Using Pay for Success in Health Care

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1. Introduction

In many ways, health-related interventions and Pay for Success (PFS) are natural bedfellows. Since the 2010 passage of the Patient Protection and Affordable Care Act (Affordable Care Act), the federal government has increasingly emphasized cost-effectiveness, pay for performance measures, and policy innovation across all of its health programs and in policy. At the same time, PFS is emerging as an innovative approach to address social problems, and it addresses these elements of the Affordable Care Act (Exhibit 1). PFS ties funding for an intervention to achievement of its outcomes and impacts in the community, enabling government or other payors (for example, health insurance providers or hospitals) to pay only for what works. Interest in PFS models for health-related interventions has been increasing, and this brief is designed to address opportunities to initiate PFS projects in this arena. Other policy developments have fueled interest in PFS financing models as well, including long-standing efforts to reduce health care costs per capita and an increasing focus on prevention. Only one of the PFS projects that have launched in the United States (as of July 2016) has a health-related objective, but many more are in development.

Exhibit 1. Parallels between the Affordable Care Act and PFS

Affordable Care Act	Pay for Success
✓Improving outcomes	✓Improving outcomes
✓Innovative policy	✓Innovative approach
✓Pay for performance	✓Pay for outcomes
✓Cost-effectiveness	✓Cost effectiveness or cost savings

Role of CNCS

The Corporation for National and Community Service's (CNCS) Social Innovation Fund (SIF) PFS Grant Program is in the process of markedly changing the landscape of PFS in health care and disease prevention. This initiative has funded 11 grantees: eight in 2014, its inaugural year, and another three in 2016, to either provide feasibility assessment and capacity building assistance or to structure transactions for PFS projects. Healthy futures, which includes promoting healthy lifestyles and reducing the risk factors that can lead to illness, is one of the three key areas of focus designated by CNCS for the SIF PFS program, and two of the program's 2014 grantees are focusing exclusively on supporting PFS projects related to healthy futures. Through their selected subrecipients, these 11 grantees are supporting the development of approximately 70 projects, and about 20 of these projects have a primary focus on healthy futures.

Objective of the brief

The brief is intended to assist stakeholders and government agencies considering using PFS in health-related interventions. It identifies the motivations for using PFS financing models to support health-related interventions, the challenges involved, and early insights about using PFS models with health-related interventions. To illustrate these points, we provide examples from in-depth discussions with service providers and intermediaries working on three different PFS projects being implemented or in late stages of development. These projects were selected based on the health issues they address, their different stages of development, and the role of Medicaid in each project. The observations from this brief were also drawn from a review of the PFS projects that have been launched to date in the United States and the health-related projects now in development under the SIF PFS program.

Outline of the brief

The next section of this brief introduces three specific health-related PFS projects and draws conclusions about how PFS can be used with health care initiatives. Because Medicaid is one of the largest payors of health care in the U.S. (about 16 percent of total health spending), and the Medicaid-eligible population is often similar to the populations targeted by PFS projects, there are potential synergies between Medicaid and PFS. These are described in Section 3. Section 4 describes the early insights and emerging themes from the body of health-related PFS projects reviewed in this brief.

Profiles of the three health-related PFS projects are provided in Appendix A. Definitions of key terms related to relevant health policy are in Appendix B; a glossary of terms related to Pay for Success is in Appendix C; and resources and references are provided in Appendix D.

2. The Promise of Pay for Success in Health Care

Although the projects profiled in this brief cover different health-related interventions, all three illustrate the promise of PFS in the health care space, the difficulty in realizing that promise, and the possible paths to overcoming those difficulties, as discussed in the remainder of the brief.

- **The Green and Healthy Homes Initiative (GHHI)** is currently seeking state Medicaid support to implement a PFS asthma prevention intervention in Baltimore, MD in partnership with the Hopkins Medicaid Managed Care Organization (MCO). The intervention helps repair or retrofit homes in order to reduce episodes of asthma among residents, and particularly children.
- **Meals on Wheels America** completed a feasibility assessment in January 2016 of an enhanced program that includes case management and well-being checks on seniors around Maryland in addition to the standard daily meal delivery. Meals on Wheels America is now using support from the SIF PFS program to identify end payors and investors. One of its member organizations, Meals on Wheels of Central Maryland, will provide the services. The project will seek to reduce emergency department visits, hospital admissions and length of stay, and readmissions.
- **Nurse-Family Partnership (NFP)** is the service provider for the statewide South Carolina Department of Health and Human Services' PFS Project, which launched in April 2016. The project provides nurse home visits to first-time mothers and their infants in high-poverty communities to reduce preterm births, child hospitalizations, emergency department usage (due to injury) and to increase healthy spacing between births.

