

Population Health Funding Vehicles

This document provides examples of funding vehicles available to states as they work to sustainably integrate population health into their health system transformation efforts. The examples are categorized by the three “buckets” of traditional clinical approaches, innovative patient-centered care, and broad community-wide approaches.

BUCKET 1: TRADITIONAL CLINICAL APPROACHES

State programs

- [Tobacco quitline](#)

A quitline is a tobacco cessation service available through a toll-free telephone number. Quitlines are staffed by counselors trained specifically to help smokers quit. Quitlines deliver information, advice, support, and referrals to tobacco users—regardless of their geographic location, race/ethnicity, or economic status—in all U.S. states.

- [Massachusetts QuitWorks](#)

QuitWorks links patients who want to quit smoking to the full range of the state's tobacco treatment services. All it takes to use QuitWorks are a clinician, a patient who uses tobacco, and the QuitWorks tools. Using a simple referral process, any physician, nurse, or other clinician in a small practice or a large practice, health center, or hospital can easily and quickly refer any patient who uses tobacco, regardless of the patient's health insurance status. The referral forms are faxed or electronically transmitted to the Massachusetts Smokers' Helpline, the state-funded QuitWorks service provider.

- [Utah Tobacco Quitline](#)

- [West Virginia Tobacco Quitline](#)

- [Partnership for a Tobacco Free Maine](#)

- [New York State Smokers' Quitline](#)

- [Million Hearts Program](#)

Heart disease and stroke are the first and fourth leading causes of death in the United States. Heart disease is responsible for 1 of every 4 deaths in the country. Million Hearts® is a national initiative that has set an ambitious goal to prevent 1 million heart attacks and strokes by 2017. The impact will be even greater over time.

Million Hearts® aims to prevent heart disease and stroke by: Improving access to effective care; improving the quality of care for the ABCS (aspirin, blood pressure, cholesterol, smoking cessation); focusing clinical attention on the prevention of heart attack and stroke; activating the public to lead a heart-healthy lifestyle; improving the prescription and adherence to appropriate medications for the ABCS.

Attachment 1. Examples of Financing Vehicles for Population Health

- [National Diabetes Prevention Program](#)

The CDC-led National Diabetes Prevention Program is an evidence-based lifestyle change program for preventing type 2 diabetes. The year-long program helps participants make real lifestyle changes such as eating healthier, including physical activity into their daily lives, and improving problem-solving and coping skills. Participants meet with a trained lifestyle coach and a small group of people who are making lifestyle changes to prevent diabetes. Sessions are weekly for 6 months and then monthly for 6 months. This proven program can help people with prediabetes and/or at risk for type 2 diabetes make achievable and realistic lifestyle changes and cut their risk of developing type 2 diabetes by 58 percent.
- [Maine Diabetes Prevention and Control Program](#)

The Maine Diabetes Prevention and Control Program, funded by the Centers for Disease Control and Prevention, dedicates its resources to promote: Excellence in diabetes care; increase access to care; support efforts to enhance a more efficient and effective healthcare system for the people in Maine.

Medicare

- Section 2713 of the Affordable Care Act requires Medicare funding of preventive services including USPSTF recommendations related to behavior change (e.g., alcohol screening, tobacco screening, behavioral therapy for obesity).

Medicaid

- The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid [SSA Section 1905(r)].
- A Medicaid rule change issued in July 2013 allows for practitioners to provide and be reimbursed for furnishing preventive services *recommended by* a physician or licensed provider (i.e., services are no longer required to be *provided by* a physician or other licensed provider), contingent on inclusion in a CMS-approved Medicaid state plan. States retain the authority to define practitioner qualifications, ensure appropriateness of services, etc. [42 CFR 440.130(c)].
 - [Medicaid Preventive Services: Regulatory Change](#) (informational PowerPoint slides)
- Affordable Care Act Section 4106(b) establishes a one percentage point increase in the federal medical assistance percentage (FMAP) effective January 1, 2013, applied to expenditures for adult vaccines and clinical preventive services to states that cover, without cost-sharing, a full list of specified preventive services and adult vaccines.
 - [State Medicaid Director Letter](#), February 1, 2013
 - [Question and Answer document](#)
- Additional resources and information about Prevention Initiatives, including tobacco cessation, immunizations, and maternal and child health, can be found [here](#).

