



NATIONAL APPROACHES TO WHOLE-PERSON CARE IN THE SAFETY NET

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In collaboration with the California Association of Public Hospitals & Health Systems
and the California Health Care Safety Net Institute

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OVERVIEW

An individual's health is greatly influenced by the social and economic conditions in which they live, work, and play. Safety-net populations often experience a multitude of physical and behavioral health issues stemming from or amplified by psychosocial challenges such as housing instability, unemployment, and food insecurity, which influence access to care and health outcomes. There is a growing interest in better coordinating social services, behavioral health, health services, and public health in the safety net to create models of "whole-person care," recognizing that vulnerable individuals often have unmet needs spanning multiple systems. For the purposes of this paper, we propose a **working definition of Whole-Person Care as the coordination of health, behavioral health, and social services in a patient-centered manner with the goals of improved health outcomes and more efficient and effective use of resources.**

This White Paper is the first of two papers that seek to identify policy recommendations and next steps for advancing whole-person care for California's vulnerable populations. This paper is based on a review of published articles and gray literature on delivery system transformation models that touch on whole-person care concepts, with focus on dual-eligible demonstrations, safety-net accountable care organizations, and Accountable Care Communities. It is supplemented by interviews with state officials and safety-net providers in nine other states and draws on preliminary research conducted in five California counties.

This White Paper is composed of five sections and introduces the reader to the concept of whole-person care through a six-dimension framework, as well as provides examples from across the nation that are promoting and implementing whole-person care approaches through various delivery system models and funding mechanisms. We hope the six-dimension framework of whole-person care proposed here can serve as a framework for future work on this topic.

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As a non-profit trade organization representing California's public health care systems, CAPH works to strengthen the capacity of its member health care systems to advance community health; ensure access to comprehensive, high quality, culturally sensitive health care services for all Californians; and educate the next generation of health care professionals. SNI is the quality improvement, transformation and research partner of CAPH, designing and directing programs that accelerate the spread of innovative practices among California's public hospitals, public clinics and beyond.

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SECTION I: INTRODUCTION AND OBJECTIVES

INTRODUCTION

Service providers who work with safety-net populations have long recognized the close interplay between an individual's socioeconomic circumstances, psychosocial conditions, and health. Individuals seen by safety-net providers often have unmet health and behavioral health needs as well as challenging psychosocial issues such as housing instability, unemployment, and food insecurity, which influence access to care and health outcomes. Indeed, studies of population health reveal that an individual's health outcomes are heavily influenced by his or her social determinants of health^a—that is, where he/she lives, works, and ages.^{1,2,3,4}

Rising healthcare costs and the Affordable Care Act have elevated the demand for providers to assume increased accountability for cost and quality outcomes. Among safety-net health providers, responding to this demand includes a heightened recognition that individuals' behavioral health and basic economic needs and stressors must be addressed along with immediate health concerns.

However, existing organizational structures, financing and data systems for social services, mental health, substance use, public health, and medical services are siloed, often resulting in uncoordinated, insufficient, or potentially duplicative services or unmet needs at the patient level. There is a need to coordinate across systems to create “whole-person care” that overcomes the complexity of treating safety-net populations within the confines of the current systems. Whole-person care plays a critical role in a coordinated delivery system that addresses the medical, behavioral, and social needs of the safety-net population. For the purposes of this paper, we propose a **working definition of whole-person care as the coordination of health, behavioral health, and social services in a patient-centered manner with the goals of improved health outcomes and more efficient and effective use of resources.**⁵

Objectives of the White Paper

With the support of Blue Shield of California Foundation (BSCF), this White Paper is the first of two papers that seek to identify policy recommendations and next steps for advancing whole-person care for California's vulnerable populations. The impetus for both papers stems from a growing interest in linking social services, behavioral health, and public health to healthcare delivery transformation in the safety net. The objectives of this paper are to:

- I. Outline the need for whole-person care.
- II. Build on the proposed working definition of whole-person care by outlining a framework of six key dimensions of whole-person care. We will use this framework in a subsequent paper to analyze whole-person care activities, opportunities, and challenges across five California counties.

^a As defined by the World Health Organization, “the social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities—the unfair and avoidable differences in health status seen within and between countries.”

- III. Utilize the six-dimension framework to reflect on three notable approaches being employed across the country that can be vehicles for delivering whole-person care: 1) dual-eligible demonstrations, 2) safety-net accountable care organizations (ACOs), and 3) accountable care communities.
- IV. Discuss key insights based on national experience for California and its counties and public hospitals interested in pursuing or advancing whole-person care. These insights will be fused with primary research in five California counties in a second paper (forthcoming Summer 2014).

Methods

The analysis for this White Paper is based on a review of published articles and gray literature on delivery system transformation models that touch on whole-person care concepts, with focus on dual-eligible demonstrations, safety-net ACOs, and accountable care communities. It is also supplemented by insights gathered by the JSI research team across multiple projects spanning three years addressing payment reform and delivery system transformation with a focus on safety-net populations; these projects have included interviews with state officials and representatives of ACOs and programs in Colorado, California, Massachusetts, Minnesota, Alabama, Oregon, New York, Missouri, Vermont, and North Carolina. With the support of BSCF and in collaboration with partners at California Association of Public Hospitals and Health Systems (CAPH) and the California Health Care Safety Net Institute (SNI), we have also conducted individual interviews and facilitated group meetings in five California counties with interest in whole-person care. Based on emerging themes from interviews, group meetings, and a growing body of literature, we have identified six dimensions of whole-person care that were common across our own primary research and that of others.^{6,7} These six dimensions serve as a framework for future work on this topic and are described in further detail in Section II.

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SECTION II: THE NEED FOR WHOLE-PERSON CARE

THE NEED FOR WHOLE-PERSON CARE

The need for whole-person care is evident at the patient, provider, and system levels. From a patient perspective, the need for whole-person care centers on the current experience of navigating and interacting with multiple, uncoordinated systems. Even if health, behavioral health, and social services are individually functioning as “cylinders of excellence,”⁸ the experience can feel overwhelming and confusing for a patient interacting with uncoordinated systems, as he or she might receive mixed messages from multiple providers, which may include more than one care manager. At the health provider level, lack of attention to an individual’s social and behavioral health needs can result in less than optimal quality outcomes, potentially duplicated services, and inefficient use of health system resources, such as high emergency department utilization and other costly and avoidable care.⁹ At the system level, multiple state or county agencies may be simultaneously identifying and intervening with the same high-need individuals but not coordinating services, resulting in less than optimal outcomes for vulnerable individuals and less than optimal use of public resources.

Integrated care systems and global budgets have been held up as holding the most promise of delivery and payment reforms for reducing healthcare expenditures.¹⁰ Examples of integrated care have generally focused on the integration of physician and hospital services or of primary care and specialty services. They have not consistently incorporated the broad range of social services, and thus the term “integrated care” has become too narrow to describe a system that addresses the full spectrum of patient experience and needs.

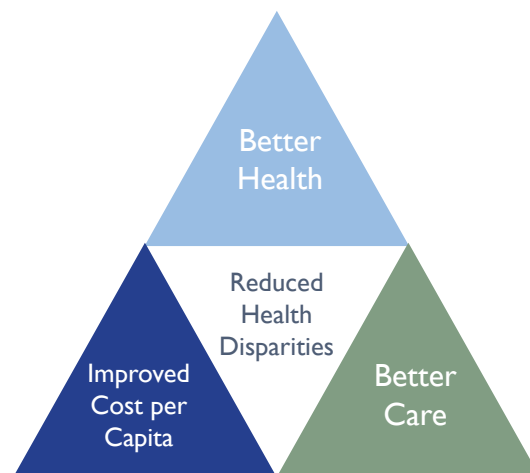


Exhibit 1. The Triple Aim

In this White Paper, we posit that expanding the notion of integration beyond the health sector to include coordination of a broad range of health, behavioral health, and social services holds the most promise for achieving the Triple Aim (depicted in Exhibit 1) of improved health outcomes, improved patient experience, and reduced per-capita costs while also reducing health disparities and optimizing use of public resources.¹¹ We focus on the notion of whole-person care because of its broad application to a diverse range of contexts.

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SECTION III: DIMENSIONS OF WHOLE-PERSON CARE

DIMENSIONS OF WHOLE-PERSON CARE

This section explores how the following six dimensions shown in Exhibit 2 influence and facilitate the ultimate delivery of whole-person care: 1) target population; 2) patient-centered care focused on social, physical, and behavioral needs of the individual; 3) coordination of services across sectors; 4) shared data; 5) financial flexibility; and 6) collaborative leadership. Each dimension can be operationalized differently depending on the needs of a particular population, organizational structure, or other context.

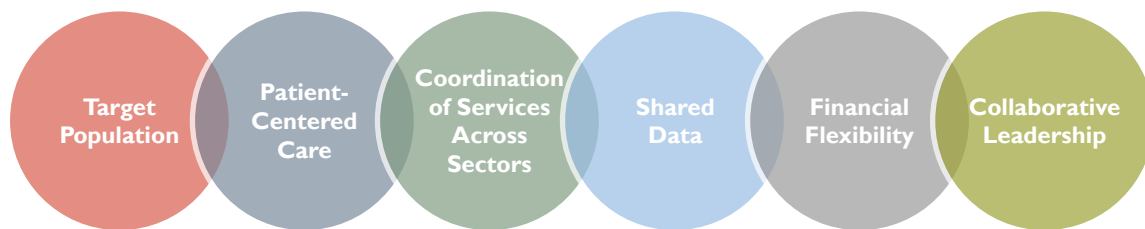


Exhibit 2. Dimensions of Whole-Person Care

Target Population

A key starting point for implementing whole-person care is identifying a target population. One can take either a narrow or a population-based approach to identifying the population. In most narrow approaches, the service model is targeted to a small sub-population—such as those individuals who are deemed high-risk or high-cost—with service needs across physical health, behavioral health, and social services sectors.

