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The New Jersey Medicaid Accountable Care Organization Demonstration: Lessons from the Implementation Process

Frank J. Thompson, Ph.D.
Joel C. Cantor, Sc.D.



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The New Jersey Medicaid Accountable Care Organization Demonstration: Lessons from the Implementation Process

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Executive Summary

This report presents lessons from the initial implementation of the New Jersey Medicaid Accountable Care Organization (ACO) demonstration. The demonstration enabled the certification of ACOs for Medicaid enrollees in various areas of the state. The ACOs are coalitions of health care providers, social service providers, and community representatives organized as nonprofit organizations. They seek to foster greater access to higher quality care while reducing health care costs for Medicaid enrollees in defined geographic areas. ACOs that achieve their performance and cost control goals may receive additional revenue from Medicaid in the form of shared savings. The three-year demonstration sought to illuminate the potential utility of the ACO model in achieving these goals.

In August 2011, Governor Chris Christie signed legislation authorizing the demonstration. After the New Jersey Department of Human Services promulgated a final rule interpreting and detailing provisions of the statute in May 2014, seven provider coalitions formally applied for ACO certification. In July 2015, three of them - the Camden Coalition of Healthcare Providers, Healthy Greater Newark, and the Trenton Health Team - obtained state approval to launch their operations.

This report focuses on the nature and origins of the issues and challenges that surfaced in the four years between the initial legislative authorization and the certification of three ACOs. We seek to distill lessons for all stakeholders interested in building Medicaid ACOs, and to inform New Jersey policymakers who may wish to consider program revisions during or following the three-year demonstration. Evidence for this report partly derives from publicly available government documents and articles in professional journals. We also draw heavily on 19 semi-structured interviews with 26 ACO stakeholders in New Jersey, which were conducted from July through October 2015. The interviewees included leaders from the coalitions that applied to be ACOs, New Jersey Medicaid administrators, representatives of advocacy groups, staff from private foundations, personnel from organizations that provided technical assistance to ACO applicants, and individuals from Medicaid managed care organizations.

Challenges

The interviews with stakeholders identified five major challenges in the initial implementation phase of the ACO demonstration. The first involved securing adequate *provider participation* in the ACOs. The law required that applicants have the “support” of all the general hospitals, no less than 75% of the “qualified” primary care providers (e.g., physicians engaged in family or internal medicine, physician assistants, advanced practice nurses) and at least four behavioral health care specialists within their designated areas. It further specified that a “qualified” primary care provider had to devote at least 25% of his or her professional time to serving Medicaid enrollees, or 10 hours per seven-day week. In striving to meet this standard, ACO applicants became enmeshed in the “denominator problem.” Meeting the 75% requirement necessitated that applicants identify the universe of primary care providers serving Medicaid enrollees in their ACO areas. No such list of these providers was readily available. Efforts to identify the denominator by scrutinizing the lists of providers affiliated with Medicaid managed care organizations did not yield a solution. Finally, state officials examined Medicaid claims and encounter data to develop lists of the pertinent primary care providers in the proposed ACO areas. Concerned that these data were proprietary, however, officials declined requests from applicants to share the provider lists with them. The resulting information gap made it difficult for applicants to gauge whether they had met the provider participation requirement. Failure to meet this requirement was the key factor in the Department of Human Services’ decision not to certify four of the seven ACO applicants.

The second key implementation challenge centered on the *optional participation of Medicaid managed care organizations* (MCOs). New Jersey contracts with several MCOs to organize and pay for health care for approximately 95% of its Medicaid enrollees. The founding statute did not, however, require MCOs to participate in shared savings arrangements or otherwise cooperate with the ACOs. ACO applicants did not have to present formal evidence that they would eventually partner with MCOs. But all of them fathomed that the eventual success of the ACO demonstrations depended heavily on MCO involvement. Some interviewees expressed concern that the authorizing legislation provided little incentive for MCOs to partner with the ACOs. ACO applicants had varying degrees of success in engaging with the major Medicaid MCOs during the initial implementation phase.

The *absence of state funding* to support the start-up costs of ACOs posed a third implementation challenge. This absence made it more difficult for applicants to conduct outreach and recruit providers. It also limited the number of staff state Medicaid officials could devote to implementing the ACO demonstration thereby contributing to delay. Moreover, in nearly 75% of the interviews, the respondents said that any shared savings the ACOs might eventually generate would probably be insufficient to compensate them for start-up and operating costs. The lack of state funding and the optional nature of MCO involvement heightened the importance of private

foundation grants for ACO applicants. All but one of the interviews indicated that foundation support was either important or a prerequisite for the creation of a viable ACO. In this regard, the critical catalytic role played by the Newark-based Nicholson Foundation stands out. After passage of the legislation, the Nicholson Foundation gave a grant to the New Jersey Health Care Quality Institute to encourage the submission of Medicaid ACO applications from coalitions in areas identified by the Rutgers Center for State Health Policy as having a sufficiently large Medicaid population to possess the potential for achieving shared savings. The grant also allowed the Quality Institute to provide technical assistance to ACO applicants. In addition, the Nicholson Foundation funded infrastructure grants for coalitions in Camden and Trenton to expedite their development of viable ACOs. Sensitive to the funding challenge the ACOs faced, the Christie administration's budget proposal for Fiscal Year 2017 contained \$3 million for the three certified ACOs.

