

The Impact of IRS Activities on At Risk Citizens

The IRS was asked during a telephone conversation:

“How many citizens die each year as a result of your activities?”

The response provided was immediate and without any hesitation:

“We are not required to provide those statistics”

Analyzing this afterwards reveals telling and indicting facts.

- 1) This response is clearly coached and representatives indoctrinated with prepared answers.
- 2) The IRS is aware of the fact that citizens are dying as a result of their activities.
- 3) The IRS has taken steps to block requests that they track these occurrences.
- 4) The IRS is not mitigating or reacting to potential at risk situations.
- 5) The IRS views such consequences as “collateral damage” and acceptable.

Now of course the 16th Amendment allows the government to discriminate against citizens based on their earned income and apply taxation accordingly. The consequences of this is the need to track citizens income and the subsequent bureaucratic burden this places. Unfortunately persons at risk due to mental health conditions and psychological behavioral patterns from birth are thereby facing additional severe discrimination that is not covered and allowed.

This 20% of the population is therefore at higher risk due to nothing more than their birth characteristics and make-up. This is not something those citizens can easily change, nor can it be simply outsourced to third party service providers to interact on their behalf, and often is associated with additional medical events in their lives, or the people around them.

For example, persons at risk of depression with introverted behaviors, their response is likely to be shutting themselves away and avoiding contact. The IRS response to that situation is unfortunately repressive, with a “guilty until proven innocent” action set including penalties, interest, asset seizure and placement of liens and levees. This can quickly become catastrophic for persons at risk.

Similarly persons with a natural distrust and rejection of authoritarian control will react to demands with discounting and ignoring. Again the quick trigger actions of the IRS to such behavior is unfortunate and then extremely hard to remediate.

But what of the IRS claim that they are “not required to keep statistics”? In today’s world there is rarely no smoking gun, and it turns out in this case also. The IRS aggressively actions property liens and those are public records. The death records nationally are also public records. Therefore by combining a search for death records where the IRS has a property lien we can see such correlations.

What can we expect from such results, that the IRS does not want us to know? Alarmingly the total number of related deaths over a ten year period runs into many thousands of people. This is a unique situation; while obviously government actions and legislations result in citizen deaths, those are indirect rather than direct, (excepting law enforcement responding to situations caused by citizens actions).

In this case of persons at risk the IRS is directly responsible and from bureaucratic actions by government against citizens.

Clearly what is needed is to replace the IRS with a new means of indirect taxation that is not directly levied against citizens. One that avoids discriminating against at risk citizens. The ability to enact and implement such a system is now possible for today's modern society. The proposal is called The FAIRtax and the corresponding legislation HR 25.

Recently we have seen the Supreme Court rule on discrimination for citizens based on their birth sexual orientations and overturn hundreds of years of entrenched bureaucratic government actions.

I would urge this committee to take all steps to immediately fast track adoption of the principles and methods detailed by the FAIRtax and to take this country forward away from the dark damaging and dangerous practices that have become norm for the IRS today.

Sadly this will all come too late for two of my friends who have taken their lives as a direct result of harassment from the IRS.

Ways and Means Committee Submission

1. All submissions and supplementary materials must be submitted in a single document via email, provided in Word format and must not exceed a total of 10 pages.
2. All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. The name, company, address, telephone, and fax numbers of each witness must be included in the body of the email. Please exclude any personal identifiable information in the attached submission.
3. Failure to follow the formatting requirements may result in the exclusion of a submission. All submissions for the record are final.

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American Society of Clinical Oncology

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Statement prepared for:
House Ways and Means Committee
Subcommittee on Health

Implementation of *Medicare Access & CHIP Reauthorization Act of 2015* (MACRA)
May 11, 2016

The American Society of Clinical Oncology (ASCO) is pleased to submit this statement in connection with the hearing entitled, “Implementation of *Medicare Access & CHIP Reauthorization Act of 2015* (MACRA).” ASCO is grateful to the Ways & Means Committee, particularly to this subcommittee, for their work to develop MACRA. We provided extensive feedback to you during development of the legislation, which we publically supported and promoted.

The collaborative environment you created resulted in overwhelming bipartisan support in both the House and Senate. As a part of the provider community, we appreciate this important step toward a more rational payment system and feel ownership over this as well. ASCO will continue to work with you and CMS to ensure this legislation works for oncology providers and their Medicare patients.

The emphasis on quality and value that underpins MACRA is entirely consistent with ASCO’s mission and work. For more than a decade, we have been focused on the delivery of high quality, high value care for every patient with cancer. Our longstanding performance measurement system, QOPI, is a qualified clinical data registry, which has a high degree of support and participation among our members. It is even beginning to penetrate international practices. We also are well on the path to building a rapid learning system for oncology, called CancerLinQ, which we believe will revolutionize cancer care. We are hopeful that these important systems can thrive under MACRA.

