

Section 5: Navigating Health Care Industry Partners as You Build Collaboration



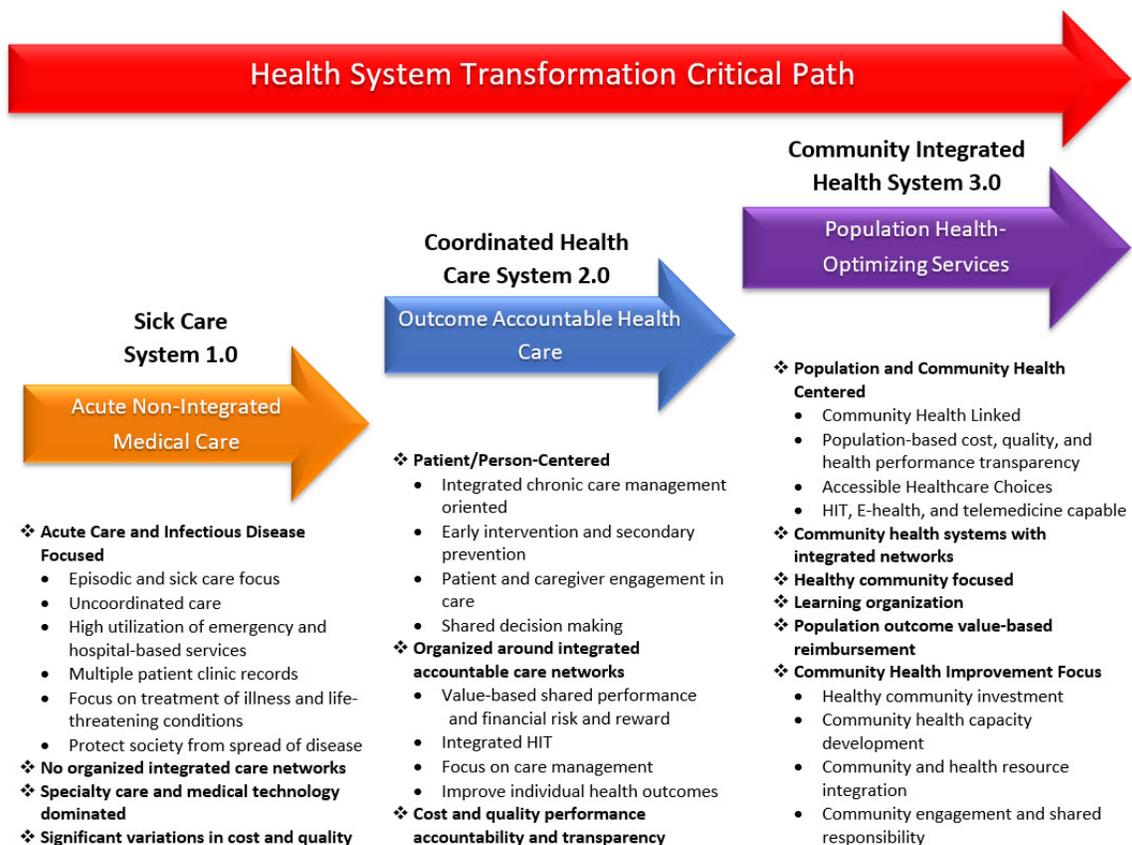
For readers who want in-depth information on health care industry trends, key health care providers and funders, and the emerging delivery and payment models that are opening new opportunities for Energy-Plus-Health collaborations.

5.1 Introduction

This section provides PAs with an understanding of the most relevant health care topics essential for Energy-Plus-Health collaborations.

5.2 Health Delivery System Market Shift

The health care industry is in a rapid state of change. In addition to redesigning payment structures and delivery systems, knowledge of diseases and treatments is also advancing, opening new doors of collaboration between energy efficiency, housing, and health care. Figure 5 illustrates a high-level overview of the health system transformation. Many health care systems are in the process of moving from System 1.0 to 2.0, with a goal of getting to 3.0 within 5 years. Innovative 2.0 systems are testing 3.0 models and are an excellent fit for Energy-Plus-Health partnerships.



