Financing That Rewards Better Health and Well-Being: Proceedings of a Workshop in Brief (2021)

DETAILS

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Proceedings of a Workshop

IN BRIEF

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Financing That Rewards Better Health and Well-Being

Proceedings of a Workshop—in Brief

On May 25, May 28, and June 2, 2021, the National Academy of Medicine (NAM) Leadership Consortium and the Health and Medicine Division's Board on Health Care Services of the National Academies of Sciences, Engineering, and Medicine hosted a virtual workshop series titled Financing That Rewards Better Health and Well-Being.[1] The workshop featured invited speakers and discussions focused on the need to transform the United States' current model of health care financing, which rewards the volume of services provided, to a model that incentivizes integrated payment approaches that are person-centered and holistic in advancing individual, community, and population health. The objectives included identifying examples of care delivery and payment models that are focused on patient outcomes and advancing health equity, considering barriers and opportunities to scaling effective integrated payment models and approaches, and discussing strategies for transforming health financing to improve equity and individual and population health. This Proceedings of a Workshop—in Brief highlights the presentations and discussions that occurred throughout the workshop series.[2] Suggestions from individual speakers are summarized in Box 1.

BOX 1
SUGGESTIONS FROM INDIVIDUAL WORKSHOP PARTICIPANTS FOR FINANCING AND PAYMENT MODELS THAT REWARD BETTER HEALTH AND WELL-BEING

Reimagining Approaches to Care for the Entire Population

- Integrate services that drive health and well-being. (Abramson, Backus, Birch, Chomilo, Cohen, Conway, Ferris, Fogel, Halfon, Hameed, Ibarra, Kligler, Walker)
- Extend domains of care to encompass communities. (Abramson, Alley, Brower, Erickson, Gupta, Halfon, Hameed, Ibarra, Pegus)
- Invest in health care and social supports for infants and children to address health disparities that occur early in life. (Briscoe, Halfon, Walker)

continued

[1] The workshop agenda and presentations are available at https://nam.edu/financing-that-rewards-health (accessed June 23, 2021).
[2] This Proceedings of a Workshop—in Brief is not intended to provide a comprehensive summary of information shared during the workshop. The information summarized here reflects the knowledge and opinions of individual workshop participants and should not be seen as a consensus of the workshop participants, the planning committee, or the National Academies of Sciences, Engineering, and Medicine.

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BOX 1 CONTINUED

- Engage in effective life-stage care strategies. (Berwick, Birch, Halfon, Ibarra)
- Provide high-quality care to older adults and individuals with disabilities. (Lewis)
- Expand the use of home- and community-based services. (Berwick, Lewis, Halfon)
- Make full use of telehealth, virtual health, and other technologies. (Alley, Cohen, Lee, Lewis)

Redesigning Health Financing to Incentivize Whole-Person/Population Health and Well-Being

- Establish health system accountability based on meaningful quality measures. (Alley, Ferris, Mann, Walker)
- Invest in a workforce that can provide whole-person and population health. (Alley, Backus, Briscoe, Gupta, Ibarra, Lewis, Walker)
- Leverage state, local, and federal funding opportunities to experiment, authorize, assess, and extend care delivery and financing innovations. (Alley, Backus, Birch, Chomilo, Ibarra, Fowler, Kinzer, Lewis, Mann, Nichols)
- Set longer time horizons for return on investments in health. (Brower, Halfon, Muhlestein, Walker)
- Use universal empanelment[a] to provide high-quality primary care. (Berwick, Bitton)
- Use lessons from the COVID-19 pandemic to recognize gaps and the fragility of fee-for-service financing strategies and transition away from their use. (Cohen, Ferris, Hameed, Lewis, Mann, Nichols)
- Connect the public- and private-sector producers of better health with the entities interested in investing in better health to direct resources to address the social determinants of health. (Erickson)
- Shift resources toward vulnerable populations with low incomes to improve population health and lower the costs of health care. (Berwick)
- Leverage market forces to aid the health system in moving away from fee-for-service financing structures. (Erickson)
- Implement mandatory payment strategies that do not operate on fee-for-service business models. (Fowler, Muhlestein)
- Eliminate frictional costs[b] and "gaming the system." (Brower, Ferris, Fowler)

Cross-Cutting Suggestions

- Ensure that equity is a major driver of transformed health care delivery and financing. (Alley, Berwick, Briscoe, Chomilo, Mann, Pegus, Walker)
- Study how relationships in complex systems give rise to collective behaviors to learn how to redirect those systems. (Fogel)
- Create a shared digital infrastructure to enable better communication, coordination, data sharing, and strategic investments. (Birch, Cohen, Ferris, Fowler, Gupta, Kinzer, Lee, Nichols, Walker)
- Build on collaborative, cross-sector partnerships to advance better health and well-being. (Bitton, Brower, Ferris, Nichols, Shurney, Pegus)
- Ensure that patients are at the center of payment and care. (Gupta, Hameed, Ibarra)

NOTE: This list is the rapporteurs' summary of points made by the individual speakers identified and the statements have not been endorsed or verified by the National Academies of Sciences, Engineering, and Medicine. They are not intended to reflect a consensus among workshop participants.

