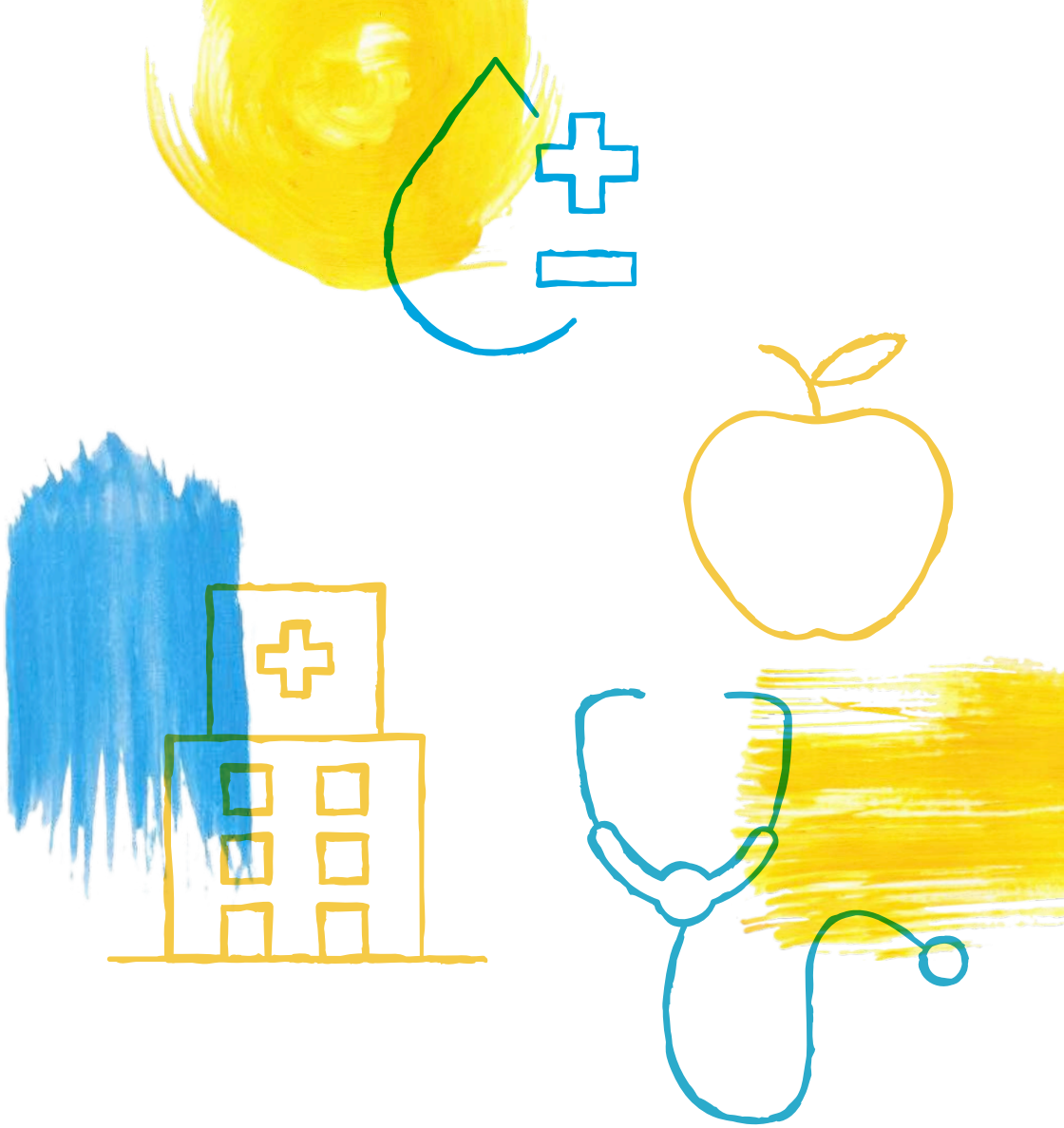
LISC



JULY 2019

Michigan Value-Based Purchasing and Pay for Success

Tools to Expand Diabetes Prevention Program and Address Social Determinants of Health

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Introduction & Executive Summary

The Local Initiatives Support Corporation (LISC) and the National Kidney Foundation of Michigan (NKFM), under the auspices of the Social Innovation Fund, a program of the Corporation for National and Community Service, have partnered to test ways to expand the availability of the Diabetes Prevention Program (DPP) in low-income communities of six counties in Michigan. DPP is a non-medical, lifestyle intervention program demonstrated in controlled tests to prevent or delay the onset of diabetes more effectively than medical interventions.

LISC and NKFM have designed a Pay for Success model in which private and philanthropic investors can pay for prediabetic patients with Medicaid insurance coverage to participate in DPP.

LISC and NKFM have designed a Pay for Success (PFS) model in which private and philanthropic investors can pay for prediabetic patients with Medicaid insurance coverage to participate in DPP. Upon achievement of program milestones (i.e., "success"), as defined by patient participation in the program and weight loss after participation, the private and philanthropic investors would be reimbursed by Medicaid managed care organizations (MCOs) providing coverage for the patients. The MCOs, in turn, could expect a healthier clientele, leading to reduced medical expenses and creating a return on their payment to the investors.

Although DPP is now a reimbursable expense under Medicare, it is not directly reimbursable under Medicaid in most states, including Michigan. Within a PFS framework, however, it appears to fit within the value-based purchasing (VBP) arrangements encouraged under Michigan Medicaid's master contract with MCOs.

The LISC and NKFM effort, therefore, is motivated by the:

- growing prevalence of type 2 diabetes, particularly in minority and low-income communities;
- DPP's demonstrated success in countering the onset of the disease;
- DPP's attendant health and financial benefits; and
- potential for a sustainable program under the PFS/VBP contracting model.

To date, the PFS initiative has not been adopted by any MCOs in Michigan. To better understand barriers seen by MCOs to adopting the DPP program within a PFS framework, LISC and NKFM retained the University of Michigan's Center for Health and Research Transformation (CHRT) to interview MCO executives. CHRT's findings of the MCOs' viewpoints and concerns are detailed below in **Section III** of this report.

To find a path forward, we brought many of the participants in this effort together for a full-day convening in East Lansing. The highlight of this convening was the stated interest of Robert Gordon, the Director of Michigan's Department of Health and Human Services (MDHHS), in supporting the expanded implementation of DPP and other proven prevention interventions.

Support from the leader of MDHHS creates clear possibilities, and **Section V** of this paper includes brief descriptions of some sustainable funding solutions, of which PFS is just one.

In this white paper, we describe the LISC/NKFM initiative, including:

- background on the prevalence of diabetes;
- strategies to counter its growth, including a PFS/VBP payment mechanism;
- MCO concerns learned in the CHRT interviews;
- lessons from the convening; and
- sustainable funding solutions that could create potential paths forward. In addition to PFS, these include direct Medicaid funding as a covered benefit, state appropriations, and the concept of a local health-outcomes trust with pooled resources designed to overcome the barriers of siloed interests.

DPP is a non-medical, lifestyle intervention program demonstrated in controlled tests to prevent or delay the onset of diabetes more effectively than medical interventions.

"I'm a full believer of the program because it does help people in many aspects of their life."

— Managed Care Representative

I. Background

The Problem of Diabetes — Nationally and Locally

Diabetes is one of the most significant and costly chronic diseases and a leading cause of kidney disease, heart disease, stroke, amputation, and blindness.

National figures for type 2 diabetes and prediabetes demonstrate the depth of the problem:

- **The prevalence of type 2 diabetes continues to increase,** especially among vulnerable and underserved populations. U.S. Centers for Disease Control and Prevention (CDC) 2016 data show that 12.7% of non-Hispanic Black adults and 12.1% of Hispanic adults have diabetes.[1] These figures are significantly higher than the national average of 9.4% (30.3 million Americans) in 2015, which itself is up from 8.3%, or 25.8 million Americans, in 2010.[2]

$327 bn

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- **The annual total costs of diabetes are estimated at $327 billion** in 2017, including $237 billion in direct medical costs and $90 billion in reduced productivity.[3]
- Average medical expenditures for people with diagnosed diabetes were about $16,750 per year. About $9,600 of this amount was attributed to diabetes. After adjusting for age group and sex, average **medical expenditures among people with diagnosed diabetes were about 2.3 times higher than expenditures for people without diabetes.**[4]
- **Indirect costs of diabetes** include increased absenteeism ($3.3 billion) and reduced productivity while at work ($26.9 billion) for the employed population, reduced productivity for those not in the labor force ($2.3 billion), inability to work because of disease-related disability ($37.5 billion), and lost productivity due to 277,000 premature deaths attributed to diabetes ($19.9 billion).[5]
- **The CDC estimates that more than one in three (33.9%) adults nationwide, 84.1 million, have prediabetes,** with blood glucose levels higher than normal but not yet high enough to be diagnosed as diabetes. However, it found that only 11.6% of those with prediabetes are aware of their condition. The impact is greater for older adults, with nearly half of all Americans over the age of 65 having prediabetes.[6]
- **Without intervention, 15% to 30% of those with prediabetes will progress to type 2 diabetes within three to five years.**[7] Risk for diabetes can be reduced with lifestyle modifications, leading to prevention or delay of diabetes.

37%

of the adult population in Michigan have prediabetes.

The incidence of diabetes and prediabetes in Michigan exceeds national averages:

- An estimated 12.9% of Michigan adults have diabetes, approximately 1.1 million people. This figure includes an estimated 259,000 who have diabetes but don't know it, greatly increasing their health risk.[8]
- 2.7 million people in Michigan, 37% of the adult population, have prediabetes.[9]
- Each year, approximately 46,000 additional people in Michigan are diagnosed with diabetes.[10]
- Diagnosed diabetes costs an estimated $9.7 billion in Michigan annually, including $7 billion in direct medical costs and $2.7 billion in indirect costs from lost productivity.[11]
- The burden of diabetes is especially pronounced for racial minorities and persons with low income. The CDC puts the incidence of diabetes for Black, Hispanic, and white adult populations in Michigan at 14.6%, 11.8%, and 10.6%, respectively. For adults with an income below $25,000 it is 18.6%, compared to 6.7% for those with an income of $75,000 or greater.[12]

These figures reflect that diabetes and its related risk factors are like many other chronic conditions, with low-income communities and communities of color disproportionately affected as compared to higher-income and white populations.