Exhibit 2 includes a summary of these projects; additional details are in Appendix A. The glossaries in Appendix B and C describe key terms used in these project profiles. All three of the projects profiled are being led by service providers with multiple U.S. locations; two of them have been involved with the SIF PFS program. Each offers a specific, evidence-based service that has been shown to demonstrate consistent health outcomes and produce cost savings. These services can be categorized as public health services that focus on prevention and promotion of better health, and not as clinical health services such as those delivered by medical providers in offices or hospitals. These projects aim to reduce asthma-related hospital visits; prevent falls among seniors; and reduce preterm births, among other goals. Prevention services like these have always been a part of the public health system, but now represent only five percent of total health care spending.[1]

[1] Klein Walker, D., The Affordable Care Act at Five Years: Where is Prevention? *Huffington Post*, March 7, 2016. Retrieved from: http://www.huffingtonpost.com/deborah-klein-walker/the-affordable-care-act-a_3_b_9395240.html

Exhibit 2. Summary of Profiled Projects

	Baltimore GHHI	South Carolina Nurse-Family Partnership	Meals on Wheels America
Project partners			
Service provider	GHHI	NFP	Meals on Wheels of Central Maryland
Payor	Hopkins' Medicaid MCO (Priority Partners MCO)	South Carolina Department of Health and Human Services (state Medicaid agency)	Currently finalizing arrangements with hospital system(s)
Evaluator	Hilltop Institute at the University of Maryland Baltimore County	J-PAL North America	Currently finalizing selection of independent evaluator
Intermediary	Social Finance	Social Finance and NFP	Quantified Ventures LLC
Project characteristics			
Intervention	In-home technical intervention with in-depth and personalized behavioral education for the family.	Home visiting for vulnerable first-time parents with registered nurses from early pregnancy through the child's second birthday	Senior support services: a combination of daily home-delivered meals, socialization, case management with an enhanced in-home assessment, safety checks with minor home repairs, and referrals.
Project status	Transaction structuring	Services launched April 2016	Transaction structuring
Health issue being addressed	Reducing the incidence of asthma caused by unhealthy housing	Maternal and child health	Food security, nutrition, safety and fall prevention, and social isolation for seniors
Outcome metrics	Reduction of utilization across inpatient, outpatient, professional services, and other categories, will be evaluated quarterly using the actual health expenditure data of the children served, from a data-sharing agreement	•Reduction in preterm births •Reduction in child hospitalization and emergency department usage due to injury •Increase in healthy spacing between births	•Reduction in emergency department visits • Reduction in hospital admissions and average length of stay • Reduction in hospital 30-day readmissions
Geographic area	Baltimore City and County, MD and some areas in the surrounding counties	28 of 46 counties in South Carolina	Baltimore metro area

Given the health care community's current focus on the "triple aim" of improved patient experience, improved health outcomes, and reduced cost of care per capita—all of which are also aims of PFS projects in the health care space in general and these projects in particular—these services may be a good fit for PFS arrangements when the following conditions are met:

- The projects rely on an evidence-based intervention,
- The intervention has been shown to produce savings in health care services over the long term, and
- Sources of financing to scale the programs are limited or not readily available in the local context where the project seeks to operate.

Other PFS projects with a health-related intervention have similar characteristics. For example, several PFS projects now in development will provide permanent supportive housing (PSH) to formerly homeless people. Evidence demonstrates

that PSH reduces emergency room visits, the rate of incarceration, and the use of emergency detoxification services.[2] In general, PFS represents an opportunity to scale public health services that have proven to be cost-effective but that do not fit the traditional scope of health care services.

The three PFS projects profiled in this document – as well as other health-related projects in development – have similar motivations for combining health interventions and PFS. Specifically, PFS has the potential to provide start-up capital that is otherwise rarely available in social services. Service providers often have capital available only for current operations, not for the investment needed to expand their services. For example, project implementers report that PFS has been critical to NFP's strategy in South Carolina. The financing associated with the PFS agreement provided the up-front capital needed to increase staffing to provide home visiting services during a ramp-up period of six to nine months. The PFS financing allowed NFP to hire and train nurses, build up their caseload, and set up the necessary data systems.

As another example, PFS can provide the financing needed to design a model that, while already demonstrated to be effective, has yet to be replicated in multiple locations. For example, Meals on Wheels' goal is to produce a replicable model that can be rolled out through other affiliates in the Meals on Wheels network.

In addition, as described more in the next section, all of the three projects see PFS as an opportunity for service providers to engage Medicaid. Although the PFS financing offers a sort of start-up capital for expansion, some service providers see Medicaid as a potential payor of services provided. That is, once the PFS financing allows the service provider to scale the program, Medicaid funding can sustain the program's ongoing operations.

