POLICY

Medicare Advantage Plan Representatives' Perspectives on Pay for Success

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ABSTRACT

OBJECTIVES: To understand how Medicare Advantage (MA) plan representatives perceive the alternative financing model Pay for Success (PFS) and its potential to address members' social risk factors.

STUDY DESIGN: Semistructured qualitative interviews designed to understand plan representatives' priorities regarding addressing nonmedical needs of their members, awareness of and experiences with PFS, and thoughts about implementing PFS as a method to address members' nonmedical needs.

METHODS: Interviews with 38 upper-management representatives from 17 MA plans, which represent 65% of MA beneficiaries nationally, were conducted from July to November 2018. Plans varied in geographic coverage, star rating, and enrollment. Transcripts were qualitatively analyzed to understand overarching themes and patterns of responses.

RESULTS: MA plan representatives were largely unfamiliar with PFS and were interested in learning more about how it could address members' social needs. When probed about specific requirements of PFS, responses varied: Some reported willingness to share data with project partners and be reviewed by independent evaluators; others expressed their preference to keep data and performance analysis internal to the organization. Although most representatives prioritized innovation, some were more risk averse and preferred to use traditional methods to deliver new services.

CONCLUSIONS: MA plan representatives were unfamiliar with PFS, but most expressed interest in it as an alternative model for funding initiatives to address members' social needs. Education of MA representatives about PFS as an alternative payment model for innovative programming is warranted. However, further guidance from CMS is needed to assuage the concerns raised by these representatives.

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Pay for Success (PFS) is a model whereby investors provide capital to fund an intervention to address social, health, or environmental needs.[1,2] In particular, PFS allows for initial financing of evidence-based programs to address social risk factors[3] for vulnerable groups.[4,5] The success of the initiative is evaluated by an independent entity and the investor is repaid by the outcome funder if the predetermined, contracted outcomes are achieved.[6] PFS reduces the financial risk of innovation for funders by shifting up-front payment responsibilities to more risk-tolerant investors. PFS also allows greater evidence and data to be collected to inform future programmatic decision making.[7] PFS projects have been implemented in 20 countries to date (including the United States, Canada, the United Kingdom, the Netherlands, and several other European countries), targeting housing, behavioral health, foster youth, early childhood education, and chronic disease, among other issues.[4] Twenty-two percent of PFS projects are US-based,[4] and although these projects are still in progress, early reporting indicates that many are achieving their predetermined outcomes.[8-10]

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Despite the recent growth of PFS initiatives in public health and their potential to address the historic underfunding of programs to target social risk factors in the United States,[11] there has been limited adoption of these initiatives in the healthcare sector. One area of healthcare that could potentially benefit from PFS is the Medicare Advantage (MA) program. MA is the fastest-growing segment of the Medicare market,[11] now covering more than one-third of all Medicare beneficiaries.[12] MA plans are paid on a capitated basis, receiving a set annual amount to cover the comprehensive needs of their members each year. As a result, MA plans may have an increased incentive to improve outcomes and reduce costs. Unlike traditional Medicare, MA plans may offer supplemental benefits outside of standard medical care, including fitness memberships, vision care, nursing hotlines, and case management. The Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act passed in 2018 expanded the definition of supplemental benefits to include nonmedical services (eg, caregiver support, in-home supportive services, adult day care) and newly allows

TAKEAWAY POINTS

- Pay for Success (PFS) is an alternative model of financing innovative services with potentially substantial public health impacts.
- PFS projects have been implemented in 20 countries, targeting issues such as housing, behavioral health, and chronic disease. However, PFS has yet to be used in Medicare Advantage.
- Through qualitative interviews with representatives of plans covering 65% of Medicare Advantage beneficiaries nationally, we found that although most were unfamiliar with PFS, they expressed interest in it as a model for funding initiatives to address social risk factors.
- Further education of plan representatives about PFS is needed, and further guidance from CMS is required to assuage plan representatives' concerns.

plans to target these benefits to specific populations beginning in 2020.[13,14] This new flexibility for supplemental benefits could be instrumental in addressing upstream social risk factors and presents an opportunity to consider the ways in which MA plans may use PFS as a financial risk mitigation tool to experiment with offering new services and benefits.

PFS may provide MA plans a valuable opportunity to offer expanded benefits and services to their members without assuming additional financial risk. In a PFS model, MA plans could test innovative programming that addresses nonmedical needs, and if program outcomes are successfully achieved, the MA plan could then incorporate those services into their benefits packages. Additionally, PFS projects with well-defined, targeted outcomes measures would contribute to the creation of a larger evidence base to further support the value of addressing nonmedical needs in this population. Despite this potential, little is known about MA plan leaders' perceptions or awareness of PFS. The purpose of this research was to understand MA plan leaders' interest in uptake of PFS and the barriers and opportunities that they see to PFS adoption.