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The Problem of Diabetes for Medicaid-Eligible Adults

Approximately 570,000 enrollees in Michigan's Medicaid program have prediabetes, using the CDC estimate for Michigan of 37%.[13] This is likely a very conservative assumption. Given the figures cited above, showing that lower-income adults have nearly triple the diabetes incidence as higher-income adults, it is reasonable to assume that Medicaid enrollees have a higher incidence of prediabetes, perhaps much higher, than the statewide estimate of 37%. In addition to the human toll, these figures suggest a substantial and growing financial burden for the state.

Michigan largely conducts its Medicaid program though managed care plans (i.e., insurance companies), with roughly 80% of Medicaid beneficiaries enrolled in Medicaid plans.[14] This suggests that the plans could have very strong financial incentives, particularly in value-based arrangements, to prevent the continued growth of diabetes.

CHART 1: MICHIGAN MEDICAID MARKET SHARE BY INSURANCE PLAN

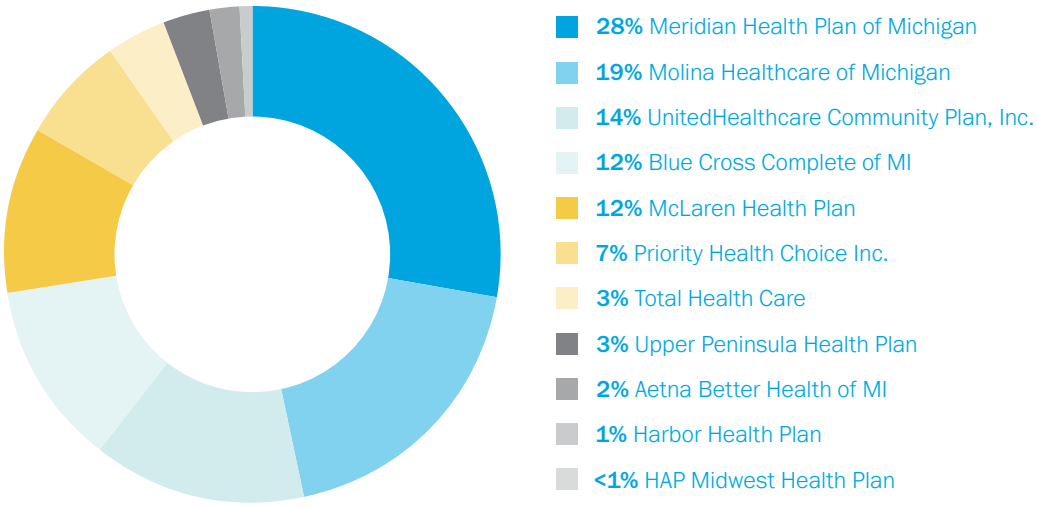

Chart 1 shows the market share of each of the insurance companies providing Medicaid plans in Michigan. It is reasonable to assume that each company's share of diabetic and prediabetic patients is similar to its overall market share.[15]

Like most states, Michigan's population, including Medicaid enrollees, is concentrated in a relatively small number of counties with urban centers. Two-thirds of Michigan's Medicaid enrollees reside in 10 of the state's 83 counties.[16] That concentration makes it easier to provide specialized services efficiently, and NKFM provides diabetes prevention services in six of those counties, clustered around Detroit, Flint, and Grand Rapids.

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CHART 2: PREVALENCE OF MEDICAID ENROLLEES WITH PREDIABETES; MICHIGAN TOP 10 COUNTIES BY MEDICAID-ENROLLED ADULT POPULATION

#	County	Adult Medicaid Enrollees	Estimated Medicaid Prediabetic Population
1	Wayne	432,270	160,000
2	Macomb	125,005	46,000
3	Oakland	117,698	44,000
4	Genesee	83,786	31,000
5	Kent	80,730	30,000
6	Ingham	43,710	16,000
7	Saginaw	36,516	14,000
8	Washtenaw	35,980	13,000
9	Kalamazoo	34,293	13,000
10	Muskegon	33,229	12,000

Chart 2 shows adult enrollees in the 10 counties with the largest Medicaid enrollment, along with an estimate of the number with prediabetes, rounded to the nearest 1,000. The shaded lines indicate counties where NKFM provides diabetes prevention services.[17]

February 2019 enrollment figures; Michigan Department of Health and Human Services.
Shaded rows indicate where the NKFM offers diabetes prevention services.

II. Strategies to Counter the Growth of Type 2 Diabetes

The Problem of Funding for Prevention/Addressing Social Determinants of Health

Preventing or delaying prediabetes from developing into type 2 diabetes can have strong impacts on individual health, while decreasing overall health care costs. However, the current allocation of funding for U.S. health care limits funding for preventive services or services that address social determinants of health. According to the *Journal of the American Medical Association,* most medical payments are fee-for-service, with payment proportional to the volume and intensity of services provided, not based on improvements in population health. Despite the widespread understanding of the importance of addressing social determinants of health, finding sustainable funding models to pay for it remains a challenge.

Pay for Success: Alignment with Michigan State Policy as a Value-Based Approach

The LISC/NKFM Pay for Success DPP initiative aligns with the Diabetes Prevention Action Plan of the Michigan Department of Health and Human Services, the Michigan SIM, and MCO contract language to advance the state's push towards alternative payment models (APMs) and population health management.

$9.7 bn

Diagnosed diabetes costs an estimated $9.7 billion in Michigan annually.

A key focus of the Michigan SIM is increasing the use of APMs to promote service delivery and maximize the opportunities for enhanced reimbursement. The language includes a provision encouraging value-based payments that "reward providers for outcomes." The language specifically notes that payments can cover services that promote "coordinated and appropriate care" and are "traditionally not reimbursable" through Medicaid.

This language appears to enable value-based payments under a Pay for Success (PFS) initiative. PFS allows programs to contract and pay for outcomes, rather than services. These programs demonstrate success through measurable outcomes with the agreement that a back-end payer, in this case a Medicaid plan, will repay costs based on outcomes and only to the extent of program success. Independent funders and investors will provide the upfront working capital to cover the costs of service delivery until outcomes are achieved. PFS can be a useful tool for Medicaid plans to, at minimal risk, engage in value-based purchasing (VBP) arrangements, support partnerships with community-based organizations, and address social determinants of health.

CHART 3: DPP PAY FOR SUCCESS ALIGNMENT WITH MICHIGAN STATE POLICY

Source	Goal	Alignment
Diabetes Prevention Action Plan	**Prediabetes Awareness:** By 2018, implement a multi-faceted communications plan to increase public and health care provider awareness of prediabetes and the Diabetes Prevention Program (DPP) offerings.	**High Impact**
	Health Systems Policy: By 2018, engage four health care partners to develop systems to screen, test, and refer patients with prediabetes and those at risk for developing type 2 diabetes to a Diabetes Prevention Recognized Program (DPRP).	**High Impact**
	Health Systems Policy: By 2018, increase DPP reimbursement coverage through at least one Michigan Medicaid plan and one private insurer.	**High Impact**
	Community-clinical Linkages: By 2018, establish bi-directional referral systems between eight health care providers and Michigan DPRPs.	**Medium Impact**
State Innovation Model (SIM)	Community Health Innovation Regions designated as part of SIM in Jackson County, Muskegon County, Genesee County, the Northern Region, and the Washtenaw/Livingston counties area.	**Medium Impact**
	Setting goals for the use of alternative payment models (APMs), starting with payers in the Michigan Medicaid program. APMs to be based on quality metrics including prevention, quality of care, health outcomes, or utilization issues.	**High Impact**
Template MCO Contract	Payment reform and value-based payment language	**High Impact**
	Population health management focusing on data aggregation, analysis, and dissemination; addressing health disparities; health promotion and disease prevention; and providing care management services and other targeted interventions.	**High Impact**
	Pay for performance in the areas of: 1, population health and health equity and, 2, Healthy Michigan Plan cost-sharing/ value-based services.	**Medium Impact**

Additional detail on the multiple sections within the State of Michigan's standard MCO contract language to advance the push towards value-based care delivery models and outcomes-based APMs and population health management can be seen in the **Appendix.**

NKFM's Work Providing the Diabetes Prevention Program in Michigan

In 2017, the Diabetes Prevention Center at the National Kidney Foundation of Michigan (NKFM) was selected to receive PFS transaction structuring services from LISC for the Diabetes Prevention Program (DPP). The DPP is a year-long, evidence-based lifestyle change program aimed at people who have prediabetes or are at high risk for developing type 2 diabetes. Trained lifestyle coaches help participants work towards losing 5-7% of their body weight through healthy eating and participating in 150 minutes of physical activity per week. The NKFM's Diabetes Prevention Center is a CDC-recognized provider of the DPP, and through LISC's transaction structuring services, NKFM began exploring creative ways to fund expansion of these services to Medicaid-eligible adults under value-based payments.

The DPP is implemented as an in-person small group intervention, facilitated by a trained lifestyle coach, in community settings. Each cohort of 15 to 20 meets for one hour, once per week for 14 weeks, then every other week for three to four weeks, followed by once per month for six months. This schedule provides intensive coaching and group support as participants are establishing new lifestyle changes. The level of intensity is gradually decreased to encourage participants' self-management and confidence in their ability to maintain the behavior changes. Participant engagement is enhanced through virtual interfaces, connection to community resources, feedback from the lifestyle coach, and social support.

58%

Participation in the DPP reduced the risk of progression to diabetes by over 58% compared with placebo.

Over the last 15 years, a number of studies have evaluated the design and effectiveness of lifestyle interventions for delaying or preventing the onset of type 2 diabetes among overweight and obese adults with blood glucose levels in the prediabetes range. The National Institutes of Health (NIH)-funded Diabetes Prevention Program Study, a large-scale multi-site randomized controlled clinical trial of 3,234 overweight adults with prediabetes, proved that a structured intensive behavioral coaching intervention that lowered body weight by 7% through a low-fat diet and increased physical activity reduced the risk of progression to diabetes by 58% over three years compared with placebo. Among adults 60 years and older, the risk reduction was even greater at 71%. This translates to one case of diabetes prevented for every 7 adults receiving the DPP.[18] The DPP's striking results tell us that millions of high-risk people can modify their diet and exercise to lose a small amount of weight to delay or prevent the development of type 2 diabetes. Most recently, Medicare approved the DPP as a reimbursable service to prevent the onset of type 2 diabetes among Medicare beneficiaries with an indication of prediabetes under a performance-based payment model.[19]

Based on its experience working with underserved communities, NKFM understands the challenges of addressing social determinants of health, including, in the DPP context, the challenges of attaining specific outcomes like weight loss. **Chart 4** below shows DPP recognition standards established by the CDC, as compared to the results achieved by all participants in NKFM's DPP programs and the results achieved by participants who reside in underserved areas of Wayne and Oakland counties.

