FUNDERS FORUM
on Accountable Health

Federal Options to Support the ACH Infrastructure

Funders Forum Issue Brief

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The Funders Forum on Accountable Health

The Funders Forum on Accountable Health is a collaborative at George Washington University's Milken Institute School of Public Health that works to advance accountable communities for health (ACH) models by promoting dialogue and catalyzing change among public and private funders of ACH efforts across the country.

The Forum is a common table for funders of ACH efforts to share ideas and experiences, explore potential collaborations, support common assessment approaches, and build a community of practice. The following foundations support the Forum: Blue Shield of California Foundation, Episcopal Health Foundation, RCHN Community Health Foundation, Robert Wood Johnson Foundation, The California Endowment, The Commonwealth Fund, The Kresge Foundation, and W. K. Kellogg Foundation.

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INTRODUCTION AND OVERVIEW

The advent of value-based care has accelerated national and local efforts to address social determinants of health (SDOH), defined as "the conditions in which people are born, grow, live, work and age."[1] Public and private funders have begun to test innovative, community-based strategies to address SDOH, and Accountable Communities for Health (ACH) have emerged as one promising model.

Accountable Communities for Health are multi-faceted, multi-stakeholder entities that address unmet health and social needs to improve the health of the individuals and communities they serve. ACHs may facilitate assistance at both the individual and community level with housing, food, employment, transportation, and other needs to help remove immediate barriers to better health and wellbeing.

The Funders Forum on Accountable Health has identified more than 100 accountable-health-type initiatives across the country. As one example, at the federal level the Centers for Medicare and Medicaid Services (CMS) has seeded the *Accountable Health Communities* model in 29 sites across the nation, and will soon launch the accountable health model entitled *Integrating Care for Kids*. A second example is the *California Accountable Communities for Health Initiative (CACHI),* a demonstration started in 2016 that now supports 13 communities and is funded by seven foundations.

In early stages of formation, ACHs are often supported by philanthropic or publicly-funded grants and other sources of critical but time-limited funding. As ACHs have matured, it has become increasingly imperative to identify sources of financing for both programmatic and non-programmatic (e.g., administrative) services that can sustain the ACH in the long-term and ensure its standing as a trusted steward of resources for a community.

To date, national discourse has focused more on funding for ACH programmatic activities, with considerably less attention to financial support for the operational infrastructure of the ACH. Yet, such operational functions—also called "backbone" functions—are critical for ACH effectiveness by supporting ACH capacity building, strategic planning and evaluation, and administration, among other activities. The ACH infrastructure and its role in coordinating and aligning interventions across sectors may be considered an intervention itself; without a strong

ACH infrastructure, this innovative model could face ongoing challenges to comprehensive community health improvement.

Box 1. ACH Infrastructure Functions

- **Community engagement**
- **Strategic planning**
- **Convening and aligning stakeholders**
- **Standards adoption and best practice promulgation**
- **Program evaluation**
- **Community health assessment**
- **Training and case management***
- **Data sharing, collection, and analysis**
- **Community and resource development**
- **Public policy advocacy**
- **Fundraising and financial management**
- **Administration**
- **Development of a portfolio of interventions**

***Case management may also be programmatic activity.**

The Funders Forum, working with Manatt, Phelps & Phillips, conducted a legal and policy review of various funding streams at the federal, state, and local level in order to assess their potential for financing the backbone functions of an ACH. This review considered whether such funds could be coordinated (braided) or pooled (blended), and sought real world, illustrative examples.[2]

This Issue Brief summarizes findings from this review, with focus on the most feasible options for supporting ACH backbone functions in the long-term.

MENU OF OPTIONS TO SUPPORT THE ACH INFRASTRUCTURE

The old adage—if you've seen one, you've seen one—applies in the ACH context. Some ACH activities are strongly public health focused, whereas others are more closely aligned with health care systems, and other ACH activities are focused on SDOH. The policy environment for ACHs varies considerably, which can also shape the menu of viable financing approaches. As such, this brief provides options to support the infrastructure of ACHs across the spectrum. In addition, illustrative examples are provided along with information regarding whether such funding can be braided or blended (pooled) with other financing streams.

