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Year 1 of the New Jersey Medicaid Accountable Care Organization Demonstration Project: Assessment of Operations and Care Management Strategies

Derek DeLia, Ph.D.
Michael J. Yedidia, Ph.D.
Oliver Lontok, M.D., M.P.H.



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Executive Summary

In August 2011, Governor Chris Christie signed legislation authorizing the New Jersey Medicaid Accountable Care Organization (ACO) Demonstration Project (NJ P.L. 2011, c.114). In July 2015, three applicants – the Camden Coalition of Healthcare Providers, Healthy Greater Newark, and the Trenton Health Team – obtained state certification to participate in the Demonstration as ACOs.

This report was produced to provide support to the Department of Human Services (DHS) in its annual evaluation of the Demonstration. It summarizes findings from in-depth interviews with ACO leadership designed to assess the state of ACO operations and care management strategies at the end of Demonstration Year 1 (July 1, 2015–June 30, 2016). These interviews, conducted in May and June of 2016, focused on how the three certified ACOs in Camden, Newark, and Trenton have approached the first year of operations and the kinds of care management strategies they plan to implement in the near future. To better understand the specific functioning of the certified ACOs, additional interviews were conducted with ACO applicants from Paterson and New Brunswick who were not certified but had indicated plans to pursue accountable care activities outside of the Demonstration. It is important to emphasize that the findings in this report are derived exclusively from interviews with ACO representatives selected for their clinical and administrative leadership roles, and therefore, reflect ACO experiences and perspectives only. The findings also reflect a snapshot of ACO development as it stood in May and June of 2016, and therefore, does not account for activities that have occurred since that time.

Overall, the Camden ACO, which has the most experience functioning as a provider coalition and has received the most external grant funding, is the furthest along in its operations. Moreover, the Paterson community has continued to pursue some form of Medicaid accountable care activities, while the New Brunswick community has not.

Analysis of interview transcripts generated five major themes that are summarized below.

- **Theme 1:** Overall, the ACO construct is viewed as part of a larger community health improvement strategy with components and organizations outside of the ACO itself.

- Theme 2: ACOs are developing strategies to engage, and prove their value to, largely skeptical MCOs.
- Theme 3: ACOs continue to define and rethink the most important patient subgroups to target for focused intervention.
- Theme 4: ACOs are developing precisely targeted strategies to engage providers and improve targeted subsets of quality measures.
- Theme 5: ACOs rely on multiple and unstable funding sources to cover costs and retain staff. Uncertain funding limits longer term planning.

The findings in this report document the state of ACO development in the first year of New Jersey's Medicaid ACO Demonstration. The Camden ACO is well developed with clear care coordination strategies and two shared savings contracts in place with MCOs. Camden leadership is confident that their efforts are leading to meaningful improvements in patient outcomes, especially those that relate to their 7-Day Pledge to ensure patients receive appropriate follow-up after hospital episodes. Activities in Camden suggest that metrics related to their 7-Day Pledge (e.g., rates of follow-up visits, hospital readmissions) are the most likely to show early impact in the quantitative evaluation that will be prepared when complete data have been assembled and analyzed.

Although they are still refining details, the ACO in Trenton has made progress in developing strategies to link data analytics and provider engagement. It has also successfully negotiated an MCO service delivery contract.

The Newark ACO is less developed and, unlike the other two ACOs, has yet to engage successfully with an MCO. They have spent the first year of the Demonstration focused on solidifying their provider/social service coalitions, building the required infrastructure and data analytics, and thinking through the focus of their care management strategies, which they plan to coordinate with other pre-existing initiatives within their provider community. The Paterson community, which did not receive certification to participate in the Demonstration, remains committed to developing some form of accountable care arrangement. They view the ACO label as important for attracting funds and other resources to advance their population health improvement goals. The New Brunswick community, though initially interested in continuing some form of Medicaid accountable care activities, has not developed a particular focus ever since they were denied certification.

Given its slow start and ongoing funding uncertainties, the NJ Medicaid ACO Demonstration is not expected to produce substantial changes in healthcare delivery and costs of care in its first year. This situation, however, is not unusual for the early stages of ACO development, as similar experiences have been found in the early stages of the Medicare Shared Savings Program and other states' Medicaid ACO initiatives. Given more time, however, the Demonstration may continue to foster innovative partnerships and approaches that will yield measurable results later in the Demonstration.

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Introduction

In August 2011, Governor Chris Christie signed legislation authorizing the New Jersey Medicaid Accountable Care Organization (ACO) Demonstration Project (NJ P.L. 2011, c.114). The Demonstration was designed in part to generate evidence that will inform subsequent policymaking regarding accountable care reforms in Medicaid. To support this goal, the program creates broad, flexible guidelines within which not-for-profit coalitions of providers can form ACOs. These ACOs must take responsibility for all Medicaid enrollees living within a specified geographic area. Area definitions (i.e., large cities or collections of municipalities) are left to each ACO subject to the requirement that at least 5,000 Medicaid enrollees live in the defined area.

Subject to state approval, ACOs are given the flexibility to develop their own target populations for enhanced care management, quality benchmarks, and shared savings mechanisms. Although shared savings arrangements are required for Medicaid fee-for-service (FFS) populations and services, such arrangements between ACOs and managed care organizations (MCOs) are permitted but not required under the Demonstration. Nevertheless, since the vast majority of NJFamilyCare enrollees are enrolled in an MCO, managed care participation is crucial to Medicaid accountable care activities in NJ.