CHART 4: NKFM DPP OUTCOMES FOR ALL AND UNDERSERVED POPULATIONS (NOV. 2012 – OCT. 2017)

DPP Outcomes	CDC Standards[20]	NKFM DPP Outcomes for CDC Reported Workshops[21]	NKFM DPP Outcomes in Target Community[22]
DPP Workshops (#)	N/A	142	37
DPP Enrollees (#)	N/A	1,580	364
Average # of Sessions Attended (Weekly)	9	15.58	13.9
Average Weight Loss (at 6 Months)	5.0%	6.0%	2.8%
Average Weekly Physical activity minutes (at 6 Months)	150	201	223
Participants with >= 5% Weight Loss	N/A	959	81
% of Participants with >=5% Weight Loss	N/A	60.7%	22.3%
Average # of Sessions Attended (Monthly)	3	3.3	3.2

NKFM's efforts to improve outcomes in underserved communities include:

- using supplementary and/or tailored materials that are more relevant to participants' ethnicity, financial means, and cultural preferences;
- training community health workers (CHWs) from the community to be lifestyle coaches;
- making physical activity and healthy foods more accessible for participants by providing food and physical activity demonstrations, arranging guest speakers on these topics, and providing information about other community resources; and
- providing additional lifestyle coaching time to encourage individuals.

NKFM has demonstrated that DPP works in populations with a high burden of disease and made substantial progress building capacity for providing DPP across the state, including working with health systems, providers, and plans to attract participants to the program.

LISC and Pay for Success

Through a grant from the Social Innovation Fund, a former program of the Corporation for National and Community Service, LISC seeks to advance the PFS field by providing transaction structuring services to PFS projects that are ready to scale from a pilot/feasibility stage to development and launch. PFS is an approach to contracting that ties payment for service delivery to the achievement of measurable outcomes. In a PFS contract, a third party provides initial funding to cover the cost of the program, an independent evaluator determines whether the agreed-upon outcomes have been met, then the payer for outcomes provides funding if and when the services delivered achieve a pre-agreed-upon result.

LISC and NKFM set a goal to implement the DPP by using PFS transaction structuring services to enable up to 3,500 Medicaid-eligible adults who are at increased risk for type 2 diabetes in Michigan's Wayne, Oakland, Macomb, Kent, Genesee, and Muskegon counties. Reaching such an ambitious goal would require active engagement by the MCOs operating in the state.

III. MCOs, DPP, and PFS: Summary of Interview Findings

Given the important role Medicaid managed care organizations (MCOs) play in the program design — recruiting participants, as well as paying for successful outcomes — LISC and NKFM engaged the University of Michigan's Center for Health and Research Transformation (CHRT) to independently evaluate the knowledge of 10 MCOs regarding the DPP and PFS, their willingness to participate in the LISC-NKFM initiative, and barriers to implementation among Medicaid clients. The MCOs were:

- Aetna Better Health of MI
- Blue Cross Complete of MI
- HAP Midwest Health Plan
- Harbor Health Plan
- McLaren Health Plan
- Meridian Health Plan of Michigan
- Molina Healthcare of Michigan
- Priority Health Choice Inc.
- Total Health Care
- UnitedHealthcare Community Plan, Inc.

BACKGROUND ON METHODS

CHRT contacted the 10 MCOs with the goal of conducting key informant interviews with appropriate executives to gain a nuanced understanding of their knowledge and experience with the DPP and PFS and their willingness to participate in the LISC and NKFM initiative. Interviews were completed with 13 respondents from eight MCOs (representing a variety of roles within their respective organizations, shown in **Chart 5**). Two MCOs were unable to complete interviews within the designated project timeline. CHRT utilized purposive sampling by having existing contacts at the MCOs and contacts identified through the Michigan Association of Health Plans direct our interview request to the right individuals based on the subject matter. CHRT also gave respondents post-interview opportunities to identify individuals within the organization who could provide additional insights; however, in general respondents indicated that they were the right people to talk to about these topics and did not refer CHRT to others for additional interviews. Interview questions focused on:

1. MCOs' familiarity with DPP, including any experience reimbursing its use for any portion of their insured clientele;
2. perceived barriers to implementing the program for a Medicaid clientele;
3. reasons they might see to reimburse or not reimburse DPP services for clients covered by Medicaid;
4. MCOs' familiarity with PFS or value-based payments (VBPs);
5. perceived barriers to using a PFS structure, both generally and in this specific diabetes prevention application; and/or
6. the degree to which MCOs see a PFS structure addressing barriers to their willingness to reimburse DPP services for a Medicaid clientele.

Interviews were conducted from August to November 2018.

The CHRT analysts used inductive qualitative thematic analysis to identify the key themes in the data.[23] Two independent coders participated in meetings to come to consensus over themes and coding structure. CHRT utilized NVivo 12[24] to organize and manage the interview data.

CHART 5: NUMBER OF RESPONDENTS BY ROLE (N=13)

Role	Number of Interview Respondents
Clinical Operations Medical Management Integrated Health Care Health Services	● ● ● ● ●
Population Health Chief Medical Officer	● ● ●
Director of Government Program Medicaid	● ●
Quality	●

Results: DPP

FAMILIARITY AND EXPERIENCE

Three respondents indicated that they were very familiar with the DPP. One MCO indicated its organization is "the only health plan in Michigan currently that is reimbursing for the DPP for our full commercial and Medicare product." One respondent had experience as a DPP participant. Only one MCO lacked a respondent who was at least somewhat familiar with the program.

If we're going to be relevant in the community, then we've got to be able to help manage overall health care costs. I think we all have that responsibility collectively.

In addition to offering the DPP to certain non-Medicaid populations, one MCO implemented a DPP pilot program for Medicaid beneficiaries several years ago, which was not successful. However, the representative did express interest in revisiting the Medicaid population in the future, saying, "I'm a firm believer in another day, another time, different circumstances, maybe we can have different results because I've certainly seen the results…in both of our commercial and Medicare populations. And it's a prevalent, chronic condition that the state wants us to be doing much more work with and has actually designed some projects around incentivizing us to do that."

A second respondent indicated some involvement with the DPP, saying, "We pay a certain amount of money, per member, per month to [a large physician organization] to do a number of different care management programs for a subset of our membership. And one of those things is actually to establish a DPP program in their area." Five did not have any experience implementing the DPP, although one of these acknowledged some conversations had taken place with the NKFM regarding the potential implementation of a pilot.

BENEFITS

When asked what the perceived or realized benefits of the DPP were, the majority of respondents focused on the impact the program would have on clients' health and wellbeing (**Chart 6**). The most common theme was improvements in health outcomes and quality of life. Other common responses included empowerment and capacity building, diabetes education and knowledge, disease prevention and improved self-management, lifestyle change, healthy eating and weight loss, and increased physical activity. One respondent, reflecting on their experience with the DPP, gave their endorsement, saying, "I'm a full believer of the program because it does help people in many aspects of their life."

The other major area discussed focused on reducing health care costs, increasing value, and achieving the "triple aim." One respondent put it concisely, saying, "The incentive is that if you can prevent someone who is a prediabetic to not transition to the next stage, you're saving — you're improving the members' health, you're improving their outcomes. And in the end…there's always that cost component."

Another respondent stated, "If we're going to be relevant in the community, then we've got to be able to help manage overall health care costs. I think we all have that responsibility collectively. We want to invest in programs that are going to improve health and then hopefully, collectively overall, drive down health care costs. Better to spend a little bit now, right, than a lot later."

CHALLENGES

Challenges associated with implementing the DPP among Medicaid clientele are displayed in **Chart 7.** Engagement of the Medicaid population represented a challenge anticipated by respondents. One respondent summed up this point saying, "I do think one of the barriers is the length of the program and some members being able to commit to that. But I do think the Medicaid members... if they're committed enough and willing to do the work, they could benefit highly from this program."

A number of barriers were identified that would make engagement of the Medicaid population a challenge for a 16-week program, such as transience, demands of family care, other life priorities, and factors related to social determinants of health (e.g. lack of access to healthy food, lack of transportation). Summing up this point, one respondent said, "I know that we throw around the term 'social determinants' a lot, but for our members, quite frankly, when they've got to figure out where they're getting their next meal from or whether or not they're going to have safe and secure housing or worried about the food or water that they're drinking, then sometimes the management of a chronic condition kind of falls secondary to all of those other issues that are going on. That there isn't good and available childcare. They don't have transportation. All of those kinds of things... And I'm not saying that we can't overcome these challenges because I think we can. But I think we have to go in eyes wide open...I think it's thinking creatively to help our members be successful."

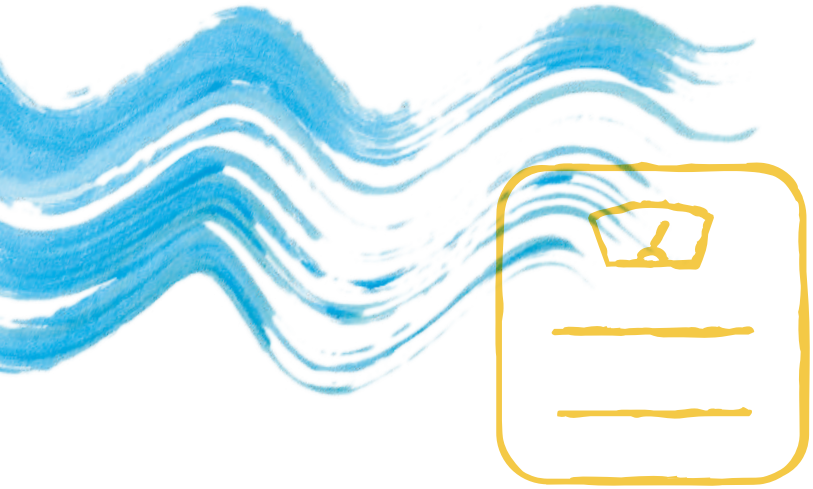


CHART 6: BENEFITS OF IMPLEMENTING DPP FOR YOUR MEDICAID CLIENTELE

Response	Number of Interview Respondents
Improve Health Outcomes, Quality of Life	● ● ● ● ● ● ●
Diabetes Education	● ● ● ●
Empowering, Building Capacity	● ● ● ●
Prevention and Self-management	● ● ● ●
Healthy Eating	● ● ●
Weight Loss	● ● ●
Reduce Cost, Value	● ● ●
Address Social Determinants of Health	●
Engagement	●
Lifestyle Change	●
Physical Activity	●
Triple Aim	●

Factors related to program logistics were also mentioned as potential barriers, including frequency of the program activities, location, and meeting times. Lastly, factors such as lack of reimbursement for Medicaid and the prediabetic population not being a priority for the health plan represented additional challenges.