Alternatively, recognizing that a large segment of the patient population would likely benefit from improved care coordination across multiple systems, one can apply a whole-person care model to an entire patient population. The patient population can also be further defined at specific levels within or across systems, with three common approaches: the provider-panel level, a health plan service-line level (e.g. individuals who are dually eligible for Medicare and Medicaid), and a community level. Panel-level and service-line level approaches tend to be centered within the health sector. By contrast, in a community-level approach, a county might start with a focus on its entire geographically defined community and attempt to coordinate health, behavioral health, public health, and social services for all individuals in the community. Application of a community-level model generally includes maintaining a focus on traditional public health activities such as disease prevention and health promotion at the broadest levels (e.g. infrastructure, policy, food access, physical activity, etc.). Even with broader population approaches, a more intensive program or intervention for high-risk individuals is frequently embedded in the approach.

Patient-Centered Care

Regardless of target population, the whole-person care model rests on the idea that care needs to be tailored to the individual, taking into account the complex constellation of social, behavioral, and physical health needs a vulnerable individual has in a consumer-centric manner. At the most basic level, “patient-centered” means delivering the right care to a patient at the right time and in the right place. While different systems will call individuals by different monikers—client, patient, customer, consumer—we use the term patient-centered as a key foundational dimension of whole-person care because individuals in need of care are often patients interacting with one or more parts of the health system. This dimension shares many similarities with the notion of patient-centered medical home (PCMH) advanced by the National Committee for Quality Assurance (NCQA) and patient-centered health home (PCHH) defined by Section 2703 of the Affordable Care Act. While not equivalent, having PCMH and/or PCHH services embedded within whole-person care efforts can serve as a proxy for patient-centered care.

While there are multiple ways to provide patient-centered care, there are emerging commonalities across systems that are delivering it. “Patient-centered” often means that the individual—and often, his or her family—is actively engaged in his or her care in an appropriate setting, whether that be a primary care clinic, behavioral health clinic, or homeless shelter. Patient-centered care is also often characterized by multiple providers working with an individual to develop a single, individualized care plan that takes into account the patient’s goals, motivations, and needs across multiple systems. Lastly, individuals may have a designated care manager or care coordinator to support the implementation of the care plan, connect the patient to a range of appropriate services, coordinate multiple services, monitor progress towards care plan goals, and adjust interventions as needed along the way. Research increasingly supports the notion that it is most effective for vulnerable patients to have a designated care manager or care coordinator that works directly with the patient face-to-face in a trusted setting, such as a patient-centered health home.

Coordination of Services Across Sectors

Exhibit 3 depicts the numerous public services and systems that individuals in the safety net might interact with, including physical health (e.g., primary care, specialty care, hospitals), mental health, substance use treatment services, criminal justice, public health, and social services. Social services can include eligibility for Medicaid and other public programs such as the Supplemental Nutrition Assistance Program (SNAP/ CalFresh), Women, Infants, and Children (WIC), or general relief assistance. It can also include direct services, such as housing, foster care, and employment assistance. The degree to which these various systems are communicating and coordinating with one another at the system level represents one aspect of how whole-person care is operationalized at the patient level.



Exhibit 3. Whole-Person Care Model

Coordination between multiple providers and agencies serving a single individual is the key goal in a whole-person care model. Coordination can be achieved through integration and/or collaboration between discrete entities. Integration most often means that all services are delivered by a single organization, at times in a single physical location. Coordination can be achieved through collaboration between discrete organizations that have distinct leaders, goals, budgets, and staff. In a collaboration model or an integration model, there must be a shared goal of coordinated care. Coordination most often includes both relationships and communication between service providers in different arms of a single organization or across different organizations. Coordination tools can include face-to-face meetings, case conferences, shared care plans, and even shared access to client data.

Financial Flexibility

Financial flexibility can support and enhance whole-person care by allowing providers to spend funds flexibly to meet individuals' needs rather than funding requirements of public payers. Public financing for health, behavioral health, public health, and social services are siloed funding streams. These siloes can be further complicated by separate funding streams within the same sector. For instance, Medicaid and Medicare both fund health services for individuals who are eligible for both Medicare and Medicaid (dually eligible, or "duals"). Another example is in many states, substance use and mental health depend on separate funding streams within behavioral health. By design, categorical programs, such as Medicaid, have strict requirements about acceptable uses of funding. While helpful for ensuring dollars are spent on a national priority such as low-income health services, categorical funding also limits flexibility despite evidence that spending in a different way may best meet a patient's need. For example, assisting with paying an electric bill may be the best way to ensure a low-income patient's compliance with a drug regimen requiring refrigerated medication, or providing supportive housing to a homeless patient may be the best way to ensure he does not inappropriately utilize the emergency department.

There are three primary mechanisms used to create the financial flexibility needed to provide whole-person care: 1) capitated payments in health (global or partial capitation), 2) blended funding, and 3) braided funding. Capitation payments can be in the form of global capitation or supplemental per-member-per-month (PMPM) payments—paid on top of capitated or fee-for-service (FFS) rates—that are paid prospectively to providers or risk-bearing entities, to provide a set of defined services to a patient population within a set budget. Global capitation payments can be used more flexibly than traditional FFS payments to offer a broader mix of services that may not be reimbursed on an FFS basis, such as fitness classes, telemedicine, or group visits. In contrast, partial capitation (supplemental) PMPM payments are frequently tied to specific services such as case management, care coordination, or other patient-centered health home activities. If either global capitation PMPM payments or supplemental PMPM payments are generous enough, providers may have sufficient funds to invest in improving care for assigned patients through innovative modalities of care (e.g., patient portals, telemedicine), utilizing non-traditional staff in care delivery (e.g., hiring and training a peer-navigator workforce), delivery system transformation (e.g., PCMH), or other efforts.

The second mechanism to enhance flexibility is blended funding of previously discrete funding streams. Blended funding, such as that being used in state duals demonstrations, refers to when two agencies at any level (e.g., county, state, federal) agree to jointly fund a set of services, and the funds are pooled into a single payment to organizations responsible for delivering or contracting for the delivery of services. Services financed by blended funding could include case management and care coordination within the health sector but could also extend to services such as supportive housing, eligibility and enrollment for public programs, food assistance, or transportation.

The third mechanism is braided funding, whereby two or more agencies jointly pay for a package of services but the funding stream and reporting requirements remain separate. For example, there are multiple examples in California counties where mental health funding is used to pay for staff in primary care clinics to provide integrated behavioral health services.

The Affordable Care Act and prior health reform efforts have introduced a multiplicity of new payment arrangements that create opportunities for using funds more flexibly to provide whole-person care at the provider and managed-care levels. These include varying degrees of capitation as well as access to shared savings if a provider's patient population costs less than a payer expects while simultaneously meeting quality and access targets. Whole-person care is being facilitated by financial flexibility achieved at different levels: at the state level through waivers, Centers for Medicare & Medicare Innovation (CMMI) State Innovation Models and other CMMI demonstrations; at the county level; at the managed care organization (MCO) level; and at the provider level. Regardless of where the flexibility originates, the key is that providers have increased discretion in how to spend funds to optimize outcomes for an individual.

Shared Data

A key dimension of whole-person care is the sharing of data across multiple sectors. There are four major spheres of data that can be shared: eligibility, health, behavioral health (including mental health and substance use), and social services (including utilization of community-based social services such as housing). Due to the siloed nature of health, behavioral health, and social service systems, as well as privacy laws and concerns, each system typically has its own data system, including individual-level demographic information and utilization data that is not or cannot be shared between providers or across sectors. Data is siloed not only between sectors, but also within a sector itself. For example, primary care, behavioral health, hospitals—and sometimes departments within hospitals—may all be working in different electronic health records. Furthermore, some providers may not yet have implemented electronic health records. This separation of data is a barrier to whole-person care because providers may not be aware of care that patients have sought or received elsewhere, resulting in potentially unnecessary duplication of services or care teams spending onerous amounts of time trying to piece together the range of services a patient might have sought. For patients, separation of data can result in having to recount a personal history multiple times and possibly receiving conflicting messages from service providers.

Shared data across sectors could help in providing whole-person care through multiple pathways. First, shared data can be used to target high-need individuals with specific patient-centered interventions. For example, identifying individuals who have high utilization across sectors could result in communication between service providers to establish a shared care plan for identified complex individuals. Second, shared data can allow for coordinating services in real time across entities, such as when a primary care practice is alerted that one of its patients is in the hospital. Third, shared data is needed to test and prove that whole-person care may produce results across multiple sectors. Finally, shared data provides the foundation for implementing braided or blended funding streams or instituting value-based payment systems that reward performance across sectors.

Collaborative Leadership

Collaborative leadership is critical to implementing and addressing all five other dimensions of the whole-person-care model because whole-person care requires meaningful transformation within and across systems. At the conclusion of the large-scale Safety Net Medical Home Initiative project, investigators reflected that of eight key change concepts, engaged leadership was one of two “foundational issues” that “if not addressed first,” made “meaningful transformation difficult at best.”¹⁵ Leadership is critical to create a unifying vision for system transformation focused on addressing the full set of physical health, social, and behavioral issues that impact health outcomes. In addition to shaping a vision for care that addresses social determinants of health, leadership is required to make a compelling case for financial flexibility; foster and maintain relationships across entities that may not have traditionally collaborated; and galvanize time, energy, and resources to identify priority populations and share data. Leadership is also important at multiple levels; for instance, while political leadership can galvanize resources and create vision, clinical leadership within a primary care practice or departmental leadership within a social services agency is essential for implementation of that vision or executing a process redesign.

The initiative to lead multiple systems towards developing whole-person care can come from any agency or entity that has accountability for the target population, including a public hospital or health system; county or state government or agency; a managed care organization or health plan; or a community-based organization. The lead agency inevitably shapes the approach to whole-person care. For example, a public hospital focusing on high-risk individuals may advocate for a cross-sectoral approach upon recognizing that the individuals with high hospital utilization rates are also interacting with behavioral health and social services agencies and even the law enforcement system in significant ways. We label the sixth dimension Collaborative Leadership because regardless of the approach or which agency or entity takes the first step, whole-person care inevitably requires leaders from multiple sectors and at multiple levels of organizations to collaborate toward a common vision and implement change.

