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## ANALYSIS

# Financing The Infrastructure Of Accountable Communities For Health Is Key To Long-Term Sustainability

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**ABSTRACT** Accountable Communities for Health (ACHs) are collaborative partnerships spanning health, public health, and social services that seek to improve the health of individuals and communities by addressing social determinants of health such as housing, food security, employment, and transportation. ACHs require funding not only for programs and services but also for core infrastructure functions. We conducted a legal and policy review to identify potential funding streams specifically for ACH infrastructure activities. We found multiple and credible options at the federal and state levels and in the public health, health insurance, and philanthropic and private sectors. Such options could support ACH infrastructure directly or through reimbursement for administrative costs associated with programmatic work. Yet we also found that there is no dedicated or explicit source of funding for these critical functions. For sustainable and long-term ACH support, policy makers and program administrators should clarify and define ACH infrastructure functions and, where appropriate, explicitly recognize supporting these functions as an allowable use of funds and facilitate their coordination across program funding streams.

**W**ithin the context of health system transformation, including value-based payment and population health initiatives, providers and policy makers at the federal, state, and local levels are increasingly focusing on social determinants of health. These are defined as “the conditions in which people are born, grow, live, work and age.”<sup>1</sup>

Accountable Communities for Health (ACHs) have emerged as one promising model to address social determinants of health. ACHs are collaborative, multisector partnerships that span health, public health, and social services and seek to improve the health of individuals and

local communities by providing services related to health, housing, food security, employment, and transportation, among others.

More than a hundred ACHs or similar entities exist in the US.<sup>2,3</sup> For example, the Centers for Medicare and Medicaid Services (CMS) is testing the Accountable Health Communities Model in twenty-nine sites across twenty-one states (Katherine Verlander, deputy director, Division of Population Health Incentives and Infrastructure, Center for Medicare and Medicaid Innovation, personal communication, October 21, 2019, and February 29, 2020) and has launched one more accountable health model, Integrated Care for Kids.<sup>4</sup>

Despite significant variation, ACHs have a

common vision and shared agenda that was developed with meaningful community engagement and partnership. They facilitate and support a portfolio of interventions and collect and analyze data on outcomes for continuous learning.<sup>5</sup> Public or private funding (or some combination thereof) is available, often through the introduction of new health system delivery and payment models.<sup>6</sup> Additionally, ACHs have formal governance in place, often with a lead organization that assumes accountability for community health improvement.<sup>7</sup>

Although considerable attention has been focused on financing ACH programs and services, an equally compelling question is how the ACH itself can be supported. Emerging evidence suggests that a robust ACH infrastructure that provides core support for a wide range of operational, nonprogrammatic functions is critical for long-term success.<sup>8</sup> This infrastructure—also called the “backbone” of an ACH—is considered a necessary precondition for the effective implementation of interventions to address social determinants of health, as reflected in theoretical modeling and the design of newer models.<sup>9,10</sup> ACH infrastructure functions include community engagement, strategic planning, and program evaluation, among others.<sup>11</sup>

In this article we review potential options for funding the ACH infrastructure, with a focus on public sources by themselves or in combination with private sources. We discuss the benefits and limitations of these options and provide policy recommendations for expanding infrastructure support to strengthen and sustain the ACH model in the long term.

## Study Data And Methods

We conducted a legal and policy analysis of a broad array of potential financing mechanisms for infrastructure activities for Accountable Communities for Health that offer programs or services relating to health (physical and mental/behavioral), housing, employment, and food. In addition, we examined whether funding sources could support ACH training or case management activities, which could be considered either programmatic services for consumers or infrastructure-related activities.

Generally, ACHs that seek to address individual and community health needs rely upon programs and services across multiple sectors. These programs and services can be supported by multiple funding streams, depending on the requirements associated with the funding. Therefore, our analysis also considered whether a particular funding stream could be braided or blended with other sources of funding when

used for a common purpose.