BUCKET 2: INNOVATIVE PATIENT-CENTERED CARE

State programs

- [Vermont Blueprint for Health Community Health Teams](#)
Community Health Teams (CHTs) are perhaps the most important innovation in the Vermont Blueprint. Recognizing that efficient and effective coordination of services has not been readily available to the general population or well integrated across primary care and human services, the CHT staff act as organizing elements to integrate care on behalf of patients. These local multi-disciplinary teams are designed and hired at the community (Health Service Area) level. Local leadership convenes a planning group to determine the most appropriate use of these positions, which can vary depending upon the demographics.
 - [VT Blueprint for Health 2014 Annual Report](#) (see Section 5c, page 57)
- [Camden Coalition of Healthcare Providers](#) (New Jersey)
“As a coalition of Camden health care providers, community partners, and advocates, we are committed to elevating the health of patients facing the most complex medical and social challenges.

We are a non-profit organization working in the community to improve health and reduce costs. We innovate and test health care delivery models to improve patient outcomes and reduce the cost of their care using data driven, human-centered practices. Drawing on the experiences of our clinical team and patients, Coalition staff also work to transform health care cost and delivery at the policy level.”

Medicare

- The Medicare home health benefit covers medical social services, which can include services “necessary to resolve social or emotional problems that are or are expected to be an impediment to the effective treatment of the patient’s medical condition or rate of recovery.” [SSA Section 1861(m)]

Notes: See SSA Section 1862 for a list of items or services explicitly prohibited from payment under Medicare Parts A & B.

Medicaid

- The Program for All-Inclusive Care for the Elderly (PACE) provides comprehensive medical and social services (including meals; caregiver training, support groups, and respite care; social work counseling; transportation to the PACE center for medically necessary activities) to certain frail, community-dwelling elderly individuals who are dually eligible for Medicare and Medicaid. [SSA Section 1934]
- Within the parameters set by [State Medicaid Director \(SMD\) Letter #11-004](#) and [SMD Letter #10-016](#) states may request [90/10 Health Information Technology \(HITECH\) administrative funding](#) for a wide range of HIE activities that support providers' adoption and meaningful use of EHRs.

Attachment 1. Examples of Financing Vehicles for Population Health

Medicaid waivers

- Medicaid 1915(c) waivers can provide a combination of standard medical services and non-medical services. Standard services include but are not limited to: case management (i.e. supports and service coordination), homemaker, home health aide, personal care, adult day health services, habilitation (both day and residential), and respite care. States can also propose "other" types of services that may assist in diverting and/or transitioning individuals from institutional settings into their homes and community.
 - [Louisiana Permanent Supportive Housing \(PSH\) program](#)
The Louisiana Permanent Supportive Housing (PSH) program links affordable rental housing with voluntary, flexible, and individualized services to people with severe and complex disabilities, enabling them to live successfully in the community. The supportive housing services offered to beneficiaries under the PSH are authorized under a Medicaid 1915(c) waiver, known as Louisiana's [Community Choices waiver](#) (0866.R01.00).
- Under Section 1915(c) of the Social Security Act, subject to CMS approval, Home and Community-based Services (Medicaid) Waivers may provide for nutritional services including home-delivered meals. States such as MD, AL and AK specifically include meals and/or home delivered meals provisions in their programs.
 - Maryland Older Adults [0265.R04.00]
Provides adult medical day care, case management, personal care, respite, assisted living, assistive devices and equipment, behavior consultation, dietitian/nutritionist services, environmental accessibility adaptations, environmental assessments, family/consumer training, home delivered meals, PERS, senior center plus, transition services for aged individuals ages 65 - no max age and physically disabled 50-64.
 - Alabama Home and Community-Based Waiver for the Elderly and Disabled [0068.R06.00]
Provides adult day health, case management, homemaker, personal care, skilled respite, companion service, home delivered meals-breakfast meals (7/wk), home delivered meals-frozen meals (14/wk), home delivered meals-frozen meals (7/wk), home delivered meals-shelf stable meals (2 annually), unskilled respite for aged individuals (65+).
 - Alaskans Living Independently [0261.R04.00]
Provides adult day, care coordination, respite, chore, environmental mods, meals, residential supported living, specialized medical equipment and supplies, specialized private duty nursing, transportation for aged individuals 65 - no max age, physically disabled ages 21-64
- Medicaid 1115 Research & Demonstration Projects allow for experimental, pilot, or demonstration projects that give states additional flexibility to improve their programs, including the provision of services not typically covered by Medicaid.
 - [Vermont Global Commitment to Health](#)
Provides "Therapeutic Child Care" for infants of mothers with substance abuse, providing an enriched environment not otherwise available to promote healthy child development.
[\[Additional resources\]](#)