Reimbursement

Only one MCO indicated that it is currently reimbursing the DPP for any portion of its clientele. As stated above, this organization is reimbursing for its full commercial and Medicare product, but not currently for Medicaid. In describing why the health plan decided to reimburse the DPP, the MCO representative stated, "We see the value. We know what it does. And if you know the rate of diabetes progression, if you don't stop it now, I mean, one in three in 2050. Costs are unsustainable, and then the cost upon [progression to] diabetes [is] even worse. So, as a health plan, we see that."

CHART 7: CHALLENGES TO IMPLEMENTING DPP FOR YOUR MEDICAID CLIENTELE

Response	Number of Interview References
Transportation	● ● ● ● ● ●
Engagement	● ● ● ● ●
Program Length, Frequency	● ● ● ●
Childcare, Family Care	● ● ●
Lack of Healthy Food Access	● ● ●
Program Location	● ● ●
Social Determinants of Health	● ● ●
Lack of Reimbursement for Medicaid	● ●
Other Life Priorities	● ●
Health Literacy, General Literacy	● ●
Challenges Associated with Providers and Practitioners	●
Meeting Items	●
Prediabetic Population Not a Focus for the Health Plan	●
Transience	●

Despite the widespread understanding of the importance of addressing social determinants of health, finding sustainable funding models to pay for it remains a challenge.

Asked what additional information is needed to convince their organizations of the value of the program, respondents identified information on cost and return on investment (n=6), data on health benefits and disease prevention (n=6), as well as programmatic details (n=3). One respondent summarized these points saying, "I think you could get buy-in to support an initiative like this if you could highlight what the benefits are and how it relates to return on investment… We always do some cost/benefit analysis. And so, we probably would need evidence of where this has been implemented before. What was the participation and engagement rate? What were some of the health outcomes? And what were some of the cost/benefit outcomes before we would invest in a program?"

I think you could get buy-in to support an initiative like this if you could highlight what the benefits are and how it relates to return on investment… We always do some cost/benefit analysis. And so, we probably would need evidence of where this has been implemented before.

PFS/VBP

FAMILIARITY AND EXPERIENCE

No MCOs described themselves as very familiar with PFS. One stated that they were somewhat familiar with the model, saying they "had a discussion around this last year…with [a] third-party vendor…and then us paying if those results are obtained."

The other MCOs were not familiar with PFS and many confused PFS with pay for performance. For example, in response to a question about their experience with PFS, a respondent replied, "We've paid providers for achieving certain outcomes and savings for a number of years." CHRT attempted to mitigate this confusion partway through the interview process by providing a more detailed description of PFS to respondents.

One indicated that they were familiar with risk arrangements, "which it sounds like it could be somewhat of the same type of format."

Nearly all of the MCOs described themselves as very familiar (n=3) or somewhat familiar (n=4) with VBP. Note: The respondent for one organization felt that they were not the right person to speak to VBP-related questions.

Representatives from one plan stated, "We work frequently with alternative payment models and value-based arrangements. So, those are mostly focused on pay for performance and include shared savings models, for example, which incorporate quality measures."

CHART 8: BENEFITS TO USING A PFS/VBP STRUCTURE IN ORGANIZATION

Response	Number of Interview References
Health Outcomes, Quality of Life	● ● ● ● ● ● ●
Lower Financial Risk, Lower Cost, Value	● ● ● ● ● ● ●
Better Care Management	● ●
Patient-Centered	● ●
Prevention and Self-management	● ●
Quality of Program Implementation	● ●
Clinical Transformation	● ●
Upfront Funding Makes It Desirable	●

BENEFITS

The primary benefits described by the MCOs (**Chart 8**) related to PFS/VBP structures were positive effects on client health and wellbeing. Similarly, reflecting on the impact on clients, respondents highlighted improved disease prevention and self-management. Both of these responses tie into the theme of PFS/VBP being patient-centered, in that these models tie payment to outcomes, driving quality program implementation. In addition, respondents identified the lower financial risk, lower cost, and greater value associated with the funding structure. The PFS/VBP structure was also thought to improve care coordination and case management and drive clinical transformation.

CHALLENGES

In reflecting on challenges associated with PFS/VBP (**Chart 9**), respondents focused on how success would be attributed and measured, raising concerns that success may be difficult to attribute correctly, given the phenomenon of Medicaid churn and movement across health plans. Depending on how success will be measured, respondents also had concerns about obtaining the appropriate data, reporting on measures, and meeting goals. Discussing this topic, one respondent stated, "But more the challenge is that how many of those members stay with us and for how long to be able to reap the benefits of that?" Another respondent touched on this point, saying, "How can we wrap our arms around these members? Because they might not be Medicaid for very long."

The other concern related to potential difficulties operationalizing the PFS/VBP models and to the unknowns of operational details.

To what extent do you see PFS/VBP as an approach to overcoming funding barriers related to DPP for Medicaid clientele?

Responses ranged from optimistic to pessimistic to "wait and see," with respondents saying that they:

- could see PFS/VBP as an approach to overcome funding barriers related to the DPP for Medicaid clientele (two plans).
- would be "open" to seeing more details on what the model would look like.
- would need buy-in from "contracting team and the executives" regarding the model, but that they are "not opposed to value-based arrangements."
- were less optimistic about the model and stated, "I don't know that I see it overcoming barriers to the non-coverage of it by Medicaid today."
- would need more information on PFS before they could say one way or another.

CHART 9: BARRIERS TO USING A PFS/VBP STRUCTURE IN ORGANIZATION

Response	Number of Interview References
Attributing Success Appropriately (Concern Regarding Churn)	● ●
Obtaining Data and Reporting	● ●
Measurable Goals and Metrics of Success	● ●
Meeting Goals	●
Operationalizing	●

Willingness to Participate in the Future Initiative

Three MCOs expressed strong interest in having further discussions about the proposed initiative. For example, a respondent stated, "I think there would be very strong interest in doing it, but…I can't say, 'Yes, we'll absolutely do it.' But I believe we could muster the support." The respondent went on to point out the need to show numbers supporting the clinical benefits of the program in order to convince other decision-makers within the organization.

Only one indicated that they were not likely interested at this time, as they would like to see the results of their ongoing internal diabetes-related program before they would move forward with the LISC-NKFM initiative (although they did not totally close the door on the opportunity). The other four MCOs expressed some interest but felt that they needed more information or they were not the appropriate person to say whether or not the organization would be willing to move forward. Results are shown in **Chart 10.**

CHART 10: WOULD YOUR ORGANIZATION BE WILLING TO PARTICIPATE IN THIS INITIATIVE?

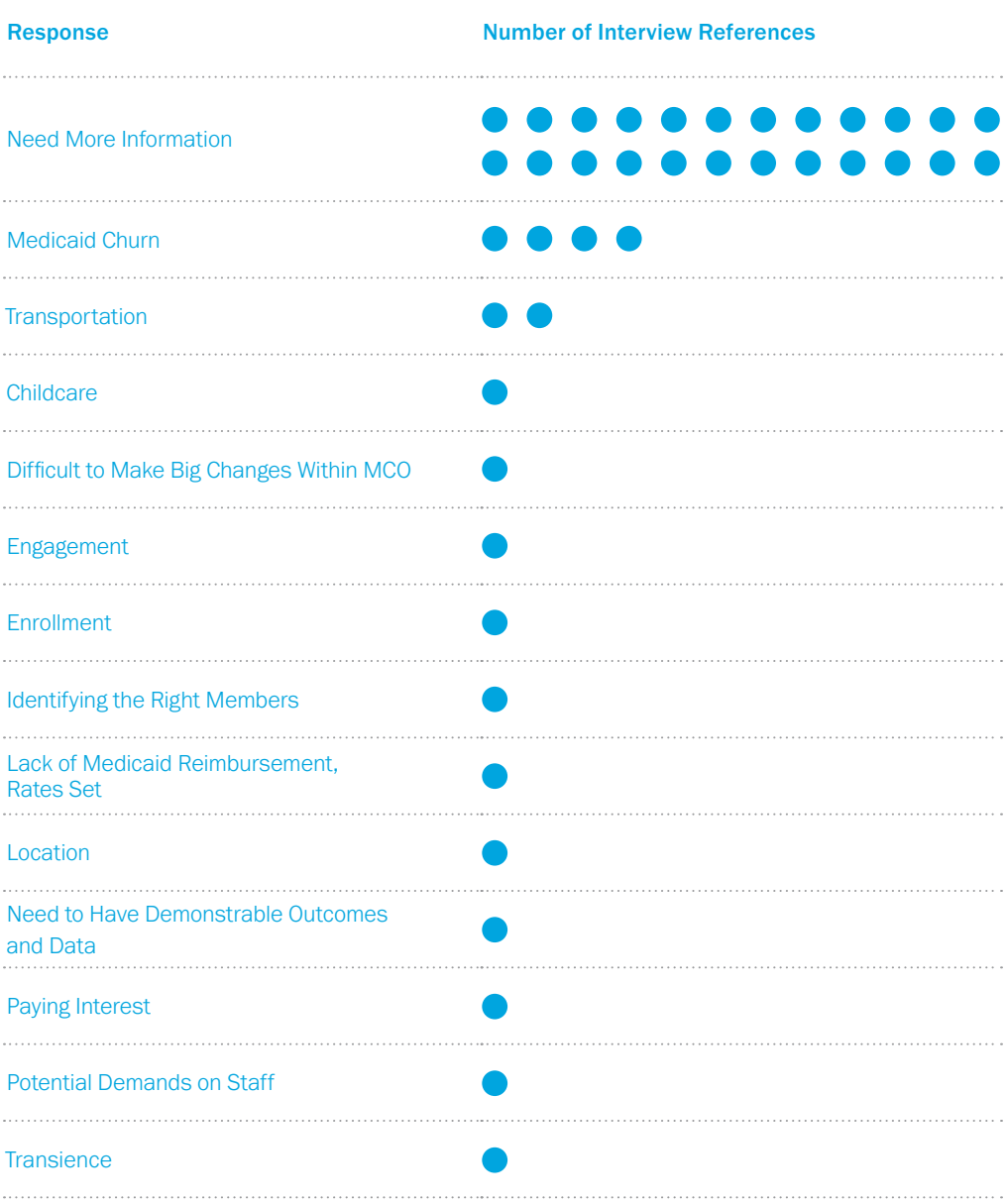
Response Category	Number of MCOs
Yes	● ● ●
Not Decided at This Level	● ●
Need More Information	● ●
No	●

BENEFITS

When asked about the perceived benefits of the DPP-PFS initiative (**Chart 11**), the most common responses related to improving health and wellness of members, improving prevention and self-management, and empowering clients. The second most common theme related to lower financial risk and reduced costs. Innovation of the model appealed to two of the MCOs and there were responses that indicated that this would fit with current alternative payment models with an organization as well as that the PFS seemed to fit DPP well. The community focus of the initiative and the free program offerings for members were seen as positives as well.