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SECTION IV: NATIONAL APPROACHES TO WHOLE-PERSON CARE IN THE SAFETY NET

The following section applies the dimensions of whole-person care to three notable approaches being employed across the country that can be vehicles for delivering whole-person care. Selected duals demonstrations, accountable care organizations (ACOs), and newly emerging accountable care communities (ACCs) highlight efforts in whole-person care at a sub-population level, a patient population level, and a community level, respectively. We have chosen to highlight these approaches because they are national in scope and they share the goal of better coordinating care across sectors to ultimately impact health outcomes. It is also important to note that while we treat each of these approaches distinctly in this review, in practice, these efforts are often complementary and even overlapping. Each subsection summarizes efforts in select states and provides cross-state analysis, with an emphasis on unique or notable ways of addressing certain dimensions of the whole-person care framework.

DUAL-ELIGIBLE DEMONSTRATIONS

Dual-eligible demonstrations represent a vehicle for approaching whole-person care for a sub-population of individuals. Dual-eligible Medicare and Medicaid beneficiaries are among the most complex and costly patients in the health system due to a combination of socioeconomic issues and multiple chronic health conditions. These nine million beneficiaries account for a disproportionate share of spending in both programs, due to their poorer health status and resultant higher use of services as compared to other beneficiaries. The high total baseline costs for these beneficiaries also suggest that the financial benefits of coordinating care may be even greater than for other high-risk safety-net populations. The traditionally siloed Medicare and Medicaid funding streams have the potential to compromise the quality of care for dual eligibles and also limit the incentives for cost-saving innovations, such as interventions that might require investment from Medicaid but result in Medicare savings. In fact, many predict that the majority of savings associated with better care under blended funding streams will come from Medicare Part A, a notion supported by evaluations of precursors to duals demonstrations.¹⁷

Acknowledging these poorly aligned incentives, the Center for Medicare and Medicaid Innovation (CMMI) is accelerating a move toward whole-person care for dual-eligible enrollees through demonstrations in 15 states to design new models to “increase access to quality, seamless integrated programs for Medicare-Medicaid enrollees.”¹⁸ These duals demonstration projects, along with their precursors in some states, represent a move toward more coordinated whole-person care because they are bringing together a previously uncoordinated continuum of providers (primary care, specialty care, behavioral health, community long-term care, home health) employing a strategy of integrated funding streams.

As of January 2014, nine states have finalized memoranda of understanding (MOU) with Centers for Medicare and Medicaid Services (CMS) to implement financial or administrative alignment models that are estimated to encompass over 1.1 million dual-eligible beneficiaries.¹⁹ In seven of nine approved demonstrations, managed care plans will receive capitated payments from CMS for Medicare services and from the state for Medicaid services,²⁰ providing much-needed financial flexibility to care for this complex population. In these demonstrations, managed care plans are paid to coordinate services for beneficiaries

through a person-centered planning process focused on the strengths, needs, and preferences of the individual beneficiary.²¹ While some variation exists, the most common strategies for patient-centered, coordinated care include behavioral health integration, coordination with health home efforts, coordination with long-term care, use of non-traditional healthcare workers, and providing additional services not currently offered to duals in standard benefit packages, such as peer support, home modifications, and non-emergency transportation.²²

Analysis of Model States: Dual-Eligible Demonstrations

This section explores the duals demonstration projects in Massachusetts, Minnesota, and New York because they represent three states that had a history of state-level leadership in providing integrated care for dual-eligible individuals even prior to the CMMI Demonstration. The following section describes the important features of these states' duals demonstration initiatives and how these demonstrations allowing the blending of Medicare and Medicaid funding are further expanding states' commitments to improving whole-person care.

Massachusetts

Massachusetts' duals demonstration program builds upon the state's history of innovative delivery and payment system reforms. Since 2003, Massachusetts Medicaid has partnered with the regional office of CMS in developing a unique partnership to form the Senior Care Options (SCO) plan, which focused on providing comprehensive and coordinated care to the dual-eligible population for the first time. Commonwealth Care Alliance (CCA), a nonprofit, comprehensive care system that was one of three original contractors for the SCO demonstration, has gained national regard for its ability to achieve certain cost and quality targets such as shorter hospital stays, fewer hospital admissions and ED visits, and lower costs and length of stay among the CCA population.²³

Drawing on the SCO experience, Massachusetts was the first state to finalize an MOU with CMS for the CMMI Dual Demonstration program and is distinctive because of its focus on dual-eligible individuals between the ages of 21 and 64 (see additional eligibility requirements in Exhibit 4). MassHealth (the Massachusetts Medicaid program) contracts with three managed care plans referred to as "Integrated Care Organizations" (ICOs). To ensure patient-centered care that is coordinated across multiple sectors, ICOs are required to contract with community-based organizations to provide Independent Living and Long-Term Services and Supports (IL-LTSS) Coordinators who are responsible for enrollees' needs and for coordinating with community-based services, as appropriate.²⁴

Another key feature of the Massachusetts demonstration is its use of combined Medicare and Medicaid funds to pay ICOs a risk-adjusted, capitated rate for providing all the services of Medicare Parts A, B, and D, and MassHealth. ICOs have financial flexibility to use the capitated payments to offer "flexible benefits," as specified by the member's Individualized Care Plan and as medically necessary (see Exhibit 4).²⁵ For example, ICO beneficiaries have access to diversionary behavioral health services—such as clinical support services for substance abuse, psychiatric day treatment, and structured outpatient addiction programs—as well as new community support services not currently available through MassHealth.²⁶

ICOs are given the responsibility and flexibility to negotiate their own contract terms and rates with providers. One strategy for delegating both accountability and flexibility to individual providers is that ICOs, such as Commonwealth Care Alliance, are offering providers contracts that include both a capitated monthly payment as well as risk-sharing agreements in which providers share the full or partial savings/losses related to their assigned enrollees' costs.²⁷ The capitated payment provides flexibility in how providers deliver services, while the risk-sharing agreements incent providers to have financial accountability for beneficiaries' total cost of care in the health system.

Minnesota

Minnesota builds upon a long history of providing whole-person care and blended financing for dual-eligible beneficiaries. In 1995, Minnesota became the first state to obtain CMS approval for a Medicare payment demonstration—the Minnesota Senior Health Options (MSHO) program—that allowed full integration of Medicare and Medicaid managed care contracts and financing to cover primary, acute, and Long Term Support Services for seniors in Minneapolis-St. Paul metropolitan area.²⁸

The MSHO program represents a pioneer effort in integrating care for dual eligibles in Minnesota with the goal of improving beneficiary experiences and addressing administrative efficiencies.²⁹ Minnesota promotes relationships between MSHO plans and providers called Integrated Care System Partnerships (ICSPs). ICSPs' goals are ultimately to coordinate health and community-based services, such as in-home support services, to improve coordination between Medicare and Medicaid services, to help beneficiaries remain in their homes or choice of community settings, and to improve health outcomes in all settings.

While Minnesota's demonstration allows enrollment into MSHO plans to remain voluntary, Minnesota's demonstration will test a whole-person-centered strategy of providing a single set of enrollment materials and an integrated enrollment system in which beneficiaries can use a single form and process to simultaneously enroll in Medicare and Medicaid managed care. Under the demonstration, plans continue to provide Medicare benefits at least equivalent to the basic benefit levels included in Medicare Parts A, B, and D, and Medicaid benefits based on existing Medicaid MCO contracts.³⁰

Minnesota's Dual Demonstration and other reform efforts benefit from a separate State effort to incorporate financial flexibility that also promoted patient-centered care and coordination of services across the system. In 2008, the State implemented a system-wide, multi-payer payment and delivery system reform known as the Minnesota Health Care Home (HCH) program, which pre-dates the Section 2703 Health Homes in other states. The HCH initiative was an early move toward whole-person care. It was designed to incent providers to assume accountability for a patient population while providing supplemental resources to primary care providers for care coordination. PMPM payments were structured in recognition that additional resources would be required to address social determinants of health such as concurrent behavioral health diagnosis and receiving care in a language other than English.³¹ ICSP models will continue to provide supplemental PMPM payments to primary care providers to incent better care coordination. ICSPs will also continue pay-for-performance and risk share and gain with Health Care Home (HCHs) for further integrating primary and long-term care coordination and delivery.

New York

New York has a number of major initiatives underway to care for its dual-eligible population. Although the care for dual eligibles has been largely uncoordinated and paid for on a fee-for-service basis, New York has provided care to some dual eligibles who are over 55 years old through the Program of All-Inclusive Care for the Elderly (PACE) program and Medicaid Advantage programs. Other dual eligibles are part of the partially capitated Managed Long-Term Care Plans, the Personal Care Services, or Home and Community-Based Services (HCBS) waiver programs to provide community-based LTSS.³² In response to the highly uncoordinated nature of and varying coverage rules under each of these programs, through the duals demonstration, New York has decided to enhance one of its Medicaid Advantage programs' service delivery system and benefit package.

New York's demonstration is a three-way contract with CMS and Fully Integrated Duals Advantage (FIDA) Plans, which are Medicare-Medicaid Plans (MMPs) that will provide integrated benefits to dual-eligible individuals. It will test a capitated model for elderly and nonelderly dual-eligible beneficiaries who live in a participating FIDA county and who: a) receive nursing facility services, or b) receive nursing facility diversion and transition home and community-based waiver services, or c) require more than 120 days of community-based LTSS. These individuals represent some of the highest-cost beneficiaries among the already complex and high-cost dual-eligible population, especially in New York, which has one of the highest levels of spending per state resident for long-term care services.^{a,33}

The delivery features, scope of benefits, and ability to use funding flexibly to meet individual needs are components of whole-person care made possible through FIDA plans. A key feature of FIDA Plans is the requirement that they use a patient-centered, Interdisciplinary Team (IDT) approach to providing each participant with an individualized comprehensive care planning process. Under a capitated payment, FIDA plans will be required to provide all medically necessary services under Medicare Parts, A, B, and D, Medicaid, and the 1115(a) and 1915(c) waivers. To address psychosocial needs of patients, FIDA demonstration-covered services also include: non-emergency transportation, nutrition counseling, community integration counseling, home delivered and congregate meals, peer-delivered services, peer mentoring, and wellness counseling. The FIDA plans are also able to use the capitated payment to enhance services with traditionally non-covered items or services at the discretion of the interdisciplinary care team.³⁴ This financial flexibility is balanced with accountability in that New York will employ a capitation rate quality withhold for all FIDA Plans.

