Blueprint for a Healthier America

Sustaining Community Health Improvement Efforts: The Need for a Financial Manager

Problem

Communities across the country are struggling with health challenges that have consequences for the well-being of children and families and for the broader productivity, vitality and economic well-being of their neighborhoods, schools and workplaces. While the broad use of evidence-based and common sense strategies could reduce rates of these health problems and lower healthcare spending, there is no mechanism to ensure that health improvement efforts can be sustained over time and supported at a sufficient level to achieve desired outcomes in communities around the country.

There are several barriers to establishing a mechanism for sustainable health improvement initiatives. For one, many "population health" efforts focus on the disease *du jour* and shifting priorities and often are limited in duration and funding, supported by short-term grants. There has not been sufficient investment to scale or sustain them over time to achieve results.

Many healthcare decisions are also made at the federal-state level (through Medicare and Medicaid) or through private healthcare plans – in decision making processes separated from many other state-local cost drivers, such as social services, public safety, criminal justice and education.

Finally, health improvement, especially community-based or population-level approaches, have not been prioritized or incentivized by the healthcare system, where expenditures have been driven by fee-for-service and individually-focused delivery and payment approaches. While this is changing, it is still in a moment of transformation. The structure of the competitive healthcare market does not incentivize health systems, hospitals, or health insurers to work across sectors or to collaborate within sectors to invest in health at the community level, and thus health services and community-wide health improvement initiatives have not been well integrated with other social service and community and economic development efforts.[i] And health systems engaging in "population health" improvement efforts have often addressed the issue from the lens of managing the health of their patients or "patient pool," such as through care coordination "population health management," rather than by investing in broader community-wide approaches.[ii]

Thus sustainable financing for community health improvement has been a major challenge, not only because of the lack of predictable resources, but also because of misaligned incentives and silo-ed funding streams that undermine efforts to take a sustainable, holistic, and community-wide approach. Examination of successful, sustainable population health initiatives has shown that the ability to tap into and coordinate various funding streams is a key strategy for financial sustainability. Braiding and blending funding and financing from various sources to support a community health improvement initiative is emerging as a key strategy for achieving long-term impact.[iii]

Solution: A Financial Manager

Building the capacity to conduct multi-sector work requires a dedicated and resourceful integrator entity that convenes a broad coalition of committed partners to develop and implement a strategy for health improvement. Leadership with the vision and courage to champion change is key: to shift mindset from output-oriented to outcome-focused, to work with funders in a relational rather than transactional manner, and to stimulate a new way to define success, identify measures and implement programs.

Financial management is a key component of the success of any local health improvement partnership. Financing and funding, however, cannot be focused solely on providing discreet programs, services or systems change interventions, but must also take into account the cost of doing business at a cross-sectoral, population level. Currently, most non-profits do not have adequate resources for administration, substantial reserves or the capacity to respond to new incentives, for example, financing from Community Development Financial Institutions (CDFIs). Coordinating traditional and new funding/financing sources and engaging in cross sector-work can require creative legal agreements between partnering organizations, navigating complicated tax credit processes, robust data collection/evaluation capacity, organizational change management, thinking beyond one's own department or organization (a culture of collaboration), a willingness to adapt and improvise, etc. - all of this requires entrepreneurial, creative and persistent personnel with bold vision, strong relationship skills, and deep expertise in their respective fields (law, finance, business, data management, and so on).

If there is no existing mechanism for raising and managing the money to support local health initiatives on an ongoing basis, structures must be developed that have the ability to raise money from a range of different funders and responsibly manage the funds to provide accountability and oversight for the proper use of funds. This includes developing strategies for bringing existing community assets together from a range of potential funding streams.

