

**GOING BEYOND COVERAGE  
TO IMPROVE COMMUNITY HEALTH**

**Health Reform Implementation:  
Opportunities for Place-Based Initiatives**

**Issue Brief #1**

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## Going Beyond Coverage to Improve Community Health

### *Health Reform Implementation: Opportunities for Place-Based Initiatives*

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#### **Place-Based Initiatives and Health Reform**

Increasingly, local community, city and county leaders committed to improving health outcomes are focused on “place” and are interested in how they can bring policy, practices and other resources together within neighborhoods and communities to improve the health and well-being of residents. This interest has led to a range of efforts – grouped here as “place-based initiatives,” or PBIs – that seek to strengthen prevention efforts, better integrate and coordinate services and achieve equity across populations. The aim is to create a community environment that promotes and protects health, while also addressing individual needs and choices. With their focus on population health and their roots in community change, PBIs and their champions have much to contribute as the nation takes action to implement health reform. This issue brief is part of a series prepared by the Center for the Study of Social Policy and supported by The California Endowment and its partner, the Community Clinics Initiative, to provide the leaders and advocates of place-based initiatives with the information they need to play a proactive and effective role as health reform unfolds.

#### ***Beyond Coverage***

The Patient Protection and Affordable Care Act (ACA)<sup>1</sup> is perhaps best known for expansion of health care coverage and benefits. However, provisions of the new law go well beyond coverage, seeking to transform health services and interventions in communities nationwide. A number of provisions in the ACA provide significant opportunities for community-, city- and county-level action to improve health across the population, and therefore are particularly relevant for place-based initiatives. These include provisions that focus on:

- (1) Changing community environments to better promote health and prevent disease;
- (2) Serving individuals and families more holistically, including better links between health care and other community services and supports;
- (3) Developing additional health facilities to serve vulnerable populations; and
- (4) Promoting new financing and service delivery structures to create more integrated and cost-effective care.

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Across these and other provisions, the ACA includes at least three types of opportunities for communities and their place-based work:

- New funding, which in some cases is substantial;
- New priorities and framing around health and health care, with greater attention to prevention, coordination and integration, social determinants, equity, and health across the lifecycle; and
- A focus on state and local innovation with an eye toward spreading and scaling effective strategies.

This issue brief provides an initial analysis of these and related opportunities in the Act, with a focus on potential roles and other implications for place-based initiatives and their champions. The provisions are grouped into four broad categories, as noted above. This is by no means an exhaustive list, but rather an initial sampling provided to help make the ACA and its implications for PBIs more understandable, immediate and actionable.

## *1. Changing Community Environments to Better Promote Health and Prevent Disease*

Title IV of the ACA – Prevention of Chronic Disease and Improving Public Health – contains provisions that fit well with place-based efforts to promote health by changing community environments. Several provisions in particular stand out:

### **Prevention and Public Health Fund**

The Prevention and Public Health Fund (Section 4002), which is administered by the Department of Health and Human Services (HHS), provides significant new resources to expand and sustain a national investment in prevention and public health programs. The Fund is intended to support a number of community- and population-focused prevention provisions within the ACA (e.g., Community Transformation Grants and the National Prevention Strategy – see below), as well as other population health programs (e.g., immunization) and public health infrastructure. Thus, these funds have particular relevance for place-based work.

When the ACA was passed, a total of \$15 billion was appropriated for the first 10 years, starting with \$500 million in 2010, and increasing incrementally to \$2 billion per year in 2015, with funding to be maintained at that level in the following years. Some of the Fund's resources, however, have been diverted for other uses. In 2010, a significant portion of the Fund was redirected to support health workforce development; and in February 2012, Congress passed new legislation cutting \$5 billion from the Fund over 10 years – a third of the total originally appropriated – to pay for an extension of the payroll tax cut and to help cover Medicare payments to physicians. Given this history, it will be important for PBIs and community-based prevention advocates to closely monitor maintenance and use of the Fund going forward.

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## Community Transformation Grants

Perhaps the most notable place-oriented provision in the ACA is the new Community Transformation Grants program (Section 4201), which has been funded through the Prevention and Public Health Fund and is administered by the Centers for Disease Control and Prevention (CDC). In many ways, Community Transformation Grants (CTGs) build on the place-based work around the country, focusing on the built environment as well as other social and environmental contributors to health. Specifically, the CTG program provides funding for community preventive health activities aimed at reducing chronic disease rates, preventing secondary conditions, addressing health disparities, and strengthening the evidence base for prevention.