Cross-State Analysis: Dual-Eligible Demonstrations

In the following cross-state analysis, we highlight select dimensions of the whole-person care framework that are notable across duals demonstrations (see Exhibit 4).

Collaborative Leadership

While general leadership in launching duals demonstration programs came from the federal government, leadership from states was crucial in pursuing these opportunities provided by duals demonstration grants.

^a \$1,139 per New York resident versus the US average of \$412 per resident.

In particular, collaboration between Medicaid and other state agencies responsible for aging and disability services played an important role both in submitting the grant applications and in creating an environment of collaboration necessary to implement the programs. Furthermore, leadership from health plans at the local level was also critical in exploring and establishing programs along with their community partners.

Target Population and Coordination of Services Across Sectors

Duals demonstrations have variable approaches to target population and degree of coordination across sectors. Although the three states' programs all target duals populations, there are differences in the specific subpopulations these states are focusing on with regard to age (elderly versus non elderly), enrollment criteria (inclusions and exclusions as well as auto-enrollment versus voluntary), geographic focus (statewide versus specific counties), and degree of functional impairment. States also vary in the scope of services provided in the demonstration. To participate in the duals demonstration, states are required to offer a broad package of traditional benefits that includes primary, acute, behavioral health, and long-term supports and services, but have discretion to offer broader benefits to meet the social and medical needs of participating patients. Whereas Minnesota is not changing the standard benefits or services offered in its current program, Massachusetts and New York are requiring a much broader set of medical and non-medical services highlighted in the Service Integration section of Exhibit 4.

Financial Flexibility

All three states have financial flexibility to deliver more coordinated whole-person care through blended capitated rates jointly set by Medicare and Medicaid, which are paid to the managed care entities selected to participate in the duals demonstration. The capitated payments also give the participating plans the flexibility to offer services that have not traditionally been covered by Medicaid or Medicare. For example, care coordinators in all three states will be critical to ensure that dual-eligible beneficiaries are able to receive patient-centered and coordinated services and that patients are connected to newly included community-based services. Although Massachusetts and New York are both implementing a capitated payment at the health plan level, there is still variation in terms of the extent to which plans are aligning incentives with contracted provider organizations. Provider payment strategies to align plan and provider incentives include paying capitation to all contracted primary care and other provider groups, offering health home care coordination payments, pay-for-performance, and risk gain/loss sharing. Aligning incentives between the health plan and provider levels is considered essential to the delivery of whole-person care. For this reason, several states such as Colorado and Oregon have plans to build their duals demonstrations as an extension of their safety-net ACO programs.

Shared Data

Data integration and sharing will be critical for all duals demonstration projects. By virtue of having a single plan financially responsible for claims and encounter data for Medicare and Medicaid services, plans will be able to conduct data analysis of all services provided to an individual, a task which was previously both difficult and costly. It will also be important to monitor how plans share data with providers and how providers share data between entities, given that community-based, LTSS, and health providers coordinate care on behalf of dual-eligible beneficiaries.

While the three states examined above are taking slightly different approaches in their duals demonstrations, these initiatives offer preliminary insights into how state and plan level leadership, selection of target population, patient-centered care strategies, coordination across sectors, financial flexibility, and novel sharing of data create a latticework for providing whole-person care to one complex and costly population. Over time, duals demonstration projects may offer states, health plans, and providers a rich resource for identifying best practices for whole-person care for other high-risk target populations.

Exhibit 4. Comparison of Three State Duals Demonstration Projects by Dimensions of Whole-Person Care

	Massachusetts	Minnesota	New York
Target Population	Non-elderly adult (ages 21-64) dual eligible beneficiaries	Dual eligible beneficiaries (age 65 or older)	Adult dual eligible beneficiaries (age 21 or older)
Estimated number eligible	90,000	36,000	170,000
Enrollment criteria	<ul style="list-style-type: none"> Massachusetts residents eligible for full Medicaid benefits under MassHealth Standard or CommonHealth, and enrolled in Medicare Part A and Part B Without any other comprehensive coverage Not participating in Home and Community Based Services (HCBS) Not residing in an Intermediate Care Facility (ICF/MR) 	<ul style="list-style-type: none"> Currently enrolled or choose to enroll in one of 8 MSHO programs 	<ul style="list-style-type: none"> Entitled to benefits under Medicare Part A and enrolled under Parts B and D, and receiving full Medicaid benefits Reside in one of the eight FIDA demonstration counties, AND: Nursing Facility clinically eligible and receiving facility-based long term support services; OR eligible for the Nursing Home Transition and Diversion Waiver (NHTD); OR Require community-based Long Term Supports and Services (LTSS) for more than 120 days
Geography	8 full counties and 1 partial county	Statewide	8 counties
Coordination of Services Across Sectors	MassHealth and Medicare services Diversionary behavioral health services required	Demonstration will not fundamentally change benefits packages, choice of providers and plans for beneficiaries	Required to provide all medically necessary services under Medicare Parts, A, B and D, Medicaid, and the 1115(a) and 1915(c) waivers
Financial Model	Capitated with savings percentage and quality withhold of 1% of capitated rate that ICOs can earn back for quality outcomes	Not testing a CMS financial alignment model; maintain existing integrated capitated payment and delivery system	Capitated with savings percentage and quality withhold (1% in Year 1, 2% in Year 2, 3% in Year 3) which can be earned back by meeting specified quality measures

SAFETY-NET ACCOUNTABLE CARE ORGANIZATIONS

Safety-net accountable care organizations can represent a vehicle for approaching whole-person care at the provider panel level and the patient population level. The Affordable Care Act's promotion of ACOs has advanced the notion of better coordinating care for a defined patient population with the goals of improving quality and cost outcomes. While originally designed as a delivery system and payment reform model for Medicare populations, ACOs are being adopted in the commercial sector and are emerging in Medicaid. In applying the ACO concept to care for vulnerable populations nationally, terms such as "safety-net ACO,"³⁵ "social ACO,"³⁶ and "TACO" (totally accountable care organization)³⁷ have emerged. These approaches all address the idea that improving health and cost outcomes of vulnerable populations will necessitate incorporating health, behavioral health, and social services³⁸ in the ACO model.

In states with mature Medicaid managed care programs, as well as those with fee-for-service programs, ACOs are being viewed as a strategy to promote critical delivery system transformation, with emerging evidence suggesting their effectiveness in improving quality and controlling costs.^{a,b} There is active ACO formation occurring in at least 19 state Medicaid programs with considerable variability across states.³⁹ Colorado, Oregon, Minnesota, Massachusetts, and Alabama are early pioneers in explicitly promoting the development of Medicaid ACOs on a statewide basis.⁴⁰

Analysis of Model States and Organizations: Safety-Net ACOs

The following section summarizes and reflects on emerging evidence from state Medicaid ACO demonstrations in Colorado, Oregon, Minnesota, Massachusetts, and Alabama across the six dimensions of whole-person care. Refer to Exhibit 5 for a cross-state comparison of these dimensions within each state's ACO program.

Colorado

Colorado is in the early stages of statewide Medicaid ACO development and draws upon the successful network-based model used in North Carolina Community Care.⁴¹ Colorado's Medicaid ACO initiative is also built on its pre-existing medical home model and a statewide data infrastructure. The initiative is implemented through ACO-like Regional Care Collaborative Organizations (RCCOs) designated for each of seven regions across the state. Colorado's ACO demonstration includes a three-layer payment model for participating providers that includes: 1) FFS payments for medical services rendered to enrolled Medicaid beneficiaries, 2) supplemental PMPM for medical home services, and 3) pay-for-performance (P4P) incentive payments for meeting certain quality^c measures.⁴² Both the PMPM for PCMH and the P4P payments represent steps toward financial flexibility at the provider level. Colorado is also cautiously moving toward a shared-risk model with downside risk; House Bill 12-1281, passed in June 2012, established a pilot to test full-risk global capitation with one RCCO in Western Colorado that is comprehensive and integrates physical health, behavioral health, and substance abuse services.⁴³

a Evidence of the effectiveness of fledgling safety-net ACOs is only beginning to emerge, though some of the initial outcomes are promising at both the ACO and the state level. According to Colorado's Accountable Care Collaborative Annual Report (FY2013-14), the RCCO program has shown a 15-20% reduction for hospital readmissions and 25% reduction in high-cost imaging services; a 22% reduction in hospital admissions among RCCO members with chronic obstructive pulmonary disease; lower rates of chronic health conditions relative to clients not enrolled in the RCCOs; a slower rate of emergency room utilization increase by RCCO enrollees; and a \$6 million net reduction in total cost of care (cost avoidance) for clients enrolled in the RCCOs. In Oregon, data from the first nine months of their CCO program show that emergency department use is decreasing, primary care use is increasing, and spending has been reduced. Finally, although Hennepin Health's (in Minnesota) target population is small, they have reaped substantial savings in their first year of operation.

b Measures include reduced emergency room visits, hospital readmissions, utilization of medical imaging, and well-child visits.

c Measures include reduced emergency room visits, hospital readmissions, utilization of medical imaging, and well-child visits.

In terms of target population, enrollment in an RCCO is voluntary, and 47% of Colorado's total Medicaid population was enrolled at the end FY2012-13.⁴⁴ Furthermore, a number of populations, such as dual-eligible beneficiaries and Medicaid managed care clients, are currently excluded from the program. However, all Medicaid expansion populations are enrolled in the RCCOs, and Colorado is also planning to extend the RCCOs to include dual-eligible beneficiaries pending CMS approval.⁴⁵

Colorado's ACO initiative has been acknowledged for investing in shared data and data analytics.⁴⁶ An external contractor aggregates, cleans, and analyzes FFS claims data that is then provided to the state, RCCOs, and providers to identify best practices and opportunities for quality improvement, to conduct cost evaluation, to calculate provider incentive payments, and to eventually provide real-time data for care management.⁴⁷ Even though data sharing and analysis is contained to only health sector data, Colorado's efforts highlight the critical role of data in whole-person care.

