Pay for Success Financing to Improve Asthma Outcomes

Lessons Learned from Two Feasibility Cohorts

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Preface

As Pay for Success (PFS) financing expands further into the public health field, GHHI strives to improve, standardize, and accelerate the feasibility process for its projects as well as others in development through documenting and sharing lessons learned. GHHI has a distinct perspective as both a direct service provider in Baltimore as well as a technical assistance provider to organizations exploring PFS in public health. This document provides key reflections to date in GHHI’s experience implementing asthma-focused PFS feasibility studies with two cohorts of healthcare and service provider partners in 10 jurisdictions across the country. PFS practitioners and thought leaders have published several high-quality resources about lessons learned already, so our primary goal is to provide particular insight that will be helpful for organizations interested in either 1) PFS financing to improve asthma or other public health outcomes, or 2) a cohort approach to PFS feasibility studies.

While this document focuses on learnings from our asthma PFS projects, these lessons apply across several other issue areas, particularly those in public health. With funding from the Corporation for National and Community Service’s Social Innovation Fund, GHHI will expand its technical assistance services in 2017 to advance PFS projects that address the social determinants of health.¹ To date, GHHI has focused on asthma due to both the immensity of the problem as well as the clear and direct connection between comprehensive asthma interventions and cost savings to the healthcare system.

In this document, we provide an overview of the gap in asthma care, GHHI’s work to scale evidence-based asthma interventions through Pay for Success financing, and the lessons we have learned from leading 11 PFS feasibility studies across the country. We organize our primary lessons learned into three sections:

1. General feasibility lessons
2. The benefits and challenges of a cohort approach to feasibility
3. The economic feasibility of asthma-focused Pay for Success projects
4. Pay for Success and Medicaid

The current gap in asthma care

Asthma affects over 25 million people, including 7 million children, in the United States. The annual cost of asthma is estimated to be over $56 billion. It is also a leading cause of absenteeism and third-leading cause of hospitalizations for children. According to the Centers for Disease Control and Prevention, rates of asthma are increasing every year in the U.S.

The growing problem of asthma must be addressed through comprehensive, guidelines-based care rooted in evidence. The National Asthma Education and

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Prevention Program, in coordination with the National Heart, Lung, and Blood Institute, provides guidelines for asthma care in the Expert Panel Report 3 (EPR-3): Guidelines for the Diagnosis and Management of Asthma. The guidelines provide recommendations for a comprehensive set of services that includes the following four components of asthma care:

1. Assessing and monitoring asthma severity and asthma control
2. Education for a partnership in care
3. Control of environmental factors and comorbid conditions that affect asthma
4. Medications

The EPR-3 guidelines are backed by research, regularly updated, and supported by clinical experts across the public health field. The Community Preventive Services Task Force, a panel of public health and prevention experts appointed by the Centers for Disease Control and Prevention (CDC), also performed a systematic review of evidence and published The Community Guide. This panel recommends home-based multi-trigger, multicomponent interventions with a specific focus on control of environmental factors that affect asthma.

Despite the consensus among experts around the need for home-based services that include environmental control of asthma triggers, these services are not commonly provided to Medicaid-enrolled populations who need them most. There is wide variability in what specific services are covered by Medicaid in different states, but overall, services to reduce asthma triggers in homes are grossly under-covered by Medicaid.

To illustrate this gap in services, let us assume a Medicaid-enrolled child has an asthma attack and is hospitalized as a result. Her doctor may develop an asthma action plan with her parents and provide them with long-term control medications. This family may,

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however, live in an unhealthy home with mold in the bedroom wall that initially triggered the asthma attack. Whether this Medicaid-enrolled family understands that the mold triggered the asthma attack or not, they may not have the resources to pay a certified assessor to examine their home and have the mold removed. Even while taking controller medication, the little girl could continue to visit the hospital for asthma episodes triggered by the mold that remains in her bedroom wall. In this situation, expensive acute care services would continue to rack up and the girl would continue to suffer.