As described in another report (Thompson and Cantor, 2016), the Demonstration experienced some delays and implementation challenges in the rule making and certification processes. In May of 2014, the New Jersey Department of Human Services promulgated the final rule for implementing the Demonstration (NJ DHS, DMAHS 2014) and in July 2015, three applicants – the Camden Coalition of Healthcare Providers, Healthy Greater Newark, and the Trenton Health Team – obtained state certification to participate in the Demonstration as ACOs. The other applicants were the Healthy Cumberland Initiative, the Healthy Gloucester Initiative, New Brunswick Health Partners, and the Passaic County Comprehensive ACO (led by providers in Paterson). An eighth group, the Coastal Healthcare Coalition, initially submitted an application but then withdrew it. Although these other communities are not officially part of the Demonstration, the Division of Medical Assistance and Health Services (DMAHS) offered to work with non-certified applicants that wished to engage in accountable care activities to the extent

allowable under current law. Soon after the certification decisions were made, New Brunswick Health Partners and the Passaic County Comprehensive ACO (referred to as the Paterson ACO, henceforth) met with DMAHS to discuss potential opportunities for further engagement.

In the enabling legislation, the Rutgers Center for State Health Policy (CSHP) was authorized to conduct analysis and provide other support to the Department of Human Services (DHS) in its annual evaluation of the Demonstration. This report is intended to contribute to the fulfillment of this provision of the law for the first evaluation year. For the entire Demonstration, the CSHP evaluation work will use a mixed methods design with interrelated components of quantitative and qualitative analysis. Specifically, Medicaid claims data are used to measure healthcare spending and quality metrics for certified ACOs and comparison regions. In-depth semi-structured interviews are conducted to obtain more timely and granular details about ACO activities. The mixed methods approach incorporates feedback loops where tabulations from the claims data help frame interview discussions and interview findings inform subsequent data analyses.

This report summarizes findings from the first round of ACO interviews, which assess the state of ACO operations and care management strategies at the end of Demonstration Year 1 (July 1, 2015–June 30, 2016). As described in more detail below, these interviews were designed to yield an understanding of how the three certified ACOs have approached the first year of operations and the kinds of care management strategies they plan to implement in the near future. To better understand the specific functioning of the certified ACOs, additional interviews were conducted with New Brunswick Health Partners and the Passaic County Comprehensive ACO who had indicated plans to pursue accountable care activities outside of the Demonstration.

After describing the interview research methodology, the report outlines the major themes derived from the interviews and highlights other issues that were raised and discussed. The report then derives implications for the remainder of the Demonstration. It also highlights broader implications for Medicaid payment and delivery reform in New Jersey and across the nation.

Methods

The study team conducted a total of 14 interviews (with 16 individuals) across the five sites in May and June of 2016. Thus, the interviews reflect ACO activities, accomplishments, and plans at that specific point in time and do not capture later developments. The conduct and analysis of the interviews were also done in full recognition that each ACO community began the Demonstration at varying levels of experience and development. The Camden ACO in particular has built upon a long history as a provider coalition, which includes substantial external grant support from The Nicholson Foundation as well as from other resources. Interview subjects were identified as those most knowledgeable about organizational, clinical, and quality improvement

functions and included each ACO's CEO and medical director or their designates. The interviews, which took 60–90 minutes each, were based on a semi-structured protocol designed to probe for information about each site's management & organizational strategy, quality improvement efforts, patient loyalty to providers, care coordination activities, and future plans for improving Medicaid patient outcomes & controlling costs. (The interview protocol for ACO leadership is found in the Appendix. The protocol was slightly modified for applicants that were not chosen to participate in the Demonstration. A copy of the modified protocol is available from the authors upon request.)

During the interviews, members of the study team presented a large number of charts with statistical information derived from Medicaid claims and encounter data. The charts displayed baseline trends in measures of healthcare spending and quality for Medicaid beneficiaries in each interviewee's ACO region compared to other parts of NJ in 2011–2014 (the last year for which complete data were available at the time of the interviews). This information helped to focus the discussions on actual activities taking place and gaps in care that require attention. Specific information presented in the charts included avoidable hospitalizations & associated spending, post-discharge follow-up visits, hospital use within & outside of each ACO among the ACO's assigned patients, fragmentation of patient visits across primary care providers, prevalence of behavioral health (BH) conditions, total spending (i.e., total costs of care) among patients with BH conditions, psychiatric admission rates, and rates of follow-up with a psychiatric care provider after psychiatric discharge. Outside of this report, the ACO's responses to the tabulated statistics will inform the forthcoming first year of quantitative analysis under the evaluation.

For this report, the study team performed a content analysis of the transcribed interviews and derived core themes and perspectives, which are outlined below. Verbatim quotes are presented that typify the views of the respondents regarding the major themes. Emphasis was placed on information that is new and common to most sites.

Findings

Theme 1: Overall, the ACO construct is viewed as part of a larger community health improvement strategy with components and organizations outside of the ACO itself.

The certified ACOs have ongoing activities outside of the ACO, which is viewed as a means to support broader activities. The needs of the high-utilizing Medicaid population, in particular the influence of social determinants on their health, influences this broader focus on cross-sector arrangements, beyond the confines of the health care delivery system. The three certified ACOs along with Paterson are building upon and enhancing some standalone hospital-based initiatives (e.g., care navigators). In a few cases, the Delivery System Reform Incentive Payment (DSRIP)

program was mentioned as a building block for further activities. Some mentioned building on current Center for Medicare and Medicaid Services (CMS) initiatives more broadly.

ACO work often transcends the official ACO boundaries – i.e., outside geographic area, not just Medicaid patients. Camden focuses mainly on the 15 or so practices covered by its Horizon and United contracts (and all patients seen by those providers regardless of whether or not they live in the designated zip codes). The MCO contracts mainly support Camden’s 7-Day Pledge initiative, which is an activity that is embedded within the ACO but also applies to patients who do not live in the designated ACO zip codes. The initiative offers enhanced payments to primary care providers who provide follow-up care to patients recently discharged from the emergency department or inpatient care within 7 days. It is designed to promote longer appointments and greater access for patients in this critical window of time.