**‘BRAIDING’ AND ‘BLENDING’** We defined *braiding* as coordinating distinct funding streams to pay for a variety of services and functions. The funding streams are not combined: Instead, each is used to support backbone functions in accordance with the stream’s purpose, eligibility rules, reporting requirements, and other considerations. Rhode Island’s ACH initiative called Health Equity Zones is a good example of the use of braiding. The initiative relies on federal funds from the Health Resources and Services Administration (HRSA), Substance Abuse and Mental Health Services Administration (SAMHSA), and Centers for Disease Control and Prevention (CDC), as well as state and local sources.<sup>12</sup>

In contrast, blending allows an ACH to simplify administration by pooling multiple funding sources, although generally each funding stream still has separate reporting requirements to ensure the appropriate use of the funds.<sup>13</sup> The ability to braid or blend different funding sources is an important long-term strategy for ACHs, although both approaches require significant leadership, organizational resources, and technical expertise.

**LIMITATIONS** Our study had several limitations. First, the work focused primarily on sources from the public sector, with or without additional private-sector sources, for funding the ACH infrastructure, as studying these options meant that we could use relevant statutory, regulatory, and programmatic materials.

Second, although the analysis was intended to be comprehensive in its approach, our research on funding options was not exhaustive. The federal agencies discussed below offer other grants and programs that we did not examine but that could support ACH backbone efforts.

Finally, some federal agencies and their programs, such as the Department of Veterans Affairs and the TRICARE program, were excluded from the analysis. These and other agencies or programs could be important partners for ACH efforts.

## Study Results

Our analysis identified multiple credible funding options for Accountable Communities for Health infrastructure activities, including federal grants and cooperative agreements, contracts with Medicaid managed care organizations, and public-private financing arrangements. Some of these funding mechanisms are already in use, while others have not yet been tested by ACHs. We divided these funding options into three categories: public health and social services pro-

grams, public insurance programs, and private and philanthropic initiatives.

**PUBLIC HEALTH AND SOCIAL SERVICES PROGRAMS** Strong candidates for funding ACH infrastructure activities from public health and social services programs are outlined in exhibit 1. Many of these programs are authorized by the Public Health Service Act or the Social Security Act, and many are administered by agencies of the Department of Health and Human Services (HHS).

Generally, HHS grant programs offer significant flexibility, although for an ACH to obtain infrastructure funds, its core activities must be consistent with the program’s mission and goals as detailed in the authorizing law and regulations. In some instances, the authorizing program language explicitly includes backbone functions. For example, Community Mental Health Services Block Grant funding may be

used for “planning, administration, and educational activities related to providing services.”<sup>14</sup>

We found that certain HHS program funds could support multiple ACH infrastructure functions even when they were not specified—including the coordination of health and social services, planning and evaluation, adoption and use of health information technology, and training, among others. Although certain ACH infrastructure activities (such as training) can be funded as direct services, backbone activities are generally financed as administrative or overhead costs—which means that funding for these efforts may be capped. For example, SAMHSA block grants limit overhead costs to 5 percent of a state’s block grant. Notably, none of the HHS funding opportunities in this category allow funds to be blended.

In addition to HHS grant program opportunities, ACHs could take advantage of more limited

**EXHIBIT 1**

**Sources of public health and social services funding for Accountable Communities for Health (ACH) infrastructure functions**