A fourth major challenge centered on *legal process and delay*. The 2011 founding legislation mandated the New Jersey Department of Human Services to adopt "rules and regulations establishing the standards for gainsharing plans" and other requirements deemed "necessary to carry out the provisions of this act" within 180 days of the law's effective date (NJ P.L. 2011, c.114, C.30.4D-8.15). However, the department did not promulgate the final regulation until mid-2014, roughly two and half years after the law took effect. It took nearly four years from the signing of the Medicaid ACO legislation to the certification of three applicants in July 2015. Interview respondents identified two primary sources of delay. The first consisted of antitrust issues associated with the ACOs. The Sherman Antitrust Act of 1890 prohibits collaborations that "unreasonably restrain trade." Considerable legal uncertainty persisted as to how this applied to ACOs. State Medicaid officials therefore engaged in extensive discussions with not only the Centers for Medicare and Medicaid Services (CMS), but also the Federal Trade Commission and the US Department of Justice before implementing the ACO demonstration. The transparency and due process requirements associated with administrative rulemaking in New Jersey also kindled appreciable delay. In interpreting a statute, state administrators must publish a proposed rule, give stakeholders an opportunity to comment, and publicly summarize their response to these comments when they issue the final rule. Rulemaking was particularly challenging for state officials in the case of the Medicaid ACOs because, unlike many other pilot projects, the legislation authorizing the demonstration was quite detailed and prescriptive.

Issues of *quality metrics and reporting* comprised the fifth challenge. The 2011 legislation mandated that state Medicaid officials at least annually examine ACO performance on certain indicators. These included such factors as emergency room use, health screening, and hospitalization rates for enrollees with chronic conditions, and hospital readmissions. Subsequently, state officials proposed a draft set of mandatory and voluntary measures. Performance on these measures would eventually factor into any shared savings that ACOs might be eligible to receive. ACO aspirants did not have to submit detailed quality plans addressing

specific metrics as part of the application process. Nonetheless, concerns about quality metrics and reporting surfaced during the initial implementation phase. Some stakeholders questioned whether some of the proposed metrics were valid and up-to-date. Others noted that the considerable number of mandatory measures increased reporting costs and might vitiate a focus on the most important objectives. Some stakeholders also believed that the proposed measures were not sufficiently integrated with those used by other payers, especially the quality metrics employed by Medicaid MCOs. Finally, some interviewees worried that they might not have sufficiently timely access to claims and encounter data to facilitate effective care coordination for high-utilizing patients.

Lessons

The implementation challenges encountered during the initial phase of the ACO demonstration point to the relevance of the five lessons listed below, which are explicated later in this report. If New Jersey policymakers and stakeholders in other states seek to strengthen prospects for strong performance by greater numbers of Medicaid ACOs, these lessons merit consideration.

Lesson 1: The detailed, prescriptive character of the founding legislation in New Jersey created implementation challenges and may have undercut the ability of the demonstration to reach its full potential.

Lesson 2: Demanding, numerical targets for ACO participation by primary care providers coupled with limitations in data that the state could share created formidable implementation challenges and weakened the ability of the ACO demonstration to achieve its full potential.

Lesson 3: Launching Medicaid ACOs without additional state funding impeded implementation and necessitated alternative support from private sources to sustain the initiative.

Lesson 4: The voluntary participation of Medicaid managed care organizations envisioned by the founding ACO legislation heightened the transaction costs for applicants and may weaken the ability of the ACOs to achieve their full potential.

Lesson 5: Assuring the timeliness and validity of quality metrics, promoting greater congruence among the measures used by Medicaid ACOs and other payers, and paring the reporting costs associated with the metrics may well increase prospects for the diffusion of successful ACOs.

The New Jersey ACO law calls for the Department of Human Services, working in concert with the state Department of Health, and drawing on data provide by the Rutgers Center for

State Health Policy to assess annually ACO progress toward quality and cost sharing objectives. The stakeholders interviewed proffered policy recommendations in response to the challenges they have experienced during the initial implementation phase of the ACO demonstration project. If the experience going forward leads policymakers and other stakeholders to favor further expansion of Medicaid ACOs in New Jersey, the lessons presented and policy solutions offered in this report merit consideration.

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Introduction

This report presents lessons from the initial implementation of the New Jersey Medicaid Accountable Care Organization (ACO) demonstration. The demonstration enabled the certification of ACOs for Medicaid enrollees in various areas of the state. The ACOs are coalitions of health care providers, social service providers, and community representatives organized as nonprofit organizations. They seek to foster greater access to higher quality care while reducing health care costs for Medicaid enrollees in defined geographic areas. ACOs that achieve their performance and cost control goals may receive additional revenue from Medicaid in the form of shared savings. The three-year demonstration sought to illuminate the potential utility of the ACO model in achieving these goals.

In August 2011, Governor Chris Christie signed legislation authorizing the demonstration. In May 2013, the New Jersey Department of Human Services (NJHHS, DMAHS 2013) published a proposed rule interpreting and detailing various provisions of the statute. After obtaining comments on the proposal from an array of stakeholders, the department issued a final rule one year later in 2014. In June and July of that year, seven provider coalitions formally applied for ACO certification. Twelve months later, in July 2015, three of the applicants - the Camden Coalition of Healthcare Providers, Healthy Greater Newark, and the Trenton Health Team - obtained state certification to launch their operations.¹

This report focuses on the nature and origins of the issues and challenges that surfaced in the four years between the initial legislative authorization and the certification of three ACOs.² We seek to distill lessons for all stakeholders interested in building Medicaid ACOs, and to inform

¹ The other applicants were the Healthy Cumberland Initiative, the Healthy Gloucester Initiative, New Brunswick Health Partners, and the Passaic County Comprehensive Accountable Care Organization. An eighth group, the Coastal Healthcare Coalition, initially submitted an application but then withdrew it. Subsequently, Medicaid officials offered to work with non-certified applicants that wished to engage in accountable care activities to the extent allowable under current law.

