



Washington State's Effort to Improve Maternal and Infant Outcomes in Medicaid Using Pay for Success Financing

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Nemours® Children's Health System

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Introduction

Washington is recognized as a leader among states for enacting delivery system transformation to improve the health and well-being of its 7 million residents. Despite its achievements, like every other state, Washington faces difficult decisions about how to spend its resources. The Washington Health Care Authority (HCA), the agency that oversees the state's Medicaid program, has been exploring using pay for success financing to make a decision about whether to expand services in Medicaid that would improve maternal and infant outcomes.

This case study will highlight the key accelerators and barriers in Washington's decision to seriously consider using pay for success financing to pilot and determine the return on investment (ROI) of group prenatal care services for Medicaid recipients. As other state Medicaid programs consider adopting pay for success arrangements, Washington's experience can shed light and help them as they analyze their readiness and confront similar decisions.

Background

Impact investments are investments expected to deliver both financial and social returns. Pay for success financing is one type of impact investment strategy that is gaining traction as a way for states to pay for prevention services that address social determinants of health and improve outcomes for vulnerable populations. Many individuals would like Medicaid to fund these upstream prevention services but the ability to do so is often limited by federal statute and/or regulations, state budgetary constraints, or other issues.

In a pay for success arrangement, private investors finance the expansion or scaling of services on a demonstration basis, and in doing so may unleash capital that is otherwise unavailable. Private investors are repaid by the public sector only when the intervention achieves its pre-set outcomes. Investors may lose their money, make back principal or make a return (or programmatic reinvestment) depending on how successful the program is versus the status quo. Pay for success financing has been described as “a three-way contract between government, a provider, and investors in which investors provide funding upfront to pay for program services, and the government is only required to pay back investors if and when the provider meets agreed upon outcome metrics.”¹

Research suggests significant potential for pay for success financing to address the social determinants of health.² This case study highlights one such approach being considered under Medicaid to finance a proven prevention intervention – group prenatal care – in expanded care settings. The pay for success initiative helps the public sector, in this case Medicaid, build the case for covering the intervention at a broader scale to address health and social needs while reducing longer term costs.

What is Pay for Success financing?

Pay-for-success financing is a strategy that seeks to:

- mobilize new funding to improve outcomes for vulnerable populations;
- expand effective services;
- provide preventive interventions that will reduce the need for high-cost utilization of public services;
- use data to enhance collaboration among payers and service providers; and
- ensure that public expenditures are only spent to the degree that programs achieve measurable impact across meaningful outcomes.³

While a growing body of evidence indicates that investments in upstream prevention to address the social determinants of health may improve health outcomes and reduce costs,⁴ local, state, and federal governments face a number of barriers to investing in these interventions. There often is a time lag between when a service is provided and the positive outcome is achieved, making it difficult for states to invest in upstream prevention interventions within annual or biannual budget cycles. The further downstream outcomes are realized, the more challenging it is to attribute them to a particular intervention or investment. And, while the conceptual underpinning supports investing in upstream prevention, it is not a given that outcomes will be achieved and investments will reduce costs. This uncertainty is another factor that prevents more governments from taking on the risk of upstream prevention.

The pay for success financing under consideration in Washington state attempts to address these barriers by unleashing capital that can be used to improve outcomes in the Medicaid population. This infusion of capital enables preventive services to be funded upfront with investor capital, thus providing a longer timeframe to realize positive outcomes and savings before payments based on positive outcomes are due. Medicaid programs are much more likely to experiment with offering new or expanded preventive services if the private sector takes on financial risk, covering the costs if the intervention does not save money over the long-term. The idea is to build the case for scaling such prevention-oriented services. Once proven, Medicaid and the managed care organizations (MCOs) would have evidence of ROI and thus confidence for larger-scale expansions.