Source	Mechanism or program	Authority	Strength of funding opportunity	Considerations
ACF	Temporary Assistance for Needy Families	SSA, Title IV, Part A, Sec. 401–419	Strong	Flexible dollars are available but are limited to eligible services and recipients
ACF	Social Services Block Grant Program	SSA, Title XX, Subtitle A, Sec. 2001–2009	Strong	Flexible (but limited) dollars are available that can cover a wide range of administrative or backbone activities
CDC	National Center for Chronic Disease Prevention and Health Promotion grants	PHSA, Sec. 301(a)	Strong	Funds are available for capacity building but are limited to programs involving diabetes and cardiovascular disease
SAMHSA	Substance Abuse Prevention and Treatment Block Grant	PHSA, Sec. 1921–1935	Strong	Flexible funds are available but are limited to programs involving substance use disorders
SAMHSA	Community Mental Health Services Block Grant	PHSA, Sec. 1911–1920	Strong	Flexible funds are available but are limited to programs involving mental health
HRSA	Health Center Program	PHSA, Sec. 330	Strong	Opportunity exists for ACH backbone funding to the extent an ACH serves as a community health center or runs a network of centers
USDA	Supplemental Nutrition Assistance Program	7 U.S.C. Sec. 2011–2036c	Limited	Funds are available if states subcontract with ACHs to provide outreach and other administrative activities
HUD	Community Development Block Grant Program	42 U.S.C. Sec. 5301–5321	Strong	Funds can be used to build capacity for providing a variety of social services
HUD	Section 8 subsidies	42 U.S.C. Sec. 1437f	Limited	Funds are available if states or local public housing agencies, which administer housing assistance programs, subcontract with ACHs
DOL	Workforce Innovation and Opportunity Act (WIOA) of 2014 title I grants	Pub. L. 113-128 (2014), Title I	Limited	Funds are available for backbone functions if an ACH is eligible to receive WIOA funds or serves as a subcontractor for a recipient

**SOURCE** Authors’ analysis of relevant federal statutes and regulations for the above programs. **NOTES** Each mechanism’s or program’s characterization as a “strong” or “limited” opportunity for funding ACH backbone activities reflects the authors’ assessment of multiple considerations, such as the range of activities that may be funded, the breadth of the recipient population served, and whether dollars are tied to the delivery of programmatic services. In addition, the strength of a particular program as a funding source for the ACH backbone will likely depend on several factors on the ground, such as the type of organization that acts as the ACH lead entity, the need for start-up or long-term funding, the services provided by the ACH to community members, and the needs and characteristics of the community being served. ACF is Administration for Children and Families. SSA is Social Security Act. CDC is Centers for Disease Control and Prevention. PHSA is Public Health Service Act. SAMHSA is Substance Abuse and Mental Health Services Administration. HRSA is Health Resources and Services Administration. USDA is Department of Agriculture. HUD is Department of Housing and Urban Development. DOL is Department of Labor.

funding opportunities through programs at the Departments of Agriculture, Labor, and Housing and Urban Development, primarily by contracting with the entities at the state or local level responsible for administering the programs. Performing activities on behalf of these entities would allow ACHs to draw down dollars for related overhead costs. For example, an ACH that conducts Supplemental Nutritional Assistance Program (SNAP) outreach directly or through community partners could receive funds by contracting with state agencies that administer SNAP benefits. (SNAP outreach funds are financed jointly by states and the federal government.)

One strong non-HHS candidate for providing ACH backbone funding is the Community Development Block Grant Program of the Department of Housing and Urban Development. Up to 20 percent of the program’s funds may be used for planning (including data collection and analyses) and administrative costs (including program management, coordination, monitoring, and evaluation) that are related to the provision of services under the grant.

**PUBLIC INSURANCE PROGRAMS** There are numerous strong candidates for funding ACH infrastructure functions through health insurance programs administered by CMS, as outlined in exhibit 2. The Medicaid program in particular

**EXHIBIT 2**

**Sources of funding for Accountable Communities for Health (ACH) infrastructure functions through Medicaid, the Children’s Health Insurance Program (CHIP), Medicare, and the Marketplaces**

