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Paths to Sustainability for Innovative Delivery System Programs

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Key findings

- We found widespread interest and activity in testing new care delivery models to improve health care quality and reduce costs in Massachusetts. However, the environment presents great uncertainty for the sustainability of these programs.
- There was little interest in establishing new fee-for-service payments for functions such as care coordination because of the possibility of higher total payments if utilization of other services did not decrease.
- Payers and ACOs are looking for models that can quickly reduce costs—approaches that will offset additional investments with immediate efficiencies. Respondents widely identified increasing the amount of provider payment that is "at risk" as a key to increasing the amount of innovation in care delivery.
- Innovation will likely be concentrated in delivery systems that can manage financial risk and have the experience and capacity to develop better ways of caring for patients. Payers interested in innovation should seek ways to provide support and build the capacity of smaller and less-experienced providers as well.
- Providers are unlikely to be able to sustain innovative care delivery models by seeking only additional fee-for-service payments for nonvisit functions.
- More clearly defined criteria for success, and guidance for health care providers on how to measure and demonstrate that success, could help advance innovation.

SUMMARY ■ Innovative health care delivery organizations are developing programs that aim to improve quality and demonstrate reductions in unnecessary use of acute care and costs. These programs are often incompatible with fee-for-service payment systems. Providers that seek to innovate how they deliver care can adversely affect their financial performance in two ways. First, payers may not directly reimburse important components of the care delivery program. For example, care coordination services have not typically been reimbursable services under fee-for-service. Second, to the extent that improvements in care decrease health care utilization, providers may face decreased revenue (Toussaint, Milstein, and Shortell, 2013). To address these issues, payers and providers have been using new payment methods to align financial incentives with quality improvement and cost reduction goals. To make these changes, providers are changing their business models, organizational structures, and how they deliver care. Accountable care organizations (ACOs), in which groups of providers coordinate delivery and are paid in relation to quality and total cost of care for a defined population, are perhaps the most visible of these changes.

Grants or related methods for funding pilots can provide time-limited support for health care organizations to identify effective methods of improving care for their patient populations. For programs to last beyond the end of grant funding, they must have a sustainable business model. Given the rapid changes in health care payment and delivery, it can be difficult for organizations to determine what types of programs are likely to be sustainable.

The objective of this study was to identify paths to sustainability for innovative care delivery programs. Using a sample of health plans and ACOs in Massachusetts, we sought to identify the methods they are using to reimburse new care delivery models, criteria that health plans use to determine eligibility for these models, and criteria that ACOs apply for their investments in delivery innovations.

We interviewed individuals with decisionmaking authority about financial support for innovative care delivery programs at seven health plans and five ACOs in Massachusetts. We asked respondents about the primary payment arrangements supporting these programs, the criteria they used to decide whether to support these programs, barriers to sustainability, and proposed solutions to those barriers. We defined *innovative care delivery programs* as newer methods for patient care that aim to improve quality and reduce inefficiencies, giving three examples based on real pilot programs: (1) in a community mental health care clinic, a nurse is assigned to coordinate care for medically and socially complex, high-cost patients; (2) in a hospital, a community health worker is assigned to coordinate care for medically and socially complex, high-cost patients; (3) in a community health center, a community health worker and pharmacist team to help complex patients by completing a full medication reconciliation.

The following themes emerged from these interviews:

- All of the respondents indicated that they were currently supporting innovative care delivery programs intended to improve quality and reduce costs. The most common short-term objective of these programs was to improve the coordination of care for the highest-risk patients.
- Health plans reported that the predominant type of payment to support care delivery innovations was global payment; plan representatives reported paying providers directly for nonvisit functions in only a few cases.
- Most respondents indicated that innovative programs were developed centrally by the plan or ACO and then disseminated to providers; cases where individual providers brought programs to the attention of the plan/ACO were rare.
- Decisions are based mainly on expected potential and less on demonstrated past performance. Generalizability, adequate provider capacity, experience in managing financial risk, leadership buy-in, and experience implementing similar programs are other criteria respondents commonly apply.
- Providers currently face conflicting payment incentives from fee-for-service and alternative payment models. Accelerating the shift away from fee-for-service could support changes in care delivery by reducing how much the innovations might negatively impact providers' revenue.