[a] Empanelment refers to a "continuous, iterative set of processes that identify and assign populations to practices, care teams, or clinicians that have a responsibility to know their assigned population and proactively deliver coordinated primary care" (Bearden et al., 2019; NASEM, 2021, p. 312).

[b] Frictional costs refer to the total costs—both direct and indirect costs—associated with a financial transaction.

BACKGROUND AND CONTEXT

Michael McGinnis from the NAM described the current health care system as falling short in delivering efficiency, effectiveness, equity, and positive patient and family experiences. The dominant problem today, he said, is the fragmentation caused by the nation's fee-for-service payment system (McClellan et al., 2017; Ross and Greenberg, 2020). Moreover, the problem extends beyond the health care system to health in general, because inefficiencies in health care draw resources and attention away from the urgent need to address the broader economic and social determinants of health (SDOH). "We need to change the way we go about paying for health and health care," he said.

The COVID-19 pandemic particularly highlighted the lack of integration across health and health care, the failings of the fee-for-service model, and the consequences of inequities, said Kisha Davis from Aledade. Davis added that, beyond contributing to decreased life expectancy in the United States, the pandemic underscored severe inequities with respect to race, ethnicity, and income, demonstrating the inability of current financing models to reward better health and well-being for all Americans even in the face of a public health crisis (Dalsania et al., 2021; Woolf et al., 2021).

A health care delivery model that supports whole-person and population health would have a set of distinctive characteristics, said Hoangmai Pham from the Institute for Exceptional Care. Pham added that such a model would advance health through health promotion and disease prevention while ensuring high-quality treatment when needed. It would support and reinforce the importance of equitably enhancing health and well-being for the entire population within communities. It would be person-centered rather than clinician-centered, and would provide care that is holistic, integrated, and continuous rather than fragmented and episodic. It would use accountability mechanisms and metrics that matter most to the people, the families, and the populations receiving health care. The goal of the workshop series was to explore health financing mechanisms that could make possible this kind of care so that the population and each individual reaches their full potential for health and well-being.

ENVISIONING AN INTEGRATED HEALTH CARE DELIVERY AND FINANCING SYSTEM

The Future of Health Financing for Improved Health Outcomes

In an opening discussion, Mandy Cohen from the North Carolina Department of Health and Human Services and Timothy Ferris from the National Health Service touched on many of the major themes that arose during the first of three meetings in the series, in which speakers envisioned an integrated health care delivery and financing system. Cohen emphasized that health depends on factors beyond the health care system, including public health systems, social services, education, and economic forces. Thus, she said, the health care system needs to have the right financing systems in place to enable an integrated infrastructure that focuses on health broadly.

Ferris observed that fee-for-service payment is not the enemy of an efficient and effective health care system; nor is capitation[3] salvation. Health care consists of a heterogeneous set of services, and some of those services can be paid on a fee-for-service basis. He said the goal is the horizontal integration of the health system to provide services for individuals to both improve health and achieve whole-person and population health.

Both observed that the COVID-19 pandemic revealed the weaknesses in the current health care financing system as well as the potential for reform. During the pandemic, health care delivery organizations across the country started collaborating in extraordinary ways that had not occurred before, Ferris said, and large organizations redeployed resources in more integrated ways. "That opportunity shone a light on what is possible if we're actually collaborating and cooperating toward health," Ferris said, noting that integration is more difficult when entire systems have to deliver a great diversity of services.

Ferris emphasized that the technical means and much of the infrastructure necessary to deliver accountability based on health outcomes are available but are not being optimally used. A national plan for delivery based on outcomes does not exist. He described as an example that each state and insurer have a different set of measurement requirements. Ferris suggested looking to Michael Porter and his colleagues' framework for outcomes,[4] particularly in terms of a small number of risk-adjusted outcomes, including morbidity, mortality, and patient-reported outcomes. Holding the health care system accountable for these measures could help to integrate financing by orienting it around the same set of health outcomes independently of funding source.

Cohen agreed that clear measures of health are important but said the focus should be on incentive alignment around health, developing a shared infrastructure, and facilitating process redesign in care delivery. For example, North Carolina has been working to develop a platform that could allow the health care system, the human services

[3] Capitation refers to a payment model that provides a fixed amount of money to physicians for the delivery of health care services regardless of whether the patient seeks care and how much it costs (NASEM, 2021).

