



Reimagining Financing & Capital Flows for Health Equity

Hosted by HealthBegins and the UC Berkeley School of Public Health Social Impact Team, in collaboration with Common Health Coalition

Pre-Convening Innovations and Infrastructure Proposals

In the days leading up to the February 19th, 2026 convening, many attendees shared promising and **innovative solutions** and models to help unlock and align financing and capital flows for health equity. Many also shared **proposals** to improve the enabling infrastructure (i.e. industry practices, policy/regulatory environment, and accountability mechanisms) for these innovative solutions.

On February 19th, over 60 cross-sector leaders reviewed and added to this list of innovative solutions. Recognizing that there was no lack of existing and emerging innovative ideas, they then refined and prioritized a slate of concrete actions and opportunities to shape industry practices and policies in order to clear the path for more financing and capital flows for health equity.

Please see below for input provided by attendees prior to the February 19th convening:

A. **Innovative solutions**

B. **Proposed** Industry practices, Policy/regulatory levers, and Accountability mechanisms

A. Innovative solutions

1. Innovative Approaches to Measuring and Paying for Value

| Innovation Name | Description | Barriers |
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| Health-Credits Market | Market rewarding insurers for sustained health risk improvements even when plan switching occurs. Incentivizes long-term chronic care and prevention investment. | Risk score calculation at entry/exit has admin costs. Enrollment cycles are too short to recover costs. |
| Blended Value for Health Equity Model | Framework quantifying financial, economic, and social value for health investments. 5X more value captured in previous models; Total Value score aligns CFOs. | No formal incentives for assess/report on value. Lack of common equity-focused ROI methodologies. |
| VBP Models including Social Care | Payment design accounting for upfront costs and links to short-term quality measures. Economic models like FIM show significant long-term savings. | 12-month state budget cycles impede long-term improvement. Lack of actuarial experience with social care. |
| CalAIM and Quality | Analysis of CalAIM services utilization and the tie to quality outcomes. Allows for financial justification of continued investment in CalAIM. | Need for collaboration to pool data from all plans. Fragmented data silos within health plans. |
| CEA Registry | Online database of 15,000+ studies providing base for social ROI. 15,000+ studies; over 800 papers have cited the registry. | Need resources to promote and educate on guidelines. Political opposition to using CEA to "ration." |
| Novel Equity-Focused CEA | DCEA (health-gain weighting) and MCDA (non-health benefits). Finds "efficiency" in interventions previously deemed "inefficient." | Federal restrictions on CEA for Medicare. Actuarial reliance on standard QALYs. |

2. Innovative Service and Integration Models

| Innovation Name | Description | Barriers |
|--------------------------|---|--|
| Educating Doctors | Medical education for shared-community providers. Better outcomes when providers share race/language. | US lack of general support for medical education. Lowest reimbursement for safety-net doctors. |
| Wildflower Health | Maternal health management providing shared savings to physician practices. 2.6 ROI; proven results in maternal outcomes. | Very slow adoption process for payers. |

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| Clubhouse Model | Integration of non-clinical therapeutic community into care. Reduces Medicaid costs by 21%; saves \$11k per member/year. | Historic exclusion from Medicaid reimbursement. Skepticism of non-clinical complementary supports. |
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3. Innovative Alternative Financing Mechanisms

| Innovation Name | Description | Barriers |
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| Family Human Capital Strategy | Private investors fund childhood human capital; Gov shares adult fiscal gains. IRR of 13.7% found in similar childhood programs. | Political constraints on increasing tax revenues. Lack of mechanism to return gov gains to investors. |
| CAPGI | Calculates "Business Case" and determines fair share contributions. 3x ROI in Cleveland; Waco law enforcement savings success. | "Wrong pocket" regulation hurdles. Free-rider incentive; lack of neutral conveners. |
| Impact Investing Fund for Aging Populations | Pooled 5% AUM impact strategy using foundation capital. Scales innovation where Medicaid rate flexibility is limited. | Fiscal pressure from Medicaid cuts. Institutional bias toward facility-based care. |
| Investing in Flourishing | Stacking multiple shared savings agreements along life course. Mid-demonstration in OH and MD child hospitals. | Data sharing agreements. Hidden outcomes valuations; rate resetting lag. |
| Community Prevention R&D Fund | Philanthropy pays; payors replenish fund if goals are met. De-risks the "test" for states to expand coverage. | Unclear how outcomes interacts with MLR. Complexity of Medicaid finance; secretive valuations. |
| Public Health Bonds | Municipal/social bonds raising upfront capital for infrastructure, repaid through revenue or savings. Proven in US lead-abatement. | Debt ceiling limits; lack of repayment streams. High transaction costs; long-dated ROI skepticism. |