We support MACRA's emphasis on value over volume. ASCO is focused on the cost of cancer care and what it means for patients with cancer. We have developed a wide range of education and related tools that support and encourage patient-physician conversations about the cost of their care. We also have a robust portfolio of clinical guidance for physicians, including a value framework designed to inform and support shared decision-making and the selection of high value care options.

CMS Proposed Rule

CMS released a proposed rule on April 27, 2016, setting out potential regulations for implementation of two pathways for professionals to satisfy MACRA's requirements, the Merit Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs). While ASCO is still reviewing the 962 page rule, a few of our initial impressions are outlined below. We look forward to sharing our written response to the proposed rule with the Committee once it is finalized.

The Merit Based Incentive Payment System (MIPS)

MACRA established MIPS as the default physician payment system to replace the SGR-based physician reimbursement system. MIPS will provide positive and negative payment adjustment to physicians based on their performance across four performance categories. The performance categories are:

- The Quality Performance Category
- The Resource Use Performance Category
- The Clinical Practice Improvement Activity Performance Category
- The Advancing Care Information Performance Category

With the exception of the Clinical Practice Improvement Activity (CPIA) performance category, the new performance categories are based heavily on existing CMS quality and value improvement programs.

Resource Utilization

ASCO has weighed-in with CMS on a number of areas in implementation of specific importance to oncology. Although we support the transition to value-based payment, we remain concerned that the MIPS methodology for measuring resource utilization could unfairly penalize an oncologist who provides medically necessary care with high-costs that are outside of the oncologist's control. Currently, CMS assesses resource use through the Value-Based Payment Modifier (VBM), which is too blunt of an instrument to protect and promote high-quality oncology care. To be successful in implementing MACRA, policymakers must learn from and avoid the mistakes made in implementing the VBM.

The treatment of cancer is clinically complex and highly specialized, creating many factors that must be considered to accurately evaluate medical oncology resource use in a way that protects the interests of patients. There are more than 120 different types of cancer (and through advances in molecular diagnostics, this list is growing), and the most appropriate treatment option for a particular patient often involves the administration of a multi-drug regimen. In many instances, the selection of the most appropriate anticancer drug for an individual patient is based on the fact that there is a single molecular entity without any clinically equivalent substitute that provides a clear clinical advantage for the individual. In these common scenarios, the medical oncologist is left with little flexibility to reduce drug utilization costs by selecting lower cost alternatives. It is counterproductive to achieving the highest quality of care for a patient to force a provider to choose one therapy over another solely due to costs that are set outside of the oncologist's office.

Congress and CMS must not assume that variations in resource needs among patients and medical oncology providers will "average out" over time. It is common for medical oncologists to specialize in treating particular types or sub-types of cancer. There are some physicians and many oncology practices that specialize in treating the most complex—and often most costly—oncology patients. In some of those instances, there will be significant differences in resource consumption compared with other providers. We are especially concerned that if resource use measurement does not account for these clinical differences, CMS may inadvertently unfairly penalize practices and create access barriers for patients with complex and molecularly unique forms of cancer. Congress and CMS should take this situation into consideration for any process used to measure resource use in oncology and should not implement such a process until there is confidence the methodology will adequately protect quality and access to care for patients with these complex illnesses.

Given the factors described above, and because drug pricing is outside of the control of treating physicians, ASCO recommends that Congress and CMS adopt a more nuanced approach for evaluating oncology resource use. We urge Congress to work with CMS to exclude the use of raw drug expenditures in resource use determinations. Instead, CMS should assess drug resource use by evaluating adherence to evidence-based, value-based medical decision-making. ASCO endorses the use of high-quality clinical pathways in oncology as a mechanism to assess the provision of such care.

Appropriately designed clinical oncology pathways are detailed, evidence-based treatment protocols for delivering quality cancer care for specific patient presentations, including type and stage of disease. Clinical oncology pathways are a tool that can be used to appropriately align incentives for cancer patients and providers for resource use assessment in

cancer care. Pathways are being used by an increasing number of private payers to ensure evidence-based, value-based care for cancer patients. Used in this way, clinical oncology pathways can enable oncologists, payers, and patients to provide assurances that patients are receiving clinically appropriate therapies without unnecessary costs, including drugs. Oncology pathways balance the considerations of clinical efficacy, safety, toxicities, cost, and scientific advances, including the growing personalization of therapy based on molecular diagnostics.¹ Simply put, clinical pathways help to ensure that the right patient gets the right drug at the right time. Since compliance with appropriately designed oncology pathways define optimal care, medically appropriate concordance with pathway programs that have been developed and peer-reviewed by oncologists should be considered a major quality indicator.