State Medicaid programs are interested in exploring pay-for-success financing because this strategy:

- pays for what works, commensurate to how much it works;
- leverages third-party capital to assist in providing or expanding prevention services; and
- informs officials about the efficacy of interventions to guide future funding decisions.⁵

Washington's Proposed Pay for Success Project

Intervention: Washington is exploring a pay for success project in which investors will provide upfront capital to clinics and obstetrician/gynecological physician practices to offer group prenatal care and other services to improve maternal and infant outcomes and reduce pre-term births. The financing would help clinics and providers cover the cost of introducing group prenatal care and other services to their clinic or practice. Specifically, it could help with training costs, gaining certification as a group prenatal care provider, materials and, in some cases, hiring staff to coordinate scheduling and managing the program. In this initiative, the pay for success capital is intended to be used for start-up costs associated with expanding group prenatal care, as well as ongoing implementation during the project period. At the end of the project, partners will determine whether ongoing costs for providing group prenatal care would be covered through additional value-based purchasing agreements (that may or may not need pay for success funders), or through the original structure for covering prenatal care, in this case, Medicaid.

Mechanism: In Washington, all Medicaid MCOs are subject to a two percent withholding of their premium by HCA. MCOs are able to earn back their withholding from HCA through the achievement of value-based purchasing targets and performance-based measures. MCOs have flexibility in how they manage their provider contracts in the interest of achieving these goals. For the pay for success initiative, Washington is considering a two-contract structure within the Medicaid program. Under the first contract, a Medicaid MCO would opt to make payments to providers based on achieved outcomes. This would deepen the “value-based payment” concept, enabling MCOs to fully share risks and rewards with providers. The second contract would enable providers to have

a direct relationship with pay for success funders; the pay for success funders would give providers upfront capital to scale new services. Providers only would repay funders if they receive outcome payments from Medicaid MCOs. If the clinics and providers do not achieve the pre-determined outcomes, they will not need to repay the funders.

Optional participation of providers. The Washington proposal for pay for success financing is targeted at those providers and clinics who would need help accessing expansion capital. These clinics would be connected to investors to cover the costs of introducing group prenatal care and other services at their clinics. Some clinics – especially larger clinics that are part of health care systems – may already have access to resources to expand or cover group prenatal care and would not be interested in the pay for success financing. Clinics that don't need expansion capital or those that already offer group prenatal care services, however, would still benefit from the outcomes payments being made through the HCA withhold for achieving desired outcomes with their patients.

Accelerators:

Washington's HCA engaged with outside organizations with expertise and funding to help move through the decision-making process.

Engaging organizations with expertise and funding is key to ushering the state through the decision-making process. In Washington state's case, Nemours Children's Health System connected the key players initially and helped move the state forward in the early planning phases. Social Finance, a nonprofit organization dedicated to mobilizing capital to drive social progress, served as an intermediary and provided critical expertise to help the state through the design process. Social Finance's work was supported by the Kresge Foundation and the Robert Wood Johnson Foundation, which further engaged the Center for Health Care Strategies to advise on the project.

Nemours recognized the challenge of financing upstream prevention efforts in Medicaid and invited Washington state and several other states to come together in a two-day meeting in July of 2017 – funded by the AcademyHealth — to consider options, including pay for success financing. In addition to the states, Nemours invited experts from The Kresge Foundation and Social Finance to educate the states about pay for success financing. Following the July meeting, Nemours convened calls with Washington's HCA in which Social Finance discussed the pay for success development process and what makes a strong pay for success project. Nemours funded Social Finance to do preparatory work to identify potential interventions and then facilitate a one-day workshop on October 20, 2017 for key staff at HCA and its sister agency collaborators to discuss prevention interventions. Nemours paid for the early stages of Social Finance's time and for technical assistance of Medicaid experts. Social Finance secured funding from foundations and other entities to support their efforts to help HCA move through the assessment and design phases of this process.

Washington state demonstrated readiness to undertake a Pay for Success initiative

Washington has demonstrated a long-term commitment to transforming its delivery system to improve the health and well-being of its 7 million residents. The state's most recent effort, called Healthier Washington, includes several broad transformation goals: using accountable communities of health (ACHs) to spur local population health innovation; shifting to value-based purchasing; investing in the development of measures and tools needed to analyze, interpret and translate data into action; and encouraging provider behavior change that supports transitions to value-based integrated care.

