EFFECTIVE PARTNERSHIPS BETWEEN COMMUNITY-BASED ORGANIZATIONS AND HEALTHCARE: A POSSIBLE PATH TO SUSTAINABILITY

MEALS on WHEELS AMERICA

Quantified® Ventures

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EXECUTIVE SUMMARY

In 2017, Meals on Wheels America and its partner, Quantified Ventures, embarked on a new initiative with a large healthcare company via its national Medicare Advantage (MA) plan. This initiative presented an important opportunity for Meals on Wheels America to scale its service delivery to homebound seniors, and for the MA plan to develop a new home-delivered meal benefit in conjunction with other supportive services for its enrollees.

The intervention delivered through this innovative partnership was to be financed through a Pay for Success (PFS) transaction. Impact investors were to cover the upfront capital costs to scale the intervention, with the MA plan agreeing to repay investors once targeted outcomes were achieved – in this case, reductions in emergency department and hospital utilization. While the concept presented a "triple win" opportunity for all parties engaged, several practical challenges emerged as the partners worked through key steps in the deal development process. Ultimately, the MA plan decided to finance the project through a direct contract rather than with PFS. It is worth noting that even this decision represents progress; absent the initiation of PFS conversations, the new relationship between Meals on Wheels America and the MA plan may not have been forged.

This white paper examines several of the key themes and issues that surfaced during this effort, and that are likely to influence the ability of other community-based organizations (CBOs) to effectively partner with health plans or health systems to finance innovation and enhanced service delivery.

KEY THEMES AND ISSUES

- In advance of approaching a prospective partner, CBOs should:
  - Take stock of the regulatory and business environment in which they operate;
  - Quantify the value of their service in a clear business case that speaks to relevant audiences;
  - Understand requirements for data sharing and demonstrate an ability to meet those requirements; and
  - Ensure capacity for service to scale.

  By coming prepared for these types of conversations, the CBO will find a more receptive partner audience.

- Several MA plan features present particular challenges relative to alignment with PFS financing. Some of these issues are unique to MA plans, and their implications are not necessarily deal breakers; however, they should be considered at early stages of conversation.

- Aside from plan type, other important health partner characteristics should be assessed, including organizational size, readiness and sophistication.

While the ultimate financing mechanism to scale the Meals on Wheels America intervention for homebound seniors was not PFS, the very act of going through this entire rigorous and deliberative analytic process helped to establish a trusting relationship between all partners, and resulted in a more comprehensive understanding of the Meals on Wheels America value proposition. Now positioned to scale services through this direct service contract instead of through PFS, we – Meals on Wheels America and Quantified Ventures – encourage others to reflect on our experiences and apply the learnings from this first-ever effort of using PFS with an MA plan to their own related efforts; doing so will help to accelerate progress for their individual endeavors, and for the field. In this way, every effort can be viewed as a success, so long as new learnings are gained and shared to advance the vision of a thriving market for outcomes-based financing in healthy aging.

