State Playbook: Pay for Success Financing
How to Use Innovative Financing to Fund Innovation in Medicaid Value-Based Purchasing Programs

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A toolkit for States and the Centers for Medicare and Medicaid Services to develop an ecosystem of managed care innovation using alternate payment mechanisms and Pay for Success financing.
The Green & Healthy Homes Initiative (GHHI), founded in 1986, is a national 501(c)(3) nonprofit, nonpartisan organization that provides evidence-based direct services and technical assistance to create healthy, safe and energy efficient homes to improve health, economic and social outcomes for low-income families while reducing public and private healthcare costs.

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Executive Summary

Creating appropriate and actuarially sound mechanisms to leverage federal funding in Pay for Success financed public health projects is possible through integrating value-based purchases.

The U.S. Department of Health and Human Services (HHS) projected that the Centers for Medicare and Medicaid Services (CMS) budget will exceed USD 1 trillion dollars in 2017. They use the majority of funds to cover necessary medical expenses of populations qualifying for the respective programs. However, in some cases these medical expenditures can be prevented with non-medical expenditures, which can also generate substantial benefits for society beyond medical coverage. This playbook is designed to assist states to take advantage of these opportunities.

The barriers to seizing these opportunities are restrictions on the use of funds in the publicly-financed healthcare system, especially for Medicaid beneficiaries. For example, regulations prevent reimbursement for non-medical expenditures, even when the alternate use of funds has direct medical impacts and has been undertaken for medically relevant purposes. Investments in preventive or supportive services that abate the need for medical services have been shown, in many cases, to result not only in better health, but also more cost-effective solutions. Further, dollars spent on preventive care frequently have secondary effects that benefit communities beyond medical utilization measures.

There are potential resolutions for this impasse. One of the most promising is a recent change in managed care regulations that allows for states to require or enable their partnering managed care entities to develop value-based purchasing arrangements. This dynamic allows states and managed care entities the ability to create payment mechanisms that pay for outcomes, not costs. These outcomes may be generated from alternate services that do address the root causes of many of the costliest medical conditions. States can use this relationship with their managed care entities to secure federally matched funds to address the social determinants of health by investing in their communities.

1 (U.S. Department of Health and Human Services, 2016)
Consider the case for asthma prevention: CMS spent more on medical utilization for asthma patients in every single state in the country in 2014 than they did for cancer patients according to data tables they made available.\(^2\) This comparison is insightful when considering the role that the social determinants of health play in medical needs. As much as 40 percent of asthma medical utilization is directly attributable to the home environment;\(^3\) however, regulations prohibit reimbursing managed care entities for addressing the home-based causes and triggers of asthma directly because those housing services are not narrowly defined medical benefits. Those same regulations allow reimbursement for a value-based purchasing arrangement where a managed care entity purchases directly reductions an asthma patients’ total cost of care.

States can and are developing Pay for Success strategies to address public health needs, including Arizona and Texas, and many others are working to overcome limitations preventing adoption. The key issues are those of risk, reward, and capacity for managed care entities and health-related social service providers. States and managed care entities using publicly-financed healthcare dollars are rightfully risk averse in adopting new service delivery models that put taxpayer dollars at risk. Health-related social service providers are often incapable of supporting large-scale service delivery, waiting for the outcomes of the actions to secure payment due to financial limitations.

There is a mechanism that allows funding the provision of health-related social-service interventions that leverages the potential future value of the programs. Pay for Success financing agreements allow outside parties, usually foundations, to ‘invest’ in the programs – providing funds to deliver services. When evaluated, the managed care entity would make a value-based payment to the foundation or other investors based on the measured value created by the program. The Pay for Success financing arrangement funds the provision of services, while mitigating the risk of program success for the taxpayer and managed care entities responsible for publicly-financed healthcare expenditures.

\(^2\) (The Center for Medicare and Medicaid Services, 2016)
\(^3\) (Robert Wood Johnson Foundation Commission to Build a Healthier America, 2009, p. 85)
Additionally, there will be an aggregate effect reducing cost and improving quality in running many smaller ground-up projects in concert with ongoing top-down efforts from the states and federal authorities. Ground-level innovation can be disseminated and institutionalized by states and federal partners. Managed care entities can pick from the most effective models to continue their drive to provide higher quality care that improves health, even beyond the traditional continuum of care, and still brings down aggregate costs.

The Path Forward

The path forward requires multiple actions, but by creating scalable state-wide frameworks, states can add a valuable tool for using publicly-financed healthcare dollars more efficiently and even as a tool for investing in improved public health outcomes.

States can take three key steps to advance investments in service-delivery innovation:

1. Amend managed-care contracts to allow managed care entities to undertake value-based purchasing arrangements of their own design to enable innovation and financial risk-mitigation through Pay for Success arrangements;  
2. Provide economic motives or incentives for public health innovation, especially in the form of value-based purchasing; and  
3. Ensure that the necessary infrastructure support allows for high-quality project development; for example, by making administrative claims records available to actuaries to conduct program evaluations.

Implementation checklist using example timeline:

- State amends managed care contracts to allow for managed-care entities to undertake their own value-based purchasing arrangements, with appropriate controls;  
- Managed care entities undertake value-based purchasing arrangements by subcontracting for or directly conducting research, feasibility determination, and project development efforts that include raising funds for services;  
- Project is implemented by the managed care entity’s team;

Currently, only short-term projects are financially beneficial to managed care entities, please see (Olson & McKnight, Pay for Success: Managed-Care Rate Setting Implications, 2016)
Project contracts with actuarial service providers to evaluate the outcomes against a statewide administrative claims record or best alternative;

- Based on the evaluation outcome, the managed care entity will compensate their subcontractors under a value-based purchasing agreement; and

- The state includes the value-based purchasing in the managed care entities capitation-rate development and medical-loss ratio calculations.

- The state identifies and scales projects that are successful and scales them to statewide efforts, generating savings that much larger than the initial project.

Playbook Overview
The Green & Healthy Homes Initiative created this document to provide a roadmap for states with an interest in Pay for Success and leading innovative programs that make strategic investments in the health of their communities, which requires a focus on paying for programs based on the impact they have. This document will provide a strategic overview of these issues as well as a highly tactical playbook, complete with specific resources designed to aid implementation of such programs attached in appendices.

State Playbook for Medicaid Pay for Success Financing
This document provides a strategic overview of Pay for Success as well as a tactical guide for implementation of programs, complete with draft contract language adopted from an active state contract in value-based purchasing, managed care program application templates, and other resources. It references other documents for in-depth discussions of related topics, which collectively form a guide for states to finance innovation with Pay for Success arrangements.