We identified a highly uncertain environment for the sustainability of care delivery innovations despite a high degree of interest in these programs. Dynamics in the current environment suggest that innovation will likely be concentrated in health care delivery systems that are able to manage financial risk and that have experience and capacity in delivery innovation. For providers seeking to innovate, the central challenge will be building the capacity to manage financial risk in global payment arrangements and to support improvements in care. This will be particularly challenging for smaller organizations. Payers interested in innovation should seek ways to provide support and build the capacity of smaller and less-experienced providers so that they, too, can innovate and improve how they provide care. While the Massachusetts health care context differs from other markets, many of the observations of local health plan and ACO representatives were quite general and would likely be widely applicable to other regions.

METHODS

We interviewed individuals with decisionmaking authority about financial support for care delivery programs at seven health plans and five ACOs in Massachusetts. The seven plans included both private- and public-sector payers, and their service areas encompass geographic diversity across Massachusetts. Commensurate with the mission of the Blue Cross Blue Shield of Massachusetts Foundation, the plans we interviewed largely serve members with low incomes, behavioral health diagnoses, and complex medical conditions. The ACOs we interviewed represented diversity in geography and size. We also generally selected more-established ACOs, so they could better speak to their experience. Following procedures approved by our Institutional Review Board, we assured interview participants that we would not attribute their responses to our questions to particular institutions or individuals. To ensure this, we do not provide more-detailed information about interview participants that could be used to identify them.

We conducted interviews by phone with a dedicated notetaker. We asked respondents about the primary payment arrangements they used to support care delivery programs, the criteria they use to make decisions about whether to support programs designed to improve the delivery of care, barriers to sustainability, and their ideas for how to overcome those barriers. As already stated, we defined *innovative care delivery programs* as newer methods for patient care that aim to improve quality and reduce inefficiencies, giving three examples based on real pilot programs: (1) in a community mental health care clinic, a nurse is assigned to coordinate care for medically and socially complex, high-cost patients; (2) in a hospital, a community health worker is assigned to coordinate care for medically and socially complex, high cost patients; (3) in a community health center, a community health worker and pharmacist team help complex patients by completing a full medication reconciliation. Two researchers performed a thematic analysis on the interview notes.

RESULTS

Innovative Care Delivery Models

All of the respondents indicated that they were currently supporting innovative care delivery programs designed to improve quality and reduce costs. The most common objective of these programs was to improve the coordination of care for the highest-risk patients. The most common models included integrated behavioral and primary health care (Center for Integrated Healthcare Solutions, undated), patient-centered medical homes (Jackson et al., 2013), care coordinators (McDonald et al., 2007), and virtual care (Friedman et al., 1997). In addition, ACO respondents reported using systematic efforts to encourage physicians to refer patients to preferred providers (Mechanic et al., 2011) to improve the quality and efficiency of care.

Financing of Innovative Care Delivery Programs

Respondents generally referred to limited funding available to support innovative care delivery models and described a "chicken or the egg" problem: Fee-for-service payment methods do not support innovative care delivery models, but meaningful changes in care delivery require investment before yielding a return. Some respondents indicated that their organizations had a financial surplus from prior periods that they allocated to support delivery reforms; without a surplus, it was difficult to provide adequate investment. In turn, care delivery programs were often expected to generate savings over a very short time frame (often one or two years) to provide the cash flow needed to sustain investment. One respondent from a health plan described it thus:

> Built into the program was the expectation of savings and all additional costs would be funded out of savings and there would be no additional funding mechanisms. That's a tall order.

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In a few cases, health plan respondents reported that they give providers payments for "nonvisit functions," such as care management. However, plan representatives explained that the predominant type of payment to support care delivery innovation was "global payment," which refers to a range of methods that establishes spending targets to cover all of, or the vast majority of, expected costs for health care services to be delivered to a specific population during a stated period of time. Global payment methods involve sharing some proportion of savings generated below a predetermined budget ("upside risk") and in some cases a negotiated portion of costs that exceed a predetermined budget ("downside risk"), with the specific arrangement adjusted for providers' ability to manage risk. ACOs commonly passed along upside, and sometimes downside, financial risk to practices within the ACO. One ACO respondent described using a simpler set of incentive targets for its providers compared with the more complex targets for which the overall ACO was accountable in its risk contracts. The payer created a set of incentives for the ACO, and the ACO created a different, simpler, but compatible set of incentives for its providers:

> We try to internalize the fragmented external world so providers have less to worry about…We don't want to have too many things for providers to worry about. Certain providers care more about one thing than others.