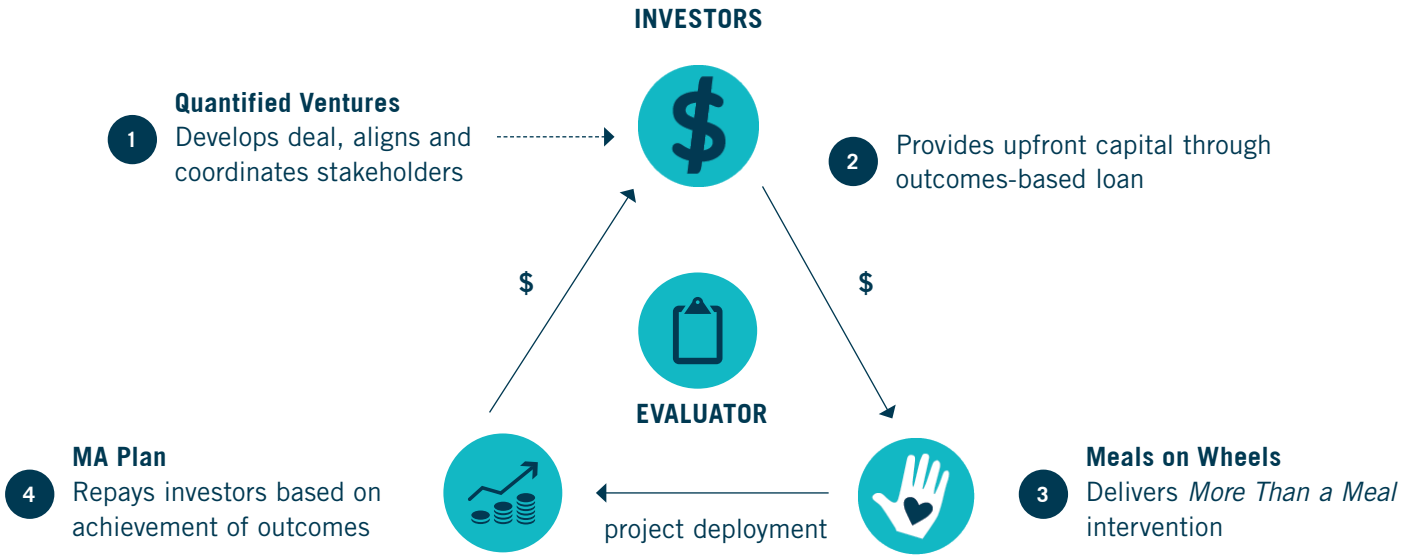
1. BACKGROUND

This white paper recaps the project and explores several key learnings that we hope will expand the knowledge base of how community-based organizations (CBOs) can work effectively with health plans to scale their services through outcomes-based financing, such as Pay for Success (PFS). Overall, PFS may have the potential to become a common way for Medicare Advantage (MA) plans to finance enrollee services, but several significant barriers must be addressed, some requiring consultation with the Centers for Medicare & Medicaid Services (CMS).

In 2017, Meals on Wheels America began developing its second PFS[1] project. On the heels of positive progress made in its first PFS endeavor with Johns Hopkins Bayview Medical Center in Baltimore, MD and a Central Maryland affiliate, Meals on Wheels America engaged a network of its Members in greater Salt Lake City, UT in a Feasibility Assessment. This Member network had spent months developing plans for a large-scale partnership with a local health plan which, though it never materialized, helped prepare the Meals on Wheels Members for expansion and scale. With the support of Quantified Ventures – an outcomes-based financing advisory firm – PFS was determined to be a viable tool for supporting these scale ambitions through a partnership between the Utah network and one or more MA plans.

[1] "Pay for Success" is a contract between impact investors, Service Providers and risk-bearing entities (i.e., payor), in which impact investors provide the capital, and the payor repays the investor once the Service Provider achieves pre-defined outcomes.

Figure 1: The Pay for Success More Than a Meal Model



Building on the movement to value-based care and the increased recognition that access to nutritious food is essential to health, Meals on Wheels America has made a concerted effort over the past decade to bolster this evidence base, and better integrate its Members' services with traditional healthcare delivery. Through its work with a government-sponsored health plan consulting firm, Meals on Wheels America was able to map outcomes demonstrated through its 2015 *More Than a Meal* Pilot Research Study[2] to specific MA Star Ratings – quality metrics that carry financial rewards for MA plans. Findings indicated that Meals on Wheels programs providing basic care coordination and management services could influence several Star Ratings measures – representing a significant opportunity to improve the outcomes of Medicare beneficiaries, while also improving the bottom line of MA plans. This represents a significant value proposition for Meals on Wheels America given the steady growth MA has experienced over the past two decades, now covering over 33% of Medicare beneficiaries – up from just 5.3% of the population in 2003.[3]

Recognizing this opportunity, but mindful of the barriers that CBOs face in partnering with health plans, Meals on Wheels America determined that PFS could be the right tool to break down barriers and enable successful partnerships with plans. By removing one of the most significant hurdles to partnering – the upfront capital required for building capacity to scale – the hypothesis was that plans would be more likely to partner. Following the Utah Feasibility Assessment, Meals on Wheels America applied for, and was awarded, a grant from Nonprofit Finance Fund – through its support from the Social Innovation Fund's Pay for Success program – in 2017 to support the work of structuring such a transaction.

[2] Thomas, K. S., Akobundu, U., & Dosa, D. (2015, 11). More Than A Meal? A Randomized Control Trial Comparing the Effects of Home-Delivered Meals Programs on Participants' Feelings of Loneliness. The Journals of Gerontology Series B: Psychological Sciences and Social Sciences, 71(6), 1049-1058. doi:10.1093/geronb/gbv111

[3] 10, 2. P. (2018, February 01). Medicare Advantage. Retrieved from https://www.kff.org/medicare/fact-sheet/medicare-advantage/

