Financial Sustainability for Complex Care Models Serving Low-Income Patients: a New Role for Philanthropy

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This paper shares lessons learned from providing planning and technical assistance to the grantees of the Merck Foundation's 5-year, $16 million initiative, *Bridging the Gap: Reducing Disparities in Diabetes Care*, designed to improve access to high-quality diabetes care and reduce disparities in health outcomes among vulnerable and underserved U.S. populations with type 2 diabetes. Our objective was to co-create, with the sites, financial sustainability plans to sustain their work once the initiative had ended and to improve and/or expand it to serve more patients, better. Financial sustainability is an unfamiliar concept in this context, largely because the current payment system inadequately compensates providers for the value their care models provide to patients and to insurers. Our assessment and recommendations are based on our experiences working with each of the sites on sustainability plans. The sites were diverse in terms of their approaches to clinical transformation and integration of SDOH interventions, geography, organizational context, external environment, and populations served. These factors influenced the sites' capacity to build and implement viable financial sustainability strategies and the eventual plans themselves. Philanthropy has a critical role in investing in providers' capacity to develop and implement financial sustainability plans.

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BACKGROUND AND RATIONALE

In 2017, the Merck Foundation funded *Bridging the Gap: Reducing Disparities in Diabetes Care* (the initiative), a 5-year, $16M initiative that facilitated grants to eight sites across the country.[1] The initiative's mission was to improve access to high-quality diabetes care and reduce disparities in health outcomes among vulnerable and underserved U.S. populations with type 2 diabetes. Each site combined clinical transformation with cross-sector strategies to address social determinants of health (SDOH). The Social Impact Exchange, a nonprofit organization that works nationally to support equitable systems change in a variety of fields (primarily education, health, and economic opportunity), received a grant from the Merck Foundation to work with each site to develop a plan to ensure the sustainability of their work.

The initiative sites included large healthcare systems (3), nonprofit organizations operating as Federally Qualified Health Centers (FQHC) or collaborating directly with community and healthcare partners (2), government entities working with FQHCs (2), and a university working with FQHCs (1). All serve low-income people, most of whom have Medicaid insurance or are dual eligible, with many uninsured patients. Most sites' patient populations were primarily comprised of people of color, in some cases immigrants, many of whom were undocumented. In addition to public reimbursement, these organizations raise dollars through private philanthropy and government grants to fund innovations to improve patient and community health, and in some cases to remain solvent.

Historically, financial sustainability has been an elusive goal for the nonprofit sector caring for marginalized populations. This is largely a function of the way government funding for services for low-income people is structured: low margins, inconsistent, often challenging to obtain, and almost always inadequate. The current payment system does not appropriately compensate initiative sites for the value their care models provide to patients and to insurers. While philanthropy plays an important funding role by supplementing insufficient public dollars, it rarely directly supports revenue-generating initiatives that enable financial sustainability. Furthermore, philanthropy is not designed to provide support indefinitely; foundations typically limit the number of years that an individual grantee can receive funding before "cycling off."

Important shifts in the healthcare market have increased the possibility of financial sustainability for integrating medical and social care to advance health equity.[2] These changes include increased pressure for equitable access, quality, and outcomes in health care; payers' interest in lowering costs; growing recognition of the extent to which social factors such as housing, food insecurity, and structural racism shape health; and movement toward value-based care.[3] Federal authorities are accelerating the use of Medicare and Medicaid resources to address SDOH.[4] States are similarly using waiver authorities and other policy changes to expand resources, services, and partnerships.[5]

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The initiative sites and others have demonstrated important positive outcomes that provide a strong case for exploring pathways to financial sustainability.[6,7]

- *Improved Access to Care for Underserved Populations*: All sites serve patients who qualify for Medicaid; at several sites, 20–40% of the patients are undocumented and/or uninsured.
- *Quality of Care and Health Outcomes*: The sites have improved health outcomes, such as reduced A1c levels.[8–10]
- *Cost Savings*: One site has shown that the interventions have saved money for payers or hospital ACOs.[10]
- *Competitive Advantage*: Some sites have reported being approached by insurers seeking to maintain or grow their footprint because they know that these providers have developed comprehensive care models that address SDOH needs and can succeed under value-based payment.
- *Virtuous Cycle*: Financially viable business models will sustain the programs, and increased revenues will allow for program growth, thereby serving more patients, further decreasing costs, and increasing savings. Comprehensive care models extend beyond diabetes to other chronic diseases such as hypertension.

RECOMMENDATIONS

A New Role for Philanthropy: Capacity Building for Financial Sustainability

Philanthropy has a critical role to play investing in long-term viability rather than simply supporting short-term program implementation. The goal should be the creation of a viable, long-term business model that over time reduces reliance on private philanthropy and maximizes billable revenues from contracts with private and public payers. This is particularly important for the sites that delivered services at FQHCs. As smaller, stand-alone nonprofits and independent clinics, they do not have access to the institutional resources of larger healthcare systems.