CHART 11: PERCEIVED BENEFITS OF DPP-PFS INITIATIVE

CHART 12: PERCEIVED CHALLENGES OF DPP-PFS INITIATIVE



CHALLENGES

Chart 12 shows the challenges respondents identified regarding the proposed initiative from LISC and the NKFM. By far the most common challenge was the need for more information about what the initiative entails. **Chart 13** displays where additional information would be valuable to MCOs in their decision-making.

CHART 13: WHAT ADDITIONAL INFORMATION IS NEEDED IN ORDER TO PROCEED?

Response	Number of Interview References
Finances	● ● ● ●
Operational Details	● ● ●
Evidence of Previous Success	● ● ●
Metrics of Success	● ●
Return on Investment	● ●
Health Outcomes	● ●
Third-Party Payer	● ●
Formal Proposal	● ●
Timeline	● ●
Quality of Care	●
Process to Identify Population	●
Potential Conflicts of Interest	●

The amount of financial commitment expected of the MCOs and the potential costs of the program were the most common pieces of information respondents referred to when asked what additional information was needed to move forward.

Respondents also expressed a desire to see more evidence of previous success using the PFS model to support health promotion programs (particularly in the U.S. health care system, with PFS having strong ties to the United Kingdom). Specifically, respondents were interested in seeing more data on return on investment, health outcomes, and quality of care.

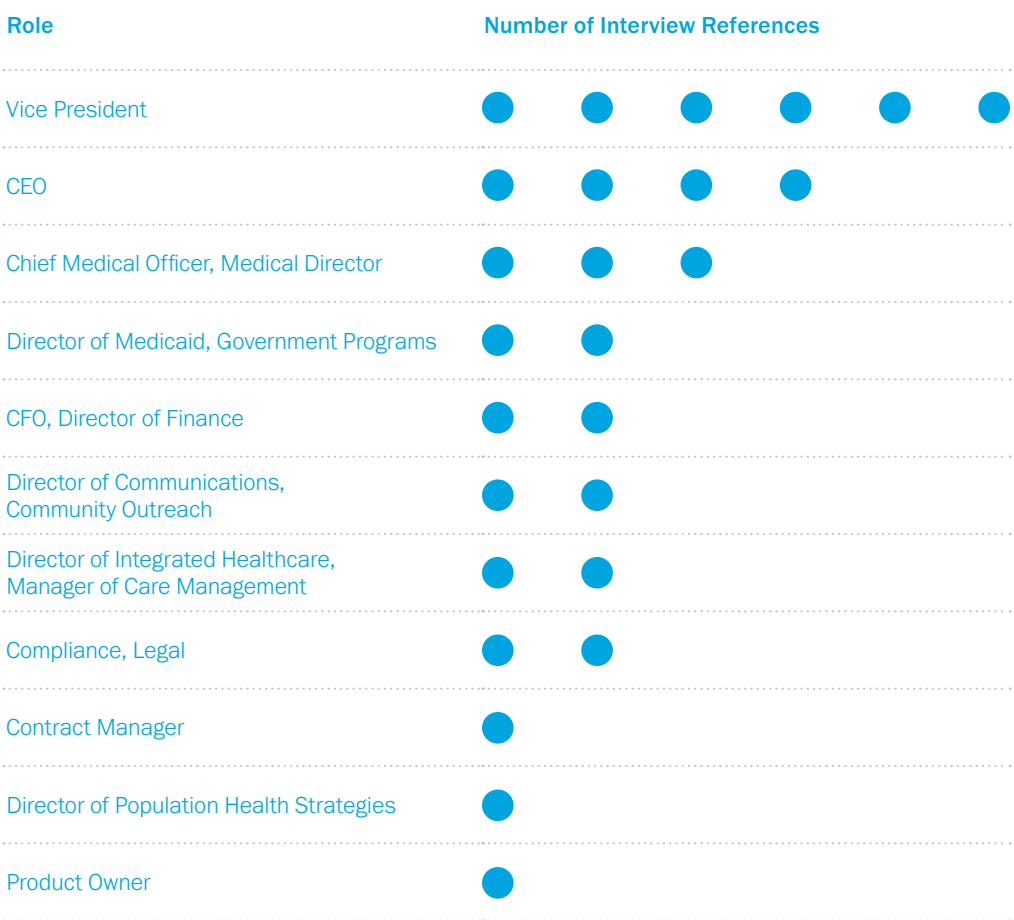
Operational details were also of interest. Issues discussed throughout the interviews include specific metrics that will be used to measure success, third-party payers (and potential for conflicts of interest between the third-party payer and the MCO), process for identifying the population, and proposed timeline. Under the operations theme, the question was raised about how the initiative would handle churn among the Medicaid population in regards to an individual's enrollment in the DPP, and how to track that individual's data over time and attribute success to the appropriate health plan.

Speaking about the challenges associated with creating big changes within MCOs, one respondent stated, "These are very old organizations. Health care is old school. And it's very uncomfortable to change how one behaves, including in your old-school model."

Who Needs to Be on Board to Move Forward with the Program?

When asked to identify stakeholders within their organizations who would need to be on board in order to move this initiative forward, respondents provided a wide range of roles outlined in **Chart 14.**

CHART 14: DECISION-MAKERS NEEDED TO ADVANCE THE PROGRAM WITHIN THE MCOS



CONCLUSIONS

The MCO representatives interviewed had some knowledge of the DPP. Only one is currently reimbursing the DPP for their clientele (Medicare and commercial population only). Respondents had very little knowledge of PFS and in many cases confused it with pay for performance. Respondents had a great deal of experience with VBP.

Three MCOs expressed interest in participating in a future initiative. Only one MCO indicated they weren't interested at this time, while others indicated that they needed more information before they would be able to say whether or not they would be willing to participate.

Next Steps

CHRT has introduced the NKFM staff to representatives from all eight MCOs who took part in the key informant interviews. NKFM followed up with additional information on the proposed initiative in order to move the work forward.

CHRT will conduct focus groups with Medicaid beneficiaries who participated in previous implementations of the DPP with the NKFM to identify barriers to participation among that population.

IV. Lessons from a Convening of PFS and Health Sector Professionals

To share experience and further examine potential solutions to the barriers practitioners face as they seek to address social determinants of health and use PFS as a tool, LISC and NKFM organized a full-day convening in East Lansing, "Pay for Success and the Social Determinants of Health," in May 2019.

Highlights from the gathering include:

- extremely supportive remarks from MDHHS Director Robert Gordon, who is interested in supporting a greatly expanded rollout of the Diabetes Prevention Program (DPP) and other proven prevention strategies;
- examples from the field of successful interventions focused on not only diabetes prevention, but also asthma, early childhood development, and other critical health priorities; and
- key lessons learned to build trust and successfully reach Medicaid and other higher-risk and underserved populations.

Given the support and interest of MDHHS Director Gordon, there is a real opportunity now to advance and spread these prevention strategies and interventions for Medicaid populations in Michigan.

He cited a specific interest in taking advantage of a new federal initiative, the Social Impact Programs to Pay for Results Act (SIPPRA). He and others saw it as a "game-changer" as it provides federal funds over an extended investment period (up to seven years) without the regulatory restraints associated with Medicaid and many other federal funding streams.

Other highlights include:

- Paula Lantz, Professor of Health Policy at the University of Michigan Ford School of Public Policy, gave an overview of PFS and its evolution, describing its ability to bring private capital to address public policy problems, and the particular appropriateness of the PFS design for addressing social determinants of health (SDOH).
- She noted that PFS, with a need to create return on investment within investors' limited timeframes of a few years, is best used for the quickest cost-savings interventions for highest-need populations, versus interventions that are effective for a broader population but take a long time to unfold.
- She placed PFS within the larger context of a movement towards performance-based contracting and a growing demand for specific evidence to support public programs.

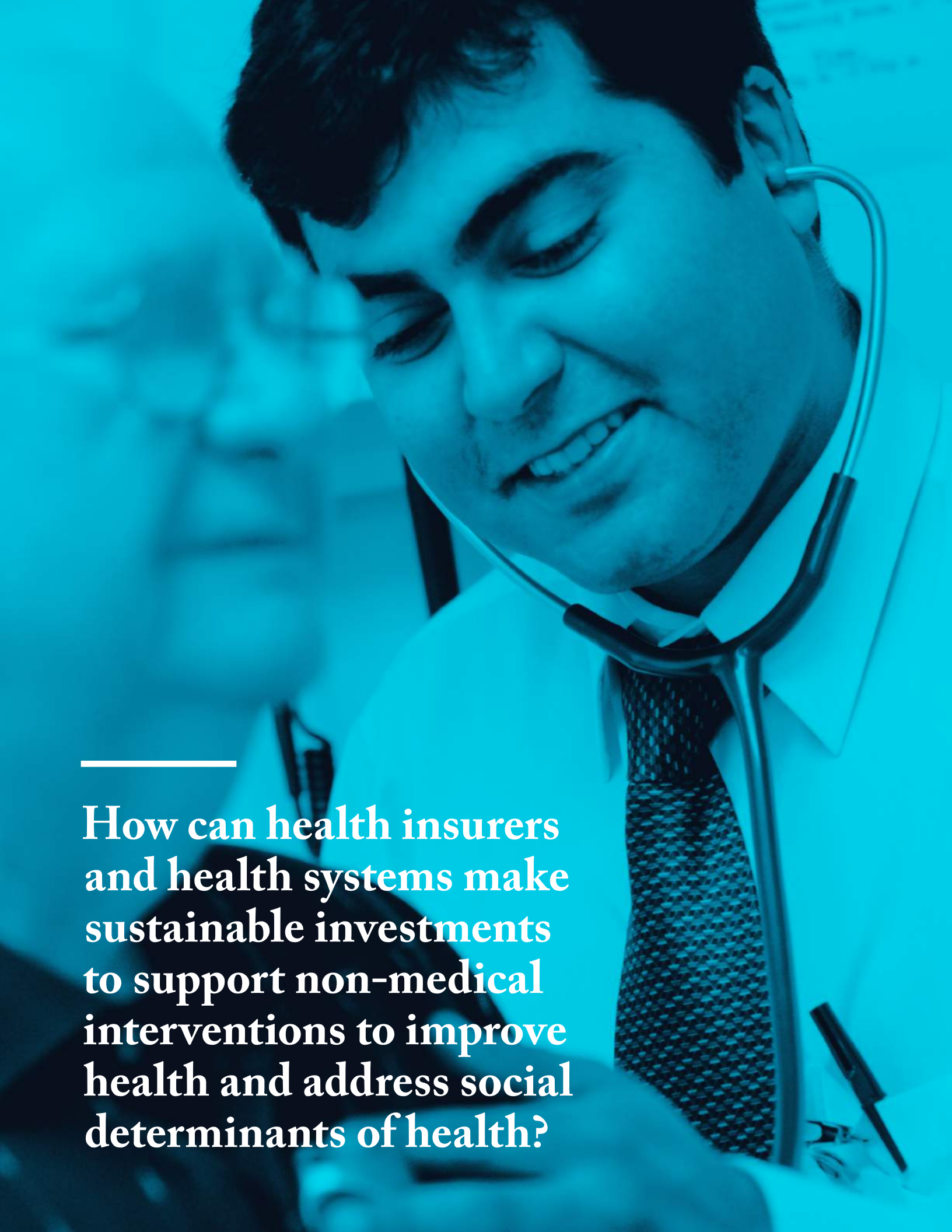
- Patrick Kelly of CHRT outlined the findings of the MCO interviews, detailed in section 3 of this paper, including the MCOs' general familiarity with DPP, lack of familiarity with PFS, and their universal recognition of the need to address the rapidly growing prevalence of type 2 diabetes. As one MCO executive observed, we are on a path towards an unfolding disaster, with a third of the population expected to have diabetes by 2050 if the problem is not addressed.
- In a panel on partnerships with insurers to address SDOH, there was a common theme of building trust and credibility to overcome on-the-ground challenges. The panel included Arlene Guindon of NKFM, Ruth Ann Gordon of the Green & Healthy Homes Initiative (GHHI), and Jeremy Moore of Spectrum Health.