2. PROJECT SUMMARY

HEALTH PLAN PARTNER SELECTION

Quantified Ventures and Meals on Wheels America began the work of prioritizing, engaging and securing an MA payor (i.e., the entity that values the intervention and commits to investor repayment contingent upon achievement of project outcomes). After several months of unsuccessful discussions with MA plans in the Utah market (where willing Meals on Wheels service providers were seeking a partner), the decision was made to broaden the aperture to identify a plan with a different service area, and with whom we could jointly select a geographic area for the project based on the MA plan's preferences/needs and Meals on Wheels' readiness. In summer 2017, a healthcare company with a large national MA plan presence committed to exploring the role of project payor.[4] The prospect of an outcomes-based financing tool like PFS, combined with the strong national brand of Meals on Wheels, appealed to this large organization that is inundated with sales pitches and requests from prospective vendors. Meals on Wheels is not the only home-delivered meal service available in the market, but the unique prospect of being able to shift the financial risk of contracting until valued outcomes were achieved – coupled with Meals on Wheels America's strong evidence base – was intriguing for the payor. Having already decided to improve its meal benefit in the coming year by expanding its offering to the allowable limit of 40 meals post-discharge per year, or 20 doctor-ordered meals following an exacerbation of a chronic condition per condition per year, the payor was also eager to include the combination of home-delivered meals in conjunction with other supportive services in its plan benefit offering. Ultimately, Meals on Wheels America was successful in targeting and selecting its partner payor because of the alignment between Meals on Wheels' offering and the plan's desire to improve plan enrollee outcomes through a focus on social determinants of health.

PROJECT STRUCTURE AND TIMING

Following selection of the payor, the team needed to define the financial and regulatory classification of the meal delivery benefit to determine whether it must be included in the bid[5] to CMS or offered through a "non-bid" offering. Because home-delivered meals are a defined benefit in MA, and must be offered to all eligible enrollees, the options were constrained as to how the intervention would be classified. The benefit must be included in the bid if offered by an MA plan or, alternatively, could be offered by/through the plan's network of contracted providers. The latter would have essentially required the payor to relinquish control of the benefit's utilization, so the decision was made to include the project in the bid and offer the benefit through the MA plan. In this scenario, plans submit their bids to CMS the first Monday of June each year for a contract start date in the following January. Due to the timing of our engagement, we had to determine whether a request for positive benefit change could be used to amend the plan's existing bid submission, squeezing the intervention into the 2018 plan year (i.e., service beginning January 1, 2018). Because CMS has no history of allowing – or formal mechanism to accommodate – mid-year positive benefit changes subsequent to submission of the bid, the payor and team chose instead to prepare for the 2019 bid process.

[4] The company, due to ongoing contracting and market negotiations with Meals on Wheels, has asked not to be named.
[5] Medicare pays plans by way of a formal, annual bidding process. MA plans submit "bids" every June, with the bid calculated by estimated enrollee costs for all Medicare Part A and B services.

SUPPLEMENTAL BENEFITS CHANGE

In the course of the project, the team adjusted to take advantage of two major policy changes from CMS. Legally, until now, CMS allowed MA plans little flexibility to pay for services provided through CBOs addressing social determinants of health. Most services were considered non-medical and, therefore, non-allowable, thus presenting little impetus for healthcare organizations to partner with human and social service organizations. In spring 2018, two updates changed that calculus, allowing for greater MA plan flexibility and innovation. The Bipartisan Budget Act of 2018, specifically the CHRONIC Care Act[6], expanded the definition of "primarily health-related supplemental benefits" to include services that are expected to improve or maintain the health and function of chronically ill MA enrollees, including expanded telemedicine benefits and in-home modifications. While these provisions will not be implemented until 2020, the 2019 Medicare Advantage and Part D Final Rate Notice and Call Letter[7] dramatically expanded CMS' definition of health-related supplemental benefits effective in 2019. Specifically, the Final Rate Notice expanded the definition to include benefits that may "diagnose, prevent or treat an illness or injury, compensate for physical impairments, lessen the functional or psychological impact of health conditions, or reduce avoidable emergency care utilization." In other words, it illuminated a path for experimentation in a way never seen before. Using the flexibility in this guidance, the payor was able to submit a 2019 bid request expanding the benefit offering beyond the previously allowable benefit, based upon available evidence demonstrating that the expansion would likely improve the health outcomes of the plan's enrollees at a greater value than the current benefit.

GEOGRAPHY SELECTION

Both the payor and Meals on Wheels have a national footprint, which brings both strength and complexity in terms of project geography selection. Fortunately, the plan had spent time prioritizing several key markets based upon food insecurity prevalence and market propensity for innovation. Working from this short list of markets, Meals on Wheels America then engaged its local Members in each market, sometimes consisting of three to five autonomous Meals on Wheels programs that would collectively need to cover the entire market. Meals on Wheels America interviewed each program to assess readiness for scale, determine service offerings and gauge ability to effectively partner with a large health plan (e.g., compliance, data security, billing). In parallel, the plan engaged its local market leaders to determine whether it would want to include the Meals on Wheels benefit in its offerings. The payor and Meals on Wheels America coalesced around three markets where interest and readiness aligned.