Trenton and Newark have a fairly fluid/flexible definition of which hospitals are in the ACO. In Trenton, hospitals that are well outside of the city (e.g., Capital Health-Hopewell) are included in the ACO due to patient referral patterns within hospital systems. In Newark, the ACO is prepared to add more hospitals to their coalition based on where their patients seek care. This approach blends what are usually considered two distinct approaches to ACO patient assignment – i.e., where patients live (geography based) and where patients receive most of their care (utilization based).

Though the ACO is viewed as one among many initiatives, it is considered important as a hub for organizing and tying activities together. This perspective was stated strongly at the Paterson site, which is trying to function as an ACO even though it is not part of the Demo. Having something official is important to them to keep everyone engaged formally, to facilitate new sources of data, and to attract funding. As one participant phrased it,

“At the end of the day, informal networks and referral networks, as strong as they are, need to put a stamp [on their work]... we have a coalition and we are legally bound or organized to function in this particular way. The money is following the work coalition or ACO.”

When contemplating the future, interviewees appear to be ambivalent about the likelihood of success of the Demo’s concept of the ACO in the short and long run. The consensus is that the ACO currently serves an important function as a focal point for activity. But many leaders feel that this activity may morph into something else later. Much of this perspective seems to be driven by delays in implementation of the Demo. While waiting for the Demo to launch, the certified ACOs have been thinking through other possibilities to organize the work they want to do.

The Newark ACO, in particular, has faced multiple difficulties in defining and operationalizing its ACO. They currently manage disparate grants and activities that they hope to stitch into an ACO. Operationally, the ACO itself is loosely held together with contract work,

buying time from people in other organizations. Due to financial uncertainties (described more fully below), they remain reluctant to commit to full-time staff in the absence of stable funding.

Theme 2: ACOs are developing strategies to engage, and prove their value to, largely skeptical MCOs.

All three certified ACOs have sought to develop shared savings or other care coordination contracts with MCOs. In Paterson, St. Joseph's Hospital is discussing hospital-based shared savings arrangements with MCOs that are separate from their activities as part of the larger Paterson provider coalition. The Camden ACO has executed shared savings agreements with United and Horizon. Based on our other work with Camden, we know that United has been very collaborative and interested in joint learning in a long term relationship. The Horizon contract has been more difficult for Camden. Horizon controls the flow of information and is not fully transparent in how their savings calculations are done. Camden has accepted these conditions, however, to get a foot in the door with Horizon.

At the time of the interviews, the Trenton ACO was negotiating a service delivery contract with Amerigroup to improve healthcare quality and coordination but with no shared savings component. Since that time, the contract has been finalized. Trenton also pursued an agreement with Horizon but at the time of the interview Horizon had not shown interest.

The Newark ACO has experienced the most struggles with MCO engagement. They are currently pursuing a shared savings arrangement with Well Care. They have tried but made no progress with Horizon and United who cover approximately 80% of Medicaid patients in the area. According to an interviewee from Newark, part of the resistance from Horizon has to do with skepticism about the cost-saving value of the model in Camden, which has been a catalyst for the Medicaid ACO Demo in NJ:

“We go to Horizon. 75% percent of the Medicaid patients in Newark are Horizon. We're like, "Come on board with us." Horizon says, "We have no interest in talking to you whatsoever." "Why?", we say. "Because we're not convinced that the Camden model works." This is what they mean: it's very clear that the team in Camden can make a difference for these patients. It's not at all clear that it's cost effective, at all. If I can save \$500 in Medicaid expenditures, but it costs me \$1,000 of resources because I've got all these grants and all this kind of stuff, is that really cost saving? I don't think so. There's not math that any of us do that makes that the case.”

According to this respondent, the MCOs are awaiting sound evidence from a controlled evaluation before making any commitment:

“Nobody's willing to come right out and say, "We don't think this works," but there's enough concern on their part as well in terms of whether or not this is truly a cost effective model to have also be reluctant to give us any true dollars.”

The ACOs believe they can add value to managed care efforts by working with patients at the ground level, helping patients gain required authorizations and referrals for care, and following up with patients in the community. Several commented on the need and potential interest of MCOs in moving away from telephonic case management toward more in-person case management, which the ACOs are better positioned to do. An interviewee from the Camden ACO framed the general MCO value proposition this way:

“We can be an innovation engine for managed care. I think that we can do it in a community specific and a community sensitive way with a lot more relationships within the local community. If there is good learning there they can bring it back to Horizon membership, United membership and spread it elsewhere. We have also heard very specifically from United that they benefit in terms of brand from association with us. There is good will that we possess that they can borrow if they have a relationship with us. That is not lost on us.”

Another interviewee suggested that ACOs, as a coalition of providers, rather than payers are in a better position to gain patient trust:

“Patients don't trust payers. ... They don't want to talk directly, or be honest with the payer. It's not the right person to talk to the patient.”

Interviewees offered many specific examples of where ACOs are well positioned to add value that is beyond MCOs' capabilities. One interviewee commented on the potential role of the ACO in ending duplicative and fragmented case management across payers and providers:

“What United at least is willing to do is two things, I believe. What we know for sure they're willing to do, as well as Well Care, is to have their case managers who are working with Medicaid patients from our three ZIP codes coordinate with our Clinical Director and Case Management Team, so that at a minimum we stop all of this triple case management. You've got your case manager from United. You've got your case manager from Saint Michael's. You've got your case manager from Newark Beth, and your UBHC, and they're all working on the same patient and nobody's talking to each other. One of our goals is to do that, and they have all agreed that they're willing to cooperate with us on that one.”