Effective intervention takes time — years — and effective action at the population level requires coalitions and partnerships between organizations that must last for years, even as staff turn over in the various organizations over time.

The intertwined themes of trust and building connections came up in multiple contexts:

- The best-designed, "perfect" policy will fail immediately unless it is accompanied by effective outreach and personal connection to the communities involved.
- Similarly, a program will succeed or fail based on the effective training and specific capabilities of frontline staff, such as community health workers (CHWs), to reach and engage with the clientele they are working with.
- Effective intervention takes time — years — and effective action at the population level requires coalitions and partnerships between organizations that must last for years, even as staff turn over in the various organizations over time.

Although PFS was a theme of the convening, there was a recognition that it is simply a means for achieving desirable outcomes, which is the goal. Sometimes the evidence built while designing a PFS program is enough in itself to convince policy makers to "flip the policy" and directly fund an intervention. Ruth Ann Gordon of GHHI and Stephanie Mercier of CSH gave examples of asthma prevention and supportive housing solutions, respectively, where their work to design a PFS solution resulted not in a PFS engagement, but in new, direct public funding to address the problem.



How can health insurers and health systems make sustainable investments to support non-medical interventions to improve health and address social determinants of health?

V. Sustainable Payment Structures to Address Social Determinants of Health

The interest of MDHHS, from the top, creates real opportunities. Nonetheless, along with implementation hurdles, questions remain about how to best fund interventions. How can health insurers and health systems make sustainable investments to support non-medical interventions to improve health and address social determinants of health? Investment, if any, is currently likely to be limited in size and duration, since there is no assurance of return on that investment.

A recent study notes that social determinants are akin to public goods — the benefits of addressing them are clear, but there is little incentive for private investment to do so because the benefits accrue widely and not necessarily to those who invest.[25] Any private investment at a scale commensurate with the problems, therefore, becomes an unsustainable spend-down of resources.

In the case of Medicaid plans, impediments include:

- Medicaid churning, i.e., patients revolving on and off Medicaid coverage as their income fluctuates; and
- switching insurance plans — even if patients maintain Medicaid coverage, they might not stay with a particular Medicaid plan over an extended period of time.

Social determinants are akin to public goods — the benefits of addressing them are clear, but there is little incentive for private investment to do so because the benefits accrue widely.

Under either circumstance, this means that the time from an intervention to measurable results in better health with lower costs can easily well exceed a patient's relationship with a particular plan.

These challenges were confirmed by MCO respondents to the CHRT interviews, as quoted in **Section III** above:

> [R]espondents focused on how success would be attributed and measured, raising concerns that success may be difficult to attribute correctly, given the phenomenon of Medicaid churn and movement across health plans. Depending on how success will be measured, respondents also had concerns about obtaining the appropriate data, reporting on measures, and meeting goals. Discussing this topic, one respondent stated, "But more the challenge is that how many of those members stay with us and for how long to be able to reap the benefits of that?" Another respondent touched on this point saying, "How can we wrap our arms around these members? Because they might not be Medicaid for very long."

Other barriers cited by MCOs can be seen in **Chart 9** (page 23) above.

Where the effects of churn, movement across plans, and other factors cited by MCO executives can be controlled or diminished, the ability of health insurers and the health sector to address certain factors underlying the social determinants can be significant. Examples of manageable investment producing a return in better health and reduced health care spending include the following:

- For persons with asthma, the Green & Healthy Homes Initiative (GHHI) has shown that targeted interventions in housing quality and patient education can deliver immediate health improvements, including reductions in acute episodes, which can quickly reduce insurers' costs.
- For homeless individuals with a range of health and mental health co-morbidities, CSH (fka the Corporation for Supportive Housing) has demonstrated the health benefits and financial returns associated with supportive housing.
- For low-income, first-time mothers, the work of the Nurse-Family Partnership has resulted in better health for both the mothers and their children, along with long-term improvements in educational and financial prospects. The work of Spectrum Health's Strong Beginnings program is showing similar results.
- As this report has discussed, the Diabetes Prevention Program (DPP) has a proven record of producing better health and lower costs.

The most straightforward first step is to have the costs of the initial intervention covered.

How, then, to overcome churn and other barriers so that MCOs and the health care sector can undertake proven, targeted interventions and expect a return, thereby creating a sustainable enterprise from these investments in health? How to create a long-term alignment of interests promoting better health and a sustainable business model?

From the standpoint of provider organizations and MCOs, the most straightforward first step is to have the costs of the initial intervention covered. With initial costs covered, the question of who (in addition to the patient) may benefit in the long-term health improvements and cost reductions is somewhat moot — to provider organizations and MCOs.

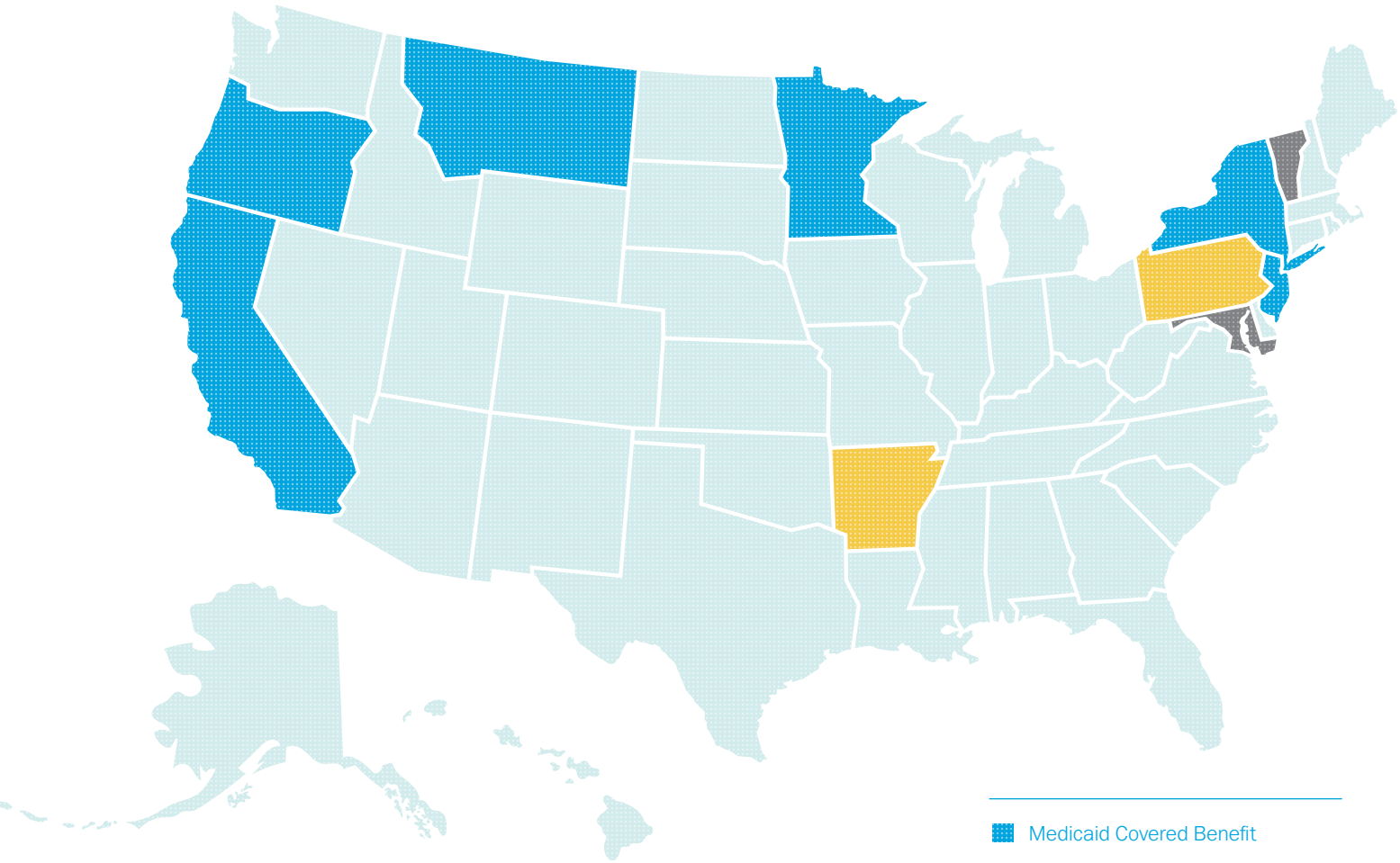
But where does the money to pay them come from? Who has a long-term, sustainable financial interest in covering the costs of intervention?

In the case of diabetes prevention, Medicare and many private insurers have chosen to fund non-medical DPP interventions. For Medicare, the equation is perhaps most straightforward. Medicare is a single-payer system for a captive market, so the health benefits accrue to its members and the health-related cost benefits stay within Medicare.

