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# Challenges to Policy Implementation: An Examination of an Integrated Health Care Delivery System Demonstration Project

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**Challenges to Policy Implementation:  
An Examination of an Integrated Health Care Delivery System  
Demonstration Project**

Kaitlin Roh

Macalester College  
Political Science Honors Thesis

Thesis Advisor: Prof. Michael Zis, Political Science

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## **Abstract**

US health care costs are among the highest of all industrialized nations. In an effort to reduce costs and improve health outcomes, new delivery models – including accountable care organizations – have been developed. Yet, as revealed through interviews with key participants in Hennepin County's delivery project, significant challenges to implementing them exist. They include obstacles that inherently arise from implementing a means-tested health care policy within a competitive, federalized governing structure. Because these challenges are not unique to Hennepin County, this project can help similar projects and may push policy towards the integration of the health care and social service systems.



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## **Introduction**

US health care costs are among the highest of all industrialized nations and for the last several years, they have been on the rise, out-pacing inflation and annual income growth. According to the Kaiser Family Foundation, “Expenditures in the United States on health care surpassed \$2.3 trillion in 2008, more than three times the \$714 billion spent in 1990, and over eight times the \$253 billion spent in 1980.”<sup>1</sup> Despite these expenditures, the US health system underperforms most other developed countries, and the US ranks last in nearly all measures of health care equity. Furthermore, those with the most need – those with characteristics of poverty, chronic illness, and/or addiction – are the least likely to receive good quality care and the most likely to pay inequitably for the care they do receive. Ultimately, this drives up the cost of the whole system since these populations cannot access preventative care, get sick and then seek treatment through the emergency department and/or are hospitalized – the most expensive real estate in health care services.

Two problems exist at the core of the US health care value problem. First, there are high levels of fragmentation within the system, and second, inappropriate financial incentives for providers are to blame for the relatively low health care value. Providers include primary care physicians, specialists, hospitals, lab technicians, surgeons, therapists and many more kinds, who – for the majority of patients – do not communicate and coordinate with each other. For example, if you have an appointment with your cardiologist and then go see your

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<sup>1</sup> “U.S. Health Care Costs: Background Brief.” kaiserEDU.org. The Kaiser Family Foundation, Last accessed April 16, 2012. <http://www.kaiseredu.org/Issue-Modules/US-Health-Care-Costs/Background-Brief.aspx>.

primary care physician, your primary care physician has no idea what your cardiologist recommended and vice versa. Then you as the patient are left trying to explain what each of the providers did and recommended to the other providers. In other words, most providers do not coordinate care with the patient at the center of care. In a few places, however, patient-centered medical home models have been implemented in an effort to better integrate health care services. These models are coordinated care models that incorporate such principles as whole-person orientation, increased access, and improved quality and safety. But, patient-centered medical home models were not enough as they focused on primary care and not the entire health care system.

As such, accountability has now been purposely introduced into the US health care system through demonstration projects. The principles and goals of medical home models have been subsumed as the foundation of new, larger and more varied integrated health delivery system reforms, which incorporate the key concept of accountability. Accountable care organization (ACO) is the term currently used to describe a health care delivery system that seeks to reduce health care costs while improving health care outcomes for targeted populations through reformed payment methods, coordinated care models (including those adopted from the medical home philosophy), and health information technology. The accountability piece attempts to make providers more responsible for their patients' health outcomes by changing payment methods to reward quality of services over quantity. The Patient Protection and Affordable Care Act – the United States federal health care reform of 2010 – includes policy concerning

both medical home and ACO models. In the end though, both medical homes and ACOs are highly complex care models with unclear and frequently disputed definitions, making them difficult to implement.

Examining medical home and ACO models and their implementation, this study has a dual purpose. First, this study seeks to answer questions of implementation concerning integrated health care delivery system models, particularly ACO or ACO-like models: What are the challenges of implementation that these new reform models face? Will these challenges inhibit successful implementation? And second, policy implementation literature has yet to find a universal framework that can either adequately describe the various factors that affect implementation or predict the successful implementation of a policy. This study therefore uses its examination of complex health care policy to compare and scrutinize two models of policy implementation – Sabatier & Mazmanian’s conceptual framework to policy implementation and Majone & Wildavsky’s implementation as evolution model.

Using a case study of one integrated health care delivery system demonstration project, this study combines content analysis of reports and statutes with semi-structured, in-depth interviews. The case study is of Hennepin Health, a demonstration project in the largest county in Minnesota, and the interview participants are key actors involved in the process of developing and implementing the Hennepin Health demonstration project. Hennepin Health is a unique model and case study because it is a health system reform led by a county government and incorporates social services as part of the model. This project

explains the common challenges that any integrated health care delivery system reform in the US faces, demonstrating the significant barriers that exist for successful implementation. Because of the evolution of policy, the experience from former projects and the identification of possible solutions to the articulated barriers by participants, Hennepin Health will most likely be successful in improving health outcomes and at least controlling health care costs for its targeted population. Regardless of its success, though, Hennepin Health has strong implications for local, state and federal policy for more intimately integrated health care and social service systems. And as for the second part of the research question, this case study points out the inadequacies of both policy implementation models, showing how their complexity inhibits their use and that both are incapable of predicting successful implementation.

In the end, Hennepin Health is a case study that exhibits the need for political scientists to develop more predictive, rather than just descriptive, policy implementation models. If a better way to identify factors that affect successful implementation could be used to correct those issues during policy creation or the early stages of implementation, more policies – including the implementation of Hennepin Health – could be implemented successfully. As for this case study's role in health care and social service policy, if successful for their objectives, Hennepin Health has the potential to transform America's fragmented health care and social service delivery model.

To exhibit these findings, the paper follows accordingly. The first section examines policy implementation theory, giving brief overviews of Lipsky's street-

level bureaucracy theory and Sabatier & Mazmanian's, as well as Majone & Wildavsky's, models. The section ends with a short comparison of the last two models. The next section covers literature concerning medical home models and ACOs. Giving definitions for ACOs, and medical home models as the foundational care models to ACOs, along with the history and development of these models, sets up the potential challenges these reforms face. The second section also covers payment models, legislation that contains ACOs, and the importance of reform success. A short methodological statement is the third section, explaining the interview process. And finally, the fourth section includes this study's analysis, implications and limitations. It describes in detail the Hennepin Health project and its difference from typical ACOs. Then, the challenges to implementing the project are outlined under four categories: governance, means-tested programs, US health care and program evaluation. Following is a comparison of the two policy implementation models in relation to Hennepin Health. This final section ends with implications for future implementation research and future US health care and social policy, as well as a delineation of this study's limitations.

## **Policy Implementation Literature**

Researchers study implementation and attempt to develop policy implementation models to find out what makes a policy and its subsequent implementation successful, but also to eventually predict implementation success. Being able to predict what makes implementation successful should help policy-makers address social problems through better policies and regulations, as well as anticipate and plan for likely barriers. It is the predictive quality of a model that is important for this project, with the goal being to extrapolate what influences the success of implementation and to generalize that to the implementation of health care and social policy.

In the late 1970s, Michael Lipsky's street-level bureaucracy theory forced political scientists to take a more serious consideration of what happens to policy *after* it has been created and the role of individuals employed by the government to carry out implementation. Since that push, much literature has been produced concerning policy implementation. However, due to the inherently complex nature of implementation, researchers within this area have found little to agree on and moreover, have few conclusive theories on how implementation actually occurs. In fact, the more intricate and convoluted policy is – like health care policy – the more difficult it is to neatly fit an implementation model to it. Looking across the literature though, authors have found a few similar ways to discuss policy implementation. Some have examined it with a more linear approach, which typically involves a discussion of top-down versus bottom-up

approaches, or a combination there of.<sup>1</sup> Sabatier & Mazmanian provide the most referenced and comprehensive linear framework for policy implementation with the presentation of five stages of implementation. Another pair of prominent authors within the field of implementation study has taken a more holistic approach to the study of implementation. Majone & Wildavsky's model focuses on the evolutionary tendencies of policy creation and implementation.

The following sections provide a short synopsis of Lipsky's contributions to implementation research, as well as more detailed examinations of Sabatier & Mazmanian's implementation framework and Majone & Wildavsky's models of implementation. Succeeding is a comparison and critique of the two pairs' work. And finally, within this section's conclusion is a look at the importance of studying implementation models, particularly the two models referenced here.

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<sup>1</sup> In chapter eight, "Policy Implementation and Policy Failure" of his book *An Introduction to the Policy Process*, Thomas Birkland lays out three approaches to implementation: top-down, bottom-up, and a combined approach. In the first approach, Birkland explains that implementation is viewed as being a chain, beginning with a policy message being sent from the top and then followed down the chain (p. 179). The top-down approach assumes that the policy contains clearly defined goals and policy tools and is characterized by an authoritative statement, and that "policy designers have good knowledge of the capacity and commitment of the implementers" (p. 179). According to Birkland, this model ultimately fails due to the following obstacles: a lack of consensus about goals; lack of cooperation or a refusal to implement at state and local levels; competing interests; and insufficient incentives and/or sanctions for compliance (pp. 179-181). In opposition to the top-down approach, Birkland describes a bottom-up approach, which relies heavily on the idea of backward mapping: examining those on the street-level who implement the policy and then go up the policy chain (p. 182). This approach assumes that goals are ambitious (and not explicit) and sometimes in conflict with existing policies, local level implementers are allowed a great deal of bargaining during the implementation process, and the policy ultimately works through a network of actors (pp. 182-183). Some shortcomings include: overemphasis on local level power, negating a potential lack of resources, and an assumption that groups are active in participation (p. 183). To overcome the failures of both of these models, Birkland concludes that the synthesis of these models, which he refers to as "A Third Generation of Implementation Research," is the best model for describing implementation processes (p. 184). This combined method sees implementation as a process of negotiation and communication; the idea of sending messages between being key to implementation success.

## **Lipsky**

The bottom-up approach originates from the work of Michael Lipsky (1980) and his description of how ‘street-level bureaucrats’ implement policies mandated from above. Lipsky coined the term ‘street-level bureaucrats’ in his book *Street-level Bureaucracy: Dilemmas of the Individual in Public Services* published in 1980. Lipsky made a compelling case for the role and power that street-level bureaucrats exert in policy implementation. Within his model, Lipsky defines street-level bureaucrats as “public service workers who interact directly with citizens in the course of their jobs, and who have substantial discretion in the execution of their work.”<sup>2</sup> This includes police officers, teachers, principals, public health workers, public lawyers, court officers, social workers, and many other public employees. From Lipsky’s point of view, street-level bureaucrats hold all the power in determining policy goals and the success of these goals because of their individual discretion in enforcing, partially enforcing, or ignoring policies put forth from the legislature and from high-level bureaucrats. The actions that street-level bureaucrats take make up the services delivered by the government. Most people encounter government through these services – and in fact most people solely encounter government in this manner. Therefore, government, as distributed by street-level bureaucrats, is the only government that these people know. This places a significant amount of power in the hands of street-level bureaucrats.

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<sup>2</sup> Lipsky, Michael. *Street-Level Bureaucracy: Dilemmas of the Individual in Public Services*. New York: Russell Sage Foundation, 1980, p. 3.

Critics of the street-level bureaucracy model argue that Lipsky gives too much power to public service workers, but agree that these same workers play some role in policy decisions and do not simply implement decisions made by elected officials.<sup>3</sup> Street-level bureaucrats may be able to delay implementation but not avoid it, typically due to a lack of resources.<sup>4</sup> Despite the critiques, many researchers have incorporated Lipsky's basic idea about the role that street-level bureaucrats – those who in reality act out or implement policies – into their own models by giving some thought, and even some power, to street-level bureaucrats.<sup>5</sup>

As the genesis of formal policy implementation research, Lipsky's research is foundational to any exploration of implementation theory, but as will be seen from the following models, more recent implementation theory discredits the idea that implementation is unidirectional. No longer do researchers believe that policy-makers write legislation, rules and regulation, and it is enacted exactly by letter or in the manner of its intention. Nor do researchers believe, like Lipsky claimed, that street-level bureaucrats are in complete control of the implementation process. Instead, researchers give credit to both the top – the policy-creators, and the bottom – local agents who work at the general public level.

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<sup>3</sup> Evans, Tony and John Harris. "Street-Level Bureaucracy, Social Work and the (Exaggerated) Death of Discretion." *British Journal of Social Work* 34, no. 6 (2004).

<sup>4</sup> Birkland, Thomas A. *An Introduction to the Policy Process: Theories, Concepts, and Models of Public Policy Making*. Armonk, N.Y.: M.E. Sharpe, 2001, p. 184.

<sup>5</sup> Maynard-Moody, Steven and Michael Musheno. *Cops, Teachers, Counselors: Stories from the Front Lines of Public Service*. Ann Arbor: University of Michigan Press, 2003.

## **Sabatier & Mazmanian**

Paul Sabatier and Daniel Mazmanian have thus far put forth one of the most comprehensive frameworks for policy implementation, giving insight into the process. In “A Conceptual Framework of the Implementation Process” (1980), Sabatier & Mazmanian lay out a two-part framework for analyzing policy implementation. First, they assess the characteristics of the policy, actors and systems involved; these characteristics are sorted under three categories: 1) tractability of the problem, 2) the ability of the statute to structure implementation, and 3) the nonstatutory variables affecting implementation.<sup>6</sup> The tractability of the problem is tied to behavioral change. Understanding the behavior, its variance, the percentage of the population exhibiting a particular behavior, and the amount of behavior change required are all parts of tractability.<sup>7</sup> By highlighting tractability as one of the three categories of characteristics that shape implementation, Sabatier & Mazmanian enrich research surrounding policy implementation by forcing political scientists to examine the process as even beginning prior to the creation of policy. Instead, the authors infer, research should begin with an examination of how the characteristics of the problem (behaviors necessary to change) can play a role in implementation success or failure. The model predicts more difficult, or less tractable, societal problems and behaviors are going to have lower rates of implementation success.

The category of structuring implementation within statutes is the area in which the problem and its parts are linked to the ways in which policy-creators

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<sup>6</sup> Theodoulou, Stella Z. and Matthew Alan Cahn. *Public Policy: The Essential Readings*. Englewood Cliffs, N.J.: Prentice Hall, 1995, p. 154.

<sup>7</sup> *Ibid.*, pp. 154-157.

choose to address them. Through the policy, creators decide not only the goals of a policy but also *how* to reach those goals; they must formulate the policy with a view of execution.<sup>8</sup> Such a policy characteristic focuses on the role that policy-creators have in the implementation process. The first part of structuring implementation begins with clearly defining the problem and then stating clear, explicit, precise, measurable and realizable objectives that are ranked in importance.<sup>9</sup>

Next, structuring implementation involves incorporating a valid causal relationship, which is not only highly emphasized throughout this framework, but is also seen within other authors' work.<sup>10</sup> The structuring of policy must follow a means-end theory in which the final results are "genetically related" to the original policy idea.<sup>11</sup> In other words, the policy clearly states not only how to complete the objectives, but also how the objectives fix the problem.

Resources are the next important feature to consider when structuring implementation. Sabatier & Mazmanian stress the importance of having adequate financial resources available during the implementation process, but other authors add resources such as expertise of the subject,<sup>12</sup> healthy state and local

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<sup>8</sup> Theodoulou and Cahn, *Public Policy: The Essential Readings*.

<sup>9</sup> Weissert and Weissert, Birkland, Majone, and Gerston all agree with Sabatier & Mazmanian in this regard, and Birkland ties a lack of consensus about goals and competing or conflicting goals to an opportunity for street-level bureaucracy to play a larger role in implementation. And as Gerston writes, "...complete coordination of competing objectives into compatible goals can bring on implementation failure," if failure is defined as street-level bureaucracy not implementing policy as directed or not fulfilling the policy-creators' objectives (p. 114).

<sup>10</sup> Birkland, *An Introduction to the Policy Process: Theories, Concepts, and Models of Public Policy Making*.

<sup>11</sup> Theodoulou and Cahn, *Public Policy: The Essential Readings*, pp. 140-153.

<sup>12</sup> *Ibid.*, pp. 140-153; Weissert, Carol S. and William G. Weissert. *Governing Health: The Politics of Health Policy*. Baltimore: Johns Hopkins University Press, 2006.

economies,<sup>13</sup> implementers' capacity and commitment,<sup>14</sup> technology, and political and legal resources.<sup>15</sup> These resources are important in order to entice both implementers and target groups to comply with policy rules, to monitor compliance and to ensure understanding of both policy objectives and design. In order to properly structure implementation, a policy must also contain incentives for compliance, sanctions for non-compliance or a combination of both.<sup>16</sup> All authors describe these control techniques using different words or phrases, and Sabatier & Mazmanian choose to focus on the idea of compliance. They break down the concept of compliance into four parts: target group attitudes about legitimacy of rules; sanctions available to penalize noncompliance; the costs to target groups of compliance; and the probability that noncompliance will be detected and/or prosecuted. All policy needs to be structured with these parts of compliance in mind in order to be successful.