This interviewee elaborated further:

“What ideally we want is for all of these managed care organizations to give us money so that we can hire case managers who aren't payer bound, so that you have a case manager who can take care of a patient regardless of who their insurer is. Because we know there's a subset of these patients that actually change

insurers. If they give the money to us to hire the case manager, then if I was Well Care yesterday, and I'm Horizon today, that case manager can remain constant. With the model I just described to you, if I'm United today, but I become Horizon tomorrow, that United person is no longer going to provide services for that very same patient, but because they've changed insurers they can't work with them anymore. That's why we want to get some dollars from them to help develop our case management system.”

Another area, cited by respondents, in which ACOs might excel is in making use of very precise, culturally informed information to advance local population health goals. In one example, a Bengali pediatrician learned that Bengali children in the area were told falsely that certain foods at school contained meat products that are forbidden within their faith. As a trusted member of the community, this pediatrician was able to convince these children that the information was false and that the food offering was both highly nutritious and acceptable in their faith. For the interview respondent, this experience illustrated a general principle:

“We can do all the nutrition counseling in the entire world, but if the kids aren't going to eat it because a bully next to them is telling them it's the wrong food, that's against their religion, you're never going to get nutrition.”

A second example focused on the problem of asthma within a local Muslim population:

“We have a big problem with [some of] our Muslim population, they smoke Hookah. Their asthma is exacerbated by that. We have to go out and we have to get members of that community that can teach our classes on smoking cessation. Talking about what the standard curriculum is, is not going to make a dent in that population.”

A third example focused on a partnership between the ACO with local churches that combines an innovative combination of data sharing and in-person contact with patients:

“This is where big data meets the need for actual work with people ... we will literally be getting the congregational leaders to individually consent to their congregants regularly, to have their information shared in our Health Information Exchange, so that we can then tag them too. ... We can know when someone belongs to a congregation who hits our health information exchange, we'll hopefully know what congregation they go to, who that leader is of the congregation, and what primary care clinic they go to.”

Using this information, ministers can be informed when one of their congregants has been hospitalized. They can provide them with food, visitors, and other support.

Finally, an interviewee mentioned the value ACOs could add in terms of sharing data that is not available to MCOs and coordinating care management for patients with behavioral health issues:

“... in New Jersey they [managed care plans] don't manage the claims for behavioral health. They only see the meds, so their ability to be able to see what's happening, the other side of patients who have behavioral health issues, will greatly benefit in terms of care coordination, and I think they're looking to be part of the team.”

Theme 3: ACOs continue to define and rethink the most important patient subgroups to target for focused intervention.

In general, the ACO communities have had an initial focus on adult high users who have multiple chronic illnesses and behavioral health conditions. Moving forward, however, the high-user work is becoming less emphasized for a variety of reasons. ACOs find it hard to figure out how much of the costs and utilization within this group is really modifiable and how much is driven by regression to the mean. There are also some growing doubts that the very high-user strategy will give as much “bang for the buck” as initially thought.

Instead, there is growing attention to the idea that ACOs would have a greater impact on population health and healthcare spending if they targeted a larger group of patients – e.g., the top 10% of high users rather than the top 1%. Emphasis is also being shifted toward patients classified as “rising risk” instead of those already classified as “high risk”. One interviewee gave a clear example of the aspiration for identifying and managing high-risk patients:

“Adults with COPD who are not quite meeting the criteria that make them high utilizing, but have poorly controlled disease, and who then are at risk of either tipping one way or the other. In other words, if we can get them into routine, better ongoing care [they] could actually become better managed, better controlled, and then reduce cost and have better outcomes, or they will continue in that direction that they're heading, as we call them rising risk, and become high utilizing patients or actually become non-utilizing patients because they die. It is the risk stratification methodology that I think we'd like to develop ...”

An interviewee from the Trenton ACO, which is still defining their key focus areas, described the need for precise targeting of patients where the ACO can have a large measurable impact:

“We're still defining what are the specific opportunities ... We'd rather work deeply on a more narrow segment of the population and have a huge win than to try to do a broad intervention that's not going to be successful. That's also frankly why we're not sure that the cost savings is the right measure. We know the ultrahigh cost people we're unlikely to impact. There's going to be so much noise in that small population that we won't know whether we did something. We'd

rather look at some other areas where we can clearly measure the impact that we're having to know if we're doing something positive.”

At the Camden ACO, their main population health strategy is not focused on patient-subgroups or their conditions but rather on a key delivery system issue – namely, reconnection to primary care following hospitalization or multiple ED use. Providers are given incentives for spending time with these patients, reviewing their discharge instructions, doing medication reconciliation, and talking about why they were hospitalized and how to stay out of the hospital or ED. Similarly, the Newark ACO seeks to use resources from the state to focus on health literacy within their entire population in addition to the more targeted focus on rising risk patients:

“The other part of our budget is we have two health educators that we want to fund with the million dollars so that we are [going] — out to churches and community based organizations, and saying, ‘Let's just talk about health. Let's actually talk about not even having you get to the rising risk category.’ ”

Most Medicaid enrollees are children, and children are prominent among those patients with high costs. Yet, ACO communities are just beginning to examine how to improve their engagement with pediatric populations. One interviewee pointed out that working with children will require better relationships with schools and school nurses. The Camden ACO is currently developing a strategy for informing school nurses when a student goes to the ED or is hospitalized. But they are still trying to formulate an appropriate follow-up strategy (e.g., updating asthma action plan). An interviewee from the Newark ACO suggested that in the short term, issues affecting children may be picked up as part of their broader community-wide care strategies:

“By the way, I think we will make attempts in the health education side to ... better educate parents about if you have kids with asthma, and your kid is going to the ER a lot, and you're not having an inhaled steroid kind of thing. I think those are some strategies, but not in terms of our major work.”