² This report complements the work of Yedidia, Lontok, and Cantor (2013), which focused on planning activities of some of the ACO applicants.

the decision making of New Jersey officials who may wish to consider policy revisions during or following the three-year demonstration.

This report opens with a brief description of methodology followed by an overview of the law authorizing the Medicaid ACOs. The third section assays the major implementation challenges that ACO applicants and state Medicaid officials encountered during this initial phase. We then distill five lessons from our findings that may be of value to stakeholders in New Jersey and other states.

Methods

Evidence for this report partly derives from publicly available government documents and articles in professional journals. We also draw heavily on 19 semi-structured interviews with 26 ACO stakeholders in New Jersey, which we conducted from July through October 2015.³ The interviews averaged about an hour with 12 being conducted in person and the remainder by phone. The interviewees included leaders from the coalitions that applied to be ACOs, New Jersey Medicaid administrators, representatives of advocacy groups, staff from private foundations, employees from organizations that provided technical assistance to ACO applicants, and individuals from Medicaid managed care organizations. With oral permission from the interviewees, we audio-taped and transcribed the conversations.

The interviews probed stakeholder perceptions of key implementation issues and challenges that emerged in the initial implementation phase (see the Appendix for the interview protocol). We opened the interviews by giving respondents the opportunity to identify the challenges that were foremost in their minds without any specific prompting. We followed with a series of specific questions derived from a review of the program documents (e.g., the law, administrative regulations) and more general observations concerning the application process. For instance, we asked questions concerning the law's requirements related to provider participation, quality metrics, electronic medical records, and gainsharing.⁴ In each case, we probed whether the issue had posed a challenge for applicants and the state during implementation. Two members of the Center for State Health Policy independently performed a content analysis of the interviews, and subsequently reached consensus on their core themes and perspectives.

The Legislative Template

The founding legislation (NJ P.L. 2011, c.114) specified multiple requirements for New Jersey provider coalitions seeking to become Medicaid ACOs. At the most basic level, applicants had to

³ Six interviews involved multiple individuals from the same stakeholder organization (e.g., an ACO applicant).

⁴ Gainsharing refers to the processes involved in allocating any ACO cost savings to particular stakeholders or functions.

map out a geographic area (specifying zip codes) that contained at least 5,000 Medicaid enrollees. Certified ACOs would eventually be responsible for the health, service utilization, and the costs of all Medicaid enrollees in their geographic areas.⁵ Applicants also had to assemble providers willing to participate in the ACO. The law required that applicants have the “support” of all the general hospitals, no less than 75% of the “qualified” primary care providers (e.g., physicians engaged in family or internal medicine, physician assistants, advanced practice nurses) and at least four behavioral health care specialists within their designated areas. It further specified that a “qualified” primary care provider had to devote at least 25% of his or her professional time to serving Medicaid enrollees, or 10 hours per seven-day week. ACO applicants had to pledge that their participating providers would use electronic prescribing and medical records.

The role of managed care organizations (MCOs) loomed large in significance for the ACO demonstration. New Jersey contracts with several MCOs to organize and pay for health care for approximately 95% of its Medicaid enrollees.⁶ The founding statute did not, however, require MCOs to participate in shared savings arrangements or otherwise cooperate with the ACOs. This meant that the ACOs would eventually need to negotiate directly with the MCOs to secure their voluntary participation.

The law went to some lengths to specify the governance characteristics of the ACOs. Applicants had to form a “nonprofit corporation” with governing boards representing the interests of a spectrum of providers (e.g., hospitals, physicians, behavioral health specialists), patients, and social service agencies located in its defined geographic area. The law further mandated that the board include at least two voting members from “consumer organizations capable of advocating on behalf of patients” in the ACO’s area (NJ P.L 2011, c.114, 3). It also required applicants to demonstrate that they had a process in place for soliciting comments from and otherwise engaging community members on the gainsharing plan that certified ACOs would eventually submit to state Medicaid officials for approval.⁷ This plan would specify the ACO’s method for calculating savings and how it would apportion any savings among participating coalition members.

⁵ In contrast, those served by Medicare ACOs are “attributed” to them for purposes of assessing quality and costs. New Jersey’s ACOs are responsible for all Medicaid enrollees in their areas regardless of “whether the ACO actually engages with a particular patient.” (Cantor et al. 2014, 1188)

⁶ In contrast to medical care, New Jersey has historically relied on fee-for-service to provide long term services and supports to Medicaid enrollees. The state currently has a waiver to transition most of these services to managed care.

⁷ The statute specified that ACO applicants have “a process for receipt of gainsharing payments from the department and any voluntarily participating managed care organizations.” Applicants did not, however, have to develop a specific plan during the initial implementation phase.

In these and other ways the founding legislation prescribed the characteristics and parameters for ACOs. The legislation did not, however, provide funding for ACO start-up costs or the subsequent implementation of the demonstration.⁸

Implementation Issues and Challenges

The interviews with stakeholders identified several challenges in the initial phase of the ACO demonstration. These challenges varied in their severity and pervasiveness. On balance, the most salient challenges revolved around issues of provider participation in the ACOs, the role of Medicaid managed care organizations, funding, procedural requirements leading to delay, and quality metrics.