[4] See https://www.isc.hbs.edu/health-care/value-based-health-care/key-concepts/Pages/measure-outcomes-and-cost.aspx (accessed July 29, 2021).

system, and the public health system to talk with each other, share data, and invest resources in an enlightened and strategic way, she said, though much work still remains to be done on measures and process redesign.

Finally, Ferris observed that the "frictional costs" caused by the lack of integration between insurers and health care providers is probably between $100 billion and $200 billion per year. "If we could pull those [funds] out and spend those on caring for people and improving their health, it would make an enormous difference," he said.

Financing, Payment, and Whole-Person and Population Health

Building on the points made by Cohen and Ferris, Dawn Alley from the Center for Medicare & Medicaid Innovation (CMMI) observed that the innovative payment and service delivery models CMMI has been testing show that accountability paired with actionable data can unlock meaningful quality improvement. In addition, meaningful accountability for cost and quality is important and can allow for hiring community health workers (CHWs), screening for health-related social needs, leveraging telehealth, offering supplemental benefits, and using different ways to engage patients. Alley mentioned the importance of scalability and making community-level investments sustainable. She highlighted examples of geographic and multicare models, such as Vermont's All-Payer Accountable Care Organization (ACO) model and Maryland's Total Cost of Care model, which are demonstrating sustainable financing for place-based and community-based programs. She also cited an accountable health community in Cleveland, which is working with local entities to pool resources that can be directed toward community-level health services. Moreover, Alley stated that payment is only one enabler of system transformation—quality measurement and healthy equity are also needed.

Len Nichols from the Urban Institute made the point that the health care system needs to "pay smarter" in terms of the value of health-related social needs. Health-related social services provide public benefits, Nichols said. He added, they not only benefit the recipients of those services but also reduce health care costs, can encourage employment, and are likely to improve school and law enforcement outcomes, all of which benefit governments and taxpayers. As an example of this approach, he cited a program called CAPGI,[5] the Collaborative Approach to Public Goods Investment, that is now being implemented in various locations to create a shared funding stream adequate to sustain and scale social services needed by the collaborators.

Nichols described the pandemic and the Black Lives Matter movement as further revealing glaring inequities and increasing attention to learning about and paying for upstream services that can improve health and reduce costs. Nichols also suggested that paying smarter means paying for the "connective tissue" or infrastructure. Infrastructure for local health and social service ecosystems can build relationships among health care organizations, local government agencies, and philanthropies to address problems. He noted that such an infrastructure functions like a public good: "For it to be adequately financed, it must be collaboratively financed." Nichols additionally highlighted the potential of braiding and blending funding approaches oriented toward SDOH as a path toward "smarter" payment strategies. A task force could clarify and guide what government program funds could be combined to further common missions, Nichols said, with a second task to identify statutory changes based on current evidence that could enable more beneficial braiding and blending of funding approaches to achieve whole-person health.

As an integrated payment and care delivery system, the Veterans Health Administration (VHA) has opportunities to experiment with financing for whole-person care, said VHA's Benjamin Kligler. For example, its Whole Health initiative incorporates standard clinical care but adds complementary integrative health approaches, including yoga, acupuncture, and tai chi. It also integrates health coaching and nonclinical partners who work with veterans to focus on what is most important to the quality of the individual's life. Kligler suggested that a health infrastructure that goes beyond treating disease to actually promoting health be made available through the community rather than through health care systems. Most importantly, empowering individuals to take charge of their own health is critical, with the health system helping people identify and acquire the skills, assistance, and tools they need to achieve their health-related goals. "We have to get responsibility for [moving] health and well-being out of the health care system and into the hands of the community and the people," he said.

The workshop series spotlighted three innovative programs focused on whole-person and population health. Box 2 provides information on Bread for the City.

Payment Models for Advancing Health Equity and Community Health

Nathan Chomilo from the Minnesota Department of Human Services described the Minnesota Medicaid Integrated Health Partnership (IHP) program's goal of improving the health of Medicaid and MinnesotaCare[6] enrollees by lower-

[5] See https://capgi.urban.org/wp-content/uploads/2020/08/CAPGI-Fact-Sheet-8-13-2020.pdf (accessed July 27, 2021).

[6] MinnesotaCare is Minnesota's basic health program for people with low incomes who do not qualify for Medicaid. Individuals on MinnesotaCare may be required to pay a monthly premium based on their income and household size.

BOX 2
INNOVATION SPOTLIGHT: BREAD FOR THE CITY

Bread for the City—one of three innovative programs spotlighted during the workshop series—is a federally qualified health center in Washington, DC, that demonstrates how care for individuals with complex health needs can be combined with equity-based social services, said Randi Abramson, the organization's chief medical officer. This multiservice organization provides medical care, food, clothing, social services, legal services, and advocacy all under one roof.