Still, there is widespread concern that many of the problems faced by high-utilizing children are beyond the scope of ACO care management. As an example, one interviewee raised the issue of premature births:

“Who's going to try to reduce the stays for these preemies who have a gazillion issues, that need to be in the neonatal intensive care unit?”

Other interviewees suggested that certain types of high-cost patient care, for adults as well as children, may not be modifiable and should be pulled out of ACO cost-of-care performance measures. Some examples provided for children include pediatric cancer and skilled in-home care. Examples for the broader population include high-cost medical equipment, hepatitis C drugs, and other high-cost drugs. An interviewee from the Camden ACO indicated that this issue deserves more study before being resolved.

Theme 4: ACOs are developing precisely targeted strategies to engage providers and improve targeted subsets of quality measures.

As discussed earlier, a major driver of activity in the Camden ACO is its 7-Day Pledge. Primary care physicians (with assistance from others in the community) commit to making office appointments for hospitalized patients within 7 days of discharge. As a Camden interviewee explained, it is assumed that this activity will result in improvement in other quality measures as well:

“[The intent] is to not lose the forest for the trees. The trees are these individual metrics, and the forest is really access to healthcare. If you can give patients access and positive experiences, then generally, not always because there's some clinics that have all the access [in the] world and are still doing terrible, but generally the rising tide lifts all boats with these metrics.”

Representatives of the other ACOs echoed the idea that too many measures are distracting and that a narrower focus is required. From the Trenton ACO:

“I think this also goes to the philosophy of quality measurement overall. I think each community needs to measure a series of things. I think there are probably twenty or thirty measures ... We don't have the capacity to impact all of those, so I think we need to be disciplined about what we're measuring first, and then second, and third ... I think the danger would be that we would focus on the wrong ones first. Just like we can't construct an intervention on 50,000 people we can't focus on 40 quality measures right now. We won't achieve a damn thing.”

The Trenton ACO is currently in the process of deciding on a subset of metrics that will be “meaningful,” “measurable,” and from which they can learn. The Newark ACO, in their quality improvement strategy, is trying to balance the Demonstration's regulatory requirements with their own quality improvement goals as well as other quality performance standards to which their providers are held, such as the Delivery System Reform Incentive Payment (DSRIP) Program.

The ACO communities have developed somewhat mixed and nuanced views of how financial incentives and provider-level performance reporting can be applied to motivate providers. The Camden ACO views these tools as transitory – i.e., as a mechanism to convince providers to initiate changes in their practice patterns in ways that are consistent with the ACO's goals:

“ ... there are some practices where the incentive is meaningless ... because they're bought into the work and they get that [for] this population of folks who have been to the hospital recently, they need to treat differently and they need to engage differently. ... The money was just a way for ... us to buy their attention. Now their attention's bought, ... we could take the money away and ... they would more or less be still doing the work.”

Within Camden's 7-Day Pledge initiative, financial incentives and performance score cards are used to frame detailed discussions about how physicians are treating patients and how the ACO can be supportive:

"... we show up at their practice every month with a check and we sit down with them. We make four champions sit down with us every month and before they get that check, we're talking about their score card and how they did on the Seven Day Pledge. We're not looking at HEDIS metrics, we're not looking at all the other stuff. Just how they did. We're using it. That metric, we don't even use it like, 'Well you've gotta get better.' It's like, 'Let's have a conversation. ... 'What are you doing right? What are you doing wrong? How can we support you? Is this meaningful to you?' ... We think of this as a human campaign and the data just starts a conversation. It's not the end of the conversation."

The Trenton ACO is currently developing a provider engagement strategy that involves data analytics and provider-level reporting of quality metrics. The strategy envisions increasing levels of performance transparency as described below:

"We have not yet started to push out reports to the provider community. We need to pick the area or two or three areas of focus. Then we need to get the analytics in a place where they are easily understandable. Then we need to push them out to the provider community probably down to individual providers and provider groups that are de-identified first. To really make everyone see there's going to be a new level of transparency here ... we'll tell you you're this bar graph compared to everybody else. We're not going to share your name yet, but in the future we will be, because we need to have these conversations around quality and ultimately cost."

As mentioned above, the Newark ACO is developing a quality improvement strategy that builds on other pre-existing initiatives. This is driven in part by uncertainty about the sustained availability of funds for the ACO to implement direct pay-for-performance mechanisms. Currently, the ACO seeks to create "win-win" situations by helping providers meet the quality performance goals that have previously been set. As one respondent commented:

"... if I don't have an ability to incentivize these providers to meet quality metrics that we make up, then the degree to which I tie the quality measures that we utilize to match those that are already part of programs where these providers are incentivized is kind of a win-win. That really is much of how we're looking [at it]. We're focusing a lot on cholesterol, and hypertension, and CHF readmissions, and diabetes because it all ties in with what they're looking at in the hospitals as part of the DSRIP."

In Paterson, which did not receive ACO certification, the coalition is focusing on small, discrete initiatives that they hope to bring together under a unified ACO-like approach in the future:

“Rather than solving things in a more global way, we're focusing on that asthma population who needs housing or transportation and we'll get a focus team around that. It's a little bit upside down. Normally you have [committees] and you have sub committees. I think to a certain extent we're forming the sub committees of which we hope to ultimately pull that umbrella together. Right now we're doing it more in an ad hoc subcommittee way and bringing the partners to the table.”

