At the core of the work of an Accountable Care Community (ACC) is the shift from a system that buys medical care to one that buys health. To do this, new financial incentives are needed to re-align the health care system away from volume to value.[24] While this is beginning to happen, as discussed in Chapter 1, changing an industry that accounts for 18 percent of the United States Gross Domestic Product and more than $3.3 trillion in spending is challenging.[20] While many within the health care industry agree that addressing non-clinical drivers of health is critical to achieving improved population health and lowering costs, doing so requires a significant shift in the identity of the health care industry and its funding. For this reason, the most daunting and critical challenge in implementing ACC models is developing sustainable financing strategies for community-based services that support improved health outcomes.

ACCs attempt to bridge the critical gap between clinical care and community services in the current health care delivery system. ACCs aim to develop systems whereby health care payers "purchase" social services as a means to improve wellness and reduce overall costs. Most examples of successful implementation of ACCs that have incorporated payment have been driven by either government-funded health programs (Medicaid and Medicare), insurance companies, or large health care systems. Therefore, there are no clear financing models for community-based, multi-payer, multi-health care system ACC efforts to follow.

AT THE CORE OF THE WORK OF AN ACCOUNTABLE CARE COMMUNITY (ACC) IS THE SHIFT FROM A SYSTEM THAT BUYS MEDICAL CARE TO ONE THAT BUYS HEALTH.

ACC models have been shown to produce both cost savings and cost avoidance.[79, 80, m] Cost saving measures are those that reduce current spending (two- to five-year time horizon), which can be seen in financial statements when comparing year-over-year spending. Much of the short-term work of ACCs aims to achieve and document cost savings. Many ACC efforts aim to reduce avoidable acute care because doing so produces cost savings. For example, ensuring individuals with asthma have clean, mold- and bug-free housing can produce cost savings by reducing emergency room visits immediately. When year-to-year costs for individuals with asthma are reviewed, evidence of cost savings can be seen. In the long term, ACCs ultimately aim to achieve cost avoidance. Cost avoidance measures are those that, when implemented, prevent future health conditions from occurring. Savings from cost avoidance measures cannot be seen in short-term budget statements. Many efforts to address drivers of health, such as education, employment, and neighborhood safety, are prevention efforts which aim to achieve cost avoidance. While ACCs focus on health care savings, the work of human services organizations has been shown to produce savings in areas such as corrections, public safety, and public benefits.[74] For this reason, developing sustainable financing for non-clinical drivers of health care services will require an examination of where savings accrue. Successful ACCs will include stakeholders in sectors outside of health care who may benefit from long-term cost avoidance because of ACC efforts. Since these stakeholders stand to benefit in the long term from ACC efforts, they should be engaged as potential sources of funding.

THE MOST DAUNTING AND CRITICAL CHALLENGE IN IMPLEMENTING ACC MODELS IS DEVELOPING SUSTAINABLE FINANCING STRATEGIES FOR COMMUNITY-BASED SERVICES THAT SUPPORT IMPROVED HEALTH OUTCOMES.

As discussed in Chapter 1, many of the services to address people's social, behavioral, economic, and environmental health needs are not currently well-funded in communities. Yet, increasingly these services are crucial to reigning in health care costs. The formation of ACCs provides a bridge for communication and partnership among health care organizations (i.e., payers and health care providers), public health, local and tribal government, and human services organizations. Together, community members can assess how to best work together to better align and coordinate social services and health care. ACCs must then develop systems to facilitate communication and coordination between human services organizations and health care organizations and capture data about service provision, costs, and savings. Sustainable payment systems must be developed to financially support organizations that effectively improve health outcomes and/or lower costs at levels that meet the needs of the community.

Funding Needs Vary Based on Stage of Development

The short-term and long-term funding challenges for ACCs are different. In the short-term, ACCs may need funding to form and for partners to begin working together (described in more detail below). Because ACC models are most likely to succeed within value-based purchasing health care models, which are just beginning to be implemented, human services organization activities will need a source of funding in the short-term to increase capacity, evaluation, and partnership. In the long-term, data on services delivered, costs, improvements in health, and cost savings/avoidance should provide means to develop financial models to support the provision of services to address health-related social needs within the realm of health.