METHODS

Context

This research was an exploratory aim of a larger project that sought to understand the experiences of 1 MA plan, henceforth referred to as plan A, that had considered implementing a PFS project. For more information, see the recent study by several of this paper's authors.[14] We conducted a preliminary interview with representatives of plan A with the goal of understanding the opportunities and barriers to implementing PFS in the MA environment. We then interviewed representatives of 16 additional MA plans in an effort to see if they shared the perspectives revealed by representatives of plan A about the attractiveness of PFS and potential barriers to implementing a PFS project.

Sampling

We conducted semistructured interviews with representatives from 17 MA plans around the country that represent more than 65% of MA beneficiaries nationally. Following our preliminary interview with the representatives of plan A, we began with a convenience sample of known MA contacts and solicited contact information for representatives of other plans upon completion of each interview. We continued to recruit representatives of plans with varying characteristics (ie, plan enrollment, star rating, age of organization) and geographic locations until saturation was achieved.[15] For each plan, we asked to speak with those knowledgeable about the interview topics, and representatives self-identified.

Procedures

Based on our preliminary interview with representatives from plan A, we designed semistructured interviews to understand MA plan representatives' knowledge of and receptivity to PFS initiatives. We drafted the interview guide (**eAppendix** [available at **ajmc.com**]) and reviewed it among the project team and advisors, including research and industry experts in PFS and MA. In advance of each interview, representatives were emailed the interview guide and information about PFS. This was done to ensure that the most appropriate leaders from each plan participated in the interview and that operational definitions when discussing PFS were universally understood. Interviews were conducted over the phone and recorded (with representatives' consent), and lasted about 1 hour. This project did not require institutional review board review as it was deemed not to be human subjects research by the Brown University Institutional Review Board.

Qualitative Analysis

Interview transcripts were qualitatively analyzed using a modified grounded theory approach to identify overarching concepts and themes.[16-19] We first developed a preliminary coding scheme based on the questions asked in our interview protocol, then adjusted the scheme in an iterative process to add codes and refine code definitions. Initially, all qualitative analysis team members (4 of this paper's authors: E.A.G., T.F.W., E.M., J.F.B.) read and individually coded the first 2 transcripts. In subsequent team meetings, we discussed and refined the coding scheme and code definitions according to how well the codes fit the transcript data. We discussed preliminary patterns that we perceived in the data and reconciled our interpretations of the first coded transcripts. We continued this process, with at least 2 team members coding each transcript independently, then meeting to reconcile codes, discuss potential themes, track prevalence of these themes across transcripts, and search for competing interpretations. During analysis, we kept a comprehensive audit trail that recorded ongoing team decisions, including selection and definitions of codes and discussion of emerging themes.[17,20-23] Coded data were entered into Nvivo (QSR International; Melbourne, Australia) to allow for comparative and relational analyses across themes.

RESULTS

Plan and Representative Characteristics

The 17 participating plans varied in their geographic coverage, enrollment, star rating, and organizational age. Plan characteristics are provided in **Table 1**. Interviews were conducted with 1 to 6 participants per plan for a total of 38 representative participants. Representatives included those in upper-level management roles (eg, president, chief medical officer, vice president of medical affairs, director of health policy) who had been in their positions between 1 and 30 years.

TABLE 1. Organizational Characteristics[a]

Plan	National/ Regional	Age of Organization in Years	Star Rating	Plan Enrollment
A	National	>50	3-4	>3,000,000
1	Regional	10-50	<3	<50,000
2	National	>50	3-4	>3,000,000
3	Regional	10-50	3-4	100,000-250,000
4	Regional	10-50	3-4	50,000-100,000
5	National	<10	3-4	<50,000
6	Regional	>50	>4	50,000-100,000
7	Regional	10-50	>4	50,000-100,000
8	Regional	10-50	New	<50,000
9	Regional	10-50	>4	100,000-250,000
10	Regional	10-50	>4	100,000-250,000
11	Regional	>50	>4	100,000-250,000
12	Regional	10-50	>4	<50,000
13	National	>50	3-4	250,000-500,000
14	Regional	10-50	>4	50,000-100,000
15	National	>50	3-4	500,000-1,000,000
16	Regional	>50	>4	100,000-250,000

[a]Data were rounded to protect organization anonymity.