3. Medicaid and Pay for Success

The Affordable Care Act's emphasis on cost-effectiveness, pay for performance, continuous quality improvement and policy innovation extends to Medicaid; many states are transforming their Medicaid systems by organizing and paying for health care differently. In the last five years, Medicaid at the federal level has strongly encouraged state Medicaid programs to employ alternative payment methodologies that reward value over volume. The Medicare and Medicaid Innovation Center created by the Affordable Care Act is assisting states in testing delivery system innovations supported by payment reforms, and the Center for Medicaid and CHIP Services (CMCS) has encouraged states to use existing or newly proposed Medicaid authorities to advance value-based purchasing and integrated care models. Given that Medicaid accounts for one out of every six dollars spent on health care in the United States and insures 19.6 percent of the population,[3] this change has the potential to be an important development for PFS and its advocates.

Potential roles for Medicaid in PFS projects

Given its role in the U.S. health care system, and the fact that some of the savings from a health-related PFS project are likely to accrue to Medicaid by averting costly inpatient hospitalizations, emergency department visits, and nursing home stays, it is not surprising that all discussants remarked on the importance of Medicaid when exploring PFS projects. Traditionally, Medicaid has served as a stable source of ongoing revenue in the health care system by paying for health

[2] See Martinez, T. & Burt, M. (2006). Impact of Permanent Supportive Housing on the Use of Acute Care Services by Homeless Adults. *Psychiatric Services*, *57*, 992-999. See also Larimer, M.E., Malone, D.K., Garner, M.D., et al. (2009). Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons with Severe Alcohol Problems. *The Journal of the American Medical Association*, *301(13)*, 1349-1357.

[3] Barnett, J. C. and Vornovitsky, M. S. (2016). Current Population Reports, P60-257, Health Insurance Coverage in the United States: 2015, U.S. Government Printing Office, Washington, DC. Retrieved from: http://www.census.gov/library/publications/2016/demo/p60-257.html

care services on a fee-for-service basis or through capitated managed care arrangements. Medicaid also makes payments linked to quality and value through alternative payment methodologies.[4] PFS provides opportunities to extend these roles.

Medicaid is currently providing reimbursement for services for several PFS projects, including the South Carolina NFP PFS project, where the South Carolina Department of Health and Human Services is the outcomes payor.[5] Several projects in development are exploring the possibility of Medicaid MCOs as potential payors. Whether or not Medicaid MCOs can serve as payors depends on several factors, some of which are location specific. For example, in Maryland, Meals on Wheels explored the possibility of partnering with a Medicaid MCO, but the MCO does not cover Meals on Wheels' target population. In another example, the service provider has had discussions with both federal Centers for Medicare and Medicaid Services (CMS) and the state Medicaid agency about their developing PFS project. It has not yet been determined whether a PFS agreement can be executed under current regulations or whether federal approval from CMS is needed to make payments to PFS investors without later penalties regarding rate-settings or federal participation in Medicaid.

Medicaid coverage of services can be an important financial sustainability goal for public health programs seeking to continue or expand service provision. Medicaid may cover entire PFS health interventions or some of the services that comprise those interventions. For example, the Denver Social Impact Bond program aims to improve housing stability and reduce criminal justice involvement for 250 chronically homeless adults with mental health and substance abuse issues. The project is leveraging Medicaid reimbursement for some of the costs of providing behavioral and physical health services to this population.[6] In some instances, Medicaid may reimburse for PFS intervention services under the existing Medicaid state plan. In other cases, a state plan amendment or Medicaid waiver may be needed. Given that the process of obtaining a waiver can be lengthy, state leadership buy-in and a champion at the state Medicaid agency are key ingredients. For example, in the South Carolina NFP PFS project, leadership in the state Medicaid agency initiated discussions with CMS about its plans to apply for a 1915(b) Medicaid Waiver early in the process and obtained approval within approximately six months. The 1915(b) waiver granted to South Carolina in 2016, which runs through 2020, allowed for the implementation of enhanced prenatal, postpartum, and infant home visit services that would not otherwise have been allowed under the applicable federal regulations. If the project is successful, the Medicaid waiver may be renewed for another five years.