Note: The terms "braided" and "blended" can be confusing; we defined braiding as coordinating distinct funding streams to pay for a variety of services and functions. These funds are not combined. Governing entities managing braided funds must ensure that spending from each funding stream is appropriately used given its purposes, eligibility rules, and other considerations, which may generate administrative burdens and costs. Blending dollars allows a funding recipient to more easily combine dollars from multiple resources. A governing entity can draw from this common pool of funds to support its backbone functions, although tracking and reporting of each funding stream is generally still required.[3]

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Within the Department of Health and Human Services (HHS), several agencies—and programs administered by these agencies—could be the source of funding for ACH infrastructure activities: the Centers for Medicare and Medicaid Services (CMS), Administration for Children and Families (ACF), Centers for Disease Control and Prevention (CDC), Substance Abuse and Mental Health Services Administration (SAMHSA), and Health Resources and Services Administration (HRSA). Generally, HHS funding must be tracked to specific programmatic services or beneficiaries, and thus may be braided but not blended with other financing streams. In addition, although statutory authority exists for each of these options, in some cases HHS may need to clarify the specific allowable uses for infrastructure funding through rulemaking, sub-regulatory guidance, agreements and program announcements, as well as informal communications.

CENTERS FOR MEDICARE AND MEDICAID SERVICES

Medicaid

Within the Medicaid program, federal statute authorizes several mechanisms that could support financing the ACH infrastructure: State Plan Amendments, Medicaid managed care contracting, and Section 1115 waivers, as well as provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act. These mechanisms are available to all states, regardless of Medicaid expansion. With the exception of some value-based payments, Medicaid funding must be used to support activities specific to Medicaid beneficiaries and services, and thus could be braided (not blended) with other resources.

State Plan

The State Plan is the formal, written agreement between a state and the federal government that, among many provisions, indicates which optional groups, services, or programs the state has chosen to cover or implement. States make changes to their State Plan through State Plan Amendments (SPAs).

Although State Plan authorities address coverage of programmatic services, they could allow funding for ACH backbone activities under two general circumstances. First, if an ACH is a service provider, the ACH could draw down federal dollars as reimbursement for overhead costs associated with these services. Alternatively, the ACH could contract with a service provider to furnish training and administrative support for Medicaid-covered programmatic services, allowing the ACH to secure related funding, as appropriate.[4,5]

Multiple State Plan authorities allow states to cover optional Medicaid services that help address SDOH, making these authorities particularly relevant for ACHs. States that do not currently cover these optional services and those who cover them but seek to modify the scope of the benefit would need to submit a SPA to CMS to provide coverage. The most likely candidates for funding ACH backbone functions are the following:

- *Case Management Services:* States may provide both case management and Targeted Case Management services to beneficiaries. Through this authority, Medicaid will cover the cost of connecting beneficiaries to medical, social, educational, and other services and supports. If ACHs provide case management services or contract with other organizations to provide these services, ACHs may receive infrastructure funding for the work they do associated with the provision of such services through the overhead component of the payments.

- *Health Home Services:* States may provide health home services, including care coordination, to beneficiaries with chronic conditions, including substance use disorder, diabetes, heart disease, asthma, and mental health conditions. Most health home activities are programmatic, and ACHs may receive infrastructure funding through the overhead component of programmatic service payments. However, some health home services also could be ACH backbone activities, such as care coordination, referrals to community and social support services, and use of health information technology (IT) to link services. Thus, ACHs could receive both direct and indirect cost reimbursement under this authority.

- *Rehabilitative Services*: This authority permits states to provide "medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner," which can include community health workers or peer specialists—individuals who can help connect beneficiaries to community-based organizations.[6] This authority generally covers programmatic rather than backbone services, allowing ACHs to receive funding for their role through the overhead component of service payments.

Managed Care Mechanisms

Separately or in combination with other Medicaid funding strategies, Medicaid managed care contracting provides several strong funding opportunities for supporting ACH backbone activities.[7] Although states generally cannot require Managed Care Organizations (MCOs) to cover backbone activities that fall outside the Medicaid State Plan, MCOs may use Medicaid funding (or other MCO funds) to finance ACH backbone efforts because ACHs can help MCOs carry out their responsibilities and improve outcomes. For example, ACHs can address housing, utilities, and transportation needs, all of which have a meaningful impact on patients' ability to obtain care and manage health conditions appropriately. In turn, MCOs may benefit from patients' increased adherence to recommended care plans, reduced admissions and preventable hospitalizations, and better health and care experiences for their members.