Findings From the Interview With Plan A

Results from the preliminary interview with representatives of plan A revealed nuanced perspectives regarding PFS. Plan A made efforts to engage in a PFS model to address members' nonmedical needs. Initially, they met with a community-based organization about providing an intervention to target food insecurity among their members. Representatives from plan A indicated that they "like the Pay for Success model" because it "mitigates [their] risk" in testing innovative services. Ultimately, however, plan A decided not to pursue the PFS approach, instead opting for a more familiar model (plan–vendor contract). Representatives from plan A noted that a major barrier to the PFS model was that the cost of a new benefit might potentially be incorporated into premiums and borne by the plan's members, before it is known if the outcomes will be achieved: "In a [PFS] model, we don't have confidence that if it's not successful, then the cost to [the member] will be zero. And yet, we've already priced something into the plan for the end patient to pay. If we pay nothing and they have to pay something, the government's not going to like that" (plan A).

Representatives from plan A also described hesitancy with regard to sharing data with project partners and having outcomes evaluated by an independent third party. Although such sharing is often a component of plan–vendor contracts, this was highlighted as a potential barrier to PFS. Additionally, representatives from plan A described that although they perceive PFS to be potentially valuable, they would like more of a "blueprint" for how it could be implemented before they engage in it themselves. Plan A representatives further discussed the concept of risk aversion and how uptake of PFS might be limited by the fear of "jeopardiz[ing]" their relationship with CMS—they were concerned about operating within CMS' existing parameters. For representative quotes, see **Table 2**.

Findings From the Interviews With Additional MA Plans

The interviews carried out with representatives from 16 other MA plans revealed that representatives were largely unfamiliar with PFS compared with those from plan A, although they were receptive to further exploring its potential value. When probed about specific components of PFS, including willingness to share data and taking on the risk associated with an alternative payment model, representatives had varying responses. These themes are discussed here.

Awareness of and receptivity to PFS. Representatives had a range of familiarity with PFS. Some had never heard of PFS or first discovered it as a result of our sending introductory materials for the interview, some had "read about it" but did not have "personal experience" (plan 1), and others were more familiar with PFS, indicating that PFS had been discussed at recent board meetings (plan 7) or that they were collaborating with consultant groups to think through the possibility of implementation (plan 16). Representatives recognized the potential of PFS to address members' social risk and mitigate the financial risk of a new intervention. They suggested that PFS was "right up our alley" (plan 13) and that it "fills a gap" (plan 3). Representatives also expressed interest in receiving more information about this payment mechanism (plan 1). Other representatives highlighted potential barriers to PFS, including a desire for additional evidence. Representatives were hesitant to be among the first to implement PFS (plan 8) and expressed concerns about both incorporating this model "within the confines of CMS" (plan 11) and achieving a balance of risks and rewards (plan 9). For representative quotes, see **Table 3**.

Receptivity to data sharing and working with an independent evaluator. Representatives discussed their willingness to share data with external partners, as well as their receptivity to having outcomes assessed by an independent evaluator. Representatives described their plans as being "very open and hav[ing] a desire to continually evaluate the efficacy of our work" (plan 11), but they also highlighted that they must "know at the beginning" of the relationship with service providers and evaluators what they will be collecting and measuring and "build that into the work effort"

TABLE 2. Illustrative Quotes of Findings From the Interview With Representatives of Plan A

Key Words	Quote
Like PFS, mitigates risk	I like the [PFS] model. I'd love to test it out, because it, theoretically, down the road, would open up more opportunities to test things without a lot of evidence, [see whether] they're successful. It mitigates our risk a little bit.
Cost of benefits priced into plan and borne by plans' members	The challenge is, when you're designing a plan that the government's going to have to approve, any benefit that goes in, we price to the premium that gets charged back to the patient. In a [PFS] model, we don't have confidence that if it's not successful, then the cost to [the member] will be zero. And yet, we've already priced something into the plan for the end patient to pay. If we pay nothing and they have to pay something, the government's not going to like that....They're not comfortable with us charging patients for something that we may or may not end up paying for.
Hesitancy sharing data and having outcomes evaluated by third party	It's always an issue when we're sharing data outside the walls....What I would say is, we have really sophisticated analytics inside our organization. Typically, we like to do it all ourselves in-house, so that we're confident in the numbers. Trusting a third party to do it would involve a leap of faith. Not to say it can't be overcome, but we would obviously have to agree up front, between all parties, about who the third-party evaluator is, their credentials and experience and so forth. Then, [we'd have to see] if there's a way to somehow allow for some corroboration with some internal analysis.
Would prefer "blueprint," additional guidance from CMS	I think that one of the biggest hindrances, too, is just the amount of risk that's involved with it, based on the fact that this is unprecedented with CMS....Until they really think that they're willing to embrace these new, innovative concepts, like an innovative funding model, I don't know if we're going to really have a blueprint as to how to best implement this. It really is a challenge.
Risk averse, fear of jeopardizing relationship with CMS	I think you have to have a culture that's willing to experiment and push the envelope a little bit sometimes. I think that's on the positive side. On the opposite side, sometimes when you're a big company that's heavily reliant on government contracts, there's a tendency to go ultraconservative, because you understand the model of how to be profitable... so anything that deviates from that jeopardizes the model that's in place....We are such a large Medicare company [that] we aren't going to jeopardize our relationship with CMS. While we're willing to take some risks and look at new, innovative models, we do have to operate within those parameters.