Value-Based Purchasing Authority
The State Playbook provides an overview of regulatory updates for Medicaid managed care, specifically relevant to value-based purchasing authority as it relates to Pay for Success projects. GHHI’s findings are that value-based purchasing arrangements can enable

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(Olson & McKnight, Policy Analysis: 2016 CMS Medicaid Managed-Care Value-Based Purchasing Authority, 2016)
Pay for Success projects and overcome the managed care rate-setting implications that have historically prevented substantial investments in long-term population health.

**Contract Options for Innovation**
An overview and analysis of value-based purchasing contracts using shared savings, shared risk, and rate-cards to advance investments in public health, potentially across agencies and levels of government.

**Outcomes-Based Payment Handbook**
An outcomes-based payment is a specific type of value-based purchase where measured savings is used to pay for services as a method of shared-savings or full-risk payment. This document is a practitioner’s handbook that illustrates how to create, calculate, and implement outcomes-based payments in medical-claims records.

**Evaluating Value-Based Purchasing Arrangements**
This document provides an overview of how complex value-based purchasing arrangements, intended to be cost-neutral or better, can use savings to base their payment to their subcontracted service providers. The focus is on ensuring highly-rigorous but practical evaluation methods that comply with regulations and industry standards.

**Pending: Pay for Success in Public Health**
This briefing document provides a high-level overview in two parts (1) Pay for Success 101: The Basics and (2) Pay for Success 201: Public Health. The first section briefly provides high-level detail about Pay for Success in general. The second section turns to providing an overview of in-depth issues related to operating Pay for Success projects in public health.

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6 (Olson & McKnight, Outcomes-Based Payments Handbook, 2016)
7 Invalid source specified.
Pending: The Feasibility of Addressing Asthma with Pay for Success

An overview of findings from 11 national feasibility studies to fund comprehensive home-based interventions with outcomes-based payments, financed by Pay for Success arrangements.
# Table of Contents

Executive Summary ........................................................................................................... i

The Path Forward .............................................................................................................. iii
Playbook Overview ........................................................................................................... iv

Table of Contents .............................................................................................................. vii

Background ...................................................................................................................... 1

How to Pay for Success? .................................................................................................. 2

Contracting Overview .................................................................................................... 3
State Contracts with Managed Care Entities ................................................................. 4
State Governance of Managed Care Entity Proposals .................................................... 7
Types of Proposals That Enable Pay for Success ........................................................... 10
Incentivizing Public Health Innovation Programs ......................................................... 14

Examples from Around the Country .............................................................................. 16

Arizona ............................................................................................................................. 17
Texas ............................................................................................................................... 18

Bibliography ................................................................................................................... 19

Appendix: Cover Letter For CMS ................................................................................. 22
Appendix: Managed Care Contract Language ............................................................... 23
Appendix: Value-Based Contracting Proposal Template ............................................. 25
Appendix: Example Application for Value-Based Payment Arrangement ............... 26
Background

This document serves to provide an overview of why states would undertake value-based purchasing arrangements and how they can implement them using Pay for Success financing arrangements.

The Green & Healthy Homes Initiative (GHHI) is currently working with a portfolio of 11 Pay for Success projects in 10 states that address the root-causes and triggers of asthma in homes. In this work, we conducted a structural analysis of the publicly-financed healthcare system to identify opportunities to leverage Pay for Success financing to invest in public health. We also identified the key challenges, immediately turning to our partners to solve them.

This document was designed as a practitioner’s guide to implementing Pay for Success in public health. It is broken down into sections with differing purposes that include:

1. An executive summary that was designed to be suitable as a stand-alone briefing document summarizing this work;
2. A section designed to lay forth a discrete path for states to undertake when working to advance a Pay for Success project in public health;
3. A section showing examples from around the country of how the state contract mechanisms have been used to enable value-based purchasing and illustrating their applicability to public health innovation financed by Pay for Success programs; and
4. An overview of other literature that is very relevant for this document, designed to let us keep this work as specific as possible to the practitioner’s needs, pointing them to comprehensive resources where appropriate.

The combination of value-based purchasing and Pay for Success financing can be another tool in the public health innovation toolkit that fills gaps left by other methods. It provides budget-neutral (or positive) methods of funding public health innovation projects and allows transferring innovation risk from the publicly-financed healthcare systems and the taxpayers they steward to entities with the purpose of taking risk either for financial gain or to advance missions that drive their organizations.
How to Pay for Success?

States can finance public health innovation through Pay for Success by implementing a contractual framework that allows managed care entities to propose value-based purchasing arrangements that pay for the impact programs have on public health outcomes.

Historically, managed care entities have had complicated and sometimes conflicting economic incentives. These incentive conflicts have caused by nuances in managed care rate setting practices and the trade-offs between short-term savings capture and long-term investments in public health. States can mitigate these conflicts by establishing appropriate frameworks that provide economic incentives to invest in the long-term health of a population.

Pay for Success projects have contracting needs for each party to be appropriately involved in the project.

Pay for Success is one tool states have at their disposal. It can be difficult for a state to implement directly, but states can use indirect relationships to do so. The managed care

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8 For further reading, please see (Olson & McKnight, Pay for Success: Managed-Care Rate Setting Implications, 2016)
9 For further reading, please see (Olson & McKnight, An Equitable Value-Sharing Framework for Managed Care, 2016)
10 For an in-depth look at how Pay for Success works in public health, please see (Olson & McKnight, Pay for Success in Public Health, 2017).
entities can then raise funds for public health innovation projects to experiment with service-delivery innovations in a risk-mitigated environment. This decentralized framework has multiple parts that the state should be aware of when considering Pay for Success, but states are only involved in part of that system.

Projects involve the following minimum components:

1. A contract between a state and managed care entity;
2. A contract between a managed care entity and a service-providing partner, and
3. A series of contracts between the service-providing partner and their network.

These contracts are all detailed in the following sections and have the collective purpose of allowing a managed care entity to change the way it pays for care by transitioning from fee-for-service based payment arrangements to value-based purchasing arrangements. This set of contracts focuses on allowing managed care entities to use value-based purchasing arrangements with their subcontractors. By aligning the managed care entity’s payment arrangement with their own compensation arrangement from the state, they will have reduced risk during innovation and increased economic incentives to further the state’s aim of paying for value – specifically by improving health through better quality of care and reducing costs.