Provider Participation

Assembling a network of providers to participate in the Medicaid ACOs was quite challenging for applicants, especially those that had not established provider coalitions prior to the 2011 legislation. As one stakeholder observed, it is “hard” to “change the dynamic in an industry” which has long featured “competition as opposed to cooperation and collaboration.” Some applicants skirted the need to forge cooperation among hospitals in the ACO area by carefully managing geographic boundaries (i.e., the chosen zip codes) to assure that it had only one facility. In other cases, however, applicants took on the task of persuading hospitals to participate. In the case of one ACO applicant, “getting two hospitals to work together was a huge lift... It took months. It took negotiations. It took a huge effort.” Having cooperation “happen even when ... there might be good reason for it from a patient care perspective, it’s difficult.”

Enticing private primary care providers to join the ACO also vexed many applicants. One noted that the ACOs leadership team had to overcome “a long history of animosity” among primary care providers toward the area’s federally qualified community health center (FQHC) and general hospital. These private providers “have this idea that all the funding for this kind of thing ends up with the hospital or the FQHC, but the work ends up with them.” In a similar vein, one applicant noted that the three providers essential to the ACO – a hospital, a private multi-specialty group, and a community health center – differed greatly in strategic objectives and cultures. They were “just not natural business partners.” Still another applicant pointed to the role of uncertainty in discouraging primary care practitioners from participating. These providers are expected “to kind of sign on the dotted line. They are clueless and I am clueless about what does that really mean... What does this mean that our relationship needs to look like with them?”

In dealing with provider participation, the three applicants that achieved state certification faced fewer difficulties because they had previously established formal provider

⁸ The Christie administration’s budget proposal for Fiscal Year 2017 sought to alter this circumstance by incorporating \$3 million in funding for the three certified ACOs (NJOMB 2016).

coalitions. They had built provider networks of trust and reciprocity (i.e., social capital) well before their applications. Under the leadership of Dr. Jeffrey Brenner, the Camden Coalition of Healthcare Providers was the pacesetter in this regard. Formed in the early 2000s, the Camden Coalition attracted national attention for its creative approach to serving “hot spotters” – individuals with the most acute health problems who account for a vastly disproportionate share of Medicaid costs (e.g., Gawande 2011). The Camden experience played a pivotal role in galvanizing and shaping the 2011 legislation authorizing the Medicaid ACO demonstration. The Camden Coalition’s board consisted of the three hospitals in the city, local primary care offices, community organizing groups, behavioral health specialists, and others. The Greater Newark Healthcare Coalition began as a workgroup in 2008 and incorporated in 2010. It consisted of hospitals in Newark as well as federally qualified health centers, behavioral health providers, representatives from state and local health departments, and others.⁹ So too, the Trenton Health Team, which took root in 2006, included such key providers as the city’s Department of Health and Human Services, both of the city’s hospitals, and a federally qualified health center. Even though these coalitions had a leg up in assembling the provider networks needed to create an ACO, however, meeting the state’s provider participation requirements still proved difficult.

A key challenge for these three, as well as the other applicants, stemmed from what came to be called the “denominator problem.” As noted previously, the statute required that at least 75% of primary care providers in the targeted area “support” the Medicaid ACO. The law also specified the minimum number of hours that a physician had to spend serving Medicaid enrollees to qualify as participating. Sensing the stringency of this requirement and its potential impact in damping the number of certified ACOs, several stakeholders argued for a flexible interpretation of this statutory provision in the administrative rulemaking process. They contended, for instance, that it exceeded the intent of the statute to equate provider “support” with full participation in the ACO. But the Department of Human Services (NJHHS, DMAHS 2013, 2014) rejected this argument thereby equating support with participation. The department also required ACO applicants to document that the requisite percentage of providers had signed on for the full three years of the demonstration.

Meeting the 75% requirement necessitated, of course, that applicants identify the universe of primary care providers serving Medicaid enrollees in their areas. No such list was readily available and compiling one consumed considerable time.¹⁰ At first, various stakeholders thought they might be able to derive the denominator from the lists of physicians identified as participating in Medicaid managed care plans. But this proved futile. Calls to providers on the managed care lists found that many were no longer at the posted addresses or accepting

⁹ It deserves note that, unlike Camden and Trenton, the Newark ACO application did not designate the entire city as its geographic area.

¹⁰ This was especially true if one adopted a literal interpretation of the law concerning the time commitment to Medicaid that participating physicians had to exhibit. Compiling such a list would require an extraordinary research effort.

Medicaid enrollees. Thus, relying on the managed care lists meant that, as one applicant put it, “The denominator was way too high” thereby exacerbating the problem of achieving 75% participation.

State Medicaid administrators became aware of the shortcomings of the managed care rosters and attempted to come up with a more accurate tally by having analytic staff examine Medicaid claims and encounter data. This research allowed the Department of Human Services to base their lists of primary care providers in each ACO demonstration area on the active involvement of providers in serving Medicaid enrollees. The analysis uncovered that some physicians listed as specialists actually provided substantial amounts of primary care. The provider lists based on claims and encounter data subsequently became the basis for departmental decisions on whether ACO applicants had met the participation standard.

Frustration with the 75% target nonetheless persisted among applicants because Medicaid administrators initially deemed their lists “proprietary.” They believed that releasing the names would violate their state contracts with the MCOs. The determination that the state lacked the authority to share the lists created tensions between Medicaid officials and the applicants. As one applicant put it:

We submitted a list. They said “you did not meet the 75% threshold.” We said ‘Hmmm, we think we’re around 90%, but what’s your denominator? Show us the list.’ They said “we can’t.”