Source: Adapted from CMMI

Figure 1: Health system transformation critical path.¹

⁴⁰Neal Halfon, Peter Long, Debbie I. Chang, James Hester, Moira Inkelas, and Anthony Rodgers, "Applying A 3.0 Transformation Framework To Guide Large-Scale Health System Reform, Health Affairs," November 2014. <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2014.0485>.

Health care system transformation includes payment reform. Sick Care System 1.0 is covered by a fee-for-service reimbursement model involving health insurance payments for services rendered. The system rewards patient volume and quantity of services but does not address patient outcomes from those services.² Under the fee-for-service model, a sick person generates more revenue for the health care team than does a healthy person, but resources to administer treatments do not deliver positive outcomes in proportion to the dollars invested.

Coordinated Health Care System 2.0 and Community Integrated Health System 3.0 require a value-based payment model to reinforce the systems' design and to reward all parties for quality outcomes, which motivates preventive considerations like indoor environmental conditions.

The Brookings Institute published a "Beginners' Guide to New Health Care Payment Models,"³ summarized here. Three commonly proposed value-based care models are:

- Accountable care organizations (ACOs).
- Bundled payments.
- Patient-centered medical homes.

5.2.1 Accountable Care Organizations

ACOs are groups of providers—primary care, specialty care, hospitals, clinics, etc.—that together share responsibility for overall quality, cost, and care for a large patient population. The providers coordinate care to decrease overall costs and look for ways to reduce redundant services and overlapping care. The providers continue to bill or track these cases as if working with a fee-for-service model. This allows them to align total ACO costs with health quality benchmarks. If the total ACO costs are higher than the established target, the ACO can be penalized, and if the costs are lower with benchmarks met, the ACO might receive a share of the cost savings. This shared-target model encourages providers to work together to meet their patient population health and cost targets.

ACOs identify and coordinate care treatment of patients in high-cost risk categories, such as full onset chronic illness with rising risks and complex costs from active, catastrophic conditions. Patients in lower-risk categories are deemed to be healthy and perhaps only in the early stages of or in a stable chronic illness. Lower-risk patients can be treated through preventive health measures and health assessments. Healthy homes programs can serve patients in all risk categories; those in the higher-risk categories are likely to deliver the most cost-effective outcomes in the short-term.

5.2.2 Bundled Payments

Under bundled payments, the provider estimates the total cost of all care services a patient will receive per episode in a given period for a specific problem (like joint replacement).⁴ The provider receives the bundled fees for these services, minus 2-3%. If the provider can deliver all treatment for less cost than the bundled reduced fee, the provider can keep the difference. If the treatment requires more reimbursement than the bundled reduced fee, the provider must absorb

⁴¹USC-Brookings Schaeffer Initiative for Health Policy, "The beginner's guide to new health care payment models," July 23, 2014. <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2014/07/23/the-beginners-guide-to-new-health-care-payment-models/>

⁴²Ibid.

⁴³Ibid.

the difference. Bundled payments thus encourage care teams to work together to avoid redundancy or unnecessary complications through improvements in patient care coordination and management. Providers also gain flexibility to aggregate the costs and reimbursements across a patient population so that higher cost treatments can be balanced with reductions in care delivery for other patients.

5.2.3 Patient-Centered Medical Homes

Patient-centered medical homes overlay existing funding models with monthly payments for enhanced coordination among a team of physicians, nurses, nutritionists, social workers, psychologists, and relevant specialists. The team builds strong relationships with each other, the patients, and the patients' caregivers. The total savings from the coordinated care and subsequent improvements in health are expected to be lower than the established monthly payments received by the patient-centered medical home. This approach predicts that coordination and integrated treatment approaches will avoid duplication and unnecessary services. The presence of a more comprehensive support network also enhances the patient's likelihood of success.

The restructured payment and treatment models described in this section use upstream, evidence-based interventions that create opportunities to consider the social determinants of health to varying degrees. Value-based payment models greatly increase the potential for success because they fundamentally shift expenses for care from acute treatment to disease prevention, with the goal of reducing costs while improving outcomes.