The final pieces of structured implementation are the number of veto or clearance points involved in enforcement actions, the assignment of implementation to sympathetic agencies and officials,<sup>17</sup> inter-agency relationships and hierarchy,<sup>18</sup> the number of people and agencies involved,<sup>19</sup> and the new policy's relationship to previous and/or existing policies.<sup>20</sup>

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<sup>13</sup> Anderson, James E. *Public Policymaking an Introduction*. Boston, MA: Cengage, 2011.

<sup>14</sup> Birkland, *An Introduction to the Policy Process: Theories, Concepts, and Models of Public Policy Making*, p. 179; Theodoulou and Cahn, *Public Policy: The Essential Readings*.

<sup>15</sup> Theodoulou and Cahn, *Public Policy: The Essential Readings*.

<sup>16</sup> Anderson calls the combination of the two "control techniques." (Anderson, *Public Policymaking an Introduction*, pp. 242-243)

<sup>17</sup> Theodoulou and Cahn, *Public Policy: The Essential Readings*.

<sup>18</sup> Weissert and Weissert, *Governing Health: The Politics of Health Policy*.

Many of the variables that impact implementation can be regulated through a well-written policy, but there are still variables and characteristics of the implementation process that operate outside of the policy and its stipulations. Sabatier & Mazmanian refer to these as nonstatutory variables, which includes variations of the following: media attention, public support, political support, resources, and attitudes, skill and commitment of implementing agencies and officials. While these are all important in determining if a policy can be or is being implemented successfully, a few variables that fall under this category deserve emphasis. First, Birkland describes policy learning as a characteristic that impacts implementation.<sup>21</sup> This type of learning is when policy-creators learn how to both better structure policies and how to better advocate for policies. Policy learning also includes when political institutions (including governmental agencies) learn how to either better implement or better avoid implementation. The second variable that deserves special attention is the impact that time and changes in social, economic, political and technological conditions have in the attainability of objectives.<sup>22</sup> Time and its relationship with change are significant to implementation. The concept of change makes defining successful implementation and predicting implementation success difficult as policy – and subsequently its implementation – is constantly evolving for its own benefit.

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<sup>19</sup> Ibid.; Gerston, Larry N. *Public Policy Making: Process and Principles*. Armonk, N.Y.: M.E. Sharpe, 2004.

<sup>20</sup> Birkland, *An Introduction to the Policy Process: Theories, Concepts, and Models of Public Policy Making*.

<sup>21</sup> Ibid.

<sup>22</sup> Ibid.; Theodoulou and Cahn, *Public Policy: The Essential Readings*, pp. 153-172.

Therefore change over time is a vital part of the implementation process and one that researchers need to better evaluate.

The third and final variable to add to Sabatier & Mazmanian's list of nonstatutory variables is bargaining and the role of street-level bureaucrats in determining implementation. Most researchers emphasize the importance of bargaining, negotiation, communication and political maneuvering in implementation. Policy truly works through a network of actors, and the bargaining that occurs after a policy is written is just as important as the intentions and objectives of the policy-creators.<sup>23</sup> Bargaining highlights the role that street-level bureaucrats, as described by Lipsky, play in the implementation process.

Following the details of how each of these characteristics play into implementation success, Sabatier & Mazmanian break down the process of implementation into five stages: "(1) the policy outputs (decisions) of the implementing agencies; (2) the compliance of target groups with those decisions; (3) the actual impacts of the agency decisions; (4) the perceived impacts of those decisions; and finally, (5) the political system's evaluation of a statute in terms of major revisions (or attempted revisions) in its content."<sup>24</sup> These five stages have a loose linear progression, although Sabatier & Mazmanian place no time restrictions on the completion of any of the stages. In the first stage, agencies create policies and regulations from statutory objectives. This is the first place for slippage between statute objectives and implementation. The second stage is the target group's decision to comply with the implementing agency's regulations.

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<sup>23</sup> Birkland, *An Introduction to the Policy Process: Theories, Concepts, and Models of Public Policy Making*.

<sup>24</sup> Theodoulou and Cahn, *Public Policy: The Essential Readings*, p. 167.

Within this stage, sanctions or incentive that promote compliance are important. Actual compliance with policy and its objectives is the third stage, followed closely by the perception of impact by “constituency groups and sovereigns in the policy subsystem” as the fourth stage.<sup>25</sup> And finally, feedback and revision round out the implementation process. Sabatier & Mazmanian recognize the inevitability of revision for policies post initial implementation.<sup>26</sup> At the end of these stages, the process begins again with the revised policy.

### **Majone & Wildavsky**

In their article, “Implementation as Evolution” (1973), Giandomenico Majone and Aaron Wildavsky put forth three models of implementation: implementation as control, implementation as interaction, and implementation as evolution, eventually advocating for the last model as the most accurate. First, looking at the implementation as control model, this model is similar to the top-down ideas from other authors. The initial plan and its realization are on the same logical level, becoming a means-end theory with policy creators directing and agencies following set instructions in a rational manner.<sup>27</sup> Such a model is similar to ideas about a top-down approach where the policy has clear goals and a detailed plan as to how to reach those goals. Furthermore, the implementation as control model encompasses many of the techniques of control and compliance measures that another researcher later describes in his work.<sup>28</sup> Yet this model fails, Majone & Wildavsky argue, because it is “too clean” and leaves out the

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<sup>25</sup> Ibid., p. 170.

<sup>26</sup> Ibid.

<sup>27</sup> Ibid., p. 141.

<sup>28</sup> Anderson, *Public Policymaking an Introduction*.

intricacies of real life: "...it leaves out the detours, the blind alleys, the discarded hypotheses, the constraints tightened and loosened, the lumpy stuff of life in favor of a predigested formula."<sup>29</sup> The overall failures of the implementation as control model are summed up to what we all know about reality: there are few black and white situations – most involve some gray area.

To then incorporate street-level bureaucracy in the mix, the implementation as interaction model emphasizes communication through consensus, bargaining, and political maneuvering. The focus of this model is a goal and process dichotomy, which implies that implementation success or failure is divorced from policy success or failure. Implementation is its own reward because the process is the purpose, not the goals set forth by clear policy. Ultimately, the outcomes of policy cannot be predictable because implementation is the result of the interaction of many participants and not solely the policy-creators' or the implementers' actions or intentions. In the end, Majone & Wildavsky state that this model, like the implementation as control model, fails to describe the implementation process because it is inadequate for assessing the worth of policy ideas. It places the quality of policy ideas on the same level as the social forces that are capturing and corrupting the process.

Finally, Majone & Wildavsky build the case for their third model, implementation as evolution. The authors state that all policy plans are potentialities, and their realization depends on both the intrinsic qualities of the policy and external circumstances. The authors view multiplicity, the balance of objectives and constraints, as the most important factor in implementation. Ideas

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<sup>29</sup> Theodoulou and Cahn, *Public Policy: The Essential Readings*, p. 141.

shape policy and its objectives, but these are constantly evolving to conform to new situations or to address new problems. Policy-creators frequently alter objectives due to resources available or find the resources to meet their old objectives. And most importantly, “We choose after the act as well as before...Indeed, old patterns of behavior are often retrospectively rationalized to fit new notions about appropriate objectives.”<sup>30</sup> The implementation as evolution model allows for not only a strong policy to direct implementation and for the interaction that occurs between the top and the bottom, but also for the changing of ideas and circumstances in an endless evolution process. The final results of implementation are always “genetically related” to the original policy idea, but solutions change as problems are re-framed and reformulated.

### **A Comparison and Critique of the Two Models**

The most significant difference between the two models – Sabatier & Mazmanian and Majone & Wildavsky – is that the first model presents a more linear projection with five phases while the latter presents a more holistic view on implementation. Although both sets of authors allow for communication between the policy creators and policy implementers, Majone & Wildavsky center their model on the concept of ever-present change and adaption, making a clear distinction between the second model they described – implementation as interaction – and the model of implementation as evolution. The role of communication is secondary to the role of change in their model. Sabatier & Mazmanian, on the other hand, do not give communication or change, or any other of the characteristics that they describe, precedence over the other

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<sup>30</sup> Theodoulou and Cahn, *Public Policy: The Essential Readings*, pp. 146-147.

characteristics. Change in policy-makers', agencies' and society's attitudes have equal weight with problem tractability and communication through policy structuring. Furthermore, Sabatier & Mazmanian provide a step-by-step, frame-by-frame view of implementation through the description of five stages. Conversely, when examining implementation through Majone & Wildavsky's model, snap shots of implementation can be taken at any point in time, but within each of these snap shots, all the components that affect implementation will be present – with each snap shot being a unique combination of these components.

Despite this difference in the essence of the two models, both models have one important similarity: they acknowledge that at any point implementation is never complete. Majone & Wildavsky do this through the idea of evolution and change; similar to any organism in nature, the process of evolution is never complete. Sabatier & Mazmanian give space to this same idea by ending their set of stages with policy evaluation and revision. In a sense, they are making the claim that policy creation and implementation is never complete because it must always come back to the stage of evaluation and revision. In conclusion, Sabatier & Mazmanian have a linear projection for implementation while Majone & Wildavsky take on a more holistic analysis, but both concede that implementation is a constant process.

However, both models have their own faults. Sabatier & Mazmanian's framework for implementation, while delineated by characteristics and neatly placed into five stages, is still a highly complex and overwhelming model. Many of the characteristics overlap or at least impact each other, and since

implementation in a continuous process, distinguishing the separate stages is difficult. Therefore, while the framework is comprehensive from a research standpoint, it may also be too comprehensive to realistically use in examining the implementation of a policy. Its functionality, which is its ability to predict whether implementation will be successful or not, is limited by the sheer complexity of the model.

Majone & Wildavsky's fault lies within the very axis of their model: its dependence on change and the inability to pinpoint the factors that impact implementation. By relying so heavily on the idea of change and evolution, the authors unfairly undermine the factors and patterns within implementation that have already been identified as affecting implementation and its success. While it is true that researchers struggle to exactly forecast implementation outcomes, particularly due to the role of evolution, there are incentives, sanctions, techniques of control, and other factors – many of which have already been identified in research – that predictably play significant roles in the implementation process.

In the end, the two models' greatest assets when placed against one another are paradoxically also the two models' greatest failures. First, Sabatier & Mazmanian outline many variables that may influence implementation, giving individuals involved in policy-making and implementation insight into what will potentially affect implementation. Majone & Wildavsky's greatest quality is their holistic approach, being able to see the big picture. As for the models' insufficiencies, Sabatier & Mazmanian's model is not robust enough. It outlines in great detail the many characteristics that could impact implementation, but by

not ranking these characteristics in terms of which have the most effect, the authors leave policy-creators and implementers guessing as to which characteristics to prioritize and address. On the other hand, Majone & Wildavsky take too general of an approach, giving no specific characteristics and no direction within their model.

However, simply combining the two models is not sufficient. Neither of the models is predictive – and therefore has limited functionality – and even if used in conjunction, the conjoined model would fail to predict implementation success. The models can be applied post-hoc to describe implementation success or failure, but neither predicts implementation success to assist in structuring policy for that success. Such limitations of these implementation models are demonstrated later with the case study of Hennepin Health.

## Literature Concerning ACOs and Medical Homes

Accountable care organizations – once described as the unicorn of health care, something that was imagined in all its fullness but never actually seen – are now tangible and significant health care models, which have the potential to substantially reform the US health care system. In fact, Crosson argues that the ACO model is too important to fail, claiming that the alternative to *not* fundamentally changing the United States’ current health care system is “likely to be a type of indiscriminate cost cutting that will leave the nation with a damaged health care system, reduced access to care services, and declining quality of care.”<sup>1</sup> The challenges to implementing ACOs and similar models shadow the importance that Crosson and others have placed on the successful implementation of ACOs within the health care system – or at least the successful implementation of a health care delivery and payment overhaul. Within this paper, the modified ACO model that Hennepin County has adopted acts as a case study for questions concerning health care policy implementation in general, as well as specific to delivery system reform success. To better understand Hennepin County’s new project though, some background information on ACOs is important, including the evolution of the ACO model, how the medical home care model fits as a foundation to ACOs, the payment reforms required as part of an ACO, why it is so vital for ACO models to succeed, and ACOs’ current role in legislation. Such information provides necessary depth to understanding ACO and medical home

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<sup>1</sup> Crosson, Francis J. “The Accountable Care Organization: Whatever its Growing Pains, the Concept is Too Vitally Important to Fail.” *Health Affairs* 30, no. 7 (2011): 1250-1255, p. 1250.

models in order to fully appreciate the significance of their implementation challenges.

The history of ACOs developed from coordinated care concepts, which emerged in the late 1960s, through the periods of HMOs and managed care in the 1990s and early 2000s to the demonstration projects that, in recent years, have shaped the broad and flexible definition of ACOs. But what truly brought about ACOs' emergence was the combination of the evolution of key primary care concepts – particularly medical home<sup>2</sup> models – and the dire need for payment and incentive reforms within the US health care system. In order to better understand the ideals and core concepts of ACOs, how ACOs differ from previous system models, and ultimately, what ACOs might mean for our current health care system, it is essential to know the history and theory of medical home models and two prominent payment methods: fee-for-service (FFS) and capitation. As such, this section will give a broad working definition for ACOs followed by more in-depth discussions of medical home models and payment methods and reform. The part involving medical home models will answer key questions, including what a medical home is, challenges to implementing medical homes, and potential for successful implementation of these care models. In the discussion concerning payment methods and reforms, a brief synopsis of what fee-for-service and capitation models are will be provided. And finally, this section will end with a discussion of the role that ACOs presently have within legislation and the model's importance in overall health care reform.

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<sup>2</sup> Throughout this paper, medical home will be an all-encompassing term for medical home, health home, and health care home models.

## Accountable Care Organizations

ACOs were born from frustration with the misalignment of financial incentives and quality care delivery. As Mark McClellan – one of the two people responsible for coining the term – wrote:

The notion of ACOs emerged in response to a growing consensus among the clinical and academic communities, including the Medicare Payment Advisory Commission and the Institute of Medicine, that shared accountability among providers could address the gaps in quality and unnecessary costs caused by fragmented and poorly coordinated care.<sup>3</sup>

ACOs were therefore envisioned as a means to correct such incentive problems by providing enhanced financial compensation for activities that improve care quality, such as care coordination. These activities are not typically reimbursed through traditional fee-for-service and capitation models, meaning there is no financial incentive to provide care coordination and other similar services to patients.<sup>4</sup> Furthermore, the Congressional Budget Office does not believe that there is sufficient evidence that health information technology, care coordination, and disease management alone reduce health care costs.<sup>5</sup> Yet, as with any new design or model, ACOs face their own challenges of implementation.

### *Definition of Accountable Care Organizations*

There is no precise structure of an ACO as the definition of an ACO is flexible with a greater focus on the goals rather than precise structuring policies. ACOs are relatively new concepts in health care policy, and as defined by

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<sup>3</sup> McClellan, Mark and Elliot Fisher. “Accountable Care Organizations: A Framework For Evaluating Proposed Rules.” *Health Affairs* (blog), March 31, 2011.

<sup>4</sup> Ibid.

<sup>5</sup> McClellan, Mark, Aaron N. McKethan, Julie L. Lewis, Joachin Roski, and Elliott S. Fisher. “A National Strategy to Put Accountable Care into Practice.” *Health Affairs* 29, no. 5 (2010): 982-990, p. 985.

McClellan, “ACOs consist of providers who are jointly held accountable for achieving measured quality improvements and reductions in the rate of spending growth.”<sup>6</sup> The two goals are simple: improve quality and lower costs. These are the same goals that the health care system has had for decades. ACOs must achieve overall, per capita improvements in quality and cost for a particular population.<sup>7</sup> However, reaching those goals has clearly eluded health care policy makers and providers. The actual structure of an ACO involves the melding of medical home models that tackle care coordination and payment methods that better incentivize quality of care and improved health outcomes. The combination of medical home models and payment reform is a way to address both goals. But, like the two previously stated goals, marrying coordinated care delivery with payment that incentivizes quality over quantity is a formula that has been attempted and has not yet been successful on a broad scale in the US.

An ACO is more than the simple melding of these two concepts though. In order to accomplish the goals of quality and cost reduction, the medical home model, as part of an ACO, must evolve into a medical neighborhood model.<sup>8</sup> No longer can care coordination be isolated to primary care providers coordinating care with hospitals and specialists, bearing the entire financial and organizational burden. Instead, the whole network of providers now needs to share in the responsibility of patient care coordination and delivery. In the same vein, payment

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<sup>6</sup> Ibid., p. 982.

<sup>7</sup> Ibid., p. 983.