Over time, the organization has grown from a volunteer-driven medical clinic to a medical home. Abramson described a holistic medical home as including primary care, dental, vision, needle exchange, health education, and behavioral health services, among others. "We're very holistic," said Abramson. "We want to make sure that we're listening to the community, hitting all the bases, and trying to find the resources that need to be brought into the community," she added. As an example of the benefits made possible by this level of integration, a program to refer people with intellectual disabilities to the clinic helped reduce emergency department visits while providing for greater flexibility and access to care.

During the COVID-19 pandemic, Bread for the City quickly instituted walk-up SARS-CoV-2 testing, not just for clients, but also for staff. The organization was also able to quickly vaccinate nearly 100 percent of the clients and staff, due to long-established relationships. "That's a reflection of trusting relationships, listening to the community, and being there when the community needs you to be there," Abramson said.

ing the cost of care through flexible arrangements between providers and the state. The value-based contracts with providers focus on cost, quality, and health outcomes. Chomilo noted that IHP 2.0, launched in 2018, enhanced the arrangements to focus more clearly on SDOH through population-based payment, social risk adjustment, health equity interventions and metrics, and accountable care partnerships. He mentioned that the IHP has addressed issues such as food insecurity, the opioid crisis, and housing instability, all of which can help improve health equity. In addition, Chomilo discussed the importance of embedding health equity and addressing structural racism explicitly in the IHPs, stating, "Addressing structural racism and promoting anti-racism is essential to really addressing health equity." In addition, Chomilo concluded, "We want to ensure that the financial incentives are aligned with our efforts around health equity and institutional racism so that we don't continue to see gaps persist."

Asaf Bitton from Ariadne Labs and Harvard Medical School pointed out that primary care is a focal point for achieving health equity and community health. As a recent member of the National Academies' Committee on Implementing High-Quality Primary Care, Bitton emphasized one of the report's five objectives for making high-quality primary care available for everyone in the United States: to "pay for primary care teams to care for people, not doctors to deliver services" (NASEM, 2021, p. 370). He described the fee-for-service system as impeding the delivery of high-quality and equitable primary care and instead suggested moving toward a capitated system that is adjusted for social and medical risk, though some fee-for-service payments could be retained to balance incentives. In addition, Bitton highlighted the necessity of universal empanelment through partnerships and collaboration to make equitable and high-quality primary care available to everyone. He also described the need for an accountability framework, such as a scorecard, that would allow for an understanding of progress on common metrics.

Kara Odom Walker from Nemours said, "If we can invest in healthier kids, we will have a better opportunity to have healthier adults." She noted that investment in poverty reduction, parental emotional health, and increased access to health care and mental health services before the age of 5 provides a substantial window of opportunity to improve health equity, but there are many challenges to making these early investments. Some of these include the underresourcing of many social service providers, funds existing in the "wrong pocket," the lack of short-term return on investment (ROI), and the lack of focus on the family, not just the child. Nemours is working to improve health equity by rethinking multidisciplinary teams to integrate behavioral health care providers, CHWs, and care navigators. Nemours is also investing in evidence-based programs like home visiting, leveraging data to measure equity and the impact of related interventions, and providing bias training. Walker emphasized the importance of paying for equity-focused quality measures, investing in data systems to uncover inequities, measuring equity-based interventions, and reinforcing the need to invest more in health in light of the COVID pandemic.

EXAMINING INNOVATIVE MODELS AND LEVERS UNDERSCORED DURING THE COVID-19 PANDEMIC

Elements of Financing and Payment Models That Effectively Reward Better Health and Well-Being

Sharon Lewis from Health Management Associates began by pointing out that Medicaid is the primary payer for long-term services and supports at present, with few coverage or financing alternatives available. The COVID-19 pandemic produced an inflection point that has made it possible to envision a different way of addressing the support needs of older adults and people with disabilities. It has broadened ways in which home- and community-based services are being implemented, including with remote support and telehealth, and by expanding flexibilities in paying family members as caregivers. New roles have emerged for nontraditional care providers, case managers, support coordinators, and communication technologies. The COVID-19 pandemic may even have created ways to take on funding reform, in part through the expansion of alternatives to nursing facilities and institutional care, consistent with research demonstrating most Americans' desire to age in place at home. Lewis emphasized family as "the backbone of our long-term services and support systems" and highlighted the need to ensure that payment models and delivery systems address a person's needs within the context of family.

Patrick Conway from Care Solutions at Optum cited several existing models that focus on whole-person care. Through CMMI, Conway worked on state innovation models to invest in care systems aimed at better health experiences and outcomes for the population served, and lower costs. The Integrated Care for Kids Model has sought to improve the quality of care for children under 21 years of age covered by Medicaid, through prevention, early identification, and the treatment of behavioral and physical health needs. Similarly, at Optum, Conway has been working on fully capitated systems that integrate team-based physical, mental, and social care for the whole person. He added that, for example, home- and community-care programs for dual-eligible[7] patients have dramatically reduced hospitalizations, emergency room visits, and costs (Ruiz et al., 2017). Mental and behavioral health care programs provide systematic treatment integrated with primary care for depression, anxiety, substance use, and other conditions. The primary care program provides data and analytics, decision support tools, home and community care, and other resources to replace fee-for-service payments with an integrated system of care, said Conway.