THE FORMATION OF ACCS PROVIDES A BRIDGE FOR COMMUNICATION AND PARTNERSHIP AMONG HEALTH CARE ORGANIZATIONS, PUBLIC HEALTH, LOCAL AND TRIBAL GOVERNMENT, AND HUMAN SERVICES ORGANIZATIONS.

[m] *Throughout this chapter, the term savings will refer to both cost savings and cost avoidance.*

IN THE SHORT-TERM, ACCS MAY NEED FUNDING TO FORM AND FOR PARTNERS TO BEGIN WORKING TOGETHER

ACC Start-Up Funding

Funding for planning and development is needed when ACCs form and begin to explore how partners can better coordinate their work to improve health outcomes. ACC partnership development can be a time-consuming process involving health care organizations, human services organizations, partners, community members, and other stakeholders. The process of developing a shared vocabulary, agenda, alignment of activities, and plan for action may require the assistance of outside groups to facilitate discussion. Legal counsel is necessary for groups that would like to have shared governance and/or benefits. Additionally, partners may require assistance with technologies to develop communication and data capacities for ACC work. These activities can be costly and may require outside financial support. The most likely sources of funding for these activities are state and local philanthropies, local and tribal government, and partners within the ACC who have the resources to support the work. Given the impact ACCs can have on the health and well-being of their communities, local businesses could be valuable partners in funding and supporting ACCs.

Ultimately, communities should aim to blend multiple sources of funding, such as hospital community benefit dollars (explained in Chapter 2), local and tribal government budget allocations, social-impact bonds, and/or wellness funds (more information and resources on these funding mechanisms can be found in Partnering to Improve Health: A Guide to Starting an Accountable Care Community (www.nciom.org/nc-health-data/guide-to-accountable-care-communities)). These approaches ensure that more entities in the community have a stake in an ACC's success. While sustainable funding is a long-term goal of an ACC, there are steps partners can take in the development stages, such as developing a case statement including the potential benefits, to appeal to investors for the future. To help ACCs with funding for the initial stages of partnership development, the Task Force recommends:

IN THE LONG-TERM, DATA ON SERVICES DELIVERED, COSTS, IMPROVEMENTS IN HEALTH, AND COST SAVINGS/AVOIDANCE SHOULD PROVIDE MEANS TO DEVELOP FINANCIAL MODELS TO SUPPORT THE PROVISION OF SERVICES TO ADDRESS HEALTH-RELATED SOCIAL NEEDS WITHIN THE REALM OF HEALTH

Recommendation 6.1:
Support Initial Development of Local Accountable Care Communities

a) Philanthropies should:

i) Provide support for capacity development in communities to help local leaders interested in creating an Accountable Care Community.

ii) Provide grant funding to support the development of local Accountable Care Communities. When possible, philanthropies should coordinate portfolios of work with other philanthropies and streamline reporting requirements.

iii) Require local Accountable Care Communities to develop a lead entity, plans for funding and sustainability, outcomes measures, and an evaluation plan.

b) Prepaid Health Plans, Medicaid, and other payers should develop strategies to financially support local Accountable Care Community efforts and provide subject-area expertise as partners in community coalitions.

c) Health care systems should direct community benefit dollars toward a greater mix of investments that impact the drivers of health. These investments may include community partnerships, such as development of an Accountable Care Community model; infrastructure building, such as the NCCARE3060 resource platform; or direct investment in addressing health-related social needs of the community related to housing, food, transportation, interpersonal safety, or other needs. Community benefit investments should be aligned with the Community Health Assessment, Community Health Needs Assessment, and Community Health Action Plan.

d) Local businesses should direct funds to support Accountable Care Community efforts and/or donate subject-area expertise as partners in community coalitions.