The revenue model should cover the full cost of the services, infrastructure, and overhead. Ideally, services would be priced based on the value to the buyer and not solely on costs to the seller. This model would yield higher profit margins and allow the providers to generate revenue that would support expansion of the program or cover expenses for which other sources of funding are unavailable (e.g., serving uninsured patients).

Targeted philanthropic investment can support financial sustainability in at least two ways. The first is funding financial technical assistance for clinical management teams that lack the detailed business planning skills to make the value case for novel interventions to address medical and social needs. Such assistance might include basic financial modeling, development of value propositions, pricing expertise, and preparing for negotiations with payers.

Second, philanthropy could cover start-up costs and targeted investments related to building a business. For example, data collection, analysis, and reporting to demonstrate positive patient outcomes and cost savings to payers require significant up-front investment, ongoing operational costs, and highly skilled staff. Funding for data systems and personnel is often very hard for clinics to secure; philanthropy can help build this capacity.

Technical Assistance Options for Building a Sustainable Financial Model

Capacity building at the clinical level is essential; however, clinical practices are often very limited in their ability to achieve financial sustainability in an unsupportive policy environment. The partner sites were considerably diverse internally (e.g., organizational structure, internal capacity, programmatic model) and externally (e.g., regulatory rules and partnership realities) and operated within different regulatory environment. Their ability to develop a financial sustainability plan depended heavily on the opportunities and constraints presented by both internal resources and structures and state or local payment policies. Clearly, there is no "one size fits all" model for financial sustainability.

The sites' sustainability options fell into four categories:

1. Create a sustainable financial model and value proposition; prepare to negotiate with payers.

a. Build a financial model.

SIE worked with several sites to develop a detailed financial model that articulates the actual costs of the services, establishes the revenue the sites will need to cover their costs on an ongoing basis, and earns sufficient additional revenue to build an intervention that could treat more patients or support other parts of the operation. A core assumption was that the model would be used to negotiate a per-member, per-month (PMPM) rate with the payer and that the PMPM would be based not only on the cost of delivering services but on some reasonable assumption of cost savings that the payer was realizing.

b. Develop a value proposition.

The SIE team then worked with the partner sites to create a value proposition statement that made the case to payers. Depending on the specific circumstances, the typical value proposition had the following sections: return on investment, improved quality of care and patient outcomes, surplus revenues that increase capacity to serve more patients and increase earnings for the payer, increased share of the Medicaid market, credibility as a supporter of health care equity, and being ahead of regulatory changes that will support value-based care.

iii. Prepare to meet with payers.

The SIE team worked directly with grantees to create a presentation with tailored talking points. For example, one site met with a payer that wanted to enter their market and was bidding on a request for procurement from the state. The site highlighted how a partnership with them would allow the payer to demonstrate its unique value to the state.

2. Develop a value proposition for internal stakeholders.

Population health programs that decrease hospital admissions could mean lost revenue in the short term for health care delivery organizations paid predominantly by fee-for-service systems. Therefore, population health might not be aligned with their current business model. The value proposition might need to be modified for the internal audience, for example, by emphasizing the utility of being ahead of eventual regulatory changes and market trends that support value-based care and alternative payment models.[2]

3. Leverage existing payer relationships to identify new ways to earn revenue through billing.

One of the partner sites a municipal public health department, formed a partnership to create a financial sustainability plan with a consortium of the city's 10 FQHCs and a CHW technical assistance and service provider that staffed the CHW component of the initiative. In response to challenges the FQHCs faced in billing for CHW services, the local health department and the provider developed a payment model that allowed the provider to bill payers for CHW services, negotiate higher rates, and use initiative funds to pay for the difference between the reimbursement rate and the actual cost of the CHW.

Another site which operates an FQHC worked with a private payer to provide diabetes management services to a commercially insured population. The director of the site understood that a successful pilot could open the door to serving members receiving Medicaid. The expansion subsequently occurred.

4. Leverage new funding opportunities created through favorable policy changes.

One initiative site, part of a large healthcare system, used grant funding to enhance its existing care coordination care model, which positioned them favorably for a 5-year, $5.5M grant from the state. The clinical transformation strategies and SDOH-related services tested and supported by the initiative aligned their work more closely with the state's all-payer rate-setting system.

CONCLUSION

The current payment system does not appropriately compensate health care delivery organizations for the value their care models provide to low-income, underserved patients and to insurers. Existing models of financing care do not position clinical providers to develop, let alone sustain or grow, high-quality, effective treatment models that meet their patients' complex health and social needs. If commitments to equitable outcomes for all patients are sincere, it is time to invest in helping providers achieve financial sustainability. Philanthropy can support providers through sustainability planning, targeted technical assistance, and funding start-up costs. Advocates and policy makers can create operating environments that value comprehensive care in tangible ways and incentivize and require payers to compensate providers appropriately.

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