A critical issue for MCOs pertains to the medical loss ratio (MLR), which is calculated by dividing the sum of claims for covered services, quality improvement expenses, and fraud prevention expenses (the numerator) by a plan's capitation revenue minus taxes and fees (the denominator). States must set MCO capitation rates at a level that results in plans incurring an MLR of at least 85 percent. ACH backbone functions can be included in an MCO's MLR numerator to the extent these functions qualify as health care quality improvement activities, which include activities to improve health outcomes (e.g. case management) and increase wellness and promotion (e.g. public health education campaigns that are performed in conjunction with state or local health departments).

A number of policy levers authorize or incentivize MCOs to support the ACH infrastructure. For some of these, states may require clarifying guidance or agreement by CMS.

- *Value-Based Purchasing (VBP) Arrangements:* States can implement VBP arrangements with MCOs—and can require or incentivize MCOs to establish VBP arrangements with providers. Such payment arrangements encourage (and sometimes explicitly require) plans and providers to provide or facilitate the provision of nonmedical services related to health-related social needs. VBP arrangements may include payments based on shared savings achieved by reducing health costs and utilization while maintaining or improving quality. MCOs could contract with ACHs to help them meet the metrics that trigger shared savings and could also enter into arrangements to share these savings with ACHs; states could also leverage the procurement process to encourage MCOs to share these savings with ACHs. These shared savings payments could be used by ACHs to cover backbone activities, including those not directly linked to Medicaid-covered services. Thus, this strategy is particularly flexible as well as potentially sustainable.

- *Value-Added Services*: MCOs may voluntarily opt to cover services that are not included in the State Plan as "value-added" services using their capitated Medicaid payments. MCOs opt to do so if they believe investment will improve outcomes and reduce costs. Within this context, MCOs could cover ACH backbone functions as value-added services at their discretion. The spending on value-added services is not calculated into the capitated payment rate, but the state may allow it to be considered as a quality improvement activity for purposes of calculating plans' Medical Loss Ratio.

- *Operational Non-Benefit Costs:* Capitation rates for MCOs must include reasonable, appropriate, and attainable expenses, including costs related to MCO administration, taxes, licensing and regulatory fees, contributions to reserves, risk margins, costs of capital, and "other operational costs" associated with providing services under the MCO contract.[8] MCOs that contract with ACHs to do some of their administration functions could pay for ACH backbone activities through this mechanism.

- *Care Coordination*: Federal regulations require MCOs to coordinate services for each enrollee. This includes coordination between settings of care; with services provided by other MCOs; with services covered by Fee-For-Service (FFS) Medicaid; and with services provided by community and social support providers. ACHs could draw down Medicaid funds for care coordination by contracting with MCOs to provide these services on their behalf. Because these services are programmatic, ACHs could receive reimbursement for related overhead costs as well.[9]

- *State-imposed MCO Fees:* States could impose fees on MCOs to fund backbone activities, and could consider pairing these fees with incentive payments to help offset the added financial burden to plans. However, states could not target only Medicaid insurers with these assessments, and would have to levy such fees broadly.[10]

Oregon supports its ACH with a state-imposed MCO fee and incentive payments

Oregon has an overall health care provider fee that is used for the State's required Medicaid matching funds, and is used to support Coordinated Care Organizations, which function as ACHs in the state. The state also provided incentive payments in its more recent (2016) contracts with its MCOs for meeting quality of care measures. Additionally, the MCO contracts include language to encourage use of "health related services" to replace or reduce the need for medical services. Such services could be provided at the individual or community level, such as support for a farmer's market or meal preparation.[11]

Section 1115 Waiver

Section 1115 of the Social Security Act allows HHS to waive certain requirements of the Medicaid program to support state demonstrations that the Secretary of HHS determines will further the objectives of the program and be budget neutral for the federal government. Such waivers provide a strong funding opportunity for ACH backbone activities, to the extent that a waiver's terms and conditions allow funds to be used for these activities and depending on the population covered by the waiver. Pursuing funding for ACH infrastructure needs through a Section 1115 waiver would likely need to occur as part of a broader state-sponsored accountable-health-type initiative; it could be part of a new waiver request or as an amendment to an existing waiver. Waivers require a significant investment of state Medicaid agency time to develop and negotiate with HHS, and approval is contingent on the priorities and standards of the federal administration reviewing the waiver at the time. Waivers are typically approved for five years and can be renewed; because waiver authority is generally time limited, this strategy is best seen as a pathway to ongoing, sustainable financing.