**Proving the business case at scale**

Pay for Success represents a promising opportunity to overcome the current gap in asthma services. GHHI is currently building cross-sector partnerships across the country to scale comprehensive evidence-based interventions for asthmatics in low-income communities through private investment tied to outcomes. GHHI seeks to demonstrate at scale that these interventions reduce acute care visits and save money for Medicaid. The end goal is consistent, sustainable funding from Medicaid for these services.

GHHI is involved in asthma-focused Pay for Success projects as a direct service provider as well as a technical assistance provider. GHHI is a service provider in a PFS project currently in the transaction structuring phase that will target Johns Hopkins Medicine’s pediatric asthma patients. In September 2016, GHHI completed a set of five PFS feasibility studies funded by the Corporation for National and Community Service’s Social Innovation Fund for its first asthma PFS feasibility cohort. Three of the projects from this first cohort are currently transitioning to the transaction structuring phase. GHHI will complete a second set of feasibility studies in 2017 with another five-site asthma PFS feasibility cohort funded by the Robert Wood Johnson Foundation. These two asthma Pay for Success feasibility cohorts have offered a tremendous opportunity for all involved to learn from different perspectives and across several contexts. For more information, please see GHHI’s *Update from the Field: Paying for Success to Improve Asthma Outcomes.*

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General Feasibility Lessons

There is a growing inventory of published resources on lessons learned from feasibility studies within the ever-changing Pay for Success landscape and GHHI has some common takeaways from its experiences. As these general lessons are well documented in other publications, we will not address them in depth here. We would like to, however, give mention of some of them upfront to emphasize their importance.

Data

Acquiring complete and accurate data, analyzing it in the right way, and communicating the analysis effectively are essential procedures in a feasibility analysis. Executing business associate agreements and data use agreements and then extracting and transferring the data can be an extraordinarily time-consuming process. GHHI’s goal on each feasibility study is to start this process as early as possible and maintain clear communication through each step to avoid missteps or duplication.

Pilots

In many cases, PFS projects involve service providers implementing an intervention in a different way, at a larger scale, and/or with new partners. For these reasons, it is imperative to test plans—especially processes related to referral and enrollment of a target population—through early piloting. This is another activity that should be performed as early as appropriate.

Stakeholder engagement

Education, education, education. PFS is still a new concept to most individuals and organizations. Partners involved in a feasibility study must take time to educate internal and external stakeholders thoroughly—often multiple times—on the mechanics, opportunities, and risks of PFS. Doing this early and often not only socializes the concept among stakeholders, but also increases community buy-in and support.
The Benefits and Challenges of a Cohort Approach to Feasibility

GHHI initially made a strategic decision to group multiple Pay for Success feasibility studies into cohorts for a number of reasons. Initially, we had planned to implement our first CNCS-funded PFS feasibility studies one-by-one. However, as we developed our plans further, we felt that a cohort approach made more sense for a number of reasons. A cohort approach offers economies of scale and collective learning, and also allows us to leverage the uniqueness of the projects within the PFS field. We identified similar policy and regulatory issues facing all the projects and felt that a cohort model could help incubate potential solutions and allow for real-time comparison. The distinct aspects of the asthma PFS projects are outlined above. Below are key takeaways from our efforts to capitalize upon opportunities and overcome challenges associated with implementing asthma-focused PFS feasibility cohorts.

What Makes GHHI’s Asthma PFS Projects Unique?