See also Recommendations 2.4 Support Local Health Departments to be Leaders in Accountable Care Communities and 2.7 Provide Technical Assistance to Accountable Care Communities.

Funding for Implementation Activities of ACCs

Once an ACC has formed and developed a plan for how partners will work together and what work they will do, the ACC must identify funding for implementation. There are two main areas that need funding in this stage: systems and services. ACC work typically involves developing and implementing new systems to screen, refer, provide navigation assistance, track receipt of services and outcomes data, and pay for services. Organizations must also hire and/or train staff and redesign their workflows to incorporate new activities and technologies. Developing and implementing new systems requires financial support and technical assistance (as discussed in Recommendation 2.7 - Provide Technical Assistance to Accountable Care Communities). ACCs must also identify funding for the provision of services.

North Carolina is in a unique position with the development of NCCARE360 (described in Chapter 3), which will provide the technical backbone for the efforts of ACCs in North Carolina to link people to needed services.[n] NCCARE360 solves many of the challenges ACCs face as they consider systems that facilitate communication and coordination between health care organizations and human services organizations. The Platform will provide a solution to bridge the technology gap and coordination challenges among different types of providers. NCCARE360 also will facilitate the screening and referral process and data tracking necessary for high-functioning ACCs. The platform is funded through the NCCARE360 public-private partnership and will be subsidized for organizations for at least the first five years. By providing a subsidized system, the organizations involved, including the North Carolina Department of Health and Human Services (NC DHHS), hope NCCARE360 will become a shared utility that is used by health care organizations, human services organizations, payers, and individuals across the state. NCCARE360 partners also are expected to on-board human services and health care organizations, including training for how to use the platform and workflow integration.

To utilize NCCARE360, organizations may need additional computers, IT support, and staff time to interface with the platform. Within Medicaid transformation, Prepaid Health Plans will receive per member per month payments that will support the implementation of screening, referral, navigation assistance (in the form of care management for some populations), and follow-up. Prepaid Health Plans will be required to use NCCARE360 and track various data needed to assess which interventions create positive outcomes and/or reduce costs. Other payers and health care providers are being encouraged to use the Platform as well. Providers may or may not be reimbursed for screening, referral, and navigation services according to the policies of individual payers. There is currently no payment system for services rendered by human services organizations through NCCARE360.[o]

Under an ACC model, one objective is to increase the use of human services organizations to meet health-related social needs (e.g., food, housing, transportation). As discussed in Chapter 4, increases in referrals to human services organizations may place burdens on these organizations that they may not be able to meet without additional resources. Human services organizations are typically funded by a combination of sources, which may include individual donations, corporate contributions, foundation grants, government grants and contracts, tax revenue, investment interests, and fees for services. While larger human services organizations (e.g., county Department of Social Services, Housing Authority) may have relatively dependable budgets, smaller human services organizations (e.g., local food banks, domestic violence shelters) often operate with little or no financial reserves, lack access to capital, and often run operating deficits.[74] Many human services organizations do not have the resources needed to significantly increase their operations without additional funding.

During the implementation phase of ACC development, philanthropic organizations and state programs may be available to support these short-term development efforts. Public revenues may also be a possibility through taxes, assessments, public fees, or tax credits. Other sources of funding for human services organizations within an ACC are health care systems and payers (i.e., insurers). Obtaining funding for services provided by human services organizations in a fee-for-service health care landscape may require upfront conversations about incentives for each party. Provider participation can be encouraged by including strategies to address short-term goals that show specific cost-savings and standards that both providers and payers are already held accountable for, like reductions in emergency department visits among high-risk populations.[81] Many providers and payers are investing in efforts to address the underlying drivers of health as a means to reduce costs; however, there are constraints, particularly related to payment models that complicate these investments. North Carolina's upcoming Healthy Opportunities pilot programs (described in Chapter 3) as part of Medicaid transformation, as well as continuing efforts to move to value-based payment among private insurers, may help increase support for ACCs.