<sup>8</sup> Nutting, Paul A., Benjamin F. Crabtree, William L. Miller, Kurt C. Stange, Elizabeth Stewart, and Carlos Jaen. “Transforming Physician Practices to Patient-Centered Medical Homes: Lessons from the National Demonstration Project.” *Health Affairs* 30, no. 3 (2011): 439-445, p. 443.

methods cannot continue as is. Significant changes need to occur so that financial reimbursement better reflects the health outcomes desired. McClellan argues that ACOs therefore need to have a great deal of flexibility in aspects of design, allowing groups of providers the ability to try new and innovative approaches to delivery.<sup>9</sup> Additionally, ACOs have one new over-arching theme compared to former reforms and models: the concept of accountability. Being part of the term's name, accountability is the essential concept for the structure of a delivery system:

The core idea of the ACO is that groups of providers – hospitals, physicians, some combination of both – will agree to be responsible for all of the medical care for a certain number of people, even for the care that they're not directly providing. The responsibility – or to match the coinage, the accountability – is supposed to extend to both the cost and the quality of the care being delivered.<sup>10</sup>

ACO structure allows for a variety of provider configurations, but ultimately all of these providers are accountable for a group of patients. They are responsible for the care provided, the cost of care and the patients' health outcomes; they are even responsible for the patients when they seek care outside of the ACO's provider configuration. This creates high incentive to make the patient experience so exceptional that patients do not seek care outside of the ACO. McClellan believes that a provider partnership with a hospital is favorable, but not necessary. Conversely, a strong base of primary care is necessary for an ACO to function successfully.<sup>11</sup>

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<sup>9</sup> McClellan et al., "A National Strategy to Put Accountable Care into Practice," p. 983.

<sup>10</sup> "Accountable Care Organizations." *Harvard Health Publications*. Last modified 1 April 2011.

<sup>11</sup> McClellan et al., "A National Strategy to Put Accountable Care into Practice," p. 983.

An ACO has six components: a people-centered foundation; a medical home; a high-value network; population health data management; ACO leadership; and payer partnership. The first core component demands that ACOs adopt a people-centered perspective, where a focus on patients’ “engagement, activation, [and] satisfaction” will drive better overall outcomes through high-quality experiences.<sup>12</sup> Next, the incorporation of a medical home model – which itself is a complex care coordination and delivery concept – is discussed later in this section. The third component, a high-value network, is a network of specialists and non-primary care providers that is highly integrated and coordinated with continual improvement.<sup>13</sup> Fourth, the concept of population health data management refers to the information technology (IT) that is used within an ACO. Moving beyond what IT resources and tools were previously required to do, IT in an ACO is used to:

...Collect data on individual health status; stratify and target populations based on their risk and need for care; engage people in their health using patient health records or online portal; connect to a health information exchange to ensure portability of records; and direct physicians toward appropriate, evidence-based care protocols.<sup>14</sup>

High expectations have been placed on the evolution and use of health IT in ACO models. The fifth component, ACO leadership, encompasses the idea that sophisticated leadership from primary care physicians, specialists, hospitals and other providers with joint legal, financial, and medical management can overcome

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<sup>12</sup> DeVore, Susan and R. Wesley Champion. “Driving Population Health through Accountable Care Organizations.” *Health Affairs* 30, no. 1 (2011): 41-50, p. 43.

<sup>13</sup> *Ibid.*, p. 44.

<sup>14</sup> *Ibid.*

the current fragmentation in the health care system.<sup>15</sup> The providers are not only accountable to their patients, but they are ultimately responsible to each other through shared risk and shared leadership. And finally, an ACO model requires payer partnership, including “predictive modeling, case management, network and medical management, and financial reporting” so that ACOs do not simply become another provider or insurance monopoly.<sup>16</sup> Such monopolies in the past have locked patients into one system of care and inevitably driven up costs. These six components themselves are difficult concepts to pin down and implement within the health care system. As such, an ACO, which would encapsulate all six components, is a complicated model to put into practice and requires the flexibility that McClellan suggests to adapt to the needs of the populations being served and the providers involved.

When implementing an ACO, groups of providers need to have a comprehensive performance measurement. While measurement is not a necessary component for an ACO to function, it is necessary to demonstrate that cost savings are from improvement to care and not care cuts.<sup>17</sup> Having comprehensive performance measurement will also aid in the testing of different ACO approaches in the hope of reproducing successful approaches in different regions and with various populations. However, having rigorous quality measures and being able to determine what savings and improved health resulted from preventive care is difficult.

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<sup>15</sup> Ibid.

<sup>16</sup> Ibid.

<sup>17</sup> McClellan et al., “A National Strategy to Put Accountable Care into Practice,” p. 986.

### *How an ACO differs from HMOs and managed care plans*

ACOs differ from health maintenance organizations (HMOs) and other managed care plans in some significant ways. HMOs and other managed care plans have been in place since the 1970s when the federal government passed the Health Maintenance Organization Act of 1973. An HMO is a managed care insurance plan where the HMO contracts with primary care providers and specialists to create a network of providers for patients. Primary care providers act as gatekeepers to seeing specialists; only through a referral from a primary care physician can patients have their specialist visits covered by the HMO. Like an ACO though, HMOs and managed care plans come in a large variety of structures. Other similarities include the fact that patients are members of a provider network with a specific group of providers and that the providers are paid primarily per member rather than per procedure or test.<sup>18</sup> However, the ways in which an ACO differs is important. First, ACOs do not turn provider groups into insurers.<sup>19</sup> Second, in terms of the patients themselves, they will not be required to enroll in an ACO in order to receive services, and they are also not restricted to in-network or participating providers.<sup>20</sup> There is no incentive for primary care physicians to act as gatekeepers because their patients are not required to see them first and patients' care will be covered even if received out of network. As such, unlike other managed care plans, an ACO emphasizes shared

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<sup>18</sup> Emanuel, Ezekiel and Jeffrey Liebman. "The End of Health Insurance Companies." *Opinionator: Exclusive Online Commentary from The Times. New York Times*, January 30, 2012.

<sup>19</sup> McClellan and Fisher, "Accountable Care Organizations: A Framework For Evaluating Proposed Rules."

<sup>20</sup> "Accountable Care Organizations."

risk among providers with financial incentives for quality improvement rather than denial of care. ACOs are encouraged to invest in data collection and case managers because of the newly created financial incentives.<sup>21</sup> And finally, HMOs and other managed care plans are typically national corporations, but ACOs are local health care provider groups, working together through partner leadership and shared risk.<sup>22</sup>

### **Medical Homes**

Medical home models are highly beneficial for patients in the manner in which care is coordinated, but since reform to primary care has not been enough, then there is a need to view medical homes as part of a whole system reform. With financial incentives remaining as is, there are concerns about primary care physicians' ability to address budgetary concerns. "[A]nalysts have expressed concern that savings achieved through implementing medical homes may not reliably offset the costs of the medical home payments to the participating primary care providers on a long-term and sustainable basis."<sup>23</sup> Financial changes are needed to reimburse for coordinating services, to invest in necessary infrastructure, and to narrow the payment gap between primary care and specialty providers.<sup>24</sup> Furthermore, within medical homes, patients are assigned to one provider, often based on their most recent visit; however, within an ACO – which is designed for shared responsibility, patients have a whole provider team.<sup>25</sup> For

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<sup>21</sup> Ibid.

<sup>22</sup> Emanuel and Liebman, "The End of Health Insurance Companies."

<sup>23</sup> McClellan et al., "A National Strategy to Put Accountable Care into Practice," p. 983.

<sup>24</sup> Landon, Bruce E., James M. Gill, Richard C. Antonelli, and Eugene C. Rich, "Prospects for Rebuilding Primary Care Using the Patient-Centered Medical Home." *Health Affairs* 29, no. 5 (2010): 827-834, p. 832.

<sup>25</sup> McClellan et al., "A National Strategy to Put Accountable Care into Practice."

these reasons, incorporating medical home models within the ACO design, reaping the benefits of coordinated care while ensuring a broader approach to properly incentivizing and reimbursing these services, is fundamental to reaching the goals of an ACO. And in order to properly understand the ACO model, it is important to grasp the concept of a medical home.

*Definition of a medical home model*

One group of authors broadly defines the patient-centered medical home as a “model of comprehensive health care delivery and payment reform that emphasizes the central role of primary care.”<sup>26</sup> Another author writes, “A patient-centered medical home is an enhanced model of primary care in which care teams, led by a primary care provider, attend to the multifaceted needs of patients and provide whole-person, comprehensive, coordinated, and patient-centered care.”<sup>27</sup> The components of a medical home, depending on what source you reference, are:

- a personal physician-patient relationship,
- physician-directed, team-based medical practice,
- whole-person orientation,
- coordinated and integrated care,
- ensured quality and safety,
- improved access, information and communication for patients,
- use of health information technology,
- and payment reform.<sup>28</sup>

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<sup>26</sup> Rittenhouse, Diane R., Lawrence P. Casalino, Robin R. Gillies, Stephen M. Shortell, and Bernard Lau. “Measuring the Medical Home Infrastructure in Large Medical Groups.” *Health Affairs* 27, no. 5 (2008): 1246-1258, pp. 1246-1247.

<sup>27</sup> Takach, Mary. “Reinventing Medicaid: State Innovations to Qualify and Pay for Patient-Centered Medical Homes show Promising Results.” *Health Affairs* 30, no. 7 (2011): 1325-1334, p. 1325.

<sup>28</sup> Rittenhouse et al., “Measuring the Medical Home Infrastructure in Large Medical Groups,” p. 1247; Nutting et al., “Transforming Physician Practices to Patient-Centered Medical Homes: Lessons from the National Demonstration Project,” p. 440.

Ultimately though, there is no single, agreed-upon operational definition, set of components or required activities for a patient-centered medical home.<sup>29</sup> The standards upon which providers are certified and then reimbursed for services also vary. Such wide variation of definitions and compensation policies has created a significant barrier to the universal implementation of medical homes.

*Challenges to implementation of medical homes*

Medical homes face challenges of qualification and financial barriers to scalability, unstable Medicaid populations, unrealistic expectations and change fatigue. Since medical homes are the foundation of ACOs, the challenges that medical home models face in implementation are transposed to ACOs. Having multiple sets of standards across the country presents challenges to practices that wish to receive financial compensation, particularly for Medicaid providers who are expected to meet both the National Committee for Quality Assurance (NCQA) and state-specific standards.<sup>30</sup> Currently, most providers voluntarily become certified through standards established by the NCQA. The Center for Medical Home Improvement is another institution that evaluates the implementation of medical homes within practices, assessing them across six dimensions into a

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<sup>29</sup> Reid, Robert J., Katie Coleman, Eric A. Johnson, Paul A. Fishman, Clarissa Hsu, Eric B. Larson, Michael P. Soman, Claire E. Trescott, and Michael Erikson. "The Group Health Medical Home at Year Two: Cost Savings, Higher Patient Satisfaction, and Less Burnout for Providers." *Health Affairs* 29, no. 5 (2010): 835-843, p. 835.

<sup>30</sup> The Medicaid program is funded and operated jointly by the state and federal governments. As such, each state has its own Medicaid program regulations, but there are also national regulations. Providers are therefore required to follow both federal and state regulations in order to receive financial reimbursement for services performed for Medicaid patients.

series of attributes with four levels of performance.<sup>31</sup> On top of these national sets of standards, individual states have modified NCQA standards or created their own for reimbursement of medical home services. Maine, Maryland, Massachusetts, New York and Pennsylvania have all modified the NCQA standards in an effort to “fill perceived gaps.”<sup>32</sup> On the other hand, six states – including Minnesota – have created their own qualification standards.

Now with federal regulations through the Patient Protection and Affordable Care Act providing compensation and stipulations for health care home services for Medicare and Medicaid recipients, the guidelines that practices must follow are even further complicated. While the details are to be clarified through the regulatory process, the law currently indicates that “expanded access to care, comprehensive care management, coordinated and integrated care, appropriate use of information technology (IT), referral to community and social support services, and continuous quality improvement” will all be a part of the health homes’ definition.<sup>33</sup> As Fields, et al. write, the complexity in criteria makes widespread standardization difficult:

Practically speaking the complexity in the various guidelines and criteria may limit the number of physician practices that could implement a medical home successfully. Indeed, the Congressional Budget Office estimated in 2008 that only about 1 percent of medical practices at the time could meet the criteria for medical homes as defined in the Centers for Medicare and Medicaid Services (CMS) demonstration criteria. This

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<sup>31</sup> Fields, Daniel, Elizabeth Leshen, and Kavita Patel. “Driving Quality Gains and Cost Savings through Adoption of Medical Homes.” *Health Affairs* 29, no. 5 (2010): 819-826, p. 820.

<sup>32</sup> Takach, “Reinventing Medicaid: State Innovations to Qualify and Pay for Patient-Centered Medical Homes show Promising Results,” p. 1327.

<sup>33</sup> Abrams, Melinda, Edward L. Schor, and Stephen Schoenbaum. “How Physician Practices Could Share Personnel and Resources to Support Medical Homes.” *Health Affairs* 29, no. 6 (2010): 1194-1199, p. 1195.

complexity would make it more challenging to scale medical homes to make them the standard practice.<sup>34</sup>

Multiple sets of standards is just one of the challenges that widespread medical home implementation faces. Practices, particularly small-sized practices,<sup>35</sup> may struggle to meet the complex, comprehensive and costly requirements of installing and employing health information technology and obtaining the personnel and information needed to connect patients to necessary community services.<sup>36</sup> In general, scalability is at least doubtful since few clinics thus far have been able to implement every aspect of the medical home model.<sup>37</sup>

Endeavors to meet these costly standards will be particularly difficult if financial support is not available. As of current legislation, some researchers argue that financial incentives do not exist or are not strong enough to entice practices to make essential changes within primary care to include medical home services. Bielaszka-DuVernay contends that Medicare and Medicaid must make significant reforms to their reimbursement policies for the inclusion of medical home services.<sup>38</sup> Rittenhouse, et al. agrees stating, “Changing the way in which primary care physicians are paid by aligning incentives to prepare and evaluate practices, to pay for the coordination and integration of care, and to reward higher

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<sup>34</sup> Fields et al., “Driving Quality Gains and Cost Savings through Adoption of Medical Homes,” p. 822.

<sup>35</sup> Berenson, Robert A., Terry Hammons, David N. Gans, Stephen Zuckerman, Katie Merrell, William S. Underwood, and Aimee F. Williams. “A House is Not a Home: Keeping Patients at the Center of Practice Redesign.” *Health Affairs* 27, no. 5 (2008), p. 1226.

<sup>36</sup> Nutting et al., “Transforming Physician Practices to Patient-Centered Medical Homes: Lessons from the National Demonstration Project,” p. 440.

<sup>37</sup> Sidorov, Jaan E. “The Patient-Centered Medical Home for Chronic Illness: Is it Ready for Prime Time?” *Health Affairs* 27, no. 5 (2008): 1231-1234, p. 1232.

<sup>38</sup> Bielaszka-DuVernay, Christina. “Improving the Coordination of Care for Medicaid Beneficiaries in Pennsylvania.” *Health Affairs* 30, no. 3 (2011): 426-430, p. 430; Bielaszka-DuVernay, Christina. “Taking Public Health Approaches to Care in Massachusetts.” *Health Affairs* 30, no. 3 (2011): 435-438, p. 438.

performance is deemed essential for the success of the model.”<sup>39</sup> Current payment models fall under the categories of fee-for-service (FFS), capitation, or some combination of these two core concepts.

Another challenge to implementing and standardizing medical home models includes a characteristic particular to Medicaid recipients. Because Medicaid is a means-tested program, there is a lack of continuity in enrollment for Medicaid recipients. They frequently “churn on and off” eligibility multiple times each year.<sup>40</sup> Therefore, primary care providers do not want to be care coordinators for this population, as financial reimbursement for their services is not guaranteed. Challenges based on the population served also bring into question: who are the target populations for medical homes and ACOs. Some argue that the most effective way to utilize these models is by targeting specific subpopulations – such as Medicaid recipients, disease-specific patients, or the most costly patients. Others believe that the models are tools that, once modified and more fully developed, can reshape the entire primary care system and health care field. Thus far, most demonstrations have been targeted towards specific subpopulations; these subpopulations are usually high-user, high-cost patients. By targeting the highest cost within the system, program directors hope to lower overall health care costs.

And finally, change fatigue has been cited as a further challenge to implementation. Nutting, et al. reveal from a national demonstration project that

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<sup>39</sup> Rittenhouse et al., “Measuring the Medical Home Infrastructure in Large Medical Groups,” p. 1257.

<sup>40</sup> Bielaszka-DuVernay, “Taking Public Health Approaches to Care in Massachusetts,” p. 438.

the pace in which practices were obliged to instigate the medical home principles created change fatigue, which resulted in “faltering progress, unresolved tension and conflict, burn-out and turnover, and both passive and active resistance to further change.”<sup>41</sup> By no means an exhaustive list of the possible obstacles of implementing medical homes, these are important factors to consider as the health field and health care policies continue to push for the implementation of medical home principles.