5.2.4 Pay for Success

Pay for Success (PFS) is social services reimbursement model that is similar to health care-driven value-based payment structures. PFS uses private or foundation program related investments to provide up-front capital to fund social services with quality and effectiveness guarantees, as shown Figure 6, with repayment from government entities based on outcomes.

The Pay for Success model creates public-private partnerships with government, service providers and impact investors to address chronic social issues. In 2018, the Social Impact Partnerships to Pay for Results Act (the Results Act) was enacted as part of the Bipartisan Budget Bill. The Results Act appropriated \$100 million overseen by the US Treasury Department to launch Pay for Success initiatives over a 10-year period.⁵

The PFS model is also known as *social impact bonding*. PFS' primary value is that it shifts financial risk away from service providers and government payers, toward investors that receive payment from service providers (or government) based on the savings from more efficient service delivery. Several healthy homes collaborations are exploring this model as a sustainable reimbursement mechanism for in-home interventions and associated population health outcome metrics. The Green and Healthy Homes Initiative currently has fourteen PFS projects in development to address the social determinants of health through evidence-based interventions and offers a wealth of tools online.⁶

⁴⁴Green & Healthy Homes Initiative, Innovative Financing and Pay for Success, <https://www.greenandhealthyhomes.org/services/innovation/>

⁴⁵Ibid



Figure 2: The pay-for-success model, with cycles for outcomes and role of investors.⁷

5.2.5 How New Health Care Funding Supports Innovation

National trends in health-care delivery systems and managed care payment approaches that change the Fee-for-Service model began before the Affordable Care Act (ACA), but the ACA furthered the momentum for state flexibility to experiment with emerging models. With legacy fee-for-service payment models, some states are experimenting with programs that link patients with services to improve home conditions, such as in-home asthma intervention programs, with reimbursement for those in-home services covered by the health care payer. Any variation of managed care that delivers in-home services opens opportunities to integrate healthy homes services that can improve health outcomes for chronic disease worsened by housing conditions.

The [Centers for Medicare and Medicaid Services \(CMS\) Innovation Center](https://www.cms.gov/innovationcenter) allows states to create demonstration projects to support innovative health care payment and service delivery models. The type of demonstration project is determined by the state’s plan submitted to CMS. State health departments, Medicare and Medicaid officers, and CMS are resources for

⁴⁶ Nonprofit Finance Fund, What is Pay for Success? <https://www.payforsuccess.org/learn/basics/#what-is-pay-for-success>. Adapted for VEIC use in this Playbook.

identifying local pilot projects and opportunities for healthy-home energy efficiency programming. The [National Center for Healthy Housing](#) and [Green and Healthy Homes Initiative](#) also offer a plethora of healthy homes reimbursement tools and case studies on their websites. If a state does not include healthy homes approaches in its current demonstration plan, the groundwork can be laid to build support for inclusion of healthy homes programming in successive state CMS plans.

5.2.6 Identifying the Entry Point to Health Care

Energy-Plus-Health programs can explore a range of possible entry points to the health care industry. Working at more than one level of the health care system will reveal the optimum pathways to partnership and ensure long-term sustainable collaboration. Common points of engagement are:

- ✓ Health care providers,
- ✓ Hospitals,
- ✓ Federally qualified health centers and community health clinics,
- ✓ Nursing homes,
- ✓ Home health agencies and service providers,
- ✓ Progressive primary and specialty care physician practices,
- ✓ School nurse associations,
- ✓ Coordinated care organizations,
- ✓ Accountable care organization,
- ✓ Managed care organization,
- ✓ Medical homes,
- ✓ Health payer organizations including government and private payers that deliver health care coverage,
- ✓ Government: Medicare, Medicaid, Federal and Military, and/or
- ✓ State and local public health departments.

Due to system variability, infrastructure mapping is best done through a local health provider market analysis. Additional explanations for the roles the above health care actors fulfill is provided below.

5.3 Health Care Sector Providers

5.3.1 Hospitals

Hospitals are likely partners for Energy-Plus-Health programs and the type of partnership the hospital can offer will be dependent on the business framework of the hospital. As explained in *Amplifying the Impact of Partnerships*, payer and provider organizations represent six profiles: “Innovators, Academics, Current-state optimizers, Mission-driven Experimenters, Operational

Philanthropists, and Stepping Toward Value.”⁴⁸ The hospital profiles in this resource can help PAs assess which ones might be responsive to Energy-Plus-Health program value statements.