Source	Mechanism or program	Authority	Strength of funding opportunity	Considerations
Medicaid	Section 1115 waivers	SSA, Sec. 1115	Strong	Typically (though not always) limited to Medicaid enrollees; typically involves intensive design and approval process with the federal government
Medicaid	State plan amendment (SPA)	SSA, Sec. 1905(a)(13), 1905(a)(19), 1915(g)(1), and 1945(h)(1)	Limited	Limited to administrative costs associated with programmatic services; authorizes payment for care coordination
Medicaid	Home and community-based services (waiver and SPA)	SSA, Sec. 1915(c) and 1915(i)	Limited	Limited to administrative costs associated with programmatic services
Medicaid	Managed care mechanisms	SSA, Sec. 1932; 42 C.F.R., Part 438	Strong	Mechanisms to fund ACH backbone activities sustainably (for example, states can require or encourage MCOs to pass shared savings to ACHs, which can use these dollars for backbone functions)
Medicaid	HITECH Act	SSA, Sec. 1903(t) and 1903(a)(3)(F)	Strong	Enhanced match for administrative costs to cover start-up costs associated with implementing EHRs
CHIP	Health services initiatives	SSA, Sec. 2105(a)(1)(D)(ii)	Strong	Flexible dollars, capped and limited to initiatives targeted to low-income children
Medicare	MA supplemental benefits	SSA, Sec. 1852	Limited	Limited to costs associated with programmatic services
Medicare	Care coordination requirements	SSA, Sec. 1851	Limited	MA plans not subject to state control (this strategy would make ACHs subject to federal obligations attached to MA subcontractors)
Marketplaces	Essential health benefits	PHSA, Sec. 2707; ACA, Sec. 1302	Limited	May require states to pull back benefits from other essential health benefits categories
Marketplaces	State requirements for qualified health plans	ACA, Sec. 1311(d)(3)	Strong	Funds available if states impose administrative requirements on qualified health plans (but could drive up consumers’ costs)
Marketplaces	State innovation waivers	ACA, Sec. 1332	Potential <sup>a</sup>	Redirecting funds may make it difficult for a state to comply with the ACA’s statutory guardrails for Section 1332 waivers (which generally require states to provide coverage comparable to the coverage that would have been provided without a waiver)

**SOURCE** Authors’ analysis of relevant federal statutes and regulations for the above programs administered by the Centers for Medicare and Medicaid Services. **NOTES** “Strong” and “limited” funding assessments are explained in the notes to exhibit 1. SSA is Social Security Act. MCO is managed care organization. HITECH is Health Information Technology for Economic and Clinical Health Act of 2009. EHR is electronic health record. MA is Medicare Advantage. PHSA is Public Health Service Act. ACA is Affordable Care Act. <sup>a</sup>Characterized as “potential” because this mechanism depends heavily on the federal government’s discretion and, unlike Section 1115 waivers, there is no state precedent for using such waivers to finance a community-based infrastructure.



offers multiple mechanisms that may be available in all states—even those that did not expand eligibility for Medicaid. These include Medicaid state plan benefits, managed care organization contracting authorities, and Section 1115 waivers—as well as funding from the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009.

Medicaid state plans describe the programmatic services that beneficiaries receive (such as case management) and the payments for those services. Payment could include funding for ACH backbone activities that qualify as the administrative or overhead component of authorized services. Specifically, if an ACH is a service provider or contracts with a service provider, it could draw down funding for the overhead costs associated with the services delivered to consumers.<sup>15,16</sup>

Medicaid managed care organization contracting provides multiple pathways for funding ACH backbone functions that can be pursued separately or in combination. As one pathway, capitation payments could be used to fund the functions as value-added services.<sup>17,18</sup> Another option would be for the organizations to directly contract with ACHs to provide care coordination, administrative support related to the provision of care coordination, or both. Some of these expenditures could be considered quality improvement initiatives for the purpose of meeting the managed care organizations' medical loss ratio requirements.<sup>19</sup>

Another pathway that involves managed care organizations flows from value-based purchasing arrangements between the organizations and state Medicaid programs. States are increasingly establishing value-based purchasing payment, including some initiatives that would incentivize plans and providers to offer non-medical services to address social determinants of health. Managed care organizations, independently or with encouragement from states, could share the savings (from reduced health care costs and utilization) generated from such arrangements with ACHs to support backbone activities. Because shared savings are not required to be used for Medicaid-covered services, these funds could be blended as well as braided. An additional pathway is a state-required contribution from managed care organizations to help finance ACH infrastructure needs, which would spread the cost of supporting an ACH across all of the managed care organizations that benefited from the ACH's activities.