[6] Alkema, G., Burke, M., Tumlinson, A. March 2018. The CHRONIC Care Act of 2018: Advancing Care for Adults with Complex Needs. https://www.thescanfoundation.org/sites/default/files/chronic_care_act_brief_030718_final.pdf

[7] "Announcement of Calendar Year (CY) 2019 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter". Centers for Medicare & Medicaid Services. https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2019.pdf

SHIFT FROM PFS TO DIRECT REIMBURSEMENT

In spring 2018, several elements left the project team to decide whether to continue pursuing PFS or pivot to an alternate financing strategy, including: the constraints of the 2019 bid deadline; several outstanding questions required to enable PFS in its most traditional structure (e.g., outcomes valuation and evaluation design, outcomes-based payment structures); and the complexity of legal arrangements required to implement the payor's complex, multi-stakeholder highly-regulated business infrastructure. Several significant barriers – which will be discussed in the following "Learnings" section of this white paper – ultimately supported the decision to pursue a direct reimbursement strategy, positioning Meals on Wheels America similarly to other vendors contracting with the health plan. PFS was initially offered as a risk-mitigating bridge to direct payment from the plan but, through the methodical process of structuring the components of the PFS project, the plan obtained the information and data needed to recognize the value and pay directly. While a loss for the PFS field (this would have been the first PFS project with an MA plan as the payor), the ultimate project result is a win for Meals on Wheels programs and the thousands of Medicare beneficiaries who will receive better services and care. It is still the intent of Meals on Wheels America and the health plan to rigorously evaluate the outcomes associated with the intervention offering. This evidence will support the plan's future decision of whether, and, if so, to what degree, it will scale the Meals on Wheels intervention in 2020 and beyond.

3. LEARNINGS

While this project did not result in the anticipated PFS transaction, it did considerably advance our understanding of what must happen for PFS to be a tool compatible with MA plan interests, needs and constraints. This first effort at structuring a PFS project in MA yielded important learnings that can be applied by both CBOs and health plans seeking to partner – regardless of the financing vehicle. Some of our most valuable lessons could not have been unearthed by interviewing experts or conducting a research project; some things can only be learned through experience, and this is certainly the case here. It was only through Meals on Wheels America's commitment to dedicate limited resources to a project with such an uncertain outcome that we can now reflect back on, and make use of, this important lesson. Recognizing that not all organizations will be interested in or able to take this same leap, we encourage others to leverage the learnings from this first effort as they pursue related efforts. We also encourage others to help us build upon these learnings by contributing their own experiences and lessons; with such an approach, every effort can be viewed as a success, so long as new learnings are gained and shared to advance the vision of a thriving market for outcomes-based financing in healthy aging.

MAKE IT EASY FOR PLANS TO SAY "YES"

Health plans and systems are inundated with requests for pilot projects and data requests by vendors and CBOs. With limited time and resources, they have become great at finding ways to say "no, thanks" or, for the lucky ones, "yes, if…" It is these "yes, if" responses that could potentially represent an impetus for a partnership – when that "if" is tied to improved data and evidence, and can be pursued with minimal risk. But even the promise of shifting financial risk for project implementation to investors, as is often the case in a PFS project, does not remove the need for service providers to approach discussions and negotiations with a compelling business case capturing the full value of their services.

In our experience, four distinct information and preparation domains are key:

1. KNOWING YOUR AUDIENCE
2. BUSINESS CASE
3. DATA READINESS
4. SCALE POTENTIAL

PFS was likely the third most important factor in the plan saying "yes" to working with Meals on Wheels America, behind alignment with plan needs and Meals on Wheels America's understanding of the health plan's business as compared to other CBOs'. The latter is a variable that every organization can influence to establish these partnerships over time. Nonprofit Finance Fund, in partnership with the Kresge Foundation, developed a valuable resource for service providers, health plans and health systems seeking more effective partnerships: Partnering for Better Community Health.[8]

[8] Human Services Organizations: Partnering for Better Community Health. Nonprofit Finance Fund. May 2018. https://nff.org/news/new-report-human-service-organizations-partnering-better-community-health

KEY DOMAINS:

KNOWING YOUR AUDIENCE: As CBOs do with foundations and philanthropic funders, likewise work to familiarize yourself with the business model, product lines and vendor contracting requirements of your target plan and market, whether MA, Medicaid Managed Care, Health System, Employer, Government or other. This knowledge of your target customer's complex operational and regulatory environment will be well received and will enable a more efficient and speedy sales cycle – which is hugely valuable in an industry known for notoriously long sales cycles and with complex regulatory requirements. In the early days of PFS in the healthcare industry, there will be two important learning curves: one for the plan as they come to understand PFS, and one for the service provider as they come to more fully understand the plan's specific business and product lines. There is little a service provider can do to influence the time required to get the plan up the PFS learning curve. You can, however, enter into conversations with a plan having already begun your journey up their learning curve. Understanding what a plan can and cannot do or pay for will help you – the service provider – understand whether PFS is even the right tool to help overcome some of the known barriers to project implementation and scale. Do this by:

1. Speaking with other, non-competitive vendors who have successfully contracted with your same target customer base.
2. When possible, considering hiring talent, or working with an outside advisor with relevant experience in your target customer market.

BUSINESS CASE: Large managed care entities are constrained by patient privacy laws and protective of data valued as intellectual property, and are therefore reluctant to openly share enrollee data, so the onus is most often on the service provider to do the work of building the business case to convince the payor of the need and the return on investment (ROI), absent the knowledge of the specific patients who will be served. Concerns about intellectual property, enrollee privacy, data security, regulatory considerations and competition contribute to this reluctance and are just as important as bandwidth limitations and competing priorities. The demands on plan and health system personnel and data systems are significant, so it is critically important to be judicious in the ask, and to be prepared for how and when to make it.

When modeling the business case in PFS, we most often start with a relatively simple cost-benefit analysis, intended to demonstrate a viable path toward a positive ROI for the payor. By understanding the target audience, you can build a more informed budget showing which personnel and service costs currently residing with the plan can be replaced by the intervention's personnel and services. Knowing your target market of plan enrollees in a given geography will also support your efforts to estimate your costs required to scale and serve the unmet need. On the flip side, you should be confident in your ability to lay out a strong case for the impact your intervention or services could produce. This should be based on impact data that your program or similar programs have demonstrated. While a Randomized Controlled Trial evaluation is unnecessary, you should feel confident enough in the data that exists to develop a specific, targeted percentage improvement in the outcomes of focus. You likely will not have access to enrollee-specific, or even aggregate-level, data from the plan at the onset of the conversation, but do not wait for the plan to provide this data. Utilize the best data available to you to create a sound business case, understanding that some of the inputs – like historical utilization and costs for a specific subpopulation – will be assumptions that will later change.

Additionally, get creative in valuing your service. Value is multi-faceted, and while reduced utilization and cost savings are the most common measures of value, plans may also want to see your projected impact on HEDIS (Healthcare Effectiveness Data and Information Set) and Star Ratings – both of which have significant enrollee retention and revenue generation implications associated with the improvement of discrete measures. By developing this thorough business case, the plan leaders will be much more likely to seriously engage, and as a byproduct of the exercise, you shift the onus to the plan to provide validated inputs from accurate and timely enrollee data. At that point, you are working together to develop a business case, ROI model and eventually, a pricing proposal. The need to come prepared with a business case extends beyond PFS to any organization wishing to contract with a payor and be compensated for the full value of their service. The SCAN Foundation and others have developed helpful ROI calculators[9] that can be used to simplify the work of developing a cost-benefit analysis for healthcare payors.

DATA READINESS: In terms of requesting enrollee data from the health plan, be prepared to discuss exactly what data you will need, for what specific purpose and how it will be managed and protected. For many interventions, it is critical for the plan and the service provider to have a two-way, real- or near real-time communication flow. If there is a chance that enrollee data could be shared in the planning, implementation and/or project evaluation, invest in compliant and secure information technology infrastructure that is recognized in the healthcare community, or partner with an organization that can do this on your behalf. At the same time, understand that there are many Electronic Health Records (EHR), and that flexibility is required to meet the unique needs of your target plan. Some may be okay with you using your own system, while others may want to provide you with laptops and programs associated with their system.

Regardless of the specifics, coming prepared with an understanding that this is an important element of developing a partnership and a commitment to work with the plan to do whatever it takes to comply with their unique systems and data infrastructure will be well received. Apart from the technology, develop staff training and mechanisms to comply with HIPAA requirements. Just as important to the health plan as the technology infrastructure is their confidence that your staff will securely manage Protected Health Information (PHI), and adequately respond if breaches or violations do occur.