Barriers to Medicaid-PFS partnership

As described above, there have been numerous instances of innovation in the use of PFS to support projects relating to healthy futures. However, significant barriers to Medicaid-PFS partnership remain. First, as noted above, states must seek approval from the federal government to spend federal Medicaid funds on some non-clinical services. States develop their Medicaid programs within federal parameters that define allowable services, and must seek approval from CMS for program changes. Because most PFS programs offer a comprehensive array of non-clinical services, it can be challenging

[4] Alternative Payment Model Framework and Progress Tracking (APM FPT) Work Group. January 12, 2016. Alternative Payment Model (APM) Framework. Final White Paper. Retrieved from: https://hcp-lan.org/workproducts/apm-whitepaper-onepager.pdf

[5] Another example is the Massachusetts Chronic Homelessness Pay for Success Initiative. See Garvey, M. (2015), Pay For Success in the U.S.: Summaries of Financed Projects, Institute for Child Success, December. Retrieved from: http://www.payforsuccess.org/sites/default/files/summary_of_pay_for_success_social_impact_bonds_Massachusetts_homelessness.pdf

[6] Nonprofit Finance Fund. Denver Social Impact Bond Initiative: Permanent Supportive Housing. Retrieved from: http://www.nonprofitfinancefund.org/sites/default/files/docs/2016/Denver%20SIB%20Summary_NFF2.pdf

to determine the appropriate Medicaid authorities and payment mechanisms that may allow PFS programs to be financed with federal Medicaid funds.

As states expand their use of Medicaid managed care, there is another challenge: the incentives for managed care organizations, providers, and state Medicaid agency payors do not always align. Since PFS programs are often premised on the expectation of long-term cost savings as a result of preventive services, CMS, Medicaid MCOs, and state Medicaid agencies will need to negotiate both how up-front costs will be paid, and how long-term savings will be shared. MCOs or other Medicaid intermediaries who receive capitated payments may be concerned that their reimbursement rates will fall when savings are realized. Medicaid MCOs are required to cover certain preventive services, but these may or may not be the services included in a particular PFS program.

4. Early Insights on PFS in Health Care

Although PFS is still a young model and much remains to be discovered and verified, early insights from implementers and stakeholders point to how and why many kinds of health-related interventions may be a good fit for PFS. We identified key emerging themes related to providers, the PFS model, and the health care environment to consider when planning health-related PFS projects. These insights are summarized below.

Evaluating the local environment for a health-related PFS project

Payment reform is underway and varies by state. Discussants noted that ongoing payment reforms are underway as Medicaid shifts from a fee-for-service reimbursement system to value-based performance payments. There is substantial variation in how health care is paid for in different states. The potential alignment between payment reforms and PFS must be further explored to identify when and where such reforms create opportunities for PFS health projects to advance. Service providers with multiple U.S. locations may be able to seize opportunities in areas where the alignment supports a PFS project.

State PFS champions improve the odds of success. The involvement of leaders at various levels of government is key to gain support for PFS whether the project is health-related or not. But for projects seeking Medicaid involvement in particular, having state Medicaid agency support and leadership involvement is essential. As described earlier, the South Carolina State Medicaid leadership worked with CMS before submitting an application for the waiver. This helped expedite the process so that the turnaround time for review and approval was relatively short.

Considerations for selecting the intervention and structuring the PFS project

Strong evidence for the effectiveness of the intervention is a key factor for readiness to engage in PFS. All three projects profiled in this brief deliver interventions with evidence that the services are effective in both improving health outcomes and producing cost savings. This evidence is from widely accepted sources including outcome evaluations, randomized controlled trials, longitudinal analysis of service utilization records with client data, and actuarial analyses. These sources have been used to make the business case for their programs to demonstrate the value of their interventions for clients and health care cost savings. Having credible research on the demonstrated health outcomes and cost savings associated with their program has facilitated their readiness for and engagement in PFS**.** As one PFS project implementer said, "Starting from scratch, without the evidence base, would be a big lift…."

The unique concerns of health care service providers and payors require careful consideration to ensure that PFS does not inadvertently create barriers or disincentives to participation. As described above, MCOs, who might usefully serve as payors for PFS projects, may be wary of projects that address preventative care like the three profiled here because *too*

much cost savings may mean that Medicaid capitation rates would be lowered over time as cost savings are realized. CMS, State Medicaid agencies, and MCOs will need to engage in ongoing discussions about sharing risks and savings accrued through PFS programs.

The health care system is heavily regulated, which may increase the complexity of PFS projects. Complexities related to Medicaid have been discussed. But private payors, too, must comply with myriad regulatory requirements, including those surrounding data security under the Health Insurance Portability and Accountability Act (HIPAA). Regardless of the payor, projects will often be required to develop or adapt mechanisms to track program operations' compliance, which is particularly complicated in this policy domain, and therefore might not be able to be modeled on other, non-health PFS projects.

PFS supports scaling services to reach a larger segment of the target population. PFS implementers point out that a minimum project scale is needed to make the effort of a PFS project pay off. For example, in two locations NFP did not pursue potential PFS projects because the population in need of services was too small to justify the effort and costs involved with structuring a PFS project. Further, a rigorous evaluation requires a robust number of participants to demonstrate outcomes.