One intended effect of these payment methods was to provide flexibility to providers in how they deliver care. One health plan representative explained:

> There are no requirements on the…payment. They can invest in infrastructure or hire a care manager. The philosophy is: Doctors know how to be doctors and the current model does not allow them to do that because of the reimbursement structure.

However, respondents were not altogether agnostic as to how the delivery of care should occur. Health plan and ACO representatives reported providing in-kind support for care delivery programs. Common types of in-kind support included paying for a care manager to work either at the health plan or at the providers' site; using data analysis to identify high-risk patients; providing data to help providers identify their own opportunities for improvement; and gathering information on best practices. For example, one health plan respondent described:

> We do predictive modeling to find the sweet spot for intervention given the little resources we have…We make it directly available to network providers based on predictive modeling. We try to integrate behavioral health data with medical and pharmacy data to find members that are likely to have readmission or high admission rates. Case managers are getting these people engaged. We share these programs with providers that are taking risk.

Some health plan respondents questioned the premise that shifting away from fee-for-service was a prerequisite for care delivery innovation. They suspected that some innovative providers are able to support innovative programs using revenue from reimbursable services. They argued that providers should be able to start innovating in the fee-for-service environment, then make the case that savings should be shared, rather than waiting for new sources of payment to start innovating.

Development and Spread of Care Delivery Programs

Respondents described that most innovative care delivery programs were developed centrally by the payer/ACO and disseminated to providers ("inside-out" innovation). They

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typically applied these programs at sites they considered most ready for success, and then spread them to other sites, replicating characteristics they expected to foster success. In rare cases, innovation occurred in the opposite direction ("outside-in"): Innovative providers had developed and piloted care delivery programs that they then shared with the payer/ACO. Generally, the payers and ACOs viewed most front-line providers as lacking the capacity to innovate without central support. One ACO representative noted:

> We have some of that [providers bringing ideas for delivery innovations to the ACO], but that tends to happen more when medical directors have an idea and do not know how to operationalize it, then they will come to us. The challenge for the offices is that they're so busy that they can't do it. They don't have project managers, so we've taken the ideas and thought about how to roll them out.

Criteria for Support of Innovative Care Delivery Programs

We asked ACO and health plan representatives to describe the criteria used to select innovative care delivery programs for implementation, to select providers to participate in the programs, and to monitor and evaluate existing programs. In many cases, respondents did not differentiate between "pilot testing" and "implementation" phases. Rather, they viewed implementation as a gradual process, starting with a few favorable sites and expanding over time, subject to continuous monitoring that could result in program changes or termination.

Program Scale and Impact

Two of the criteria that ACOs and health plans use most often to assess innovative care delivery programs are the potential scale and impact of the program. Scale and impact depend on the number of relevant and affected patients, as well as the potential for improvement in quality and reduction in costs of care for that population. Payers and ACOs use these criteria both to select innovative care delivery programs for implementation and to choose implementation sites: Providers that have larger patient populations (beneficiaries of the health plan) are more likely to be selected for participation. An ACO respondent explained:

> The procedure is to assess the size of the potential impact. We take a look at the investment per program and what segment of the population it will impact.

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A health plan respondent augmented this idea:

> We want to know that they have enough patients of ours to have enough confidence in the information—it needs to be actuarially sound. If you have 20,000 patients and someone wants to do the program for 200 of them, then the front desk will say we can't do it differently for just that group of 200.

While respondents viewed savings potential as an important factor in determining which innovative care delivery programs to support with an initial investment, they do not require that a program demonstrate cost savings in a pilot before making an investment. Instead, they often based decisions on anecdotal evidence from peer organizations or published reports as to what types of delivery programs are likely to lead to savings. They then monitored costs over time for program participants. Two ACO respondents explained:

> I would like to say it is more scientific; we do pursue some pilots that are more tried and true in the literature. We also follow hunches that we think will impact cost and quality. The initiatives supported have a mixture of evidence supporting them—some are well supported, while others are very much pilot programs.

> There is no real criterion. We just evaluate these along with other programs or things in the budget. We have

> to argue quality vs. cost. It's difficult because you can't always quantify patient care in dollars.

In summary, health plans and ACOs do not seem to require deep evidence of the past performance of a program. Rather, they base decisions regarding innovative care delivery programs on expected potential. However, after implementation, ACO and health plan leaders expect care delivery programs to meet quality and cost benchmarks quickly.