Piyush Gupta from Cityblock Health described the organization's model, which is based on the goal of transitioning from referral-based medicine to relationship-based medicine. Cityblock invests in preventative care, largely through a CHW model, to reduce the total cost of care, and invests the savings into primary care, behavioral health care, and the social needs of its members. Using a technology-driven approach, it captures data from multiple sources and provides frontline workers with digital support tools to deliver evidence-based care and support communities. Its goals are to ensure that its members have access to care whenever they need it, are confident in the quality of the care they are receiving, and receive the care and services that they need and want. Gupta described a case study of Sonia, a Cityblock member with multiple chronic diseases and unmet social needs. The key care team members in community health, behavioral health, and primary care identified behavioral health needs, enrolled Sonia in a food pantry and in a housing program, coordinated a temporary stay in a hotel during the COVID-19 pandemic, and secured permanent housing. One individual, highlighted by Gupta, has achieved a 21 percent reduction in hospital use, a 24 percent reduction in monthly costs, and zero emergency department visits since April 2020. This model is both scalable and expanding, Gupta said, and demonstrates reduced costs while building engagement and trust.

The workshop series spotlighted three innovative programs focused on whole-person and population health. Box 3 provides an innovation spotlight of the Petaluma Health Center.

Innovative Federal and State Models for Financing Whole-Person and Population Health

Donna Kinzer from DK Healthcare Consulting described Maryland's All-Payer/Total Cost of Care model, which has shifted away from a fee-for-service model toward payments based on global revenues with an emphasis on population health outcomes. Since 2014, the amount that a hospital is able to earn through inpatient and outpatient charges has been set at the beginning of the year, thereby incentivizing reductions in preventable admissions and greater control of the total cost of care as well as improving individual and population health outcomes. In 2019, this model was extended beyond hospitals to encompass the entire health care delivery system, with an emphasis on a statewide primary care program, care redesign, a robust health information exchange, and population health. The model has three domains of focus in terms of population health outcomes: improving hospital outcomes, enhancing the transformation process across the continuum of care, and improving population health. Key goals and targets built into the payment models include reducing avoidable hospital admissions, improving care coordination for patients with chronic condi-

[7] Dual-eligible refers to individuals who are enrolled in both Medicare and Medicaid.

BOX 3
INNOVATION SPOTLIGHT: PETALUMA HEALTH CENTER

The foundation of health at the Petaluma Health Center is community wellness and equity, said Fasih Hameed, the organization's director of integrative medicine and wellness. A federally qualified health center serving about 35,000 people at 4 main clinical sites, Petaluma Health Center is patient-centered by design. It emphasizes food security and nutrition through nutritionists and certified diabetic educators, community partners, a seasonal "farmacy," and an on-site garden and demonstration kitchen. It facilitates access to transportation and housing services along with access to medical care. It works to reduce violence, racism, loneliness, and trauma through such means as shared medical visits, recovery services, and integrative medicine consults. Free exercise classes, mental health groups, and social events help provide stress reduction to improve well-being.

Clinician burnout was a problem even before the COVID-19 pandemic, and the center was forced to pivot to meet the intensified challenges that the pandemic brought. As vulnerable communities were disproportionately impacted by the pandemic, Petaluma Health Center received a flood of patients, straining the center's supplies and services. Group medical visits aided in meeting demand prior to the pandemic, but the lack of an official government billing policy makes maintaining these models difficult, and converting to telegroups is even more challenging, Hameed noted. Hameed concluded that both before and during the pandemic, the fee-for-service model was neither sustainable nor effective, and sent the wrong message: "If we care about these things, if we care about people, value people, we will shift the funding to align with these values," said Hameed.

tions, reducing diabetes through body mass index reduction targets for the adult population, reducing opioid use through overdose mortality reduction targets, and improving maternal and child health through reductions in severe maternal morbidity and decreased asthma-related emergency room use for children.