SCALE POTENTIAL: State Medicaid agencies and many health plans are bound by regulation to provide programs and interventions that meet "uniformity" criteria – or smaller pilot projects with the potential to scale to meet the needs of all relevant populations in the state. This can conflict with how PFS projects are structured (i.e., with a well understood, pre-selected, tightly defined target population often residing in a relatively small geographic area). While we do not believe that "uniformity" would preclude a project with a more tightly defined geography from being allowable as a pilot project, some State Medicaid agencies seek assurance that the intervention could be rolled out statewide upon success. For many service providers, this is nothing but a positive. For others who currently lack scale or have a mandate to operate only at a local level, this may require the consideration of strategic partnerships or some other means of engaging similar service providers who, working together, could serve a much broader geography. In addition, larger health plans serving millions of enrollees will need to make the case internally that a small PFS pilot project can be scaled; otherwise, it may not be worth the plan's time or resources to commit to pilot project development.

[9] http://www.thescanfoundation.org/business-case-person-centered-care

BALANCING REGULATORY AND PROJECT NEEDS

There are two key issues related to MA plan regulatory structures and business cycles that introduce complexity in relation to how PFS projects are often structured: uniformity of benefits and the annual bid cycle.

UNIFORMITY OF BENEFITS: The target populations and scale of PFS projects are often carefully targeted in order to focus the intervention on a population in which the evidence suggests the intervention will have the intended effect. The reason for this is simple: If investors are deploying their capital into an intervention with their return contingent upon the intervention's effectiveness, everyone should want the intervention to be effective. By offering the intervention to a broader population, you introduce risk that it may not be as impactful as projected. This method of project structuring inherently conflicts with a key regulation to which MA plans are subjected – uniformity of benefits. Targeted benefits currently must provide for equal treatment of enrollees with the same health status or disease state for whom such services and benefits are useful, and must be consistent with equal access and anti-discrimination provisions in section 1852 of the Social Security Act.[10] In short, this means that when offering a benefit to enrollees based upon health status or disease, the benefit must be readily available to all individuals who meet those characteristics in the plan's contract. The problem with this is that some MA contracts span several states and serve hundreds of thousands of enrollees. Very few service providers have the scale needed to fulfill this requirement. There are, however, contracts that are relatively small, serving only one or several counties. Service providers can access CMS data, offering near real-time enrollment numbers for plans, showing the counties and enrollment numbers in an MA contract.[11] Spend time understanding these data before engaging with plans to ensure that services can be delivered to all enrolled within a contracted geographic area. The MA regulatory changes described above (CMS expanded definition of health-related supplemental benefits in 2019 and allowance of non-uniform, condition-tailored benefit offerings beginning in 2020) will lessen the impact of this issue.

Uniformity of benefits also presents a challenge in the budgeting and modeling projections necessary for PFS projects. Budgets are built based in part upon the number projected to be served. Without knowing how many will ultimately take advantage of the intervention, estimating variable costs and projected impact size can be a challenge for the service provider to estimate. Depending on the intervention, it may be possible to work with the payor to access historical benefit uptake data for similar interventions, but for new interventions, this may be a difficult challenge to overcome. For budget estimates, building in a buffer that can be called upon if the intervention uptake surpasses projections may be a good tactic to mitigate the risk of under-budgeting.

ANNUAL BID CYCLE: PFS projects often span multiple years, as it can take time to ramp up the project to desired scale, and then achieve the projected outcomes. For some projects, outcomes can take as long as five to seven years to accrue to the payor. However, approximately 18% of an MA plan's enrollees are estimated to be at risk of switching plans and not remaining enrolled in any given year.[12] In addition, MA plans are required to submit bids, which cover geography and benefit offerings, among other things, to CMS every June. A number of changes can occur between plan years, including: changes in CMS guidance; plan decisions to re-bid (or not) or make significant changes to their bid; award status for a specific population and geography (i.e., plans are not guaranteed awards beyond a year term); and enrollee disenrollment. Any one of these changes could disrupt the project and introduce significant investor risk.

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[10] (2018, April) "Uniformity Requirements and Benefit Flexibility Changes Highlights". SNP Alliance. http://www.snpalliance.org/media/1204/phr-supplementals-and-uniformity_summary_5118_snpa.pdf

[11] Medicare Advantage/Part D Contract and Enrollment Data. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/index.html

[12] Jacobson, G., Neuman, T. (2016, September). "Medicare Advantage Plan Switching: Exception or Norm?". Henry J. Kaiser Family Foundation. www.kff.org/report-section/medicare-advantage-plan-switching-exception-or-norm-issue-brief/