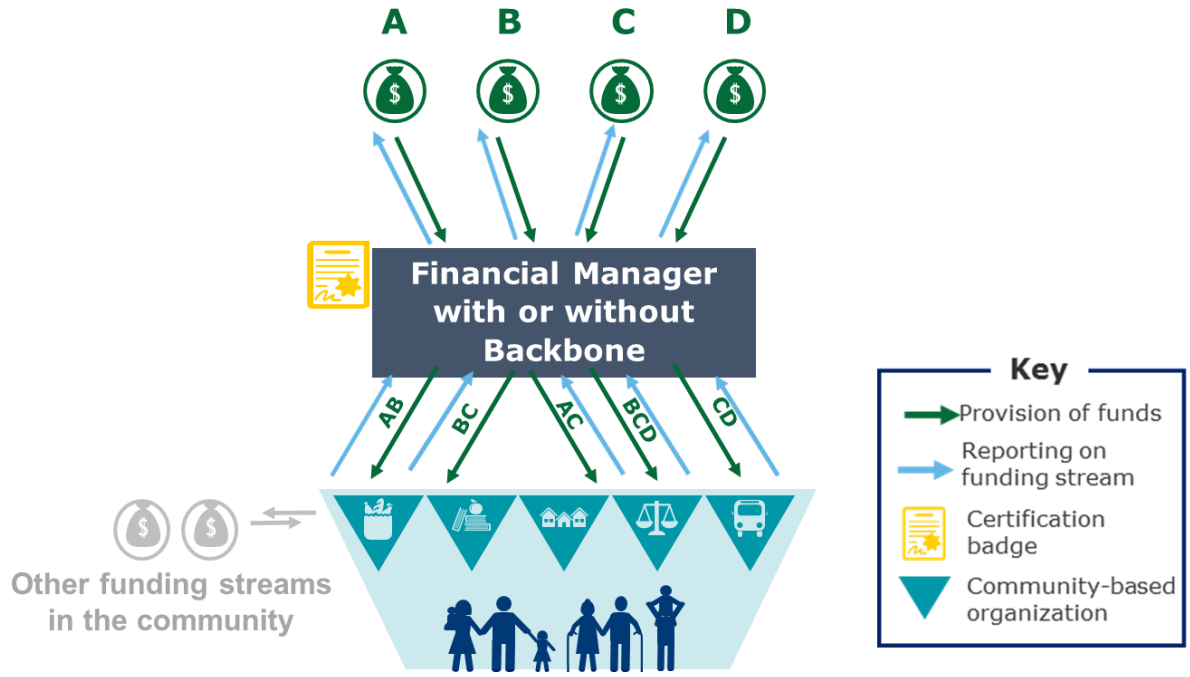
A formal fiscal intermediary can provide the needed financial capacities to coordinate various funding sources. This financial management role can be taken on by the lead partner itself within a local health improvement partnership (the integrator, backbone or quarterback) — or by a separate financial manager or trust, or other existing organizations like local community foundations, United Ways, other established intermediary nonprofits, hospitals, community health centers or health systems, community development financial institutions or community development corporations. In some communities, there may be models with multiple leads working together to fulfill this fiduciary role. The appropriate entity(s) to assume this role will depend on the community's needs and assets and the lead organization's capacity, as well as the willingness of the community and other local organizations to entrust this existing lead organization with the fiduciary role.

The financial manager must be capable of bringing various streams of funding together to sustain the community health improvement initiative. A certification process could help ensure accountability and afford benefits to the financial manager, in terms of reducing the bureaucracy inherent in the management of multiple funding streams. The financial manager would bring the fiduciary capabilities to local health improvement efforts, and would ease the financial complexity related to cross-sector work, in the same way the lead partner is responsible for managing the partnerships to steer the coalition in the right direction.

The Benefits of a Financial Manager

Financial management is a key component of the success and sustainability of a local health improvement partnership. If there is no existing mechanism for raising and managing the money from a range of funders to sustain the initiative, the lead manager must develop these capacities or engage an organization that has the capacity to provide financial management, accountability and oversight. Overall, the need is to provide stable, ongoing, responsible structures for financial management. In many communities, this need can be served through existing entities. In other cases, it may be helpful to develop these fiduciary capacities.

Figure 1: Financial Manager Model



Core Roles and Functions of a Financial Manager

While the structure and model for a financial manager will vary based on community-level assets and existing entities, financial managers would share the following core roles and functions:

1. Identifying and leveraging new funding sources that are not typically coordinated (such as non-traditional, innovative funding streams from community development and other sectors);
2. Providing fiduciary oversight and management to coordinate multiple funding sources;
3. Governing the prioritization of spending on evidence-based interventions to ensure accountability to the target community; and
4. Serving as a trusted fiscal intermediary between sectors that affect health (e.g., healthcare, public health, social services) – which have different missions, cultures, and ways of operating, and may lack experience working together.