New York's Medicaid Section 1115 Waiver supports Staten Island's ACH

Among the 25 groups included in New York State's Medicaid Section 1115 waiver is the Staten Island Performing Provider System (SIPPS). This ACH seeks to improve population health through collaborative partnerships across health care, public health, social services, education, and the justice system. SIPPS' infrastructure activities have included creation of a data exchange system for both clinical and non-clinical services, which has helped to build capacity within community based organizations through enhanced technology and training.[12]

North Carolina's Medicaid Section 1115 Waiver supports Health Opportunity Pilots

North Carolina's Medicaid Section 1115 waiver includes up to $650 million to support the activities of Healthy Opportunity Pilots, accountable health type structures to address housing, food, transportation, and interpersonal safety in 2-4 regions in the state. Up to $100 million can be used for infrastructure and capacity building. These Pilots will be coordinated with Medicaid MCOs over the five years of the waiver to improve health outcomes and reduce costs of enrollees in specified geographic areas of the state. With continued evaluation and assessment of outcomes, North Carolina plans to integrate Healthy Opportunities Pilots into the state's Medicaid program broadly, with long-term support built into MCO rate setting.[13, 14]

Health Information Technology for Economic and Clinical Health (HITECH) Act

A number of ACHs are focused on backbone activities relating to electronic health record (EHR) technology and health information exchanges (HIEs). For example, the backbone organization for Oklahoma's Accountable Health Community is the HIE. For this and other ACHs, the HITECH Act provides a strong opportunity to receive start-up funding.

This Act permits states to receive incentive payments for Medicaid Eligible Providers (Medicaid EPs) to adopt, implement, upgrade, and meaningfully use certified EHR technology through 2021. Medicaid EPs include clinical providers in federally qualified health centers or rural health clinics. They can voluntarily assign their incentive payments to state-designated entities that promote the adoption of EHR technology, which could include ACHs.

Under HITECH, states also are enabled to receive a 90 percent federal match through 2021 for related administrative expenses, including administrative costs for initiatives to encourage the adoption of EHR technology, subject to HHS approval.[15] Under certain conditions, states may claim this enhanced match for costs to help Medicaid EPs meet Medicaid meaningful use requirements, including connection to state registries and other Medicaid providers such as behavioral health providers, pharmacies, public health providers, community-based providers, among others. As such, states could contract with ACHs to help spur the adoption and use of technologies that support the exchange of information.

This funding opportunity has limits. Medicaid cannot be the sole funding source for implementing HIE entities or services, and the enhanced match must be used to help Medicaid EPs meet meaningful use requirements and is not available for ongoing operations and

maintenance.[16] Because States have some flexibility in structuring their requests for HITECH funding, ACHs could work with their State Medicaid agencies to clarify which health IT capabilities and partners qualify for funding.

Children's Health Insurance Program

The Children's Health Insurance Program (CHIP) authorizes states to use a limited portion of their CHIP funding for initiatives beyond coverage that improve low-income children's health. To do so, states must submit a CHIP SPA to CMS to implement a Health Services Initiative (HSI). As of February 2019, CMS has approved 71 HSIs in 24 states, some of which are addressing SDOH.[17][18]

Activities covered through HSIs are broadly defined as including those that "protect the public health, protect the health of individuals, improve or promote a State's capacity to deliver public health services, or strengthen the human and material resources necessary to accomplish public health goals relating to improving the health of children . . ." Thus, ACH capacity-related activities could be covered under this authority to the extent these activities support efforts to improve low-income children's health.