Aside from being involved in GHHI’s PFS feasibility cohort model, the asthma PFS projects are unique in several other ways. Below are some of the qualities that make these projects distinct from the majority of other PFS projects in development:

- Most involve private entities (in lieu of government agencies), such as a Medicaid managed care organization, in the role of back-end payer
- All will utilize Medicaid funds for success payments to investors
- Most have the back-end payer heavily involved in the feasibility study from the beginning of the project
- Most have the back-end payer involved in the delivery of services
- All utilize actuarial analysis for cost savings projections
- All have projections showing a direct ROI with medical cost savings alone with one streamlined source of data (Medicaid claims records)
Benefits of a Cohort Approach to Feasibility

- Cross-site learning
- Economies of scale
- Comparative analysis and tools
- Insight into standardizing activities and materials

Cross-site learning

One of the primary opportunities made available by a cohort approach to PFS feasibility is learning and collaboration between partnerships at different sites that are all going through the feasibility process concurrently. Multiple asthma home visiting organizations in our cohorts have mature, award-winning programs. These organizations have knowledge and experience from which other partnerships with newer programs have benefited. GHHI actively seeks to leverage ideas and examples from all sites to share across the cohort. We facilitate regular cross-site webinars, site-to-site calls, and hold our annual Executive Leadership Institute in which representatives from each site meet and exchange ideas and experiences. On multiple occasions, we have arranged for representatives from different PFS feasibility cohort sites to collaborate on presentations in webinars and at conferences about lessons learned from their experiences. Additionally, we have a shared folder system on which the entire cohort can share files and see work produced in all the different projects. We have found that all of these activities contribute toward increased cohort engagement as well as improved technical assistance services and capacity building activities during the feasibility phase.

Economies of scale

Combining technical assistance services for multiple sites within a cohort also allows GHHI to leverage economies of scale, decreasing costs while improving the quality of services. GHHI frequently offers webinars to the full cohort to launch specific services or to educate about specific topics beneficial to multiple sites. We always record webinars and provide them to a shared cohort folder afterwards for staff who are unable to
attend. These full-cohort activities save us time and costs by not having to offer them multiple times to different sites.

Beyond feasibility, a cohort of PFS projects completing the feasibility phase at roughly the same time offers potential for bundling PFS transactions in the future. Providing the opportunity to invest in a bundle of projects could attract investors interested in broadening their impact while reducing transaction costs. This would require various complex project components to come together at the right time, but a critical mass of multiple projects advancing towards a transaction could also help overcome regulatory or political hurdles.

**Comparative analysis and tools**

Performing feasibility analyses across multiple sites concurrently provides a valuable opportunity to perform timely comparative analysis. GHHI has improved its assessment of PFS feasibility overall by comparing economic, operational, and payment mechanism components of projects at different sites. The cohort approach afforded opportunities in these three areas of feasibility that GHHI would not have been able to take advantage of if we led the studies one-by-one. Service providers at different sites receive real-time information about operational models at other sites in the cohort to inform their planning. GHHI has also leveraged the cohort model in its analysis of Medicaid regulations in different jurisdictions, providing valuable reference points for our discussions with Medicaid officials.

One of the areas in which a cohort structure is particularly beneficial is data analysis for economic modeling. During the upfront data analysis process, our actuary partners leveraged the cohort model by building manual data from other baseline claims analyses to fill data gaps present in some of the datasets provided by healthcare partners. This was helpful for sites with newer health plans that did not have as much historical data as mature programs.

While working with the first cohort on each of the project’s intervention budgets, GHHI developed two tools that allow sites to compare individual budgets as well as averages across all project budgets at a high level. One tool allows for comparison of staff and FTE allocation per unit and the other tool allows for comparison of services, supplies, and associated costs per unit. These two tools have proved beneficial to project teams in
our second cohort by giving them a relevant measuring stick as they refine their project budgets.