1. Securing and coordinating new funding sources

The financial manager would develop strategies for securing public and private funding from a range of funders across various sectors, such as:

- Federal, state and local governments, including grant programs;
- The healthcare system, including public and private providers and insurers, hospitals and community benefit investments;
- Social services such as, housing, anti-hunger, domestic violence and other sectors such as agriculture, transportation and/or environmental agencies/ community organizations;
- Businesses;
- Philanthropic organizations;
- Social impact financing mechanisms, such as Community Development Investment Funds, tax credits, revolving loan funds, program-related investment grants, social impact bonds and pay-for-performance initiatives; and
- A Wellness Trust or other formal structure where there is direct community investment, from government support, tax revenue or another ongoing source.

2. **Providing fiduciary oversight and accountability to manage multiple funding sources**

The financial manager would have the capacity to meet the accounting and accountability requirements of multiple funders. A financial manager also needs the skills and credibility to engender trust across a range of public and private sector funders and be able to meet their application and reporting requirements.

Multi-sector coalitions working to improve community health face many challenges as they braid together the funding streams to sustain their work:

- Most federal, state and local grants have distinct application and reporting requirements. Community benefit funds, economic development funds and philanthropies which typically invest in community health all have unique accounting and measurement requirements;
- Tapping into healthcare funding typically requires billing capacity;
- Value-based payment is complicated, requiring partnerships and data, analysis and outcome measures;
- Investors may want access to shared savings and returns or measurement of the impact of funds used;
- Social investment instruments, such as community development funds and New Market Tax Credits, have different funding requirements and typically require repayment or demonstration of return on their investment (sometimes through "pay-for-success" or performance contracts); andCreating mechanisms for demonstrating returns and value across sectors and partners is complex. Dealing with the "wrong pocket" issue – where funds may come from one funder but the results may most directly benefit another is a challenge that has not yet been solved. For instance, when funding for a housing initiative, supported by government housing agencies, yields savings for a health system and lowers costs of other social services, there is rarely any mechanism to evaluate or reinvest the savings accrued by the health system or social service agencies.

The financial manager would have a systems that are adequate to address some of these challenges and that have the capacity to analyze the costs and potential shared savings or returns that health improvement initiatives achieve. This is important for evaluating the impact of the initiative – and understanding the return on the investment or contribution from the different funders. A financial management system that is set up to address cross sector investments and returns needs to have: standard data classifications to record financial events; common practices for similar transactions; and consistently applied internal controls (for data entry, transaction processing and reporting).

The financial manager needs a data system that has the ability to integrate data from multiple sectors and leverage big data. A financial manager also needs the analytical skills to extract information from such a data system, including predictive analytic capabilities, risk analysis and geo-coding.

3. **Governing the prioritization of spending on evidence-based interventions to ensure accountability to the target community**

The financial manager, together with the integrator, needs to have mechanisms in place to govern the prioritization of spending to ensure that the multi-sector coalition is accountable to its community. The flow of funds may occur in several ways:

The integrator/financial manager may hire the staff to implement all the evidence-based strategies according to the strategic plan set by the multi-sector coalitions.

The integrator/financial manager may subcontract some or all of the funds to other community-based organizations to implement the evidence-based strategies in the coalition's strategic plan. This is sometimes referred to as "regranting".

4. Serving as a trusted fiscal intermediary between sectors, partners and funders

The financial manager is a bridge builder between sectors, partners and sometimes funders. The financial manager and the integrator build trusting relationships, facilitate communications across sectors, identify shared goals, develop strategic plans that leverage the assets of all of the partners, and track progress toward the goals of the strategic plan.

Certifying Financial Managers

Accountability of financial managers could be certified, similar to Community Development Financial Institution certification. Creating a version of a "CDFI for Health" could establish a mechanism to help set baseline standards and credential local entities that are qualified to take on this financial management role.

Just as CDFIs provide a recognizable, reliable system for groups like banks to use to help manage their Community Reinvestment Act (CRA) obligations CDFIs for Health could help play that role for nonprofit hospitals – as a scalable, reliable resource for investing community benefit funds in community health improvement programs – providing capable financial management and fiduciary responsibility. It could also leverage resources from other funders for stronger collective impact.

In the summer of 2016, TFAH and Monitor Deloitte conducted a series of interviews and workshops with experts to examine the potential for developing certification for financial management of local health improvement partnerships. Building a model for certification – such as the role certification plays for CDFIs – supports baseline criteria for operational standards, integrity and accountability way beyond an annual audit. This gives the local communities the ability to focus on partnerships, performance and delivering outcomes.