State and local government agencies, Indian tribes, state and local nonprofit organizations, and national networks of community-based organizations are all eligible to apply for CTG funds. For fiscal year (FY) 2012, the CDC awarded approximately \$103 million in CTG program funds to 61 grantees. Of these, 26 were for capacity-building and 35 for implementation. A second round of funding is expected for FY 2013, subject to appropriations.

As outlined by the CDC,<sup>2</sup> grantees are required to develop plans that focus on four types of interventions: policy, environmental, programmatic and infrastructure. (CTG funds are not to be used for direct clinical services.) These interventions, in turn, are expected to produce measureable changes in community health. In general, grantees are expected to target at least a 5% improvement in outcomes at the population level, including 5% reductions in: death and disability due to tobacco use, the rate of obesity, and death and disability due to heart disease.

As administered by the CDC, all CTG grantees are required to address three priority areas or “strategic directions”: (1) tobacco-free living, (2) active living and healthy eating, and (3) evidence-based clinical and preventive services (specifically, prevention and control of high blood pressure). In addition, sites may also choose to address social and emotional wellness, and/or healthy and safe physical environments.

While the total funding for the first year of the CTG program is relatively small compared to original expectations, this program has much to recommend it from the perspective of place-based initiatives:

- First, CTGs are almost a direct match with the priorities of place-based efforts now underway in communities across the country. Like many of these efforts, CTGs focus on helping communities that suffer disproportionate burdens of preventable conditions by going beyond individual behaviors and choices to also address social and environmental contributors to health. The CTG program provides a new source of funding for this work.
- In addition, the CTG program’s dual focus – on both capacity-building and implementation grants – provides the opportunity to simultaneously advance practice and evidence among communities that have already implemented high-quality place-based strategies, while also providing the opportunity for other communities to lay the foundations for future place-based work. For place-based efforts, this means that the “start-ups” don’t have to compete with “super-stars” for funding.

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- Finally, the planning process required for preparing and submitting applications for CTG funding can lay the foundation for future collaboration and effective community prevention – even among sites that do not receive funding through the program. (Unfunded sites could continue collaborative efforts, further refine planning and perhaps undertake limited implementation using existing resources. At a minimum, these sites could maintain infrastructure for collaboration and prepare new applications for the next CTG funding cycle. )

### **National Prevention Council and National Prevention Strategy**

The ACA also created a cross-agency National Prevention, Health Promotion and Public Health Council (Section 4001) charged with identifying and coordinating wellness, health promotion and disease prevention strategies across federal agencies. The Council’s first report, *National Prevention Strategy: America’s Plan for Better Health and Wellness*, provides the framework for a national health agenda that, in the words of the Surgeon General, “will move us from a system of sick care to one based on wellness and prevention.”<sup>3</sup>

The report focuses on four strategic directions for prevention, which are well aligned with the work of PBIs: healthy and safe community environments, clinical and community preventive services, empowered people, and elimination of health disparities.

The *National Prevention Strategy* is particularly useful for PBIs because it assembles in one document the rationale and evidence base for place-based work, a description of the relationship between clinical and community prevention strategies, a strategic set of actions, and key documents that can be used to develop, implement and spread place-based prevention efforts. In addition, the National Prevention Council’s collaborative, multi-agency effort can serve as a model for cross-agency work at the state and local levels.

While it does not provide direct funding to place-based efforts, the Council and its *Strategy* provide one more set of resources that can be used and cited by PBIs to make the case for improved policies, programs and funding. Long term, it is expected that the *Strategy* will be used as a guide for the development of future initiatives supported by the Health and Prevention Fund.

### **Additional Requirements for Charitable Hospitals**

Finally, Section 9007 of the ACA, Additional Requirements for Charitable Hospitals, requires hospitals that qualify under Section 501(c)(3) of the Internal Revenue Code to conduct a community health needs assessment at least once every three taxable years (beginning in March 2012) and adopt an implementation strategy to meet community needs identified through the assessment.

This process must take into account input from people representing the broad interests of the community served by the facility, including those with special knowledge or expertise in public health. In addition, the needs assessment process must be made widely available to the public.