Considerations for partnering with Medicaid

Medicaid's potential as a payor is both tremendously promising and complex. One out of every six dollars spent on health care in the United States is spent by Medicaid, making it an enormously consequential player in the health care space. However, since each state administers its own Medicaid program (subject to federal requirements), it is more accurate to say that there are many dozens of different "Medicaids" than it is to refer to Medicaid as a monolithic program. As such, many questions regarding Medicaid's role as a payor in PFS projects will have to be resolved on a state-by-state or even project-by-project level. The three profiled organizations explored Medicaid's potential roles within their specific state contexts during their PFS projects' assessment phases.

A state's Medicaid eligibility rules are a key element in assessing potential alignment with a PFS project. Whether or not a state chose to expand Medicaid eligibility affects which individuals are able to enroll in Medicaid coverage. Before inviting Medicaid to partner, PFS projects will want to assess to what extent their own target populations overlap with populations served by a state's Medicaid program.

Previous provider experience with Medicaid is helpful for projects considering involvement of Medicaid in a PFS project. Developing the expertise and systems needed by service providers to bill Medicaid for services takes time and effort and may be too burdensome for service providers also undertaking a PFS project.

Service providers assessing feasibility of PFS may benefit from having a partner with expertise in Medicaid and PFS. Given the complexities of Medicaid and the unique state Medicaid programs, such experts can help with identifying the target population; assessing related eligibility, enrollment, and capacity issues; understanding the Medicaid system and how Medicaid is organized and financed in a particular state; and other current health care initiatives underway that may result in opportunities or challenges. All three of the projects profiled work with a partner with specific expertise in Medicaid.

Dedicating appropriate resources to PFS project development

Because it is a newly emerging and still-evolving model, the time and complexity involved in PFS projects can be daunting for first-time implementers. Discussants observed that organizations that are interested in pursuing a PFS project should anticipate "a long and challenging road" ahead. Indeed, to successfully complete a PFS project,

organizations must commit significant financial, human, and systemic resources to their efforts. For example, PFS intermediaries estimate that PFS project implementers should plan for at least six to nine months to complete the feasibility assessment. Commitment to the PFS project is critical to its continued progress and ultimate success, so organizations should enter the process with a clear understanding of what is involved, and an internal commitment to see the process through.

PFS project implementers should plan to dedicate resources to educating stakeholders. Although not specific to health-related PFS projects, it is important to note that all three PFS projects profiled in this brief reported that potential investors, payors, and other stakeholders were often only loosely familiar with PFS, and that securing commitments therefore involved explaining details of the PFS model. It also involved describing the benefits of the intervention to the end payor including the intervention's evidence base, its alignment with the payors' policy priorities, benefits to the target population, and future cost savings that may result from the intervention. In locations where PFS projects have already been implemented or are under development, stakeholders may be much more familiar with PFS, which streamlines this process.

There is value in sharing best practices across PFS implementers. Organizations embarking on a PFS project in the future will be able to build upon what has worked well for PFS project implementers thus far. Future projects would benefit from a coordinated effort to share best practices. Likewise, stakeholders of existing projects can provide valuable direction and insights for organizations in early stages of exploring a PFS project. For example, state Medicaid agencies seeking waivers from CMS in order to support PFS health projects could work to replicate South Carolina's successful process including the state's consultations with CMS experts during waiver development.

CNCS' SIF PFS Grant Program has shared knowledge about best practices by creating a cohort of PFS project implementers. CNCS facilitates communication among this cohort via convenings, webinars, and materials that offer opportunities to share developments and successes in the field as they unfold. Other agencies do this as well. One recent example is the National Institute for Health Care Management (NIHCM) Foundation's webinar on PFS as a new financing model and its potential benefits in expanding access to early childhood interventions that improve outcomes for children, often while reducing government spending. Several service providers, intermediaries, and contractors that are currently engaged in PFS also offer materials online. In the future, a cohort of implementers and stakeholders working on health-related PFS projects could collectively work through challenges unique to the health care environment.

Taken together, these themes paint a picture of a PFS field very much still in development and being explored in a complex and constantly changing health care environment. When these changes are viewed in combination with the relative novelty of the PFS model itself, the general picture that emerges is one of a landscape as open to possibility as it is quickly evolving.

About this Brief

This research was commissioned by CNCS as a component of the CNCS Process Evaluation of the SIF PFS Grant Program. Other topics have included *Pay for Success Financial Mechanisms* and *Service Provider Capacity Building for a Pay for Success Project* (both published in September 2015). These briefs, and other process evaluation reports, are available online at:

http://www.nationalservice.gov/programs/social-innovation-fund/our-programs/sif-pay-success/pay-success-national-evaluation