The certification process could also entail benefits for financial managers. For instance, there could be mechanisms for streamlined or coordinated processes for certified integrators and intermediaries applying and reporting on related federal, state or local public or private grants, bonds or loans – demonstrating outcomes for defined shared goals across programs in exchange for increased flexibility and reduced bureaucracy.

Some benefits of a certification process include: generating credibility and transparency; establishing accountability; creating standardized criteria and a uniform level of rigor; reassuring funders about the integrity of coordinated funds; providing a gateway to flexibility in exchange for demonstrated results; and facilitating a shift from reporting on compliance to reporting on outcomes.

There could be increased benefits for more advanced criteria – such as designations or "badges" for strong data capabilities and legal safeguards and use of evidence-based practices. Over time, financial managers with a proven track record for management and improved outcomes could have other benefits, such as the eligibility for simplified funding – such as coordinated or combined grants – from government, philanthropic and private funders.

The certifying body could be via the federal or state governments or a consortium of experts and affiliated entities that help provide similar local certifications for other sectors, such as the Association of Government Accountants. There would also need to be designated funding – through the government and/or a set of engaged stakeholders – to support the certification process.

Some potential criteria identified for financial managers include that they should:

1. **Be a legal entity, allowing them to enter into agreements and contracts, incur and pay debts and be responsible for actions;**
2. **Meet fiscal accountability standards, including the ability to manage funds from multiple funders, monitor and track funds and have audit and evaluation capabilities—including providing a complete audit trail;** entities would also need to demonstrate an ability and system capacity to perform complex financial management and accounting functions, including:
   - a robust cost accounting system;
   - an integrated financial management system, with standard data classifications established and used to record financial events, common processes used to process similar transactions, consistently applied internal controls over data entry/transaction processing/reporting, and systems that fit together to support all financial functions;
   - ability to prepare financial statements and reports in accordance with Federal accounting and reporting standards
   - systems to assure data quality and to safeguard the integrity of operations and data; and
   - qualified staff with financial acumen, including a CFO.
3. **Have a defined mission, or partner with an organization with a defined mission, of advancing community health and wellness that aligns with identified community priorities;**
4. **Demonstrate support from community stakeholders, such as funders, community organizations and political leaders;** this could include demonstrating a history of community engagement, partnerships/relationships with diverse stakeholders, or cross-sectoral engagement within the community.
5. **Have mechanisms for ensuring transparency to the community it serves and funders, including making financial information available to stakeholders; and**
6. **Demonstrate an ability to seek and accept diverse sources of funds, and large sums.**

Recommendations to Build *Sustainable* Health Improvement Partnerships

Lessons learned from the most successful health improvement initiatives can serve as examples for national change and local execution. These lessons can be used to support a scalable, sustainable model to improve health, increase the vitality of communities across the country and bring down healthcare costs. The following are recommendations to help build and sustain health improvement partnerships based on current and past initiatives. These recommendations include:

1. **Support Local Health Improvement Partnerships to Address Top Priorities in Communities**
   A Local Health Improvement Partnership pilot program should be created – via community health and prevention programs at the Centers for Disease Control and Prevention (CDC), the Substance Abuse and Mental Health Services Agency (SAMHSA), the Health Resources and Services Administration (HRSA) and other agencies to support planning, capacity building and implementation grants to localities. Estimated costs for supporting a "lead partner" (often established, experienced institutions or intermediary nonprofits in communities) is around $250,000 to $500,000 per year.

2. **Broaden Implementation of Evidence-Based, High Impact Strategies – And Create Academic/Expert Health Improvement Institutes in Every State**
   Experts at the CDC, National Institutes of Health (NIH), SAMHSA, public health agencies, healthcare systems and other organizations have been rapidly identifying a growing set of the strongest health improvement strategies – which allow local communities and health systems to determine which of the most effective available programs best match their needs. The creation of an expert network in states would be an important new tool that would provide support and technical assistance to local communities in their selection, implementation and evaluation of

programs and services. These expert organizations would contribute to growing the evidence-base for programs – using their findings to inform and improve efforts.