Program Characteristics

Health plan and ACO representatives described several criteria related to the design of innovative care delivery programs that they typically apply in decisions about what programs to support: potential scalability, patient engagement, and appropriate staffing. However, providers generally have a fair degree of latitude in how they implement these programs.

One criterion is the potential scalability of the innovative care delivery program. Payer and ACO representatives were concerned that the reasons for a program's success at a given site may be due to a specific factor (or factors), condition, or the environment. If other sites do not share the contextual factors that were critical to the program's success, then the scalability (and therefore, overall impact) of the program could be low.

Several respondents also described patient engagement as an important component of innovative care delivery programs. One health plan respondent explained:

> Another element is willingness to venture into the community to engage high utilizers and try to recapture them into the clinical program. Unsuccessful sites are unwilling to venture beyond the walls of practice.

A third criterion that respondents described was related to staffing. No respondents described any particular requirements for the staffing arrangement. However, respondents explained that they do look at the overall staffing plan for a care delivery program to ensure that it maximizes efficiency, and that any added staff are reducing workload elsewhere. One health plan respondent described:

> What you need to do in thinking about a community health worker or nurse and pharmacist working together is to think of this from the practice perspective. What kind of staffing can you afford, and if you use a community health worker and that has a benefit in keeping patients healthier, does that reduce the work for doctors in any way or make the daily flow of practice more efficient?

Provider Characteristics

Health plan and ACO representatives also described several criteria that they apply to provider organizations seeking to participate in innovative care delivery programs: capacity and resources, leadership, and experience.

The most important criterion that payers and ACOs apply to providers is capacity and adequacy of the resources to manage a health care delivery innovation program. Specific aspects of capacity that respondents mentioned included experience in implementing standardized processes to improve delivery, experience in managing financial risk, communications processes, and robust health information technology infrastructure. Payers and ACOs also assess providers based on their capacity to deliver certain types of care for priority populations, as described by one health plan respondent:

> We are trying to codify—how do we quantify the readiness of providers…for what we think is a holistic approach to treating mental health patients. We will take that assessment and convert it into a skilled plan to progress them towards being the best in that particular space.

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Respondents also described leadership as an important factor they consider in implementation of an innovative care delivery program. Health plan and ACO representatives determine whether provider leadership fully embraces the care delivery program and has integrated it well into existing clinical and accountability processes. One health plan respondent explained:

> Successful groups are the ones that have a shift in the culture from top down, where the top executive all the way down to front-line decisionmakers are on board in terms of movement in alternative payment methods.

A related criterion is experience. Respondents explained that providers were selected for participation based on their past experience with similar models. In particular, respondents strongly valued personal relationships and trust that had been built through previous collaborations on similar initiatives.

Improving the Sustainability of Care Delivery Programs

Several proposals to improve the sustainability of innovative care delivery programs emerged in interviews with health plan and ACO representatives. First, respondents indicated that the payment environment had not shifted far enough from fee-for-service to support changes in care delivery in meaningful ways. A health plan respondent explained:

> If the financial model pushes this along in the direction we're talking about, then that is a help. Whether it's shared savings, capitation, or ACO, those alternative payment methodologies make this easier to achieve. That is partly a policy decision.

An ACO respondent was more specific:

> In order to make the business model work, they need more patients. It is not currently sustainable with 40–50 percent of patients on these contracts.

Specialty care was highlighted by one ACO representative as an area where fee-for-service still dominates, limiting the potential for changing utilization patterns:

> Until we radically change the fee-for-service environment for specialists, it's going to be difficult to wrestle down utilization. There can be intermediate steps and ways to get specialists engaged, but it's not easy.

On the other hand, respondents were generally concerned about the capacity of many providers to take on financial risk and make substantial changes in how care is delivered. Two health plan respondents explained:

Respondents were generally concerned about the capacity of many providers to take on financial risk and make substantial changes in how care is delivered.

> The large medical groups that are operating in the commercial space are able to do this well…Practices reside along a broad continuum to do this, so we'd be overly optimistic if we say this will change the delivery system in five years.

> Most provider organizations are not equipped to do large-scale innovation. They are still trying to [navigate] between the current way of doing business and the future way. The overall challenge is that we don't have a good way of funding that transition.

The balance between maintaining autonomy while still making changes in how providers deliver care was highlighted by one ACO respondent:

> Our biggest problem is office fatigue and overload… I look at what larger systems are doing, and they are changing the workflow and changing people's roles. We need to do that and take it a step forward. This is challenging for physicians who have chosen to be independent. So, our challenge is how to allow them to be autonomous but provide them with support.