Ena Backus from the State of Vermont Agency of Human Services described the Vermont All-Payer ACO model, which is similarly moving away from fee-for-service toward value-based payment to moderate growth in health care costs, improve the quality and experience of care, and improve population health. The model aims to improve population health outcomes by increasing access to primary care, decreasing deaths due to drug overdose and suicide, and reducing the prevalence and morbidity of chronic disease. Backus described the signature innovation of the model as "committing to payment change as a lever for improving population health outcomes in addition to those population health strategies and public health strategies that we would typically think of in our state." The state's model aligns payer programs, including those of Medicare, Medicaid, and commercial payers, around a statewide care organization built on a foundation of advanced primary care and integrated care, including patient-centered medical homes, community health teams, and care coordination to integrate health and community services. More than 160 organizations participate in the model, including most of the hospitals in the state, independent practitioners, federally qualified health centers, home health providers, skilled nursing facilities, and agencies for mental health and substance use disorders, enabling the coordination needed for wraparound services and supports.

Cindy Mann from Manatt Health offered a broader perspective based on her previous experience at the Centers for Medicare & Medicaid Services. Given the success of experiments at the state level, combined with the health equity issues highlighted by the COVID-19 pandemic, she suggested that the federal government is now ready to move more broadly toward financing reform. Global budgets based on total cost of care, whether at the state level, the payer level, the provider level, or the health plan level, provide the flexibility for funds to be used wisely for cost-effective innovations to buy health and not just health care. Issues of equity, underutilization, and tools to measure quality and outcomes all need to be considered under such approaches, but much can be learned from existing models to scale successful initiatives nationwide. Mann stated, "When all the signals are aligned across the sectors and the payers, the ability to move that needle is certainly enhanced."

Innovative Private Models for Financing Whole-Person and Population Health

David Fogel, former chief executive officer and founder of Casey Health Institute (CHI), described its private model, which combined an integrative health staff model; primary care delivered through patient-centered medical homes;

interdisciplinary team-based collaboration; and a population-health, value-based care payment program. The value-based platform was essential to the business model and sustainability, said Fogel. On key metrics—including pharmacy costs, 30-day readmissions, emergency room visits, and inpatient admissions—the organization outperformed conventional primary care providers, even though its patients had a higher illness burden score. Despite its effectiveness, the CHI model was not financially sustainable, Fogel noted. He said financing reform needs to happen, but changing such a system requires connecting local actions simultaneously in different areas so that the system becomes aligned with the shared goals and collective consciousness of the whole.

Dexter Shurney from Adventist Health described the importance of the lifestyle medicine approach to care, which "uses evidence-based behavioral interventions to treat and manage chronic diseases related to lifestyle" (ACPM, 2019). As executive director of global health benefits at Cummins, Shurney used a lifestyle medicine approach to try to improve the health of the company's employees through such measures as good nutrition, physical activity, better sleep, stress reduction, and avoiding alcohol and tobacco. Physician bonuses were tied not to the services they provided but to improvements in the health status of the populations they served. He has been bringing the same approach to health care at Adventist Health. Collaborations are essential in this effort, he said, because progress will require such steps as benefit redesign, alternative reimbursement models, and better use of technology.

Finally, Cheryl Pegus from Walmart described how her company has more than 5,100 retail sites with 90 percent of Americans living within 10 minutes of a site (Walmart, 2019). Because most of the company's employees live in the communities Walmart serves, Pegus emphasized the importance of focusing on their needs, which represent the needs of the community. By partnering with multiple stakeholders to ensure communities' access to COVID-19 vaccines and by providing education to combat vaccination hesitancy, Walmart has helped to address social equity and community health throughout the pandemic. Pegus said that further addressing equity necessitates an understanding that "health care occurs outside of a clinician's office" and a strengthened focus on care for the whole individual. She noted that SDOH drive an estimated 70 percent of health outcomes, most notably for individuals with chronic conditions, and addressing them lowers costs and improves outcomes (Bradley et al., 2016). As such, Pegus stated, Walmart is committed to making equity a strategic priority, building infrastructure to support health equity, addressing the multiple determinants of health, eliminating racism and other forms of oppression, and collaborating with communities to improve health equity.

STRATEGIES FOR INTEGRATED PAYMENT APPROACHES TO EFFICIENCY, EFFECTIVENESS, AND EQUITY

Transformation Levers

Sue Birch from the Washington State Health Care Authority (HCA) highlighted the ways in which her organization has taken advantage of federal and state regulatory levers to implement a wide variety of innovations for value-aligned care transformation. In striving for lower costs, better outcomes, and better consumer and provider experiences, HCA has financially integrated physical and behavioral health to support a life-stage approach to health, developed an innovative value-based purchasing model for hepatitis C therapies, and created and implemented a first-in-the-nation public option available on Washington's health insurance exchange. It has also established a Health Care Cost Transparency Board and utilized Medicaid waivers and various grants to design innovative payment models and build the infrastructure necessary to support care redesign.[8] Birch also described Washington State's efforts to break down the silos between social services and health care programs and to pay for population health on a broad scale.