Paterson interviewees emphasized multiple times that there is a large volume of excess healthcare utilization that should be targeted by their coalition (e.g., multiple scans, other tests). But they are very clear about how challenging it will be to change prevailing practice patterns, in part because a reduction in physician payment would result from lower volume. They also anticipate resistance to changing patterns of care that physicians view as clinically safe and effective. Thus they view creation of incentives for shared savings as crucial for aligning these physicians' interests with those of the coalition. They also envision the authorization of a clinical director who can steer disparate providers into a disciplined population health focus:

“One of our visions is to have a clinical director as part of the coalition and I think there's an absolute value to having that third party, almost independent person, looking at each organization's quality objectives and bringing that together with a population health vision on top of it. Again, each organization may be focusing on a particular area or a different aspect of it, how do we bring this together and really develop some mutual goals. ... I think there's tremendous value to that one third party saying, 'I don't have an affinity to you, here's what's the data's saying, here's the clinical need.' “

Theme 5: ACOs rely on multiple and unstable funding sources to cover costs and retain staff. Uncertain funding limits longer term planning.

Despite their widely varying stages of development, the certified ACOs and the Paterson community are similar in their use of a patchwork of varied funding sources to cover their initial and ongoing costs. Although the Camden ACO is clearly the most developed and experienced in its operations and fundraising, it too faces a number of financial challenges and uncertainties. The one-million dollar state appropriation for each of the certified ACOs has been very helpful to Camden to sustain their activities and absolutely essential for Trenton and Newark to begin theirs. The level of funding is widely viewed as adequate for the initial year of the Demo. In the words of a Trenton interviewee:

“I think a million is kind of the minimum to do something meaningful and not just dabble. It's how many personnel resources can the ACO directly deploy to go out and work with providers to identify need, or provide care management, or work with providers on quality reporting that they don't currently have time to do ...”

But the lack of ongoing state support raises questions about the sustainability of ACO activities. Outside of Camden, communities are hesitant to bring on permanent fulltime staff. The Trenton ACO has entered into a management services agreement with the broader Trenton Health Team, which deals with administration, human resources, payroll, and financial structures. The Newark ACO is buying time (typically 20% FTEs) of case managers from local hospitals and other area providers. The rationale was articulated this way:

“I am extremely reluctant to staff up an ACO with our own employees in an environment where I'm not convinced that [the] million dollars will be ongoing. I don't want ... to be part of getting people engaged in these activities with employment, and then saying nine months into this, ‘... this money's not here anymore, and you're out of a job.’ As a Board, we had this conversation because if we pick up [part of] these FTEs, we'll save some money for our partnering organizations, but they can then devote resources to the patients in our ZIP codes. They're already part of an existing system, and the organizations will know this money may go away, but you still have these employees. We are much more comfortable using that. If we begin over a two to three year period to get a sense that the ACO money will become embedded in state government in a real ongoing way, I think then we would seek to transform these employees to become our own, and have a different level of comfort about how we do case management.”

All of the communities rely to some degree on outside grants, most notably from The Nicholson Foundation, which has been instrumental in galvanizing start-up and ongoing activities. Camden and Trenton ACOs also draw on resources from broader community organizations under which the ACOs are subsumed (i.e., Camden Coalition of Health Care Providers, Trenton Health Team). Although shared savings is generally used as a motivating principle for ACO providers, ACO leaders are cautious in their expectations of shared savings as a mechanism for covering ACO costs. As noted above, the Paterson community is an exception in terms of the magnitude of perceived shared savings potential.

Regarding sustainability, one interviewee suggested that ACOs might take on population-focused tasks currently performed by MCOs:

“I think there's a certain percentage of money that the managed care organizations have to use for outreach, or whatever they call it. Let's just take that money off the top, devote it ACOs, and let us then grow, and thrive, and do this

work without constantly having to chase grant dollars. It's just not a rational way to do this work.”

Discussion

The findings above document the state of ACO development in the first year of New Jersey’s Medicaid ACO Demonstration. With its long history as a provider coalition, the Camden ACO is well developed with clear care coordination strategies and two shared savings contracts in place with MCOs. Camden leadership is confident that their efforts are leading to meaningful improvements in patient outcomes, especially those that relate to their 7-Day Pledge to ensure patients receive appropriate follow-up after hospital episodes. Although the forthcoming quantitative evaluation will cover a wide variety of performance metrics, activities in Camden suggest that metrics related to their 7-Day Pledge (e.g., rates of follow-up visits, hospital readmissions) are the most likely to show early impact.¹

Although they are still refining details, the ACO in Trenton has made progress in developing strategies to link data analytics and provider engagement. They have also successfully negotiated an MCO service delivery contract.

The Newark ACO is less developed and had not engaged successfully with an MCO at the time of the interviews. They have spent the first year of the Demonstration focused on solidifying their provider/social service coalitions, building the required infrastructure and data analytics, and thinking through the focus of their care management strategies, which they plan to tie into other pre-existing initiatives within their provider community.

The Paterson community, which did not receive certification to participate in the Demonstration, remains committed to developing some form of accountable care arrangement. They view the ACO label as important for attracting funds and other resources to advance their population health improvement goals (e.g., regular access to Medicaid claims and encounter data from DMAHS, which is currently provided to the three certified ACOs). The New Brunswick community, though initially interested in continuing some form of Medicaid accountable care activities, has not developed a particular focus ever since they were denied certification.

The ACOs in Trenton and Newark have struggled to enter into any form of shared savings contracts with MCOs. Although the Trenton ACO has negotiated a service delivery contract with one MCO, this contract does not involve any shared savings component. Interviewees report that the lack of traction with MCOs is driven by two factors: 1) the voluntary nature of MCO participation embedded within the Demonstration and 2) MCO doubts about the cost and quality benefits of working closely with Medicaid ACOs in NJ.

¹ Given a 6-month runout period, claims and encounter data for the first year of the Demonstration were not finalized until the end of January 2017. Additional time is needed to format the data, create measures, and conduct analysis.