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This section of the ACA also requires tax-exempt hospitals to be transparent with regard to criteria for free care or reduced fees, provide emergency care regardless of ability to pay, and use fair billing and collection practices.

Section 9007 was included in the ACA to address concerns that tax-exempt hospitals are not fulfilling their “charitable missions,” broadly defined as community benefits to promote health.<sup>4</sup> Nonprofit hospitals failing to comply with these requirements risk revocation of their tax-exempt status. In addition, nonprofit hospitals that fail to meet the community health needs assessment requirements are subject to a \$50,000 excise tax per year per noncompliant facility.<sup>5</sup>

The new needs assessment requirements provide an opportunity for PBIs and their community partners to help identify unmet needs and service system gaps in the communities they serve. In addition, PBIs can play a role in both planning and monitoring the resulting implementation strategy. In some communities – such as Montgomery County, MD and Hartford, CT – nonprofit hospitals are collaborating with each other and working with their local public health and human services departments to produce one community-wide assessment. This sets the stage for community-wide action that might be integrated or aligned with ongoing place-based work.

## *2. Serving Individuals and Families More Holistically, Including Better Links Between Health Care and Other Community Services and Supports*

The ACA includes a number of provisions that support more holistic approaches to health and related services, focusing on the “whole person” or “whole family.” These provisions promote better coordination across health care services and between health care and other community services and supports. Four provisions are of particular note:

### **Health Homes for Enrollees with Chronic Conditions**

The state option to provide Health Homes for Enrollees with Chronic Conditions (Section 2703) provides enhanced federal funding for states choosing to expand or implement a “health home” initiative for Medicaid enrollees with chronic conditions. The health home approach is designed to focus on the “whole person,” better integrating physical and mental health care and better linking enrollees to additional services and supports in their communities.

Since January 1, 2011, states have been able to apply to the Centers for Medicare and Medicaid Services (CMS) for up to \$500,000 for planning activities related to the development of a health home initiative.<sup>6</sup> States can use these funds to develop a State Plan Amendment (SPA) to provide health home services. As a further incentive, the ACA authorizes a 90 percent federal match rate for the six specified health home services during the first eight quarters after a state’s health home SPA is approved.

The six specific services that are eligible for an enhanced federal match and that health homes must provide include: comprehensive case management, care coordination and health promotion, transitional

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care, patient and family support, referral to community and social support services, and the use of health information technology, as appropriate.

Eligible enrollees include children or adults who have: two or more chronic conditions, one chronic condition and are at-risk of another, or one serious and persistent mental health condition.

States have a lot of flexibility in defining who can provide health home services and what services are covered. First, they have the opportunity to choose among three health home provider arrangements: (1) a designated provider, (2) a team of health care professionals that links to a designated provider, and/or (3) a health team. In states offering more than one arrangement, enrollees may choose among them. States are also given leeway to expand on the ACA's fairly extensive list of potential "designated providers." Finally, while the Act identifies six specific eligible chronic conditions as a starting point (asthma, diabetes, heart disease, obesity, a mental health condition or a substance abuse disorder), states may elect to target only one or a few conditions and can also target populations "with higher numbers or severity of chronic or mental health conditions."<sup>7</sup>

As states shape their health home plans, PBIs and their community and county partners have an important role to play, identifying chronic health needs in their communities and advocating for populations that might otherwise be overlooked. Children and youth in particular might be overlooked if plans are targeted to enrollees with "higher severity" or to chronic conditions more prevalent among adults.

Place-based initiatives can also weigh in on the potential for community-based organizations and providers to be "designated providers" in their state's health home plan. Finally, once health home initiatives are in place, counties and communities have a role in connecting eligible individuals to a health home so that they can benefit from this more comprehensive and holistic approach to care.

### **Community Health Teams to Support the Patient-Centered Medical Home**

In a companion piece to the health home provision, the ACA authorizes funding to states or their designees to establish Community Health Teams to Support the Patient-Centered Medical Home (Section 3502). Community Health Teams (CHTs) are community-based interdisciplinary teams comprised of a variety of health care providers intended to provide support services and funding (through capitated payments) to primary care practices serving as health care homes. The ACA spells out a broad array of requirements for CHTs, stressing strong linkages to non-clinical community services to improve health. The ACA requires CHTs to provide services to individuals with chronic conditions who are eligible for health homes as described above.