Medicaid Waivers

Several states are similarly testing DPP as a reimbursable Medicaid service, and the CDC ran a three-year demonstration of DPP for Medicaid populations. The CDC demonstration, recently concluded, was conducted in Maryland, via MCOs, and in Oregon, via Coordinated Care Organizations (CCOs, an Oregon arrangement that is similar to Medicaid Accountable Care Organizations or ACOs). Enrollees in both states generally achieved participation, weight loss, and exercise goals. Maryland has received an 1115 waiver from the Centers for Medicare & Medicaid Services (CMS) to make the program a reimbursable Medicaid benefit on a continuing basis, and Oregon is continuing the program under existing authority.[26]

STATES WHERE NATIONAL DPP IS A MEDICAID COVERED BENEFIT, 2019[27]



Current as of May 1, 2019

State Funding

The 1115 waiver route (and the federal matching funds it brings) is not always feasible, but a state government might nonetheless make a decision to fund proven non-medical interventions, such as the asthma intervention and other examples listed above. The state would be calculating that its residents will be long-term beneficiaries, not only with better health and better quality of life, but also reduced needs for social services, stronger educational achievement, and increased workforce participation, all of which is, of course, to the benefit of the state. State-supported interventions have taken place, for example, in New York and Massachusetts:

- New York State has, since 2012, directed $107 million of state Medicaid funding from the state's general fund, without a federal match, to fund some 5,000 units of congregate and scattered-site supportive housing, including service funding, rent subsidies, and capital dollars. The units serve high-cost Medicaid recipients, typically formerly homeless individuals struggling with mental illness, substance use disorders, HIV/AIDS, and/or other chronic medical conditions.[28]

- Massachusetts created a Prevention and Wellness Trust Fund, a $60 million, four-year trial, with the broad goals of reducing the prevalence of preventable health conditions and reducing health care costs. The Wellness Trust chose to focus on clinical-community partnerships addressing childhood asthma, falls among older adults, hypertension, and tobacco use. A Harvard evaluation of the program found "positive impact on outcomes, costs, and systems innovations,"[29] including reductions in blood pressure, higher than average reductions in pediatric asthma, and fewer falls. Despite positive results, the Wellness Trust has thus far not been extended beyond its trial period (which ended in 2018), because the state has not approved a source of continued funding. The trial was funded by a tax on insurers and hospitals. So the concept of a dedicated Wellness Trust is demonstrated as an effective funding vehicle, but ironically the question of how to fund the funding vehicle remains.

SIPPRA

$66 m

the U.S. Treasury Department has recently announced the availability of $66 million via the Social Impact Partnerships to Pay for Results Act.

As discussed above, PFS is designed to encourage investment in prevention by reducing payers' risk. And the structure has the added benefit of qualifying under many definitions of value-based payment arrangements. But it still requires an end-payer who finds value in paying for success. To encourage take-up of the PFS model, and to further demonstrate the potential of social determinants-related interventions, the U.S. Treasury Department has recently announced the availability of $66 million via the Social Impact Partnerships to Pay for Results Act (SIPPRA). The funds are available to states and localities to make end payments for successful results. SIPPRA allows up to a seven-year timeframe, which is longer than most PFS programs and more in line with the actual timeframes required for many interventions to show meaningful results.[30]

Health Outcomes Trust

Any intervention to address social determinants requires a considerable level of coordination between community-based organizations (CBOs), medical providers, payers, and levels of government. One strategy, to improve results from whatever funding sources may be available, is for all stakeholders to come together in a formal fashion. This concept could include local employers, as well as providers, CBOs, payers, and public agencies, in a model referred to as a community health trust or a health outcomes trust. Participants, all of whom benefit from improved outcomes, can pool resources through the trust, creating an alignment of interests somewhat like an ACO or a local single payer.[31]

With pooled funds directed towards prevention, organizations work together to tackle something they know is collectively worthwhile. In the case of MCOs, the intention is to share in the costs and savings equitably, tracking patients over time so that each MCO can be rewarded for its investments in prevention, even if a patient is later with another plan.

In the case of MCOs, the intention is to share in the costs and savings equitably, tracking patients over time so that each MCO can be rewarded for its investments in prevention.

How Others Are Looking at Addressing Social Determinants of Health Through Pay for Success

THE GREEN & HEALTHY HOMES INITIATIVE

The Green & Healthy Homes Initiative (GHHI) is advancing high-quality evidence-based interventions that efficiently connect funding to meaningful health, economic, and social outcomes in order to foster health equity for people in low-income communities.[32] GHHI currently provides technical assistance and project management services for over a dozen Pay for Success and other social innovation projects in development with government, health care, and community-based service provider partners across the country. The majority of these projects focus on improving asthma outcomes through comprehensive interventions that include removal of asthma triggers in homes. GHHI is also expanding development of social innovation projects that focus on improving outcomes related to lead hazard reduction, energy efficiency, and aging in place for older adults, among others."[33]

GHHI has three designated sites in Michigan located in Detroit, Lansing, and Flint. In 2016, GHHI conducted a feasibility study in Grand Rapids for an asthma PFS project. The project partners were Spectrum Health and Priority Health, and they worked with three service providers in the area. GHHI determined that Pay for Success financing was viable for a three-year pilot, enrolling 396 patients, with a $1.08 million projected net benefit in medical cost savings over 10 years. GHHI spoke with local MCOs and state government agencies to become the back-end payer, but no project has launched to date.[34]

SPECTRUM HEALTH — STRONG BEGINNINGS

Strong Beginnings is a federal Healthy Start program and community partnership dedicated to improving the health and wellbeing of African-American and Latino families during pregnancy and early childhood.[35]

The program, a partnership of 10 community agencies administered by Spectrum Health in Grand Rapids and Kent County, focuses on improving health and early childhood development outcomes for high-risk mothers and their babies through home visitation, community programs, and better coordination of care throughout pregnancy until the child's second birthday.

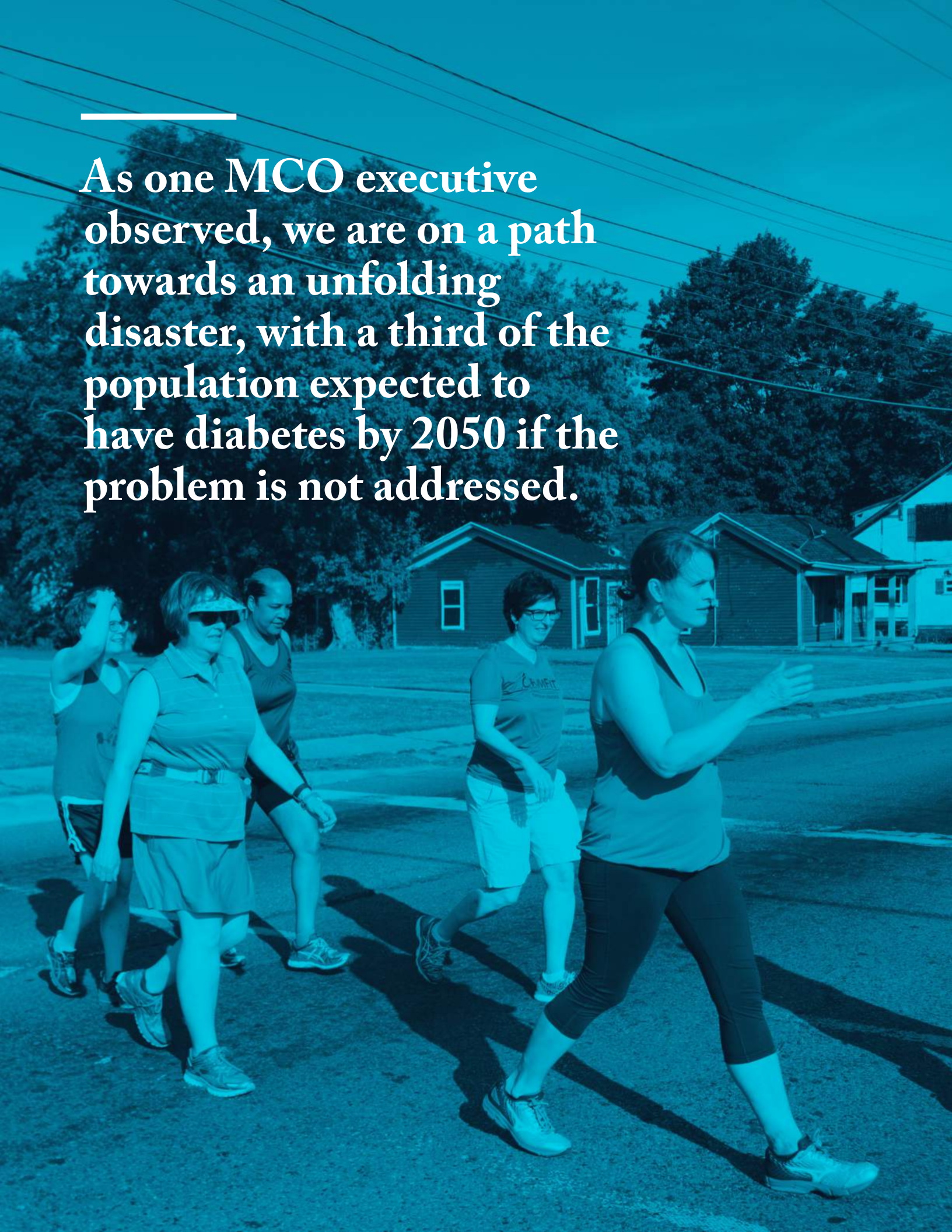
50%

The program has helped reduce infant mortality and adverse birth outcomes by 50% for African Americans.

Strong Beginnings seeks to promote racial equity and eliminate disparities in birth outcomes between whites and people of color. All services are offered free of charge and are available in English and Spanish. Since 2004, the program has helped reduce infant mortality and adverse birth outcomes by 50% for African Americans.[36]

Strong Beginnings employs community health workers (CHWs), who work with nurses and social workers and connect families to needed resources. The program includes the *Strong Fathers/Padres Fuertes* fatherhood initiative, offering individual and group support for male partners.

In 2016, Strong Beginnings was chosen as a Pay for Success pilot program by the state of Michigan with the goals of reducing preterm births and rapid repeat pregnancies, which lead to poorer life outcomes for both mothers and children. The program seeks to provide home visits for every Medicaid-eligible first-time mother in Kent County, with a comprehensive set of support services, including parenting and life-skills building.[37] It does not yet have reported outcomes. The project uses a Medicaid waiver from CMS to leverage federal funding and allow Strong Beginnings to bill Medicaid directly for services, reducing the financial burden on the state by allowing the federal government to pay for a portion of the project's costs.