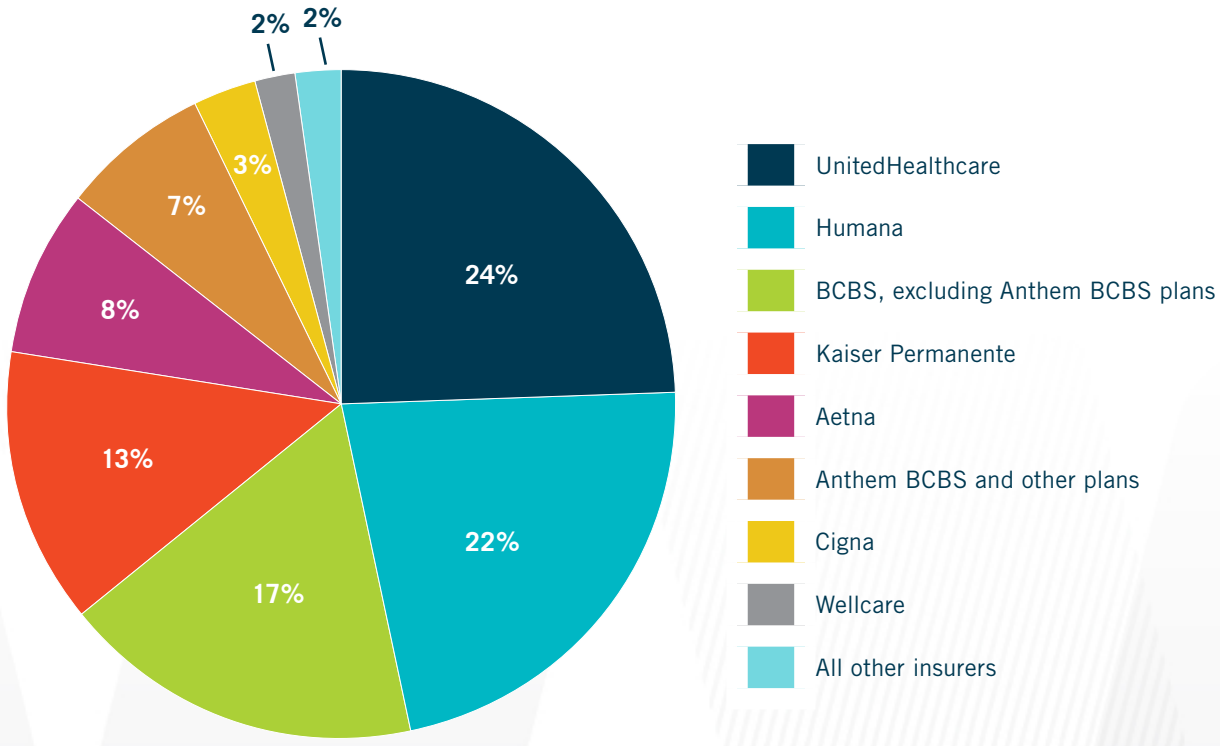
The timing of the annual bid cycle also presents complications and introduces risk to the service provider. With the bid due every year in June, it is critical to ensure that PFS project development aligns with the rigid bid timeline, or risk delaying project implementation by up to a year. A risk for service providers is that the bid could be submitted in June and accepted in October, with the service provider entering into a contract with the payor during a time frame that would obligate them to provide the contracted service before receiving a commitment from investors to finance the transaction. If a bid were to be accepted in October, but the project is unable to secure the investment by January 1 of the following year, this would leave the service provider on the hook to provide the services absent the availability of enabling capital.

These challenges may be perceived as too difficult to address when the intervention is included as a defined benefit in the bid. Interventions that can be bundled into care management programs or other existing services that do not have to be included in the bid submission may be better suited for PFS in MA, as they would not be subject to all of the restrictions applied to benefits inherent in the bid process.

ORGANIZATIONAL SIZE MATTERS

Simply put, size matters. There are very real pros and cons that should be considered when selecting a health plan partner, and that changes depending on the size and scale of the organization. In Figure 2, you can see that eight plans (including all Blue Cross Blue Shield plans) control 78% of MA enrollment. These plans – referred to in this section as "The Bigs" – largely operate nationally. All other insurers – referred to in this section as "The Smalls" – make up 22% of the market, and largely operate on a county or state level.

Figure 2: Medicare Advantage Enrollment by Firm, 2017[13]



[13] Jacobson, G., Damico, A., Neuman, T. (2017, June). "Medicare Advantage 2017 Spotlight: Enrollment Market Update". Henry J. Kaiser Family Foundation. https://www.kff.org/medicare/issue-brief/medicare-advantage-2017-spotlight-enrollment-market-update/

THE BIGS:

PROS:

- Regional and national payors have the capacity to scale successful interventions across large populations. For service providers with regional or national growth ambitions, this can be an important criterion. But for every upside, there is a downside: For the largest payors, it may be hard to convince them to dedicate the time and resources of structuring a project that serves only small groups of enrollees.