One approach for engaging hospitals is to educate their employees about implementing home performance projects in their own homes. Hospitals serve as major employers and healthy staff are critical to hospital operations. Offering employee trainings regarding basic energy efficiency principles and incentive programs can entice medical personnel to experience the benefits of weatherization and efficiency in their own homes as a way to understand benefits for patients.

Engaging hospitals at multiple levels increases potential for program success. Suggested entry points include:

- Human resource departments that might promote energy efficiency program offerings and/or trainings to the employees;
- Population health officers, community health workers, or equity officers that seek opportunities to integrate community resources into overall patient wellness strategies. These employees have an outward-facing role to build resources and are likely to demonstrate interest in funding healthy homes programming through partnerships to apply for grants or simply leverage funding; and
- Executive directors concerned with cost, particularly if for hospitals that have their own ACO or managed care plan. The population health, equity, and community health officers can help collaboratives build the case to request executive-level support for pilot or demonstration projects that document health outcomes from Energy-Plus-Health programs.

Common engagement points include boards of directors, c-suite executives and departmental managers, specialty physicians, and community health teams and care coordinators. It can be helpful to remind hospitals of their own industry’s indoor air quality standards for medical facilities to help highlight its importance.

5.3.2 Community Health Needs Assessments and Community Health Benefits Funds

To qualify for tax exemption as charitable organizations, nonprofit hospitals must engage in activities that benefit their communities. These are known as *hospital community benefits*. Community benefit activities “help build the capacity of the community to address health needs and often address the ‘upstream’ factors and social determinants that impact health, such as education, air quality, and access to nutritious food.”⁴⁹ These activities must comply with Internal Revenue Service (IRS) regulations; paying for housing rehabilitation work for vulnerable populations is an example of an eligible community benefit.

The ACA introduced new requirements that introduced the need for tax-exempt hospitals to conduct a [community health needs assessment](#) (CHNA) at least once every three years, which

⁴⁷ Garg, P., and Schrader, C., “Amplifying the Impact of Partnerships: A Simple Framework to Help Engage Payers and Providers.” Oliver Wyman, 2018.

⁴⁸ Community Benefit Insight, Community Benefit Spending 101, <http://www.communitybenefitinsight.org/?page=info.cb101>

offer broad public comment opportunities and lead to widely available results.¹⁰ The hospital must then adopt an implementation plan, basing the strategies on the CHNA.^{11,12}

Many CHNAs identify population health concerns related to asthma and COPD, but often overlook housing deficiencies as a platform for reducing chronic respiratory illnesses, due to limitations in the types of health and community data collected and analyzed. Public comment periods are opportunities for energy efficiency and weatherization programs to educate CHNA administrators about complementary data sets that highlight housing quality as a social determinant of respiratory health, safety, and fall prevention for households facing these risks. Inclusion of housing conditions in CHNAs can support requests for community benefit funds to improve housing.¹³

5.3.3 Community Health Teams

Patient-centered medical homes (PCMHs) and nonprofit hospitals commonly deploy community health teams (CHTs), to assess patients' needs, coordinate community-based support programs, and provide multidisciplinary care.¹⁴ Some non-PCMH-health-care provider systems are beginning to adapt tools like CHTs for improving care coordination. Depending on CHT directives and metrics, CHTs can be a strong partner for delivering healthy homes programming. Some CHTs already provide in-home services that complement energy efficiency services. These can enhance program design and impact.

5.3.4 Community Health Workers

Community health workers (CHWs) are public health workers with a deep connection to the community they serve. They work for government agencies, nonprofit organizations, faith-based groups and health care providers to reduce persistent disparities in health care and health outcomes across the community. The CHW care delivery model lends itself well to a partnership that relies on the CHW as the trusted messenger, who can engage households to achieve mutual goals shared by energy efficiency and healthy homes programs to sustain household behavior changes.