Additionally, GHHI built a reference class analysis tool for the purposes of comparison as well as refinement of economic assumptions. The tool is capable of comparing relative size and makeup of baseline claims data from the various healthcare partners. Furthermore, GHHI used the tool to compare key economic variables and refine assumptions for sites that had less experiential evidence. One of the health plans with a newer care management program, for example, has not yet collected sufficient data to determine an attrition rate for its high-utilizer asthma patients. GHHI initially assumed a conservative attrition rate based on the highest seen elsewhere and then later refined this assumptions based on the lower attrition rate for the health plan’s total population as well as on rates experienced in similar asthma care management programs at other cohort sites. Please see GHHI’s economic modeling handbook for Pay for Success feasibility studies to learn more details on GHHI’s economic feasibility work.7

**Insight into standardizing activities and materials**

Through our work with PFS feasibility cohorts, our technical assistance team at GHHI has been able to understand in a timely manner what the common needs are across projects. This understanding informs our development of templates and other resources to help guide project partners through the feasibility process. Materials that the majority of projects find useful endure while materials that do not quite fit project needs are consistently refined. As feasibility technical assistance materials are simplified and improved, the feasibility study process becomes more efficient. Please see the GHHI Pay for Success Toolkit for examples of some of these materials.8

The cohort approach has improved GHHI’s internal tools as well. One example of a tool improved through our ability to assess multiple projects simultaneously is the GHHI PFS Feasibility Rubric. GHHI identified patterns related to strengths and weaknesses in


8 Green & Healthy Homes Initiative. “GHHI Pay for Success Toolkit.” https://www.dropbox.com/sh/pi9xacddrshty9o/AABGA7zB9WAmJeTh5zR7Gqqza?dl=0
various areas of feasibility across multiple projects. From these patterns, we developed a rubric to assess and rate the feasibility of PFS projects objectively. We have shared this rubric as a tool for others in the PFS field to use on feasibility studies across issue areas. To access and learn more about the rubric, please see GHHI’s publication, *Determining the Feasibility of Pay for Success Projects.*

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### Challenges of a Cohort Approach to Feasibility

- *Balancing standardization with customization*
- *Logistical hurdles*
- *Diffused focus*

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**Balancing standardization with customization**

While the cohort model provides insight into standardizing activities and materials, the fact that every project is unique makes this challenging. Technical assistance providers must be willing and able to customize services, as circumstances require. A particular challenge is advancing the cohort on the same timeline when projects have differences in needs. Different jurisdictions have different Medicaid regulations and state priorities, which has required GHHI to tailor the content and timing of discussions with Medicaid leaders. The asthma programs in different projects are fundamentally similar, but with several nuances that require GHHI to expend more or less assistance on certain activities such as budget refinement, partnership development, or process flow planning. At times, we have needed to create project-specific materials or travel to in-person meetings for sites with particular needs. These activities do not always align with the cohort timeline, but we allow for flexibility in this regard and take advantage of learnings from other projects to help expedite or dive deeper into certain activities when needed.

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Logistical hurdles

Implementing a cohort of feasibility studies simultaneously presents logistical hurdles for which there must be a plan. GH HI strives to combine activities when possible and appropriate, but there are certain project-specific calls or meetings that must overlap. Technical assistance providers must plan and budget for buffer time and backup options when multiple project needs require attention at the same time. To address this, GH HI structured its team so that, for each project, there is a site lead and a site support staff person. If a site lead’s attention is needed on another site for a call or in-person visit, then the site support will fill in. Additionally, we have functional leads to assist on specific activities such as budget refinement or data support. We have learned that a high level of careful project planning, early scheduling, and clear communications can overcome the logistical hurdles presented by the cohort structure.

Diffused focus

Beyond the logistical hurdles of a cohort model, there is also the challenge of maintaining a balance of focus across projects. When we initially decided to shift plans for our first feasibility cohort from a staggered approach to a cohort approach, we extended the feasibility timeline to adjust for the fact that our team’s attention and resources would be spread across multiple projects (the overall timeline for completing five studies was still shorter). During implementation of the studies, we have had to pay close attention to the fluctuating needs of each project and ensure that we are dedicating an appropriate amount of resources in a timely manner and prioritizing effectively. To prevent us from losing track of these needs, we hold regular internal team meetings to review site-specific issues and prioritize resources accordingly.