4. Innovative Place-based and Community Investment Approaches

| Innovation Name | Description | Barriers |
|---|---|--|
| Wellness Fund | Multiple funding streams and collective regional governance. Narrative proof of success for hyper-local priorities. | Siloed/categorical funding activities. Short budget cycles vs systemic change. |
| Community Codedesign Investment | Cohort-driven approach providing multi-year "runway" for projects. NJ model leveraged \$4.68M into \$98M in 4 years. | Need for state programs synergistic with private capital. Need runway for patient capital readiness. |
| Place-based Investing Leadership | Directing 1% of system assets into geographically-focused impact loans. \$1.35B allocated to date; supported 40k housing units. | Economic uncertainty and Medicaid cuts. Not currently recognized as "Community Benefit." |
| Health Prescribed Housing™ | Precision matching of Medicaid members to housing supply/SDOH. 80%+ fewer ER visits; 50%+ lower cost of care. | Reimbursement to providers should be mandatory. MCO avoidance of infrastructure funding. |
| BOS Collaborative | Collaborative table aligning funding with community land trusts. Leverage private/public capital 10X. | Misunderstanding of shared equity models. Risk assessments prevent land trust flow. |

5. Innovative Infrastructure and Capacity Building Models

| Innovation Name | Description | Barriers |
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| Loan Compliance Infrastructure | Mission-aligned servicing infra for smaller programs. Reduced administrative costs through centralized scale. | Servicing contracts require massive scale. Low resource program demand suppression. |
| Medi-Cal Standard for Pension Fund Investments | CRA-style standard adding Medi-Cal track record to pension (CalPERS) due diligence. Based on CRA success (\$2T+ directed). | 60-year-old statutory framework waivers. Backbone fragility; scale friction. |
| Leverage MIPS to improve healthcare / public health interoperability | Leveraging Medicare MIPS for hospital public health reporting. Improved public health reporting uptake by hospitals. | Slow state-level data modernization. Onboarding capacity limits. |



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| Health Promote Tool | ROI tool integrating health and property management data. Shows property-level social ROI for landlords/plans. | Silos between property and health data systems. Fragmentation of property-level health interventions. |
| Health Enterprise Zones | Multi-sector coalitions using tax credits and grants to attract providers to underserved ZIP codes. In MD, associated with 18,562 fewer inpatient stays and net savings outweighing investment. | Sustainability depends on time-limited grants; lack of permanent funding; cross-payer data silos. Recruitment challenges in medically underserved areas. |
| Asset Alignment | Building capacity for investors to align total assets (not grants) with health. Can unlock 50X more capital for community health. | Foundation 5% requirements do not reward impact. 12-month ACO and premium cycles. |

B. Proposed Industry practices, Policy/regulatory levers, and Accountability mechanisms

Proposed Industry Standards

| Recommendation | Detailed Industry Standard Recommendation |
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| Collaborative Funding & Power Sharing | Standards for shared power that address actuarial limitations, specifically the current lack of cross-sector and social benefit calculations in standard ROI. |
| Blended Return Accounting | Standards recognizing the difference in returns between impact portfolios and market rates as formal Community Benefit, encouraging CIO/CFO alignment. |
| Mission Mandates | Right of First Refusal for mission-aligned developers and making "health and equity in all policies" a standard project requirement for all capital deployment. |
| Standardized Health-Credits | Voluntary or statutory implementation of health-credits across all insurers to reward long-term risk reduction. Requires standardized entry/exit risk scoring protocols. |
| Investment Recognition | Establishing place-based impact investing as a core health system investment strategy, moving beyond the "1% carveout" to total asset alignment. |
| Certified Medi-Cal Financial Backbones (CMFB) | Establishing a DHCS verification pathway for local backbones and standardized track records for fund managers to build trust with pension funds. |
| Workforce Economic Standards | Mandating that Medicaid-funded systems pay staff at levels that make them income-ineligible for Medicaid themselves, breaking the cycle of poverty. |
| Property-Level ROI | Utilizing the "Health Promote" tool for property-level ROI calculation and bundling Medicaid with HUD vouchers as a housing standard. |
| Regulatory Collaboration | Utilizing regulation to force collaboration across the healthcare sector, specifically aligning local community reinvestment funds across competing plans. |
| Aging Service Standards | Implementing standardized impact reporting for aging and social risk-adjusted rate setting for Home and Community Based Services (HCBS). |
| Multi-year Attribution | Transitioning to multi-year Medicaid ACO assignments (3-5 years) to allow for the capture of prevention ROI and long-term member stability. |
| Whole Person Care Standards | Statutory and financial standards for coalition sustaining funds, integrated data systems, and CHW/Peer workforce development. |
| Public Risk Tolerance | Standards for public investment that are explicitly allowed to be "risky" (ok to fail) to support early-stage innovations and include lease-to-own requirements. |
| Neutral Outcome Valuation | Establishing neutral industry mediators to set "outcome values" and prices for community partners to simplify contracting and outcome-based pricing consistency. |
| Universal Claims Data | Standardizing claims data across all payers to enable large-scale investment in programs with non-financial ROI. Focus on Z-code adoption and multi-payer data sharing agreements. |
| Lived-Experience Metrics | Adopting metrics and measures guided by people with lived experience, such as the "Measures that Matter" project. Prioritizing social connectivity over clinical utilization alone. |