In similar fashion, another applicant observed:

We felt very good about the list we sent in ... (which) we thought more than exceeded the 75% threshold. We were rather shocked when the state told us it did not, so the whole process of identification and approach, it really could have been handled in a much better way...

Overall, 17 of our 19 interviews identified the 75% requirement as a significant challenge and source of delay in establishing the Medicaid ACOs. Failure to meet this requirement played a pivotal role in the Department of Human Services’ decision not to certify four applicants.

Medicaid Managed Care Organizations

ACO applicants did not have to present formal evidence that they would eventually partner with MCOs. But all of them fathomed that the eventual success of the ACO demonstrations depended heavily on MCO involvement. As one applicant put it:

The place of managed care organizations in this process is the single most important issue for people to think about... It is interesting to think about whether it is sensible in a Medicaid system to have both a managed care system and an ACO system. Whether they fit harmoniously together...

Another applicant thought that this harmony would be far from simple to achieve noting that:

A lot was left to the expectation that you would sit down with managed care organizations and sing Kumbaya, and then they would give you money toward care management and devise some program... There's some pretty big assumptions there and ... a lot of those assumptions are a little spurious, to say the least. I'll give you an example around the care management piece...Medicaid is already paying managed care organizations to do, theoretically, care management...Are [the MCOs] willing to give up those dollars to an ACO to do that? I don't think so.

Medicaid managed care organizations tend to invest significant resources in care management. For instance, a stakeholder noted that one MCO had "175 field-based care managers [who] can take their computers out in the field, and...have full capability." These care managers seek out high utilizers of medical care, do assessments, create care plans, and order services to promote more integrated care. Moreover, the MCOs have signed shared savings contracts to foster care coordination with certain providers that serve large numbers of Medicaid enrollees. One MCO, for example, not only has contracts with the Camden Coalition of Healthcare Providers, but also a community health center which is a member of that ACO. The presence of ACOs as a third party complicates MCO initiatives to promote care coordination for high utilizers of medical care. Out of deference to the ACOs, it at times inhibits MCOs from signing shared savings contracts with heavy-volume Medicaid providers in their networks. Evidence from our interviews also suggests that some providers may have refrained from creating a Medicaid ACO because they believe that they can achieve greater shared savings by directly partnering with the MCOs.

The Medicaid MCOs wish to remain engaged in and remunerated for care coordination through their state contracts. During the initial implementation phase, they took steps to cooperate with the ACOs, especially with more developed provider coalitions. MCOs have signed contracts with the Camden Coalition of Healthcare Providers. MCOs have also indicated a willingness to engage in discussions and possibly provide funding to the certified ACOs in Trenton and Newark. However, the other four applicants faced more difficulties in generating interest among the MCOs. One such applicant noted that interest in collaboration tended to be greatest among MCOs with smaller Medicaid enrollments in the area. In contrast, MCOs with larger market shares declined to engage in discussions.

Overall, the interviewees varied in their assessments of whether the MCOs and ACOs will be able to forge meaningful partnerships under the current legal framework. Some stakeholders envision that partnerships may take the form of several discrete, highly focused contracts between the ACOs and MCOs to provide care coordination for specific cohorts of Medicaid enrollees. They suggest that MCOs may be drawn to these contracts because the ACOs have community ties that give them comparative advantage in reaching out to chronic high utilizers.

Other stakeholders, however, expressed more doubt about the prospects for strong partnerships, noting that the law provides no money or other tools to incentivize MCO participation. They stress that the state will have to play a key role in encouraging MCO involvement. As one applicant noted, “When you are talking about negotiation between a small nonprofit and ... [managed care organizations], it’s not exactly an equal playing field. If the state isn’t putting their thumb on the scale, then that’s a problem.”

Funding and Administrative Capacity

The absence of funding in the 2011 authorizing legislation posed a two-fold challenge. First, it limited the staff that Medicaid administrators could readily devote to the demonstration. One stakeholder noted that the ACO legislation surfaced at a time when Medicaid officials faced pressure to prioritize two “massive changes” – the movement of large numbers of fee-for-service Medicaid enrollees into managed care under a global waiver from the federal government, and the Medicaid expansion under the Affordable Care Act. To compound problems, the state agency responsible for Medicaid had experienced some staff turnover and had not always been able to replace the departing employees. Given these factors, state implementation of the ACO demonstration primarily came to rest on the shoulders of one official. While commending the efforts of this official, several stakeholders identified limited state staffing of the ACO project as a source of delay in the initial implementation phase.

The paucity of funding also posed direct challenges for applicants who struggled to cover the start-up costs associated with creating an ACO. As one applicant noted, the quest to become certified was held together by “bailing wire and bubble gum.” For instance, one applicant faced delay because it had to rely on pro bono legal services to become a 501(c)3 nonprofit organization. Another applicant underscored that it lacked the staff needed to conduct outreach to providers and the community. Certain stakeholders also noted that the absence of funding made it harder to attract providers to the ACOs. In this vein, one applicant observed that recruiting private physicians would have been easier “if there was some kind of carrot to get them to the table.” Another said that if the legislation had provided funding to incentivize doctors, you would have the required 75% of primary care providers “knocking at your door to participate.” Given the absence of funding, one applicant summed up the experience of trying to create an ACO as “running really fast and [feeling] like the thing you are running toward is a mirage.” More established provider coalitions, such as the one in Camden and those based in larger organizations, could more readily float the upfront costs of applying. But even these applicants identified the dearth of funding as a significant challenge.