The state's Section 1115 demonstration waiver provides more flexibility for potential structures and funding sources used in a pay for success initiative. Moreover, the state's sophisticated data and development of models that quantify how spending in one state system affects savings to other state systems ensure that it is equipped to show how investment can result in savings globally.

The Medicaid Director and her key staff were engaged from the outset in the process of identifying areas that could benefit from a pay for success financing approach. Prior to the first convening, staff devoted time to exploring a range of potential interventions including evaluating the availability and quality of their own program data and reviewing national and local studies of these interventions. Once a focus was determined, a designated working group met regularly to provide inputs for the costs modeling analysis, review methodology for the cost-benefit analysis and review the timelines for a pay for success project implementation. Finally, leaders from the state actively engage in spreading their work through presentations at conferences and meetings. They value and make time for sharing their experiences with colleagues from other states.

Washington's Medicaid director is a champion for this work.

The state's Medicaid Director recognized the potential of a pay for success financing approach early on and continued to be a committed leader throughout the process. She briefed the state officials who needed to sign off on this approach and kept key legislators abreast of her team's efforts. Most importantly, she prioritized the work and generated momentum to move the initiative forward.

The Medicaid Director convened the key players to initiate the pay for success work and designated a workgroup of high-level staff to assess promising interventions and analyze data. These dedicated staff members had expertise in areas ranging from policy to data to managed care. Getting the right decision-makers to the table to problem solve is critical to success. It's also important to motivate them to keep moving forward amidst their other responsibilities.

Washington's Medicaid program had access to key data holders in the state.

Access to data and the key data holders (not solely in Medicaid) and a willingness to collect data are important to be able to: understand costs and benefits for a specific target population; predict expected effects of the intervention; and establish payment rates for outcomes. Washington's Medicaid program prioritized data collection and analysis within its own system, such as total HCA expenditures associated with different birth outcomes. In addition, the staff in the Medicaid program had strong working relationships with the data holders in other agencies as evidenced by the participation of staff from the Washington State Department of Social and Health Services, Research and Data Analysis in the initial convening.