As one MCO executive observed, we are on a path towards an unfolding disaster, with a third of the population expected to have diabetes by 2050 if the problem is not addressed.

Appendix

Background on Michigan State Policies Regarding Alternative Payment Models

A key focus of the Michigan State Innovation Model is increasing the use of alternative payment models (APMs) to promote service delivery and maximize the opportunities for enhanced reimbursement. In 2016, the state first amended its Medicaid health plan contracts with alternative payment language to collect baseline activities and learn about reform approaches. The state has since incorporated feedback from Medicaid health plans into contracts, including setting specific APM threshold targets for the proportion of a plan's overall population and payments that are required to be associated with an APM over the term of the contract.

Michigan Medicaid Sample Health Plan Contract

Below is a high-level summary based on the 2018 Michigan Medicaid Sample Health Plan Contract sections and provisions that illustrate the importance of value-based payments and population health management for MDHHS going forward.

A key focus of the Michigan State Innovation Model is increasing the use of alternative payment models (APMs) to promote service delivery and maximize the opportunities for enhanced reimbursement.

SECTION III. PAYMENT REFORM

A. **Value-Based Payment Models.** The language includes a provision encouraging value-based payments that "reward providers for outcomes." The language specifically notes that payments can cover services that promote "coordinated and appropriate care" and are "traditionally not reimbursable" through Medicaid. We believe this language is broad enough to enable value-based payments under a Pay for Success initiative. New requirements in 2018 include reporting semi-annually to MDHHS on Medicaid health plan health care services reimbursed under value-based payments.

SECTION X. POPULATION HEALTH MANAGEMENT

A. **Data Aggregation, Analysis, and Dissemination.** The language includes a provision around utilizing information "to address health disparities, improve community collaboration, and enhance care coordination, care management, targeted interventions, and complex care management services for targeted populations" including "persons with high prevalence Chronic Conditions, such as diabetes" through the use of information such as claims data, pharmacy data, and laboratory results, supplemented by utilization management data, health risk assessment results, and eligibility status.

B. **Addressing Health Disparities.** The provision discusses population health management interventions that are designed to address the social determinants of health, reduce disparities in health outcomes, and achieve health equity. In order to address health disparities, contractors are to:

    - participate in community-led initiatives to improve population health;
    - enter into agreements with community-based organizations (CBOs) to coordinate population health interventions rooted in evidence-based medicine and national best practices; and
    - support the design and implementation of community health worker (CHW) interventions delivered by CBOs.

C. **Health Promotion and Disease Prevention.** The language specifies that contractors must ensure enrollees have "access to evidence-based/best practices educational programs," either in-house or through referral to CBOs, to reduce the impact of common risk factors and to promote the adoption of healthy behaviors. A strong focus for MDHHS in population health management is emphasizing the importance of health promotion and disease prevention that incorporates community-based health and wellness strategies in a manner that is informed by the life experiences, personal preferences, desires and cultures of the target population.

D. **Providing Care Management Services and Other Targeted Interventions.** The language specifies that a contractor must "offer evidence-based [targeted] interventions that have demonstrated ability to address social determinants of health and reduce health disparities" to subpopulations experiencing health disparities. Additionally, this provision requires contractors to participate in the Medicaid Health Equity Project (defined below).

XI. QUALITY IMPROVEMENT AND PROGRAM DEVELOPMENT

A. **Quality Assessment and Performance Improvement Program (QAPI).** The provision specifies the requirements of managed care quality measurement and improvement. MDHHS requires MCOs to include performance improvement projects and to collect and submit performance measurement data to monitor and improve health promotion and disease prevention, as well as to assess the performance of interventions that target subpopulations experiencing health disparities or address the social determinants of health.

B. **Medicaid Health Equity Project.** The language specifies the MCOs' participation with the Medicaid Health Equity Project.

APPENDIX 3B: PAYMENT REFORM REPORT

- MCOs must report on health care services reimbursed through value-based payment arrangements.

APPENDIX 5B: PAY FOR PERFORMANCE ON POPULATION HEALTH MANAGEMENT AND HEALTH EQUITY

- The purpose of this 2018 pay for performance program is to promote population health management and efforts to address social determinants of health for the Michigan Medicaid managed care population. The focus of the 2018 contract is on homelessness and low birth weight.

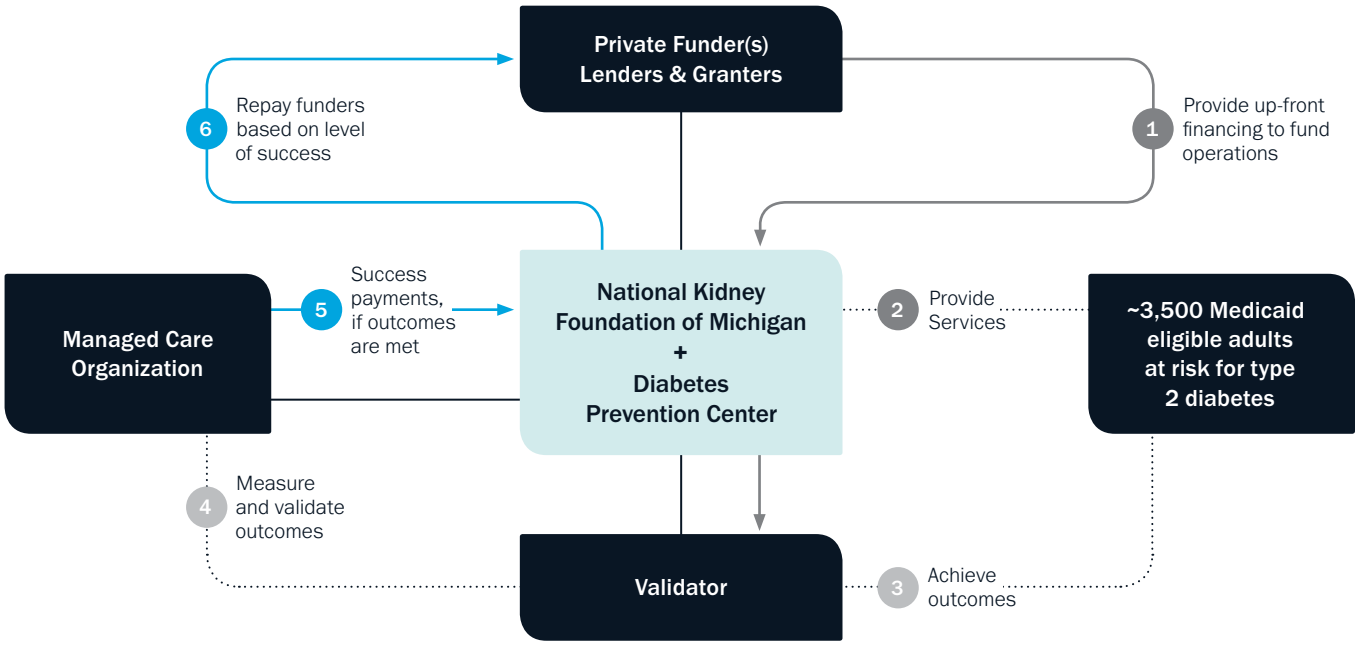
APPENDIX 5D: PAY FOR PERFORMANCE — HEALTHY MICHIGAN PLAN COST-SHARING AND VALUED-BASED SERVICES

- This includes specific language around creating or maintaining systems and processes to implement cost-sharing requirements and to ensure the provision of value-based services.

Proposed Pay for Success Project Structure

The diagram below provides an illustrative overview of the contemplated structure of the National Kidney Foundation of Michigan's (NKFM) Diabetes Prevention Center (DPC) PFS project.

This structure transfers risk from the MCO to the private funders while giving DPC the capacity and flexibility to expand its program. Additionally, based on discussion with the Michigan Association of Health Plans and Michigan Medicaid, this structure conforms to the value-based payment arrangements outlined in Michigan Medicaid's Sample Health Plan Contract. Please note the description is summary in nature.



Contractual Agreements

$ PFS Investment

$ Success Payment

Services

1. Private funders will provide upfront financing for social service delivery to NKFM.
2. NKFM will use the funds to provide the Diabetes Prevention Program to eligible participants.
3. Through the provision of services, DPC will work to achieve agreed-upon outcomes, including session attendance, weight loss and average number of physical activity minutes per week.
4. The program will engage an independent validator/evaluator to measure and evaluate these outcomes.
5. If the outcomes are met, the back-end payer, the managed care organization (MCO), will pay success-based payments to the intermediary.
6. The intermediary will, in turn, pay back private funders.

Endnotes

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Local Initiatives Support Corporation

Together with residents and partners, the Local Initiatives Support Corporation (LISC) forges resilient and inclusive communities of opportunity across America — great places to live, work, visit, do business, and raise families. Since 1979, LISC has invested $20 billion to build or rehab 400,500 affordable homes and apartments and develop 66.8 million square feet of retail, community, and educational space. LISC's Pay for Success work is funded through the Social Innovation Fund, a program of the Corporation for National and Community Service. lisc.org

Center for Health and Research Transformation

The Center for Health and Research Transformation (CHRT) is an independent 501(c)(3) impact organization, located at the University of Michigan, that works to transform research and evidence into actionable policy approaches that advance health care delivery, the health of the population, and access to care. chrt.org

Harbor Road Advisory

Harbor Road Advisory is a consulting practice focused on strategies and investment to create and sustain healthy communities. Its clients include a national portfolio of loan funds — Community Development Financial Institutions (CDFIs) — plus public agencies, foundations and community organizations supporting health, housing, and economic development activities in low-income communities, as well as financing to support environmentally sustainable business practices.

National Kidney Foundation of Michigan

The mission of the National Kidney Foundation of Michigan is to prevent kidney disease and improve the quality of life for those living with it. The organization is recognized for its success in sound fiscal management by receiving a 4-star rating, for the last 11 years in a row, from Charity Navigator — the nation's leading charity evaluator. nkfm.org

The Social Innovation Fund

The Social Innovation Fund (SIF) was a program of the Corporation for National and Community Service (CNCS) that received funding from 2010 to 2016. Using public and private resources to find and grow community-based nonprofits with evidence of results, SIF intermediaries received funding to award subgrants that focus on overcoming challenges in economic opportunity, healthy futures, and youth development. Although CNCS made its last SIF intermediary awards in fiscal year 2016, SIF intermediaries will continue to administer their subgrant programs until their federal funding is exhausted.

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