PFS indicates Pay for Success.

(plan 7). Representatives also highlighted the need to be confident that they are working with "appropriate partners" (plan 5). Such representatives were also willing to work with an independent evaluator for the purposes of assessing whether or not predefined outcomes were achieved. Some representatives reported working with third-party evaluators "many times in the past" (plan 6) and employing "external partners" to assess outcomes (plan 16). However, other representatives expressed hesitancy to share data with outside evaluators, preferring instead to conduct evaluations in-house (eg, plans 3, 4, and 9), or they highlighted barriers to sharing data outside of their organization. Some representatives described their plans as "very hesitant to share our data outside of our organization" (plan 8), citing "a really high bar...dictated by federal and state law" (plan 2), as well as the competitive environment in which they work (plan 1). See **Table 4** for representative quotes.

Willingness to innovate/test new services. When asked about their willingness to consider alternative payment models like PFS, representatives responded by commenting more broadly on their willingness to innovate. Some representatives were very open to testing new services and programs. These were representatives of plans that tended to be smaller and less established in their markets, and they seemed to view innovation as a way to differentiate themselves from more well-known, larger plans. Such representatives described their plans as having the need to pilot interventions "in our DNA" (plan 12), liking to "test and learn" (plan 13), viewing "excellence in innovation" as a "pillar" of their plan (plan 9), and being a "giant intervention machine" (plan 5). These plans often had informal methods and acceptance of quickly testing innovative ideas. Plans that were more risk averse tended to be larger, with more formal, established systems around innovation and the testing of new services or programs. Such representatives described requiring "extensive research" examining "what's already been proven in the literature" (plan 16), wanting to be "pretty sure of the outcome that we want" before committing resources (plan 3), desiring to "build on already-gathered evidence" (plan 1), having thorough processes in place for vetting new ideas (plan 4), and the importance of ensuring return on investment (plan 15). For representative quotes, see **Table 5**.

DISCUSSION

The purpose of this research was to understand MA plan representatives' perspectives and interest in PFS as a mechanism to develop new initiatives targeting members' social risk factors. MA plan representatives in this study were largely unfamiliar with PFS and were generally interested in learning more. Similarly, those who were familiar with PFS expressed receptivity to exploring it further. Although some representatives reported willingness to share data and measures with project partners and to work with an independent evaluator to assess if predetermined outcomes had been met for the purposes of repayment, others were more hesitant and voiced concerns or expressed their preference to validate analyses internally. Lastly, although most representatives described a mission of innovation and goals of piloting new programs and services, some were more risk averse and described preferring to use tried-and-true methods to deliver new programs and services.