Appendix A. Pay for Success Project Profiles

Baltimore Green & Healthy Homes Initiative (GHHI) Pay for Success Project

Project Name	Baltimore GHHI PFS Project
Lead agency name	• GHHI
Intermediary	• Social Finance
Project status	• Transaction structuring • Seeking state Medicaid agency approval to authorize Johns Hopkins Medicaid MCO (Priority Partners MCO) to enter into a PFS contract, allowing them to cull savings and use those savings to make PFS outcomes payments.
Health issue(s) being addressed	• Reducing the incidence of asthma caused by unhealthy housing
Project objective(s)	• Cost reductions from avoided asthma-related hospitalizations and emergency department visits through reducing home-based asthma triggers and providing asthma care management in the home. • Improve health outcomes for low-income families and reduce public and private costs to the health care and energy production sectors by combining health and energy housing interventions into an efficient delivery model. • Scale and sustain GHHI's program.
Intervention	• GHHI manages a direct service program in Baltimore that combines in-home technical intervention with in-depth and personalized behavioral education for the family. After a family is referred to GHHI, the organization begins a long-term relationship with the family in their home, including an initial in-home assessment and educational session, an intervention to remove known asthma triggers, and follow-up sessions throughout the year to ensure the family is maintaining the home to GHHI's standards. Interventions may include: carpet removal, roof repair, pest management, and other related evidence-based interventions.
Service provider	• GHHI will conduct the asthma reduction intervention. • Johns Hopkins Hospital and Healthcare System – Medicaid MCO (Priority Partners MCO) will provide care management services, medical services and referrals to GHHI.
Target population	• Project will serve approximately 1,200 – 1,500 members of Hopkins Medicaid MCO (across 3 years) who have been in the emergency room or hospitalized for asthma.
Geographic area(s) of project	• Baltimore City and County, MD and some areas in the surrounding counties.
Data source(s) for outcomes	• Medicaid claims data will be used to determine if the reduction in medical costs for the GHHI population was attained. If medical costs are adequately reduced, a payment will be triggered from Hopkins Medicaid MCO to the investors.
Outcome metric(s)	• The health outcomes, measured in the reduction of utilization across inpatient, outpatient, professional services, and other categories, will be evaluated quarterly by the Hilltop Institute at the University of Maryland Baltimore County using the actual health expenditure data of the children served, from a data-sharing agreement with the Maryland Department of Health and Mental Hygiene (Maryland's State Medicaid agency).

Project Name	Baltimore GHHI PFS Project
Evaluation type	• Hilltop Institute will evaluate the efficacy of the GHHI program by comparing the children who have received the intervention with those in two comparison groups: (1) children who are Hopkins Medicaid MCO members and meet the eligibility criteria but do not receive the intervention, and (2) children who are non-Hopkins Medicaid MCO members and meet the criteria but do not receive the intervention.
Evaluator	• Hilltop Institute at the University of Maryland Baltimore County
Payor(s)	• Hopkins Medicaid MCO ("Priority Partners" MCO)
Investor(s)	• Two major investment firms and two national foundations. (Names to be released at closing)
Entities/organization(s) benefiting from the realized savings from this project	• Hopkins Medicaid MCO (Priority Partners MCO) • State Medicaid • CMS/Federal Medicaid • Schools • Workplaces
Where to find more information about this project	Green & Healthy Homes Initiative website http://www.greenandhealthyhomes.org/get-help/pay-success

South Carolina Nurse-Family Partnership Pay for Success Project

Project Name	Nurse-Family Partnership (NFP) – South Carolina
Lead agency name	• South Carolina Department of Health and Human Services (SC DHHS) • NFP
Intermediary	• Social Finance - PFS intermediary • NFP - provider intermediary
Project status	• Launched April 2016
Health issue(s) being addressed	• Maternal and child health
Project objective(s)	• Support the health and development of first-time mothers and their children • Build a pathway to sustainability for NFP in South Carolina • Evaluate effectiveness of efficiencies in NFP model
Intervention	• Home visiting for vulnerable first-time parents with registered nurses from early pregnancy through child's second birthday
Service provider	• NFP implementing agencies
Target population and estimated number served/to be served	• Project aims to enroll 3,200 first-time pregnant mothers and their children over 4 years. Services to be delivered over 5- 6 years.
Geographic area(s) of project	• 28 of 46 counties in South Carolina
Data source(s) for outcomes	• Multiple, including: vital statistics birth records, baseline survey, Medicaid enrollment and claims, and all-payer health utilization data
Outcome metric(s) or Payment metric(s)	• Reduction in preterm births • Reduction in child hospitalization and emergency department usage due to injury • Increase in healthy spacing between births • Increase the number of first-time mothers served living in high-poverty zip codes
Evaluation type	• Randomized controlled trial, which will evaluate how well NFP is working and whether a 25 percent reduction in the cost of services combined with model modernization affects outcomes for mothers and children
Evaluator	• J-PAL North America
Payor(s)	• SC DHHS will make up to $7.5 million in success payments to sustain NFP's services (based on positive evaluation results).
Investor(s)	• Philanthropic funders have committed $17 million to the project: BlueCross BlueShield of South Carolina Foundation, The Boeing Company, The Duke Endowment, Greenville, SC First Steps, and a consortium of private funders.
Entities/organization(s) benefiting from the realized savings from this project	• Families and communities • SC DHHS • Federal government
Where to find more information about this project	NFP website: http://www.nursefamilypartnership.org/ South Carolina NFP PFS project fact sheet https://www.scdhhs.gov/sites/default/files/2-16-16-SC-NFP-PFS-Fact-Sheet_3.pdf PFS Contract between SC DHHS, NFP and The Children's Trust Fund of SC https://www.scdhhs.gov/sites/default/files/2016_0321_AMENDED%20NFP%20PFS%20Contract_vFinal%20Executed.pdf Approved 1915(b) Medicaid waiver https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/SC_Enhanced-Prenatal-Postpartum-Home-Visitation-Managed-Care.pdf