In principle, the shared savings ultimately generated by the ACOs might eventually cover their start-up and operating costs, and we specifically probed this possibility in our interviews. Respondents expressed doubts that gainsharing would play that role in nearly 75% of the interviews. Those expressing skepticism voiced several themes. One applicant pointed to the

difficulties of overcoming the “divorce between the social support system” and the “biomedical system” as the core barrier to significant savings. One stakeholder noted that “it’s hard to build [an ACO] cheaply and correctly” while another observed, “I don’t know how you how you get us to the point of shared savings if there isn’t an initial investment in infrastructure ... right off the bat.” Others saw the ACOs as being less about cost sharing than enhancing the quality of care. In this view, the Medicaid ACOs are less about a “big pot of gold at the end of the rainbow” than about improving “the quality of health and healthcare” for the Medicaid population.

The remaining cluster of interviewees held out more hope that shared savings would help sustain the ACOs. Certain stakeholders pointed to research performed by the Rutgers Center for State Health Policy to suggest the potential for substantial savings by targeting high utilizers for care coordination and related benefits.¹¹ Other stakeholders pointed to the experience of Medicaid ACOs in Colorado, Minnesota, and Oregon in achieving significant shared savings and other goals. Within New Jersey, one stakeholder noted that substantial gainsharing had resulted from an agreement (external to the ACO) between a managed care organization and CAMCare, a federally qualified health center in Camden. However, even those who held out greater hope for generating shared savings noted that over time gainsharing would diminish. In this respect, one stakeholder observed that the “business model” underpinning the Medicaid ACO over the longer term “kills it.” If the ACO “does really, really well, at some point you will hit a natural bottom and ... at that point the model needs to flip into” some other approach.

The absence of state funding and the optional nature of MCO involvement heightened the importance of private foundation grants for ACO applicants. All but one of the interviews indicated that foundation support was either important or a prerequisite for the creation of a viable ACO. In this regard, the critical catalytic role played by the Newark-based Nicholson Foundation stands out. In the words of one stakeholder, the Medicaid ACO demonstration “probably would have gone nowhere without the Nicholson Foundation’s support.” The foundation had been interested in the promise of Medicaid ACOs prior to the 2011 authorizing legislation. It provided funding to the Center for Health Care Strategies to forge a learning collaborative focused on Medicaid ACOs nationally. After passage of the legislation, the Nicholson Foundation gave a grant to the New Jersey Health Care Quality Institute to encourage the submission of Medicaid ACO applications from coalitions in areas identified by the Rutgers Center for State Health Policy as having a the potential for achieving substantial shared savings. The grant also allowed the Quality Institute to provide technical assistance to ACO applicants throughout the initial implementation period. The Nicholson Foundation encouraged the Camden Coalition of Healthcare Providers to offer such assistance to other ACO applicants as

¹¹ An analysis performed by the center targeted 13 communities that were possible candidates for participation in the ACO demonstration. It found that “the potential savings among Medicaid enrollees are considerable, particularly if Medicaid ACOs can develop ways to successfully address the high burden of chronic illness and behavioral health conditions prevalent in the prospective demonstration communities.” (Cantor et al. 2014, 1185)

well. In no small part because of these initiatives, the applicants generally affirmed that they had sufficient access to technical assistance. However, one applicant commented that “it would have been useful to have more technical assistance from people outside the state of New Jersey” in order to make the ACO initiative less driven by the Camden model. In addition to supporting technical assistance, the Nicholson Foundation supplied infrastructure grants for provider coalitions in Camden and Trenton to expedite their development of viable ACOs. Nearly all the other applicants reported having discussions with Nicholson about the possibility of funding.

While the Nicholson Foundation’s support drew praise from across the spectrum of stakeholders, one felt that the policy “dynamics in New Jersey have made [foundation support] too important.” It made the ACO demonstration “vulnerable to the whims of private philanthropy” in a way that would not be the case if the state or managed care organizations provided significant funding.

Legal Process and Delay

The 2011 founding legislation mandated the New Jersey Department of Human Services to adopt “rules and regulations establishing the standards for gainsharing plans” and other requirements deemed “necessary to carry out the provisions of this act” within 180 days of the law’s effective date¹² (NJ P.L. 2011, c.114, C.30.4D–8.15). Instead, the department did not promulgate the final regulation until mid-2014, roughly two and half years after the law took effect. It took nearly four years from the signing of the Medicaid ACO legislation to the certification of three applicants in July 2015. Hence, considerable delay characterized the implementation of the ACO demonstration.

Not all observers viewed delay as problematic. One stakeholder noted that delay gave provider coalitions more time to learn of the demonstration initiative, obtain technical assistance and assemble their applications. One applicant asserted that delay provided “more time to develop our capabilities in terms of our health information exchange and population health analytics.” It also allowed them “to develop our care management intervention, and really understand what is the appropriate patient population.” However, another stakeholder lamented that delay caused the “momentum that was initially there” in some communities to fade. “Stakeholders weren’t necessarily willing to commit to anything if it wasn’t clear that the ACOs were going to happen so some of that community building and coalition building kind of faltered.” One applicant noted that the delay created fiscal stress and the threat of staff reductions because a private foundation grant for the ACO’s infrastructure ran out before the state certification decision.