TABLE 3. Illustrative Quotes: Plan Awareness of and Receptivity to PFS

Key Words	Quote
Had not heard of it	I don't think I've heard the actual phrase, "Pay for Success." (plan 10)
Read about it, but no experience	I've read about it; I don't have personal experience. (plan 1)
First discovered through interview	It's a very interesting concept, what you just described, but I'm not aware of it....What you just described is the first I've heard of it. (plan 6)
Discussed at recent board meeting	People were just talking about that concept at a board meeting I was at last week. (plan 7)
Heard of it, thinking through implications	I've heard of it. It's not something that I've dug into at this point....I've not spent any real time assessing what this could mean for us or should mean for us. (plan 15)
Working with consulting groups	We're working with some consulting groups who are bringing this kind of approach to the table. We're not really doing anything currently in that space....I definitely think it's a direction that we are actively having discussion about but haven't put into practice with any of our current programs or pilots. (plan 16)
"Right up our alley"	[Plan] does a lot of risk contracting. This would be very attractive to us to do. Again, I think it's something [that] would probably be right up our alley. To what level or how big we would do it, I don't know how big potentially we would go. (plan 13)
Fascinated to read about PFS, fills a gap	I was fascinated to read about [PFS], the innovative payment models that are out there. I wasn't actually aware of them, so it was really interesting because it solves for some of the challenges that we're coming up against....When I was reading about it, I was like, oh, I completely see the need for this. Yeah, it would be very helpful....I think it fills a gap....It would help us to move in the direction we want to move, but we want to do so in a less risky way. (plan 3)
Wondered how you find investors, interested in more information	How would they go about even setting that up? How do you even go about finding private investors who want to invest that way? I guess I'm just curious if there's more information or somewhere you can point me to read more. (plan 1)
Desire for additional evidence	What we're seeing is a hesitancy from some of our government partners to say, "Point to the place that's already been successful in this and then we might consider it," but this body of work is so new we don't really have a lot of, "Point to the place where it's been successful" examples....The private sector has been very willing to invest in this, but really making the [PFS] model happen requires, or should require, shared investment and shared risk across both public and private sectors. (plan 8)
Working within the "confines of CMS"	It is an intriguing concept. I think the challenge that most health plans would run across would be how to present that type of a financial arrangement within the confines of CMS and the risk that we take....I don't think it's impossible, but it would add a complexity that...It's something to think about. (plan 11)
Achieving a balance of risks and rewards	It's a great model and there's a role, I think, for health insurers to be deferring risk, if you will, with other capital partners. There's an interesting point where you get to, "Well, if this is really evidence-based and we're actually implementing the program, let's just make the investment." You know?...It's really on those margins. Is it working? Will it really work? If it doesn't, it's a high risk and maybe we want to defer that risk with the capital, but it's sort of like this can work, let's test it ourselves and just keep more control over it....I mean, it's always nice to sort of go into partners with more capital, but if it can really work, let's make it work....It's like, "Yeah, we might want to partner here or we might just want to kind of try to scale this in different ways without that other capital." (plan 9)

PFS indicates Pay for Success.

With the passage of the CHRONIC Care Act and recent industry changes,[13] managed care organizations, like MA, are increasingly looking to address members' social needs in addition to their medical needs.[24] The findings of this study align with those of previous work that has also found that although MA plans may be interested in expanding the types of services they are offering, hesitation about regulation and the true potential of programs that address social needs remains.[14] In 2019, when MA plans were first granted flexibility in offering new supplemental benefits, only 12.7% of plans offered any newly available service.[25] PFS could be one way to increase uptake of new supplemental benefit offerings in future contract years, as it may help mitigate plan financial risk.

However, in addition to the barriers revealed in our interviews, a number of other barriers may be potentially problematic in employing PFS in MA. First, as highlighted by representatives of plan A, CMS may not allow a plan to layer the costs of an intervention onto members' premiums, costs that they will be required to pay whether or not the plan ultimately achieves the intervention's anticipated outcomes. Further regulatory guidance from CMS is needed to help plans understand the extent to which this arrangement would be allowable. Second, many PFS projects are multiyear, whereas MA contracts are annual. This introduces risk to the investors if the plan changes vendors, decides not to rebid, or is not awarded the contract from CMS, or if other regulatory changes disrupt the project. More work is needed to understand the degree to which plan reserves or other funding pools can be tapped to repay investors in the case that projects are prematurely shut down due to contracting or CMS policy changes. Third, if an MA bid is submitted in June, accepted in October, and expected to be deployed on January 1, but the project is unable to secure an investment to fund the service delivery, the service provider, typically a community-based organization (CBO) partner, will still be expected to provide the services, but without

TABLE 4. Illustrative Quotes: Data Sharing and Receptivity to an Independent Evaluator