*Significance of medical homes' success*

Literature on the success of medical home models in terms of improving care quality and lowering costs has been a mixed bag<sup>42</sup> with some researchers asserting that medical homes cannot be expected to solve all problems within the health system. Until quite recently there had been no published results indicating cost savings, and there still remains a lack of head-to-head studies demonstrating that a patient-centered medical home performs better than disease management or other coordinated care programs.<sup>43</sup> Furthermore, when critiquing the high expectations and assumptions given to the successful change that medical home models would produce, Ehrlich et al. pointed out that “coordination may increase costs by revealing unmet needs and improving service access/usage.”<sup>44</sup> However, a couple studies have demonstrated cost savings reaped from implementing

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<sup>41</sup> Nutting et al., “Transforming Physician Practices to Patient-Centered Medical Homes: Lessons from the National Demonstration Project,” p. 442.

<sup>42</sup> Takach, “Reinventing Medicaid: State Innovations to Qualify and Pay for Patient-Centered Medical Homes show Promising Results,” p. 1331.

<sup>43</sup> Sidorov, “The Patient-Centered Medical Home for Chronic Illness: Is it Ready for Prime Time?” p. 1232.

<sup>44</sup> Ehrlich, Carolyn, Elizabeth Kendall, Heidi Muenchberger, and Kylie Armstrong. “Coordinated Care: What does that Really Mean?” *Health & Social Care in the Community* 17, no. 6 (2009): 619-627, p. 625.

medical home models. North Carolina Medicaid saved \$231 million in 2005-2006 with their patient-centered medical home,<sup>45</sup> and Group Health Cooperative in Washington had a 1.5:1 return on investment, lower physician burnout rates, and better patient experiences after the first two years of implementation.<sup>46</sup> Finally, Takach reviewed findings from Oklahoma, Colorado and Vermont and concluded:

...Modest increases in payment aligned with quality improvement standards have not only resulted in promising trends for costs and quality, but have also greatly improved access to care...States have found that modest increases in payments coupled with other kinds of assistance to practices have been enough to motivate providers to meet medical homes quality standards.<sup>47</sup>

With Takach's findings, it appears that there might be at least "promising" quality improvements associated with "modest increases" of state health care spending. And while not a certainty such improvements are possible, especially when patient-centered medical homes are implemented in a way that addresses the challenges previously discussed and when coupled with financial reform.

For successful implementation and results, researchers suggest payment system reforms, setting a consistent definition and expectations,<sup>48</sup> having systems and people that are flexible and willing to adapt to change,<sup>49</sup> strong commitment of health care leaders to support "necessary, structural and personal

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<sup>45</sup> Rittenhouse et al., "Measuring the Medical Home Infrastructure in Large Medical Groups," p. 1257.

<sup>46</sup> Reid et al., "The Group Health Medical Home at Year Two: Cost Savings, Higher Patient Satisfaction, and Less Burnout for Providers," pp. 836-837, 839, 841.

<sup>47</sup> Takach, "Reinventing Medicaid: State Innovations to Qualify and Pay for Patient-Centered Medical Homes show Promising Results," p. 1332.

<sup>48</sup> Fields et al., "Driving quality gains and cost savings through adoption of medical homes," p. 825.

<sup>49</sup> Nutting et al., "Transforming Physician Practices to Patient-Centered Medical Homes: Lessons from the National Demonstration Project," p. 441.

transformations,”<sup>50</sup> helping small practices share resources,<sup>51</sup> and placing the patient-centered medical home model in the larger health care neighborhood as an ACO. As Nutting et al write, “To be successful, the medical home must evolve in collaboration with the larger neighborhood, as is envisioned by accountable care organizations. Similarly, these organizations need the primary care foundation that a medical home can provide.”<sup>52</sup> Because of the need to look at reform for the whole system, envisioning a neighborhood rather than just a home, ACOs with medical homes as their base have captured the attention of health care professionals and policy-makers and give hope for positive, systemic reform.

### **Payment Methods and Reforms**

Traditional payment models include fee-for-service and capitation – each with their own drawbacks. A fee-for-service model (FFS) gives providers payment for each service a patient receives. Such a system incentivizes quantity over quality as providers make more money for more services performed. Capitation, on the other hand, gives providers a lump sum to care for patients. Within this model, providers are incentivized to provide less care – the opposite of FFS. In a capitation system, since providers receive the same amount of money per patient, they make more money when they provide fewer services to patients. In other words, capitation incentivizes denying access to services. While fewer

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<sup>50</sup> Epstein, Ronald M., Kevin Fiscella, Cara S. Lesser, and Kurt C. Stange. “Why the Nation Needs A Policy Push on Patient-Centered Health Care.” *Health Affairs* 29, no. 8 (2010): 1489-1495, p. 1493.

<sup>51</sup> Rittenhouse, Diane R., Lawrence P. Casalino, Stephen M. Shortell, Sean R. McClellan, Robin R. Gillies, Jeffrey A. Alexander, and Melinda L. Drum. “Small and Medium-Size Physician Practices Use Few Patient-Centered Medical Home Processes.” *Health Affairs* 30, no. 8 (2011): 1575-84, p. 1583.

<sup>52</sup> Nutting et al., “Transforming Physician Practices to Patient-Centered Medical Homes: Lessons from the National Demonstration Project,” p. 443.

services may not mean lower quality care, providers and patients need to be careful that fewer services do not become a causal variable for poor quality. Another issue with capitation is that it discourages providers from caring for the sickest patients, those with the most complex health care needs who require the most services.

In recent years, combinations of FFS and capitation with risk-adjustment additions have been used to try to combat the consequences of each of these payment methods when used separately. Payment reform has been of particular interest in efforts to support the adoption of medical homes and now, ACOs. Providers need financial support for the start-up costs of a medical home or an ACO, including new health information technology, new personnel and/or training of previous staff, and more. As Landon et al argue, “Getting the payments right is vital” if reforms within the health system are to be successful and eventually become widespread.<sup>53</sup>

Many viable payment strategies exist for an ACO to adopt. The important piece from these payment strategies is that they create incentives for quality, efficiency and effectiveness. Furthermore, some researchers believe that payment reform alone is not enough to change the health care system to meet cost and quality goals; such payment reforms would produce better results when tied to accountability as in an ACO.<sup>54</sup>

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<sup>53</sup> Landon et al., “Prospects for Rebuilding Primary Care Using the Patient-Centered Medical Home,” p. 830.

<sup>54</sup> McClellan et al., “A National Strategy to Put Accountable Care into Practice.”

## **Current Legislation Concerning Accountable Care Organizations**

The federal government through the Centers for Medicare and Medicaid Services (CMS) is currently working on policy regulations for ACO models incorporated in the Medicare program. Section 3022 of the Patient Protection and Affordable Care Act institutes the Medicare Shared Savings program, a program that provides for the short-term implementation of ACOs for Medicare populations. CMS, the Office of the Inspector General, the Federal Trade Commission, the Antitrust Division of the Department of Justice, and the IRS have all released proposed regulations for the implementation of these ACOs. The Department of Justice and the Federal Trade Commission have also issued guidelines that allowed ACOs and other innovative health care delivery systems to form and operate without violating antitrust laws.<sup>55</sup> The regulations require ACOs to improve on 65 quality metrics across five domains: patient and caregiver's experience of care, care coordination, patient safety, preventive health, and at-risk population health or the health of frail elderly populations.<sup>56</sup> In addition to ACOs, Medicare under the Patient Protection and Affordable Care Act now has mechanisms for medical home demonstrations called the Multi-Payer Advanced Primary Care Practice Demonstration. Operating under Section 402 of PL 90-248, the Social Security Act, as amended (42 USC 1395b-1), providers will receive payment for traditional Medicare FFS claims in the standard manner, but individual states will pay providers for medical home start-up costs and for providing services that are not typically covered by Medicare FFS. This

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<sup>55</sup> McClellan and Fisher. "Accountable Care Organizations: A Framework For Evaluating Proposed Rules."

<sup>56</sup> Ibid.

demonstration is expected to be budget-neutral and emphasize prevention, health IT, care coordination and shared decision-making among patients and their providers.

Beyond the federal legislation though, Takach argues that states are the breeding ground for innovation in medical homes – and subsequently ACOs:

The Affordable Care Act allows states to test new – or improve existing – patient-centered medical home models... States are laboratories for innovation with the patient-centered medical home model. The strategies they try and the lessons they learn can inform new approaches to primary care in both the public and private sectors.<sup>57</sup>

Ultimately the recent federal legislation has allowed states to develop innovative approaches to health care delivery, testing ACO and medical home models. The case study of Hennepin Health used within this paper demonstrates this very phenomenon. Minnesota – through new federal and state legislation – was able to develop a new approach to delivering health care to specific Medicaid populations. What makes Hennepin Health unique and how such a program came about will be elaborated on further in the discussion section.

### **Challenges of Implementation for ACOs**

Pitfalls, critiques or concerns: whatever language is used for the description, the challenges that ACOs face in terms of inception and implementation are numerous. The challenges could include:

- *A lack of common understanding about what an ACO is.*<sup>58</sup> As was previously established, the definition of an ACO is highly flexible and ambiguous in terms of structure. While this gives groups of providers

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<sup>57</sup> Takach, “Reinventing Medicaid: State Innovations to Qualify and Pay for Patient-Centered Medical Homes show Promising Results,” p. 1332.

<sup>58</sup> McClellan et al., “A National Strategy to Put Accountable Care into Practice,” p. 987.

who want to establish an ACO more flexibility and room for creativity, it also gives them little guidance as to what works and what does not work when establishing and running an ACO. Gathering such information will be a vital part of any ACO demonstration project, not only to improve the pilot program, but also to generate information and experience that can be used in other locations or for other patient populations.

- *A lack of knowledge and experience of providers and payers in establishing organizational and legal structures of an ACO.*<sup>59</sup> As with any new system, the employees required to implement the new structures may lack the necessary knowledge and experience to be able to do so successfully. However, a study by the American Medical Group Association estimated that more than a hundred member medical groups across the nation are ready and able to transition to an ACO model.<sup>60</sup> And in fact, Crosson writes, "...the accountable care organization concept has created an opportunity for physicians and hospitals to rethink their respective roles, form working partnerships, and even rethink the governance structure of health care delivery institutions."<sup>61</sup> Perhaps, ACOs should be better thought of as an opportunity for providers and payers to re-define their current roles and create new responsibilities within these roles.

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<sup>59</sup> Ibid.

<sup>60</sup> Crosson, "The Accountable Care Organization: Whatever its Growing Pains, the Concept is Too Vitally Important to Fail," p. 1252.

<sup>61</sup> Ibid., p. 1253.

- *Uncertainty about providers' financial ability to support an ACO.*

There is a level of uncertainty about the ability of providers to put in the capital investment for developing and initially managing an ACO. Crosson believes that such an investment is manageable for large medical groups; although, problems may arise for medium- or small-sized medical groups. "But," he argues, "Many of these costs can be mitigated through partnerships with hospitals, arrangements with insurance plans, and the development of information systems funded by and distributed within local communities."<sup>62</sup> With the lack of financial ability and knowledge and experience challenges, some would add that while primary care providers are in a better position to offer patients sensible, cost-effective choices, hospitals are in a better position to lead and operate ACOs because of the up-front costs and systems required. However, some health economists are worried that hospitals will not be responsive to incentives to reduce spending.<sup>63</sup> This is an additional layer to consider within challenges to implementation.

- *Uncertainty about legal ramifications of shared responsibility.*<sup>64</sup> There is a concern that ACOs will accelerate a trend towards hospital mergers and the consolidation of health care providers.<sup>65</sup> However, the federal government is already working to clarify this aspect; as was

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<sup>62</sup> Ibid., p. 1252.

<sup>63</sup> "Accountable Care Organizations."

<sup>64</sup> McClellan et al., "A National Strategy to Put Accountable Care into Practice," p. 987.

<sup>65</sup> "Accountable Care Organizations."

previously stated, the Department of Justice and the Federal Trade Commission have issued guidance concerning antitrust laws.

- *Fear that ACOs will release a torrent of federal regulations.* As of yet, this fear is unfounded since only quality measurement regulations are foreseen. Furthermore, the accountability nature of ACOs will hopefully offer more self-management to replace government-management.<sup>66</sup>
- *Low-level patient participation and enrollment.* In other words, if we build it, will they come? Providers are concerned that patients may not want to enroll in or receive their services through an ACO. ACOs may be rejected by patients, the public and the media in the same way that managed care was rejected in the late 1990s.<sup>67</sup>

All of these are considerable challenges to the implementation of ACOs. Despite the magnitude of these barriers, McClellan and his associates have some suggestions for overcoming them. First, they suggest having a national pilot program effort with clear and transparent principles.<sup>68</sup> This would allow both public and private entities to test what works and what does not work across patient populations and regions within the US. Along those same lines, the specifications concerning cost and quality measures need to remain consistent.<sup>69</sup> We will only be able to properly evaluate and compare different ACO models if the standards to which they are held are the same. State and federal governments

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<sup>66</sup> Crosson, “The Accountable Care Organization: Whatever its Growing Pains, the Concept is Too Vitally Important to Fail,” p. 1251.

<sup>67</sup> Ibid., p. 1253.

<sup>68</sup> McClellan et al., “A National Strategy to Put Accountable Care into Practice,” p. 988.

<sup>69</sup> Ibid.

should look to provide technical support for implementation.<sup>70</sup> They should provide opportunities for pilot programs and other institutions to exchange experiences and knowledge. ACOs will need assistance in “implementing reliable, transparent, timely, and valid measures of quality and cost... [And] achieving improvements in measured performance, setting budget benchmarks, and addressing legal and other issues.”<sup>71</sup> Additionally, newly formed ACOs will need financial and technical support for investments in infrastructure, process and organization redesign.<sup>72</sup> Such support can come through the government or through sharing of resources among groups of providers. The final two mechanisms to overcoming these involve evaluation. ACOs are going to need on-going evaluation, which will require a more straightforward process for Medicare and Medicaid participation, as well as public participation.<sup>73</sup> Furthermore, improved antitrust monitoring and evaluation is needed. According to McClellan, “Accountable care reforms could provide an alternative way of addressing the anticompetitive risk of consolidation.”<sup>74</sup> If regulations are written properly, the shared accountability and other characteristics of ACOs may mitigate the risk that sole consolidation would have.

As illustrated in previous sections, ACOs and other care delivery model reforms face challenges of certification and scalability, uncertain definitions and financial viability, unstable Medicaid populations, lack of provider expertise, complex legal ramifications and new regulations, unrealistic expectations and

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<sup>70</sup> Ibid.

<sup>71</sup> Ibid.

<sup>72</sup> Ibid.

<sup>73</sup> Ibid., p. 989.

<sup>74</sup> Ibid.

change fatigue. The challenges of implementing ACOs parallel many of the aspects of implementation that Sabatier & Mazmanian and Majone & Wildavsky outline within their policy implementation models. First, for Sabatier & Mazmanian, all of the challenges mentioned fit under one or two of their categories. For example, the issues that arise from Medicaid's eligibility and enrollment process falls under the category of problem tractability, which describes the characteristics of society's problems and population behavior that needs to change through implementation of a policy. The questions concerning model definitions and configuration fall under the authors' category of policy structure. Since the general implementation of these models varies greatly, the ability of a single policy or one set of policies to structure implementation of new delivery models across the nation or even within one state may be challenging. Complex legal ramifications and new regulations also fall within Sabatier & Mazmanian's second category with attempts to structure policy for implementation. And finally, lack of expertise and financial means to establish medical homes and ACOs falls under the authors' third category – nonstatutory variables – because they are resources that policy cannot necessarily structure into implementation.

As for Majone & Wildavsky, their emphasis on change and evolution parallels the entire process behind the development of ACOs. ACOs developed from medical home models, evolving from a 'home' to a 'neighborhood' concept. Payment, care and delivery models have all gone through significant periods of change with ACOs emerging from the trials of HMOs and managed care plans.

As new models emerged and new implementation challenges arose, new policies and regulations were mandated. The challenges discussed thus far are general obstacles to the implementation of ACOs, but through this study, challenges to the implementation of a new approach to health care delivery, a modified ACO – Hennepin Health – are examined.

### **Importance of ACO Success**

So why is it so important for an ACO to succeed? Why is it so vital that a new approach to health care delivery be created and implemented successfully? Simply put, the US health care system as is needs reform in order to produce better value: lower health care costs and improved health care outcomes. “Enhancing value requires both explicit delivery system reform strategies and the associated organizational capacity to execute change.”<sup>75</sup> Legislative reforms and strong leadership is necessary to execute this change, and currently, ACOs have been incorporated as part of the Patient Protection and Affordable Care Act – the most recent and most comprehensive health care legislation. As McClellan argues:

Only by fostering real accountability for both quality and costs – effectively linking payments with appropriate investments in infrastructure and process improvements – will we be able to make the transition to a health care system that better addresses major gaps in performance and makes critical clinical and process transformation feasible and sustainable. Developing and testing accountable care organizations... represents a critical step away from purely volume-driven payments and toward payments emphasizing value.<sup>76</sup>

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<sup>75</sup> Paulus, Ronald A., Karen Davis, and Glenn D. Steele. “Continuous Innovation in Health Care: Implications of the Geisinger Experience.” *Health Affairs* 27, no. 5 (2008): 1235.