Alabama

Alabama's trajectory is similar to Colorado's in terms of building upon pre-existing patient-centered care initiatives in the state. Alabama is building its safety-net ACOs on top of a pre-existing network management pilot that has targeted high-cost Medicaid patients.⁴⁸ In June 2013, Alabama's legislature enacted Act 2013-261,⁴⁹ approving the development of four Regional Care Organizations (RCOs) across the state to manage a continuum of health care services and provide a comprehensive package of Medicaid benefits under a single capitated rate. While there is considerable variation across the four RCOs, the North Alabama Community Care Network (NACCN) in Huntsville is a broad network-based program that exemplifies Alabama's efforts to address whole-person care. NACCN targets services by identifying high-risk Medicaid patients based upon high numbers of hospital admissions and ED visits and by accepting physicians' referrals to the network. Working closely with hospital staff, the Network's case managers, many of whom have training in behavioral health, conduct assessments of health, behavioral health, and social needs in order to assist patients in navigating the health care system and accessing services. NACCN monitors available community resources for addressing social determinants of health and maintains an updated resource guide that care managers use in making referrals to social services such as placement in transitional or permanent housing, vocational training, and enrollment in SNAP.⁵⁰

Massachusetts

Massachusetts is aggressively promoting ACO development in the safety net through its sweeping cost control legislation, Chapter 224, which requires that 80% of MassHealth (the state Medicaid program) beneficiaries (excluding dual eligibles) be in alternative payment contracts by 2015. Chapter 224, passed in August 2012, promotes cost containment, payment reform, and ACO development within MassHealth and among other payers.⁵¹ The legislation is the first step towards risk-based contracting for MassHealth and other payers and emphasizes innovative payment methodologies as a means to reducing costs while enhancing the quality and efficiency of care. The legislation also promotes behavioral health integration into primary care by establishing a Behavioral Health Integration Task Force. Furthermore, the state is expected to require behavioral health integration as part of ACO certification. The Act specifically promotes data integration as a building block for ACOs, requiring providers to implement interoperable electronic health records and a statewide Health Information Exchange by 2017; ACOs and other selected providers must do so by 2016.⁵²

Cambridge Health Alliance (CHA), a system of safety-net hospitals and community health centers in the Boston area serving a large, urban Medicaid population, represents a hospital-led example of a Medicaid organization moving toward coordinated health and behavioral health by implementing many of the dimensions of whole-person care. Cambridge Health Alliance has been actively pursuing ACO transformation since 2008 by building on its patient-centered medical home model.⁵³ In addition to expanding on its existing PCMH model, CHA has also worked to strengthen data capabilities, improve care management infrastructure, and integrate behavioral health into primary care over the past six years. CHA also developed and piloted a global payment model for Medicaid managed care with its former health plan, Network Health. As an early adopter of risk-based contracting within Medicaid, CHA exemplifies how having experience with managing financial risk can facilitate transformation into an ACO.

Oregon

Oregon's movement toward the development of safety-net ACOs was led by Oregon Governor John Kitzhaber. In 2011, with Oregon facing a \$1.9 billion Medicaid budget shortfall, the governor made a bold commitment as part of Oregon's 1115 Medicaid waiver to reduce annual per-capita Medicaid spending growth by at least two percentage points (roughly \$11 billion over the next decade) rather than resort to reduced provider rates or reduced Medicaid benefits. In exchange, Oregon received \$1.9 billion in federal funding over the next five years to implement broad delivery system transformation.⁵⁴ A cornerstone of this transformation was the creation of 16 Coordinated Care Organizations (CCOs), or regional ACO-like entities, receiving global capitation payments and held accountable for the complete physical, mental health, substance abuse, and dental care for the Medicaid population in each of 16 regions.⁵⁵

Oregon's ACO effort is a more comprehensive movement toward whole-person care than the efforts of Colorado and Alabama with respect to target population, patient-centered care, coordination across sectors, and flexible funding. First, CCOs serve approximately 90% of all Medicaid members in Oregon,⁵⁶ including those who are dually eligible for Medicare and Medicaid services.⁵⁷ CCOs assign beneficiaries to state-designated, patient-centered primary care homes in an effort to promote patient-centered care at the individual level. The geographic focus and inclusion of the majority of Medicaid beneficiaries in a region is also resulting in CCOs fostering coordination across sectors to address social determinants of health in an effort to impact health outcomes for safety-net populations. For example, Health Share, Oregon's largest CCO responsible for 40% of Oregon's Medicaid enrollees, regularly convenes county health departments and a social services agency, and is currently exploring coordinating the provision of housing services for select patients.⁵⁸

A key design feature to promote integrated care in Oregon's CCOs is flexible global funding. CCOs receive a global payment covering physical health care, mental health, chemical dependency services, oral health care, covered long-term services, and "other services," the latter of which could be outside the scope of services for which Medicaid typically pays.⁵⁹ Because global capitation enables some flexibility in how funds are spent, Oregon's CCOs offer a broader mix of services than Medicaid managed care plans had previously made available to their enrollees. For example, Governor Kitzhaber has indicated that the global capitation payment could fund an air conditioner that prevents hospitalizations for congestive heart failure.⁶⁰ While

there is local variation among Oregon's CCOs in how they are utilizing this enhanced flexibility, at least one CCO is giving local community health workers, called "health resiliency specialists," a small flexible spending account that they can utilize to fund patients' non-medical needs, such as a refrigerator for medication, in a discretionary fashion.⁶¹ While the global budget allows CCOs flexibility to provide a broader mix of services for their population, CCOs are also expected to extend the concept of financial flexibility to the provider level as they transition from FFS to alternative payment arrangements with network providers over time.

Oregon's efforts represent a comprehensive movement toward whole-person care, with providers, policymakers, and CMS alike watching carefully to see how extending services beyond health ultimately impacts the state's Medicaid cost-control goals.

Minnesota

The state of Minnesota is actively promoting safety-net ACOs through the Health Care Delivery Systems (HCDS) Demonstration pilot and related efforts to promote innovative payment and delivery system reforms. While not part of the HCDS pilot, Hennepin Health is one of the state's most prominent safety-net ACOs and is the result of legislation aiming to pilot payment and delivery system reform in the state.⁶² Hennepin Health is an ACO composed of the county medical center, the county health and human services department, a county health plan, and a federally qualified health center (FQHC). Hennepin Health's vision and initial experience is boldly promoting a national dialogue on a "social ACO" model for addressing social determinants of health and delivering whole-person care to the Medicaid expansion population. The operation of Hennepin County's health and social service agencies within a single system aligns with their vision of highly coordinated services.⁶³ Hennepin's integrated approach builds upon a health home model and intensive high-risk case management for a small cohort of high-risk, high-cost patients. One characteristic of Hennepin Health's integrated approach is a "single accountable individual" taking responsibility for the coordination of services to meet a patient's social, behavioral, and economic needs as well as health needs, in order for health problems to be effectively treated. Hennepin has also implemented a risk-assessment tool that incorporates a wide range of social and behavioral topics, including housing, food security, substance addiction, and mental health; Hennepin plans to utilize this data alongside electronic medical record and claims data to identify patients for participation in high-risk care management, to identify patient needs, and to assess results. While Hennepin has yet to integrate funding streams for behavioral health, health services, and social services in their ACO, their collaborative efforts among social services, behavioral health, and physical health for a small population are catalyzing discussions among other health systems and safety-net ACOs nationally.⁶⁴

Cross-State Analysis: Safety-Net ACOs

In the following cross-state analysis, we highlight select dimensions of the whole-person care framework that are notable across safety-net ACO demonstrations (see Exhibit 5).

Collaborative Leadership

In all of the safety-net ACOs analyzed above, leadership from both the state and local levels was critical to the formation and early direction of ACOs. In Oregon, a waiver and leadership from the Governor's office was crucial in catalyzing safety-net ACO formation. In Alabama, Colorado, Minnesota, and Massachusetts, explicit legislation facilitated the creation of safety-net ACO models. Massachusetts has gone as far as establishing an aggressive goal of 80% of the Medicaid population being served by provider organizations paid through risk-based contracts by July 2015.⁶⁹

The leadership needed for implementation of a whole-person care vision can come from different institutions. In the case of Cambridge Health Alliance, a safety-net hospital galvanized community partners in mental health and other county services as well as its affiliated health plan to implement whole-person clinical and financial strategies within an ACO. In contrast, leadership at Hennepin Health came out of social services to bring together a broad group of county, hospital, health plan, and FQHC executives, resulting in the ACO pursuing a delivery system approach focused on addressing social determinants of health. In Oregon, different CCOs are led by a variety of provider, plan, and community leadership.⁷⁰ For example, in Central Oregon, the CCO is led by a council of equally voting members from the hospital, the health plan, and community providers, whereas in Portland, the largest CCO is led by a managed care organization. In all cases, collaborative leadership at multiple levels was critical in both the visioning and implementation of delivery system transformations that moved closer to whole-person care.

Target Population

The target populations varied in these examples of statewide ACO programs. Colorado and Oregon broadly targeted large segments of their Medicaid populations for initial roll-out of their programs. In contrast, Alabama and Hennepin Health began by managing high-risk populations and plan to extend them to a larger percent of their Medicaid populations. Whether the starting point for whole-person care is broad or narrow, both approaches include stratifying populations to focus service coordination for those individuals who are most in need of whole-person care—those who are at high risk of using social, behavioral, and health services and/or are actively engaged in using services in various systems. Furthermore, in public systems, proving the financial value of whole-person care necessitates focusing on those who are the highest utilizers and highest cost. Even in approaches focused on a narrow population, a distinguishing goal of forming collaborations to deliver whole-person care to one sub-population is to create sustainable system transformations needed to benefit other target populations in the future.