Key Words	Quotes
Very open to sharing data	I think we're willing to share, with the caveat that obviously we'd need to make sure there's value in that for us....I do think we're very open and have a desire to continually evaluate the efficacy of our work....We have begun, and have shared some of our data with others to be able to help us assess that. (plan 11)
Must know what will be collected and measured and built into work effort	If we're working jointly on a project, very open, but we set up the structure and agreement on what we're going to be doing and sharing hopefully at the beginning, because if you don't know what you're trying to measure at the beginning, you're not going to be collecting the right information....So, we're really open to sharing when we know at the beginning and we build that into the work effort that will be on our part for working within our organization. (plan 7)
Working with appropriate partners	And if we've found an appropriate partner that we believe in...We have some partners that help augment certain pieces of the care delivery stack, and we are [very open] with these people. We're sharing everything down to salary data of the folks who are working with them. So I don't see a concern there....Once we get past the phase of "Is this the right partner, and is this someone who [plan] wants to really work with?", I have very little heartburn about sharing information and co-developing ideas. (plan 5)
Have used third-party evaluators in the past	That would not be an issue. We've done that many times in the past, including the third-party evaluator. (plan 6)
Employ external partners to assess outcomes	There are times that we even kind of employ some external partners. [The university] is actually working with us on the [program title] randomized controlled trial. We tap into internal resources but also sometimes find external partners who are a good fit as well. (plan 16)
Having external evaluations is a big part of what they do	That's definitely a big part of what we do, including having external evaluations come in and say, "Hey, this is how you guys are doing as a whole," and we sort of consider ourselves to have joint responsibility for the outcome since we work as a team, and therefore we, I think, we try to present it that way, but we absolutely share. "These are how the patients enrolled in our joint teams are doing, here [are] areas for improvement, here's where we're doing well from a data perspective"—we try to do a lot of that. (plan 10)
"Very hesitant to share our data outside of our organization"	I would say that we tend to be very hesitant to share our data outside of our organization at all. And only in these specific, prenegotiated ways are we sharing member data with community-based partners, and only in aggregate form. It's all deidentified, aggregated data that look at, basically we're wanting to measure, is the trajectory moving in the right direction based on our partnership, not really looking at it at the Joe Smith level of: Has Joe Smith gotten better? (plan 8)
"Really high bar there.... A lot of that is dictated by federal and state law."	Obviously when we're talking about sharing, anything...that includes beneficiary data, PHI, or proprietary financial data, there's a really high bar there....If that was something we decided from a business [perspective,] to engage in that type of relationship and share that kind of information, then there's a whole formal protocol and process that we would have to follow in order to share that type of information. And a lot of that is dictated by federal and state law. (plan 2)
Competitive environment	I wouldn't want to make a blanket statement and say we would always share the data....It is a very, very competitive environment so those kind of normal concerns around competitive data would guide us in that decision-making process too. (plan 1)
Will also do analyses in-house	Regardless of if the provider or the vendor does analysis or not, we would always do it as well. So it could be in addition to, but there's always that vetting process here. (plan 4)
Conduct analyses in parallel with outside evaluator	We have a very strong analytics department....We have a good process in place for assessing outcomes and evaluating that.... Often we don't have the kind of setup that you're talking about, the independent evaluator, but when we are doing things with our existing vendors, we're often running the same things at the same time as them because we want to understand if there are differences and what we see as outcome on the metrics that we find as well. We often do things in parallel. (plan 3)
Skilled evaluation expertise in-house	The reality is [that] we have a highly skilled evaluation expertise...that would be a part of any of that team to make sure that we're bought into the design and then, if it's a secondary or third-party data broker kind of model. We've done that before in different ways, so it is one of those things that slows these things down in a big way, but I don't think it's ever insurmountable. It ties into like, "OK. Well, we can do this evaluation." Again, should we just do it and evaluate it ourselves to know if it's working? That kind of thing, or recognizing if you do go into these things, that as you've said, that's one of the components of having that independent evaluator, which is a third-party financial sort of risk sharing. (plan 9)

PHI indicates personal health information.

the capital required to do so effectively. To mitigate this risk, plans should consider how investors could be conditionally secured before CMS approval of the bid, or ways in which MA plans can act as a bridge financing vehicle for performance-based contracts with CBOs that require startup and bridge funding.

In the standard PFS model in which investor repayment flows from the plan back to the investor through a special purpose vehicle, a legal entity created for a limited business transaction, there may be regulatory barriers to the adoption of PFS programs by MA plans. Guidance from CMS is needed on how this cash flow model may or may not align with regulations. This may be further complicated in Dual Eligible Special Needs Plans and Medicare–Medicaid plans within MA, both of which are additionally subject to state Medicaid regulation. However, more traditional forms of performance-based contracting between MA plans and providers could be applied to CBOs, opening up the ability of CBOs to partner with plans and