As ACCs begin working to address unmet health-related social needs, new models of payment will need to be developed and tested. Therefore, the Task Force recommends:

Recommendation 6.2:

Funding for Local Accountable Care Community Implementation

a) Prepaid Health Plans, Medicaid, other payers, and health care providers should develop and test payment models for coverage of social services to improve wellness and reduce overall costs in alignment with the Community Health Assessment, Community Health Needs Assessment, and Community Health Action Plan in the communities they serve and/or provide payment for services rendered by Accountable Care Communities and their partners.

b) Philanthropies should provide bridge financing to Accountable Care Communities transitioning from startup funding to payment structures that can support human services organizations providing services for those with health-related social needs.

c) Local governments should consider using local tax revenues to support Accountable Care Community activities.

See also Recommendations 2.3 Provide Guidance on Cross-Agency Collaboration to Address Drivers of Health, 2.7 Provide Technical Assistance to Accountable Care Communities, and 6.5 Develop Sustainable Accountable Care Community Funding.

[n] *The NCCARE360 resource platform is one part of the NC DHHS infrastructure for creating "Healthy Opportunities" for all North Carolinians. See Chapter 3 for more information.*

[o] *Except for within the Medicaid Healthy Opportunities pilot programs (see Chapter 3).*

State Efforts to Develop Sustainable Payment Models for Unmet Health-Related Social Needs

Transforming Medicaid[p] is part of the state's "Healthy Opportunities"[q] work. One goal of Healthy Opportunities is to develop innovative approaches to foster "strategic interventions and investments in...food, housing, transportation, and interpersonal safety...[that] will provide short and long-term cost savings and make our health care system more efficient."[58] Strategies to do this have been incorporated into the state's 1115 Medicaid Waiver.

Under Medicaid transformation, NC DHHS will remain responsible for the Medicaid and NC Health Choice programs but will contract with Prepaid Health Plans to provide managed care services to most individuals enrolled in Medicaid. Prepaid Health Plans will be required to screen all enrollees using the state's standardized screening questions when they enroll (and at least annually for those determined to be high-risk) and use NCCARE360 to connect those with needs to resources that meet their needs and track outcomes.[59] The Prepaid Health Plan contracts also will incentivize Prepaid Health Plan contributions to health-related resources in each region in which they operate. For example, Prepaid Health Plans that contribute 0.1 percent of capitation payments to health-related resources will be given preference in beneficiary plan assignment.

The public-private regional pilots[r], called Healthy Opportunities pilots, that are part of North Carolina's 1115 Medicaid Waiver are designed to allow more substantial investments in non-clinical health related services with the explicit goal of learning how to finance 'health' interventions and incorporate them into value-based payments. Within the pilots, Medicaid Prepaid Health Plans will be able to pay for select services to meet beneficiary needs in the four categories (i.e., housing, transportation, food insecurity, and interpersonal safety) using Medicaid dollars. Over the course of the five-year pilots, payments for pilot services will increasingly be linked to operational ability, enrollees' health outcomes, and health care costs through various value-based payment arrangements, including incentives, withholds, and shared savings.

The pilot model will not work without better integration across health and social service organizations. To facilitate better integration, each pilot area will have a Lead Pilot Entity that will develop, manage, and oversee a network of human services organizations and social service agencies providing services; assist care managers with connecting beneficiaries to services; collect data for evaluation; and facilitate payments to organizations providing services. For the pilots, the Lead Pilot Entities will function similarly to a backbone organization for an ACC. The main difference is that an ACC incorporates a broader network of payers, local government, and organizations that address health-related social needs outside of food, housing, transportation, and interpersonal safety.

THE HEALTHY OPPORTUNITY PILOTS WILL ALLOW MORE SUBSTANTIAL INVESTMENTS IN NON-CLINICAL HEALTH RELATED SERVICES WITH THE EXPLICIT GOAL OF LEARNING HOW TO FINANCE 'HEALTH' INTERVENTIONS AND INCORPORATE THEM INTO VALUE-BASED PAYMENTS.