<sup>76</sup> McClellan et al., “A National Strategy to Put Accountable Care into Practice,” pp. 989-990.

It is crucial for ACOs and other health care delivery system reforms to succeed because health care's overall value is extremely low. By bringing accountability into the equation, the hope is to properly incentivize providers and the system for quality care over quantity.

### **Conclusion**

ACOs are complex care delivery models that incorporate medical homes as the foundational care model and a combination of capitation and fee-for-service. Accountability, or shared risk and responsibility, is the new key element to these models. Sabatier & Mazmanian's model anticipates many of the challenges faced in implementing ACOs and other health care delivery system reforms. Alternatively, Majone & Wildavsky's evolution model illustrates the evolution of ACO's development and implementation. Being more familiar with these concepts and general challenges helps to foreshadow and highlight the challenges that Hennepin Health will face during implementation.

## **Methodology**

Two goals of this project are to determine what policy implementation framework best captures health care policymaking, specifically the implementation of complex health care reform models such as medical homes and ACOs, and then to discern what barriers exist in implementation of ACOs. Using the Integrated Health Delivery Network in Hennepin County, Minnesota, as a case study, this paper examines implementation of an ACO against two prominent policy implementation theories – Majone & Wildavsky’s implementation as evolution model and Sabatier & Mazmanian’s conceptual framework of the implementation process. As of yet, the two models for policy implementation written by Majone & Wildavsky and Sabatier & Mazmanian provide the most comprehensive frameworks. Incorporating such topics as tractability of a problem, ability of a statute to structure implementation, and evolution of social problem and policy solutions, the two models incorporate the complexity that is involved with implementation and serve as ideal models to test for health care policy implementation. My research combines content analysis of reports and statutes with semi-structured, in-depth interviews of key participants involved in the processes of implementing medical home services at HCMC and developing the new demonstration project.

Medical home models and ACOs were selected for the examination of health care policy as a whole for a few reasons. First, most health care policy is inherently complex. Medical home and ACO policy with all its intricacy can be seen as a microcosm of a comprehensive health care policy for those wishing to

examine the process of implementing a model or policy that is difficult to define, to set clear goals for, and to measure successful outcomes. And second, the health care field in the US is moving towards the integration of ACOs. While just in their beginning stages, ACOs are envisioned as the next wave in health care policy reform. Hennepin County's Integrated Health Delivery Network was specifically selected as a case study because of a couple unique characteristics, including the population it serves and the social disparity approach it employs. Both of these unique characteristics provide a preliminary glance into the direction that health care policy may take.

### *Interview Process*

Interviews were used to examine implementation within this case study because participants – the implementers of the project help reconstruct the process of development and implementation. Through his street-level bureaucracy model, Lipsky intrigued political scientists and changed research concerning policy implementation. Lipsky developed the model of street-level bureaucracy, claiming that policies are truly defined by public service workers – or street level bureaucrats as he defined them – because they are how the public encounters government. The street-level bureaucracy model gives enormous amounts of power to public service workers, which ultimately undermines the role that policy-makers and other conditions might have on the implementation of a policy. Sabatier & Mazmanian provide more balance to implementation within their framework. Their first and second stages – which focus on the agency level and target groups – could be slightly expanded to incorporate individuals within

government agencies and individuals that work for and report to agencies. Majone & Wildavsky, on the other hand, compare and contrast their implementation as evolution model to a different model – one that they refer to as implementation as interaction – which is centrally grounded in Lipsky’s ideas about street-level bureaucrats and the interaction and communication that occurs between local level officials who are implementing policies and policy-creators. Although Majone & Wildavsky’s implementation as evolution model moves away from a sole focus on interaction and communication, these qualities are still contained within the model. Therefore, Majone & Wildavsky, like Sabatier & Mazmanian, give some value to Lipsky’s elevation of street-level bureaucrat input. By interviewing physicians and clinic medical directors, how the medical home model and ACO principles are actually formed and carried out at the local government- and practice-level is better assessed.

The first participants for the study were selected based on recommendations from informational interviews and the remaining participants were selected using snowball sampling, where participants were asked to recommend other potential participants for the study. Eleven interviews were conducted, recorded and transcribed. Interview duration was from 25 to 50 minutes, and all interviews were held within participants’ offices. Participants – which included Minnesota’s State Medicaid Director, the Hennepin County Administrator, current and former state legislators, and Hennepin County Medical Center’s Chief Medical Information Officer – were enthusiastic to discuss the demonstration project and willing to offer multiple suggestions for other

individuals to contact. During the interviews, participants were asked questions concerning the genesis and justification for the Hennepin County demonstration project, policies that support the project, individuals involved, negotiations made for payment and management, project evaluation, challenges and barriers, and the future of the project.

## **Hennepin Health: A Case Study**

This section describes the Hennepin Health project, followed by a discussion of current implementation challenges, which are sorted under four categories: shared governance, means-tested programs, US health care and program evaluation. Afterwards is an examination of how the two implementation models fit with this case study, ending with the implications Hennepin Health and its potential success has for future health care and social service policy and for policy implementation research and study limitations.

### *What is the Hennepin Health project?*

Launched on January 1, 2012, Hennepin Health is an integrated health care delivery system demonstration project operated by Hennepin County in Minnesota, projected to serve 12,000 individuals from the Medicaid population, and run through four core partners:

- Hennepin County Medical Center (HCMC) – a Level 1 trauma center, county (public) hospital and network of primary and specialty care clinics.
- NorthPoint Health and Wellness Center – a county-run, full-service outpatient primary care clinic and a Federally Qualified Health Center (FQHC).<sup>1</sup> It was also the first certified health care home in Minnesota.<sup>2</sup>
- Hennepin County Human Services and Public Health Department (HSPHD) – a county agency that “determines eligibility for Medicaid, as

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<sup>1</sup> FQHCs are community-based primary and preventive care clinics with services reimbursed by the federal government under the Health Center Consolidation Act (Section 330 of the Public Health Service Act).

<sup>2</sup> “Integrated Health Delivery Network: A Social Disparities Approach to Health & Health Care.” Human Services and Public Health Department, Hennepin County (2011), p. 11.

well as other health and economic support programs, administers community mental health and substance abuse services, and provides public health and human services.”<sup>3</sup>

- Metropolitan Health Plan (MHP) – the state’s only publicly owned health maintenance organization (HMO).

These four entities collaborate with an aim toward improving the quality of care for its enrollees through a more efficient care delivery system. Within their collaboration, Hennepin County acts as the final risk-bearing entity.<sup>4</sup> The demonstration project also contracts with over 50 other providers.

The target population – those eligible to receive services through the program – will consist of approximately 12,000 single adults without children who live at or below 75 percent of the federal poverty line. This population has high chemical dependency and mental health issues, as well as a significant number of individuals with housing instability and chronic illnesses.<sup>5</sup> Such characteristics are disproportionately high as compared to non-Medicaid populations and shed light on the complexity involved with caring for this particular population. Program enrollees are high users of both the health care and social service systems.

The goals of the demonstration project reflect the same goals of ACOs and other innovative integrated health care delivery system reforms. The first goal is to improve overall health outcomes for patients; this includes improving the

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<sup>3</sup> Ibid., pp. 11-12.

<sup>4</sup> Godfrey, David. Interviewed by Kaitlin Roh. Personal Interview. Saint Paul, January 23, 2012.

<sup>5</sup> “Integrated Health Delivery Network: A Social Disparities Approach to Health & Health Care,” p. 4.

quality and length of their lives and their overall experience within the health care system. The second part of the project's objective is to lower administrative and service costs to the county, state and federal government. In order to reduce costs, the program ultimately seeks to reduce emergency room use, extended hospitalization and other high-cost medical services. Reducing costs on the medical side would allow more county money to be distributed to other services, such as housing, mental health and unemployment. A final additional caveat to the second half of Hennepin Health's objective is to create a sustainable and replicable health care program.<sup>6</sup>

In order to meet these goals, Hennepin Health has adopted several key program components: a patient-centered medical home, an electronic health record (HER) combined with an integrated data warehouse, a patient tiering system, an integrated system of providers, and a capitated financial model. The first of these critical aspects is its foundation as a patient-centered medical home, emphasizing care coordination and a base in primary, preventive care. This care model reflects many of the same values of former patient-centered medical home models as discussed in previous sections, including care delivery through a health care team and a whole person orientation that incorporates medical care, behavioral care and human needs as appropriate.<sup>7</sup> A participant in this study pointed out the important role of primary care and having one point of coordination for patients, stating, "...one of the main ways to create efficiency and to create value in the way that care is delivered is to transform and strengthen

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<sup>6</sup> "Integrated Health Delivery Network: A Social Disparities Approach to Health & Health Care," p. 4.

<sup>7</sup> Ibid.

the role of primary care.”<sup>8</sup> The US health care delivery system is fragmented with little coordination between primary care and specialty care. As was pointed out with medical homes, there has been a movement for primary care physicians to become care coordinators, but without deeper reform, such work has not been successful. Using a medical home as the base, the Hennepin Health project works to blend the delivery of previously disjointed county systems: social, behavior and medical services.<sup>9</sup>

Another important component is the development of a data warehouse where each patient will have a “single, comprehensive” electronic health record that incorporates both medical and social service information. Prior to the implementation of this project, these records were kept in separate information systems.<sup>10</sup> Alongside the electronic health records and data warehouse is a patient-tiering system, which will evaluate and place Hennepin Health patients in three categories based on high-utilization and high-risk qualities. Such a system allows the program to focus resources and energy on the patients that ultimately cost the most money for the county.

Finally, Hennepin Health’s financial model has a capitation and risk-sharing format.<sup>11</sup> The Hennepin Health model is based on a total cost of care calculation where the total cost of care comes from the Minnesotan Medicaid benefit set, which was determined by the Center for Medicare and Medicaid

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<sup>8</sup> Owen, Ross. Interviewed by Kaitlin Roh. Personal Interview. Saint Paul, February 17, 2012; “One of the core pillars of the care model is the health care home.” (Clifford, Pamela. Interviewed by Kaitlin Roh. Personal Interview. Minneapolis, February 14, 2012.)

<sup>9</sup> “Integrated Health Delivery Network: A Social Disparities Approach to Health & Health Care,” p. 5.

<sup>10</sup> Ibid., p. 9.

<sup>11</sup> Ibid.

Services.<sup>12</sup> Through the Metropolitan Health Plan (MHP), the program has entered into a contract with Minnesota’s Department of Human Services (DHS) to provide managed care services for Medicaid patients.<sup>13</sup> MHP will then pay for medical services by contracted rates to both the other partners and contracted providers.<sup>14</sup> The contracted rates are estimates of the amount spent per enrollee and based on actuarial data.<sup>15</sup> As in any risk- and savings-sharing financial model, if the program is able to cut costs by reducing emergency room use, hospital admissions/readmissions and other acute care through preventive care, then the core partners will share in the savings. However, if costs continue to increase, then the partners will share in the loss of revenue with a negotiated maximum amount of risk sharing.<sup>16</sup> Savings from risk sharing within the first few years is complicated though as any savings seen during that time will be funneled into initial investments in infrastructure.<sup>17</sup>

This project also has a comprehensive evaluation and quality measurement plan – an important feature, particularly for the future institution of similar projects across the nation and the ability to learn from this initial program’s successes and pitfalls.

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<sup>12</sup> “Integrated Health Delivery Network: A Social Disparities Approach to Health & Health Care,” p. 17.

<sup>13</sup> Services contracted through MHP are done so through a PMAP contract. As such, Hennepin Health is bound to the conditions of a PMAP contract.

<sup>14</sup> “Integrated Health Delivery Network: A Social Disparities Approach to Health & Health Care,” p. 17.

<sup>15</sup> *Ibid.*, p. 18.

<sup>16</sup> *Ibid.*

<sup>17</sup> *Ibid.*

*How Hennepin Health compares to a typical ACO*

Hennepin Health is not a typical ACO.<sup>18</sup> Like an ACO, Hennepin Health is designed to create accountability around health wellness.<sup>19</sup> However, Hennepin Health has a few key differences. First and most importantly, an ACO is not required to be an HMO or its own insurance provider; in fact, most ACOs are not also HMOs. Hennepin Health, on the other hand, is an HMO and has its own insurance plan through MHP. Todd Monson, Area Director for Hennepin County Human Services and Public Health Department, explained that the HMO is “deep into” this model with the HMO doing some of the “eligibility work, the recruitment, retention and some of the contracting.”<sup>20</sup> With the inclusion of MHP as one of the core partners, Hennepin Health has an HMO and therefore is not an ACO as the literature currently specifies. Second, the program is taking care of a population that has enrolled in and chosen MHP as their managed care plan.<sup>21</sup> As stated previously, the creators of ACOs stipulated that patients do not need to specifically enroll in the ACO in order to participate. Perhaps it can be thought of as a “modified”<sup>22</sup> or “hybrid”<sup>23</sup> ACO as Hennepin Health is an integrated delivery system reform using accountability for outcomes rather than fee-for-service

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<sup>18</sup> DeCubellis, Jennifer. Interviewed by Kaitlin Roh. Personal Interview. Minneapolis, February 22, 2012.

<sup>19</sup> “The accountability for the care of the patient and truly accepting that as a value-based proposition as opposed to fee-for-service – [Hennepin Health is] true to that concept.” (Clifford)

<sup>20</sup> Monson, Todd. Interviewed by Kaitlin Roh. Personal Interview. Minneapolis, February 16, 2012.

<sup>21</sup> Jacques, Molly. Interviewed by Kaitlin Roh. Personal Interview. Minneapolis, January 26, 2012.

<sup>22</sup> Ibid.

<sup>23</sup> Monson.

reimbursement. But in the end, the project is “not an ACO”<sup>24</sup> by literature definition.<sup>25</sup>

Along that same line, Hennepin Health has a contract with DHS through MHP, but functions differently than MHP formerly operated. Pamela Clifford, Director of HCMC’s Center for Healthcare Innovation, explained that within the short timeframe, Hennepin County, HCMC and the other partners chose to contract with Minnesota’s Department of Human Services under a prepaid Medical Assistance (Minnesota’s Medicaid program) contract.<sup>26</sup> Unfortunately, she explained, “This will be MHP doing business as Hennepin Health... We’re held to all the requirements [of a typical State-County Medicaid contract],<sup>27</sup> but we’re different in many regards from that.”<sup>28</sup> Since Hennepin Health neither fits the old contract requirements it is held to or the new regulations being issued by the federal government concerning ACOs, challenges arise concerning outdated statutes and governance. More about these challenges is discussed later in this section.

The other two characteristics that make Hennepin Health different than a typical ACO are the population served and the social service providers brought into the model. Hennepin Health’s population is a Medicaid population whereas

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<sup>24</sup> Clifford.

<sup>25</sup> After reviewing the literature, it can be argued that the exact definition of an ACO is much more open-ended allowing the flexibility to incorporate an HMO as long as the accountability for outcomes piece remains in place. In that sense, Hennepin Health could best be referred to as a modified-ACO as one participant called it. In my opinion, the concept name given to this demonstration project is irrelevant. What is important is the way in which the reform model works.

<sup>26</sup> Clifford.

<sup>27</sup> The contract between DHS and Hennepin Health through MHP is a PMAP contract. Certain stipulations go along with this type of contract.

<sup>28</sup> Clifford.

ACOs currently conceptualized and initiated under the Patient Protection and Affordable Care Act are for Medicare populations.<sup>29</sup> Medicaid is a means-tested program to provide health care services to individuals and families with low income and limited resources. Some Medicaid recipients also qualify through disability eligibility. The Medicaid program is funded and operated jointly by the state and federal governments. Within Minnesota, the state funds and regulates the program, but Medicaid is run through the county governments. In other words, counties are responsible for the ground-level work. Medicare, on the other hand, is a social insurance program for individuals over 65 or who qualify based on disability. Medicare is entirely funded, regulated and operated through the federal government.

Most ACOs are only bringing together medical providers. Hennepin Health, on the other hand, is bringing in social service providers in addition to health care providers. All these providers then have an invested interest to participate in the care of an individual as they share costs.<sup>30</sup> The role of social services within the care delivery model is further examined throughout this section. In the end, Hennepin Health is not the typical ACO, but it does share in the same goals of reducing health care costs and improving health outcomes. Overall though, Hennepin Health can still be used as a generalizable case study because Hennepin Health, like an ACO, is a new health care delivery model. ACOs and other new health care delivery models face many of the same implementation challenges.

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<sup>29</sup> DeCubellis.

<sup>30</sup> Jacques.