Coordination of Services Across Sectors

There is considerable variation among safety-net ACOs in terms of types and degree of service coordination and the process by which it is being implemented. Service coordination in the Medicaid program is commonly built on the foundation of patient-centered medical homes, high-risk care management programs, and care transition programs. Often, supplemental funding in the form of PMPM payments facilitates the creation of these programs. Although provider groups are generally aware of the broad social and economic needs of their patient population, integration or coordination typically begins within health services, then extends to behavioral health services, and further to social and other human services,

including housing or rental assistance, fuel assistance, and transportation. Cambridge Health Alliance in Massachusetts and the Colorado RCCOs have generally followed this pattern by placing an initial priority on coordinating health services and then behavioral health services within health homes that are embedded in their emerging ACOs. In contrast, even at early stages of development, emerging ACOs in Alabama, Oregon, and Minnesota have designed their scope of services from the outset to extend beyond physical and behavioral health to include a wide range of social services and supports.

Financial Flexibility

Service coordination at the patient level is greatly facilitated—and in many cases made possible by—alternative payment arrangements employed by these ACOs. The ACOs described above are largely paid through global payments or through a shared savings approach, both of which are often combined with pay for performance and/or supplemental PMPM payments for care coordination in health homes. Global capitation payments to ACOs and partial capitation payments to providers allow for financial flexibility, making it possible for ACOs and the providers within them to provide a broader mix of services for their populations than standard fee-for-service payments allow. For example, the ACO demonstrations of Alabama, Oregon, and Minnesota are paying for previously uncovered social services such as temporary housing or rental assistance, home modifications, utility bills, and transportation. Hennepin Health partners voted to use a portion of the ACO’s shared savings to invest in a sobriety center that would help to reallocate resources from health to social services, a decision that would not have occurred in a straight fee-for-service environment. The “bottom line” for emerging safety-net ACOs is that alternative payment arrangements provide financial flexibility to support whole-person care by using health funding to pay for non-medical services that support optimal health outcomes and reductions in total cost of care.

Exhibit 5. Comparison of Six State Safety-Net ACO Programs by Dimensions of Whole-Person Care

	Colorado Regional Care Collaborative Organizations (RCCOs) ⁶⁵	Alabama Regional Care Organizations	Massachusetts Accountable Care Organizations	Oregon Coordinated Care Organizations (CCOs)	Minnesota Integrated Health Partnerships Demo
Target population	Medicaid FFS	High-risk Medicaid population (later expanding to majority of Medicaid)	All MassHealth (Medicaid) beneficiaries	Oregon Health Plan (Medicaid) members	MinnesotaCare (Medicaid) beneficiaries
Exclusions	Dual eligibles, Medicaid managed care	Dual eligible, those in long-term care	Dual eligibles		
Geography	Statewide (7 regions)	Statewide (5 regions)	Statewide	Statewide	Statewide
Coordination of Services Across Sectors	RCCOs and Medicaid contract with primary care to provide comprehensive primary care and coordinate clients' health needs across specialties.	RCOs will manage and coordinate physical health, behavioral health, pharmacy, and long-term care services.	Requires behavioral health integration into primary care in ACOs.	Mix of services includes physical health, mental health, chemical dependency, oral health, some LTC, and other services. Plans must specifically address serious mental illness.	Integrating physical health, behavioral health, and social services.
Financial Model	Three-layer payment model for participating providers, which includes: 1) FFS payments for medical services rendered to enrolled Medicaid beneficiaries; 2) supplemental PMPM for medical home services, and 3) pay-for-performance (P4P) incentive payments for meeting certain quality measures.	RCOs will receive a capitated rate and any shared savings will be managed by the RCO Board. RCOs can pay providers FFS, capitated rates, or through another alternative payment method. ⁶⁶	Some ACOs are being paid by global capitation from a health plan but most are only sharing in savings if global budget targets are achieved. Most provider payments are FFS with PMPM care management payments for primary care providers. Some ACOs are paying primary care capitation and/or sharing savings.	CCOs receive a global capitation payment from Medicaid. CCOs are encouraged (but not required) to use risk-based contracting providers. 2% of the CCOs' budget is withheld and distributed based on performance on 17 quality measures.	Demo sites will receive a global capitation and shared savings after Year 1 based on quality. Providers will continue to receive FFS or MCO contracted payments. Demo sites are encouraged to share gains with providers. ⁶⁷
Data Sharing	Central data repository for State Medicaid and RCCOs; Developing statewide data infrastructure.		Developing statewide Health Information Exchange. Requires providers to have interoperable EHRs.	CCOs must adopt and meet Meaningful Use standards for EHRs and participate in health information exchange.	Participants must submit data to Statewide Quality Reporting and Measurement System.
Legislation (if applicable)	RCCOs established by budget initiative in FY2009-10; House Bill 12-1281 (payment reform pilot to test full-risk global capitation model with RCCO) ⁶⁸	Act 2013-261	Chapter 224 Cost Containment Bill	House Bill 3650 (Health System Transformation) and Senate Bill 1580 (Integrated & Coordinated Care Health Care Delivery System Pilot)	Minnesota Statute 256B.0755 est. Health Care Delivery Systems Demonstration Pilot

ACCOUNTABLE CARE COMMUNITIES

An accountable care community (ACC) is an emerging concept that takes a comprehensive approach to addressing the dimensions of whole-person care by focusing on an entire community. ACCs extend core delivery system transformations, such as those discussed in safety-net ACO and duals demonstrations, to prevention and population-based health approaches in the broader community. While still a relatively new concept, ACCs introduce novel innovations within the whole-person care framework that will be important to watch as they develop further.

ACCs, frequently being launched in tandem with safety-net ACOs, are filling a gap that safety-net ACOs leave: addressing the population health in an entire community. In an ACC, a broad coalition of community stakeholders (e.g., traditional health providers, social services, local government, community-based organizations, employers, faith-based organizations, and others) collaborate in order to set the goals for population health in the specific community and to mobilize community resources, financial support, and collaboration to meet these goals. A key component of ACCs is their emphasis on targeting whole communities defined geographically, or the entirety of a Medicaid-eligible population within a geographic community. ACCs can be distinguished from safety-net ACOs and duals demonstrations in that they serve members of a community, rather than a panel of patients, and they often involve multiple payers. ACCs serving a predominantly Medicaid-eligible population coordinate health services with community resources to address the social determinants of health, such as poverty, unemployment, homelessness, poor housing, neighborhood violence, and other factors.⁷¹

Analysis of Model ACCs

ACCs are emerging in several states, with a few states explicitly supporting their development. In contrast to safety-net ACOs and duals demonstrations, ACCs are in earlier stages of development. In this section, we briefly describe four examples of early efforts to create ACCs in Akron, Ohio; Southwest Washington State; Maine; and Minnesota. While the vision of these ACCs extends the whole-person care concept to an entire community, many aspects of their implementation are yet to be resolved.

Akron, Ohio

Accountable care communities trace their origins to the broader ACO movement, but the most prominent early example was established in 2011 by the Austen BioInnovation Institute (ABIA) in Akron, Ohio. ABIA's emphasis is on leveraging resources from multiple diverse sectors in the community to integrate services across the continuum of care and affect the range of social determinants of health.⁷² The ACC consists of a multi-sector partnership with representation from public health, health systems and safety-net health services, education, employers, the Chamber of Commerce, substance abuse and mental health services, housing groups, transportation groups, economic developers, the faith community, multiple community-based programs, the City of Akron, and Summit County, among others.⁷³

The Akron ACC was launched with an initial grant of \$20 million from the Knight Foundation and therefore was not dependent upon healthcare systems adopting specific public or private payer initiatives.⁷⁴ The Akron ACC started with three major components. The first involves efforts to reduce the risk of diabetes through

weight loss and exercise programs as well as to improve care systems for those community members who already have the disease. In its first 18 months, the initiative saw positive results in terms of weight loss, a 10% reduction in the average cost per month of care for persons with diabetes, and a drop in emergency department visits associated with the condition.⁷⁵ The second component involves a focus on community-based initiatives outside the realm of physical health. Since its inception, ABIA's ACC has collaborated on 1) an initiative to expand transportation options and access to the Cuyahoga Valley National Park; 2) a regional health impact assessment of the Akron Marathon; 3) health education and screening for underserved populations through partnerships with the faith-based community; and 4) exploration of how to increase access to safe places for physical activity and healthy, affordable food options in collaboration with the Akron Metropolitan Transportation System.⁷⁶ The third major component is more traditional ACO development within the broader ACC framework. Summa Health system, a leading partner in the ACC, is in the process of developing their New Health Collaborative ACO for its Medicare Advantage plan, health system employee plan, and Medicare Shared Savings Program (MSSP), and may add commercial plans and Medicaid.⁷⁷

The Akron ACC offers a unique model of whole-person care. First, the ACC has enormous diversity in the collaborating partners involved. The partners include not only multiple layers of political support, traditional health system stakeholders, and behavioral health, but the public health system and community stakeholders whose work, taken together, spans the spectrum of the determinants of health. Second, the ACC success is being measured by health outcomes of the entire population of a defined geographic region (Summit County, OH) rather than only those individuals assigned or attributed to a certain population or payer. This geographic approach to defining a target population means that 80% of all of the county's population are served through participating hospitals, providers, and social service agencies.⁷⁸

Minnesota Accountable Health Model

In early 2013, Minnesota received a \$45 million State Innovations Model (SIM) Testing grant to test and implement an innovative, comprehensive approach to integrated whole-person care.⁷⁹ The core of their proposal is based on the Minnesota Accountable Health Model, which focuses on integrating services for the whole person across the continuum of care, including provider networks and community-based organizations.