The Healthy Opportunities pilots are designed to test how to finance and scale non-clinical interventions across multiple domains to the full population enrolled in Medicaid with the goal of applying what is learned in the pilots statewide. To facilitate this learning, the pilot program incorporates both rapid-cycle evaluation and summative evaluation. This type of data collection and evaluation is critical to developing sustainable funding models for investments in non-clinical health services. While NC DHHS is focused on populations enrolled in Medicaid, the lessons learned will be applicable to all payers. Therefore, the Task Force recommends:

Recommendation 6.3:
Support Implementation of Medicaid Healthy Opportunities Pilots

a) As part of the Healthy Opportunities pilots, the North Carolina Department of Health and Human Services should implement its plans as stated in the Prepaid Health Plan Request for Proposal and public documents to:

i) Require the Lead Pilot Entities to facilitate an Accountable Care Community by convening key local stakeholders (e.g., payers, health care providers, local government agencies, and human services organizations).

ii) Require Prepaid Health Plans to participate in the Lead Pilot Entity-led Accountable Care Communities.

iii) Develop requirements for how Prepaid Health Plans should partner with the pilots to address health-related social needs, as well as mechanisms for accountability.

iv) Develop funding streams for human services organizations participating in the pilots, in partnership with Prepaid Health Plans and other payers, including all potential federal funding streams.

v) Complete rigorous rapid-cycle and summative evaluations to identify successful components of the pilots, cost savings, and lessons learned.

vi) Develop a plan for how to sustain or improve upon pilot activities and implement successful components for Medicaid services across the state based on lessons learned from the five years in pilot communities.

b) Philanthropies should align efforts to support the Medicaid Healthy Opportunities pilots by:

[p] *See Chapter 3 for more information*
[q] *See Chapter 3 for more information*
[r] *See Chapter 3 for more information*

i) Coordinating with the North Carolina Department of Health and Human Services to provide funding for services to address drivers of health that cannot be paid for using Medicaid funds.

ii) Streamlining reporting requirements if multiple philanthropies provide pilot funding.

iii) Supporting capacity building for Lead Pilot Entities participating in the pilots (e.g., leadership development).

iv) Providing bridge financing, if needed, to support communities that transition from the Healthy Opportunities pilot model concept to one with financial return on investment.

c) The North Carolina General Assembly should approve the North Carolina Department of Health and Human Services' full spending authority under the 1115 Waiver for Medicaid transformation. The Healthy Opportunities Pilots, with the approved rapid cycle assessments and summative evaluation, will be important to ensure accountability for investments, learn which interventions are most and least effective, and inform other Accountable Care Communities efforts.

Sustained Funding for ACCs

To develop sustainable funding models, ACCs will need to capitalize on the savings created by the health improvements resulting from services provided by human services organizations. If the ACC model creates improved health outcomes as well as savings (health care dollars saved or avoided) greater than or equal to costs (dollars spent to provide services), then payers, employers, or health care providers in value-based arrangements are benefitting by avoiding costs they otherwise would have borne. To create sustainable funding, financial arrangements need to move money from those profiting from or benefitting from services provided by human services organizations to the human services organizations providing the services.

Return on Investment

Establishing long-term financing strategies for services provided by human services organizations using health care dollars is predicated on determining the return on investment of different services. In general, return on investment examines the gains or losses on an investment based on the outcomes it generated. However, return on investment calculations can vary widely depending on the time frame used to measure benefits, as well as the range of benefits and beneficiaries included. Human services organizations often calculate their return on investment by measuring the cost of the service versus the cost savings/avoidance and/or taxpayer gains realized by the service provided.[82] In an ACC, the return on investment focuses more specifically on the cost savings from avoided medical events/diagnoses within a certain time period.[83] If the benefits outweigh the costs, and can be demonstrated, there exists a financial justification to pay for services.[5]

TO DEVELOP SUSTAINABLE FUNDING MODELS, ACCS WILL NEED TO CAPITALIZE ON THE SAVINGS CREATED BY THE HEALTH IMPROVEMENTS RESULTING FROM SERVICES PROVIDED BY HUMAN SERVICES ORGANIZATIONS.