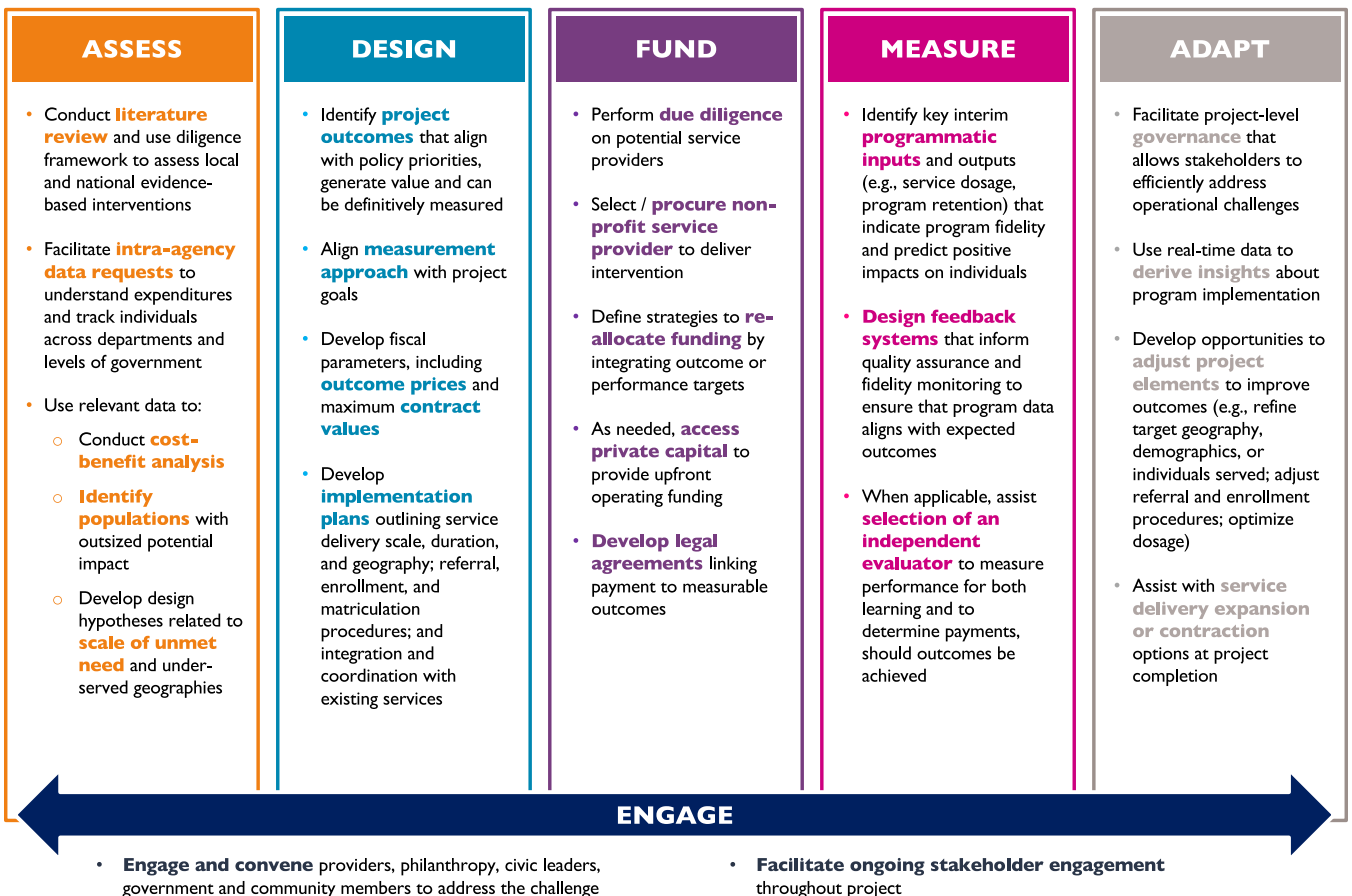
The Health Care Authority is a key influencer in the state.

The HCA can leverage its influence to convene the key partners to explore participation in this initiative. The next phase of the work in Washington involves reaching out to community partners and developing relationships to gather the right group of stakeholders to implement this project. The HCA has been instrumental in connecting key staff with ACHs, provider systems, and other large health delivery systems to generate interest and help test the funding structure proposal. In this effort, working with MCOs, provider systems and other stakeholders will be a large component of the success of the pay for success project.

Washington's HCA had ongoing access to Social Finance's leadership and expertise through funding from the Kresge Foundation and Robert Wood Johnson Foundation

Social Finance provided leadership and guidance to HCA as they determined whether to move forward with exploring a pay for success project. First, they offered clarity on the pay for success development process. They described each phase of the project, what it would entail and the usual length of time. The assessment and design phases, for example, often take three to six months while the next two phases of funding and measuring often take another twelve to eighteen months. The entire project lifespan may take three to five years. The chart below, developed by Social Finance, details the five phases of the pay for success development process. It is critical for states to understand at the outset the type of data/information that will be needed to make decisions at each step and the length of time needed for each phase of the pay for success development process.

▶ THE PAY FOR SUCCESS DEVELOPMENT PROCESS: DETAIL



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Second, Social Finance dedicated a project management team to move the initiative forward by helping with initial scoping of the potential project, setting timelines, preparing meeting materials and facilitating calls. The Social Finance team advised the workgroup staff on what makes a successful pay for success project and provided background on the pay for success projects that have launched to date. The HCA team was interested, for example, in the South Carolina pay for success project so Social Finance facilitated a call between the two states so Washington could understand the choices South Carolina made about sources of funding for outcomes payments and other topics. They assisted the state in its early scoping of potential interventions that could benefit from this financing and reviewed evidence on interventions. Social Finance describes the key features of successful Pay for Success projects as having a defined target population; a specific codified program model; strong evidence; scalable service provider(s); positive value creation (i.e., clear link to public-sector benefits within a reasonable timeframe); and payor and investor interest. As the workgroup identified potential issue areas, Social Finance helped identify potential outcomes and evaluate existing data sets to see if they were sufficient to measure the outcomes selected.

