Q1 Please provide your contact information below.

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Q2 Please describe your company or organizations overall goals and mission.

The Green & Healthy Homes Initiative (GHHI) is a 501(c)(3) nonprofit organization founded in Baltimore, Maryland in 1986. The mission of the organization is to break the link between unhealthy homes and unhealthy families by creating and advocating for healthy, safe and energy efficient homes. GHHI operates in 20 states and 61 cities nationally, and has grown from providing direct services, to be a national authority on healthy housing. GHHI's innovative finance solution offers a unique opportunity to improve health outcomes by addressing the social determinants of health, and to accelerate healthcare delivery transformation nationwide.

Q3 Please indicate which category your organization falls under.

Community Based Organization

Q4 Innovation Executive Summary. Please describe the innovation, and how it addresses the social determinants of health. Please identify how the innovation addresses the 6 innovation criteria (i.e. ROI, scaleability, feasibility, evidence based support for innovation, relevance to the Medicaid population and speed to market).

A. The innovation is a different way of paying for care using a "Category 4a" advanced alternate payment model for a specific sub population that splits financial responsibility between parties. (Please see Alternative Payment Model (APM) Framework: Final White Paper Alternative Payment Model Framework and Progress (APM FPT) Work Group 2016). We are currently developing this model nationally, including multiple projects in the state of New York. Specifically, the model creates a set of enrollment criteria based on medical appropriateness where patients have the option to opt out of program enrollment. Attributed patients are delivered services, with the service provider bearing the cost of delivering services. At the end of the payment period, the managed care plan assesses the health and healthcare cost impact for the population using an actuarially sound method, then makes an appropriate payment for the care provided. The payments attributed to each individual and recorded as a value-based care encounter in the existing encounter record – as is standard practice for all medical care. The model was designed to align with existing standards and practices of Medicaid

rate-setting and use existing data infrastructure of encounter records to address implementation issues and more nuanced financial implications associated with equitable distribution of benefits between partners. To be clear, the payments are not a 'shared savings' payment, but a value-based care payment representing the value of care provided over the volume of services that aligns with federal regulations (42 CFR 438.6(c)) and the Health Care Payment Learning & Action Network's APM Framework as a way of transitioning to fully value-based care.

B. The innovation allows parties to address the social determinants of health through creating a business model for prevention, where preventive efforts are more profitable for insurance providers than allowing existing costs to accrue. For example, the NIH meta-analysis of multiple random control trials among existing studies concluded that asthma care should include environmental controls; however, those services are largely unfunded. Every year that a high-risk asthmatic is allergic to mold and lives in a home with moldy carpets will result in Medicaid expenditures. Those medical expenditures increase the expected future costs for the population, insurance plans, and the state's Medicaid program. There is, however, a net financial penalty for an insurer to address those issues in the long run due to premium slide and other issues. The use of alternate payment models can correct and align the financial incentives to drive spending that address the social determinants of health up the point of cost-effectiveness.

C. The innovation creates a favorable landscape for each of the categories provided:

1. Return on Investment

The innovation proposed allows plans to compensate service providers for the value of their care up to the point of cost-effectiveness. This limits any downside financial-risks for the plan and the state, allowing them to ad-dress the social determinants of health and move projects forward. The implementation of an alternate payment model as opposed to a specific intervention has far higher upside potential as well, because it enables a wide range of interventions to be provided using a standardized framework that can address asthma, house-hold injury resulting in orthopedic surgical and long-term care needs, as well as behavioral health issues including preventing opioid affected pregnancies, and well beyond. For example, even including administrative costs and financing charges addressing asthma in the state could yield three dollars for every one invested over the life of a Medicaid enrollee. GHHI's primary operational research indicates that nearly USD 13.8 billion could be saved through comprehensive home-based interventions nationally. Research conducted with the New York State Energy Research and Development Authority (NYSERDA) indicates the opportunity in New York could be over 30 percent of the total cost of care for high-risk asthma patients approaching USD 50 mil-lion in the first year and continuing to accrue value over the life of the population.