Accountable Care Organizations and health insurers are limited in what services they cover by what the purchasers of individual health insurance plans (e.g., individuals, employers, or state/federal government) are willing to cover. Expanding benefits that are provided to plan enrollees increases certain 'health care' costs. In many instances there are savings in downstream costs, but not always to the same insurer or even within the health care domain. Although some health-related social services will produce positive return on investment for health in a timely manner, many more will have benefits that occur in the future or outside health budgets. This is why ACC efforts often begin by focusing on patients who use a higher-than-average number of medical services. Meeting the health-related social needs of these individuals often can reduce their medical costs much faster than those of the general population. Because many benefits from health-related social services occur outside the budget horizon of health care payers and accrue to those outside of health care, ACCs need to incorporate a wide range of partners. Local and tribal governments, education, public safety, and others who may reap the benefits all need to be at the table. Funding for many services, particularly preventive services, may only make sense when all of those benefitting pool funds. For long-term sustainability of ACC efforts, return on investment should be used to negotiate with local and tribal government, education businesses, health care systems, and insurance providers to pay for services.

Developing mechanisms to fund interventions that address the drivers of health and health equity will require evidence that such efforts are cost effective. Calculating return on investment requires data. Data on the health and social needs of those receiving services, services provided, cost of services, cost savings/avoidance for health and other budgets are held by payers, providers, NCCARE360 partners, and in other data sets controlled by the North Carolina Department of Information Technology. Data collection and analysis is critical to developing sustainable funding models for investments in non-clinical health services. In North Carolina, no entity outside of state government has the ability to collect and aggregate this data. Therefore, the Task Force recommends:

TO CREATE SUSTAINABLE FUNDING, FINANCIAL ARRANGEMENTS NEED TO MOVE MONEY FROM THOSE PROFITING FROM OR BENEFITTING FROM SERVICES PROVIDED BY HUMAN SERVICES ORGANIZATIONS TO THE HUMAN SERVICES ORGANIZATIONS PROVIDING THE SERVICES.

[5] *The focus of ACCs is on health savings, but ACC models have shown savings in other areas (e.g., education, corrections) and such partnerships should be explored.*

ALTHOUGH SOME HEALTH-RELATED SOCIAL SERVICES WILL PRODUCE POSITIVE RETURN ON INVESTMENT FOR HEALTH IN A TIMELY MANNER, MANY MORE WILL HAVE BENEFITS THAT OCCUR IN THE FUTURE OR OUTSIDE HEALTH BUDGETS.

Recommendation 6.4

Analyze Data to Determine Costs and Benefits of Health-Related Social Services

a) The Department of Information Technology should work with payers and NCCARE360 developers to ensure that data from existing state health and social service data systems can be integrated with data from the standardized screening questions and NCCARE360 to allow for analysis of the costs and benefits of addressing health-related social needs within the Medicaid program.

b) The North Carolina Department of Health and Human Services should:

i) Publicize the results of analysis done using this data and advocate for Prepaid Health Plans to adopt interventions that are proven to have positive financial returns on investment.

ii) Work with other funders of health-related social needs interventions to ensure they can access the data needed to evaluate the work of Accountable Care Communities and efforts to address health-related social needs.

iii) Conduct a rigorous cost/benefit analysis of interventions to address health-related social needs used in the Medicaid Healthy Opportunities pilots.

c) Prepaid Health Plans, Medicaid, and other payers should evaluate the return on investment for individuals covered by the Prepaid Health Plans/payers who receive services from Accountable Care Community interventions and disseminate their findings publicly to encourage greater understanding and adoption of services to meet health-related social needs.