- Large payors often have significant financial resources to commit to initiatives. For some payors, they may not view the prospect of supporting capital as an important aspect of PFS; however, there are a number of other benefits to PFS (e.g., paying for outcomes) that still apply.

- Large payors with large numbers of employees will have personnel identified to plan, design and implement the project. These personnel will likely need to interface with staff in other departments for project success. As with anything, the first few PFS projects that a health plan develops will be resource intensive as involved staff go through the learning curve(s) described previously. This capacity to dedicate the needed resources to ensure project success is critical.

- While data sophistication is not necessarily tied to the size of the plan, some of the largest health plans are the most sophisticated when it comes to data analysis. With PFS projects being so heavily dependent on modeling projected success, a plan's ability to rapidly pull accurate and complete data will expedite the project structuring.

CONS:

- The flip side of a large payor's significant resources is that there are often parts of the company that operate in silos and/or different physical locations. For a plan's first PFS project, they will likely need to obtain input and buy-in from executives, finance, legal, compliance, quality, community benefit and actuaries. The amount of time required to educate these departments on PFS and to then receive input and support at various points of the project within a large, complex organization can slow the project's development. Further, the project champion may have less influence than desired when many different stakeholders must be involved, creating a greater risk that the project may be shut down or derailed when encountering various hurdles.

- Large payors with significant business lines in government-sponsored healthcare (e.g., Medicaid and Medicare) are often naturally somewhat risk averse. With governmental customers, the number of well-intentioned rules and regulations in place can result in innovation paralysis, as the cost saving potential of any given project will never outweigh the risk of upsetting CMS or a State Medicaid agency. Compliance is king with government-sponsored health plans, and this should be the most important criteria of any PFS project.

THE SMALLS:

PROS:

- With fewer resources, the promise of tapping into a new stream of mission-aligned capital to support underfunded population health or prevention initiatives is enticing. Therefore, the value proposition of PFS becomes much stronger for small plans.

- Every executive in a small plan knows exactly whom to engage for each answer they need and where to find those persons. By nature of having a smaller organizational chart, it takes less time and energy to reach decisions, plan leaders are generally more flexible and adaptable to meet the needs of their service area, and fewer stakeholders exist to engage and satisfy when questions and problems arise.

- With most small plans seeking to seize market share from larger competitors, their propensity for innovation and tolerance for risk can be higher. PFS – being inherently innovative (and risky) due to the lack of precedent – can therefore be seen as a competitive advantage.

CONS:

- Rapidly changing competing priorities can, at any moment, introduce project delays more quickly within a small plan than a large plan; there are rarely excess resources to spread amongst the varied and numerous plan projects and priorities. Small plans often must be much more selective in deciding what to take on now versus later due to the small number of staff available to execute new projects.

- Small plans operating in one or several geographies may lack the desired scale that some service providers would like to reach. Plans often make pilot implementation decisions based on the potential scale – for example, justifying the resources dedicated to a 1,000 person pilot project if that project has the potential to reach 200,000 enrollees over time. The calculus is very different for small plans, who have more pressure to "get it right" since they do not have the volume in which to spread project implementation risk.

- Small plans with limited resources often lack data sophistication. When targeting geographies and enrollees based upon specific disease states or health status, being able to access complete data sets and then rapidly analyze data to inform project parameters is important. A lack of ability to navigate this component of the project structuring will undoubtedly delay project structuring.

4. CLOSING

Through its work with the MA plan partner, Meals on Wheels America realized that significant value and success can be attained by attempting to structure a PFS project, regardless of whether that financing mechanism or another is ultimately selected as the most appropriate structure for the project. The process of defining the mutually valued outcomes, assigning a value to those outcomes, thinking through the project evaluation and deciding upon data sharing and communications strategies are all critically important to the development of a successful pilot project. These difficult and methodical conversations led to a decision being made to fund the intervention not through PFS, but through direct reimbursement – a major win for Meals on Wheels America, its implementing network partners and the thousands of seniors who will benefit from this enhanced service offering.

This project answered important questions about the ability of an MA plan to participate in a PFS project as the payor, but it also raised just as many. More CBOs and MA plans should lean in to attempt to unlock PFS in Medicare Advantage. As more health plans define their social determinants of health strategies and CMS continues to encourage value-based payment, the promise of outcomes-based financing to improve health outcomes in Medicare looks greater than ever.