In addition to drug costs, ASCO has serious concerns that CMS is failing to implement adequate risk adjustment to assess resource use in a way that fairly addresses differences in resource use among oncologists. Cancer care is incredibly complex and growing more so with each passing year, and the costs of cancer care are highly variable depending on a patient's diagnosis, cancer stage, molecular markers, geographic access to care, comorbidities and other clinical factors. In light of these complexities, it is imperative that CMS develop a risk adjustment methodology that will be specifically used to address cancer care. Traditional administrative claims data alone are insufficient to provide a desirable risk-adjustment methodology.

We urge Congress to provide oversight in this area to ensure that medical oncologists are not subject to unfair resource use measurement due to the clinical complexity of the patient populations they serve.

Quality Reporting

Ensuring that quality reporting is based on a provider's day-to-day practice is essential for MIPS to become a useful tool for quality improvement. While we are pleased to see that CMS would use quality measures that are included in the final MIPS quality measure list *and* quality measures that are used by Qualified Clinical Data Registries (QCDRs), we are concerned with some of the uncertainty surrounding the process for approval of QCDR measures. The proposed rule would require CMS to approve QCDR measures that are non-MIPS measures on a measure-by-measure basis before providers can report QCDR measures in lieu of reporting MIPS measures. There are currently no measure sets for medical oncology or radiation oncology under the MIPS measure list. Under the proposal, we could only speculate whether

¹ Zon RT, Frame JN, Neuss MN, Page RD, Wollins DS, Stranne SK, Bosserman LD. American Society of Clinical Oncology policy statement on clinical pathways in oncology. *Journal of Oncology Practice*. 2016 [epub ahead of print].

CMS would exercise its oversight over QCDR measures in a restrictive or timely manner. The CMS verification process should be implemented in a way that embraces the use of QCDRs to improve patient care and should not in any way slow the continued use of existing, robust QCDR measures or slow the adoption of new QCDR measures.

We thank Congress for its continued support of QCDRs by requiring their inclusion in MIPS. For more than a decade, ASCO has offered its members the ability to participate in the Quality Oncology Practice Initiative (QOPI), which is designated as a QCDR and focuses specifically on measuring and assessing the quality of cancer care. Congress should ensure that CMS does not weaken the protections in MACRA that exempt quality measures developed for use in a QCDR from many of the measure development process requirements that other MIPS measures will be required to undergo. This exemption is of critical importance because it will give QCDRs, like QOPI, the flexibility to innovate and develop quality measures that are clinically relevant to specialty practice.

We urge Congress to work with CMS to improve quality reporting in cancer care by promoting the use of quality measures that are important to patients and have meaningful impacts on the day-to-day practice of oncology. Failure to promote clinically relevant quality reporting will continue the “check-the-box” reporting attitude of many providers toward the Physician Quality Reporting System (PQRS) used by Medicare today.

Finally, it is essential that Congress continue to support the implementation of group quality reporting in QCDRs. The promotion of group reporting is critical for oncology, since individual oncologists will rarely have enough cases, within any given cancer diagnosis, to report data that is statistically valid and representative of practice patterns and overall performance.

Clinical Practice Improvement Activities (CPIA)

The creation of the clinical practice improvement activities category offers an opportunity for CMS to encourage providers to engage in activities that can meaningfully improve the quality of care they provide. ASCO supports an attestation-based system that allows providers and groups to attest to participation in activities that meaningfully improve the quality of care they deliver to achieve the full clinical practice improvement activity score. We strongly support that the proposed rule has recognized several aspects of QCDR participation as a CPIAs; however, we urge Congress and CMS to ensure that important activities such as ASCO’s QOPI Certification and provider participation in clinical trials should also be included in the proposed list.

Under the proposed rule, several of the listed CPIAs may interest oncology providers, such as participation in and use of data reported to a QCDR, participation in payment reform models sponsored by the CMS Innovation Center, and longitudinal and episodic care management.

Meaningful Use of Certified Electronic Health Records Technology

MACRA requires CMS to evaluate providers based on their meaningful use of certified EHR technology. Under the proposed rule, CMS has renamed the EHR meaningful use program: “The Advancing Care Information” and made it a performance category. Consistent with recent CMS directives, the Advancing Care Information (ACI) would move to a year-long reporting period, aligning with the other performance categories under MIPS.

Additionally, although the proposed rule would eliminate the clinical decision support and computerized provider order entry objectives from the program, the proposed rule would maintain most of the required measures and objectives in place for 2016. It would score MIPS clinicians and groups on measures and objectives that correlate to Stage 3 Meaningful Use.

For the first time, the proposed rule would allow for group reporting of ACI and would also allow for reporting through qualified registries and QCDRs. This is an important improvement over the Meaningful Use program.