The SIM grant will provide funding to establish 15 "Accountable Communities for Health" (ACH) in the fall of 2014 that will integrate medical care with behavioral health services, public health, long-term care, and social services; share accountability for population health; and provide care centered on the needs of individuals and families.⁸⁰ Although leadership can come from a variety of sectors, such as provider groups, social service agencies, and public health entities, ACHs will be required to partner with an ACO. Each ACH will also be tasked with establishing community advisory teams, establishing partnerships with community organizations, identifying priority population health goals and improvement activities, ensuring community leadership/ownership, developing integrated payment models, and effectively engaging consumers. Some of these activities will be carried out by Community Care Teams, multi-disciplinary care teams consisting of clinic, hospital, community, and social services representatives. These Community Care Teams were initially funded through the state's Health Care Homes program and work towards coordination of care across the spectrum, including public health and social services.⁸¹

Minnesota has a comprehensive vision for moving toward whole-person care. The intent of Minnesota's ACH design is to serve geographic communities in regions of the state or a subpopulation within a region. Minnesota also aims to maximize enrollment in ACO models by fully aligning financial incentives across payers. This is particularly important within the state context, given that many of Minnesota's large healthcare delivery systems currently have a diverse mix of commercial, Medicaid, and Medicare patients. Furthermore, as part of the SIM grant, the state is supporting substantial investments in data infrastructure to support the efforts of the ACH and the ACO demonstrations. Although the state agencies are leading this initiative, the State is seeking to galvanize local leadership from diverse stakeholder groups.

While Minnesota is still in the process of determining the mechanisms for program implementation, the state's embrace of the ACC concept acknowledges that the ability of the current ACO to address population health has been underdeveloped thus far. ACOs without broad community support will not reach their full potential, in terms of both enrollment numbers and their ability to address social determinants of health. Community support will be particularly important in engaging social service agency partners with whom ACOs may not previously have had relationships. In planning for the ACH, the state is attempting to support local innovation in its delivery system, which, if successful, can be adapted and spread statewide.

Maine Accountable Communities Initiative

In contrast to Minnesota's approach of building their ACCs on top of their safety-net ACO demonstration, Maine is unique in its approach of using ACCs as a mechanism for launching safety-net ACOs. Through an Accountable Communities Initiative, the Maine Medicaid program (known as MaineCare) has recently introduced safety-net ACOs in the state, which will serve as the lead entity within each ACC. Under a SIM grant, Maine is building on the foundation of its multi-payer PCMH Pilot and MaineCare Health Homes Initiative to form multi-payer ACCs that commit to a set of core measures for public reporting and payment reform efforts.⁸² Maine's ACCs are designed to promote local innovations in the health care delivery and public health systems by harnessing solutions and programs that fit local priorities, resources, and context. The selected provider entities offer a broad mix of services addressing the social determinants of health in specific communities.

Each ACO within an ACC is required to develop partnerships with all the hospitals in their service area, one or more local public health agencies, and other community-based organizations, including faith-based organizations, peer and family support organizations, schools, employment agencies, Area Agencies on Aging, Community Action programs, and food assistance programs, among others. These partnerships are designed to improve transitions of care, address the psychosocial needs of high-cost members, and promote population health.

Maine is building its ACCs on three pre-existing reform initiatives: 1) a multi-payer PCMH pilot, 2) MaineCare Health Homes Initiative (under a 2703 State Plan Amendment), and 3) Community Care Teams (CCTs). The MaineCare Health Homes Initiative is being rolled out in two stages, the first of which focuses on those with two or more chronic medical conditions, and the second of which focuses on Medicaid beneficiaries

with Serious Mental Illness. Another differentiating strategy in Maine's ACCs is the use of CCTs that provide home-based care coordination and care management services to high-risk medical patients who are identified by their number of hospitalizations, ED visits, and costs. CCTs serve patients whose care is paid for through a multi-payer initiative. In addition, Maine is refining its ability to provide CCTs with real-time notification of ED visits, hospital admissions, and discharges.⁸³

ACOs within ACCs were selected at the end of 2013 and will begin operating in May 2014. By bringing together diverse community stakeholders, ACCs will help identified ACOs articulate population-based goals, leverage community resources, and coordinate primary, acute, and behavioral health care as well as community-based long-term care services and supports. The lead entities in five of the six regional ACC leading entities are hospital systems or have significant involvement from hospital partners, while the lead entity in the sixth ACC is a federally qualified health center.⁸⁴ Within the ACC, the ACO is expected to build upon and leverage MaineCare's existing programs for care coordination for members with chronic conditions, behavioral health needs, and long-term care needs. The ACO will be reimbursed based on an FFS basis and will receive shared savings if the ACO meets budgeted total cost of care calculated using MaineCare FFS claims data. The use of upside shared savings is a step toward the lead entities assuming greater shared risk in the future.

Maine's journey toward whole-person care is another example of state leadership's critical role in program formation, both in Medicaid and other state agencies. Maine's journey is also an example of an intensive stakeholder process, both internal and external to the state government. In the process of developing the initial RFP, Maine engaged a broad group of state agencies in their conceptualization of the ACC program. The state then utilized regional forums to gather feedback from healthcare stakeholders on the program model, and also solicited input through monthly meetings with Medicaid beneficiaries. Therefore, Maine's plan for establishing these community-based ACC coalitions already reflects important input from stakeholders who are committed to the delivery of whole-person care. In addition, Maine represents an example of braided funding, with the ACOs receiving shared savings, CCTs' funding through a multi-payer PCMH pilot, and the MaineCare Health Homes Initiative funded through an enhanced PMPM under a 2703 State Plan Amendment.

Southwest Washington Regional Health Alliance

The Southwest Washington Regional Health Alliance is unique because it is an example of a grassroots effort among local community stakeholders to form an ACC. The communities of Southwest Washington came together to form a 501(c)3 organization called the Southwest Washington Regional Health Alliance (RHA), a public-private partnership that is being designed to promote the health of all residents within Clark, Cowlitz, Skamania, and Wahkiakum counties. The alliance formed in 2010 with the goal of creating accountable systems of care, specifically focusing on at-risk, vulnerable populations. The Regional Health Alliance includes a broad range of stakeholders, including Kaiser Permanente, Clark County, Cowlitz County, Skamania County, Wahkiakum County, United Healthcare, Clark College, the Cowlitz Tribe, and others in the region.⁸⁵

The alliance's ACC has three components: 1) health homes, 2) ACOs, and 3) coordination with public health, housing, and other social services. The vision of the ACC is to build on a foundation of Person-Centered Healthcare Homes that provide comprehensive whole-person care. The ACC aims to use ACOs as the organizing infrastructure to help healthcare homes coordinate care with specialists, hospitals, and regional community partners. Through these ACOs, the ACC aims to incent prevention and early intervention for persons with chronic health conditions.⁸⁶

The ACC considers that movement toward payment reform is critical to delivery system transformation, and that without an integrated payment model for Medicaid, it will continue to be difficult to overcome the structural obstacles to collaboration. The ACC is promoting the use of payment models, such as global capitation, that will aid provider groups in achieving better health for the regional population, better care for individuals, and reduced cost through health status improvement.⁸⁷ The State of Washington is concurrently deciding to move to a CCO structure similar to Oregon where CCOs will receive a global capitation payment. In the coming year, the ACC in Southwest Washington faces a key decision about whether to contract with the state as a regional Coordinated Care Organization assuming financial risk, or to act as an advisory body for a health plan that bears the financial risk.⁸⁸ The ACC hopes that their efforts will eventually lead to standardizing payment models, and contract requirements across all payors—health plans (both Medicaid and health exchange plans), counties, health departments, state agencies, and other private funders.⁸⁹ While the ACC is still in its nascent stages, the alliance has created a local framework that is fitting in with the state's movement toward Accountable Care.

The experience of Southwest Washington provides an important local model for ACC development in environments in which the state government does not wish to be a leader in the development of care delivery reforms. Indeed, in the case of the RHA, movement toward an ACC preceded the SIM grant planning process, and local leadership was instrumental in articulating the alliance's vision. This contrasts with the experience of Maine and Minnesota, in which the state assumed a major leadership role in shaping and encouraging the initiatives.

Cross-State Analysis: Accountable Care Communities

In the following cross-state analysis, we highlight select dimensions of the whole-person care framework that are notable across ACC initiatives (see Exhibit 6).

Collaborative Leadership

While still a relatively new concept, ACCs introduce novel innovations within the whole-person care framework that will be important to watch as ACCs develop further. In the examples of Minnesota and Maine, the initial impetus and leadership came from state officials, whereas in Akron and Southwest Washington, local leadership was critical in the planning process. However, both cases assume that the regional ACCs will ultimately foster strong local leadership, rather than relying on state resources and political capital for continued sustainability in the future. Furthermore, because of their broad focus, ACCs are galvanizing leadership from multiple sectors of the community, including local politicians, business, education, public health, health services, behavioral health, and social services. All share the philosophy of local or regional communities being the best incubators and laboratories for reform.

Target Population

By defining the target population broadly as all individuals in a geographic community, ACCs are challenging provider and payer entities to work together towards common goals. However, there are variations among the four models in the target populations served and definition of “community.” Akron aims to serve entire communities or regions defined geographically and is measuring outcomes across the entire county’s population. However, Maine and Southwest Washington are focusing on at-risk and vulnerable populations in order to create systems that address social determinants of health in a more targeted fashion. Southwest Washington is explicit in its desire to prevent certain adverse outcomes in disadvantaged populations, including higher incarceration, problems with public housing, and the rise of certain infectious diseases.⁹²

Coordination Across Sectors

Rooted in a vision for population health improvement at the community level, ACCs are seeking to offer a broader mix of services outside of the traditional Medicaid benefits that address social determinants of health. In order to accomplish this, they are involving a larger number of coordinating partners. By comparison with efforts focused predominantly at the health system level, ACCs are involving agencies such as public health, education, criminal justice, local business, and social services in the formative visioning and implementation stages of ACC initiatives.

Financial Flexibility

ACCs all have different approaches with regard to the implementation of alternative payment arrangements. In Minnesota and Maine, the ACO components of the ACC are expected to be paid through shared savings or global capitation arrangements. In contrast, the state of Washington is moving toward a capitated payment model similar to Oregon’s CCO model, in which the RHA will participate either as a risk-bearing entity or an advisory body to a risk-bearing entity. In all cases, the global capitation is viewed as being essential to providing the flexibility needed to provide whole-person care. Braided funding will also be important, as not all funds needed for whole-person care can be blended into a single capitated rate. At least in the short term, health care services may be largely funded through a global capitated rate, whereas social service funding may be braided with health funding streams to meet community needs in a coordinated fashion.