States may draw down federal matching funds to pay for HSI costs at the enhanced CHIP rate. However, CHIP funds are capped and the portion of the CHIP funds that can be used for HSIs are also capped—a state's claims for HSI and administrative costs cannot exceed 10 percent of the state's total coverage-related claims for the CHIP program each quarter.[19] Within this cap, states must fund costs associated with administering the CHIP state plan first.

CENTERS FOR DISEASE CONTROL AND PREVENTION

Given many accountable-health-type initiatives are public health focused, CDC funding could be a potential source of revenue for supporting ACH infrastructure activities. Cooperative agreements issued by the National Center for Chronic Disease Prevention and Health Promotion are one potential source of ACH backbone funding, depending on the restrictions outlined in the cooperative agreements. Two cooperative agreements that highlight the Center's potential to support the ACH infrastructure are described below:

- Improving the Health of Americans Through Prevention and Management of Diabetes

and Heart Disease and Stroke: Funds were awarded to all states to prevent or delay type 2 diabetes among high-risk people, improve the health of people living with diabetes, and prevent and manage cardiovascular disease. The funding may be used to support the development of a statewide infrastructure to promote long-term sustainability and reimbursement for community health workers; adoption and use of EHR and health IT; and implementation of systems to facilitate referrals to community programs and resources.

- Innovative State and Local Public Health Strategies to Prevent and Manage Diabetes and Heart Disease and Stroke: Competitive grants were provided to state/local health departments to design and test approaches to address diabetes, heart disease, and stroke. The funding allows grantees to work with health care systems to establish or expand telehealth that increases access to disease management programs, as well as to implement systems that facilitate bi-directional referrals between community programs and health systems.

Rhode Island's Health Equity Zones are supported with CDC funding

The state of Rhode Island has established seven accountable-health-type Health Equity Zones using CDC funding from Communities Putting Prevention to Work, Community Transformation Grants, and the Healthy Communities Program. After developing the local infrastructure and backbone organizations, the Rhode Island Department of Health secured additional resources to support specific interventions and to integrate services at the local level. Specifically, funding was obtained from CDC's National Center for Chronic Disease Prevention and Health Promotion, Division of Diabetes Translation, and Preventive Health and Health Services (PHHS) Block Grant program, as well as HRSA's Maternal and Child Health Services Block Grant. State-wide equity measures have been used to evaluate improvements in health outcomes within each zone, which have supported successful advocacy for additional resources at the federal and state level.[20]

HEALTH RESOURCES AND SERVICES ADMINISTRATION

HRSA funds Community Health Centers (CHCs), Health Centers for the Homeless, Primary Care in Public Housing, and Migrant Health Centers. These funds could potentially support ACH infrastructure activities, particularly if a health center itself serves as an ACH for a community. Potential sources of funding include the following:

- Supplemental awards: HRSA may make supplemental awards to CHCs to implement "evidence-based models for increasing access to high-quality primary care services." Such models relate to: improving the delivery of care for individuals with multiple chronic conditions; workforce configuration; reducing the costs of care; enhancing care coordination; expanding telehealth and tech-enabled collaborative learning and capacity building; care integration, including integration of behavioral health, mental health, and SUD services; and addressing emerging public health issues. ACHs could use supplemental awards to fund backbone activities if ACHs serve as or subcontract with CHCs.

- Operating grants: HRSA may award grants for the operational costs of public and nonprofit private health centers that provide services to medically underserved populations. CHCs that also serve as ACHs may use existing operational grants or new grants for infrastructure funding.

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

Many existing ACHs are tackling substance use disorders (SUD) as part of their core mission.[21] Two block grant programs within SAMHSA could provide infrastructure support for ACHs engaged in these efforts. Both require a submission of a state plan to HHS, and funds may only support public or nonprofit private entities. Depending on the proposed backbone functions, the ACH could receive direct funding or indirect (administrative) funding, which is capped at 5 percent of the state's block grant.

Substance Abuse Prevention and Treatment Block Grant

The Substance Abuse Prevention and Treatment Block Grant (SABG) program provides a block grant to all states for the prevention and treatment of SUD and promotion of public health. Relevant to ACH infrastructure activities, states may use SABG funding to do the following:

- Improve the process for referring individuals to treatment facilities that provide appropriate treatment modalities.
- Ensure that personnel operating in state SUD prevention, treatment, and recovery systems have an opportunity to receive training.
- Coordinate SUD prevention and treatment with other services, such as health, social,

correctional and criminal justice, educational, vocational rehabilitation, and employment services.