Contracting Overview

1. State contract with managed care entity(s): Must enable the managed care entity to make value-based payments for (a) measured reductions in the total cost of care, and (or) (b) other specific health outcome measures that are included in the rate setting process in accordance with current federal regulations.
2. Managed care entity contract with intermediary: Needs to allow for the managed care entity to retroactively pay for the program’s impact on total cost of care or other health outcomes measure.  
3. Project intermediary contract with service provider(s): Can be performance-based for services, enrollment, retention, or other measures and dictates payments.

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11 The intermediary is an organization that holds the contractual relationships with other project partners.
4. Project intermediary contract with investor(s): Should align with the other funding-flows contracts from state to managed care entity, and then managed care entity to intermediary, so that risk is transferred and economic motives are aligned.

State Contracts with Managed Care Entities

State contracts with managed care entities determine the compensation and, to a large degree, the activities of those entities. The federal government’s matching of funds through the Federal Financial Participation (FFP) at the appropriate Federal Medical Assistance Percentages (FMAP) rates is restricted to certain types of programs. Complying with those requirements and securing the federal funds often determines if a project is economically viable and can continue. The requirements have recently changed.

States are now vested by CMS with the ability to require or allow their managed care entities to enter into value-based purchasing arrangements that secure Federal Financial

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12 With federal funds comprising between 50 and 83 percent of the total, states are unwilling to dedicate the additional funding and receive a decreased benefit.
Assistance and count towards the numerator in calculating the Medical Loss Ratio (MLR).\textsuperscript{13} This authority allows the state to amend their contract to require or allow their managed care entities to enter into value-based purchasing arrangements, within reason and subject to restrictions.

The regulations provide a clear authority for states to work with their managed care entity to create their own value-based purchasing programs so long as they meet certain criteria.\textsuperscript{14} These criteria include advancing at least one element of the State’s quality strategy and being able to evaluate how effectively the program does so. These value-based purchasing programs address concerns by establishing a demonstration of effectiveness to evaluate how well the program advances that state quality strategy goal. Finally, the managed care organization could either (a) advance the project using their own funds or (b) finance it using a Pay for Success mechanism to transfer the risk away from the State and managed care entity, by allowing private partners to assume the fiscal responsibility for the program. This further contributes to the State’s goals to advance the public’s general health and well-being while also reducing the cost of care for the population by providing a meaningful way to use value-based purchasing programs.

At a high level, the program would call for the following steps:

1. Amending the State’s managed care contracts to allow managed care entities to develop value-based purchasing programs so long as they meet the appropriate criteria and follow a newly established process;
2. Creating an application approvals process for value-based purchasing programs that is efficient and transparent; and
3. Developing appropriate oversight and evaluation criteria to allow the development of Pay for Success projects in the State.

\textsuperscript{13} (Olson & McKnight, Policy Analysis: 2016 CMS Medicaid Managed-Care Value-Based Purchasing Authority, 2016)

\textsuperscript{14} (Olson & McKnight, Policy Analysis: 2016 CMS Medicaid Managed-Care Value-Based Purchasing Authority, 2016)
Several states already have such contract language in place and available to the public.\textsuperscript{15} This language sets terms for future development of these value-based purchasing arrangements and sets the expectations, limits, and requirements for the development of such arrangements. Of the state requirements that GHHI has surveyed, options included:

1. Requirements to involve a percentage of spending measured in dollars;
2. Requirements to involve a percentage of providers participating;
3. Requirements to include multiple plan types (or specific plan types);
4. Requirements to target chronic or otherwise specific condition areas;
5. Requirements to target specific geographic areas;
6. Incentives or withholding arrangements for reaching spending thresholds or provider participation levels.

Each of these requirements will have an impact on the kinds of projects formed and may result in unintended consequences. Minimum requirements for dollars spent through specific arrangement types could result in inferior quality project development and ultimately dissuade the future use of tools. For example, requiring 5 percent of dollars be spent on sharing savings specifically for asthma through outcomes-based payments may result in problems if the services fail to deliver saving or if to meet that minimum spending level the managed care entity expanded services too far down the risk pyramid for the condition and undertook an economically unviable project that was financially burdensome. Further, there are applicability limits for arrangements and forcing the use of less-standard tools may have undesirable economic outcomes. Borrowing from other industries, the most effective scenario may be broadly encouraging the development of innovative approaches by embedded economic logic\textsuperscript{16} rather than contractual requirements.

Additionally, it should be noted that states will likely have to justify any additional regulatory burden placed on its managed care entities. Development of regulations will likely take place during the regular course of contract reviews and regional offices, which may vary in their stringency and approach.

\textsuperscript{15} Please see section titled “Examples from Around the Country” for details.
\textsuperscript{16} Rather than providing an incentive for a behavior, changing the business fundamentals of providing services to economically incent a desired behavior.
State Governance of Managed Care Entity Proposals

States may require their partnering managed care entities to gain state approval for their projects, though this is optional. The benefits are that the state can help guide the development of initiatives that they ultimately support and advance the strategic objectives. However, the state would also take on the responsibility of ensuring that the approval process is well-functioning and does not unduly burden their partners. A simple, easy-to-navigate, and expeditious process with high levels of transparency is preferable. Any requirements in the approval process may dissuade project participation or alter the natural economic logic that provides the clear incentives for innovation.

The appendix includes a blank managed care entity application form as an example for possible adaptation by states as well as references to states actual materials.

The process for these proposals varies as well. Many states have an annual application period, though states have no requirement for this process. Accepting rolling applications with annual delineations would provide states the most flexibility and least burden on administrative teams as there would be no single rush period.

While many states choose to require approval of value-based purchasing initiatives, some states do not. Arizona has favored requiring knowledge sharing as opposed to approvals, though they do have other checks and balances in place. Please see the Arizona-specific heading in the following section titled “Examples from Around the Country”
Application and Approval

The State should set up a clear, simple, and transparent application and approval process for value-based purchasing arrangements. Texas has already pioneered this method, and has been making incremental improvements to its program, though there is room for improvement specific to the type of project that a state wishes to implement. The key elements of such a program include the following and please see “Appendix B: value-based contracting proposal template” for an example:

a. Clearly defining who is eligible to participate in the program from an enrollee perspective as well as the class of service provider perspective,

b. What the theory of change for the program is and how it relates to advancing the goals of the state quality strategy, and

c. What specific evaluation will be conducted to determine the extent to which a program advances that state quality strategy, both in terms of affirmative evidence as well as identification of what would be sufficient to state that the program has failed.

The application process would ideally allow for rolling applications at any time, the submission of which would initiate the process. That process should be iterative and allow a collaborative development of projects where the State’s primary goal should be facilitating managed care entities’ leadership in public health service delivery innovation.