The Economic Feasibility of Asthma-Focused Pay for Success Projects

GH HI has now completed six actuarial and economic analyses from Baltimore and the first cohort of five sites. The economic analysis is a process that involves an assessment of actuarial projections utilizing baseline Medicaid claims data and then a series of team decisions around project parameters. In making these decisions, project teams balanced the desired scope (enrollment volume) with the return on investment from projected
medical cost savings. While estimates for these projects vary in specific potential enrollment volume, cost savings, and other parameters, they all indicate a positive return on investment (ROI) for a comprehensive asthma intervention targeting patients who are high utilizers of medical facilities. We outline three notable findings from our analyses below.

1) **Medical cost savings alone can stand up the projects.**

One of the commonly discussed challenges in the PFS field is the difficulty in accessing data and coordinating across different government entities to evaluate outcomes. There may be previous evidence of an intervention producing savings well above its costs, but these savings may be spread across several agencies. A sophisticated degree of coordination and integration must occur to evaluate outcomes for a PFS transaction in these situations.

For each of the asthma projects in our first cohort, actuarial projections and economic analysis indicated that the intervention resulted in medical cost savings that outweighed program costs. This greatly simplifies the payment mechanism because it means success payments can be determined from one source of data: Medicaid claims. While we know these asthma interventions produce societal value in several other forms, such as through improved school attendance for children, none of our projects has integrated additional data on top of Medicaid claims yet. Tying additional outcomes to PFS success payments in a project that has a Medicaid managed care organization as end payer, for example, would require an additional entity, such as a state education department, to be an end payer.

2) **Cost-benefit analyses reveal that interventions for asthmatics who a) experience one hospitalization or b) visit the emergency department multiple times produce a favorable return on investment across all GHHI feasibility studies to date.**

With each project team, we defined the inclusion criteria for the baseline data extract strategically to understand the economics of all subpopulations eligible for enrollment in the PFS program. The actuaries stratified the data according to various criteria on each of the projects. Teams on some projects assessed the
feasibility of including adults in addition to children or commercially enrolled patients in addition to those enrolled in Medicaid. All projects, however, looked at similar trigger event criteria. These trigger events included one or more asthma-related visits to an inpatient, emergency department (ED), or urgent care facility. For each of these trigger events, our actuary partners provided cost savings projections on which GHHI then performed economic analysis that produced the below results.

**Trigger Event Return on Investment (ROI) Findings:**

- Patients who had a) one or more inpatient visits or b) two or more ED visits always produced a significant ROI
- Patients who had one ED visit produced an ROI on most, but not all, projects
- Patients who had any number of urgent care visits but no inpatient or ED visits did not produce an ROI from projected medical cost savings

The actuaries and GHHI refined the underlying assumptions for projected costs and savings according to existing research and experience of experts in public health and of project partners. These projections assume a three-year service delivery period and estimate savings over a total of 10 years.

**3) Capture rate of hospitalized patients is the most significant determinant of ROI.**

After determining a number for service delivery years and evaluation years the teams felt were suitable, they assessed the various components of economic feasibility. GHHI performed analysis to determine the correlation each of the key economic variables had with project returns. Some of the primary determinants of ROI are assumptions related to capture rate, health plan attrition rate, housing stock (percent of properties with need for significant environmental remediation vs. properties with minimal need for environmental remediation), and ownership status (less ability to remediate properties with renters). Among these, the leading operational determinant of ROI in the projects is the capture rate of hospitalized patients. We define capture rate as the rate in which the project enrolls eligible patients. The analyses showed that this variable consistently had a
larger correlation with estimated cost savings than any other variable. For this reason, it is vital to test and refine the referral and enrollment processes in order to achieve the highest possible capture rate, especially with the hospitalized trigger group. GHHI has worked with several of the sites to refine processes so that families are engaged and referrals are made as close to the time and place of care as possible.