Although this approach would be time and labor intensive, states could design and negotiate Medicaid Section 1115 waivers with the federal government that include funding for ACH

backbone activities. For example, Washington State's waiver has allowed Medicaid Transformation Project dollars associated with the waiver to flow directly to ACHs to support numerous backbone functions: building relationships, engaging with community residents, establishing decision-making structures, and working with community partners to select projects and develop plans for them.<sup>20</sup>

Similarly, North Carolina received approval for a Section 1115 waiver to address certain health-related social needs that explicitly authorizes funding of up to \$100 million over two years for capacity building and other infrastructure activities.<sup>21</sup> Notably, funding for ongoing administrative costs will be “baked into the rates” after the two-year period has ended (Erika Ferguson, director, Office of Healthy Opportunities, North Carolina Department of Health and Human Services, personal communication, July 26 and October 30, 2019).

ACHs also could receive backbone funding available through HITECH, which allows states to receive incentive payments through 2021 for professionals and hospitals that are eligible for Medicaid electronic health record (EHR) incentive payments to offset the start-up costs of adopting and upgrading EHR technology.<sup>22</sup> ACHs could access these funds by subcontracting with eligible providers to provide certain services. For example, ACHs could develop EHR interfaces to facilitate the sharing of health and social services data for the purpose of coordinating interventions that addressed social determinants of health and health-related social needs.

Beyond Medicaid, our analysis identified two more strong public insurance options for ACH infrastructure funding. First, ACHs engaged in activities to improve low-income children's health could obtain backbone funding through flexible dollars available through health services initiatives under the Children's Health Insurance Program (CHIP).<sup>23</sup> Second, ACHs could receive funding from qualified health plans on the Marketplaces if states imposed administrative requirements on the plans to support ACH activities. However, such added requirements theoretically could lead to higher premiums for non-subsidized Marketplace enrollees and deter them from participating in the Marketplaces.

We found Medicare to be a relatively limited source of revenue for infrastructure funding. Although the provision of Special Supplemental Benefits for the Chronically Ill in the Bipartisan Budget Act of 2018 gives Medicare Advantage plans increased flexibility in addressing social determinants of health, current guidance makes no provision for supporting ACH infra-

## Mechanisms of and authority for private and philanthropic funding for Accountable Communities for Health (ACH) infrastructure functions

Mechanism or program	Authority	Strength of funding opportunity	Considerations
Community development financial institutions (CDFIs)	12 U.S.C. Sec. 4701–4750	Strong	Funds invested or loaned by a CDFI are flexible (ACH programs would need to focus on underserved communities)
Private foundation grants	I.R.C. Sec. 501(c)(3) and 509(a)	Strong	Foundations provide flexible dollars that are restricted by terms of the grant award and federal tax requirements
Nonprofit hospitals	I.R.C. Sec. 501(c)(3) and 501(r)	Strong	Hospitals may support ACH capacity building through their community benefit funds or from their operating funds
Social impact bonds (SIBs)	State law	Strong	SIBs are better suited to cover start-up costs and require partnerships with government entities and private investors

**SOURCE** Authors' analysis of private and philanthropic initiatives addressing social determinants of health and relevant federal statutes and guidance. **NOTES** The source for all mechanisms or programs is private or philanthropic funding opportunities. "Strong" funding assessments are explained in the notes to exhibit 1. I.R.C. is Internal Revenue Code.

structure.<sup>24</sup>

**PRIVATE AND PHILANTHROPIC INITIATIVES** As shown in exhibit 3, private and philanthropic initiatives are strong candidates for infrastructure funding. Foundation grants are highly flexible—albeit time-limited—sources of funding, and they already support backbone functions for a number of ACHs. For example, seven California-based foundations support the California Accountable Communities for Health Initiative, a five-year demonstration in thirteen communities with an emphasis on infrastructure development.<sup>25</sup> Notably, all of these sites receive additional support from county health and human services agencies and local not-for-profit organizations. At least four sites are partnering with Medi-Cal (California Medicaid) managed care organizations.