Many Pay for Success projects will show real promise, and based on solid and promising evaluation results, governments will certainly want to retain them or possibly scale the programs to state levels. Successful programs need to have a viable next step to reach and appropriate scale. There are indications of how to formalize this process from projects in development. Additionally, a pair of forthcoming publications by the Green & Health Homes Initiative will address this issue specifically – titled “An Evolutionary Architecture for Pay for Success” and “After Pay for Success: The End-Game”.

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18 Which may and likely should include nonstandard service provider arrangements that allow for local home or community-based organizations to participate.

19 Additionally, a pair of forthcoming publications by the Green & Health Homes Initiative will address this issue specifically – titled “An Evolutionary Architecture for Pay for Success” and “After Pay for Success: The End-Game”.
demonstration and when that roadmap for a larger-scale project can be developed. Consider that a state may wish to identify successful projects and have them adopted as statewide practices. In this case, there will need to be a mechanism in place to allow for widespread adoption of the programs including differing methods of attributing value and potentially different funding. For example, a successful county-specific asthma project may be scaled state-wide, leaving no valid nonparticipant comparison group, requiring changing the evaluation and payment type from an actuarially evaluated outcomes-based payment for shared savings or risk to another type of value-based purchase such as bundled payment or a condition-specific capitation arrangement or set risk adjustment factor with a requirement to offer services for those meeting specific risk-based criteria.

In contrast, other Pay for Success programs may yield sub-optimal results. These insights are valuable as well, demonstrating which programs less merit investment, or could stand to be scaled back, or, in some instances where a series of consistently negative assessments is found, could be eliminated. Pay for Success financing also allows taxpayers, state agencies, the federal government, and even managed care entities test programs that may generate suboptimal outcomes or even demonstrate a project’s ineffectiveness. In this context, a poor outcome is a positive result because it provides an opportunity to reorient public policy to align it with new evidence. Pay for Success projects can demonstrate that a program is ineffective, why it is ineffective, and that it does not merit investment of a government agency or taxpayer dollars. Therefore, a critical element of the application process and its approval should be stating the outcomes determination and under what circumstances the project is considered successful and in what context. This will allow for a program assessment and that will ensure future programs will not need to go down the same path, spending taxpayer dollars, and failing to produce the results that they promise.

**Oversight and Evaluation**

States should ensure appropriate oversight of Pay for Success projects, especially due to new and innovative approaches to service delivery. States are required to include evaluation requirements in their contracts, and can review those elements in their approval process, as well as monitor programs to ensure the health of the underlying population is
never jeopardized and that additional that funds are not going to a program that has no meaningful impacts on the health and well-being of the population.

The State can adopt current standards for program oversight by ensuring that the managed care entities are aware of and consent to evaluation of their program’s effectiveness using claims, administrative, and other data across multiple sources. States can require that the managed care entities have to conduct third-party evaluations of their own projects. Effective evaluations require meticulous tracking of eligibility triggers, enrollment into value-based purchasing programs, the dates services delivered, and the costs of additional services that may not be recorded in the claims record for the purposes of ensuring that the total cost-of-care represents an aggregate savings, rather than the offloading of medical costs to other social services not being appropriately tracked in evaluation the program.

Ultimately, there may be limitations that prevent a state from calculating the impact any program has on the true net-social economic value of any one person or group due to data silos, concerns over privacy, or simply not having the right data. The Department of Health and Human Services can, however, move towards including outside factors in calculating the true total cost-of-care for the State. Ambulatory services, justice system costs, and public-assistance programs can be a wonderful starting point to start learning just how complex and interdependent our social-safety net is and how to evaluate an impact on it.

**Types of Proposals That Enable Pay for Success**

Pay for Success projects can take multiple forms, broadly categorized as savings-based and proxy-measure projects. Savings-based projects use comparative analysis of the total cost of care for a population and pass that savings on in the form of a value-based payment to a service provider. In a proxy-measure project, the managed care entity picks any measure in the target population and sets a price they are willing to pay for a set change in that measure, then making a payment upon measurement of that change.
Savings-Based Projects

Successful savings-based projects are inherently cost-neutral. They allow a managed care entity to measure the cost of care for a target population receiving an intervention and compare it to a similar population not receiving the intervention, then to pay any percentage of that savings to the intervention provider. This simple design aligns economic incentives among the state, managed care entities, and service-providers by linking payments to savings. This mechanism also provides the most inventive and funding to address those with the most medical need. As groups with a history of more resource usage will have the most resources available for future savings and most incentive to produce it. These projects also serve as an excellent basis for developing long-term pricing agreements applicable after the conclusion of the value-based purchase, using the program’s evaluation to determine appropriate compensation.

The appendix includes an example application by a managed care entity seeking to undertake a value-based purchasing arrangement for preventive interventions that address social determinants of health related to asthma.

Proxy-Measure Based Projects

Projects based on proxy-measures involve determining what measures and rate the managed care entity is willing to pay for the impact of a program. For example, the managed care entity may pick condition-specific hospitalizations per thousand member-months as their proxy-measure for a project. Over time, the managed care entity would make payments at a set price per unit reduction in hospitalizations. States are already making analogous payments, for example by providing payments for HEDIS measures. The difference being that value-based purchasing is replacing medical compensation rather than providing other forms of compensation for outcomes measures.

One key issue with this type of arrangement is that it does not allow for complex interdependencies in aggregate medical utilization or potential changes in the relative value of the proxy-measures. If the cost of a hospitalization to the state or managed care entity

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20 The “savings” category is really a risk-sharing mechanism, limited to shared savings on the spectrum of value-based purchasing.
goes up during the course of the project, they would be underpaying for the services. In contrast, they could be over-paying very substantively if the intervention shifts the care burden to other costly areas. From the state’s perspective, a hospitalization is expensive in general. While some parties may be focusing on reducing the aggregate cost, other parties may not want to take the risk that a program may transfer costs. This will be one point of tension in negotiations that need to be resolved in an appropriate manner, given the purpose of the project.

In many cases, proxy measures and pre-fixed prices were practical necessities because the data for direct measures was unavailable and parties had no way of measuring true costs or subjectively assessed allocations of broader cost-bases to specific measures. When looking at medical benefits spending, the true costs are known because they are variable cash-flows that states and managed care entities can track. This raises the question of whether proxy measures are appropriate in projects that have a direct option available.