It will be important to monitor whether these efforts with broad-based leadership and political support are able to differentially promote coordination across sectors to result in greater degrees of whole-person-centered care compared to other efforts designed to generate Triple Aim outcomes for more narrowly defined populations.

Exhibit 6. Comparison of Four Accountable Care Communities by Dimensions of Whole-Person Care

	Akron, OH	Southwest Washington Regional Health Alliance	Minnesota Accountable Health Model	Maine Accountable Communities Initiative
Target population	Residents of Summit County, OH. Approximately 80% of Summit County's population represented through participating partners.	Residents within Clark, Cowlitz, Skamania and Wahkiakum counties, with a focus on vulnerable populations.	Accountable Communities for Health will serve geographic communities in regions of the state or a subpopulation within a region. Special emphasis on vulnerable and rural populations.	Maine Medicaid population receiving full MaineCare benefits.
Coordination of Services Across Sectors	Multi-sector partnership between public health, health systems and safety-net health services, education, employers, Chamber of Commerce, substance abuse and mental health services, housing, transportation, economic developers, the faith community, community-based programs, the City of Akron, and Summit Co.	501c3 organization with representation from a broad range of stakeholders, including Kaiser Permanente, Clark County, Cowlitz County, Skamania County, Wahkiakum County, United Healthcare, Clark College, the Cowlitz Tribe and others in the region.	MN will establish 15 community partnerships to improve population health based on local innovation, needs, and infrastructure. Community advisory partnerships will identify population health goals in their community and improvement activities. These will build upon the state's Community Care teams and work towards coordination of care across the spectrum, including public health and social services.	ACCs will coordinate primary, acute, and behavioral health, and community based long-term care services. ACCs required to develop contractual relationships or informal partnerships with all the hospitals in their service area, public health agencies, and other CBOs including faith based organizations, peer and family support, schools, employment agencies, Area Agencies on Aging, Community Action programs, and food assistance programs.
Financial Model	Launched with an initial grant from the Knight Foundation and Community Transformation Grant from CDC. Participating hospitals and providers receive a share of healthcare cost savings achieved by ACC program. ⁹⁰	Building on PCHH and using ACOs as the organizing infrastructure to help health homes coordinate care with specialists, hospitals, and regional community partners. Moving toward global capitation as part of Washington state health delivery reform efforts.	Focus on reducing costs for high-risk individuals, while moving the state's health system into shared savings and shared risk payment arrangements. Safety-net ACOs within these models will be reimbursed through shared savings or global capitation arrangements.	Provider entities reimbursed based on fee-for-service basis plus shared savings if they meet budgeted total costs of care calculated using MaineCare claims data. Multi-payer health home effort funds care coordinators that serve multiple providers' patients.
Data Sharing	Integrated data platform for confidential sharing of patient data and tools for data analysis and tracking of health outcomes, trends, and costs. Plans to develop an integrated and mineable data warehouse functionality to monitor and report on the health status of the community. ⁹¹		Under the SIM grant, MN is committed to developing a statewide Medicaid ACO warehouse that will provide regular reports to ACOs. MN is also preparing a roadmap for secure data exchange across the health system, social services, and other community organizations.	Health Information Exchange and all-payer claims database established and all hospitals and health plans provide data.

NATIONAL APPROACHES TO WHOLE-PERSON CARE IN THE SAFETY NET

SECTION V: CONCLUSION

CONCLUSION

Health reform has both pushed and facilitated providers to assume increased accountability for addressing the psychosocial needs of their patient populations to optimize health outcomes and ensure efficient public spending. Continued cost pressures on hospitals, counties, and states have increased the demand for accountability for containing health costs and quality outcomes. Simultaneously, health care reform has accelerated the movement toward the delivery of whole-person care by facilitating the emergence of a set of tangible approaches to coordinating physical, behavioral and social service needs for individuals, with duals demonstration projects, safety-net ACOs, and emerging ACCs representing three notable initiatives being pursued across multiple states.

All of these initiatives share the goal of addressing the need for increased accountability for achieving the vision of the Triple Aim. Along with this accountability has emerged a heightened interest in addressing the behavioral health and social needs in concert with individuals' health needs. Service providers caring for vulnerable populations have long recognized that addressing social determinants of health is critical: from housing instability to substance abuse, psychosocial challenges can both be health detriments by themselves and pose barriers to managing chronic conditions. Indeed, acknowledging the importance of addressing social determinants of health, duals demonstration projects, safety-net ACOs, and emerging ACCs are all making strides to better coordinate health, behavioral health, and social services for their target populations. These initiatives also share strategies that relate to whole-person care, including patient-centered health homes, high-risk care management, integration of behavioral health and primary care, and close coordination with social services.

Early results of individual initiatives taking a whole-person care approach show promise for affecting both quality and cost outcomes. Analysis of Colorado's RCCOs in FY2013 found significant reductions in hospital readmissions, slower rate of emergency room utilization increase, and \$6 million net reduction in total cost of care.⁹³ In Oregon, data from the first nine months of the CCO program found that emergency department use is decreasing, primary care use is increasing, and total spending has been reduced.⁹⁴ Although duals demonstrations are too new to have evidence of their effectiveness, evaluations of earlier precursors to the duals demonstrations have shown positive results.⁹⁵ A recent review of evidence of high-cost care management programs in a variety of settings and established by different types of provider groups have shown that at least five rigorously evaluated initiatives have demonstrated a positive return on investment in both cost and quality.⁹⁶ Looking across these initiatives, these early results suggest that whole-person care approaches in a range of delivery system transformations show strong potential to reduce costs while improving quality for vulnerable and underserved populations.

This paper applies a six-dimension framework to summarize and reflect on three notable approaches to delivering whole-person care from across the country. Examining these approaches reveals five major insights for those interested in pursuing or advancing whole-person care.

First, the development of coordinated systems requires collaboration between stakeholders and services across multiple sectors to provide person-centered care. Person-centered coordination will require multiple service providers to collaboratively draw on strategies for engaging individuals as active agents in their care and ultimate outcomes. Clearly identifying the target population is also critical in shaping which social service, behavioral health, and health sector partners are collaborating with one another. While the target population and the local context will vary, broad stakeholder groups that extend beyond health providers are necessary for providing care that addresses the complex array of social determinants of health. These broad coalitions require significant time and resources to develop but are critical to implementing more coordinated, whole-person-centered systems.

Second, high-risk care management is frequently an entry point into whole-person care because high-risk individuals are often interacting with health, behavioral health, and social service systems. Focusing intensive services on a small, high-risk sub-population--such as individuals who are dual-eligible, chronically homeless, or suffer from multiple chronic conditions--allows organizations to build capacity to deliver whole-person care while reducing costs for individuals who have the highest costs in the system. High-risk care management programs can foster the development of necessary infrastructure, such as risk stratification and care coordination programs, that can potentially be extended to the broader population. Successful high-risk care management can also yield savings which can be reinvested in broader population-based efforts to offer whole-person care. Furthermore, a whole-person care approach offers a framework to both achieve the Triple Aim and reduce health disparities due to its focus on socioeconomic and psychosocial issues that contribute to health inequity in a community.

Third, flexible payment methods are a key facilitator for whole-person care. This can be accomplished primarily through two methods: 1) global payment for health that allows using health funding to pay for non-medical services, or 2) braiding funding streams. As shown in the different state examples, safety-net ACO initiatives and duals demonstrations depend on global funding and using health funding to pay for non-medical services. At some point, ACCs may blend discrete health and non-health funding streams into single capitated payments as additional stakeholders join in collaboration efforts to build the health of whole communities. Given the political and administrative difficulties of moving toward fully blended funding streams, braided funding will likely be critical in achieving flexible payment systems in the near term.

Fourth, it is clear that approaches to whole-person care can be combined in mutually reinforcing manners and can provide learning opportunities across whole-person care initiatives. Indeed, vanguard states are not pursuing whole-person care initiatives in isolation but are often weaving multiple demonstrations together under a shared vision of addressing the needs of the whole person. Both Oregon's CCOs and Colorado's RCCOs build on state health home programs and will serve as the delivery system for duals demonstrations. Minnesota's health care home program supports both its safety-net ACOs and its duals demonstration, and all three efforts will be subsumed under an accountable care communities framework with the launch of the State SIM in 2014. Similarly, Maine's ACC initiative builds on a multi-payer health home program and community health teams, and promotes ACOs as a two-pronged strategy for achieving community-level goals.

Finally, committed leadership matters tremendously, though it can come from different sectors. Provider and safety-net hospitals are innovating in the creation of safety-net ACOs, often with underlying political support or pressure. States and managed care plans are taking the lead in implementing duals demonstrations, integrating traditionally disparate health and long-term care funding streams to create incentives for more coordinated care for those eligible for both Medicare and Medicaid. Local political leaders, quality councils, and foundations are spurring innovation and collaboration of a wide range of community partners in emerging ACCs that are promoting collaboration between agencies that did not traditionally work together. To advance whole-person care regardless of the underlying policy environment, sustained leadership is essential to create a unifying vision, bring multiple agencies together, galvanize political will, mobilize resources, and execute implementation of coordination strategies.

This white paper and its analysis of the dimensions of whole-person care has important implications for policy change and local action in the California context. As seen by other state examples, there are a number of different mechanisms for moving policy toward whole-person care at the state level, including waivers, SIM grants, and specific legislation. The movement can also be initiated at the local level, as the experience of some ACCs demonstrates. Regardless of the route taken, stakeholders within counties have an opportunity to explicitly develop and implement a common agenda for whole-person care. A second paper (forthcoming in Summer 2014) will fuse this assessment of national initiatives with research conducted in five California counties to specifically address opportunities and challenges to whole-person care in California's safety net.

As California's health reform efforts proceed forward, local communities will be well-served to build a foundation that can be utilized in the near term and can support future state-level efforts to facilitate whole-person care. California is working towards whole-person care along multiple fronts: California's SIM grant efforts—particularly the health homes and accountable care communities initiatives, the Coordinated Care Initiative (duals demonstration pilot in eight counties), and statewide payment and delivery system reform initiatives in the safety net. Indeed, whole-person care unites many of these efforts as a key strategy for ultimately achieving the Triple Aim and reducing disparities.

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