Successful Pay for Success projects have:

- defined target population;
- specific codified program model;
- strong evidence;
- scalable service provider(s);
- positive value creation (clear link to public-sector benefits within a reasonable timeframe); and
- payor and investor interest.

Social Finance also provided critical analytic work as the state engaged in serious exploration of a pay for success project. As part of their feasibility study, Social Finance determined reasonable cost estimates for providers to expand and maintain new programming, used the evidence base and Washington baselines to determine impact assumptions, calculated outcome payment prices needed for expanded programming to be financially viable and defined the pay for success structure. Throughout the process, Social Finance worked with the HCA team on the inputs needed for their modeling work. For example, Social Finance undertook baseline mapping of service availability, prevalence of births and birth outcomes. They analyzed population differences to determine where the intervention would have the most impact.

In addition to developing a cost modeling analysis to determine provider costs, they conducted a cost benefit analysis to determine total HCA savings. The former tested the financial feasibility of the funding mechanism; the latter demonstrated the value of pursuing the project based on savings produced. Based on the literature, they estimated a range of levels of impact. Even at the lowest levels of impact, they showed that the group prenatal care services intervention would yield significant savings.

The Kresge Foundation and Robert Wood Johnson Foundation played a critical role in this initiative. Building on existing relationships with Social Finance, the foundations, along with the Center for Health Care Strategies, provided funding to support a Social Finance team that could provide the expertise needed to design a pay for success project to expand group prenatal care services in hospitals and clinics in Washington. Medicaid staff often operate in a risk averse environment so having the financial support of foundations and outside expertise is essential to getting pay for success projects off the ground.

Washington selected an intervention that aligned with HCA Priorities

HCA first considered several broad issue areas — pediatric asthma, youth homelessness, permanent supportive housing and childhood injury prevention – before choosing to focus on improving maternal and infant outcomes. At its initial convening in October of 2017, HCA evaluated factors such as the size of the problem, the target population, and the strength of potential intervention. After more consideration, HCA decided to explore using pay for success financing to expand group prenatal care services in the state. The scope was then expanded to consider a suite of maternal services including group prenatal care. HCA broadened the scope because it aligned with HCA priorities and ongoing state initiatives regarding expanding and improving Medicaid-funded maternal care in Washington including upcoming work to develop a maternity “bundle.”

The intervention is a good match for Pay for Success Financing through Medicaid

In addition to aligning with state priorities, Washington selected an intervention that is well-suited to pay for success financing because it fits with existing Medicaid provider enrollment, billing, and reimbursement. From a Medicaid perspective, it's significant that the service delivery under the group prenatal care model didn't require any changes to how the already-covered prenatal care services are billed under Medicaid. Providers accustomed to delivering prenatal care under Medicaid follow the same provider enrollment and billing practices for group prenatal care. This makes it more straightforward for providers to implement.

Barriers:

No pay for success Medicaid model has yet been completed

Pay for success financing is a relatively new approach for state Medicaid programs. With support from Social Finance, in 2016 the South Carolina Department of Health and Human Services (SCDHHS) announced the launch of the nation's first pay for success initiative within Medicaid. The four-year initiative mobilizes Medicaid 1915(b) waiver funding and private philanthropic dollars to expand the Nurse-Family Partnership's evidence-based services statewide in South Carolina.⁶ In the South Carolina model, Medicaid funds are not being used for outcomes payments.

Until the first Medicaid project is successfully completed, it will be challenging to convince key stakeholders to move forward without an established project that can be cited as an example from which others can learn or adapt.

