Commentary

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It's Not Just Insurance: The Affordable Care Act and Population Health

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Unsuccessful Congressional efforts to replace the Patient Protection and Affordable Care Act in 2017 focused on financial strategies to fund health insurance, reduce Medicaid spending, and manage insurance subsidies, incentives, and taxes.[1,2] Assessments of the public health impacts of these proposals emphasized the potential loss of the Prevention and Public Health Fund, which supports programs administered by the Centers for Disease Control and Prevention (CDC) and implemented by state and local health departments, along with concerns about the population-level health consequences of curtailing Medicaid and weakening requirements that insurers cover various preventive services.[3-6] As debates about the future of the US health insurance policy move forward, two other dimensions of the Affordable Care Act deserve the public health community's attention: (1) provisions that aim to improve the value of the federal government's Medicare and Medicaid expenditures and (2) mandates that nonprofit hospitals assess community health needs and implement community benefit programs. These provisions push hospitals, clinicians, and insurers to embrace approaches broadly labeled as *population health*,[7] a concept with strong parallels to the methods and context of public health practice. Drawing on our experience in public health, health care, insurance, and health services research, we argue that as health policy debates move forward, public health practitioners have an important stake in the ways that the provisions of the Affordable Care Act align health care practice with public health objectives.

Value-Based Health Care Reimbursement and Public Health

In many respects, the Affordable Care Act reflects the aspirations of Berwick et al,[8] who argued that improving health care would require pursuing the "Triple Aim" of "improving the individual experience of care; improving the health of populations; and reducing the per capita costs of care." The term *population* was primarily a reference to groups of people under the care of individual providers or health care systems.[7,8] Achieving this aim implied a need to understand the characteristics and health profile of populations under care and to track key indicators of care, such as the proportions who received recommended services and had favorable health outcomes. Improved value would result from successes in achieving better health outcomes at a lower per capita cost. In 2008, Berwick et al could point to a relatively small number of vanguard systems that had embraced this approach, including the adoption of electronic health records to inform personal care and monitor health service delivery and outcomes.[8] Fast forward to the present, widespread electronic health record adoption, frustrations notwithstanding,[9] has been spurred by the Health Information Technology for Economic and Clinical Health (HITECH) Act, with incentives linked to demonstrated "meaningful use" of electronic health records to improve care delivery, monitor clinical performance, and execute mandated disease and immunization reporting to state or local health departments.[10,11]

The Affordable Care Act established the Center for Medicare & Medicaid Innovation (hereinafter, the Innovation Center) within the Centers for Medicare & Medicaid Services to develop and evaluate new reimbursement and

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incentive models in federally funded insurance programs, with the goal of improving the value of Medicare and Medicaid expenditures and population health.[12] The HITECH Act predated the Affordable Care Act and fostered health care information infrastructures that were essential to the spectrum of models launched by the Innovation Center.[13] These models included demonstration projects aimed at creating accountable care organizations, bundled payments for defined episodes of care, and other performance- or value-based reimbursement incentives. Accountable care organization demonstrations aimed to establish best practices in care management, integration, and coordination by promoting collaborations among primary and specialty outpatient providers, hospitals, and insurers.[14] Through its State Innovation Models Initiative, the Innovation Center engaged state governments to develop regulatory and policy reforms that improve health care value and, by extension, "health for the population of the participating states or territory."[15]

Across these efforts, key aims have been to reduce preventable morbidity among people with chronic conditions, who account for a disproportionate share of health care spending and whose numbers are increasing as the baby-boomer generation ages,[16] and to improve the delivery of preventive services, in alignment with Affordable Care Act coverage mandates. The Innovation Center also supports the development of "accountable health communities," which require clinical delivery sites to assess patients' unmet social needs related to housing and food insecurity, utility service, or transportation and to build links with community agencies in addressing these needs.[17] Value-based concepts are now embodied in reimbursement reforms in the Medicare Access and Children's Health Insurance Program Reauthorization Act of 2015, which mirrors the HITECH Act in support of electronic health record use.[18] Beyond their roles in providing Medicare- or Medicaid-based products, private insurers are increasingly adopting value-based reimbursement approaches.[19]

The concept of taking a population-level approach to informing health care underlies all of these strategies. Not surprisingly, the term *population health* has assumed protean meanings given the mix of settings in which it is applied.[7,20] For insurers, client populations include members of various plans, and priorities are driven by stakeholders to ensure that expenditures optimize health care outcomes and value. Insurers are also likely to have an interest in minimizing the risk of insurance pools or, alternately, in strategies to offset risks associated with requirements to insure people with high-cost conditions. For health care systems, hospitals, or individual practices, patient populations are defined not only by who is under their care or what diseases they have but also by the level of incentivized financial risk (pay-for-performance, bundled payments, shared savings, shared risk, full risk) created by contracts with insurers, which include requirements for reporting quality and cost metrics and related financial incentives. Whether imposed by government or private insurers, these arrangements create financial opportunities and risks that are shaped both by the quality of health care delivered and by social and economic circumstances in patients' homes and communities. For example, health outcomes and metrics related to the management of chronic conditions, such as hypertension or diabetes, are influenced by household financial and social situations that affect patients' ability to follow treatment regimens, creating incentives for health care providers to integrate social services into their care programs[21] and focusing attention on risk-adjusted reimbursement approaches.[22]