CHTs are specifically required to provide, among other things, the support necessary for local primary care practices to "establish a coordinated system of early intervention and referral for children at risk of developmental or behavioral problems, such as through infolines, health information technology, or other means as determined by the Secretary."<sup>8</sup> The reference to "infolines" highlights the value of centralized referral and linkage systems, which are shared resources that can efficiently and effectively serve whole communities. Thus, this provision not only supports individual primary care practices but also promotes the development of community systems to enable more holistic care across populations and communities.

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Funding for Community Health Teams is not assured. However, at least one state, Vermont, has proceeded to fund and implement its own CHT initiative with very promising early results. Place-based initiatives in counties and communities nationwide can both monitor the progress of states such as Vermont and begin to advocate for similar initiatives within their own states.

### **Maternal, Infant, and Early Childhood Home Visiting Program**

The Maternal, Infant, and Early Childhood Home Visiting Program (Section 2951) provides substantial new funding to states and Indian tribes to promote maternal health and healthy development among children and families living in at-risk communities. The program is particularly noteworthy for its use of evidence-based home visiting programs, emphasis on collaboration across health and other service systems, and focus on multiple outcomes related to healthy pregnancies, and healthy child and family development. The federal Home Visiting Program builds on the work of initiatives across the country, combining a focus on early childhood systems with a focus on place.

The federal program is funded at \$1.5 billion over five years (starting with \$100 million in FY 2010, increasing to \$250 million in FY 2011 and \$350 million in FY 2012, and leveling off at \$400 million in each of the last two years, FY 2013 and FY 2014). To receive funding, states are required to conduct a statewide needs assessment to identify at-risk communities and to assess the current status of home visiting programs in the state. Core funding has been awarded on a categorical basis to states, and additional funds have been awarded on a competitive basis to focus on innovation. In addition, a maintenance of effort requirement ensures that ACA Home Visiting funds are used to expand services and do not supplant existing funding.

While federal funds are awarded to the states (and more specifically to state Maternal and Child Health Programs),<sup>9</sup> implementation requires a true partnership between states and communities. States provide services and supports to specific communities based on a competitive process that looks at community needs as well as plans and capacity to address those needs effectively.

The ACA outlines three purposes for the Home Visiting Program:

- To strengthen and improve home visiting programs and activities carried out under Title V of the Social Security Act,
- To improve coordination of services for at-risk communities, and
- To identify and provide comprehensive services to improve outcomes for families who reside in at-risk communities.

In addition, the Act identifies an ambitious set of benchmarks to demonstrate improvements for participating families. These include:

- Improved maternal and newborn health,
- Prevention of child maltreatment and related reduction in emergency department visits,
- Improvement in school readiness and achievement,
- Reduction in crime or domestic violence,

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- Improvements in family economic self-sufficiency, and
  - Improvements in coordination and referrals for other community resources and supports.

For place-based initiatives focused on early childhood health and development, the Home Visiting Program provides an important new opportunity to build on work to date. More specifically, the Home Visiting Program provides the opportunity to:

- *Spread and Scale Evidence-Based Home Visiting Models.* As stipulated in the ACA, the program identifies effective, evidence-based home visiting models and provides the funds to implement and spread those models in communities across the country.
- *Lift Up Promising Models.* While most of the home visiting funds will go to a small set of designated evidence-based programs, up to 25 percent of state funds can be used for “promising and new approaches” (with the requirement that these be further evaluated to build a larger evidence base). This provides an opportunity for locally developed home visiting programs to be more broadly recognized and replicated; and more immediately, provides additional funding for implementation.
- *Integrate New Home Visiting Models into Existing Local Service Systems.* Ultimately, the impact of the new Home Visiting Program will depend on the extent to which it can be incorporated as one component of a larger system of care. At the community level, local PBIs can play a crucial role in helping the new home visiting programs coordinate with other resources in the community so that they become part of a seamless system of community services and supports for pregnant women, young children and their families.
- *Strengthen State and Local Service Systems.* While the Home Visiting Program’s required benchmarks are largely focused on outcomes for individual participants, the benchmark focused on “improvements in coordination and referrals for community resources and supports” provides an opportunity for communities and states to strengthen systems serving pregnant women, young children and families. For example, Home Visiting funds could be used to develop a centralized intake and referral system for home visiting services (combining existing and new services) and these same funds could be leveraged to build or further develop centralized referral and linkage systems that go beyond home visiting.