Attachment 1. Examples of Financing Vehicles for Population Health

- [Massachusetts Pediatric Asthma Pilot Program](#) [see Attachment F, page 133]
Provides an environmental assessment of the home by a specially-trained community health worker (CHW). Based on the results of the home assessment, a determination of an appropriate mitigation plan would be developed. Supplies that could contribute to asthma control include HEPA vacuums, air conditioning units, allergenic covers would be available to qualifying households based on specific triggers, patient sensitization, and need. CHWs will also be trained to support families' advocacy with landlords and property managers to promote healthy environmental conditions in the home; CHWs can educate families as to landlords' legal responsibilities for maintaining their property and help families to articulate requests for corrective action.
- [Medicaid Health Homes](#)
The Medicaid Health Home State Plan Option, authorized under the Affordable Care Act (Section 2703), allows states to design health homes to provide comprehensive care coordination for Medicaid beneficiaries with chronic conditions. States will receive enhanced federal funding during the first eight quarters of implementation to support the roll out of this new integrated model of care.
 - Missouri
Missouri's health home initiative is a collaborative venture involving the State's Medicaid Authority (MO HealthNet), the Department of Mental Health, the Missouri Coalition for Community Behavioral Healthcare (formerly known as Missouri Coalition of Community Mental Health Centers), and the Missouri Primary Care Association. The two SPAs are identical in many respects, differing only where necessary and appropriate to reflect differences in the populations served.
 - [Community Mental Health Center](#)
Community Mental Health Centers providing community psychiatric rehabilitation services under the Medicaid Rehabilitation Option with sufficient capacity to sustain a viable health home are recognized by the Missouri Department of Mental Health to serve as CMHC Healthcare Homes.

CMHC Healthcare Homes assist individuals in accessing needed health, behavioral health, and social services and supports; managing their mental illness and other chronic conditions; improving their general health; and developing and maintaining healthy lifestyles.

[State Plan Amendment](#)
 - [Missouri Primary Care Health Home](#)
MO HealthNet's Primary Care Health Home (PCHH) initiative strives to provide intensive care coordination and care management as well as address social determinants of health for a medically complex population.

[State Plan Amendment](#)

For a list of all approved health home State Plan Amendments, see [here](#).

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Notes: It is important to identify the purpose of a given service and the associated program and authority under which services are intended to be provided. For example, preventive and rehabilitative services under Medicaid are generally required to be medical/remedial in nature. In some instances, evidence may exist that a service traditionally considered a “social service” provides a health benefit and might be considered medical/remedial. In other instances, provision of such a service might not be appropriate as a preventive service but could be appropriate in the context of preventing nursing home placement.