We thank the House for passing *H.R. 6, the 21st Century Cures Act* which included a provision to encourage EHR interoperability. Continued efforts are needed to address the lack of widespread interoperability in the current health IT ecosystem and to alleviate administrative burdens of the meaningful use program prior to requiring full compliance with the meaningful use program to avoid adverse reimbursement consequences. Until widespread interoperability is achieved and the regulatory burdens associated with participation in the meaningful use program are lessened, Congress and CMS should not subject providers to penalties based on systemic problems that they had no role in creating.

Alternative Payment Models (APMs)

MACRA allows a second option for reimbursement through APMs. Participation in an Advanced APM would allow physicians to opt out of MIPS and receive an additional bonus over and above what is negotiated for a specific APM model.

ASCO's Alternative Payment Model

ASCO is encouraged by MACRA's strong emphasis on alternative payment models, and particularly the acceptance of those developed by physicians. ASCO has been developing and refining an APM for oncology since 2010. Our model, the Patient Centered Oncology Payment Model (PCOP), would fundamentally restructure the way oncology is paid for and better align payments with the patient services that are critical to delivering quality care.

PCOP was developed by a dedicated group of ASCO volunteers, who met once every two weeks for two years. The group included medical oncologists from diverse practice settings, seasoned practice administrators, and experts in physician payment and business analysis. ASCO used data from the National Practice Benchmark for Oncology and interviews with a sample of oncology practices to estimate the amount of time and money oncology practices are currently spending to deliver services to oncology patients—services that are not adequately supported by existing fee-for-service payments for office visits and infusions.

This model would also test many of the policy alternatives that have gained visibility recently, including bundled payments and episode based reimbursement. ASCO has estimated that PCOP would achieve savings for the Medicare program, while providing the necessary resources for oncology practices to provide high-quality, high-value cancer care. By matching payment more closely with actual care delivery, practices can organize care in a way that helps patients avoid expensive hospitalizations and unnecessary tests and treatments.

We believe that PCOP will qualify as an APM under MACRA because it meets the stated criteria in the law: includes quality measurement, requires more than nominal financial risk, requires the use of certified EHRs, and includes financial incentives. The Center for Medicare and Medicaid Innovation (CMMI) has its own model for oncology, the Oncology Care Model (OCM), which some have argued should suffice as the only oncology-specific APM. However, CMS should ensure that multiple oncology-specific APMs are available, including PCOP, to ensure that CMS explores multiple approaches to reforming oncology reimbursement. We believe that Congress intended to foster innovation and experimentation to reform Medicare reimbursement when MACRA was passed and that testing multiple approaches in oncology is preferable, given its clinical complexities.

ASCO is grateful for the pathway outlined in MACRA for physician developed APMs. CMS intends to keep the Physician Focused Payment Model Technical Advisory Committee (PTAC) process separate and independent. We are aware the PTAC is just forming, and we are hopeful it provides—as you intended—a meaningful opportunity for review and approval of high quality APMs like ASCO's PCOP, however we are concerned that there is still no assurance

the PTAC will review and recommend models to be tested as new payment models by CMS. In fact, CMS proposes to maintain CMMI's flexibility "to test models when it believes that it is the right time to do so, taking into account other models it is currently testing..." As part of demonstrating the criteria above, CMS proposes that payment models must address how it is different from current Medicare payment methodologies, and why the payment methodology cannot be tested under current payment methodologies. If this pathway does not work as intended, we hope that Congress will intervene and establish a clear pathway for implementation of APMs recommended by the PTAC.

Preparing Our Members for MACRA

In closing, we want to make the Committee aware of work ASCO is doing to prepare its membership to be ready for MACRA implementation. ASCO is using all the communications vehicles we have available to educate and inform our members about MACRA's ongoing implementation. We hope that oncologists can be among the best prepared specialists in the nation. While our hopes remain high that multiple APMs will be available for oncology, we know that many, if not most, of our US members will be in MIPS. To that end, we are encouraging participation in Meaningful Use, PQRS, and ASCO's own QCDR.

We've held full day seminars at our office in Alexandria, VA, nationwide webinars, presentations at state society meetings, and presented at ASCO's annual meeting so that all of our members have an opportunity to receive training on MACRA implementation. We have recruited a dedicated committee of ASCO's highest committee leadership to work on implementation and view it from broad perspectives. Additionally, we've conducted practice readiness assessments at individual sites to help practices understand what steps they will need to take ahead of MACRA implementation.

When appropriate, we will share APM information and help prepare our membership for all APMs available in oncology.

We know that there is much work ahead and we stand ready to work with Congress and CMS to ensure successful implementation of MACRA. We look forward to working together.

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Thank you for your leadership on passage and continued oversight to ensure successful implementation of MACRA. We look forward to continued work with you and your staff to ensure that Medicare beneficiaries have access to oncology services moving forward. Please contact Kristin McDonald at Kristin.McDonald@asco.org with any questions.