Neal Halfon from the University of California, Los Angeles, described another potentially transformative lever based on the concept that almost all long-term chronic health problems originate early in life, and, if engaged disruptively, can be addressed within communities and homes. The All Children Thrive initiative uses this idea to engage in "outside-in" transformation, where communities transform their activities to create a more functional and holistic health care system for children, addressing social needs and population health. Halfon suggested that strategies such as horizontal integration, bundled payments across the lifespan with long-term ROI horizons, global health budgets for municipalities, and accountable health communities can have immense utility in achieving this goal. A national learning community that engages in long-term investments in innovations to support healthy childhood development and well-being would help states address both design and funding challenges for program transformations across multiple agencies.

Alex Briscoe from the California Children's Trust described his organization's work to transform social and emotional health in children. It seeks to expand care access, transparency, and participation, while consolidating and maximizing funding and accountability, all with an overarching emphasis on equity, anti-racism, anti-poverty, and jus-

[8] See https://www.hca.wa.gov/assets/program/FundamentalsMap.pdf (accessed July 27, 2021).

tice. Specific levers include removing diagnosis as a prerequisite for behavioral health services, engaging managed care organizations with community wraparound services, incentivizing investments in education, reforming certified public expenditure programs, and shifting agency (i.e., the individuals doing the work) and power (i.e., the individuals getting paid). For example, the Trust is supporting the redefinition of scope of practice by directly investing in community health outreach workers, doulas, and peer-to-peer programs, including 10,000 new behavioral health coaches.

The workshop series spotlighted three innovative programs focused on whole-person and population health. Box 4 describes The Achievable Foundation, an innovative program providing whole-person approaches to responding to the evolving health and social needs of people with intellectual and developmental disabilities.

Accelerating Transformative Financing Approaches

Emily Brower from Trinity Health reinforced the importance of reducing frictional and transactional costs between clinicians and payers and highlighted the utility of transparency, primary care centricity, and population-based payment models in accelerating transformation toward whole-person care, equitable population health outcomes, improved patient and clinician experiences, and reduced per-capita costs. Transparency—notably, through standard fee schedules—can create a level playing field that enables health care providers to collaborate without competitive concerns, focus their energies on improving health outcomes, and reduce unnecessary care utilization and waste. Primary care models that extend to a care team, networks of specialists, and community services help to organize care around basic humanity and the factors that matter most to individuals and communities. Brower described the value in population-based payment models, in terms of holding participants clinically and financially accountable for population health. Brower described the benefits of this model compared to fee-for-service/episodic models, namely in terms of integrating Medicaid benefits for beneficiaries who are dually eligible, providing additional touchpoints, and better coordinating care. A challenge, Brower said, is to extend care and financing models to encompass families, communities, and longer-time horizons.

David Erickson from the Federal Reserve Bank of New York described the transformative potential of markets that value health. The buyers in such markets would be the entities interested in producing better health outcomes, including insurance companies, integrated health systems, government at all levels, foundations, and impact investors who want both a financial and social return on their investments. The producers are entities throughout the public, private, nonprofit, and philanthropic sectors that can act to improve places, neighborhoods, and community health. By connecting buyers and producers through such means as community development banks, statewide ACOs, and neighborhood equity funds, resources could be directed to address the upstream SDOH. In turn, a model that produced better population health could outcompete other models and shift the overall system toward new approaches.

Lastly, Elizabeth Fowler from CMMI explained that stronger incentives for whole-person/population health, risk adjustment reforms to advance innovations in care delivery and outcomes (rather than "gaming the system and up-coding services" to generate more revenue), and data infrastructures that support improved outcomes could all help drive health care providers away from the "siren song of the status quo" (in terms of fee-for-service payments) and toward alternative payment mechanisms. These alternatives, she said, would do well to support primary care and increase alignment with community-based organizations. Given the limited success of voluntary models, she noted, CMMI is exploring the possibility of mandatory models in addition to incentivizing health system value.

Imagining a Better System

In a final panel discussion, David Muhlestein from Leavitt Partners, Vivian Lee from Verily Life Sciences, and Donald Berwick from the Institute for Healthcare Improvement discussed the imperative for health system transformation away from fee-for-service financing structures and toward financing structures that reward whole-person, population health and well-being.

In 1960, health care was about 5 percent of the gross domestic product (GDP), Muhlestein began. Today, it is nearly 18 percent of the GDP (CMS, 2020) and health care is projected to account for 31 percent of government expenditures by the year 2028 (GPO, 2021). "It's not a sustainable amount of money that we're spending," he said. Muhlestein made the case for generational, long-term health care system transformation to readjust these expenditures—getting national health care spending back to about 10 percent of the GDP by the year 2050. Muhlestein emphasized the need for accomplishing this carefully to minimize negative economic consequences, given health care's substantial role in the U.S. economy. He said transforming the fee-for-service, capacity-focused business model to a needs-based model seems to be key: replacing the chassis that a reformed health system can be built on. Muhlestein said he recognized that strong leadership would be necessary for this to be actualized—and highlighted several policy proposals to this end: mandatory programs reflecting needs-based business models, long-term contracting horizons, and incentives