## **Navigators**

Finally, the ACA supports a more holistic approach to assuring health coverage by requiring every state to fund health insurance Navigators (Section 1311) by 2014. The role of the Navigators is to help consumers obtain coverage through the state’s Health Insurance Exchange, a new “health insurance marketplace”<sup>10</sup> created by the ACA that is designed to offer a range of affordable, quality insurance coverage options to individuals and families.

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Like other aspects of the ACA, the Navigator provision helps to move the nation toward a “culture of coverage” – that is, a nation where coverage is the norm across all populations, including those most often excluded.

The Navigators’ roles include providing the following in a manner that is both culturally and linguistically appropriate for the populations served:

- Providing public education campaigns to inform people about health plans available through the state’s Exchange,
- Distributing fair and impartial information regarding those plans and the availability of premium tax credits and cost-sharing reductions, and
- Facilitating enrollment in plans.

It is anticipated that the majority of people enrolling through the Exchanges will have previously been uninsured. In addition, in comparison to those who are currently covered by private insurance, people enrolling through the Exchanges are likely to be more racially and linguistically diverse, have lower incomes and have less formal education.<sup>11</sup>

Place-based initiatives that serve this population and have a strong resident engagement component are well suited to take on a Navigator role. In addition, since PBIs generally include a focus on linking community residents to needed services and supports, the Navigator role might well be integrated with other efforts to connect residents to community resources. The ACA lists a wide variety of groups that could serve as Navigators, including “community and consumer-focused nonprofit groups,” among others. This provides an important opportunity for PBIs and their community partners.

Community and consumer-focused nonprofit groups that are part of PBIs, in particular, will likely want to explore opportunities for funding to become Navigators in their communities. In addition, PBIs and their partner organizations can weigh in on how state Exchanges – which are responsible for funding and managing the Navigator system – set up their Navigator programs.

### ***3. Developing Additional Health Facilities to Serve Vulnerable Populations.***

In addition to expanding Medicaid coverage for adults, requiring the development of Health Insurance Exchanges, and requiring adults to secure coverage, the ACA also provides significant funding to create new health service providers, particularly in underserved areas.

#### **Community Health Center Trust Fund**

The ACA establishes a Community Health Center Trust Fund and commits \$9.5 billion to that fund over five years (\$1 billion in FY2011, \$1.2 billion in FY2012, \$1.5 billion in FY2013, \$2.2 billion in FY2014, and \$3.6 billion in F2015). In addition, the ACA permanently authorizes the health center program (Public Health Service Act, Section 330) and provides an additional \$1.5 billion for health center construction and renovation. Under these provisions, it has been estimated that federally qualified health

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centers (FQHCs), which include community, migrant, public housing, and homeless health centers, could provide medical homes to as many as 20 million currently uninsured people.<sup>12</sup>

Since FQHCs currently receive funding from appropriations within the overall federal budget, this funding was designed to expand federally qualified health centers to additional underserved areas. However, under the current deficit reduction climate in Washington, existing funding for FQHCs could be cut back substantially and the overall net effect of this funding commitment reduced. The President's proposed 2013 budget, for instance, has a net effect of increasing Community Health Center funding by only \$200 million, with most of the Trust Fund in the ACA used to supplant current funding within the federal budget.

### **School-Based Health Center Capital Program**

The ACA also establishes a School-Based Health Center Capital Program for the establishment or capital improvement of school-based health centers, with funds available for construction, expansion, and equipment. This program will provide \$50 million for each of the federal fiscal years 2010, 2011, 2012, and 2013. In July, 2011, HHS announced awards totaling \$95 million to 278 grantees for a two-year period (July 2011- June 2013). Preference is given to school-based health centers that serve a large population of children eligible for Medicaid, CHIP and similar programs. Since this funding can only be used for facilities, equipment and similar expenditures, the funded school-based health centers will need to secure other resources for ongoing operational costs. This section of the ACA also provides for grants for operational funding, but the Act doesn't allocate any funds for that purpose.

For FQHCs and school-based health centers (SBHCs), the goal is to provide health services that will be available to individuals, families and youth in a community, who otherwise might not be able to access health services or receive care in a setting that is culturally or linguistically appropriate for their needs.