**Rate Cards**
States have the option to prospectively establish rates for specific measures that they consider valuable. These rate-card approaches clearly indicate to all parties which public health measures the state will pay for directly or through their managed care entities. Further the rates can be part of agreements with other non-medical benefit providers. Examples include set prices for each person in an established target group that quit smoking for 180 days.

Additionally, rate cards may supplement savings arrangements, where cost savings forms the basis of an agreement with other valued measures layered on top of the payments. Consider that a program seeking cost-savings from an intervention may generate cost savings and may additional public health benefits that the state or managed care entity wants to incentivize. In these cases, the rate-card may provide a very powerful economic incentive for market participants to find creative ways to address specific issues.
Other Funding Sources

The use of rate cards also opens the door to intra-governmental collaboration. For example, a department of health may establish a rate-card for one measure, while a department of justice may establish a second rate-card for another measure, and the Medicaid program may establish a value-based purchase for cost-savings. The three programs would effectively pool resources in collaborating to address a major societal issue that touches all three areas. Each collaborating agency would only need to establish what it is willing to contribute to a project as well as data-sharing practices and agreements to enable creating a broader project that accomplishes a collective purpose.

Alignment Between Rates and Savings

With two contracts, each having multiple financial options to base the project on, there are no fewer than nine configurations of the project. They key evaluation-related issues to consider are tradeoffs of value. Does added complexity of multiple, potentially conflicting evaluations looking at different systems create value or diminish the project’s potential?

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21 For further reading, please see (Olson & McKnight, Contract Options for Value-Based Purchasing Innovation: Financing the Transition from Volume to Value-Based Payments with Pay for Success, 2017)
Incentivizing Public Health Innovation Programs

One of the most interesting approaches the State can take would be a combination of value-based purchasing programs and incentives for the managed care entities to undertake those programs, which may or may not be financed through a Pay for Success arrangement. In this approach, the State would have to undertake the same course of action as stated in the previous section to allow managed care entities to undertake value-based purchasing programs complete with contractual amendments, application, and approval processes, as well as oversight and evaluations procedures. Additionally, the State would have to choose how best to incentivize undertaking the value-based purchasing demonstrations.

Layered incentives can be a difficult proposition, but the theory behind them is sound. In aggregate, the State’s advancement of innovations in publicly financed health care will reduce the long-term cost-of-care for the population at-large. The key will be finding an equitable way to share the value created by Pay for Success projects. The incentive and withhold arrangements are then a means for the State to tip the scale in favor of issues
that may not be receiving appropriate attention or steer parties away from issue areas where the market may be reaching saturation.

The Arizona example may show a way forward. They use a 1 percent withholding of gross capitation measures, redistributing it to parties on a competitive basis for having measurable impacts on key population-health measures. Additionally, the combination of rate-cards with medical-benefit savings programs could act as strong incentives for managed care entities to develop new revenue sources in addressing the social determinants of health.
Examples from Around the Country

Across the country, states have in place mechanisms that can enable Pay for Success projects, or are at least serviceable to do so.

There are a number of examples of value-based purchasing from around the country. We focus here on those where managed care entities play a role in defining their own value-based purchasing arrangements. In the cases of Arizona and Texas, both states have enabled their managed care entities to establish such arrangements. Arizona pre-defined what arrangements were permissible for acute-care contractors and created a competitive incentive program based on a withholding. Texas requires that its managed care entities undertake a percentage of total spending under approved value-based purchasing arrangements and that each year that amount grows as a percentage of the total spending.

Both programs have interesting elements that would align with outcomes-based payments, and would enable local partners to undertake Pay for Success projects to raise funds and transfer risk to investors. In Arizona’s case, the question remains of how permissive the state will be regarding innovations in advanced value-based purchasing, such as condition specific shared savings or risk contracts with non-standard health-related social service providers being counted as a value-based purchasing strategies. Texas requires programs to work with providers, but does not explicitly include non-standard service providers in projects that address the social determinants of health in the state's application for such arrangements.

The following pages provide further detail and helpful links to the programs for further reading or research.

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22 A withholding is the mirror of an incentive. It allows states not to pay managed care entities a certain percentage of funds, which the managed care entities can earn by meeting certain conditions. In Arizona’s case the state withhold the percentage of funds for all managed care entities participating in the program, which it then redistributes primarily to the parties most successful in having the desired program outcomes.
Arizona

Arizona has a value-based purchasing arrangement that applies to Acute Care Contractors and focuses on quality improvement of health outcomes and cost savings for the areas of child and adolescent health. The program withholds one percentage of the gross capitation amount for participating parties and funnels that into a pool for quality-based payments. The pool is then paid out to participating contractors based on their ability to meet minimum quality goals and their relative performance. It requires a minimum 20 percent of contractors spending goes towards value-based payments in a given year, including any combination of strategies.

An interesting feature of this program is that the state has defined the limits of the programs and does not require application or approval of any initiative directly, though they reserve the right not to consider programs not do not meet their definitions.

The outcomes-based payments needed for Pay for Success projects could count towards any of the accountable care programs as mechanisms for shared-savings, shared-risk, or capitation payments to alternate service providers for value-based activities.24

(We are in current discussions with the State of Arizona’s payment mechanism reform project lead to add more information in the coming weeks.)

Value-based purchasing resources

1. General program link
2. Acute Program Value-Based Purchasing Initiative
3. Value-based purchasing spectrum


24 We would encourage parties to confirm with the state prior to engaging, but there is no reason not to allow them under these purchasing arrangements.
Texas

Texas has a long-standing program, included in a uniform managed care contract, which allows the partnering managed care entities to submit value-based purchasing arrangements using a simple form on an annual basis. The state requires participation in the program and requires that each managed care entity increase their proportion of value-based spending on an annual basis.

The program is open to all managed care entities.

(We are in ongoing discussions with the state as a course of regular business in support of one over pay for success projects. The section will be updated periodically.)
https://www.azahcccs.gov/shared/ACOM/

https://www.azahcccs.gov/shared/Downloads/ACOM/PolicyFiles/300/315_16_A.pdf

https://www.thecommunityguide.org/findings/asthma-home-based-multi-trigger-multicomponent-environmental-interventions-children-and


Appendix: Cover Letter For CMS

A cover letter template for states when sending the Centers for Medicare and Medicaid Services (CMS) the contract language for review as a stand-alone amendment or if asked to discuss the section as part of a broader contract procurement.

(Name )
(Title)
(Organization)
(Address)

Dear _____ (current administrator)_____,

We are writing to request ____ (an amendment to / confirmation that ) ____ the state plan for ____ (program) ____ provides for the claiming of Title XIX federal matching funds on expenditures that will improve the health outcomes and reduce health disparities among ____ (target population ex: low income children) ____.