The Seattle-King County Healthy Homes Project relied on a CHW strategy to conduct environmental assessments that identified significant moisture problems in 77% of the homes participating in a study of 274 low-income children with asthma. However, the research team “did not usually accomplish some of these interventions (e.g., installation of ventilation fans, installation of vapor barriers and ventilation of moist crawl spaces), given the resource constraints of this project.”¹⁵ This is a case where a collaborative effort with a weatherization or energy efficiency partnership could have brought building science expertise from the energy

⁴⁹ Ibid

⁵⁰ Affordable Care Act, [Patient Protection and Affordable Care Act of 2010 \(ACA\)](#).

⁵¹ In addition to having CHNAs, nonprofit hospitals are also required to have a financial assistance policy, limit hospital charges, and prohibit making collections before making reasonable efforts to determine whether an individual is eligible for assistance under the financial assistance policy.

⁵² National Center for Healthy Housing, n.d. “Hospital Community Benefits: Opportunities for Healthy Homes.” https://nchh.org/resource-library/HCF_APHA_techbrief2_community%20benefits_FINAL.pdf

⁵³ Ibid

⁵⁴ “The Seattle–King County Healthy Homes Project: Implementation of a Comprehensive Approach to Improving Indoor Environmental Quality for Low-Income Children with Asthma.” James Krieger, Tim K. Takaro, Carol Allen, Lin Song, Marcia Weaver, Sanders Chai, and Philip Dickey. Environmental Health Perspectives • VOLUME 110 | SUPPLEMENT 2 | April 2002. This project preceded the Washington State Weatherization Plus Health pilot effort described in the Case Studies, which achieved positive outcomes by leveraging more resources to implement all technologies and strategies needed.

efficiency sector to a health care challenge, using energy efficiency resources to improve outcomes.

In Vermont, CHW staff employed by participating hospitals provide the initial in-home visit for Energy-Plus-Health pilots, engage the patients, and screen them for eligibility while also delivering needed self-managed care coaching based on healthy homes principles. The CHWs also track and report all health care data for the Energy-Plus-Health pilot under data sharing agreements that comply with privacy requirements.

5.3.5 Additional Health Care Providers

Many types of health care providers exist within any given community and can be included in a market map in the market assessment phase. Which providers are ideal to target will depend on the PA's goals and the variations of community-based health care models present locally. For example, Efficiency Vermont initiated pilots with hospitals, with customer referrals also coming from specialty care physician practices and school nurse associations.

5.4 Coordinated Care Organizations

5.4.1 Managed Care Organizations

Some states contract managed care organizations (MCOs) to administer health benefits and services to Medicaid beneficiaries. State population health metrics drive these services with a goal to reduce health disparities within the state and avoid hospital readmissions. To achieve these goals, MCO contracts can incorporate in-home intervention programs and other components. MCOs can count certain quality improvement activities as a medical expense through certain cost-benefit analyses. This represents another opportunity for Energy-Plus-Health collaborations to introduce the program design and supporting data to the MCO and seek support for incorporating healthy homes interventions in treatment approaches for asthma.

5.4.2 Accountable Care Organizations and Medical Homes

Accountable care organizations and medical homes are explained in [Section 5.2.1](#).

5.4.3 Health Funding Sources

A range of public and private health payment sources may be positioned to support Energy-Plus-Health programming. As described below, a combination of these can help to support PA program efforts.

5.4.3.1 Public: Medicaid and Children's Health Insurance Program

Medicaid offers health care coverage to low-income children and adults, and the [Children's Health Insurance Program \(CHIP\)](#) provides health care coverage to the children of families that cannot afford private coverage and make too much to qualify for Medicaid. CHIP's public health initiatives allows states to use a portion of their administrative dollars for flexible activities, with no waiver required. "States have the option to draw down federal matching funds at the

enhanced CHIP rate for certain non-coverage expenditures so long as those expenditures do not exceed 10% of the total amount that a state spends on CHIP health benefits.”¹⁶

States and the federal government pay into the Medicaid and CHIP programs. While each state must meet minimum requirements of care as established by the federal government, each state has their own version of Medicaid and CHIP in their CMS-approved plans. Tracking Energy-Plus-Health program impacts on Medicaid and CHIP costs can provide compelling data to support long-term program funding.