## **Challenges to Implementation**

As seen within the review of ACO models and other types of health care delivery system reform, challenges to implementing reforms that are new, innovative and/or expansive – like Hennepin Health – can be significant and even create barriers to their success. With the inherent complexity of health care policy implementation and the multiple variables involved within the Hennepin Health project, it is easy to see that Hennepin Health’s twin aim of lowering costs and improving health outcomes faces many roadblocks. This study’s participants expanded on the most significant barriers they believe exist for the program. Those challenges speak to a few issues that are not unique to Hennepin County. In fact, a few of the barriers to implementation reflect the same barriers that literature concerning ACOs forecast. The challenges examined within this study fit into four broad categories: 1) shared governance, 2) means-tested programs, 3) US health care culture and 4) program evaluation. Following is a discussion of the specific Hennepin Health challenges that fit within these categories. In addition, participants were in a few instances able to articulate steps the partners are taking to address such barriers.

### *Shared Governance*

The United States’ governmental structure with three levels – local (county), state and federal – has created collaboration, coordination and organization problems. These structural issues are sewn into the fabric of American federalism as states are required to abide by federal law and local governments must adhere to state regulations. The layering and distribution of

regulations and responsibilities requires extensive communication and coordination to ensure that policies are followed properly and constituents receive adequate services. Moreover, shared governance and responsibilities has also led to a competition for resources among various levels of government and among departments within local governments. The problems associated with shared governance fit under Sabatier & Mazmanian's first two categories: problem tractability and structure through policy. Shared governance has itself inherent problems that are difficult to define and address, and these problems lead to difficulty in writing policy that properly structures implementation. As such, a model that is flexible and gives much discretion to the local level and individuals involved in implementing the model – like ACOs – is going to be problematic to structure at the state or federal level. In other words, creating a state or national standard for ACOs – one set of policies that regulates all new delivery systems – is extremely hard, and most likely, impossible. Some of the specific challenges that Hennepin Health faces reveal inherent problems seen within shared governance. The three challenges specifically expressed by the project participants are sharing information among the project partners, building collaborative rather than competitive relationships, and the lack of defined administration and ground-level management.

#### Sharing information

One of the most important components for the success of Hennepin Health is the ability to share information among the four core partners and contracted private and public providers. The sharing of information across systems is the

element of an ACO or health care delivery model that allows the entire model to work properly and generate higher levels of efficiency. If HCMC is not able to share pertinent patient information with the county's housing department, then the housing department may not be able to make the best assessment for prioritizing the distribution of housing units. In the same respect, information coming from the county's Department of Human Services and Public Health about a patient's housing status and living situation could be vital for a physician trying to help a patient. One example that was given was about a patient with diabetes who does not have a refrigerator to properly store insulin. If the physician is unaware that this is the underlying cause of why the patient continued to have trouble regulating his/her blood sugar levels, then no amount of instruction on insulin use would help the patient.<sup>31</sup> This is why sharing information among the systems is so vital to this project's success.

Out-dated statutes and uncertainty in the legality of sharing patient information among the partners were cited by participants as the greatest challenges to achieving patient care coordination. As innovation occurs at the local level, state and federal regulations – which ultimately govern local projects – need to continually evolve to accommodate new needs and situations. Out-dated regulations can therefore be detrimental to local innovation. Each of the different county entities is confined by separate patient privacy policies. The federal

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<sup>31</sup> Berglin, Linda. Interviewed by Kaitlin Roh. Personal Interview. Minneapolis, January 13, 2012; “We believe that for a very poor people, you can't meet their health care needs properly without addressing their basic social needs as well. We have someone that comes into the emergency room regularly, every week, because she lives in a room – she has diabetes – and she doesn't have a kitchen, so she doesn't have a refrigerator, so every week her insulin isn't good anymore. Every week she is out of whack because she's hasn't been able to use properly stored insulin. So what does a dorm refrigerator cost? Forty bucks. This is ridiculous” (Berglin).

government regulates patient privacy for medical services, and then the social services sector – which operates at the state level – follows Minnesota welfare statutes for client privacy. As one participant stated:

So there are a lot of really exciting things to do as an integrated system, but the laws do not clearly allow all the leeway we would like to have. For example, there are welfare statutes that guide what we can share on the social services side, and there are health record statutes on the health care side. There isn't something that addresses this new world where we are bringing the two sides together and what can or cannot be shared for the benefit of the individual...It makes it more difficult with the statutes not quite being up to date for these demonstration projects, and that is to the fault of the statutes. We're treading new water where it hasn't been clearly defined.<sup>32</sup>

The partners are uncertain of what information can legally be exchanged amongst all the partners. State and federal statutes have been changed through the 2008 Minnesota health reform and the Patient Protection and Affordable Care Act to allow separate government entities to work together. So now, the governance and workflows of the welfare sector and the health care sector can operate together. But the laws that regulate patient privacy in each county and state department have not been changed. Therefore, the Hennepin Health core partners have not yet been able to exchange information about a patient without first gaining explicit consent.

Clifford explained in more detail that MHP and the entire Hennepin Health program is operating under a particular contract with the state and is therefore held to the data-sharing and data-privacy components of that contract.<sup>33</sup> This has slowed the initial on-set of program information sharing and frustrated a few of the individuals involved in Hennepin Health. Jennifer DeCubellis, Area

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<sup>32</sup> DeCubellis.

<sup>33</sup> Clifford.

Director, Hennepin County Human Services and Public Health Department, described the process by which Hennepin Health was eliciting initial consent from patients to be able to share information:

So at this point our health plan isn't able to do outreach to entire members. We can't use our entire system to do that because of the limitation of the statutes. Once we touch individuals for the first time and get that consent, then we're looking to share the information across the systems [to provide benefits to patients]. That's the goal, but it ties our hand a little bit on the front end as we work through some of the legalities...[We want to do] what's best for the individual within the abilities of the law.<sup>34</sup>

Clifford confirmed this initial hold-up in her own comments, explaining that patients who were originally enrolled in MHP and who have now been transferred over to the Hennepin Health plan and program were not aware that they may be changing to Hennepin Health when they signed on.<sup>35</sup> She continued saying:

How is it that we can do something entirely new, maintain the patients' confidentiality and privacy, but be able to see what effect we're having as well as being able to utilize some of that information in a way that can positively affect our patients in their care...given all the legal constraints around the different partners?

Here again was a reiteration of the importance of being able to share information among partners for the successful completion of the project's goals. Another participant agreed, stating, "[T]o share information...is fundamental to the success of any true partnership."<sup>36</sup> Although not an issue of governance, technical issues of information sharing have been a frequent problem within the US health care system. Clifford mentioned the technical obstacles to getting all partners to share information within the electronic record warehouse. The combination of deficient statutes and regulations within the legal realm of information sharing

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<sup>34</sup> DeCubellis.

<sup>35</sup> Clifford.

<sup>36</sup> Jacques.

and the technical hiccups to the establishment and use of the data warehouse have been considerable barriers for the launch of Hennepin Health.

### Competition

Due to the structure of the government, many county and state departments are pitted against each other in competition for resources, making collaboration difficult if not impossible. Consequently, the next challenge to implementation is general collaboration across county systems and distinct departments as the project attempts to move the partners away from this competition for limited resources. One participant stated, “We’re used to working in separate camps,” calling former relationships among the separate county entities as “intense” and possibly even “confrontational” at times.<sup>37</sup> The Hennepin County Administrator Richard Johnson explained why such collaboration might be difficult:

[County departments are] independent for a reason...Part of the issue that reflects is that the different players have earned their money or gained their revenue [through] different ways. They have different accountabilities for their expenditures. They’re always concerned about the risk-reward process at the end.<sup>38</sup>

Essentially, each department was responsible for a particular portion of an individual’s care and needs. The social services sector was responsible for housing and cash assistance among other items; HCMC was responsible for the individual’s health care needs, and so on. As a result, each of these entities received their compensation from the county for only those particular actions.

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<sup>37</sup> Clifford; Monson agreed stating, “There’s always all kinds of institutional fighting, just disagreements.”

<sup>38</sup> Johnson, Richard. Interviewed by Kaitlin Roh. Personal Interview. Minneapolis, February 23, 2012.

Now, however, through collaboration, the essence of the project is to share resources. The partners share the responsibility – the accountability – for each client holistically because the risk-reward equation has been changed in an effort to produce better results. Furthermore, simply agreeing on protocols and workflows<sup>39</sup> to reach a common objective can be a challenge.

Competition can drive up costs and produce waste within the system. Particularly within health care, duplication of services is a common phenomenon.

DeCubellis explains:

Providers are used to competing with each other. And in this new world, what we're challenging the providers to do is to come to the table, to be transparent about what they are doing and not compete. And in reality, in health care with where we're going, there's no reason for us to compete because there is plenty of business. There's more business than any of us can handle unfortunately. And when we compete, that's where we duplicate services...it's a community problem and it's going to take a community solution. And so we all have to get creative; we have to be willing to share.<sup>40</sup>

Competition is a driver behind duplication of services and system waste production for a couple reasons. First, duplication of lab and medical tests is typical when health care providers cannot share information and records in real time, or at least close to real time. And second, competition produces waste because the separate entities are less willing to share a procedure or program that works, instead allowing the others to continue using ineffective and/or inefficient mechanisms. As such, DeCubellis suggests that all partners and contracted providers make both their successes and failures public. Broadcasting such information will allow the exchange of good ideas and ability to avoid repeating

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<sup>39</sup> Richard Johnson.

<sup>40</sup> DeCubellis.

ineffective approaches.<sup>41</sup> As Clifford describes, collaboration is both “the glory and the Achilles’ heel” of the project.<sup>42</sup>

#### Administrative structure and ground-level management

With regulations coming from all levels of government, translating these regulations and ideas into a new county administrative structure and ground-level management and procedures is difficult. Simply put, “Many of us feel that the biggest challenge right now is governance. We have a lot of people interested in this, committed to it, and working to make it happen, but we do not know how to make decisions, make contracts, or prioritize across a wide set of stakeholders.”<sup>43</sup> There is no clear line of authority or accountability from the street-level and through to the top with the county administrator. Again, like sharing information, the challenge of an undefined governance and management structure is closely related to the challenge of collaborative work. Governance structures have been defined and are in operation for each of the separate county departments, but now that the departments are being held accountable as a whole, a new governance structure needs to be built. Seen through Sabatier & Mazmanian’s model, there is a need for policies to better structure ground-level work. Together the partners must decide on a new set of responsibilities both within their work and to each other. Dr. Paul Johnson, Medical Director of HCMC’s Coordinated Care Clinic, describes his apprehensions about the lack of governance:

We need to have better administrative structure if we want to succeed...Organizations are working together that haven’t worked

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<sup>41</sup> Ibid.

<sup>42</sup> Clifford.

<sup>43</sup> Larsen, Kevin, MD. Interviewed by Kaitlin Roh. Personal Interview. Minneapolis, January 23, 2012.

together well before. There's a lot of good faith in leadership from places but there's no administrative structure to support change. And no funding structure to support change...It's really a problem. It rolls up to a lack of governance. There isn't an independent governance structure for whatever it is we're creating. And so it'll be a good faith effort of the part of the managers from the different partners to work together.<sup>44</sup>

In other words, a governance structure needs to be instituted, at least in some form, in order for the partners and providers to know how to work together. It would appear that the challenge of collaboration and governance go hand in hand.

Additionally, Dr. Johnson goes on to include the idea of accountability in relation to collaboration and governance. He states:

How can you be accountable as a care organization if you don't know what your accountabilities are? Where do our accountabilities roll up? Basically we have MHP accountabilities rolling up to MHP and health services to HSPSD, all the accountabilities rolling up into their own silos and then a lot of handshaking and good faith effort to be better partners, but there's no change in the management structure.<sup>45</sup>

Such questions are vital to answer in order to move the program towards success. Dr. Johnson provided two examples to illustrate these questions; both are real experiences from his work through HCMC's Coordinated Care Clinic. One patient came to the Coordinated Care Clinic needing cash assistance from the county.<sup>46</sup> The standard procedure is to have the individual pick up the application form from a county office, then go to their health care provider to have the form completed, and then return the form to the county office. But the question being asked is can this process be more efficient and easier for the client. In the same respect, Hennepin Health currently has a patient enrolled who has been admitted

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<sup>44</sup> Johnson, Paul, MD. Interviewed by Kaitlin Roh. Personal Interview. Minneapolis, January 27, 2012.

<sup>45</sup> Ibid.

<sup>46</sup> "Single adults with no income can get \$203 from the county through cash assistance if they have a medical form completed" (Dr. Paul Johnson).

into a nursing home. The patient has severe diabetes and mental health problems, and when her primary care physician was consulted, he believed she would remain the nursing home indefinitely because of her continued and increased immobility. This patient has not yet been formerly identified as a dual-eligible<sup>47</sup> with her disability status. As a dual-eligible she does not fit the population description the program was set up to serve, but without being properly identified for and enrolled as a dual eligible, she will remain in Hennepin Health. Furthermore, because of how expensive her care is between the nursing home and other services, Hennepin Health is losing a large chunk of the capitated bundle it receives. Then to complicate the situation further, there is no structure or governance to indicate which partner or staff is responsible for helping the patient to be correctly placed and receive the proper benefits.<sup>48</sup> In both of these instances, the challenge is a lack of defined roles and responsibilities. In the first, the consequences are placed on the individual, and in the second, Hennepin Health is faced with loss of revenue.

Beyond partner collaboration, the coordination of on-ground staffing and roles is another challenge that Hennepin Health faces. The ground level work of getting staff hired, defining their roles and integrating all staff within one system will be difficult. The challenge will be to go from operating at “100,000 feet”<sup>49</sup>

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<sup>47</sup> A dual-eligible is a person who is eligible to receive both Medicaid and Medicare benefits due to the combination of their economic situation and disability status and/or age.

<sup>48</sup> Dr. Paul Johnson.

<sup>49</sup> Clifford.

with “agreements and 125-page documents and data sets”<sup>50</sup> to the ground level where the “frontline staff”<sup>51</sup> know what they are supposed to do or say.

Part of the development of workflows and operations will be to make them more patient-centered. The program wants to have a whole-person perspective as they attempt to address the individual’s needs. The ideal is to be more relationship-based through effective and efficient collaboration rather than working separately: “We’re trying to be very relationship based because that’s what we think will make it successful. It is trying to figure out how it is that we do this – that’s the challenge because it’s a whole new way of doing things.”<sup>52</sup>

Two examples in how the planners have been thinking about the patient-centered concept first concern the relationship between housing and health care and second, the coordination of care for patients if/when they seek care outside of Hennepin Health. For the housing question, the goal is to allow the health care teams to be a part of the identification and prioritization of patients for housing. In other words, the care coordination staff can help patients with housing paperwork. The patient “get[s] the ‘Hennepin Health card’ and go[es] straight to housing.”<sup>53</sup>

The second example tries to address the issue of patients seeking care outside of the system and answering questions such as how to coordinate their care with other systems when necessary and who is responsible for outreach to those

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<sup>50</sup> Larsen.

<sup>51</sup> Ibid.

<sup>52</sup> Clifford.

<sup>53</sup> Ibid.

patients to bring them back into the Hennepin Health system. Hennepin Health is working hard to be patient-centered rather than system-centered.<sup>54</sup>

### *Means-tested programs*

The main problem that means-tested welfare programs face is unstable patient enrollment. Fragmentation within the system worsens enrollment issues and ultimately drives up costs. As was hinted at in the previous sections, unstable patient enrollment within a means-tested program is a problem tractability issue and can lead to resource<sup>55</sup> problems (part of Sabatier & Mazmanian's third category, nonstatutory variables). Hennepin Health clearly demonstrates this typical occurrence, and patient enrollment has been identified as both a short-term and long-term challenge. In the short term, with the launch of Hennepin Health on January 1, 2012, all the care team staff had still not been hired, and their roles and workflows had not yet been established. Therefore, clients may choose to leave the program as they may not yet know who their care team is and therefore do not feel invested in the program.<sup>56</sup> The project needs to avoid early rejection due to infrastructure not being in place. Furthermore, in the long term, Hennepin Health has the challenge of maintaining a critical mass in order to make the program financially sustainable and to demonstrate improved health and financial outcomes. Because of choice – the ability for patients to enroll or remove

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<sup>54</sup> “How do we make it easier? How do we make it a one-stop shop being very patient-centered? It's not centered around the county system. It's centered around the patient” (Clifford).

<sup>55</sup> Again, when Sabatier & Mazmanian refer to resource problems, they are referring to both intangible resources – such as expertise – and tangible resources – such as funding.