The Medicaid managed care statutes allow to require their managed care entities to participate in value-based purchasing arrangements. In states with approved plans, these value-based purchasing arrangements are allowable expenses included in the numerator of calculating managed care capitation rates. As defined in 42 CFR 438.6, these value-based purchasing arrangements are explicitly designed to allow payments for outcomes rather than the volume of services provided.

Specifically, the value-based purchasing arrangement we are proposing would ____ (require / allow) ____ managed care entities to propose their own outcomes-based payments to the state ____ (optional: for approval) ____. We are currently exploring this in context of one such proposal for addressing home-based factors that contribute to care for ____ (condition, ex: asthma) ____ patients, especially ____ (target population, ex: low-income children) ____.

We request an effective date of ____ (date) ____ for this amendment.

Thank you in advance for prompt review. Is there any questions, please do not hesitate to contact ____ (Name(s), phone(s), and email(s)) ____.

Sincerely,

(Written signature)

(Name)
(Title)
(Office)
Appendix: Managed Care Contract Language

Sample language to allow managed care entities to propose and enter into value-based purchasing agreements with states under current regulatory authorities. For inclusion in contracts during regular procurement cycles or, with modification, as a no-cost contract amendment.

This appendix is intended to as an example of the type of managed care contract language that would permit creating a value-based purchasing program. It should allow a managed care entity to apply for the program, undertake a collaborative process with the State, and develop arrangements that facilitate Pay for Success financing.

The MCE can develop and submit, as appropriate, a written plan for expansion of value-based contracting with its physician and non-physician providers that encourages innovation and collaboration among those parties while increasing quality and efficiency. Contracting and payment structures should be focused on incentivizing improvements in quality related outcomes, shared savings, or both resulting in reductions in the total cost-of-care in providing an excellent standard of care, meeting or exceeding all current state or Federal standards for the specified population.

The plan will include any mechanisms by which the MCE will provide incentive payments to hospitals, Physicians, other healthcare providers, or persons involved the delivery of services and attempt to reduce the overall cost of providing that excellent standard of care while improving the quality of care provided. The plan will also include any metrics or methods by which those incentives will be provided, the recruitment strategy for providers, and propose structure for any and all compensation provided by the program.

While the State will accept new value-based purchasing initiative plans at any time, managed care entities must submit at least one during each calendar year of their contract term using the template provided in the appendices to this document, titled “plan for value-based contracting”. The State’s appropriate agency will evaluate the plan and provide feedback to the managed care entity, which may include a request to answer clarifying questions or address concerns of the State in an updated proposal. The State’s appropriate agency will also retrospectively evaluate the managed care entity of the execution of the written plan as well as the impact that initiatives include in the plan have on the underlying health of the population.

Modifications and updates can be made to the plan after submission to and approval by both the managed care entity and the appropriate state agencies. A strict criteria for the approval of a plan is that it must meet all requirements of Federal value-based purchasing programs, comply with any and all additional state or Federal regulatory requirements, and meaningfully contribute to the health of populations in the state. Plans will be viewed more favorably based on the following criteria and the potential future applicability thereof: (1) the number of affected persons, (2) the number of participating service-providers, (3) the geographic scope of the project, (4) the potential improvement and the underlying populations health, (5) the potential fiscal impact of the program, (6) meaningful innovations associated with compensation methodology, and (7) the ability
to meaningfully improve the use of data and data sharing among those providers involvement program.

While no program could perfectly address all seven of these issue areas in full, we would stress that a quality program can select a small number of these categories and address them in meaningful ways, earning state approval. While a lesser quality proposal could address all seven categories, yet demonstrating no aim for material impact on the underlying health of the population or the potential to do so in the future, would not be considered for approval.

The state’s appropriate agencies’ retrospective review of the execution of the plan may include: (a) a review of encounter data from the managed care entity, potentially in comparison to other statewide data or other administrative data sets to ensure the effectiveness of the program; (b) administrative, financial, or other statistical reporting from the managed care entity, their partners, and others associated with a program; as well as (c) surveys, interviews, and other qualitative research with the managed care entity, their representatives, parties providing services on their behalf, and participants of the program all at the discretion of the State and its appropriate agencies.

The managed care entity has the right to request copies of this information at the conclusion of the review, subject to approval of the State and its appropriate agencies for the purposes of protecting parties, ensuring the quality of responses, the managed care entities to access to information that could be competitively sensitive in this and other industries.

The State may choose to include other elements of the program, such as references to other incentive programs, requirements related to data requests, or explicitly state its allowance of Pay for Success financing and that these programs will count towards value-base purchasing or other alternative payment model metrics.
Appendix: Value-Based Contracting Proposal Template

A possible template for managed care entities to apply for value-based purchasing arrangements under 42 CFR § 438.6 (c), using Texas’ pre-approved application template as a basis.

It is the responsibility of the managed care entity to complete the following narrative sections detailing each of its proposals as well as the accompanying summary table of those proposals.

I. Managed Care Entity name

II. Managed Care Entity geographic service areas

III. Managed care value-based contracting program title

IV. Type of value-based contracting arrangement

V. Value-based contracting level of financial risk for plan or providers

VI. Value-based contracting program type

VII. Program geographic service limitations

VIII. Managed care contracting program enrollment criteria

IX. Estimated program impact measured in enrollees

X. Estimated total claims paid to participating providers of services

XI. Estimated program impact measured in cost

XII. Expected change in health-outcome measures

XIII. Other program relationships, for example Delivery Service Reform Incentive Program (DSRIP), network access programs, or others

XIV. Description of previous-years value-based payment arrangements and structures as described in ... 

XV. Description of applicant’s prospective year’s value-based payment arrangements and structures as described in ...

XVI. Description of applicant’s proposed methodology for retrospective evaluation of its projects and its execution thereof, including changes to the process or outcomes measures and actual anticipated return on investments as described in ...

XVII. Certification that accurately reflects the information in these narratives.

XVIII. Required signatures and approvals

25 The above has been adapted from the Texas Uniform Managed Care Contracts as a guideline for development of programs applicable to Pay for Success. For reference, please see the Texas form Chapter 8.10 (State of Texas Health and Human Services, 2017).
Appendix: Example Application for Value-Based Payment Arrangement

This draft application for value-based purchasing arrangements includes an option narrative overview of the project as well as a table of necessary information for approval.