BOX 4
INNOVATION SPOTLIGHT: THE ACHIEVABLE FOUNDATION

The mission of The Achievable Foundation is to provide high-quality, integrated health care to individuals with intellectual and developmental disabilities, their families, and other vulnerable populations. The center's chief executive officer, Carmen Ibarra, described the strategies by which that mission is achieved: providing care via direct services, advocating for beneficial health care policies, and developing a knowledgeable workforce that can provide high-quality care for people with intellectual and developmental disabilities. She said the center functions with community input at its core, providing culturally appropriate, whole-person, patient- and family-centered care across the lifespan, with a high level of care coordination and services suited to vulnerable populations, patients with developmental disabilities, and their families.[a]

In 2013, the foundation became a federally qualified health center, which enabled it to receive a higher reimbursement for its publicly insured patients. Its funding comes largely from government grants and service revenue, but in fiscal year 2021, 24 percent of its funding came from government grants related to the COVID-19 pandemic. This funding is not likely to be extended, said Ibarra, yet many of the expenses associated with responding to the pandemic will continue, especially with the lengthy visits that many patients require. "We're going to need to fill that gap, either by increasing our visits or our fundraising," she said.

California is starting to modernize its funding of community health centers, which Ibarra said may allow The Achievable Foundation to continue to be innovative in its approach and meet the needs of the community, "but the devil is in the details and we're not sure ultimately how this will play out," she concluded.

[a] See https://achievable.org/patient-care/health-center-services (accessed July 27, 2021).

for adherents to non–fee-for-service business models. "As long as we're focused on paying for health care, that's what we're going to get. We need models that pay for health, not for care," he concluded.

Lee similarly asked, "How can we spend so much money and yet have poor health outcomes?" The key to fixing this disconnect and lowering costs, she explained, is better health: a space that the digital health industry can potentially contribute to via its capacity for co-producing health. Through new technologies, consumers of health can become "pro-sumers," better empowered to quit smoking, monitor their blood pressure and blood sugar, change their diets, and work with health coaches to change their behaviors, all as examples. Such technologies aim to provide individualized experiences and actionable feedback in environments where people can focus on what matters to them.

For the digital health space to fulfill its potential, companies need to be held to a higher standard in generating evidence that their products work, payment models should compensate based on actual outcomes, and data silos should be eliminated by integrating data from digital devices into electronic health record data, Lee said. Clinicians also need to be involved in developing a framework for the co-production of health, she said, with health care systems incentivized to make digital connections with patients and support the infrastructure needed to do so.

Lastly, Berwick observed that the lack of recognition of health care as a human right in the United States is "a national embarrassment," and advocated shifting resources—without rationing care—to the real causes of illness, injury, and disability: SDOH, including structural racism and inequity. "Sick people are poorer, and poor people are sicker. If we're going to help improve health and well-being in our country, we're going to have to shift resources toward people who are vulnerable and have lower incomes." Alongside this, Berwick explained, is the need to shift the ratio of per-capita spending on health care and social services to mirror international examples in which better results are achieved with a much lower percentage of the GDP spent on health care. "The ideal medical loss ratio[9] in American health care is 100 percent," and the financial manipulation and intermediation that does not add value to the system needs to be put to rest, Berwick observed.

Berwick explained that the transaction-based view of care misunderstands what matters to most people throughout their lives, especially with an aging population and growing rates of chronic illness. He suggested homes, not hospitals, should be the center of health care. Providing global budget initiatives with resources, extreme dis-

[9] Refers to the proportion of premium revenues spent on clinical services and quality improvement (CMS, 2021).

cipline, and extreme flexibility on their transformative journey could help, as could universal empanelment and a requisite set of integrators equipped to help people navigate the care system. Reducing clinician burnout, fostering continuous learning and improvement, and consolidating resources spent on health care and other services can help to improve patient journeys over lifetimes, especially for those who are under social and economic stress, Berwick noted. He concluded, "We have to take the time to understand what patients really want and then help them achieve their goals in the way that they want."

In concluding the workshop series, Pham made the case for experimentation, competition, and collaboration. If the federal government was to give specific communities permission to form community-wide coalitions and provide waivers for regulatory constraints that currently exist, such coalitions could leverage opportunities, including market forces, wherever possible. With financing from investors, these coalitions could engage in global approaches to paying for the production of health, with clear goals and metrics tied to themes identified by the community. If not required to produce an immediate ROI (but rather, functioning on a longer-time horizon), these coalitions could demonstrate proofs of concept that then could be much more widely adopted, Pham said. The result could be a resilient workforce and an improved state of individual and population health and well-being. ◆◆◆

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