Community Mental Health Services Block Grant

The Community Mental Health Services Block Grant (MHBG) authorizes funds to all states to provide comprehensive, community-based mental health services to adults and children with serious mental illnesses. In addition, states may use funds for planning, administration, and educational activities related to such services. For ACHs seeking to provide a community-based system of care for people with mental illness, MHBG may be used to coordinate with local entities to maximize the quality and value of multiple services and programs related to: health, medical and dental care, rehabilitation, employment, housing, education, law enforcement, child welfare, and other services.

Massachusetts receives SAMHSA funding for youth prevention activities

The ACH Communities that Care Coalition of Franklin County and North Quabbin in Massachusetts was founded in 2002 as a multi-sector coalition focused on promoting health and development of youth in this rural area. Drug Free Communities funding from SAMHSA was a critical component of the infrastructure and influenced the development of the coalition with strong cross-sector representation including youth organizations, law enforcement, schools, hospitals, and the business community. The Coalition also received funding from the Drug Free Communities Mentoring program and the STOP Act Funding, which resulted in successful reduction in all substance use in the community.[22]

ADMINISTRATION FOR CHILDREN AND FAMILIES

Within ACF, two social services programs provide a strong funding opportunity for supporting ACH infrastructures to the extent ACH activities are consistent with the statutory objectives and allowable target populations for each program.

Temporary Assistance for Needy Families

The Temporary Assistance for Needy Families (TANF) program is a flexible block grant for states to support low-income families with children. TANF funds can be spent on the target

population "in any manner that is reasonably calculated" to achieve the program's statutory goals relating to strengthening and supporting needy families.

ACH backbone activities could be financed through TANF as long as the ACH furthers TANF's goals and serves individuals eligible for assistance. States may spend up to 15 percent of grants for administrative purposes, excluding IT and computerization needs for tracking or monitoring. Funding not expended in a fiscal year can be carried over to the following year. States must contribute their own funds under a maintenance-of-effort requirement. Notably, a portion of TANF funds can be transferred to the Social Services Block Grant Program (SSBG, discussed below), giving states the flexibility to use such funds for individuals and services not eligible under TANF. Importantly, since federal TANF funding is capped, efforts to use these funds for ACH activities should ensure that such spending does not compromise access to needed cash assistance for families.

Social Services Block Grant Program

The SSBG provides annual federal grants to states for social services that support various goals, including achieving or maintaining economic self-support and self-sufficiency; preventing or remedying neglect or abuse among children and adults; and providing home or community-based care.

SSBG can pay for ACH programmatic and backbone efforts that support these goals. Such funds can explicitly cover the administration of social services (including planning and evaluation); personnel training; and retraining through grants to nonprofits or "individuals with social services expertise." These funds, which are capped, give significant flexibility to states, which are able to decide what services will be provided, who is eligible, and how funds are allocated among services. There is no matching requirement for states.

U.S. DEPARTMENT OF AGRICULTURE

The Supplemental Nutrition Assistance Program (SNAP) is a food assistance program jointly administered by the U.S. Department of Agriculture (USDA) and states. Although states operate the program, the federal government funds SNAP benefits and pays up to 50 percent of the program's overhead costs.

States frequently subcontract with community partners to provide outreach services, which are an administrative function of the SNAP program. Thus, an ACH that conducts SNAP outreach directly or through community partners could receive funding by contracting with state agencies that administer SNAP benefits (though federal SNAP dollars must remain under state administrative control).[23]

U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

The U.S. Department of Housing and Urban Development (HUD) potentially could provide funding for the ACH infrastructure through its Section 8 housing assistance programs as well as the Community Development Block Grant (CDBG).

Section 8 Voucher Programs

Section 8 of the Housing Act of 1937 authorizes the Housing Choice Voucher Program, which provides tenant based assistance to low-income families, and the Project Based Voucher Program, which subsidizes the rent of specific units through landlord contracts. Local, regional, and state agencies collectively called public housing agencies (PHAs) administer these programs.