FQHCs and SBHCs currently serve an important function as key safety net providers nationwide and they are expected to play an even more prominent role as health care reform is implemented. In the case of FQHCs, new coverage for low-income, previously uninsured populations will change financing for current patients. At the same time, fewer options for the uninsured may result in a net gain of patients without coverage.

Regardless of changes in financing and patient population, both new and long-standing health centers are natural allies with place-based efforts to improve health. Historically, health centers have been rooted in the communities they serve (as reflected in federal regulations requiring substantial representation of community residents on health center governing boards). In addition, health centers often serve as hubs for community health initiatives and activities that go beyond clinical care. In the case of SBHCs, there is a ready-made opportunity to link clinical care with broader school-based efforts to improve health (for example, through changes in school lunch menus, physical activity opportunities, anti-bullying campaigns, etc.).

PBIs that include health centers as active partners can work with the centers to assure that community residents are linked both to clinical care and broader community-based efforts to promote health, and they

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can further develop the capacity of health centers to serve as hubs for community health promotion and prevention. PBIs can also serve as advocates for health center funding and expansion as the centers work to meet the needs of the newly insured and the uninsured.

#### **4. Promoting New Financing and Service Delivery Structures to Create More Integrated and Cost-Effective Care**

The ACA includes several provisions designed specifically to foster state and community actions to redesign health services, particularly through changes in the way health care is organized and financed, with specific emphasis on reducing costs while improving quality of care.

##### **Accountable Care Organizations**

Accountable Care Organizations (ACOs) are new service delivery structures that bring together a network of primary care providers, specialists, hospitals and other providers to deliver a continuum of care to a defined population. Key ACO elements include: delivery system changes to promote better collaboration and integration of care, payment reform (such as shared savings), and performance measurement (focused on monitoring quality and cost for a defined population).<sup>13</sup>

Among the ACA provisions that promote the development of ACOs are the Medicare Shared Savings Program (Section 3022), which supports development of ACOs for the elderly; and the Pediatric Accountable Care Organization Demonstration project (Section 2706), which focuses on children enrolled in Medicaid and is scheduled to begin in January 2012 and end December 2016.

There is a great deal of discussion and activity around the development of ACOs, both among states and health care providers (ranging from primary care practices to hospitals). States such as Colorado, Massachusetts, Minnesota, North Carolina, Oregon, Vermont and Washington are developing data systems, building on earlier ACO pilots and demonstrations, convening stakeholders to design and promote new payment methods, shaping regional systems of care through contracts and provider education, and incorporating patient-centered medical homes as key building blocks in the development of community or region-wide ACOs.<sup>14</sup>

Many of the principles behind the development of ACOs are consistent with those of PBIs, including: promoting coordination across service providers, developing high-quality systems of care, focusing on a defined population, and providing payment based on quality and outcomes rather than on service quantity and intensity. In addition, ACOs have the potential to develop new, shared community resources for referral, linkage, and care coordination.

Place-based initiatives will likely want to closely monitor state actions related to ACOs as well as the development of ACOs in their local communities. PBIs can work to assure that ACOs help community residents: (1) access services and supports beyond medical care and (2) have an opportunity to inform and help shape ACO design to serve their needs. In particular, community stakeholders will want to make sure

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that ACOs are designed to incorporate rigorous quality monitoring and include protections for consumers (such as freedom of choice to participate in the ACO, and the right to appeal or to a medical second opinion). In addition, some PBIs may want to actively promote the development of ACOs and perhaps become the center or hub for the community components of an ACO.

### **Center for Medicare and Medicaid Innovation**

The ACA has established an important new unit at the Centers for Medicare and Medicaid Services: the new Center for Medicare and Medicaid Innovation (Section 3021), which is funded through a \$10 billion appropriation over 10 years, for fiscal years 2011 through 2019.

This new center – CMMI – was developed to test a broad range of innovative payment and service delivery models with the goal of reducing costs while also maintaining or improving quality of care. While the immediate focus is on innovations for Medicare, Medicaid and CHIP (Children’s Health Insurance Program), the Center’s broader mission is to help transform the health care system for all Americans.

CMMI uses a four-step approach to achieve its goals: (1) soliciting ideas for new models through its website and through open-door forums, (2) selecting and further developing promising models (again with stakeholder input), (3) testing and evaluating models through “Innovative Partnership Opportunities” (including competitive grant opportunities), and (4) spreading successful new models through a variety of approaches, including formal rule-making. There is an emphasis on rapid turn-around in testing, evaluation and spread.