INSTITUTE *for* CHILD SUCCESS

**Comments for the Record of the
Hearing to Markup Bills to Improve TANF
In the Full Committee on Ways and Means
On May 11, 2016**

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Introduction

The Institute for Child Success is excited by the continuing progress in Congress regarding Pay for Success financing models (sometimes called Social Impact Bonds) that can advance the well being of young children and their families. We thank Chairman Brady for holding this hearing, Representatives Young and Delaney for their leadership on H.R. 5170, and also the many members of the committee who have joined in co-sponsorship. We were also excited to see that the provisions encompassed a range of outcomes, especially including education and health outcomes, that are sometimes overlooked when working to advance the self-sufficiency of needy families. Indeed, failing to meet a basic threshold for those outcomes will often preclude improved workforce outcomes for families.

The Institute for Child Success respectfully submits the following written comments to the hearing record for your consideration. In these comments, we begin with an overview of our perspective on the benefits of Pay for Success financing. We then discuss the substantial benefits of federal involvement, the reasons that legislation is necessary for meaningful federal engagement, and the ways in which this legislation responds to that need. Finally, we address some specific questions and concerns that were raised during the hearing, regarding how Pay for Success works both in practice and as defined in H.R. 5170.

Though H.R. 5170 deals with a broader array of Pay for Success or Pay for Performance tools, and the Institute for Child Success is generally supportive of those tools, we limit our comments here to the model that is sometimes called “Social Impact Bonds” or Pay for Success Financing.

Benefits of Pay for Success Financing (or, Social Impact Bonds)

Pay for Success financing is a model that can help effective interventions scale up to improve outcomes for young children and their families, while reducing or eliminating financial risks to the taxpayers. The fundamental structure is well known to many, so we will only provide a very brief overview here. That most basic theoretical structure involves four pieces:

- An intervention that has been tested, and has demonstrated that it reliably produces outcomes;
- Investors who provide the upfront capital required to bring the intervention up to a larger scale;
- A government entity that is interested in paying for those outcomes – sometimes using funds saved as a result of those outcomes – if the agreed-upon success measures are achieved; and
- An independent evaluator that determines whether the intervention accomplishes the pre-determined measures of success and, therefore, the government should repay the investor.

Because of the relative novelty and complexity of these projects, a third-party intermediary has also been involved in many of the Pay for Success contracts entered into to-date.

Pay for Success financing provides a number of benefits over traditional government mechanisms for selecting and scaling up interventions, including:

- It allows governments to shift resources towards effective prevention and early intervention;
- It draws on expertise and energy from outside investors, who bear much or all of the financial risk if a program is ultimately not as effective as expected;
- A rigorous cost and benefit analysis is necessary to even consider a Pay for Success arrangement, increasing the ability of the government to invest wisely;
- Outcome tracking is a centerpiece at every step, allowing the necessary tracking processes to be “baked in” to an intervention from the very beginning; and
- While Pay for Success *does not* privatize critical government services (such as remedial education, criminal justice, or the like), it *does* hold the potential to reduce the overloaded demand on many of those services, allowing them to better fulfill their missions.

Pay for Success and Effective Early Childhood Interventions

As we discussed in our 2014 brief on this topic, Pay for Success is particularly well suited to help scale effective early childhood interventions.¹ Many interventions exist today with long-term outcomes that are independently compelling, create significant value for governmental entities, and produce outcomes that advance TANF’s goal of improving family self-sufficiency and improving workforce engagement. Those outcomes include:

- More economically independent mothers,
- Reduced incarceration rates,
- Fewer teen pregnancies,
- Fewer closely spaced second births and fewer preterm second births,
- Fewer injury-related visits to the emergency room,
- Reductions in child maltreatment,
- Less youth crime,
- Higher achievement in school or careers, and
- Increased lifetime earnings.

Yet despite wide agreement that we should develop and implement these effective early childhood interventions broadly, it is very challenging to do so. Many governmental agencies are working to

¹ Institute for Child Success. *Pay for Success Financing for Early Childhood Programs: A Path Forward*. 2014. Available at: http://www.instituteforchildsuccess.org/mydocuments/pay_for_success_financing_for_early_childhood_program2.pdf.

implement effective early childhood interventions, but those efforts are far from full-scale. Two barriers stand out:

- 1) **Resources are tied up in responding to problems, leaving little room for prevention.** Governments are busy putting out fires – that is, responding to problems after they happen – and after more cost-effective responses are no longer an option. Given the fiscal and political pressure faced by all governmental entities, government is rarely able to devote sufficient up-front resources to developing or implementing effective methods to prevent problems in the first place, even if those approaches would save money in the long run. For instance, the Institute of Medicine has documented the costs of failing to focus on prevention, finding that many mental, emotional, and behavioral disorders in young people are preventable, but that prevention remains underfunded.²
- 2) **The costs of wide-scale implementation are immediate, but the payback takes time.** Although many programs will deliver both social and financial returns, those benefits take time. Governments often find it difficult to afford investments with delayed returns.

