based organizations. Dr. Paulus thinks this has been much more valuable than directly donating thousands of dollars.

Questions/Discussion:

Question: Can you talk about what will happen if the sale goes through?
Answer: Robert Wood Johnson Foundation and Duke Endowment folks are advising us. First thing we're going to do is an extraordinarily detailed community health needs assessment. We also need advisory council infrastructure so each local area has ability to raise issues. Need at least one person from each county plus diverse skill sets and so forth. We will address housing, food insecurity, poverty and economic development. Totally separate entity, independent of hospital system.

Paulus presentation here.

Discussion: Recommendations Related to Funding Accountable Care Communities
Facilitators: Brieanne Lyda-McDonald, Pam Silberman, Sheree Vodicka, Adam Zolotor

Four groups discussed potential recommendations from the Task Force related to funding/financing Accountable Care Community development and maintenance.

Next Steps
Brieanne Lyda-McDonald, Project Director, NCIOM

Ms. Lyda-McDonald gave a brief presentation on the upcoming meeting dates and topics we will cover.

Lyda-McDonald presentation here.