As noted on the CMMI website, the Center’s work is organized around three types of innovation models:<sup>15</sup>

- *Patient care models* – to improve care for patients and develop ways to make care safer, more patient-centered, and more effective,
- *Seamless coordinated care models* – to develop new models that make it easier for health practitioners to work together to care for a patient, and
- *Community and population health models* – to keep families and communities healthy by strengthening public health and exploring underlying drivers of health.

CMMI has already developed a number of specific demonstration programs to support innovation, including:

- A state demonstration to design programs that integrate care for dual-eligible individuals (Medicaid and Medicare), with awards to 15 states of up to \$1 million each;
- An FQHC advanced primary care practice demonstration project to test the effectiveness of health teams working with Medicare patients;
- A multi-payer advanced primary care demonstration project, with eight states participating in providing medical homes in an integrated way through Medicare, Medicaid and private health plans;

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- A pioneer accountable care organization demonstration project, focusing on Medicare recipients; and
  - A bundled payment for care improvement demonstration.

The emphasis to date has primarily focused on clinical care for Medicare and Medicaid adult populations with chronic care needs; however, additional demonstrations could have a greater focus on children and families, and on population and community health models.

The development of CMMI has important implications for place-based initiatives, providing an opportunity to further develop, test and spread local and innovative clinical, care coordination and community health models. The CMMI website includes a call for innovative ideas and an opportunity for individuals and organizations to share their own models. PBIs can offer their ideas to CMMI via its website. In addition, PBI leaders and their county and community partners will likely want to monitor CMMI funding opportunities, and consider submitting proposals to test new care and community health models as these opportunities become available. Finally, in sites where CMMI models are being tested, PBIs and their community partners will likely want to track implementation to assure adequate consumer protections and quality monitoring.

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## Take-Away Messages for Place-Based Initiatives and Their Partners

The ACA presents important opportunities to build on current place-based strategies to significantly improve the health of communities. Neighborhood, city and county leaders committed to place-based approaches, might use the following as starting points for integrating ACA opportunities with place-based work:

- (1) Define the changes to health service delivery, systems of care, and community environments that would be most effective at the community level to improve the health of children, families, low-income populations, boys and men of color, and other populations of particular interest.** These might include:
  - Establishing health homes for all, including children, youth, families and individuals;
  - Creating additional hubs of activity around wellness (including through school-based health centers and federally qualified health centers);
  - Getting good referrals and follow-up responses to child and family needs identified in the practitioner's office, including care coordination, home visiting and other family support services;
  - Embedding individual programs such as home visiting into broader systems of care and support;
  - Ensuring that individuals and families are able to "navigate" coverage options and obtain the best match for their coverage needs;
  - Ensuring that preventive, medically necessary and emergency care are financed and readily available;
  - Creating a system of response to individual and family needs that improves healthy development and promotes innovative practices and financing structures that can be used to foster this development; and
  - Creating community environments that promote and protect health and that make it easier for individuals to make healthy choices.
  
- (2) Develop an ACA Action Agenda by crosswalking these desired changes and related place-based priorities with opportunities provided by the ACA**
  - Each community will need to decide which ACA opportunities fit best with local resources and needs.
  - Focusing first on opportunities that are most winnable or attainable will help build the momentum and relationships needed for future success.
  
- (3) Develop and strengthen partnerships at the local, state and national levels to advance the community-specific, place-based ACA Action Agenda. Potential actions might include:**
  - Participate in the planning and implementation around specific ACA provisions, such as home visiting, Community Transformation Grants and community needs assessments.
  - Work with federally qualified health centers, school-based health centers, and other safety net providers at the local level to determine how they might expand their roles as hubs for community health and how they can draw on federal, state, and community resources to do so.
  - Weigh in with ideas for innovation to the CMS Center for Innovation, members of Congress, and state and county government that meet the particular needs of place-based efforts to improve health.
  
- (4) Look for opportunities to coordinate actions with other place-based initiatives as a learning community and as an advocacy voice for further federal actions to support place-based efforts to improve health.**

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## Endnotes

<sup>1</sup> Patient Protection and Affordable Care Act (Pub.L. 111-148), as amended by the Health Care and Education Reconciliation Act (Pub.L. 111-152).