2. Scalability

Implementation of alternate payment models has far higher scalability potential than a specific intervention as it encompasses the potential for scaling any individual intervention. Linking a program's internal scalability with the effectiveness of the business model means that the most financially beneficial programs will have the highest scalability potential; programs with low return on investment will have less ability to scale using the value they create or capture.

The proposed innovation lets the state play the role of market-maker – by creating a business opportunity to address the social determinants of health rather than specifically picking and choosing to advance initiatives. This shifts the burden of making the initial investments addressing the social determinants of health to the organizations who want to deliver the services. Those providers then need to raise capital or arrange for financing for their operations, abdicating the need for public assistance in scaling the programs. By shifting the burden for investments in the social determinants of health from the Medicaid program directly to the private sector, programs scale at the rate at which they can secure financing arrangements, rather than the rate at which the state makes funding available. The best programs with the most persuasive results or evidence base will be able to raise most capital for implementation.

3. Feasibility

The feasibility of the innovation in the state of New York has been determined into specific locations as well as generally indicated for a statewide analysis. For both greater Buffalo and New York City, GHHI has conducted a feasibility study determining if the projects could advance given the underlying economics of the comprehensive asthma intervention using the proposed innovation and alternate payment models. Further, GHHI has worked with these partners to develop model contracts to implement this program in an extensible fashion to other condition areas. GHHI is working with the New York State Energy and Research Development Authority to create the necessary market-supports to demonstrate and scale this work across the state addressing healthy and energy efficient housing that

impacts asthma, household injury prevention for older adults, and even lead-poisoning hazards.

The only thing left for finalization of the precedent is n current obstacle to the implementation of the Medicaid alternate payment arrangement and official approval when your state department health's Medicaid program for the contract. For example, in Western New York as many as four plans would be willing to purchase payment program that need assurance from the state of New York that the proposed alternate payment model is appropriate.

4. Evidence-based support for innovation
The benefit of using a framework to advance alternate payment models is that there are many evidence-based innovations that can be supported by a single framework. Each innovation can then be assessed based on their independent strengths, weaknesses, and relevance to the program.

5. Relevance to the Medicaid Population
The proposed innovation is particularly relevant the Medicaid population as it provides a cost-effective way to create a business model where prevention and addressing the social determinants of health is more profitable and effective for insurance plans.

6. Speed to Market
There are currently two projects which could be launched within the next contract and cycle in the state of New York. Additionally, the New York State Energy Research and Development Authority (NYSERDA) is in the process of developing pilot sites throughout the state that would link managed care entities to community based organizations capable of providing energy efficient and healthy housing interventions for high-risk asthma patients. The resources are available to scale it effectively with significant pace, and dissemination to the broad market quickly

Implementation History
At GHHI, we have a portfolio of nearly 20 projects seeking to implement alternate payment model arrangements Nationwide with industry partners and experts, as well as with constructive engagement with the Centers for Medicaid and Medicare Services. Additionally, GHHI was invited the New York State Department of Health to present this model at a six-part state-wide New York State Value-Based Purchasing Bootcamp series in 2017, fostering engagement among plans and community based organizations. Our national implementation efforts also include national insurers, major health systems, and community-based organizations including partners: United Healthcare, the Robert Wood Johnson Foundation, the Centers for Health Care Strategies, Health Management Associates, Academy Health, and Social Finance US. We or our partners have hosted a number of convenings on related topics to bring together stakeholders, resulting in the commitment of three such sites actively working to develop their managed care contracts for negotiations, with five more slated to start the process in the coming year.

Q5 Was your innovation implemented? If so, please explain when, the number of people impacted, and the results.

No

Q6 Please identify the SDH Domain that your innovation addresses. (Select all that apply.)

Education,

Social and Community Context,

Health and Health Care,

Neighborhood and Environment,

Economic Stability

Q7 I give the Department of Health the right to share the information submitted in this application publicly (for example: on the DOH website). I understand that there is no monetary reward/reimbursement for my submission or for attending the summit should my innovation be selected.

I consent to have my innovation shared