Pay for Success and Medicaid

Throughout our feasibility cohort projects, GHHI has worked directly with several Medicaid managed care organizations (MCOs) and state Medicaid agencies to explore Pay for Success. We have engaged the federal Centers for Medicare and Medicaid Services (CMS) as well as multiple healthcare consulting firms and partners in the field to understand fully what the issues are related to unlocking Medicaid funds in PFS. Through recent delivery and payment reform programs, the healthcare field is increasingly focused on paying for value—yet Pay for Success financing, which is based entirely on paying for outcomes, has not been formally integrated into Medicaid regulations.

As Medicaid and CHIP (Children’s Health Insurance Program) provide health coverage to over 70 million people in low-income communities, the opportunity these funds represent as a potential payment source for PFS models vastly outweighs the associated challenges. GHHI’s goal is to help enable PFS financing to be a low-risk tool for Medicaid agencies to leverage their efforts in improving the quality of care while reducing costs.

Medicaid has already invested in Pay for Success models on the front end through waiver programs or reimbursement of certain services involved in PFS projects. The most notable example is a 2016 PFS transaction launched in South Carolina that focuses on

10 Medicaid.gov. “September 2016 Medicaid and CHIP Enrollment Data Highlights.”
maternal and child health. The project will expand the Nurse-Family Partnership home visiting model statewide. Among the $30 million invested in the project, $13 million were Medicaid funds from a 1915(b) waiver awarded to the South Carolina Department of Health and Human Services by CMS.

There are significant challenges to utilizing Medicaid funds in PFS transactions, particularly on the back end. To date, no PFS transactions with Medicaid as a back-end outcomes payer have been launched. There are different ways Medicaid could distribute funds as a payer in a PFS transaction—either through a Medicaid managed care organization, state Medicaid agency, or directly from federal CMS. GHHI has worked primarily with Medicaid MCOs in our PFS feasibility studies, so we focus this section mostly on the participation of these entities as PFS payers. Below are our learnings about the primary regulatory and technical issues related to utilizing Medicaid funds on the back end of PFS transactions as well as our ideas and actions to overcome them.

Primary payment mechanism challenges

_PFS...Penalized for Success?

The primary concern expressed by Medicaid managed care organizations exploring Pay for Success financing for asthma relates to the capitation rate-setting process they undergo each year with their state Medicaid agency. Capitation rates are the mechanism through which states pay Medicaid MCOs. These rates are directly tied to the MCO's costs that result from Medicaid claims for covered services. For certain populations with chronic conditions, these rates are often risk-adjusted based on severity of the condition. If the asthma PFS intervention is successful and the asthma patients experience fewer hospitalizations and emergency department (ED) visits, patient risk scores could shift downward, leading to lower capitation revenue from the state. Additionally, fewer hospitalizations and ED visits would mean fewer claims, so capitation revenue based on claims experience would decrease. With a downward adjustment of the MCO's capitation rates due to these two factors, the state would be capturing cost

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savings that the MCO needs to repay PFS investors—essentially penalizing the MCO for reducing costs.

**Need for CMS guidance**

For MCOs to feel comfortable to participate as end payers in a PFS transaction, they must know explicitly that they will be able to utilize cost savings to repay investors. Several states have Medicaid reform programs with goals that align exceptionally well with the goals of PFS financing; however, those programs have not explicitly provided for a PFS payment mechanism. Specifically, MCO leaders are looking for formal written authorization allowing them to participate in PFS as well as assurance guaranteeing that they will share in cost savings sufficiently to repay PFS investors. In our discussions with state Medicaid leaders to date, they have responded favorably to the idea of Pay for Success financing to improve asthma outcomes. They are reticent to provide technical guidance to or amend contracts with MCOs, however, until they receive guidance from CMS. As state Medicaid agencies receive annual matching funds from CMS based on their federal medical assistance percentages (FMAP), they want to ensure that PFS-financed programs are eligible for Medicaid funds and associated federal match dollars. GHHI and partners are in ongoing discussions with CMS around how these challenges might be overcome and, in the next section, we outline some of the steps we view as most suitable for doing so.