<sup>56</sup> As Monson asked, “So, will we retain clients at a time when it's not clear who their care team is?” Godfrey reiterated this sentiment stating, “First, they [Hennepin Health] have a lot of work to get their infrastructure up, but also to maintain [a client base] so that [the clients] are not opting out all the time.”

themselves from the program – Hennepin Health and all its actors need to work constantly for high patient satisfaction:

There is the ability for people to opt out of Hennepin Health in the same way that they can opt out of BlueCross, Medica or HealthPartners. Sustaining enough enrollment in this model to make the financial aspects work and to create enough of a critical mass population to demonstrate good outcomes will be a challenge...[Is there] enough patient satisfaction to keep people in that model and to be comfortable with the options and provider relationships that are available to them?<sup>57</sup>

Patient satisfaction is only one part of the equation to maintaining a critical mass though. The population that Hennepin Health is serving is a population that frequently rotates on and off benefits. In a previous program involving the same population, HCMC had space for 9,000 patients. They never reached that number, but over the course of the 9-month program, HCMC had over 12,000 patients through their system.<sup>58</sup> These previous figures demonstrate the vast amount of population instability and its potential to affect the operation of the program. Turnover of benefits happens about every eight months<sup>59</sup> and is likely caused by the fact that many of the individuals are homeless or have unstable housing<sup>60</sup> and therefore do not receive the required renewal forms by mail. Furthermore, as some live in a constant state of crisis, they may be more concerned with obtaining food and shelter for that day or week than tracking down the proper forms from various county offices. Those behind the establishment and structuring of Hennepin Health believe that the solution lies in having an “active strategy.”<sup>61</sup>

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<sup>57</sup> Owen; “[Maintaining enrollment] will depend on patient satisfaction among other things” (Godfrey).

<sup>58</sup> Larsen.

<sup>59</sup> DeCubellis.

<sup>60</sup> They are a “transient population.” (DeCubellis)

<sup>61</sup> Larsen.

The strategy is to gain access to the eligibility dates from the state of Minnesota. This would allow the different providers to see when a client's Medicaid benefits are going to expire and when they need to apply for renewal. Then the providers can help the clients fill out the proper paperwork to retain benefits. As DeCubellis explains, "...instead of bouncing them out of the system or between systems...we have the ability to keep up our record on them, keep them engaged in care, and help them retain benefits."<sup>62</sup>

Such action will ultimately save the state money for two reasons. First, the state previously paid outside contractors to do outreach to this community in an effort to prevent them from churning on and off benefits. Now, such costs will be absorbed within the capitation payments that Hennepin Health receives, as their own staff will be doing these services.<sup>63</sup> And secondly, this active policy reduces costs because patients are less likely to drop out of the system and therefore less likely to stop medication or preventive care – the cessation of which most likely increases emergency department usage, and subsequently cost, increases.<sup>64</sup> Because of previous success with HCMC's HIV program<sup>65</sup> that has such an outreach policy, Hennepin Health will likely have similar successes for maintenance of benefits.

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<sup>62</sup> DeCubellis.

<sup>63</sup> Ibid.

<sup>64</sup> Ibid.

<sup>65</sup> "So in our successful programs, like our HIV program, they have for 1500 patients one or two people who all they do is manage enrollment. So we have to have an active strategy. And the way that eligibility works is that they have to prove their level of poverty. Fill out all their paperwork. And to do that they have to be really motivated to find the forms and be living in the same place for those forms to come to you and you know what to do with them. So what our HIV program figured out is that they track in their system when are the patients due and they essentially case manage this form filling and enrollment work. So we're hoping to be able to do that same thing" (Larsen).

### *US Health Care System Challenges*

The challenge that the US health care system faces in general is matching the right payment model and care model, creating financial incentives that produce better care. Like the challenge of defining ground-level management through policy from higher levels, correctly matching care and payment models to better incentivize providers to produce better health outcomes for patients involves the ability of policies and statutes to structure implementation. Policies need to structure implementation of both care and payment models. Obtaining better health outcomes comes from both the care and payment models and how policy structured the models implementation. The US health care system has historically been reimbursed through a fee-for-service model. Within the fee-for-service mindset, providers focus solely on individuals and individual services because payment is received through individual services. A culture has been built within the system, therefore, that incentivizes providers to build their practices around these individual encounters instead of more broadly designing processes and practices for entire populations. Two participants expanded on this issue. Dr. Johnson stated:

Starting to look at populations as opposed to individual encounters and how do you create groups of providers that will take ownership around patient populations – however we define that population – that’s a re-orientation of provider perspective. That will take time for providers.<sup>66</sup>

Rather than focusing on individual patients and individual encounters with these patients, Hennepin Health hopes to take a more holistic approach to the population. Dr. Johnson repeated this sentiment, saying, “One of the key

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<sup>66</sup> Dr. Paul Johnson.

differences is the competency and mind-shifts we have to have as a health care organization to thinking about a population rather than thinking of people walking in one at a time.”<sup>67</sup> According to Dr. Johnson, switching to a population rather than individual perspective is a “gigantic shift in how organizations think.”<sup>68</sup>

The re-orientation of providers’ mindsets is to eventually take ownership of one or two patient populations. Hennepin Health in its own perspective shift is centering their program on the target population. Here that shift in perspective relates in some respect to the manner in which Hennepin Health receives compensation. Instead of receiving fee-for-services payments for individuals and the separate services they receive, Hennepin Health is receiving full capitation. As such, financial compensation from capitation, most likely, will help the organizations shift to creating processes geared towards the typical needs of the specific population. The challenge that remains though is the shift for providers within their individual encounters with each client, shifting from meeting one need at a time to a holistic-person and holistic-system orientation.

#### *Program Evaluation*

Two parts of program evaluation are giving Hennepin Health challenges when implementing. However, this problem does not reside within Hennepin Health alone, but will be issues that arise for all ACOs and new delivery system models with the shift to accountability compensation. Again, this is a policy structuring issue, but one that lies distinctly in Sabatier & Mazmanian’s fifth stage. As the program moves forward, Hennepin Health will need to find ways to

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<sup>67</sup> Ibid.

<sup>68</sup> Ibid.

show their successes in savings – not just a shifting or shuffling between county departments – and how to properly value those savings.

#### Valuing accountability and outcomes

One participant mentioned the institution of payment procedures and risk adjustment as a challenge. With a torrent of yet unanswered questions, the participant points to the uncertainty that surrounds the idea of accountability in conjunction with preventative care:

On a big scale of things we need to find out how to value that kind of work. How do you start to figure out how to pay people for preventing things, to keep people healthy, to keep them out of the hospital? How do you properly value that? How do you know when it's working? How do you know when someone didn't have a catastrophic hospitalization? That's a real challenge on the risk adjustment side to figure out what would have happened without proactive interventions. How do you avoid an emergency room visit? And how do you really know that? I think internally we have a good faith understanding that this is a value-based clinic in intervention, and the administration here is going to say that this is something we need to do to be cost-effective. But how are we going to know that for sure?<sup>69</sup>

He continued by explaining the shortfalls of current measures. First for the use of historical data, Dr. Johnson pointed out that people's health expectancy regresses to the mean. Therefore, the issue with historical data is proving that it is not simply regressing to the mean. Secondly, they could measure health outcomes from similar populations. However, the population being served by Hennepin Health is so specific and small that it is difficult to predict what would have happened with certainty or significant data. And finally, measures like patient satisfaction and accessibility can be used, but neither of those gets to the pointed

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<sup>69</sup> Ibid.

question of avoiding “next year’s catastrophe” today.<sup>70</sup> This is one place where there is great potential for outside help. Possibly the state or federal government can be of service in developing more sophisticated risk adjustment tools.

#### Demonstrating impact within social services sector

The final major barrier to implementation that was mentioned within participants’ interviews was the ability to demonstrate impact within the social services sector. The actors within Hennepin Health want to avoid a cost shifting or trickle effect to other systems. In other words, in order to demonstrate success the program must show cost-neutrality at a minimum and even better, a reduction in costs across all the systems.

DeCubellis provided a recent example of cost- and problem-shifting within the overall system.<sup>71</sup> She explained how patients would frequent the emergency room with dental pain. Some of the patients had problems getting an appointment at the dentist and would therefore go to the emergency room when the pain became unbearable. A few others had addiction issues and were seeking pain medication. The old protocol was to distribute pain medicine and tell the patient to make a dentist appointment. Now, through Hennepin Health, patients that arrive at the emergency room with dental pain are re-directed to the dental clinic. This saves the hospital and system high emergency room payments and in most cases, better resolves the patient’s issue. However, Hennepin Health soon discovered that those patients seeking pain medication began appearing in other emergency rooms. The challenge in this scenario now is to figure out how to

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<sup>70</sup> Ibid.

<sup>71</sup> DeCubellis.

communicate with systems outside of Hennepin Health about changes that may create problem-shifts like this one, how to pull those patients back into the system and how to provide them with appropriate care for their condition. In the end, the goal is not to shift costs to other systems or other hospitals, but to directly handle patient problems in the most cost-effective and productive manner.

### *Conclusion*

Many other challenges to implementing such an extensive and new approach to health care and social service delivery may exist, but these challenges were important enough to have been mentioned by the participants of this study. Hennepin Health faces challenges of shared governance, enrollment issues within a means-tested program, creating proper financial incentive and care models within the US health care system, and evaluating their program. In many ways, these challenges speak to and foreshadow the challenges that any new health care delivery approach – including any ACO – may face. Some of these challenges also overlap, pointing to the general complexity of identifying and solving the inherent problems involved with policy innovation and implementation and the collaboration of systems not typically integrated. Ultimately, however, the success of Hennepin Health is dependent upon overcoming these barriers.

### **Relation of Hennepin Health to Implementation Frameworks**

Hennepin Health – in addition to demonstrating the challenges that health care delivery system reforms face – acts as a case study for policy implementation theory. Below is an examination of how this demonstration project fits into the

two implementation models previously described and as a result, how the case study presents the practical problems of using either model.

*Sabatier & Mazmanian*

In order to systematically study Sabatier & Mazmanian's conceptual framework to implementation, this section includes how the characteristics involved in implementing Hennepin Health fit into the three categories stipulated by Sabatier & Mazmanian – tractability of the problem, ability of the statute to structure implementation, and nonstatutory variables affecting implementation – and the potential influence such characteristics have on implementation success. After that, the Hennepin Health case study is taken through the phases the project has gone through within the five-phase process. As will be seen, Sabatier & Mazmanian do a phenomenal job of including all of the potential characteristics that influence policy implementation, but such an overwhelming amount of characteristics brings into question which characteristics have causal effect (and which are simply correlated) and how much power each causal characteristic actually holds. The model is complex to the point of being non-functional.

To begin, the first category that Sabatier & Mazmanian discuss is tractability of the problem. Without even drawing from the interviews or the Hennepin Health example, the literature involving ACOs and other health care delivery system models demonstrates the complexity of the models and the problems within health care that the models are attempting to address. The US health care system is extremely complicated and the policies that try to lower costs and improve health outcomes are also intricate. Furthermore, years of

implementing different policies and models have not corrected the problems seen within the US social service and health care sectors. Therefore, the problem of cost and quality control that ACOs attempt to correct is not very tractable.

Additionally, Sabatier & Mazmanian enhance the tractability concept with the need to understand the populations involved within the policy. In the case of Hennepin Health, two populations are impacted by the project. First, the target population that the project serves is a small percentage of the overall population, but it is also a highly transient population that has displayed erratic behavior in the past. Some of the participants discussed the cause behind this population's behavior relates to their constant crisis and pursuit of basic needs.<sup>72</sup> Forums were held with the target population in order to better understand how, where and why they seek health services, as well as their ideals for receiving these services.<sup>73</sup> After identification of causes for behavior and the forums to determine the population's views, the patients' behavior may be slightly more predictable, but ultimately still adds a layer of complexity to the problem. The second population is the providers within the demonstration project. Their behaviors are driven by incentives, and getting the incentive formula correct to manipulate provider behavior within the health care system is difficult. This case study has the same problem with provider behavior – incentivizing quality over quantity. For these reasons, Hennepin Health's relation to Sabatier & Mazmanian's first category of policy characteristics suggests that Hennepin Health will struggle to successfully reach its goals. The population and its behavior is not easily managed and

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<sup>72</sup> DeCubellis.

<sup>73</sup> Ibid.

modified, not because Medicaid patients do not want to change their behavior, but because of the complexity of their life and financial situations.

The second category is the ability of a statute to structure implementation, which primarily includes a statute's ability to link the problem with a solution by specifying clear, explicit, precise, measurable and realizable objectives. This requires the statute to establish a valid causal relationship, acknowledge and distribute necessary resources, provide incentives for compliance (and conversely sanctions for non-compliance), and regulate the number of clearance points. Applying Hennepin Health to these prescribed characteristics again shows difficulties for a successful demonstration project. Firstly, Hennepin Health is required to adhere to a rigorous evaluation and measurement process, which shows that the demonstration project has created explicit objectives and put in place a manner in which to measure progress and accomplishment of those objectives. However, as suggested from the challenges section, program evaluation still faces certain barriers, particularly demonstrating improvements across all sectors integrated into the program.<sup>74</sup> As Ross Owen, Manager of Care Delivery Reform at Minnesota's Department of Human Services, explained, "[Hennepin Health] could do a great job with saving dollars within the county system in the housing sector, but if it causes a spike in health care costs, it won't necessarily look like a success in Medicaid costs."<sup>75</sup> In other words, demonstrating success across all the entities involved will be difficult. So even if the projects objectives are clear, the question remains if they are realizable. The

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<sup>74</sup> Owen.

<sup>75</sup> Ibid.

project does draw causal lines between the health care and social service sectors. Program advocates believe a patient's health outcomes are related to their housing and financial situation and have thus shaped the project around this relationship.

The next portion of this category involves resources. As the project's integration of health care and social services is a new and unique concept within the US, knowledge and experience as a resource is lacking. However, the actors involved in Hennepin Health have other programs from which to draw experience, including the Preferred Integrated Network (PINS),<sup>76</sup> HCMC's Positive Care Center,<sup>77</sup> and the Coordinated Care Clinic devised through the Coordinated Care Delivery System (CCDS).<sup>78</sup> Hennepin Health received a block grant as part of their contract, but whether that amount will be sufficient to care

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<sup>76</sup> PINS was developed in 2008 in response to the state's request for proposals to create an "integrated network for persons with co-occurring mental health and medical needs" ("Integrated Health Delivery Network: A Social Disparities Approach to Health & Health Care," p. 20). Hennepin County submitted the PINS proposal to the Minnesota Department of Human Services, but it was never approved or implemented. There is some overlap of the population of PINS and Hennepin Health's recipients. Therefore, information gathered during the PINS planning process was informative in the development of Hennepin Health's protocols and care model ("Integrated Health Delivery Network: A Social Disparities Approach to Health & Health Care," p. 23).

<sup>77</sup> HCMC's own Positive Care Center has presented a wealth of similarities for which to brainstorm solutions and stands as a successful example of care models with integrated health and other services. The Positive Care Center is designed specifically for patients who are HIV positive to provide them with comprehensive health and psychosocial services.

<sup>78</sup> CCDS was a block grant (capitation) program in which four metro-area hospitals participated. These four hospitals, including HCMC, accepted a capitation payment in return of caring for and being financially responsible for a particular patient population. Through the CCDS capitation payment, HCMC developed its Coordinated Care Clinic with part of the CCDS capitation funding. They targeted the most expensive CCDS patients, the high-utilizers of the emergency department and hospital system. Patients were re-routed from the emergency department to the Coordinated Care Clinic, where their care was more closely managed and they could get their social service needs met. Through enrollment in the Coordinated Care Clinic, HCMC's most expensive and highest-using patients experienced a 42 percent decrease in repeat hospitalizations and a 38 percent decrease in emergency department visits ("Integrated Health Delivery Network: A Social Disparities Approach to Health & Health Care," p. 21).

for all of this population's needs or not is unknown. Yet, the premise of the project is to be able to create a system that ultimately operates on that budget or less. Concerning technological resources, those involved believe in the capabilities of the data warehouse they are building, but as was stated in the challenges section, there are issues with the legal capacity to share information among the partners.<sup>79</sup> The political support behind the project is strong with the County Administrator and county board committed to health care reform. However, if such support continues as political figures change over is also unknown. So in terms of resources, Hennepin Health would appear to have several resources at their disposal – experience from previous programs, financial and technological resources, and political support, but the lack of knowledge or experience for implementing this specific of a program and the struggles with information sharing due to a lack of legal capacity may inhibit success. This particular lack of resources is a challenge inherent to ACOs in general.

Additionally, Sabatier & Mazmanian discuss the number of veto or clearance points as a characteristic that impacts implementation. Within this project, Hennepin Health has four partners, but a vast number of providers with whom they contract. The sheer amount of relationships and collaboration expected and involved within this model adds to the difficulty of successful implementation.

The third category is nonstatutory variables, which includes media attention, public support, time, changes in social, economic, political and technological conditions, and bargaining. In the case of Hennepin Health, the

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<sup>79</sup> DeCubellis; Clifford.

latter three play a role in Hennepin Health's formation and implementation and have the potential to be beneficial or inhibitory of the project's success. Hennepin Health was formed quickly, which in some respects, was the reasoning behind some of the conditions of the negotiated contract with the Minnesota Department of Human Services.<sup>80</sup> So time played a factor in the way negotiations and contracts took shape, but whether the speed in which the project was formed and organized factors into the success is not known. Changes in economic conditions with the US recession had some role in the inception of Hennepin Health. DeCubellis points out that the county needed to find a way to stretch their dollar further with more people seeking services and a smaller tax base to provide those services.<sup>81</sup> Other social, political and technological condition changes – such as the passage of the Patient Protection and Affordable Care Act and the atmosphere of health care policy reform that it created – may have influenced the project as well, but the weight of that influence is difficult, if not impossible to determine.