The voluntary nature of MCO participation is unusual among states pursuing Medicaid accountable care initiatives (Lloyd, Houston, and McGinnis 2015). Typically, these states either require MCO participation or focus on fee-for-service populations excluding enrollees in managed care. Two exceptions are Illinois and Rhode Island where MCOs have the option, but are not required, to contract with ACOs. Both of these states, however, have smaller Medicaid managed care penetration than NJ. As of July 1, 2016, the penetration rate was 63.4% in IL and 90.0% in RI compared to 94.6% in NJ (KFF 2017). Thus, NJ is the most dependent on voluntary MCO participation among these states. Moreover, the program in IL has recently faced major challenges with cuts in funding and the exodus of nearly all ACOs from the program. Currently, the RI program remains in the early stages with no reported results.

All three certified ACOs in NJ, as well as the Paterson community, believe they have something unique and important to offer MCOs. All of them described multiple examples and aspirations of what they could provide to patients and communities that could not be developed by MCOs on their own. Still, they feel to varying degrees that stronger efforts and sounder evidence on cost and quality implications are needed to counter strong MCO skepticism.

The certified ACOs in NJ have a fluid view of their structure and operations. Each one is part of a larger community health coalition that they suspect will later morph into something else. There is ongoing development and reassessment with regard to patient targeting (e.g., high user, rising risk) and priority setting for regular surveillance of core performance metrics.

The ACOs' fluid view of themselves reflects an openness to experimentation and course corrections where needed. But it also reflects concern about availability and sustainability of resources, especially outside of Camden. Some of this concern is rooted in the delayed implementation of the Demonstration (Thompson and Cantor 2016) as well as uncertainty about whether financial support from the state will continue in Demonstration Years 2 and 3. Despite their long-term plans and aspirations, the ACOs appear to be hedging somewhat against the possibility that the ACO form might not last beyond the Demonstration.

Although the Trenton ACO is clearly more developed than the one in Newark, both have spent the first year of the Demonstration, to varying degrees, building their operations, organizing staff, developing care strategies, and seeking to establish relationships with MCOs. Thus, it is not likely that these ACOs will exhibit significant improvement in quantitative performance metrics in Year 1. As ACOs with less coalition experience (e.g., infrastructure, relationships, etc.) as Camden, they appear broadly similar in their development to those in the early stages of the Medicare Shared Savings Program (MSSP). As described by the Centers for Medicare and Medicaid Services (CMS), newly formed ACOs focused initial efforts on operational capabilities and had limited opportunity to develop and implement significant care redesign (CMS 2015). For this reason, CMS decided to allow ACOs to spend more time than initially anticipated in the one-sided shared savings model (i.e., not at risk for spending increases), when they

reauthorized the MSSP (CMS 2015). Anecdotally, modest progress in the early stages is common to Medicaid ACO programs in other states as well.

Some states have Medicaid ACO programs that are further developed than the Demonstration in NJ. A few of these states (CO, OR, MN, and VT) have announced favorable results in terms of reductions in Medicaid spending and hospital use (CHCS 2016). The strongest positive evidence to date has come from an evaluation in Colorado, which found that the state's Medicaid Accountable Care Collaborative (ACC), which includes seven Regional Care Collaborative Organizations (RCCOs) that are responsible for coordinating patient care, reduced spending while maintaining quality (Lindrooth et al. 2016). Similarly, Medicaid Coordinated Care Organizations (CCOs) in Oregon achieved a number of quality improvements within a global budget designed to reduce the growth trend in medical spending from 5.4% to 3.4% annually (McConnell et al. 2016).

Relative to NJ, however, CO and OR have Medicaid ACO programs that are much more standardized in terms of performance incentives and how the ACOs are organized. They also involve substantial upfront public investments established by law or the federal waiver process in developing accountable care capabilities. In CO, RCCOs receive standardized care coordination payments per member per month and pay-for-performance bonuses. They also receive analytic support from a Statewide Data Analytics Contractor, while some providers in each RCCO received substantial grants from CMS and private sources outside of the ACC to support care coordination efforts (Lindrooth et al. 2016; Lloyd, Houston, and McGinnis 2015).

In OR, each CCO is given a fixed budget subject to withholds that are redistributed based on quality performance. The state also maintains a Transformation Center that leads learning collaboratives for CCOs, manages a Council of Clinical Innovators fellowship program to develop health system transformation leaders across the state, and provides targeted technical assistance to help CCOs meet their outcome goals (Lloyd, Houston, and McGinnis 2015). In addition, OR received \$1.9 billion over five years through a Medicaid Waiver agreement enabling the state to develop its CCOs within the global budget (McConnell 2016).

In contrast, NJ Medicaid ACOs operate independently under a non-standardized model, which includes voluntary involvement of MCOs. Initially, the ACOs relied on start-up funds from The Nicholson Foundation and other philanthropic funds, as the original Demonstration law did not authorize any state funding. In July of 2016, however, the state of New Jersey appropriated \$1 million to each of the three certified ACOs to support their first-year efforts. Whether such funding will continue in subsequent Demonstration years remains uncertain.

Given its slow start and ongoing funding uncertainties, the NJ Medicaid ACO Demonstration is not expected to produce substantial changes in healthcare delivery and costs of care in its first year. Later in 2017, the Rutgers CSHP will conduct another round of interviews with the ACO communities to gain an update on activities in the second Demonstration year. As

the Demonstration progresses, the less standardized approach in NJ may lead to innovative partnerships and approaches that will yield measurable results in later years.

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Appendix: Medicaid ACO Interview Protocol

Key: *Questions asked only of administrative staff
**Questions asked only of clinical/quality improvement staff

Baseline Interview for ACO Leaders

ACO Management and Organization

1. What is your role at the ACO? Looking at the organizational chart (provided to us ahead of the interview), describe your work with the other members of the staff.

*2. What are some of the key elements of your organizational structure that directly address the goals of your ACO –improving quality and reducing costs? Were they based on previously existing units or were they newly created?