**Overcoming PFS payment mechanism challenges**

**PFS financing models should be classified as value-based payment models**

With a desire to pay for what works and reduce overall costs, many states have implemented value-based payment (VBP) programs that allow MCOs to base payments to providers on outcomes. CMS issued the Medicaid and CHIP Managed Care Final Rule in April 2016 and the regulatory language around VBP models provides flexibility for specific contracting structures. For the most part, VBP arrangements to date still maintain a fee-for-service element, with bonuses paid to providers for meeting outcome targets. Pay for Success financing, on the other hand, is 100% value-based. PFS success payments are based entirely on verified outcomes, and an MCO would never pay more than what it gains in cost savings. The PFS financing structure is a value-based payment model, with slight differences from what medical payers normally think of as VBP—and
these differences actually reduce financial risk for Medicaid. PFS financing has a clear opportunity to thrive in the healthcare field if Medicaid leaders explicitly classify these models as a type of VBP arrangement. Additionally, the medical loss ratio of MCOs, the required percentage of their costs that must be spent on medical care and quality improvement, should be aligned with expenses that directly produce medical outcomes. As outcomes payments made to PFS investors would only occur if the intervention produces medical outcomes, these payments should classify as medical costs.

**MCO leaders and State Medicaid leaders should be proactive**

With uncertainty for the future of U.S. healthcare due to a new White House administration in 2017, CMS is unlikely to issue formal guidance in the near future. In discussions GHHI and partners have had with CMS, the agency has responded favorably to the idea of Medicaid back-end participation in PFS transactions. CMS welcomes the opportunity to review and approve state proposals for specific PFS projects prior to any future issuance of formal guidance. Leaders of MCOs and state Medicaid agencies should proactively create solutions and submit to CMS proposals that align PFS with VBP initiatives in their states. There is a strong case to be made for MCO involvement in PFS projects during this period of healthcare reform, as PFS can ease their transition to the new standard of value-based payment models in a way that shifts risk to private investors.

**Solutions should enable equitable value-sharing between states and MCOs**

In their proposals to CMS, state Medicaid agencies and MCOs interested in PFS should create arrangements that eliminate the risk that a MCO would not be able to repay PFS investors due to losses associated with capitation rate reductions. Outcomes payments made by an MCO to PFS investors should be incorporated into the capitation rate setting process. For example, one of our MCO partners submitted a proposal to its state Medicaid agency that requests capitation rates to be held constant for the term of the PFS program in order to allow for investor repayment. The specifics of these arrangements will vary state-by-state and may require amendments to contracts between states and MCOs, but a foundation of equitable value sharing should be present in all solutions.
Looking Ahead: The Coalition to Support Pay for Success in Public Health

GHHI is encouraged by the momentum of the Pay for Success field and optimistic that Medicaid will provide a path forward not only for asthma-focused PFS projects, but also for projects across other public health issue areas. GHHI seeks to engage as many practitioners and thought leaders as possible to find the best solutions to unlock Medicaid funds for PFS outcomes payments. In November 2016, GHHI launched the Coalition to Support PFS in Public Health. Through this coalition, we are building a critical mass of leaders across the public, private, and social sectors to advance outcomes-based financing models in public health in the best way possible.\[12\]

This document provides an overview of our learnings to date, but we look forward to learning many more lessons going forward with partners seeking to scale evidence-based services for populations that need them most.

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\[12\] Please contact GHHI at pfs@ghhi.org if interested in joining the coalition.
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The Green & Healthy Homes Initiative (GHHI) is a national nonprofit dedicated to breaking the link between unhealthy housing and unhealthy families. Formerly known as the Coalition to End Childhood Lead Poisoning, GHHI provides evidence-based direct services and technical assistance to create healthy, safe, and energy efficient homes. GHHI’s end goal is to improve health, economic, and social outcomes for low-income families while reducing public and private healthcare costs. To learn more, please visit www.ghhi.org.

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