TO:
FR:
RE: Value-based purchasing proposal to address the burden of asthma

The Value-Based Purchase of Home and Community Based Services

Background
The Centers for Medicare and Medicaid Services (CMS) have recently updated their managed care regulations, allowing for new value-based purchasing programs and providing guidance for their implementation. We would like to propose such a program aimed at lessening the burden of asthma for the state’s most vulnerable populations in the Harris County area. The program has multiple components: provision of services, payment for services, and financing the provision of services.

Services: The services are those that make up comprehensive asthma care management required for achieving and maintaining control of asthma exacerbations as recommended in National Asthma Education and Prevention Program Expert Panel Report 3. The intervention is a multi-factor, multi-component, home-based intervention as supported by the National Institutes of Health and recommended for children by the Centers for Disease Control. They will be provided by a consortium of clinical, home, and community-based service providers that include a home visiting program focusing on patient-centered asthma self-management education, coordination with primary care providers, as well as remediation of environmental triggers of asthma in the home. Quality asthma care involves not only initial diagnosis but also including a combination of traditional medical services.
**Payment:** We are proposing a value-based payment for the verified program impact on the total cost of care for a target population. In this mechanism, the health plan would pay for the services using actuarially assessed reductions in the total cost of care for the target population after those reductions have been evaluated and proven by an independent party. This mechanism would establish a fair price for the services after the outcomes of the program are measured and verified.

**Financing:** For the service providers to be able to provide the services, without being paid in advance or having a firm commitment of payment in advance, those services will need to be funded through alternative means. The project seeks to use Pay for Success financing, in which an independent group of funders will invest in the project to generating the economic and social benefits it may have. This group of philanthropic and commercial social impact investors will provide upfront capital to deliver the services and receive repayment if, and only if, the project successfully reduces the cost of caring for the target population.
Current Program and Payment Structure

Description of MCO’s FY15 incentive/alternative payment structures, as delineated in UMCM Chapter 8.5 “Plan for Value-Based Contracting Worksheet”

Needs to be filled out by each party...
## Proposed Alternative Program and Payment Structure

*Description of MCO’s proposed alternative payment structures, as delineated in UMCM Chapter 8.5 “Plan for Value-Based Contracting Worksheet”*

Required information:

<table>
<thead>
<tr>
<th>I.</th>
<th>Managed Care Entity name</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>II.</td>
<td>Managed Care Entity geographic service areas</td>
<td></td>
</tr>
<tr>
<td>III.</td>
<td>Managed care value-based contracting program title</td>
<td>Home-Based Asthma Control and Prevention Project</td>
</tr>
<tr>
<td>IV.</td>
<td>Value-based contracting level of financial risk for plan or providers</td>
<td>Shared savings arrangement</td>
</tr>
<tr>
<td>V.</td>
<td>Value-based contracting program type</td>
<td>Outcomes-based payments for preventive services</td>
</tr>
<tr>
<td>VI.</td>
<td>Program geographic service limitations</td>
<td></td>
</tr>
<tr>
<td>VII.</td>
<td>Managed care contracting program enrollment criteria</td>
<td>History of acute-care: Hospital admission or emergency department visit with a primary diagnosis of a respiratory condition with any associated diagnosis of asthma)</td>
</tr>
<tr>
<td>VIII.</td>
<td>Estimated program impact measured in enrollees</td>
<td>Actuarial projects indicate aggregate reductions in the total cost of care for the population may reach 40 percent reductions in hospitalizations and emergency department visits, which may translate to a 30-38 percent reduction in overall costs.</td>
</tr>
<tr>
<td>IX.</td>
<td>Estimated total claims paid to participating providers of services</td>
<td>(Excerpt from actuarial assessment)</td>
</tr>
<tr>
<td>X.</td>
<td>Estimated program impact measured in cost</td>
<td>Program reductions in medical utilization and increased use of primary care and controller medications will reduce net costs by 30-38 percent over the life of the project.</td>
</tr>
<tr>
<td>XI.</td>
<td>Expected change in health-outcome measures</td>
<td>Reductions in acute care utilization may reach 40 percent marginal improvement beyond reversion to the mean estimates. Additionally, we are exploring the impact this will have on the health of families, depression rates, pneumonia, or event cardiologic conditions.</td>
</tr>
<tr>
<td>XII. Other program relationships, for example Delivery Service Reform Incentive Program (DSRIP), network access programs, or others</td>
<td>The program operates independently of other programs, though aims to accomplish reductions in cost and improvements in care quality that other programs focus on as well. This program’s evaluation will target the incremental additive value above those other programs to ensure against double-counting.</td>
<td></td>
</tr>
<tr>
<td>---</td>
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<td></td>
</tr>
<tr>
<td>XIII. Description of previous-years value-based payment arrangements and structures as described in …</td>
<td></td>
<td></td>
</tr>
<tr>
<td>XIV. Description of applicant’s prospective year’s value-based payment arrangements and structures as described in …</td>
<td>Please see narrative sections.</td>
<td></td>
</tr>
<tr>
<td>XV. Description of applicant’s proposed methodology for retrospective evaluation of its projects and its execution thereof, including changes to the process or outcomes measures and actual anticipated return on investments as described in …</td>
<td>Please see evaluation narrative.</td>
<td></td>
</tr>
<tr>
<td>XVI. Certification that accurately reflects the information in these narratives.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Required signatures and approvals</td>
<td>x. John Hancock</td>
<td></td>
</tr>
</tbody>
</table>
NARRATIVE DESCRIPTION

Intervention services
The intervention services provided follow the Centers for Disease Control’s (CDC’s) community guide for asthma care services. The services are home-based, multi-trigger, multicomponent environmental interventions. The primary components of the services are:

1. Advanced care coordination and management with primary care integration,
2. Home-based asthma education including medication management, and
3. Environmental assessment and remediation of asthma related issues.

Value-based purchasing
In the transition from volume to value, we are intending to pioneer new types of payment models with our subcontracted service providers, especially those offering new models of potentially preventative services that focus on improving the health of populations by utilizing home and community-based services.

While there are certainly advantages to successfully pioneering these areas as a managed care entity, there are also risks that include but are not limited to risks of efficacy, operations, and pricing. In many cases, the effectiveness of proposed services may not have been proven effective in the same context as they would be delivered to a population. The current service providers in the area are not running the programs in the same manner or at the same scale required for population-based service delivery. Finally, appropriate prices for unproven services are effectively speculative leaving the possibility of overpayment or undercompensating for services in a manner that makes them untenable to deliver.