The federal government should support the creation of a network of state-based expert institutes – beginning with a pilot program for an initial set of states. These institutes should be developed building on and in consultation with state and local health departments and existing public health research centers, institutes and resources. Community-based programs at CDC, SAMHSA and other agencies could help support this effort – and states could provide additional funds to support and expand the institute's activities and scope. One model center in Pennsylvania with an annual budget of $1 million works across several related disciplines to address common risk factors associated with crime, poor health and low academic achievement. The federal government should expand funding for additional research and evaluation of community-based prevention and health improvement programs and strategies.

3. **Fully Fund the Prevention and Public Health Fund and Other Community-Based Health Improvement Efforts**

There needs to be ongoing and sufficient funding to support health improvement efforts around the country. The Prevention and Public Health Fund supports key chronic disease prevention efforts at CDC. It is scheduled to increase by $250 million in Fiscal Year (FY) 2018; and by another $250 million in FY 2020. These increased funds could be used to support a range of federal health improvement efforts, including chronic disease prevention programs at CDC; place-based multi-sector initiatives; and/or multi-agency efforts to address health factors and improve outcomes.

In addition to CDC, SAMHSA has a Prevention and Treatment Block grant program funded at around $1.8 billion per year and there are Drug-Free Community Grants totaling around $86 million.[iv] There are also new opportunities under the Every Student Succeeds Every Day (ESSA) to support healthy school initiatives via Title I fund from the U.S. Department of Education (ED).

4. **Increase Strategic Alignment of Policies and Programs to Improve Health and Other Factors that Influence Health – With a Focus on Improving Outcomes**

Since health is impacted by a wide range of factors, it is important to have a more strategic approach to prioritizing goals and investments that can leverage better outcomes across federal, state and local governments.

The National Prevention Strategy, released in 2011, and other cross-agency efforts – such as issue-based task forces and working groups – have been an important step in helping federal agencies identify many joint strategies for improving health and other goals. For instance, issues like drug prevention require efforts of multiple agencies – including the Department of Health and Human Services (HHS), Department of Justice (DoJ), Office of National Drug Control Policy (ONDCP) and ED.

The next step should be a much stronger and purposeful approach to identifying and prioritizing ways agencies can better work together and invest in the most effective strategies to improve health and achieve other goals – across housing, food and income assistance, education, transportation and other areas. This should go beyond the most obvious areas of alignment – such as healthy housing programs – to the factors that influence health – such as housing assistance programs.

There should be increased leadership for developing and implementing the next stage of this approach and strategy – this should be a priority for the White House Domestic Policy Council

and the Secretary of HHS. This approach should include a review and process for coordinating aligned programs to focus on improving outcomes – and to maximize efficiency and effectiveness of efforts and investments. Where appropriate, there should also be increased efforts to coordinate and align grant programs aimed at common goals – so funds can be leveraged to work together to better achieve these goals.

Within the federal government, there are a number of mechanisms for supporting improved cross-agency and program collaboration. For instance, the Office of Management and Budget (OMB) issued a Uniform Administrative Requirements, Cost Principles and Audit Requirements in Federal Awards (Uniform Guidance) in 2013 that permits more flexibility and innovative models for agencies to waive certain requirements in grants in exchange for demonstrated improved outcomes and cost-effective approaches.[v] Additional mechanisms should be developed that can support strategies and evaluations of the impact of programs across agencies, including of programs funded by one agency on the goals of another agency. Mechanisms that align these goals among public and private partners are also needed.

At the state and local level, a number of projects have identified strategies for coordinating health and social service investments and/or increasing investments in the social determinants that impact health – toward coordinating goals, programs and funding across sectors and agencies, such as the Milbank Memorial Fund's study of *Investing in Social Services for States' Health: Identifying and Overcoming the Barriers*; the Milbank Memorial Fund and New York State Health Foundations' *Medicaid Coverage for Social Interventions a Road Map for States*; the Commonwealth Fund's *A State Policy Framework for Integrating Health and Social Services* and the National Academy for State Health Policy's *Federal and State Policy to Promote the Integration of Primary Care and Community Resources* and the Center for Healthcare Strategies, Inc.'s *State Payment and Financing Models to Promote Health and Social Service Integration*.[vi, vii, viii, ix, x]

5. Incentivize Increased Support for Community-Based Health Improvement Efforts via Nonprofit Hospital Community Benefit Programs