TABLE 5. Illustrative Quotes: Willingness to Innovate/Test New Services

Key Words	Quotes
Piloting is "in our DNA"	[Piloting is] sort of in our DNA....Fairly frequently we'll roll out different services or benefits to a small part of the organization and just see how it works, and then increase it to a larger part of the organization. Partly because we're small....So we'll partner with people who want to try things; we get ideas and try them....I think the challenge is prioritizing all of the different things we want to try....If we have any problem, it's [that] people want to try too many things...."Please, not another pilot."...It's a really good problem to have and it's a place where people actually volunteer to be involved in projects, and "Oh, we can try this in my site," that sort of thing. (plan 12)
Like to "test and learn"	But we are very much a company that's into doing; we refer to it as "test and learn," so, we stand things up that maybe we haven't done before, do them for a year or so to monitor how they work, and then if they're working well, we roll them out on a very broad scale. (plan 13)
"Excellence in innovation" is a "pillar"	If you just offer supplemental benefit: Yeah, it's something extra you're doing for the member, but it's not really creative. It's not something that's testing some sort of innovation. What we try to do is test the theory of behavioral economics and so, while we don't have the full results yet, at least we're doing something. We're trying something new. We're using it as an opportunity, so we try to stay true to our excellence in innovation. It's one of our pillars at [plan], so we kind of try to stay true to that as much as we can. (plan 9)
"We like to fail fast, and we like to fail forward"	Loss aversion is twice as strong as positively incentivizing somebody. So, we should be repurposing some of our programs to be testing that out. I think the common denominator that you'll find amongst everything is, we like to fail fast, and we like to fail forward. (plan 10)
"Giant intervention machine"	One way of thinking about a company like [plan] is [that] it's just a giant intervention machine. How do you go and sort out all the systems so it is so easy to run a pilot that it becomes the native, default thing to do, that you then use to actually create this virtuous cycle, this virtuous feedback loop that you can you use to improve people's health?...Our ability to differentiate is our ability to deliver on those pilots, to scale them, to deliver on that execution, not to have the idea. Everybody has got good ideas. Good ideas are cheap. It's the ability to run that intervention flywheel, it's that execution piece that matters. (plan 5)
"Extensive research" examining "what's already been proven in the literature"	The other determining factor for us is really doing the research. Before we even launched the [program] there was extensive research done because we really wanna make sure that we can actually make an impact....So I think that's kind of how we approach it: What do we think, what's already been proven in the literature that we can take pieces of so that we can at least measure to determine if we're successful? Making sure we have the funding secure to be able to do the pilot and see the pilot through, so that we can determine if it's something that we can scale. Those are all things that are just critically important to us. (plan 16)
Want to be "pretty sure of the outcome that we want" before committing resources	It's challenging to use a lot of the resources that way without being pretty sure of the outcome that we want. So we've taken the approach of trying to do little smaller things and test things out, and see where we want to get some good outcomes to give us more reassurance and confidence. Then [we] start to go bigger and bigger. (plan 3)
"Build on already-gathered evidence"	So I guess in terms of what, testing is a bit different than what we decide to move forward with. Usually a lot of what we're doing is trying to build on already-gathered evidence showing [that] things work. I guess we're not trying to sort of make things up from scratch—although we do want to be innovative, we want to build it on strong evidence. (plan 1)
Thorough vetting process for ideas	It's the same way we do all of our processes like this: We have structures, like medical cost management, that [look] at all the kinds of opportunities that present themselves across the company...and then [we] try and see, "Is this a problem that exists across more than 1 division?"....We look at it and say, "Is this solution something that we think makes sense?" It's kind of vetted, it goes through a vetting process to get to the point that we say, "Okay, we're going to invest a little bit more resource in this," which means that there would be, potentially, data sharing with some analytics around those subpopulations. So all those folks that you mentioned are at the table, and depending on the various hurdles, bars, whatever you want to call it, the providers or the vendors get to certain levels, and we [either] say "Yes, we have enough here that we can move forward to the next bar," or we don't. It's a very formalized process, and all of the people you said, and more, participate in that to make sure that it makes sense. (plan 4)
The importance of ensuring ROI	Typically, when you talk about building an offering in [MA], you do basic calculations around ROI, obviously. But you also wanna make sure that they're valued in the community and understood. In other words, there's a buyer for the service that you're trying to piece together, that you understand the risks associated with it, and that there's a return or at least pays for itself....Where it gets tricky in healthcare is how do you attribute the various factors that drive an improvement in one's health?...There are things you can point to, but the problem is, it's anecdotal. When you're talking about a million and a half members, it's hard to attribute success to any 1 item....We should have more of a scientific approach to how we pilot and measure success before we launch as a business. (plan 15)

MA indicates Medicare Advantage; ROI, return on investment.

participate in risk sharing. It is likely that variations of the original PFS model will be needed to give plans confidence that they are structuring projects in a compliant manner. Future studies could explore how plans that utilize value-based contracting apply similar models to nonprovider vendors and CBOs. With the passage of the CHRONIC Care Act[13] and the expansion of the MA Value-Based Payment Insurance Design pilot,[26] MA plans will be given more flexibility in addressing social risk factors. Plans may want to test the provision of services that address social risk factors, and PFS may allow them to do so with less financial risk. In order for PFS to be a viable model, however, further guidance from CMS will likely be needed to assuage these regulatory concerns.