And finally, bargaining played a significant role in the policy of this demonstration project. First of all, negotiations and bargaining were the primary mechanism by which contracts were developed among the four partners and between the county and the state entities involved. Secondly, more than one participant explained that the Hennepin Health project is not regulated under Section 19. After Minnesota's Department of Human Services created guidelines for demonstration projects under Section 19 legislation, Hennepin County realized they were moving in a different direction in terms of what the demonstration

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<sup>80</sup> Hennepin Health is operating under a PMAP contract partially because of a shortened time frame for its development (Clifford).

<sup>81</sup> DeCubellis.

project should look like and what population they wanted to serve. Through conversations with the department, Hennepin County was allowed and encouraged to continue with their project, but it would operate under a different contract than one developed through Section 19.

As seen from the last few pages, Sabatier & Mazmanian accurately identified several characteristics that can influence policy development and implementation, and many of those factors had roles in the creation and implementation of Hennepin Health. However, the weight that each of these characteristics have in the formula that drive successful implementation is unknown. Therefore, the composition of characteristics has no predictive capability. In the end, Sabatier & Mazmanian's model is useful in a conceptual or theoretical sense in regards to the characteristics that can impact implementation, but theoretically fails to adequately describe the overall process of implementation.

#### *Majone & Wildavsky*

Majone & Wildavsky take a completely different approach to their model. They attempt to look at policy implementation holistically through their implementation as evolution model. The holistic approach makes examination from a case study extremely difficult, particularly a case study that has only recently been implemented and has not yet gathered evaluative data on its overall success. Looking at the case study of Hennepin Health, this study confirms Majone & Wildavsky's assertion that their first two models – implementation as control and implementation as interaction – fail as theories of implementation. For

the first model, control does not work in the case of Hennepin Health because Hennepin Health does not fall under Section 19; Hennepin County chose a different route for their demonstration project and DHS allowed them to do so. This might point to some level of truth to the implementation as interaction model – Hennepin County and the partners of Hennepin Health ‘interacted’ with DHS in order to develop the demonstration project and implement it. However, this model does not take into consideration the federal regulations that impacted the demonstration project’s ability to form and move forward and the evolution of health care policy models from which the project drew its parameters.

So what conclusions can be drawn about Majone & Wildavsky’s third model – implementation as evolution – from the Hennepin Health case study? First, it shows that policies are “potentialities.” Section 20, the Minnesota statute that allowed Hennepin County to develop a demonstration project such as this, was a potentiality until the project was formed and implemented.

Second, implementation *does* rely on both intrinsic qualities and external circumstances. Intrinsic qualities are the ways in which policy is written to structure implementation, and external circumstances are societal conditions and the actions of agencies and actors that are implementing the policy that influence overall implementation. These intrinsic qualities and external circumstances are not delineated by Majone & Wildavsky, but it is possible to assume that the characteristic groups and their components that Sabatier & Mazmanian outline – tractability of the problem, ability of the statute to structure implementation and nonstatutory factors – could be reorganized under Majone and Wildavsky’s two

groups. As such, the characteristics of the Hennepin Health project that may impact implementation was already discussed under the Sabatier & Mazmanian section and point to the accuracy of Majone & Wildavsky's statement.

And finally, Majone & Wildavsky believe that implementation is in a constant state of change with the end policy and its implementation being "genetically related" to the original policy idea. Operating under their holistic viewpoint, no conclusion can yet be drawn because the demonstration project has not yet reached its evaluation and ending stage. But, looking at the literature, it appears that these health care delivery system demonstrations are evolving from a history of health care policy reforms – medical home models, HMOs, etc. – and at their core, are attempting to address the same problems of cost and quality. In conclusion, Majone & Wildavsky's model also fails to be practical and predictive. It – like Sabatier & Mazmanian's model – is highly theoretical, begging the question then if a predictive implementation model can be developed.

## **Implications**

### *Implications for the study of policy implementation*

The implication of this case for the study of policy implementation is simple: a predictive and practical policy implementation model has not yet been produced and in reality, may never be produced. Implementation is an extremely complex process and is even further complicated when it attempts to address convoluted societal issues, such as health care and social services. Sabatier & Mazmanian's work on the characteristics that affect implementation is as close to a practical framework as any research has yet gotten. However, perhaps the goals

of the two models are different from each other and neither explicitly aims to predict implementation success. With their model, Sabatier & Mazmanian may be attempting to give researchers a better, more cohesive manner with which to study and talk about policy implementation. By giving a full spectrum of characteristics that may be causal variables in implementation, Sabatier & Mazmanian are giving a preview to the possible challenges, to what could go awry. Majone & Wildavsky, on the other hand, likely had a different goal for their model. They perhaps intended to provide language for describing how the process of implementation unfolds in its totality. Still, researchers may want to develop better and more rigorous ways to examine how the separate characteristics impact implementation. Answers to the following questions are areas of study to further develop: Which characteristics are causal and which are correlative? What amount or weight should each characteristic be given? And how do the characteristics change based on the type of policy being implemented (i.e. health care policy, welfare policy, etc.)?

*Effect on future health care and social service policy*

The unique features of Hennepin Health – regardless of whether the project successfully reduces costs alongside improved health outcomes – have the potential to drive state and federal health care legislation. But if Hennepin Health is successful, this demonstration project could serve as a prominent model for future health care reforms. The program’s unique features include the population served, the inclusion of social services within the care model, the ability to track recipients through the data warehouse, and the motivation as a county safety net.

First, as previously stated, ACO models currently implemented across the United States are for Medicare populations. Hennepin Health, on the other hand, is choosing to target a Medicaid population frequently overlooked. Yet this population is comprised of some of the highest utilizers of the health care and social service sectors, cost the system the most money, and have a lifespan significantly shortened by chronic disease and mental illness.<sup>82</sup> As such, this demonstration project will give insight on how to best serve this particular population and perhaps lower costs of serving this population.

The second – and most prominent – characteristic that this study’s participants mentioned was the inclusion of social services within the health care delivery model. All of the participants mentioned the social disparity concept – rolling housing, corrections and other county operations into the fold – as the main feature of Hennepin Health. Dr. Larsen stated that the initiative to find the total cost of individuals for a county was rare,<sup>83</sup> and they believe they can save money and produce better results in the end by treating patients “holistically.”<sup>84</sup> DeCubellis cites the prioritization of basic needs as an instigator to some failures of health care:

For example, hypertension is their concern. Then how many times we tell a person to take this pill and how many times it’s important to check their blood pressure regularly if they don’t know where their next meal is coming from, if they don’t know where they’re sleeping that night, no matter how much we educate, that’s not their priority. Their basic needs are their priority at that moment. So the project is front-loading those services. We believe we can use the medical dollars to cover basic needs and get better health outcomes and still reduce the overall cost by making sure that we address those needs prior to the crisis event occurring...

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<sup>82</sup> Monson.

<sup>83</sup> Larsen.

<sup>84</sup> DeCubellis.

We're engaging those individuals in preventive care, making sure they're seeing someone in primary care. We're making sure those services are available in the shelters, available in the community. And that if someone does come in to us – for example with pain in their arm, we're not just looking at their arm; we're looking at their entire situation. What are their needs? And making sure we address them holistically so that we're not just working with a part of their body. We're making sure that they really have the ability to follow through with our suggestions based on their life status.<sup>85</sup>

Recognizing that these patients have more pressing concerns than their health, until their health becomes a crisis, is an important element and will, in theory, help Hennepin County to either reduce costs or redistribute resources to create better overall value of services. Owen considers this feature to be one of the greatest challenges, but also one of the greatest opportunities.<sup>86</sup> If Hennepin Health is able to demonstrate savings (or at least cost neutrality with improved value) across all their county sectors, this will have huge implications on how to break down the silos built within social policy in general. Because of the intimate connection between social and health care services, demonstrating how the two systems can work together has the potential to change how all local governments administer and govern these services.

To make social services part of the model, it is also essential to make them part of the patient's electronic health record.<sup>87</sup> Hennepin Health does this within their data warehouse. Having all of the information in one location not only allows for better coordination for the individuals, but allows for better evaluation of the program overall. The county will be able to draw out data from the

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<sup>85</sup> DeCubellis.

<sup>86</sup> Owen.

<sup>87</sup> Berglin.

warehouse to examine and prove if the model reduces costs in the public sector over a long period of time. They want to avoid cost shifting. As DeCubellis states:

We also argue we have a unique position because we want to make sure there is no cost shifting... We can get our arms around are we shifting costs to the courts, to the jails, to the city hospital, to the public sector... So we are following people to say, 'What is the impact here if we provide some upfront basic needs and social services? Can we keep them out of the jail? Can we reduce court costs? Can we make sure they don't end up in long term care or state hospital programs or other state operated services?' We just have a little broader view and some motivations around keeping people well and out of the public sector in requiring those supports.<sup>88</sup>

Unlike most private models, Hennepin Health will be able to examine their impact across all of the public entities to find the true total cost of care results. Total cost of care models in the public sector, if successful, will have great influence in how local government programs are run.

And finally, Hennepin County is motivated as the public entity, the county safety net, to reduce overall costs and produce better value for their services. Unlike private models, the county will be required to provide services, in one way or another, even if the patient loses their state or federal benefits.<sup>89</sup> For this reason, Hennepin County is even more motivated to make this demonstration project successful.

If Hennepin Health proves successful, expansion and replication was cited by six of the study's participants as the next logical step.<sup>90</sup> There are hopes to expand the model to other populations; a couple mentioned dual-eligibles<sup>91</sup> as the next population to be incorporated into the model. Expansion to other counties

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<sup>88</sup> DeCubellis.

<sup>89</sup> Ibid.

<sup>90</sup> Ibid.; Jacques; Owen; Monson; Richard Johnson; Godfrey.

<sup>91</sup> DeCubellis; Godfrey.

and states was also mentioned. The flip side of expansion involves keeping ‘successful’ patients engaged in the model. Once a patient is no longer considered a high-user and/or Medicaid recipient, it will be important not to kick them out of a care delivery model that worked for them. As such, bringing in private insurance companies and private providers will be vital in keeping people engaged in the model.<sup>92</sup> The role of and relationships among health insurers, providers, managed care organizations and delivery systems is evolving, and demonstration projects like Hennepin Health are going to have an enormous impact on the direction health care policy – and now social service policy – takes.

At the time this study was written, the US Supreme Court was in the midst of hearing several cases arguing against the constitutionality of the Patient Protection and Affordable Care Act and would be announcing a decision in June 2012. The logical question that arises concerning this particular study is: how will the decision impact Hennepin Health and other ACO demonstration projects? If the act is repealed, will ACOs be able to move forward in implementation and expansion? A small minority of analysts believes that a decision to repeal the act would stop – or at least significantly inhibit – the implementation of ACOs. Since part of the Patient Protection and Affordable Care Act is to fund advanced health information technology and since ACOs rely so heavily on that technology, ACO models would be severely limited. In other words, the model will still be around, but resources including funding and organizational support may not be available

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<sup>92</sup> DeCubellis.

to implement it.<sup>93</sup> Many more, however, argue that as more and more ACO and ACO-like models are implemented, the Supreme Court's decision will not be able to stop their spread.<sup>94</sup> "[The implementation of ACOs] is going to continue," according to one analyst, "because there are other market imperatives forcing improvements in quality and efficiency of care."<sup>95</sup> As long as there is pressure within the system to improve quality and lower costs, new integrated care models will evolve and be implemented, which means that the Hennepin Health model may have enormous implications for the health care system regardless of any legislation or judicial decision.

### **Study Limitations**

This methodology has certain limitations. First off, due to time constraints and the inherent nature of the case study I have selected some of the characteristics that Majone & Wildavsky and Sabatier & Mazmanian mention as important for determining the level of successful implementation will not be addressed. For example, "the amount and continuity of media attention to the problem addressed by a statute"<sup>96</sup> was not scrutinized thoroughly within this paper. To remain true to the specificity and locality of the case study being examined, only media attention concerning Hennepin County's demonstration project should be studied. While the Patient Protection and Affordable Care Act as a whole and ACOs as general models have received considerable amounts of

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<sup>93</sup>Magan, GERALYN. "How Will the Supreme Court Ruling on Health Reform Impact HIT?" *LeadingAge*. Published 13 April 2012.

<sup>94</sup>Miller, Andy. "Georgia gets role in Medicare 'accountable care'." *Georgia Health News*. Published 11 April 2012.

<sup>95</sup>Larson, Jennifer. "Supreme Court Hears Affordable Care Act Arguments, Public Waits on Decision." *Nursezone*. Published 6 April 2012.

<sup>96</sup>Theodoulou and Cahn, *Public Policy: The Essential Readings*, p. 163.

media attention, the media attention surrounding the demonstration project is either not substantial or sufficient enough and would require vast amounts of time and energy to find and dissect. Therefore, this characteristic from Sabatier & Mazmanian's framework will not be considered in the discussion.

Following from that limitation is the constraint of rigor from using one case study and from the volume and complexity of characteristics involved in examining the implementation of a health care delivery system demonstration project. Using a case study allows for a more in-depth look at a new health care delivery model, but it sacrifices a level of statistical or replicable certainty. Also the sheer amount of characteristics that impact implementation and the fact that most of these characteristics are complex or nuanced makes it almost impossible to determine which characteristics are causal, correlative or not related to the success of implementation.

The third limitation – and most inhibiting limitation – is the inability to study the final implementation results of the demonstration project as the launch date was January 1, 2012, giving insufficient time to collect accurate data on success of the project. However, in all of the interviews conducted, participants were asked questions pertaining to the projected success rates of the project, likely challenges to successful implementation, and perceived impacts of the project on policy. The inability to examine the end results is probably the most detrimental limitation to the study because it is the observation of implementation success or failure that provides the most evidence for aspects of both models. This

is an area where implementation literature and theory can converge, and to not be in a position to examine how these two pieces fit together is a severe limitation.

## **Conclusion**

Americans are at a pivotal moment in terms of creating a better health care system, one with lower costs and better health outcomes. Reform is in the air, and with a movement towards establishing more integrated health care delivery systems; the potential for improved value exists. Yet, as this study suggests, inherent challenges are present within the health care system and overall political and administrative structures that act as significant barriers to reform and successful completion of generating better value. ACOs and similar health care delivery system models are complex care and payment models. Due to uncertainties about their implementation – including a lack of understanding of the ACO definition, a lack of provider and payer experience, unclear legal and financial ramifications and in general, fear of their influence on regulation and low patient participation – such models are being introduced to the system through demonstration projects. Hennepin Health in Minnesota is one of those demonstration projects.

Hennepin Health, as an integrated health care delivery system demonstration project, works to integrate health care and social services at the county level for a target population of single adults without children who live at or below 75 percent of the federal poverty line. Using a full capitation payment method from the state in conjunction with a shared risk agreement, Hennepin Health's partners have entered new territory concerning collaboration across government entities. Actors within the project who participated in this study articulated the challenges as problems of shared governance, means-tested

programs, US health care culture, and program evaluation. They are worried about how to enact complicated contacts among the partners and between the state and county at the local level; they are concerned about obtaining and retaining a critical mass patient population. They are struggling with out-dated legal regulations for patient privacy and information sharing, and they are apprehensive about their ability to demonstrate savings and improved outcomes across all the systems in which they are working. Some of these challenges were predicted by the ACO literature and others – particularly shared governance among the three levels of government – are perpetual challenges of implementing US health care and social policy.

When placed against theories of policy implementation, the theories cannot predict Hennepin Health's chances at success. Sabatier & Mazmanian's conceptual framework helps to delineate the characteristics that may factor into successful implementation. In this sense, policy creators, administrators and street-level bureaucrats are given a preview of the challenges they may face and the factors they need to consider when creating and implementing policy. However, the model fails to give insight as to which characteristics are most important, the ones that have the most influence on implementation. The inability to create a formulaic implementation model is likely due to the intricacies of the US political system and the complexity of health care and other social policy, as well as the problems they attempt to address.

For now, it is a waiting game for Hennepin Health. If the project is successful, there are significant implications for the future integration of health

care and social services, as well as ACO and ACO-like models. Counties and states may begin addressing populations holistically, trying to juggle housing, corrections, health care, and much more in one program or project rather than across separate governmental entities. Furthermore, the particular population that Hennepin Health has chosen to target is a highly transient and expensive population. If Hennepin Health can improve health outcomes and reduce costs simultaneously for this population, then the project has vast potential for replication to other geographic areas and with other populations.

Historically, sweeping health care reforms – like patient-centered medical homes, HMOs and managed care plans – have failed to produce desired results. They have been unable to reduce (or even stabilize) health care costs while simultaneously improving health outcomes. ACOs and recent health care delivery models have the potential to meet that dual goal, and to reiterate Crosson’s claim, we are at a moment when they are too important to fail.

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