- Potential solution: Until a Medicaid model is successfully completed, state Medicaid officials can look to the ongoing implementation of initiatives such as the South Carolina Nurse-Family Partnership⁷.

Perception of complexity

The mechanics of a pay for success project are not easy to convey to individuals unfamiliar with the concept. Washington benefited from a Medicaid director and staff with a good grasp of the overarching concept of pay for success financing as well as an understanding of the operational details in order to explain and generate support for the project among state officials, legislators and sister agencies. Moreover, Washington's Medicaid director was able to make the case for how the pay for success financing fits within their larger portfolio of priorities and initiatives.

- Potential solution: Developing clear talking points and fact sheets that can be shared will aid in these conversations with decision-makers.⁸

Short tenure of Medicaid Directors

Medicaid Director tenure is problematically low — median tenure of a Medicaid director is 26 months — and two thirds have been in the job for less than three years.⁹ Executive team tenure tends to be fairly low as well. In addition, agency organization structures – both state Medicaid agencies and their sister agencies — change and evolve with new administrations. This reality can significantly impact the state's planning and implementation of a pay for success project, which usually takes three to five years.

- **Potential solution:** Widespread buy-in for exploring the pay for success financing is needed to allow for expected turnover of staff at all levels working on the initiative. When staff depart, having a team of people still committed will help keep the initiative on track. A key part of this buy-in is a common understanding and agreement to goals, processes and timelines.

State Budget Cycle

Budgets are based on projections of historical costs. If a Medicaid agency's expenditures decline when interventions realize savings, the legislature may cut the future year budget. This doesn't allow sufficient time to determine which programmatic activities result in savings, and warrant repayment. Washington state elected to explore implementing its pay for success initiative through one or more MCOs. This is because MCO budgets don't go through the legislative process, so are less vulnerable to legislative appropriation of any savings. Thus, there is more time to directly connect interventions, savings, and repayments. Further, given the capitation rate payment structure between MCOs and Medicaid agencies, MCOs directly realize the near-term benefit of cost reductions achieved through improving health outcomes in the period between outcomes improvement and any future capitation rate re-setting. Thus, MCOs are well incentivized to find ways to expand patient access to preventative care. In addition, MCOs have greater flexibility to make repayments to investors.

- **Potential solution:** Working with MCOs alleviates the issue of the state decreasing the Medicaid budget when savings are achieved, and ensures a project appropriately engages the entities experiencing the near-term benefits of improved outcomes and cost reduction as outcome payers.

Repayment of Federal Medicaid Match

Another complexity to the pay for success model in Medicaid is consideration of how to account for reallocation of savings in the federal share of Medicaid expenditures. If there are identified savings within Medicaid, those savings would need to be spent on federally qualified Medicaid services. Because prevention focuses on cost avoidance, the issue is even more complex because identifying savings is challenging.

- **Potential solution:** Track Medicaid savings to ensure federal Medicaid dollars remain within the Medicaid budget. As South Carolina's Nurse-Family Partnership model matures, it may provide lessons on this point. In addition, the [Social Impact Partnerships to Pay for Results Act \(SIPPR\)](#) may help state Medicaid programs overcome this barrier. SIPPR was signed into law in early 2018 and is administered by the U.S. Department of the Treasury. Congress appropriated \$100 million for SIPPR to implement "Social Impact Partnership Demonstration Projects" and related feasibility studies. Under SIPPR, states and local governments can apply for access to federal outcomes payments, equal to the amount an approved pay for success project impacts the federal budget. As a result, to the degree a Medicaid-focused project results in savings to both state and federal Medicaid, SIPPR enables access to outcomes payments that represent the federal portion of those savings. SIPPR prohibits applicants from financing their interventions with federal funds. However, SIPPR has been described as essentially filling the funding gap.¹⁰

Need for data and sophisticated analytics

It is critical to have access to relevant baseline data, strong relationships with key data holders, and sophisticated analytic capabilities. Attribution is challenging when evaluating any prevention strategy. In this case, Washington staff expressed the challenges of attributing something that does not happen (i.e., normal weight births instead of low birth weight births) to a given intervention such as nurse home visiting. Client-level analysis was too burdensome to undertake for this initiative. The model focused on the outcome measures that could be quantified through available data, for example low birth weight, NICU admissions, or breastfeeding initiation.