Public-private partnerships and opportunities may provide ACH infrastructure funding as well. One notable example is the Treasury Department's Community Development Financial Institutions Fund,<sup>26</sup> which provides financial assistance to private financial institutions to support local economic revitalization—for example, through the provision of basic financial services, community facilities, and affordable housing. Because ACHs can play a key role in community development activities, these institutions can be ideal financing partners.<sup>27</sup> One example is the housing-focused institution called the Local Initiatives Support Corporation, which participates in Elevate Health (formerly the Pierce County ACH) in Washington State.<sup>28</sup>

Another public-private partnership model is based on social impact bonds, which are pay-for-success arrangements. Within the ACH context, the public (government) sponsor of the bond would estimate the future savings from a specified ACH intervention. Based on this infor-

mation, a private entity would invest in an ACH, with an expectation of future repayment with a premium by the government if the ACH meets agreed-upon performance benchmarks.<sup>29</sup>

Nonprofit hospitals could finance ACH backbone efforts as a community benefit, which hospitals generally are required to provide to maintain their tax-exempt status.<sup>30</sup> Additional guidance from the Internal Revenue Service (IRS) may be warranted to identify the specific infrastructure investments that would qualify as meeting the community benefit standard. The IRS has stated that "some housing improvements and other spending on social determinants of health that meet a documented community need may qualify as a community benefit for the purposes of meeting the community benefit standard."<sup>31</sup>

## Discussion

Our legal and policy analysis identified multiple options for financing backbone activities to support Accountable Communities for Health, including public health and social services programs, public insurance programs, and public-private initiatives. For most of these options, the authorizing statute is clear, and additional federal guidance is not needed. Increased awareness of these funding options will likely lead to greater uptake, consistent with applicable restrictions.

From our review, we identified four critical questions for ACHs that seek infrastructure support.

**WHO IS INVOLVED, AND WHAT ARE THE CORE ACTIVITIES?** The types of organizations that participate in the ACH and its core activities will determine the availability of funding sources. Broad multisector partnerships—a defining

characteristic of the ACH model—are advantageous not only because they expand the reach and effectiveness of an ACH but also because they increase an ACH’s eligibility for multiple and diverse streams of infrastructure funding. Additionally, state support is critical for ACHs to access larger and more sustainable sources of infrastructure funding, such as Medicaid, CHIP, and various federal grant programs.

**COULD INFRASTRUCTURE FUNCTIONS BE REIMBURSED AS DIRECT OR ADMINISTRATIVE COSTS?**

Administrative or overhead funding is an important and flexible source of funding for infrastructure activities. However, opportunities to fund such activities also exist when an ACH provides an infrastructure-related service, such as training. In those cases, the ACH could receive direct reimbursement for that activity as well as reimbursement for associated administrative costs.

**WILL FUNDS BE BRAIDED OR BLENDED?** The ability to braid or blend funds helps ACHs and their state and community partners address upstream community-level determinants of health while minimizing administrative burden and costs. Many of the funding streams identified in this review could be braided, subject to the uses permitted by the funding authority. However, this review showed that there is very limited opportunity for blending public sources of infrastructure funding. Public program funding streams will need to be linked to the specific populations or programs and activities eligible for federal dollars. In contrast, foundations and private entities often have greater flexibility and may allow both braiding and blending of their funds. Additionally, state and local governments can commit their own funds with greater flexibility. Regardless of the funding source, ACHs should avoid any diversion or diminution of funds that directly support individuals and families in need.