Health plans

- Medicaid Health Plans have developed a variety of mechanisms (primarily through grants and partnerships) to provide social services including housing support, education, and improved food access
 - The [HealthyLiving Diabetes Health Plan](#) provides special medical and pharmacy benefits for those with Diabetes, Pre-Diabetes, and High Blood Pressure and High Cholesterol

BUCKET 3: COMMUNITY-WIDE HEALTH

SIM State Examples

- [Oregon Coordinated Care Organizations](#)

Coordinated Care Organizations (CCOs) are a new way for the Oregon Health Plan. They will be the umbrella organizations that govern and administer care for OHP members in their local communities.

CCOs are local health entities that will deliver health care and coverage for people eligible for the Oregon Health Plan (Medicaid), including those also covered by Medicare. CCOs must be accountable for health outcomes of the population they serve. They will have one budget that grows at a fixed rate for mental, physical and ultimately dental care. CCOs will bring forward new models of care that are patient-centered and team-focused. They will have flexibility within the budget to deliver defined outcomes (i.e., buying asthmatic patients a vacuum cleaner to keep their homes free of dust or buying patients with congestive heart failure an air conditioner to keep them safe in hot weather). They will be governed by a partnership among health care providers, community members, and stakeholders in the health systems that have financial responsibility and risk.

[1115 Oregon Health Plan waiver](#)

[2014 Mid-year CCO Progress Report](#)

- Michigan Community Health Innovation Regions

Community Health Innovation Regions are collective impact collaboratives, composed of a broad partnership of community organizations, government agencies, business entities, health care providers from Accountable Systems of Care, payers, and individuals (including those from vulnerable populations) that come together with the common aim of raising the community's capacity for improving population health and reducing disparities. Within the Community Health Innovation Region health systems, local health departments and community stakeholders will collaboratively conduct community health needs assessments and identify and implement strategies that address community priorities. Additionally, the Community Health Innovation Region collaborative will work to establish greater integration across the health system and organized entry points for access to care with links to coordinated community services.

The Community Health Innovation Region will build on existing community partnerships in Michigan that are working for a collective impact on health outcomes. To sustain these partnerships, a Community Health Innovation Region will have a formal backbone organization. The role of this backbone organization will be to convene stakeholders into formal decision-making and operational structures that coordinate activities across partners to improve health outcomes, and create greater integration across the health system, thereby reducing sources of health risk, and strengthening assets that protect and promote health in the community. Core infrastructure and staff will be needed for logistical support, management, and quality improvement processes. Community Health Innovation Regions must demonstrate that they have a broad base of financial support from their local partners (such as health plans, businesses, Community Benefit funding, and philanthropy).

[Community Health Innovation Region: Capacity Description and Assessment](#)

[Michigan Blueprint for Health Innovation](#) (see page 93)

Attachment 1. Examples of Financing Vehicles for Population Health

- [Minnesota Accountable Health Model](#)

The Minnesota Accountable Health Model will ensure that every citizen of the state of Minnesota has the option to receive team-based, coordinated, patient-centered care that increases and facilitates access to medical care, behavioral health care, long term care, and other services.

To better integrate care and services for the whole person across the continuum of care (including health care, mental health care, long-term care and other services), the Minnesota Accountable Health Model will test a comprehensive, statewide program to close the current gaps in health information, create a quality improvement infrastructure, and provide the workforce capacity essential for team-based coordinated care. In addition to strengthening clinical health care, the Minnesota model for health system transformation will emphasize community health, preventive services, behavioral health, and other support services.