Many hospitals are expanding support for upstream community health improvement strategies by addressing key priorities such as obesity, prescription drug misuse, infant mortality and other factors that have a major impact on the health of their patients, such as housing, education and transportation. Nonprofit hospitals' community benefit funds totaled around $62.4 billion in 2011.[xi, xii] In the past, only around 5 percent of the funds have been used to support community-based prevention activities, with the majority of the funds being used to support charity care and bad debt. With expanded insurance coverage – reducing the need for as much charity care support – and value-based payment, hospitals can look at upstream approaches to improve the health of the patients and communities they serve. Since 2012, the Internal Revenue Service (IRS) has required all nonprofit hospitals to conduct regular community health needs assessments to better understand the top health concerns of the communities they serve and to develop implementation plans. Community benefit funds may be used to support health improvement initiatives. In addition, the IRS issued follow up guidance that "some community building activities may also meet the definition of community benefit," which may include addressing other factors that influence health.[xiii] Community improvement and "community building" have traditionally been reported separately, where many community building efforts have not been covered by community benefit funds, and cannot actually count the related expenses as community benefit funds. However, the IRS has not issued any official requirements for supporting community efforts. The federal government should consider additional guidance, requirements and incentives for the use of community benefit funds to support upstream community health and other factors

6. **Increase Innovative Social Investments**

There is increasing use of social investments – including community development funds and social impact bonds – to support health improvement initiatives, such as healthy food financing initiatives, capital development of Community Health Centers and co-located health-and-social service providers and family home visiting programs. Creating a financial management mechanism – to function like a CDFI for health improvement initiatives in communities – would provide a scalable way for communities to have an accountable and trusted structure for raising and managing the funds needed to support these efforts. Additional groups are exploring expanded use of "pay–for-performance" and other investment models for health improvement initiatives.

The federal and local governments should expand social investments – through CDFIs and New Market Tax Credits – into health improvement initiatives and programs, including through healthy food financing and community health center initiatives, as well as other programs that leverage collective benefits for improving health.

The federal government could also increase incentives for social investing by nonprofit hospitals by crediting differences in market returns as a community benefit. Nonprofit hospitals are increasingly investing in CDFIs and other social investments, but are not able to "count" the difference in earnings between a market rate return and the return from a socially responsible investment.[xiv]

7. **Provide Support to Medicare, Medicaid and Private Healthcare Insurers and Providers to Expand the Use of Health Improvement Strategies and Services**

Value-based healthcare models are spurring many healthcare providers and insurers to invest in innovative strategies to keep patients healthier. Medicare and Medicaid should expand support for prevention to help speed strong emerging programs into practice. The Centers for Medicare and Medicaid Services (CMS) should leverage existing authorities and initiatives – and create additional mechanisms as needed – to incentivize healthcare, public health and social service sectors to work together. Key areas that should be addressed include:

- **a.** Incentives for increased use of covered preventive services and penalties where actual use and delivery rates remain low;
- **b.** Expanding coverage and use of clinical-community programs, such as: services that use lower-cost alternatives, care coordination or community-based services, and evidence-based group diabetes and other chronic disease prevention counseling programs;[xv]
- **c.** Programs and systems that help connect patients to services that address unmet social needs, such as the Accountable Health Community (ACH) model being piloted by CMS that helps connect patients to services that address housing instability and quality; food insecurity; utility needs; interpersonal violence; and transportation needs – and other available mechanisms, such as state waivers, to support programs that help connect beneficiaries to social services as needed; and
- **d.** Expanding coverage for community-based health improvements.[xvi, xvii]

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[i] Northeastern University Institute on Urban Health Research and Practice. *Population Health Investments by Health Plans and Large Provider Organizations – Exploring the Business Case*. Boston, MA: Northeastern University, 2016. http://www.northeastern.edu/iuhrp/wp-content/uploads/2016/05/PopHealthBusinessCaseFullRpt-5-1.pdf (accessed September 2016).