Developing Long-Term Funding Strategies

In our current system, looking to payers to implement such changes makes sense on the surface. As the purveyors of health insurance plans, they seemingly have the power to control what is covered and the incentives to pay for services provided by human services organizations that can create savings in what they spend on health care. However, there are several reasons that health insurance companies alone cannot drive the move to purchasing health and well-being alone. As previously stated, health insurance companies are restricted in their spending to what is covered by the plans that have been purchased. In North Carolina, 31 percent of residents receive health insurance through state and federal government (i.e., Medicaid, Medicare, and Tricare); 47 percent receive health insurance through their employer (including self-funded plans); 12 percent purchase individual plans; and 9 percent are uninsured.[84]

As described in Chapter 1, the federal government is actually driving much of the move to value-based care, but still has strict rules that insurers must follow around what can and cannot be paid for under Medicare and Medicaid. While there may be room for innovation under some employer-purchased plans, approximately 60 percent of those plans are completely or partially self-funded, which means the companies pay for health care services for their workers, even if using a health insurance company as the administrator of the plan. Therefore, the insurance company has limited ability to innovate with these plans.[85] For the remaining insurance plans, incentives related to timing and policyholders' movement between insurers dampen insurance companies' willingness to pay for services provided by human services organizations. Under a one-year budgeting time frame, any direct payments for services or payment arrangements with health care providers must produce cost savings within the year, which is challenging. Additionally, constraints related to pricing and insurer requirements for financial returns (in light of federal requirements for minimum levels of spending on medical costs[t]) undermine the financial business case for insurers. Nonetheless, insurance companies have the opportunity to provide leadership on improving health insurance affordability and on health care transformation, through their willingness to experiment (including with payment models) and invest for potential long-term returns.

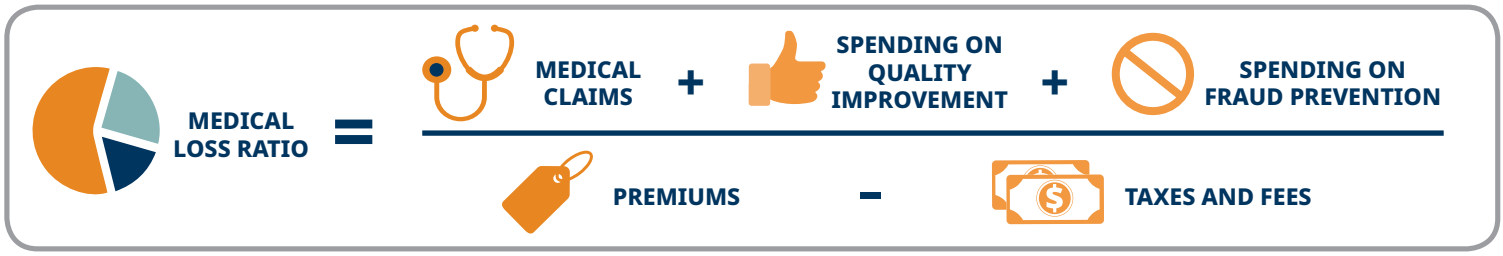
The Prepaid Health Plans that will manage care under Medicaid transformation can play a role in paying for services to meet health-related social needs for individuals enrolled in their plans. These plans will be required to use a percentage of the premiums they receive to pay for medical care and other health-related services. This is known as a medical loss ratio and is calculated as the proportion of premiums (less taxes and fees) that go to medical claims, quality improvement, and fraud prevention (see **Figure 8**).[86 u] NC DHHS will require an 88 percent medical loss ratio, meaning that plans will need to spend at least 88 percent of Medicaid premiums on medical services and quality improvement expenses. The federal government has not explicitly defined what qualifies as quality improvement, although generally these expenditures should be allocated to services that have been shown to reduce medical spending. NC DHHS has provided additional guidance in the Request for Proposals for Prepaid Health Plans. This guidance states that quality improvement expenditures may be included in the numerator of the

FUNDING FOR MANY SERVICES, PARTICULARLY PREVENTIVE SERVICES, MAY ONLY MAKE SENSE WHEN ALL OF THOSE BENEFITTING POOL FUNDS