Meals on Wheels America Social Impact Bond Transaction

Project Name	Meals on Wheels America Social Impact Bond (SIB) Transaction
Lead agency name	• Meals on Wheels America
Intermediary	• Quantified Ventures LLC
Project status	• Feasibility assessment completed January 2016 • Transaction structuring • Targeting a Spring 2017 project launch
Health issue(s) being addressed	• Senior health issues: food security, nutrition, safety and fall prevention, and social isolation.
Project objective(s)	• PFS project will measure the impact on the reduction in utilization of acute healthcare services in a hospital system. • Scale services to reach an increasingly vulnerable, aging population that wants to remain healthy and independent for as long as possible. • Build a replicable model to bring to other Meals on Wheels member organizations • Demonstrate intervention effectiveness to hospital systems to influence and improve meal delivery contracts.
Intervention	• Senior support services: a combination of daily home-delivered meals, socialization, case management with an enhanced in-home assessment, safety checks with minor home repairs, and referrals.
Service provider	• Meals on Wheels of Central Maryland
Target population	• Seniors living in poverty, predominantly in Baltimore, who are identified as "at-risk" by hospital system (payor) and who are greatly impacted by the threat of food insecurity and its resultant health and mental health conditions • Project will serve approximately 600 individuals over three years.
Geographic area(s) of project	• Baltimore Metro Area
Data source(s) for outcomes	• Hospital claims data
Outcome metric(s)	• 1) Reduction in emergency department visits • 2) Reduction in hospital admissions and average length of stay • 3) Reduction in hospital 30-day readmissions • Secondary outcomes to be measured include weight maintenance, mental health, treatment and medication compliance, disease management, increased social engagement, and management of personal health.
Evaluation type	• Randomized controlled trial comparing intervention group receiving full intervention, intervention group receiving once-weekly delivered frozen meals, and a control group receiving the standard care in place at the time of project launch.
Evaluator	• Currently finalizing selection of independent evaluator – strong interest expressed
Payor(s)	• Currently finalizing arrangements with hospital system(s) to serve as end-payor(s)
Investor(s)	• Investors prioritized and will be selected after the payor and evaluator have been secured
Entities/organization(s) benefiting from the realized savings from this project	• Hospital system(s)[7]
Where to find more information about this project	• Lucy Theilheimer, lucy@mealsonwheelsamerica.org, (571) 339-1601

[7] Information about the Global Budget Revenue system in Maryland can be found at: http://www.hscrc.state.md.us/gbr-tpr.cfm

Appendix B. Health Policy Glossary

1915(b) Medicaid Waiver. A 1915(b) Medicaid waiver is a waiver granted by CMS to a state Medicaid agency in order to waive the Medicaid requirement that enrollees have "freedom of choice" of health care providers. Historically, states have used 1915(b) waivers to allow the use of MCOs and their limited provider networks in a state Medicaid program. The 1915(b) waiver granted to South Carolina in 2016, running through 2020, allowed for the implementation of enhanced prenatal, postpartum, and infant home visit services that would not otherwise have been allowed under the applicable federal regulations.

Accountable Care Organizations (ACOs). ACOs, like MCOs, are collectives of health care providers who are both collectively responsible for the provision of care to a given population and collectively entitled to any cost savings if they are able to identify and obtain them. They are distinguished from MCOs in that ACO patients are generally able to move out of network for care, and in that providers are generally responsible for only a portion of the total cost of care, rather than any amount not provided on a per capita basis.

Affordable Care Act. The "Affordable Care Act," also known as the "Patient Protection and Affordable Care Act" (PPACA) is a 2010 law which dramatically reformed the U.S. health care system. The law contained a wide range of provisions, but most fundamentally it (a) expanded access to health insurance through tax subsidies to individuals to purchase insurance, an expansion of Medicaid, and the creation of state- or federally-run insurance exchanges, and (b) introduced a range of programs and policies intended to reform the way the federal government reimburses health care providers for their services.