HCA had a challenge in determining how to get data on the number of obstetric practices that would elect to expand group prenatal care, and assumptions regarding how many women would take up the service. The state did not want to burden the MCOs by asking them to survey their providers. Moreover, it's not in the MCO contracts to acquire this data. Social Finance conducted analysis on provider capacity based on existing data repositories.

The team formed estimates in part by looking at national data—which suggest an uptake of 50 to 75 percent for group prenatal care services—and adjusted this based on HCA's experience. HCA believes 5 to 10 percent of pregnant women on Medicaid would take up the service.

- Potential solution: Look to existing data and/or national-level data to help inform models.

Another consideration is the need to bridge understanding between those developing financial models (in this case Social Finance) with the operational aspects of Medicaid financing in each specific setting to fully capture costs. For example, Washington's reimbursement structure for the services of interest include several different components, such as a low birthweight case payment.

- Potential solution: Bring together the team developing cost-benefit models with program administrators.

Time period to launch an initiative is lengthy

As noted above, the pay for success development process often takes two years from the initial scoping period until the time the pay for success contracts are finalized. The next phase of performance management to ensure the project stays on track can last for one to three years, making the overall project development period three to five years. HCA convened (with Nemours support) a one-day workshop in October 2017 to explore several potential interventions for pay for success financing targeted at the Medicaid population. Subsequent conversations were held over the next year to select an intervention.

The serious exploratory work of Phase 1 was officially launched in August of 2018 and completed in December of 2018. After reviewing the modeling and cost-benefit analysis, HCA decided to continue to move to the next stage of the work. In the winter and spring of 2019, Social Finance and HCA reached out to community partners and developed relationships that will be needed to move the project forward. Washington's timeframe is shown below.



- Potential solution: Being very clear up front about timelines for each phase of the project will help keep expectations realistic about development of this type of initiative.

Working with partners over extended timeframes

It takes an investment of time and energy to develop relationships with local stakeholders, providers and payers that are necessary for this type of financing model. Having the support of the Medicaid Director and program staff can help facilitate the connection to potential state partners.

- Potential solution: States should ensure that participants/partners in the process understand the timeframes in advance and will allow sufficient time for the initiative to unfold.

Next Steps

HCA is committed to moving forward to the next phase of this initiative. The Social Finance team devoted the spring and summer of 2019 to reaching out to community partners to develop relationships necessary for establishing a pay for success project in Washington. During the fall of 2019, Social Finance began an engagement with one MCO to assess expanding group prenatal care in its hospitals and clinics. A significant staff change at HCA, however, has extended the timeframe. The next steps are to assess baselines, outcomes, and costs across that MCO's specific patient population in order to customize the cost-benefit analysis to that MCO. The phase of work towards transaction structuring is anticipated to take three months, with the implementation phase beginning in the winter.

Endnotes

- 1 <https://www.nursefamilypartnership.org/wp-content/uploads/2019/11/NFP-South-Carolina-PFS-Update-Nov-2019.pdf>
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- 4 Crawford, Maia and Spencer, Anna. “Making the Case for Prevention: Why Washington’s Accountable Communities of Health Should Pursue Domain 3D Chronic Disease Prevention Projects.” Available at: <https://www.movinghealthcareupstream.org/wp-content/uploads/2018/06/making-the-case-for-prevention.pdf>
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- 6 https://www.scdhhs.gov/sites/default/files/2-16-16-SC-NFP-PFS-Fact-Sheet_3.pdf
- 7 Information is available at: <https://payforsuccess.org/project/south-carolina-nurse-family-partnership>
- 8 This fact sheet is an example of resources available. It is available at: https://payforsuccess.org/sites/default/files/resource-files/2-16-16-SC-NFP-PFS-Fact-Sheet_3.pdf
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