Pay for Success can help address both of those barriers. Governments are able to implement tested interventions without immediately burdening the budget, since the model allows governments to wait until the relevant outcomes are met before payments must be made. If those interventions are ultimately effective at scale, then any resulting cost-savings can be used to help repay the investors' principal and any premium that is agreed to at the outset. Moreover, if the interventions do not produce the agreed-upon outcomes, then the government does not have to pay.

Why Does the Federal Government Need to Get Involved

One of the questions that often arises in discussions about Pay for Success is this: Why is it important for the federal government to get involved? The simple answer is that many effective interventions produce positive results and save money at both the federal and state or local levels, and - for many of those - the federal government has a significant interest. For example, some two-generation early childhood interventions result in the improved birth spacing and more economically self-sufficient mothers, and therefore reduce dependency on programs like TANF. Congress should, therefore, position federal programs to foster and leverage those outcomes. If it does so as structured in H.R. 5170, both states and the federal government will benefit.

² National Research Council (US) and Institute of Medicine (US) Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults. *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*. 2009. Available at <http://www.ncbi.nlm.nih.gov/books/NBK32775/>

In addition, the federal attention and support for outcome-based payments will incentivize jurisdictions around the country to increase accountability for outcomes in government programs. Identifying the most effective programs and tracking their outcomes requires capacity and effort. This legislation will support and incentivize jurisdictions to build that capacity. The result will be more cost-effective government investments and better outcomes for our communities and our country.

Why Do We Need Legislative Action to Support Pay for Success

The typical appropriations process presents two significant barriers that prevent agencies from engaging in meaningful Pay for Success deals, both of which are addressed by H.R. 5170. First, federal appropriations typically have to be "obligated" by September 30 of any given fiscal year. What we've learned over the last few years is that many of these deals take more than one year to develop to the contract-signing phase. Knowing that the money may evaporate after months of diligent work, but before a deal is finalized, is a substantial hurdle.

Second, federally appropriated dollars typically have to be disbursed within 5-years after the fiscal year in which they are appropriated (under 31 U.S.C 1552(a)). Many Pay for Success contracts are best suited to something a little longer than a 5-year window, if only because most programs take a couple of years to reach scale, and long-term outcomes may take several years to be fully measured after that. As an example, the first Social Impact bond out of the United Kingdom was a 6-year contract.

Both of those barriers require Congressional action, but the fix is relatively simple and is handled in H.R. 5170. However, there is a larger challenge the federal government will face as it engages in Pay for Success financing projects, and that is a challenge of human capital. Federal entities are generally not experienced in this field, and we need to develop that expertise in a deliberate fashion. Through the commission created in H.R. 5170, we can begin building expertise throughout the federal systems, allowing us to operate more efficiently in this field going forward.

What are the Limitations and Challenges of Pay for Success Financing

As with any exciting new model, it is easy to lose sight of the limitations and challenges. There are some problems for which Pay for Success is simply not a solution. For example, it does not provide a sound model for providing ongoing funding programs, or for encouraging better evaluation of programs, that are already operating at scale.³ It also is not yet well-suited to fund untested innovations (though, a robust Pay for Success mechanism might encourage novel innovations to look to earlier evaluations).

³ Some Pay for Performance systems, which are supported also by H.R. 5170 but are beyond the scope of these comments, would allow for ongoing funding and evaluations.

Similarly, Pay for Success might not make the most sense for those specific services in those rare circumstances where success is nearly guaranteed, because the model does involve premium payments in exchange for investors bearing the risk of failure. In a case where there is virtually no risk, then the investment would be less beneficial from a financial perspective. Even in that scenario, however, Pay for Success financing may provide governments with the fiscal relief they need to help shift resources from remediation towards prevention by enabling them to pay at the end of the project rather than at the beginning.

Moreover, Pay for Success financing deals are difficult to put together, from a technical perspective, so they are currently only appropriate for larger projects where the benefits exceed the transaction costs.

What are some of the technical challenges of Pay for Success financing?