Another challenge highlighted by respondents was lack of alignment across payers and care delivery programs. Several respondents called for collaboration among payers to provide the scale for providers to innovate meaningfully how they

deliver care. Multipayer collaboration can increase the number of patients who participate in innovative care delivery models, allowing providers to make greater use of the infrastructure (e.g., data analytics, performance measurement approach) in place for the care delivery model.

Finally, respondents said better understanding of the costs and effects of care delivery transformation are needed. One health plan respondent described a need for understanding costs of activities such as care coordination, and how much of that was being reimbursed and not reimbursed currently:

> We would love to understand…what activities they are billing us for, what activities are they not billing us for, and what activities could be billed for those codes.

DISCUSSION

We found widespread interest and activity in testing new care delivery models to improve health care quality and reduce costs in Massachusetts. However, the environment presents great uncertainty for the sustainability of these programs.

The predominant payment model to support innovative care delivery programs is global payment, where providers are paid in part based on expected costs of health care services to be delivered to a specified patient population, as well as performance against quality benchmarks. There was little interest in establishing new fee-for-service payments for functions such as care coordination because of the possibility of higher total payments if utilization of other services did not decrease. Global payment was preferred in part because of the flexibility it affords providers to deliver care in ways that are tailored to their patient populations. Payers and ACOs are looking for models that can quickly reduce costs—approaches that will offset additional investments with immediate efficiencies. Respondents widely identified increasing the amount of provider payment that is "at risk" as a key to increasing the amount of innovation in care delivery.

Payers and ACOs in Massachusetts generally report that they are following an "inside-out" process for developing and implementing innovations in care delivery; new programs are most commonly conceived and designed at a central office and then disseminated out to front-line providers. Respondents said it was rare for providers to develop innovative approaches and then work with payers/ACOs to find a sustainable model. Those we interviewed felt a provider's capacity and leadership were important in the implementation of reforms to health care delivery, along with a track record of implementing similar programs and an existing relationship with the payer/ACO.

These dynamics suggest that innovation will likely be concentrated in health care delivery systems that can manage financial risk and have the experience and capacity to develop better ways of caring for patients. This is consistent with a previous report by Geisinger Health System that noted "serious questions regarding [the] applicability [of innovative delivery reforms] to non-IDS [integrated delivery systems] and to any system without an EHR [electronic health record], an enterprise-wide data warehouse, and clinical leadership with centralized innovation and quality support functions" (Paulus, Davis, and Steele, 2008). For providers seeking to innovate, the central challenge will be building the capacity to manage financial risk in global payment arrangements and to support improvements in care. This will be particularly challenging for smaller organizations. Payers interested in innovation should seek ways to provide support and build the capacity of smaller and less-experienced providers so that they are prepared to get involved in reforms to care delivery as well.

Because of the central role of global payment in Massachusetts, finding ways to participate and succeed in these payment arrangements will likely be critical for innovation. Our findings suggest that providers are unlikely to be able to sustain innova-

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tive care delivery models by seeking only additional fee-for-service payments for nonvisit functions.

We found that payers and ACOs identify innovative care delivery programs for implementation based largely on expected impact, without using strict criteria to judge candidate programs or relying on quantitative measures of the effects on quality and costs. This highlights a disconnect between the level of interest in care delivery innovation, expected impact, and demonstrated impact to date. More clearly defined criteria for success, and guidance for health care providers on how to measure and demonstrate that success, could help to advance innovation.

In summary, we identified a highly uncertain environment for the sustainability of care delivery innovations despite great interest in these programs. While the Massachusetts health care market differs from others, particularly in the prevalence of global payment, many of the observations of local health plan and ACO representatives were quite general and would likely be widely applicable to other regions.

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About this report

Health care delivery organizations are developing innovative programs to improve quality and reduce inefficiencies. Examples of these programs include the use of community health workers, care coordination, care planning, health coaching, and more. While several of these programs have produced demonstrated value, they are often not compatible with current health care payment models. The project reported here, sponsored by the Blue Cross Blue Shield of Massachusetts Foundation (BCBSMA Foundation), aimed to address the sustainability of these programs in a rapidly changing health care system. Project findings are intended to help guide innovators and supporters of innovation in the design and conduct of new health care delivery programs.

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