<sup>2</sup> CDC. Public Prevention Health Fund: Community Transformation Grant - Revised Full Funding Opportunity Announcement (FOA), May 15, 2011, Accessed at: <http://www.cdc.gov/communitytransformation/>

<sup>3</sup> *National Prevention Strategy*. [www.healthcare.gov/prevention/nphpphc/strategy/report.pdf](http://www.healthcare.gov/prevention/nphpphc/strategy/report.pdf).

<sup>4</sup> Marietta, Cynthia S (July 2010). PPACA's additional requirements imposed on tax-exempt hospitals will increase transparency and accountability on fulfilling charitable missions. *Health Law Perspectives*. University of Houston Law Center, Health Law and Policy Institute.

<sup>5</sup> Davis C (July 2011). Nonprofit Hospitals and Community Benefit. Issue Brief. National Health Law Program. [http://www.healthlaw.org/images/stories/2011\\_07\\_08\\_Nonprofit\\_Hospitals\\_and\\_Community\\_Benefit.pdf](http://www.healthlaw.org/images/stories/2011_07_08_Nonprofit_Hospitals_and_Community_Benefit.pdf)  
[http://www.law.uh.edu/healthlaw/perspectives/2010/\(CM\)%20Charitable.pdf](http://www.law.uh.edu/healthlaw/perspectives/2010/(CM)%20Charitable.pdf)

<sup>6</sup> States can apply for use of up to \$500,000 in Title XIX funds at the State's pre-Recovery Act medical assistance service match rate

<sup>7</sup> CMS Guidance, November 16, 2010: <http://www.cms.gov/smdl/downloads/SMD10024.pdf>

<sup>8</sup> Office of the Legislative Council, US House of Representatives (May 2010). *Compilation of Patient Protections and Affordable Care Act*. <http://docs.house.gov/energycommerce/ppacacon.pdf>.

<sup>9</sup> Section 2951 of the ACA amends Title V of the Social Security Act by adding a new Section 511, entitled "Maternal, Infant, and Early Childhood Home Visiting Programs."

<sup>10</sup> Community Catalyst (June 2011). *Navigators: Guiding People Through the Exchange*. [http://www.communitycatalyst.org/doc\\_store/publications/Navigators\\_June\\_2011.pdf](http://www.communitycatalyst.org/doc_store/publications/Navigators_June_2011.pdf).

<sup>11</sup> Henry J. Kaiser Family Foundation (March 2011). *A Profile of Health Insurance Exchange Enrollees*. Accessed October 9, 2011 from [www.kff.org/healthreform/8147.cfm](http://www.kff.org/healthreform/8147.cfm).

<sup>12</sup> Hawkins D, Groves D (2011). The Future Role of Community Health Centers in a Changing Health Care Landscape. *J Ambulatory Care Manage*, 34(1): 90-99.

<sup>13</sup> Purington K, Gauthier A, Patel S, Miller C. (February 2011). *On the Road to Better Value: State Roles in Promoting Accountable Care Organizations*. National Academy for State Health Policy. [www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2011/Feb/On%20the%20Road%20to%20Better%20Value/1479\\_Purington\\_on\\_the\\_road\\_to\\_better\\_value\\_ACOs\\_FINAL.pdf](http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2011/Feb/On%20the%20Road%20to%20Better%20Value/1479_Purington_on_the_road_to_better_value_ACOs_FINAL.pdf)

<sup>14</sup> Ibid.

<sup>15</sup> Center for Medicare and Medicaid Innovation. *Our Team*. Accessed October 9, 2011 from <http://innovations.cms.gov/about-us/our-team/>.

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## About this Brief

This brief is one in a series exploring health reform implementation opportunities for place-based initiatives (PBIs). It is part of a broader project at the Center for the Study of Social Policy that explores how PBIs can advance implementation of health reform and how health reform implementation can further the work of PBIs. The California Endowment and its partner, the Community Clinics Initiative, have provided generous funding for this project.

**The Center for the Study of Social Policy (CSSP)** seeks to secure equal opportunities and better futures for all children and families, especially those most often left behind. Based in Washington, DC, with strong ties to communities and policymakers nationwide, the Center's work focuses on three broad areas: system reform, public policy and community change. Underlying all of CSSP's work is a strong commitment to racial equity.

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