- **Identifying rigorously tested interventions:** We have to find and develop interventions with rigorous evidence of outcomes. There are many interesting interventions out there with great confidence in, but little proof of, their results. So the first hurdle is identifying the rigorously tested programs, and then also encouraging promising programs to develop the kind of evidence that investors and governments need. H.R. 5170 draft wisely emphasizes the importance of feasibility studies to address both of these issues.
- **Identifying governmental entities:** One difficulty here flows from the fact that many governments are interested in this model primarily for interventions that produce net cost savings (in that they cost less now than they save later). However, those savings may spread among various governmental entities, especially with early childhood interventions, from Medicaid to juvenile justice to education. It is sometimes difficult to find a single agency that reaps enough of the benefits, then, to afford the full costs of a successful program. H.R. 5170 addresses this issue in two ways. First, it provides for a single entity that can look at benefits across the federal government and, second, the legislation is created to support state and municipal deals that impact federal priorities.
- **Identifying appropriate outcome metrics:** We have to be very cautious to identify outcome metrics with which the service providers, the investors, and the government are all comfortable. This is one of the most challenging elements, particularly with respect to concerns over creating perverse incentives. PFS financing should avoid the danger that providers will “game the system” by determining outcomes compared to a control group or a matched comparison group. If the evaluation is well designed, any changes in how outcomes are counted will affect both the program group and the control group and thus will not translate into better results. This challenge is also why building expertise and collaboration within the federal contracting system – as H.R. 5170 envisions – is critical to long-term success.

- **Building the system to measure success:** As mentioned above, a centerpiece of Pay for Success financing is rigorous and ongoing outcome measurement, which is challenging for even the best-resourced programs. Pay for Success, however, builds that evaluation into the model from beginning to end, and in such a way that it cannot get lost in the shuffle – investors only invest, and only get a return, if successes are measured and verified by an independent evaluator. H.R. 5170 supports that model by expressly requiring that the evaluation mechanisms be identified at the beginning.

Given these difficulties, why is so much progress happening anyway?

- **Investors are asking for it:** We frequently hear from bank executives that their high-net-worth clients increasingly seek investments that are aligned with their values. More and more, the industry is focusing on generating both direct financial returns *and* positive social outcomes.
- **Governments are looking for more cost-effective strategies to achieve public goals:** Governments – at all levels, but including the Federal Government through TANF and other programs – spend a tremendous amount of resources responding to crisis situations and providing remediation services. Those governments would normally have to sacrifice some of those critical services to invest resources in early interventions. Pay for Success allows governments breathing room to pay for interventions, in full or part, out of the long-term savings they produce. Moreover, Pay for Success financing helps governments move in a direction they are increasingly interested in: toward analyzing benefits and costs of specific strategies and choosing the ones that produce the best value for taxpayers.

Specific Questions and Concerns Raised During the May 11, 2016 Markup

We were encouraged to hear members of the Committee asking exactly the type of questions we should be thinking through during the May 11 hearing. Committee staff provided helpful answers with regard to the specific provisions of the bill, and we would like to add additional context here from the history of the Pay for Success field.

Many of those questions asked what guiderails or other protections are included in H.R. 5170 against potentially problematic provisions in a contract. Fundamentally, the first round of protections occurs before a proposal is submitted to the Commission envisioned by H.R. 5170. That proposal has to describe a range of decisions with which local governments, local service providers, and local investors have agreed. Each of those entities have to be comfortable with: the definition of what success looks like; who will independently evaluate that success; the costs associated with the project, the potential return for the investors; and – of course – who each of the parties to the agreement will be. The federal government’s role, as envisioned in 5170, is predominantly then determining the value to the federal government from the deal and – based on that valuation – which projects (if any) are the best investments for the federal government to support.

We go into more specifics below based on the history of PFS transactions in the US. More detail on those transactions can also be found using some publicly available resources. ICS has produced a summary matrix of the first nine US deals, which includes information about investors, evaluators, intermediaries, providers, and the jurisdictions involved. That summary is available online at <http://bit.ly/PFSSummariesApril2016>. Two subsequent projects have also been announced in South Carolina (fact sheet here: <http://bit.ly/PFSSouthCarolinaDHHSApril2016>) and Connecticut (press release available here: <http://bit.ly/PFSConnecticutPressReleaseFeb2016>).

Speaking to specific questions and concerns discussed during the hearing:

- **Who are the evaluators associated with these projects?** Prior evaluators have included: the Burnes Institute for Poverty and Homelessness; the Center on Urban Poverty and Community Development at Case Western Reserve University; the Evaluation Center at the University of Colorado Denver; J-Pal North America at the Massachusetts Institute of Technology; MDRC; New York State Departments of Labor Research and of Correction and Community Supervision Research; Root Cause Institute, Inc.; Sibalytics LLC; SRI International; University of California San Francisco School of Medicine; the Urban Institute; Utah State University's Early Intervention Research Institute.
- **Who selects the evaluator that ultimately determines if a project is successful? Does the investor have a say in the selection process?** This decision is part of the overall contract negotiation process. Investors would typically have to agree to the selection of an intermediary prior to entering into a contract, as would any jurisdictions or service providers who are parties to the contract.
- **Who are the investors associated with these projects?** Prior investors have included a range of philanthropic organizations, non-profit organizations, private investors, and banks, including: Adobe Services, Inc.; Bank of America Merrill Lynch; the Ben and Lucy Ana Fund at the Walton Foundation; Living Cities; Blended Catalyst Fund; Bloomberg Philanthropies; the BlueCross BlueShield foundation of South Carolina; the Boeing Company; the Boston Foundation; the California Endowment; the Cleveland Foundation; the Colorado Health Foundation; the Corporation for Supportive Housing; the Denver Foundation; the Duke Endowment; Finnegan Family Foundation; the George Gund Foundation; Goldman Sachs; Google.org the Health Trust; Greenville County, SC First Steps; J.B. and M.K. Pritzker Family Foundation; the James Irvine Foundation; the Kresge Foundation; Laura and John Arnold Foundation; Living Cities; New Profit Inc.; Nonprofit Finance Fund; Northern Trust; the Piton Foundation; the Reinvestment Fund; Roca Inc.; Robin Hood Foundation; Rockefeller Foundation; Santander Bank; Sisters of Charity Foundation of Cleveland; the Sobrato Family Foundation; Third Sector Capital Partners, Inc.; the United Way.

- **Are there limits to the return investors can get? Who determines the rate of return?** The rate of return at various levels of success is part of the overall contract negotiation process. All parties would typically have to agree to the repayment terms prior to entering into a contract. To protect against potential windfall returns, in the event that a project succeeds beyond expectations, contracts can include a cap on the total returns. This was the case in Utah's pre-k project, which included a cap at 5 percent above the municipal bond rate. Local parties in future transactions can similarly tailor the risk and return profiles to best suit the local needs.
- **Can investors terminate their efforts in these projects early? Do the contracts have parameters regarding grounds for investors terminating their effort in a project?** Contingency plans for winding down a project early are typically also included in the contract negotiation process, and those plans would be agreed to by all parties as part of that process. For instance, the project at Rikers Island included two interim evaluations; if the project was not performing as expected, the investor could wind down the project. Approximately 2 years into that 4-year project, the first interim evaluation showed that the intervention was not producing the desired outcomes, and the project ended.
- **Who are the intermediaries associated with these projects?** Not all projects have included an intermediary, though most have. Prior intermediaries and/or borrowers have included: the Corporation for Supportive Housing; Enterprise Community Partners; IFF; Massachusetts Alliance for Supportive Housing; Social Finance US; Third Sector Capital Partners; the United Way of Massachusetts Bay and Merrimack Valley; the United Way of Salt Lake; and Vera institute of Justice.
- **Who determines 'success' or outcomes in a Pay for Success project? Do investors determine success?** The definition of success is the core feature of the contract negotiation process; the definition must be something for which a jurisdiction is willing to pay, service providers are willing to be held accountable, and investors are willing to accept the risk. Each party is critical in shaping the picture of success and how it will be measured.
- **At what point(s) do these projects determine they have achieved 'success'?** The timeline for determining success and outcome payments is also detailed during the contract negotiation process. Timeline is determined based on the time needed to achieve the outcomes of interest as well as the appetite of investors for short- or long-term investment. Prior project have been scheduled to last for: 4, 5, 5.5, 6, 7, 12, and 17 years.
- **How are the players in a project chosen? At what point in the process are the investors engaged?** The choice of parties is very closely related to the definition of success, level of acceptable risk, and the rates of return. As such, investors are often engaged relatively early in

a deal structuring process. However, the exact timeline of the engagement of potential investors varies widely and has sometimes occurred after months of preliminary negotiations between jurisdictions and service providers.

- **If a feasibility study was an early element of the project, what was the timeline associated with its development?** The time and cost associated with a feasibility study varies widely based on project needs, and only some are published or publicized. We have seen several studies that take between several months and a year.

Conclusion

Pay for Success Financing is a promising tool for improving social outcomes and government efficiency. The Institute for Child Success is encouraged by the attention this financing model has received by our elected officials at the federal level, and we are even more encouraged by the Committee's positive vote on H.R. 5170. This financing model is challenging, especially for the federal government, but has tremendous potential for improving our collective fiscal position while directly improving social outcomes. We look forward to continued work with the Committee and Congress on this issue in the weeks and months to come. Thank you for the consideration of these comments.

About the Institute for Child Success

Headquartered in Greenville, South Carolina, the Institute for Child Success (ICS) is an independent, nonpartisan, nonprofit research and policy organization dedicated to the success of all young children. ICS pursues its mission in four primary ways: proposing smart public policies, grounded in research; advising governments, nonprofits, foundations, and other stakeholders on strategies to improve outcomes; Sharing knowledge, convening stakeholders, embracing solutions, and accelerating impact; and fostering the next generation of leaders. For more information, please visit: www.instituteforchildsuccess.org.