Whatever the precise implications of delay, we asked respondents in each interview what they thought caused it. In varying degrees they pointed to three primary sources, two of which

¹² The law went into effect 60 days after passage in October 2011.

involved legal processes. The first consisted of antitrust issues associated with the ACOs. The Sherman Antitrust Act of 1890 prohibits collaborations that “unreasonably restrain trade.” While the Supreme Court clarified in 1943 that the Sherman Act did not supersede the authority of states to take certain “anticompetitive” actions, considerable ambiguity persists concerning when cooperative provider agreements violate antitrust law (Grogan 2015, 634; Leibenluft 2015). Aware of this legal uncertainty, state Medicaid officials engaged in extensive discussions with not only the Centers for Medicare and Medicaid Services (CMS), but also the Federal Trade Commission and the US Department of Justice before implementing the ACO demonstration. Once administrators drafted proposed regulations, they engaged in back-and-forth discussions with the Federal Trade Commission before feeling free to proceed.

Second, the transparency and due process requirements associated with administrative rulemaking in New Jersey kindled appreciable delay. As one stakeholder noted, the rulemaking process “is built for contemplation rather than speed to the market.” The state must publish a proposed rule, give stakeholders an opportunity to comment, and publicly summarize its response to these comments when it issues the final rule. This was particularly challenging for state officials in the case of the Medicaid ACOs because, unlike many other pilot projects, the legislation authorizing the demonstration was quite detailed and prescriptive. The statute therefore necessitated a lot of interpretation. Moreover, the Medicaid ACO was a new model that called for careful reflection on the part of administrators. This meant that the attorney assigned to be chief navigator on the regulation had to hold several meetings with subject matter experts. In addition, Medicaid administrators received 16 formal communications on the proposed regulations during the 60-day comment period. These comments had to be assessed and a response drafted. Given these dynamics, Medicaid administrators did not publish the proposed rule until early May 2013, one year and nine months after the Governor signed the ACO legislation. Once published as a proposal it took another year for the Department of Human Services to assess comments and issue the final rule.

Stakeholders also identified a third source of delay not directly associated with legal process – lack of staffing in the state Medicaid agency. As noted previously, responsibility for the demonstration primarily resided with a single staff member. Given the complexities and general workload associated with implementing the program, some delay was inevitable given this staffing level.

Quality Metrics and Reporting

The 2011 legislation mandated that state Medicaid officials at least annually examine ACO performance on certain indicators. These included such factors as emergency room use, health screening, hospitalization rates for enrollees with chronic conditions, and hospital readmissions. The law did not, however, prescribe specific quality metrics for the ACOs. In promulgating regulations the New Jersey Department of Human Services (NJHHS, DMAHS 2013) clarified that

the ACOs would have to use quality measures that Medicaid officials “determined or approved.” They anticipated issuing mandatory measures applicable to all ACOs as well as a menu of optional indicators from which ACOs would select several. These indicators were to include a “valid mix” of “preventive” and “at-risk population measures” as well as metrics related to the “appropriate use of providers” and “access to care.” The regulations stated that ACO performance on these measures would factor into any shared savings that the Department of Human Services might eventually allocate. ACOs were expected to show improvement on some of these quality metrics relative to their own past performance and also attain an absolute level of proficiency on certain measures. The gainsharing plans of the ACOs also had to consider survey reports of “patient experience.” The regulations specified that administering the standard Consumer Assessment of Healthcare Providers and Systems survey (CAHPS)¹³ would be an acceptable, though not mandatory, approach. It also allowed the ACOs to select “similar survey instruments.”

Apart from the formal regulations, Medicaid officials subsequently released a draft set of quality metrics. The list included 20 mandatory measures for all ACOs sorted under six rubrics: prevention, acute care, behavioral health, chronic conditions, resource utilization, and patient satisfaction. The draft also provided a menu of some 40 optional measures from which an ACO would select six. One of the six had to be a preventive measure (e.g., breast cancer screening). The other five would target major chronic conditions – cardiovascular disease, diabetes, or respiratory ailments.

It deserves emphasis that ACO aspirants did not have to submit detailed quality plans addressing specific metrics as part of the application process. Concerns about quality metrics and reporting nonetheless surfaced during the initial implementation phase. In varying degrees stakeholders expressed four concerns about the measures. First, some questioned the validity of certain metrics. In this regard, one stakeholder termed certain of the measures “rather absurd” and another thought some of them were “outdated.” Second, the sheer number of mandatory measures sparked concern. In noting the burdens on providers of tracking a large number of metrics, one applicant observed that when the number grows too large, providers “don’t know what to focus on.” Third, some stakeholders believed that the proposed measures were not sufficiently integrated with those used by other payers.¹⁴ As one applicant put it:

The metrics are all over the place. So if you’re dealing with Horizon, that’s one set of metrics. If you’re dealing with Aetna it’s another; Medicare is a third.

Nor were the draft measures completely congruent with those used by the Medicaid MCOs. As a condition of their contracts with the state these MCOs must report on a variety of HEDIS measures designed to capture quality.¹⁵ The measures the state proposed for the ACOs went

¹³ CAHPS is a survey developed and promoted by the US Agency for Healthcare Research and Quality.

¹⁴ Issues related to alternative (at times conflicting) approaches to measuring health care quality more generally characterize performance assessment in the United States. See, for instance, Austin et al. (2015).

¹⁵ HEDIS (Healthcare Effectiveness Data and Information Set) is a well-known set of metrics promulgated by the National Committee on Quality Assurance (NCQA).

beyond HEDIS incorporating such indicators as whether a patient received follow-up care after discharge from a hospital. The different approaches to measuring quality became an issue in negotiations between the ACOs and MCOs. One stakeholder believes that managed care organizations would be more willing to work with the ACOs if a common set of quality metrics applied to each.