Limitations

This research had several limitations. Because we began with a convenience sample, we may have initially selected plans known to our organization that were proactively working on alternative payment models or innovative practices. Additionally, a convenience sample means that our findings may not be generalizable to the entire set of MA plans offered in the United States, despite our sample representing 65% of MA beneficiaries nationally. Our snowball strategy added plans with which we were not familiar, and although we selected plans of varying sizes, geographic locations, and quality, participating plans might differ from plans that did not participate. For example, plans or representatives with a particular interest in PFS may have self-selected to participate in our study. Nonetheless, results from this research provide initial evidence of how plans are approaching innovative alternative financing models like PFS.

CONCLUSIONS

Our results indicate that MA plan representatives may be interested in PFS as an option for expanding their supplemental benefits offerings and that some may be more willing or able to address challenges with PFS than others. Allowing PFS programs to be disconnected from member premiums may help plans incorporate PFS into the complex cost structure in MA as long as concerns about the regulatory environment can be addressed. Future work is needed to better understand the types of PFS arrangements that may be most efficacious to MA plans and their members. As the healthcare system continues to evolve to address upstream health issues, PFS may have the ability to impact the lives of Medicare beneficiaries. ■

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eAppendix

Interview Guide

Thank you for agreeing to speak with us. We are interested in learning more about your plan's interest in addressing the health of your members. This includes social determinants of health. We're also interested in your receptivity to alternative payment models including Pay for Success.

Before we get started, I'd like to learn a little bit more about your role and background...

What is your current role? How long have you been in it?

What are your primary responsibilities?

Nonmedical Services

We understand that MA plans may be increasingly interested in providing nonmedical services to improve the overall health and well-being of members. Oftentimes, this includes partnering with community-based, social service organizations to provide nonmedical services to better manage the overall health of individuals with complex needs. What is your perspective on the value of community based, social services (such as transportation to appointments or home-delivered meals) as a component of your plan's design or services?

Relative to other aspects of benefit design, what priority do you place on providing nonmedical services to improve the overall health of your members?

How have these priorities changed given CMS' new guidelines or the passage of the CHRONIC Care Act, which allows for more flexibility in covering non-medical benefits?

What characteristics describe your members with the greatest and most complex needs that would benefit from non-medical services? What do you see as the most needed/valuable services or benefits to address the needs of these members? Are these services currently provided?

If not, how do you decide what you cover? If not, how could these services be provided? What are the barriers to providing these services?

When you think about integrating new services, how receptive are your provider networks to these efforts?

Pay for Success/Outcomes-Based Financing

Now I want to switch gears a bit and talk about financing arrangements to pay for possible integration of these social services in plan benefit designs, specifically Pay for Success.

As you may know, In Pay for Success financing agreements, private investors provide upfront capital for the delivery of services, and these private investors are repaid if contractually agreed upon outcomes are achieved. In this arrangement, financial risk is shifted from service providers to investors, with investors underwriting the project based on the likelihood of pre-defined outcomes being achieved. Typically, an independent evaluator determines whether the agreed-upon outcomes have been met.

To what extent are you familiar with Pay for Success?

Has your plan discussed or thought about implementing Pay for Success initiatives to pilot solutions related to the non-medical needs of your members?

Is PFS an arrangement that would be attractive to your organization, perhaps in addressing social determinants of health among your members?

Why? Why Not?

If you aren't using Pay for Success, how else do you test or pilot innovative ideas for services or benefits? How do you decide what is worth testing? What informs your decisions?

For community-based organizations interested in partnering with you, how do you recommend they engage your organization?

What would you want to see from them in terms of evidence, business case, data readiness, HIPAA compliance, etc., in order to feel comfortable exploring a partnership?

What can an organization do to make themselves more appealing partners?

Concretely, what might that look like?

In Pay for Success, depending on the project you may need to engage legal counsel, finance, actuaries, compliance, quality, population health, and government affairs. How does, or would, your organization handle innovative projects that require the input and buy-in of so many parts of the organization?

Evaluation is critical to PFS. Under what circumstances would your organization be willing to share member utilization and cost data with project partners (potentially including independent

validators and evaluators) in order to establish success baselines, and then to track project success metrics?

What are your current capabilities for evaluations of new programs and products? How might these capabilities play a role in working with a community-based organization and an independent evaluator?

What other thoughts, information, feedback would you like to share with us related to this work?

Do you have colleagues from other Medicare Advantage plans that you think would be willing to speak with us? Could you please share their contact information?