Capitation. A payment arrangement for health care service providers in which providers are paid a set amount for each enrolled person assigned to them, per period of time, whether or not that person seeks care.

Centers for Medicare and Medicaid Services (CMS). CMS is the agency within HHS that is responsible, among other things, for the federal administration of Medicaid (including the approval of Section 1115 waivers), and also houses the Center for Medicare and Medicaid Innovation. This latter group, created under the terms of the Affordable Care Act, is responsible for testing new and innovative payment and delivery system models that show potential for improving the quality of care in Medicaid and other programs, whilst simultaneously slowing the rate of growth in program costs.

HIPAA. HIPAA, or the "Health Insurance Portability and Accountability Act" is a 1996 law that, broadly speaking, both (a) provides individuals the ability to transfer health insurance after job loss, and (b) sets standards for the protection and confidentiality of health and health billing information.

Managed Care Organizations (MCOs). Managed Care is a health care delivery system organized to manage cost, utilization, and quality. Medicaid managed care provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that accept a set per member per month (capitation) payment for these services.

Medicaid. The Medicaid program was enacted as part of the Social Security Amendments of 1965 (P.L. 89-97). Medicaid is a joint federal- state health insurance program for low-income U.S. citizens or permanent residents, their children, and certain citizens or permanent residents with disabilities. Although the federal government contributes a minimum of 50 percent of Medicaid funding for health services and program administration (the figure varies from state to state), states retain broad freedom to establish their own eligibility standards, their own provider certification structures, and their own administrative systems.

Medicaid Expansion. Under the terms of the Affordable Care Act, the federal government mandated that states certify as eligible individuals and families earning incomes up to 138 percent of the federal poverty line, and promised to cover 100 percent of the costs for newly-covered individuals through the year 2016, and no less than 90 percent thereafter. Under the terms of *NFIB vs. Sebelius* (2012), however, the Supreme Court ruled that states were not required to meet the federal government's mandate, and in the years since only 31 states (plus the District of Columbia) have fully implemented the Medicaid expansion.

Section 1115 Medicaid Waiver. A Section 1115 waiver, also known as a "Medicaid Demonstration" waiver, is a waiver granted by CMS to a state Medicaid agency, in order to allow the state to experiment with finance and delivery initiatives that are not otherwise allowed by federal statute. Section 1115 waivers are required to be budget-neutral for the federal government. Under these terms, 30 states (plus the District of Columbia) currently operate one or more Section 1115 Medicaid waivers.

Triple Aim. The "triple aim" is the generally agreed-upon aim of health policymakers to (a) improve patient experience of care while simultaneously (b) improving the overall health of the target population and (c) reducing the per capita cost of health care provision. Many of the Affordable Care Act's reforms—and therefore of the Innovation Center's pilot programs—aim to unify responsibility for all three aims under a single programmatic or policy roof, instead of keeping the three goals separate.

Appendix C. Pay for Success Glossary

Independent evaluator	An independent organization that assesses performance data and conducts an evaluation of intervention outcomes and impacts.
Intermediary	The entity most often responsible for overall project management/coordination, investor recruitment, and negotiation of contracts among payors, service providers, and investors in PFS projects. Intermediaries are typically responsible for entering into direct contracts with the government funder, liaising with potential investors to secure capital commitments to the transaction, and serving as the primary liaison among key players in the PFS relationship. The term has a distinct meaning in the CNCS SIF PFS Grant Program, where SIF grantees act as intermediaries who provide funding and/or technical assistance to selected subs. **Other Terms Used:** Transaction coordinator, project coordinator, government advisor, placement agent
Intervention	A model or program that offers a discrete set of products and/or services to address a specific social issue or challenge. **Other Terms Used:** Program model
Investor	Individuals or commercial, philanthropic, or community development organizations providing upfront capital that enables service providers to deliver services over the term of the PFS contract.
Payor	The entity that is ultimately responsible for paying investors proportional to the agreed amount based on the level of measureable impact achieved. In the majority of cases, the PFS payor is a government agency. **Other Terms Used:** Payer, lead organization, outcome payor, back-end payor, end payor, government payor
Pay for Success financing	The provision of upfront capital to cover the cost of the intervention deployed through a PFS project and, in some cases, to cover related costs of the PFS project (e.g., evaluation). The principal investment is only returned (and possible additional returns are only distributed) when pre-determined outcome goals are met.
Service provider	The entity that delivers a specific intervention financed by the PFS transaction in order to achieve predefined and agreed upon outcomes and/or impacts. **Other Terms Used:** Social service provider
Target population	People being served by PFS interventions.

Appendix D. Resources and References

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