ACHs that contract with PHAs to provide functions for Section 8 programs in a community potentially could receive related overhead dollars to support those efforts. For example, an ACH could provide information on housing-related resources and assistance with services, which would allow it to draw down dollars for associated overhead costs.

Community Development Block Grant Program

The CDBG Program provides funding to states and localities for activities that meet one of several statutory objectives, including the "expansion and improvement of the quantity and quality of community services." As such, CDBG potentially could support ACH infrastructures through funds for capacity building for the provision or coordination of social services.

Up to 15 percent of CDBG funds may be used for a wide range of public services: employment, crime prevention, child care, health, drug abuse, education, fair housing counseling, welfare, homebuyer down-payment assistance, or recreational needs. Eligible expenditures include reasonable overhead costs for carrying out these activities. Perhaps even more relevant for ACH backbone functions, up to 20 percent of CDBG funds may be used for planning and

administrative costs. Planning encompasses data collection and analyses, as well as preparation for program implementation. Administrative costs are the costs of program management, coordination, monitoring, and evaluation, including the costs of developing interagency and subcontractor agreements.

Denver's healthy housing initiatives are supported by HUD grant funding

The Denver Housing Authority (DHA) partnered with Denver Health and Hospital Authority, Denver Department of Environmental Health, and a newly created Community Advisory Council to develop the Mariposa Healthy Living Initiative (HLI). The Mariposa District is a mixed-income, mixed-use housing development in Denver, Colorado, which has been redeveloped with funding from HUD's Community Development Block Grant funding and HOME Investment Partnerships Program. Based on a health needs assessment, the Mariposa HLI focuses on six domains: healthy housing, sustainable and safe transportation, environmental stewardship, social cohesion, public infrastructure, and a healthy economy. Specific health care interventions include physical activity, healthy eating, access to health care and services, and lifelong learning for all stages of life.[24]

U.S. DEPARTMENT OF LABOR

Title I of the Workforce Innovation & Opportunity Act (WIOA) authorizes formula grants to states to support employment and training services for adults, dislocated workers, and youth. These grants are administered by the U.S. Department of Labor (DOL). States may reserve up to 15 percent of their allotment for statewide workforce investment activities; remaining funds are allocated to local area entities, such as workforce development boards (WDBs).

WIOA also requires states to establish "One-Stop" delivery systems administered by WDBs to provide central points of contact for individuals seeking employment, training, and related services. Through these systems, WDBs coordinate with certain required partner programs, such as TANF, and optional partners, such as SNAP.

WIOA authorizes funding for the administration and coordination of the above programs. As part of the 15 percent that a state reserves for statewide activities, the state may spend up to 5 percent on administrative costs. Local area administrative costs under WIOA formula grants are limited to 10 percent of the locale's allocation.

One example of administrative activities eligible for funding is the development and operation of information systems for a variety of purposes: tracking or monitoring participants; data collection relating to supportive services and unemployment insurance claims; and gathering performance and cost information on provider training, youth activities, and educational activities. Other eligible administrative functions include contracting and financial, property, and personnel management.

ACHs potentially could use WIOA funds for backbone activities in two ways: First, if an ACH lead entity is a WDB or other WIOA Title I funding recipient, it could access administrative dollars for eligible backbone activities consistent with the purposes of the funding. Second, if an ACH subcontracts with a WIOA recipient (such as a WDB or state) to provide workforce development or other services, it could draw down related administrative dollars.

Montana's Community Management Teams (CMTs)

As described in its State Plan for WIOA Title I funds, Montana uses Community Management Teams (CMTs)—integrated partnerships with business, education, community leaders, and workforce programs—to serve as local workforce organizations. Through CMTs, TANF and SNAP partner with workforce systems at the state and local levels to help stakeholders and agencies examine gaps and opportunities to promote integrated service strategies.[25]

U.S. DEPARTMENT OF THE TREASURY

Community Development Financial Institutions

Community Development Financial Institutions (CDFIs*)* are private financial institutions that specialize in serving individuals and communities underserved by traditional financial institutions. CDFIs include banks, credit unions, loan funds, and venture capital funds, and are supported with federal financial and technical assistance from the U.S. Department of the Treasury. Financial assistance through CDFIs may be used to develop or support community facilities, provide basic financial services and housing for low-income individuals, and support other activities deemed appropriate by the federal government. Thus, CDFIs have significant

flexibility to help finance ACH infrastructure efforts. Notably, federal funds are available specifically to support partnerships between CDFIs and community partners or organizations. This authority could be helpful for financing ACH activities focused on convening networks.