Switching from a definition of populations based on sources of health care or risk models to a definition based on the geographic lines of political jurisdictions, such as counties or states, leads to a transition to the domain of public health. Public health programs, services, and policies are variably targeted to individuals, high-risk or vulnerable groups, and populations at large within health departments' jurisdictions. Public health practitioners are familiar with the effects of social situations on health,[23] they typically work with a mix of community-based partners, and they routinely use various data sources and quantitative tools (eg, epidemiology, biostatistics), often in tandem with qualitative methods, to describe and monitor the health of populations. The public health approach to addressing the health of populations involves addressing three critical questions on an ongoing basis: (1) Who composes the population within our jurisdiction? (2) How are measures of health or health risk distributed within populations? and (3) How should this knowledge inform our work?[24]

Two parallels between the concept of population health in health care and public health practice are apparent. The first is a focus on groups (populations) and the use of metrics to monitor services and health; the second is the recognition that health and, thus, the outcome of clinical and public health services are affected by a mix of social determinants.[23] Given these parallels, where is the opportunity for public health? As the executive director of the Association of State and Territorial Health Officials predicted in early 2017, "Public health agency efforts to connect health promotion and wellness programs with healthcare delivery partners will continue to be needed . . . as payers look for savings and ways to reduce overall healthcare spending."[25] Reimbursement incentives that push health care providers and systems to pay greater attention to their patients' community situations bring them into the domain of public health but will not automatically lead them to collaborate with public health. A growing number of health departments have seized this opportunity to partner with hospitals in creating programs that bridge clinical and community services and address a spectrum of shared priorities, such as asthma control in children, the health of homeless people, smoking cessation, influenza vaccination, hypertension control, substance use disorders, and prenatal care for high-risk women.[26]

From the federal public health level, CDC is encouraging health departments to strengthen health care connections as part of chronic disease programs.[27] For example, evidence

demonstrates the value and effectiveness of community health workers in improving adherence to medical recommendations,[28] and interest in the potential for community health workers to improve health care outcomes is growing.[29] For insurers or health care systems to engage such workers, it is not necessary to involve health departments, but the opportunity for health departments to support such connections is recognized by CDC funding guidance that directs them to build "community and health system interventions" in preventing chronic diseases and their complications, by acting to "increase the engagement of non-physician team members," such as community health workers.[30]

Community Health Needs Assessments and Community Benefit Programs

A second important population health dimension of the Affordable Care Act is the requirement that nonprofit hospitals conduct periodic community health needs assessments and use these assessments to inform community benefit programs.[31] In completing a needs assessment, hospitals are required to consult at least one state, local, or tribal public health authority, and they are permitted to draw on existing health assessments for their areas.[31] The likelihood that such reports will be available is heightened by accreditation criteria that require health departments to conduct community health assessments.[32] Connections between hospitals and health departments arising from their respective involvement in community health assessments create an entrée for health departments to engage hospitals in discussing how their community benefit programs will be shaped. Although hospitals credit most community benefit spending to costs for care not fully reimbursed by Medicaid and charity care,[33] in 2009, community benefit spending dedicated to "community health improvement and community-building activities" represented $11 per capita nationally, relative to $82 and $48 median per capita spent by state and local health departments, respectively.[34] Indications that costs for unreimbursed care have decreased in Medicaid expansion states[35] hold the promise, at least theoretically, that additional funding might be dedicated to community-based spending. To the extent that such expenditures might have greater public health impacts if coordinated strategically, health departments have an opportunity to be convening partners in identifying commonalities across multiple needs assessments and mobilizing or coordinating services or resources that might be engaged, as exemplified by efforts in Chicago and San Francisco.[36,37]

Public Health Implications

Public health practice has a long history of dependence on, and collaboration with, partners in health care, including hospitals, clinicians, and insurers. The consequences of acute and long-term public health problems, such as disease outbreaks, obesity, tobacco use, chronic disease, and opioid misuse, often manifest in clinical settings. Public health recommendations, such as those for immunizations, treatment of communicable diseases, preventive screenings, health counseling, or pain management, largely depend on implementation by clinicians. In many respects, the Affordable Care Act represents a declaration of alignment of health care and public health objectives, reflecting shared interests in disease prevention and health promotion. By expanding access to Medicaid and by requiring that insurers cover certain preventive services without copayment, the Affordable Care Act advances both personal health and public health. This concept was enhanced by extending the age of coverage for young adult children up to age 26 under parents' policies and by requiring coverage for addiction services, which is vital for tackling the national epidemic of opioid use disorder.[38]

As we have highlighted in this commentary, provisions in the Affordable Care Act that foster population health approaches in health care, notably, insurance innovations that incentivize greater attention to the interface between health care outcomes and community circumstances, and mandates that nonprofit hospitals implement community benefit programs, create new opportunities for health departments to collaborate with health care partners in pursuit of shared objectives. Fulfilling these opportunities requires that health departments actively engage and support providers and insurers as they implement population health approaches to provide value in health care. As national debates about the future of federal health insurance policies move forward, public health has an important stake in, and should lend its voice to, deliberations about the future of these policies and their administration.

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