**WHAT IS THE TIME FRAME FOR NEEDING INFRASTRUCTURE SUPPORT?** To cover ACH start-up costs, certain funding opportunities are most appropriate—particularly those that are time limited: foundation grants, waivers, and social impact bonds. Other mechanisms provide more long-term and sustainable funding. These include arrangements with Medicaid managed care organizations, state plan amendments, and potentially community development financial institutions.

### Innovations In ACH Financing

Our review focused primarily on Accountable Communities for Health infrastructure funding options that realistically could be pursued at the present time. However, just as the ACH model

continues to evolve, new ideas for financing this model are being conceptualized and explored. These newer financing mechanisms may become viable sustainability strategies in the longer term.

We are aware of three innovative financing mechanisms that—although not part of our analysis—could support ACH backbone activities. First, there is increasing experimentation with different approaches to developing local wellness funds, which are community-based financing mechanisms that permit braiding and blending of resources across sectors to support community health initiatives. For example, the Imperial County ACH is supported by a wellness fund that is funded by the local health department, the California Accountable Communities for Health Initiative, and a local health plan through monthly per member fees and algorithm-based annual revenue sharing.<sup>32,33</sup>

Second, some ACHs are beginning to think beyond the “fee-for-service with overhead” model and considering the development of integrated product sets, such as community-based care coordination. These products, which would bundle services and infrastructure activities, could be offered directly by ACHs to payers<sup>34</sup> through value-based purchasing arrangements or as part of broader agreements with states.

Third, membership “dues” arrangements have been used to support at least one ACH initiative and could be viable options for infrastructure support in communities with broad ACH membership.<sup>35</sup>

In addition to these financing mechanisms, there is ongoing discussion about the feasibility of partnership or integration of ACHs with other population health or value-based models. In particular, there may be opportunities to leverage accountable care organization models to increase ACH infrastructure support in certain states. For example, Minnesota’s accountable care organization, Integrated Health Partnerships 2.0, could be an ideal partner for an ACH, given that the model encourages collaboration with community partners to address housing, food security, social services, education, and transportation.<sup>36</sup>

### Policy Recommendations

Based on our analysis, we offer the following policy recommendations to increase and sustain funding for Accountable Communities for Health infrastructure.

**CLEARLY IDENTIFY INFRASTRUCTURE FUNCTIONS** As more is learned about the critical components of ACH infrastructure, policy makers should recognize and define supportive infra-

structure functions, with input from practitioners in the field. Such clarity would encourage ACHs to invest in these functions and funders to support them.

**RECOGNIZE INFRASTRUCTURE SUPPORT AS AN ALLOWABLE USE OF FUNDS** Policy makers should explicitly identify infrastructure support as an allowable use of federal funds across all categories of funding, consistent with the funding source and arrangement.

**FACILITATE INTEGRATION WITH OTHER INITIATIVES** As policy makers move forward with new or updated initiatives related to health system transformation broadly or social determinants of health more specifically, they should consider incorporating the ACH model.

**IDENTIFY NEW FUNDING STREAMS AND MECHANISMS** Policy makers and program administrators should examine other potential sources of funding, such as the Department of Veterans Affairs or commercial health plans. In addition, newer mechanisms, such as wellness funds and social impact bonds, should be explored and tested on a larger scale.

**EXPAND RESEARCH ON INFRASTRUCTURE** Researchers should collect more evidence specifi-

cally on the cost and contribution of a strong and sustainable ACH infrastructure to the overall success of accountable health initiatives. Such research could advance ACH participation in value-based initiatives and expand private-sector investment in the ACH model.

## Conclusion

A growing number of policy makers, providers, plans, and other stakeholders in the health and social services sectors have recognized the critical need to address social determinants of health to improve health and reduce inequities. This has led to a deepening interest and increasing investment in multisector, community-based accountable health models. However, a robust and adequately funded infrastructure is necessary for the effective and efficient implementation of such models. Policy makers, as well as program and grant administrators, must expand and strengthen mechanisms for financing infrastructure needs to ensure the long-term success and sustainability of the Accountable Communities for Health model. ■

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