We intend to address this problem by making value-based payments. Specifically, we want to make retrospective payments to our subcontracted service providers for the measured impact their services have on a target population’s health outcomes. We will measure this in terms of reductions in total cost of care in comparison to an established matched comparison group, using an actuarial assessment to determine a fair price to be
paid. We will further arrange to close the financing gap for our subcontracted service providers with a Pay for Success arrangement, where an outside party will provide the initial capital, taking the risk that the services do not have an impact meriting payment.

The Financing Arrangement: Pay for Success
Pay for Success is an innovative financing arrangement that, when appropriately implemented, has several benefits. Pay for Success can:

- Allow and incentivize private investment in public health programs;
- Raise capital for service providers to continue or scale programs;
- Limit the risk of health insurance providers as they transition from volume to value, while incentivizing the advancement of service delivery innovation; and
- Test or verify the effectiveness and cost-benefit of service delivery programs in real world circumstances at their eventual scale

The agreements allow outside funders to fund public health programs and their capital is returned if, and only if, the programs prove successful. In this arrangement, typically philanthropic or commercial social impact investors will invest in social program that they believe accomplish or contribute to their economic or social missions. They often see it as a more effective way to deploy their capital than typical grants because of the possibility of a return of capital, which can be redistributed later for a broader impact.

The funding parties invest in programs by providing capital. The investment allows service providers to deliver their services to the populations at the required scale. Those services generate value for the payer—in this case, a managed care entity’s cost of care for the population will decrease. The incremental cost savings is used to repay the investors if, and only if, an independent evaluation determines that the services were effective in decreasing the cost of care. Additionally, the particular transaction can be designed with limits on the earning potential of any of the parties or the potential to leverage additional gains in a number of other ways.

External parties facilitate the entire process, including a technical assistance or capacity building specialist as well as an intermediary that arranges capital flows, manages the
project after the transaction’s launch, balances each parties’ interests, and ensures alignment on the critical decisions and relationships.\textsuperscript{26}

\textsuperscript{26} With the involvement of outside funding parties, the structure of the arrangement often requires the involvement of independent parties for the purposes of fiscal agency, evaluation, and other roles that provide checks and balances.
Evaluation proposal

1. Description of MCO methodology for retrospective evaluation of the MCO’s execution of the written plan and effectiveness of the plan, including changes in process or outcome measures and actual or anticipated return on investment (see UMCM Chapter 8.5 “Plan for Value-Based Contracting Worksheet”)

CMS requires states to ensure that the value-based purchasing program is evaluated to determine the extent to which that program advances the goals that it targeted for improvement in the State’s Quality Plan.

In State’s the Managed Care Program Goals and Objectives are:

To create a customer-centered, innovative, and adaptable managed care system that provides the highest quality of care to clients while at the same time ensures access to services. We seek accomplish this mission by contracting for measurable results that:

(1) Improve member access, satisfaction, and quality of care.
(2) Maximize program efficiency, effectiveness, and responsiveness.
(3) Limit operational costs.

The proposed value-based payment aims to advance these goals in meaningful ways and has an evaluation designed to measure the effectiveness of the program. The program will improve those areas through a focus on prevention, especially of acute care needs, and by expanding service offerings to address the root causes of problems, rather than leaving vulnerable populations to frequent facilities for treatment of symptoms in a way that frustrates and exhausts resources. The program will improve lives.

The program seeks to improve access, satisfaction, and quality of care through preventive services. Those preventive services will alleviate acute care needs, improving access and wait-times for those who need it. In turn will improve satisfaction, as will having additional services that address environmental determinants of health, which were previously beyond the reach of the medical professionals with whom we work. Finally, the quality of
care will be improved through preventive measures that will alleviate the burden of a debilitating chronic condition, returning members of vulnerable populations to health, providing them economic mobility, and reducing the cost of care while establishing a new standard of care for asthma patients.

The value-based purchasing mechanism will also advance the goal of maximizing program efficiency, effectiveness, and responsiveness. By creating a service program that identifies, assesses, and remediates the triggers of asthma in the home, medical service providers will no longer be forced to treat the symptoms of asthma that go uncontrolled due to environmental factors. This change will improve the efficiency, effectiveness, and responsiveness of managed care in the state.

The purchasing program will also limit operational costs by focusing resources on root cause remediation rather than symptom treatment. The program’s design hinges on having a lower cost of service than the cost savings they generate over a relatively short horizon, for such a substantial initial investment.27

Further, we envision this project as a road map for future projects addressing chronic conditions and establishing new standards of care, especially for highly expensive conditions and comorbidities contributed to by the social determinants of health. This individual project is as much about pioneering asthma treatment methods as it is about pioneering how we establish fair pricing for home and community-based services.

We plan to evaluate these impacts through an ongoing assessment of claims data. We seek to establish an appropriate target population, from which we can create a matched comparison group using data we have available from comparable service areas or through the use of administrative data sets provided by the State directly to our actuarial evaluation partner or though us.

27In other programs, the pay-back period for high utilizers is less than two years, while those programs may also seek to expand service delivery beyond the high utilizing tiers in the interest of defining the populations for which the services are economically beneficial or medically appropriate.
An actuary will perform the evaluation determining the outcomes-based payments will be conducted by an actuary using an actuarially-sound method comparing the total cost of care between groups over time. The actuary will establish the differential cost savings as the payment value and use this as the value-based payment in our project. That payment will be included in the charge-record for the managed care entity as an outcomes-based payment program code. For a full written description of the mechanics of this work, please see the “Outcomes-Based Payment Handbook” a GHHI publication.

The program can also measure many other metrics through the same mechanism. We are specifically seeking guidance on which of the following measures should be included in our evaluation:

- Prevented hospital admissions or hospital-days,
- Prevented days observation,
- Prevented emergency department visits,
- Improvements in medication adherence,
- Improvements in HEDIS measures, and
- Others observable from claims records.

**Program Return on Investment**

The program’s cost-benefit is currently uncertain, however, the actuarial projections for program participants indicate that there will be substantial savings. When we extrapolate the actuarial projections to the project target parameters, the program’s economic rate of return is expected to be XX percent over the program term with a financial value of dollars invested, after transaction costs of between XX-XX percent depending on a number of factors.

It is important to stipulate that the managed care entity may not benefit financially in the same manner as the upfront investors. The managed care entity has the option to fund the program in part, in which case it could benefit more financially; however, a purpose of the financing mechanism is to transfer risk from our health plan to the funder group, which may include philanthropic or institutional investors.
At the conclusion of the project, in which the managed care entity has put none of its capital or medical payments at risk, we will have the option to use the evaluation to set an appropriate set of eligibility criteria for the intervention services as well as an appropriate price, working in collaboration with the state and our home and community-based service providers.