[t] *The Affordable Care Act requirement for medical loss ratio for individual and small group (80 percent) and large group (85 percent), with rebate, includes medical claims plus narrowly-defined quality assurance activities measured annually and evaluated on 3-year rolling average to determine whether it was met and, if not, amount of rebates required to go back to policy holder.*

[u] *42 C.F.R. § 438.8.*

Figure 8. Calculation of Medical Loss Ratio



NCIOM adaptation of Exhibit 4 from Bachrach, D, Guyer, J, Meier, S, Meerschaert, J, Brandel, S. Enabling Sustainable Investments in Social Interventions: A Review of Medicaid Managed Care Rate-Setting Tools. The Commonwealth Fund. January 31, 2018. https://www.commonwealthfund.org/publications/fund-reports/2018/jan/enabling-sustainable-investment-social-interventions-review.

INSURANCE COMPANIES HAVE THE OPPORTUNITY TO PROVIDE LEADERSHIP ON IMPROVING HEALTH INSURANCE AFFORDABILITY AND ON HEALTH CARE TRANSFORMATION, THROUGH THEIR WILLINGNESS TO EXPERIMENT (INCLUDING WITH PAYMENT MODELS) AND INVEST FOR POTENTIAL LONG-TERM RETURNS.

medical loss ratio calculation if they "reflect meaningful engagement with local communities" and "are spent directly on improving outcomes for beneficiaries, such as housing initiatives or support for community-based organizations that provide meals, transportation or other essential services."[59]

Prepaid Health Plans will have incentives to pay for interventions and services that meet health-related social needs in order improve health outcomes, reduce medical service use, and reduce costs. Conversely, if interventions for health-related social needs are successful in decreasing medical claims, plans may develop concerns about the potential for premium rate reductions. Part of the considerations for setting premium rates is the recent claims experience of the plan, so reduced health care utilization can encourage lower premium rate setting. This can disincentivize Prepaid Health Plans to continue making investments in quality improvement. Therefore, a careful balance must be struck to encourage Prepaid Health Plans to invest in quality improvement, while accounting for the decrease in medical expenses that those investments intend to produce.

Aside from payer investments and compensation for services, communities can look to a variety of other funding options for long-term ACC sustainability, including local tax revenue and health care system investment. Developing sustainable funding strategies for services to meet people's health-related social needs will be heavily influenced in North Carolina by the Medicaid Healthy Opportunities pilots. However, most communities in the state will not be involved in these pilots. Those ACCs not in the pilots will not have the same level of assistance with developing sustainable financial models. There will be communities all over the state wrestling with how to make the integration of health and health-related social services sustainable from a funding perspective. ACCs outside of the pilots will need support and assistance to develop sustainable funding. Therefore, the Task Force recommends:

Recommendation 6.5

Develop Sustainable Accountable Care Community Funding

a) Local Accountable Care Community models, in partnership with local government, should evaluate private, local, state, and federal sources of funding to support Accountable Care Community activities and services to meet health-related social needs (e.g., sales and other local taxes, hospital/health care system reinvestment, Medicare and Medicaid).

b) Philanthropies should support Accountable Care Community models by:

i) Funding technical assistance and identifying organizations that provide technical assistance to help Accountable Care Communities determine the best financing model for their programs and functions. This technical assistance may include:

1. Developing a funding strategy.
2. Creating financial sustainability plans to ensure long-term financial stability of the Accountable Care Community model.

ii) Building the case and advocating for sustainable funding for Accountable Care Communities across the state using both health and financial outcomes.

c) Payers should cover interventions that are proven to have positive financial returns on investment, including providing support to human services organizations serving patients' health-related social needs.

d) The North Carolina Department of Health and Human Services should:

i) Incentivize Prepaid Health Plans to incorporate appropriate payments for services and interventions that have been shown to produce a reliable return on investment. In so doing, considerations should be made for ensuring a rate-setting process that encourages and accounts for these investments.

ii) Incorporate effective interventions from the Healthy Opportunities pilots into the statewide Medicaid plan for the next Medicaid waiver application process.