Health Services Initiatives (HSI) are available to states with a Medicaid State Plan Amendment (see below) to improve the health of low-income children eligible for CHIP and/or Medicaid and may be used to serve children regardless of income. [Maryland](#) used the HSI to establish an in-home asthma prevention program serving households participating in lead paint abatement and healthy homes programming.

Medicaid State Plan Amendments and Waivers

The Medicaid state plan is an agreement between a state and the federal government. It articulates ways in which the state will administer its Medicaid program. A state plan amendment (SPA) or a waiver can allow changes to Medicaid programs. Each has a unique purpose, requirements, and submission processes, and both can expand a state’s Medicaid program to include healthy homes services.

When a state wants to amend the plan, CMS must review and approve the SPA request from the state’s authorizing agency(ies). SPA changes must comply with all federal rules, but do not have to be budget neutral. A SPA, for example, can establish reimbursement schedules for community health workers for administering preventative services.

Waiver requests are another option to allow a state to test a new service or policy approach that does not comply with the existing Medicaid program requirements. Waivers address how services are delivered, such as who qualifies, who provides services, and how services are paid for.

There are four major types of waivers and demonstration projects. The one most relevant for advancing healthy homes programs is the Social Security Act’s [Section 1115 Research and Demonstration Project waiver](#). The Section 1115 waiver allows a state to receive permission to test, pilot, or demonstrate a new policy or new services by expanding eligibility to individuals not already covered by Medicaid or CHIP. It also allows a state to provide services not typically covered by Medicaid, or to test changes to the delivery of health care services. For example, for patients with lower respiratory disease, a waiver might allow a program to alleviate in-home triggers with energy efficiency services.

Like the SPAs, 1115 waiver projects do not have to be budget neutral (other types of waivers do have to be budget neutral). Waivers are approved for five years, with an optional extension of three more years, at the discretion of CMS.

⁵⁵ Cindy Mann, Kinda Serafi, and Arielle Traub. “Leveraging CHIP to Protect Low-Income Children from Lead.” Prepared for Robert Wood Johnson Foundation and Woodrow Wilson School of Public & International Affairs, Princeton University. January 2017.

Medicaid Early and Periodic Screening, Diagnostic, and Treatment Benefit

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit ensures that Medicaid-enrollees under age 21 receive preventive, acute care, and diagnostic and treatment services as commonly addressed within the scope of a well-child visit. Federal regulations do not limit the health education provided under EPSDT to clinical settings and can support services (such as in-home health management training) deemed “medically necessary” for those under 21 years of age.

5.4.3.2 Public: Public Health Departments

Health department services and jurisdictions vary by state. In general, health departments seek to advance community health through population health data tracking, planning and program development, promotion of local health coverage, setting and enforcing standards and providing non-clinical health services. The American Public Health Association (APHA) began a Health in All Policies framework in the past decade that many states adopted to undertake Health Impact Assessments that identify priority health conditions. Chronic respiratory illnesses consistently emerged as one of the highest needs. In states and localities where health departments have undertaken these Assessments, Tier 3 Energy-Plus-Health programs are finding value in partnering with public health departments on program design, outreach, evaluation, and funding.

5.4.3.3 Private Health Payers

There are numerous private health payer organizations. Many private insurance companies have a philanthropic or community fund that provides grants and resources to support community-based outreach and implementation efforts that improve health outcomes. Examples include: Aetna Foundation, Blue Cross Blue Shield (Blue Fund and state specific), Cigna Foundation, Humana Foundation, Kaiser Permanente, MVP Health Care Corporate Giving, Tufts Health Plan Foundation, and UnitedHealth Care Community Plan. These funds may be a resource for Energy-Plus-Health program funding, resource leveraging and outreach.

5.4.3.4 Local Innovation Grants

Program administrators can look for additional resources in their local community to support healthy homes collaborations. These opportunities will emerge as PAs join the local conversation and establish relationships. These might be local, regional, and national health care industry-specific associations; organizations; and councils that can provide valuable insights into the local health care landscape. Connecting with a state’s department of health can be a good first step in entering these high-value networks.