[ii] Trust for America's Health (TFAH). *National Forum on Hospitals, Health Systems and Population Health: Partnerships to Build a Culture of Health. Overview and Highlights*. Washington, DC: TFAH, 2016.

http://healthyamericans.org/health-issues/wp-content/uploads/2016/07/TFAH-2015-NatlForumOnHospRpt-Fnl-Rv.pdf

[iii] Braiding is coordinating funding and financing[iii] from various sources to support a single initiative or strategy, generally at the community or program-level. Braided funds remain in separate and distinguishable strands, to allow close tracking and accounting of expenses related to each separate funding source. Blending, in contrast, maximizes programmatic flexibility by combining different revenue streams into a pooled fund such that expenses can no longer be traced to their original source. See *Sustainable Funding for Healthy Communities. Local Health Trusts: Structures to Support Local Coordination of Funds*, Trust for America's Health, available at http://healthyamericans.org/health-issues/wp-content/uploads/2016/10/Local-Health-Trusts-Convening-Summary-FINAL-1.pdf

[iv] Office of National Drug Control Policy. Drug-Free Communities Support Program. In *The White House.gov*, 2016. https://www.whitehouse.gov/ondcp/drug-free-communities-support-program (accessed September 2016).
[v] 2 CFR Chapter I, Chapter II, Part 200. Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards. https://www.law.cornell.edu/cfr/text/2/part-200 (accessed September 2016).
[vi] Rogan E and Bradley E. *Investing in Social Services for States' Health: Identifying and Overcoming the Barriers*. New York: Milbank Memorial Fund, 2016. http://www.milbank.org/uploads/documents/Bradley-Rogan%20Investing%20in%20Social%20Services%20Report.pdf (accessed September 2016).
[vii] McGinnis, Crawford M and Somers SA. A State Policy Framework for Integrating Health and Social Services. *The Commonwealth Fund Issue Brief*, July 2014. http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2014/jul/1757_mcginnis_state_policy_framework_ib.pdf (accessed September 2016).
[viii] Stanek M. *Federal and State Policy to Promote the Integration of Primary Care and Community Resources*. Portland, ME: National Academy for State Health Policy, 2013. http://www.nashp.org/sites/default/files/Federal_and_State_Policy_to_Promote_the_Integration_of_Primary_Care_and_Community_Resources.pdf (accessed September 2016).
[ix] Crawford M and Houston R. State Payment and Financing Models to Promote Health and Social Service Integration. *Center for Health Care Strategies, Inc. Brief*, February 2016. http://www.chcs.org/media/Medicaid_-Soc-Service-Financing_022515_2_Final.pdf (accessed September 2016).
[x] Bachrach D, Guyer J, Levin A, et al. Medicaid Coverage of Social Interventions: A Road Map for States. *Milbank Memorial Fund, The Reforming States Group, and NYS Health Foundation Issue Brief*, July 2016. http://nyshealthfoundation.org/uploads/resources/medicaid-coverage-of-social-interventions-issue-brief-july-2016.pdf (accessed September 2016).
[xi] Rosenbaum S, Kindig DA, Bao J, et al. The Value of the Nonprofit Hospital Tax Exemption was $24.6 Billion in 2011. *Health Affairs*, 34(7): 1225-1233, 2015.
[xii] Internal Revenue Service. *Report to Congress on Private, Tax-Exempt, Taxable, and Government-Owned Hospitals.* Washington, DC: Internal Revenue Services, 2015. https://www.vha.com/AboutVHA/PublicPolicy/CommunityBenefit/Documents/Report_to_Congress_on_Hospitals_Jan_2015.pdf (accessed February 2016).
[xiii] Community Benefit and Community Building. A Suggested Approach for Determining Whether to Report a Program or Activity as Community Health Improvement. In *Catholic Health Association of the United States*, 2015. https://www.chausa.org/docs/default-source/community-benefit/guidance_for_determining-march25_2015.pdf?sfvrsn=0 (accessed September 2016).
[xiv] Community-Building Activities – Archive. In *Catholic Health Association of the United States*, 2015. https://www.chausa.org/communitybenefit/what-counts-q-a-index-a/community-building-activities-a#socially (accessed September 2016).
[xv] CMS.gov, (2016). Medicare Diabetes Prevention Program Expansion. [Press Release]. https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-07-07.html (accessed September 2016).
[xvi] Health Care Innovation Awards Round One Project Profiles. In *Centers for Medicare & Medicaid Services*, 2012. https://innovation.cms.gov/files/x/hcia-project-profiles.pdf (accessed September 2016).
[xvii] State Innovation Models Initiative: Model Test Awards Round Two. In *Centers for Medicare & Medicaid Services*, 2016. https://innovation.cms.gov/initiatives/state-innovations-model-testing-round-two/ (accessed September 2016).