Several CDFIs support ACH models

- *Building upon a gift from the Ebeid family philanthropy, the CDFI Local Initiatives Support Corporation (LISC) and ProMedica, an integrated Ohio-based health system, are investing $50 million in grants and loans to support the Ebeid Promise Initiative. This funding will support health, social, and educational services in disadvantaged communities in Toledo, Ohio.*[26]

- *In Vermont, the NEK Prosper! Caledonia & Southern Essex ACH was established in 2014, with leadership from Northeastern Vermont Regional Hospital and the local CDFI, Northern Communities Investment Corporation (NCIC), among other key stakeholders. The ACH envisions a community in which all residents are well-nourished, well-housed, mentally and physical healthy, and financially secure. Its initiatives are supported by the Northeast Kingdom Prosperity Fund, which is managed by NCIC.*[27]

- *The LISC Pawtucket/Central Falls Health Equity Zone is a part of the Rhode Island Department of Health and Centers for Disease Control's initiative to increase access to social and economic opportunities, ensure safe neighborhoods and housing, and improve access to healthy food and equitable health care. LISC Rhode Island is the backbone organization for this ACH type collaborative.*[28]

Nonprofit Hospitals/Community Benefit Funds

Nonprofit hospitals must provide benefits to the communities they serve in order to maintain their tax-exempt status.[29] To satisfy this requirement, hospitals could provide community benefits by supporting ACH activities, including by potentially bolstering an ACH's infrastructure.[30] Current federal guidance suggests that investments in ACHs generally may count as a community benefit because these entities help address SDOH; as the Internal Revenue Service (IRS) has stated, "some housing improvements and other spending on social determinants of health that meet a documented community need may qualify as community benefit for the purposes of meeting the community benefit standard."[31] However, further guidance from the IRS may be needed to determine whether and which infrastructure investments would satisfy this standard.

Nonprofit Hospitals—Community Benefit Funds

- *Collaborative Cottage Grove is an ACH in Greensboro, North Carolina. Building upon earlier work to address substandard housing, the ACH launched the Asthma Partnership Demonstration with numerous partners including the Greensboro Housing Coalition, University of North Carolina Greensboro, and Cone Health, the local non-profit hospital system. Cone Health contributed community benefit funding to participate in the ACH and support the asthma and related initiatives, which were leveraged to successfully advocate for a housing bond to increase affordable housing in the community.*[32]

- *Kaiser Permanente in California has invested community benefit dollars in the California Accountable Communities for Health Initiative (CACHI), which began in 2016. This initiative is supporting demonstrations in 13 communities across the state, focusing on community health improvement and health equity. Kaiser's funding primarily supports CACHI infrastructure activities, including the development of Wellness Funds that are designed to braid and blend funding to sustain CACHI sites in the long-term.*[33]

Social Impact Bonds

Social Impact Bonds (SIBs) are pay-for-success arrangements with private investors. The sponsoring organization (often but not always a government entity) estimates the future savings that will result from a certain intervention, and a private investor agrees to invest those estimated savings in the program with the expectation that the sponsor will repay it with interest at a later point. Repayment is triggered when the program meets certain benchmarks (e.g., reductions in emergency room use), as detailed in the arrangement between the investor and sponsor. Generally, an independent evaluator will determine whether a metric has been met.[34, 35]

Through SIBs, state and local governments could partner with private investors to provide ACHs with start-up funds that could finance both services and backbone activities. Notably, longer-term funding may be more difficult because these investments are typically paid back once the intervention achieves certain metrics.

CONCLUSION

Despite the relative newness of the ACH model, policymakers and practitioners recognize the critical need for sustainable ACH infrastructure support. As detailed in this Issue Brief, there are

multiple and credible strategies for financing the ACH infrastructure at the federal and state level. The availability of these options will depend on the local context of each ACH, namely the services provided, communities served, and characteristics of the state health care and public health systems. However, pursuing any of these options, or combination thereof, will help to expand, diversify, and sustain ACH funding in the long-term.

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