Proposed Policy/Regulatory Levers

| Recommendation | Detailed Policy/Regulatory Lever Recommendation |
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| Fiscal Integration | Turning retirement funds into impact investments and expanding LAO/CBO analysis to include cross-sector benefits (e.g., healthcare savings as a retirement return). |
| Credit Enhancements | Utilizing the CA Infrastructure Bank to provide credit enhancements, first-loss guarantees, and startup costs for mission-aligned social lending. |
| Tax Credit Incentives | Increasing state and federal tax incentives (New Markets Tax Credits expansion) specifically to encourage private place-based health investment. |
| Statutory Risk Scoring | Examining the statutory mechanisms needed for longitudinal health-credit risk scoring to track gains across insurance plan switches and year-to-year changes. |
| CFO Communication Levers | State-led strategies for wider adoption, focusing on communicating the unique "Business Case" of place-based work to health system CFOs and Treasurers. |
| CalPERS Due Diligence | Adding Medi-Cal investment track records to pension fund manager due diligence and priority reporting under the SB 54 framework. |
| MLR Guidance Reform | Explicitly classifying social driver spending (housing, food) as "Medical" or "Quality Improvement" spend within the Medical Loss Ratio framework to incentivize MCOs. |
| Housing Funding Mergers between HUD & Medicaid | Merging HUD weatherization and Medicaid home modification funds to reduce administrative friction for elderly homeowners; using I-Bank guarantees to de-risk production. |
| Rate Stability Guarantees | Executive guidance committing to multi-year Medicaid HCBS rate stability with automatic cost-of-living adjustments to protect small providers. |
| Investment Safe Harbors | Attorney General safe harbor guidance and state matching grants to de-risk and protect multi-sector investing from anti-kickback or conflict-of-interest litigation. |
| Interagency Task Force | Establishing a VP-Chaired task force of 15+ Cabinet agencies to listen to innovators and promulgate remedies to "wrong pocket" barriers across HUD, CMS, and IRS. |
| Shared Equity Requirements | Mandating specific shared equity requirements and capital absorption frameworks for all projects utilizing public housing or social infrastructure capital. |
| Revolving Repayment Fund | Setting up a dedicated repayment mechanism/fund for community prevention experiments where philanthropy funds the "test" and payers replenish the pool. |
| Mandated Resource Allocation | Policies that mandate the allocation of resources toward specific high-need populations identified through Z-code standardization and claims data. |
| Public Financing Integration | Utilizing LA/CA Centers of Excellence and NY State Clubhouse RFPs as blueprints for broader public financing integration for serious mental illness. |

Proposed Accountability Mechanisms

| Recommendation | Detailed Accountability Mechanism Recommendation |
|---------------------------------------|---|
| Regional Accountability Bodies | Establishing regional bodies modeled on school boards with a broad mandate for public health and capital alignment across sectors. |
| Lending Burden Reductions | Lowering the administrative and reporting burden for impact measurement in lending compared to standard philanthropic grants to speed up capital deployment. |
| Anti-Speculation Controls | Using Right of First Refusal and Community Benefit Agreement mandates to prevent non-mission LLCs from hoarding properties. |
| Financier-Benefit Alignment | Directly aligning long-term health benefits and savings to the specific insurance entity that provided the initial financing, preventing "free-riders." |
| "No Outcomes, No Credit" | A verification framework for fund managers focusing on access, equity, utilization, and community trust—moving beyond simple volume metrics. |
| Expenditure Transparency | Improving public transparency of hospital community benefit dollars and Medicaid MCO activities/expenditures to ensure accountability to the public trust. |
| Data Integration | Mechanisms that integrate individual health data with property management data to track real-time health impacts of housing quality improvements. |
| Collaborative Regulation | Local alignment of community reinvestment funds through collaborative regulatory oversight and joint planning between competing plans. |
| Managed Care Mandates | Tying Medicaid managed care contracts and rate-setting authority to mandatory equity performance metrics and reinvestment minimums. |
| Matching Grant Enforcement | Utilizing state matching grants as a primary lever to enforce and de-risk multi-sector capital alignment among private investors. |
| SIPRA-Style Waivers | Interagency waivers for state governments that incentivize blending and braiding funds to pursue total cost reduction across social and health budgets. |
| Community Ownership Mandates | Mandatory community ownership structures and "Shared Equity" clauses in all social infrastructure contracts utilizing state funds. |
| Technical Evaluation Support | Providing opt-in technical evaluation and data support for community-led outcomes-based trials to lower the "evidence bar" for smaller partners. |
| Flow Visibility | Implementing mechanisms to improve visibility into investment flows at the state and national level to ensure equity targets are actually being met by large systems. |
| Lived-Experience Centering | Centering accountability on metrics and outcomes specifically guided by people with lived experience (e.g., social connectivity, employment stability). |