*3. Tell me about your collaborating providers – health, behavioral health, social service. Are some of the parties collaborating for the first time? What are the main ways in which you communicate with them ... about patient care issues? Utilization issues? Financial matters? ACO governance issues? How do you maintain a consistent commitment among them to the goals of the ACO? What have been some of the challenges in your work together? How have you addressed them?

*4. What is the status of the ACO's relationship with Medicaid managed care organizations? Do you have contracts with one or more of them? Are you currently negotiating? What considerations have been key in your discussions with them?

*5. Are there key partners or types of service providers whose participation in the ACO has been difficult to secure? Why (or why not)?

6. What gaps in service or constraints on provider capacity in your region may affect your success in addressing the needs of Medicaid patients?

*7. What investments have you made in information technology – electronic medical records, a health information exchange? How would you assess their capabilities as they relate to care management? Quality improvement? Cost and utilization monitoring?

*8. How have you covered start-up costs for launching the ACO?

Quality Improvement

**9. What do you see as the major elements of your quality improvement plan that will make a difference in meeting performance goals among your ACO population? How will you engage individual providers in this effort? What do you see as effective motivators for them to make practice improvements? How will you involve non-medical providers in improvement initiatives (e.g., behavioral health and social service providers)? What do you see as major challenges?

**10. What types of data will you routinely monitor and how will you use them to provoke change among partner providers?

**11. What is the current thinking about the quality indicators that your ACO will employ for the demonstration project? Which ones have you selected, what else is being considered, and what is the logic underlying your choices?

**12. Are there quality metrics which are not captured among the State's prescribed ones that you believe are relevant to the care of Medicaid populations? Elaborate.

13. I'd like to share with you some baseline patterns from Medicaid claims and encounter data on some of the potential quality metrics that ACOs may track. [Hand charts.]

- Baseline (2011–2014) incidence and cost of avoidable admissions for Medicaid patients in your region
- Comparisons with similar data on other ACO regions and for the State's Medicaid population as a whole
- Rates of follow-up within 7 days of hospital discharge for patients in your region, other ACO regions, and the State as a whole

Are you surprised about any of these patterns?

Do they confer confidence in your ability to achieve improvements regarding your current choice of quality metrics? Why or why not?

Do they suggest other areas where you might profitably concentrate your performance-improvement resources? Elaborate.

Are there other metrics for which you would like us to produce trends to share with you in next year's interview, assuming we have the necessary data?

Patient Loyalty

14. Patient loyalty to ACO providers is often viewed as critical to success in meeting ACO goals. I have baseline data from 2011-2014 that we compiled related to this issue on Medicaid recipients in your region I'd like to share with you.

[Hand them charts showing:]

- Total hospital admissions for your ACO population in ACO hospitals compared to non-ACO hospitals and associated spending on these admissions for your ACO region and for other ACO regions.
- Avoidable hospital admissions and associated spending for ACO patients in ACO hospitals compared to non-ACO hospitals in your region and in other ACO regions.
- Use of multiple primary care providers (PCPs) and risk-adjusted total Medicaid spending on them as compared to other enrollees in your region, similar comparisons for other ACO regions and for Medicaid recipients in the State as a whole

Care Coordination

**15. What structures do you have in place for improving care coordination for your patients? Are there centralized mechanisms – such as teams for addressing complex, high-needs patients, or ACO care managers? IF SO, how will they operate? Which patients will they focus on? How will such patients be selected and engaged? IF NOT, how will you promote care coordination among your partner-providers?

**16. Do you have strategies for bridging health, behavioral health, and social service systems in caring for patients who have complex needs? Elaborate.

**17. We know from an earlier study that 38% of high-users of hospital care in 13 low-income communities had at least one behavioral health co-morbidity. I'd like to share with you some baseline data which may shed light on care coordination of such patients in your ACO region.

[Hand charts.]

- Baseline prevalence of at least one diagnosed behavioral health problem among Medicaid patients in your ACO region, total Medicaid spending on these patients as compared to others; similar data on Medicaid patients in other ACO regions and in the State as a whole
- Baseline rates of avoidable hospitalization among Medicaid patients with at least one behavioral health problem as compared to other Medicaid patients in your ACO region, other ACO regions, and the State as a whole
- Baseline rates of follow-up within 7 days following hospitalization for mental illness among Medicaid patients in your ACO region, other ACO regions, and the State as a whole

Are any of these patterns surprising to you? Do you believe your care coordination efforts will improve performance with respect to these patients? Why or why not? Do the patterns suggest the need for other care coordination strategies that you might consider in the coming year?

18. We would like to interview providers in your ACO who are responsible for care coordination efforts. Can you suggest some teams or individuals whose coordination activities typify your ACO's strategy for coordinating the care of patients with complex problems? We would like to observe care coordination discussions and interview participants.

Overall ACO Performance and Future Plans

19. How confident are you, at this stage, in your ACO's ability to improve quality and reduce spending on Medicaid recipients in your region relative to other enrollees? On what do you base your assessment?

20. Which of your strategies do you believe will have the biggest pay-offs?

21. Have you made priorities among people with particular conditions, co-morbidities, social problems? What are they?

22. Are you dedicating ACO resources to patients who have been identified as high-users of service? IF SO, how are you identifying such patients and how are you using these resources?

23. Are there particular practices or policies under-development for implementation in the coming year? Elaborate.


The Rutgers logo is rendered in a red, serif font. The letter 'R' is significantly larger and more stylized than the other letters, which are in a standard weight. The letters are all in red.

Center for State Health Policy

Center for State Health Policy
Rutgers, The State University of New Jersey
112 Paterson Street, 5th Floor
New Brunswick, NJ 08901

p. 848-932-3105 f. 732-932-0069
cshp_info@ifh.rutgers.edu
www.cshp.rutgers.edu