Goals

- Minnesota Accountable Health Model will include the establishment of up to 15 Accountable Communities for Health. These communities will develop and test strategies for creating healthy futures for patients and community members.
 - By expanding ACOs using a multi-payer approach, Minnesota will test how to provide and pay for value-based care.
 - Multi-payer alignment will occur through initiatives such as common measurement tools across payers, improved clinical data exchange at the provider level and aligned payment and risk adjustment methods for complex populations.
 - The project will also provide support to providers for health information technology and data analytics, as well as for transformation of their practices to more effectively deliver high-quality, coordinated care.
- Delaware Healthy Neighborhoods
Delaware's strategy, which focuses on the highest impact interventions for the biggest health risks (smoking, diet, exercise), supports better management of chronic conditions, reduces disease progression, and prevents new disease. By attributing all patients to a PCP (defined as primary care physicians – pediatrics, family medicine, general internal medicine – or advanced practice nurses working under Delaware's Collaborative Agreement requirement) and incentivizing PCPs to address specific measures (obesity screening, smoking, diabetes control) as well as total cost, Delaware's payers are shifting incentives to support population health.

Delaware seeks to leverage local schools, employers, and community organizations to help influence individual behavior. Success is contingent upon getting close to the individual, and therefore Delaware's focus is on creating "Healthy Neighborhoods" – local communities that come together to form a multi-stakeholder coalition to address Delaware's pressing health needs.

To bring Healthy Neighborhoods to life, Delaware will: 1) define the structure of a Healthy Neighborhood; 2) define a process to become a Healthy Neighborhood; and 3) provide targeted resources to facilitate development and learning.

[Healthy Neighborhoods Committee Charter](#)

[Choose Health Delaware: State Health Care Innovation Plan](#) (see bottom of page 77)

MISCELLANEOUS

Workforce

- Medicare provides hospital payments to approved graduate medical education (GME) programs [Section 1886(h) of the Social Security Act as added by Section 9202 of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985]. Although the payment formula is weighted by the hospital's Medicare share of total inpatient days, such payments effectively contribute to the broader patient care infrastructure.

Coordination of Care

Medicare

- Quality Improvement Organizations [SSA Section 1152-1154] coordinate across a diverse array of providers and stakeholders to improve care delivered to people with Medicare. The most recent QIO scope of work explicitly requires QIOs to include “diverse groups and/or individuals in order to gain commitments that promote a collective will for change motivated by shared values and goals. Groups and individuals shall include, but are not limited to: community service and social service providers, state and local government representatives, utility and public service providers, nutrition services, transportation services, volunteer support and business groups, professional associations, regional health initiatives/community campaigns, institutions of higher learning, including academic medical centers, health professional schools and community colleges, advocacy, service and faith-based organizations, and major healthcare purchasers or payers.”¹

Medicaid

- The Medicaid Manual notes that “The benefits an individual derives from Medicaid-covered preventive services can be significantly enhanced when these services are coordinated with the preventive care available under other programs” and encourages states to seek cooperation from other agencies, noting that “coordination can be achieved through interagency agreements, informal cooperative arrangements and increased referrals between the Medicaid agency and other programs that offer preventive care.” The Manual further notes that Medicaid regulations (42 CFR Part 431, Subpart M) contain requirements and options for interagency agreements, including required interagency agreements with the State health agency, State vocational rehabilitation agency, and title V program and optional interagency agreements with “other health and social service agencies and organizations, involving services that utilize Federal as well as State or local funds. For children, youth and pregnant women, these programs could include Head Start, title XX (Social Services Block Grant), certain education programs, and the Special Supplemental Food Program for Women, Infants, and Children (WIC). Effective coordination between the medically-oriented preventive services offered under a State's Medicaid program and the nutrition services offered by the WIC Program, for example, can play an important role in a State's overall strategy to lower its infant mortality rate.”
 - [Collaborative Improvement & Innovation Network \(CoIIN\) to Reduce Infant Mortality](#)
The Collaborative Improvement & Innovation Network (CoIIN) to Reduce Infant Mortality is a public-private partnership to reduce infant mortality and improve birth outcomes. Participants learn from one another and national experts, share best practices and lessons learned, and track progress toward shared benchmarks.

¹ <https://www.fbo.gov/index?s=opportunity&mode=form&id=dff522bababb6b9859bb783c08db6074>