“PFS Demonstrations and HHS Programs: Challenges and Opportunities”

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ASPE-HHS

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“Pay for Success” (PFS) – Original Concept

• New way for government to partner with philanthropic/private investors to fund interventions to address social needs

• *Private investors provide up-front capital* for services intended to improve outcomes and produce future government savings

• Government repays investor if measurable outcomes achieved

• *Captured savings* used for investor repayment – including ROI

• *Transfers financial risk* from government to private investors, supports experimentation/scaling without initial public expense, promotes evaluation.

• PFS evolving – models not requiring savings or private investors
PFS - HHS Attention

• PFS an Administration priority

• HHS collaborating with DPC, OMB, CNCS, HUD, Treasury, etc

• Many PFS demos relevant to HHS (e.g. asthma, pre-K, juvenile justice, reentry, home visiting, child welfare/family, homelessness, substance abuse)

• Often PFS demos focus on Medicaid populations – and assume substantial future savings may be in Medicaid

• Field interested in using Medicaid funding/savings into PFS demos

• Medicaid = approximately 80m beneficiaries and $476b state-federal expenditures (2014)
ASPE PFS Research Project

- Key HHS questions:
  - What interventions could produce *Medicaid savings*?
  - Incorporate *private investor funding* in Medicaid-PFS demo?
  - Medicaid as source of PFS *outcome payments/investor repayment*?
  - Specific *PFS-Medicaid models*?

- Extramural research project with GWU School of Public Health, 3rd Sector Capital, Altarum Institute
  - Co-PI's – Paula Lantz, Leighton Ku, Sara Rosenbaum
  - Project Officer: John Tambornino; TWG (HHS: ASPE, ACF, CMCS, CMMI, CDC, HRSA; CNCS, HUD, Treasury, Federal Reserve, OMB)
  - Period of Performance: August 2014 – December 2016
Criteria for identifying/assessing PFS opportunities in HHS program areas – incorporating Medicaid:

- Theoretical rationale
- Well-defined intervention
- Evidence of effectiveness
- Measurable outcomes
- **Evidence of Medicaid cost-savings** and cost-effectiveness
- Evaluation challenges
- Potential investor interest
- **Legal/regulatory feasible re. Medicaid**
- Administrative feasibility
ASPE PFS Research Project

• Assessments of PFS potential of 6 areas:

  1. Early Childhood Home Visiting Programs
  2. Home-Based Childhood Asthma Interventions
  3. Diabetes Prevention Program
  4. Improving Access to LARC
  5. Supportive Housing and Services for chronically homeless
  6. Supported Employment for adult with severe mental illness
## PFS Potential in Terms of Medicaid Savings

### Assessment Criteria

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<td>Several/Nurse Family Partnership</td>
<td>Environment and Case Management</td>
<td>DPP Lifestyle Intervention</td>
<td>Clinic-Based Provider Education and Stocking</td>
<td>Targeting/Assessment/Services</td>
<td>Individual Placement and Support Model</td>
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### Evidence Base for Effectiveness

- **Well-Defined Program**: Strong
- **Key Outcome Measures**: Birth outcomes; development milestones; health care use and costs
- **Evidence of Cost-Savings**: Yes, if including both Medicaid and SNAP
- **Potential Investor Interest**: Strong
- **Other Key Issues**: Long time horizon/savings to multiple government agencies

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PFS-Medicaid – Issues/Challenges

• Few interventions are cost-saving in terms of Medicaid costs alone

• Cost-savings very unlikely if federal Medicaid savings not included (due to federal match/FMAP)

• Medicaid design/authority doesn’t fit original PFS model:
  – Private 3rd-party expenditures (e.g. private investors) not recognized as state expenditure for purposes of federal matching funds
  – Future non-expenditures (i.e. savings/cost avoided) not basis for federal match
  – Non-“medical assistance” usually doesn’t qualify for federal match
  – Certain PFS scenarios appear feasible under Medicaid managed-care (MCOs)
PFS and Medicaid Managed–Care

• PFS *conceptually similar* to Medicaid managed-care:
  – MCOs have access to private capital
  – State-MCO incentives to lower health care expenditures via improved health
  – Greater focus on preventive interventions
  – State has contractual tools to incent performance/penalize non-performance
  – Managed-care focuses (to some extent) on outcomes and risk-sharing

• Question: What would PFS *add* to MCO model?
  – Allow services state cannot/will not cover under Medicaid
  – Allow services HHS cannot/will not cover under Medicaid
  – Enable reaching poor/disadvantaged populations no eligible for Medicaid
  – Provide complementary funding for service enhancement
  – Support innovation/evaluation for later Medicaid service coverage
PFS and Medicaid Managed–Care

- PFS demonstrations appear feasible via Medicaid MCOs (not in fee-for-service):
  - MCO as investor or private investors funds MCO
  - “Incentive agreements” between MCO-state and MCO-providers
  - “Incentive payments” to MCOs could be used for investor repayment (limited to 5% of capitation payment)
  - Other sources of savings – funds for investor repayment
Possible PFS Arrangement in Medicaid MCO

Figure 2. MCO PFS Model: Federal Medicaid Matching Funds Available

- Investor provides funds to managed care organization (MCO) to conduct environmental abatement (funds are not federally matchable)
- MCO contracts with community-based service organization to provide environmental abatement (funds are not federally matchable)
- Interventions yield savings to Medicaid and other state programs
- The state can share savings with MCO, which MCO can use to repay investors (funds are federally matchable)
Medicaid – Sources of Savings

• MCO Savings
  – When costs of services for enrollees is lower than PMPM capitation payment received from state
  – MCO retains margin/profit – could pass on to private investors
  – But state might reduce capitation payment in 1-2 years to reflect lower costs

• State-Federal savings related to state-MCO contract:
  – Under steady capitation payments there are *not necessarily* state-federal savings
  – Are savings if avoid costs in state-MCO contract *outside of basic capitated payment*
  – Savings to avoid costs state pays directly – are *outside of state-MCO contract*
Medicaid – Sources of Savings (2)

- State-Federal Savings when *future capitation payments reduced*
  - May be disincentive for MCO – capitation rate lowered, may not be able to sustain intervention
  - State agree in advance to *partial* capitation rate reduction?

- When fewer persons eligible for Medicaid
  - Higher incomes (but may be new federal costs to subsidize health insurance)
  - Fewer unwanted pregnancies = fewer new Medicaid recipients
Conclusions

• Near-term Medicaid savings often more limited than assumed

• Cannot fully capture whatever Medicaid savings are realized

• PFS may be incorporated into Medicaid MCO settings
  – Not natural fit – significant limitations - highly complex
  – Other considerations re. program integrity, etc

• Alternatives to Medicaid-PFS models – to innovate, focus on outcomes, reduce financial risk to government, etc

• Remaining questions:
  • Where could PFS *add value* to Medicaid MCOs?
  • How to avoid excessive complexity from combining MCOs and PFS?
  • What can PFS field learn from managed care?
  • How to distinguish dominant PFS model from PFS principle?
Thank You!

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