Fourth, some stakeholders raised issues related to the timely reporting of valid performance information. One applicant noted that in drafting their proposal “we did talk a little bit about our fear ...that we would not get the right data to be able to make decisions” and there might be problems of timeliness and accuracy. Another applicant observed that “Data is a huge problem. We’re going to get Medicaid claims data. Right. Great. But late. I can’t manage a high-utilizing patient when I got the claim that’s a month old.”

The administrative rulemaking process raised issues of the division of labor between state agencies and the ACOs in terms of data collection and reporting. In commenting on the proposed ACO rule, certain stakeholders noted that much pertinent data would be outside the control of the ACO. They wanted the state to assure that ACOs would have timely access to this information. In the case of claims-based quality metrics, one commenter recommended that Medicaid officials assume responsibility for calculating performance on these measures. However, state officials disagreed with this suggestion noting: “The Department does not intend to provide the ACOs with all of the claims-based outcome metrics. The Department believes this is counter to the organization’s commitment to become ‘accountable’ for health outcomes, quality, cost, and access to care and believes that ACOs should have the ability to collect their own data” (NJ DHS, DMAHS 2014, 34–35). Subsequently, however, New Jersey Medicaid officials committed to supplying ACOs with claims and encounter data.

Other Factors

Our interviews also probed whether the law’s requirements concerning electronic medical records and governance (e.g., board composition, nonprofit status) posed significant challenges for applicants during the initial implementation phase. By and large stakeholders said “no” though acknowledged that these issues might prove vexing down the road.

Interviewees noted that the development of electronic medical records and prescribing had made considerable headway in New Jersey especially in the case of hospitals. Funding from the federal government and Nicholson Foundation has facilitated this development. Interviewees affirmed that considerable work remained to be done, however. One applicant observed that the technology involved is still in its “infancy” and that certain providers in the ACO still relied on paper records. But no stakeholder thought that the electronic records requirement posed a significant barrier to ACO certification. All applicants attested that they would meet this requirement if certified.

So too, the governance requirements of the ACO legislation did not prove to be a stumbling block. Applicants from Camden and Trenton had already established boards and mechanisms for community participation that substantially met the law's requirements. Newark, which had also assembled a provider coalition prior to 2011, had to do more to reconfigure its governing structure to comply. While less advanced, other applicants managed to put together governing boards that met with state approval for certification purposes. In one case, state officials concluded that the community and social service organizations proposed for a board did not meet state requirements. But Medicaid administrators gave the applicant an opportunity to revise the proposal and the applicant successfully did so.

Lessons

The implementation challenges encountered during the initial phase of the ACO demonstration guided our efforts to distill lessons that may be of use to stakeholders in New Jersey and other states. The lessons below also derive from a question that we posed to the 26 stakeholders we interviewed. Specifically, we asked for their recommendations as to how to improve the initial law and the state's administrative approach to enhance prospects for the development of effective, sustainable ACOs.

Lesson 1: The detailed, prescriptive character of the founding legislation created implementation challenges and may have undercut the ability of the demonstration to reach its full potential. This theme surfaced in various ways in 12 of our 19 interviews. Some stakeholders observed that the legislation tended to be based on the Camden model. While stakeholders uniformly praised the achievements of the Camden Coalition of Healthcare Providers, and appreciated the technical assistance that Camden staff provided to other ACO applicants, some expressed concern that basing the law on the Camden experience undercut the opportunity to test different ACO models. As one applicant put it, "Variation creates the opportunity for learning ... if you want to have innovation...there needs to be a tolerance for diversity and for experimentation and change over time. You can't so strongly proscribe how this is going to be." In the view of this stakeholder, the state wound up with three certified ACOs where less prescriptive legislation might have led to a greater number, "each looking a little bit different" and providing fertile ground for learning.

Stakeholders differed in the degree and ways in which they wanted the legislation to provide more flexibility. At one extreme, two stakeholders favored minimalist legislation that would leave nearly all program details to the discretion of Medicaid officials, who could then be more responsive to the varying objectives and strategies of different applicants. Others focused more on changing particular statutory provisions, such as the standard for provider participation (see lesson 2 below). A minority preferred greater precision in certain spheres. For instance, one stakeholder praised the governance requirements for community participation in the law and

wanted them strengthened. Another applicant recommended that any subsequent ACO legislation be more specific about goals. Still another voiced support for greater specificity about gainsharing. On balance, however, most stakeholders favored movement toward greater flexibility.

Lesson 2: Demanding, numerical targets for ACO participation by primary care providers coupled with limitations in data that the state could share created formidable implementation challenges and weakened the ability of the ACO demonstration to achieve its full potential. As noted earlier, the founding legislation required 75% of the “qualified” primary care providers in the ACO’s area to participate. It further defined the amount of time that a physician had to spend treating Medicaid enrollees to be considered a qualified provider. Seemingly simple and straightforward, this requirement fueled delay, imposed substantial administrative costs on state officials and applicants, and was the key barrier to ACO certification for four applicants. Applicants quickly discovered that MCO lists inflated the actual numbers of primary care providers serving Medicaid enrollees in their areas. Eventually, state Medicaid administrators committed substantial staff time to mining claims and encounter data in the various ACO territories to determine the denominator needed to compute the 75%. But proprietary concerns then prompted Medicaid officials to withhold the lists from the ACO applicants. This put these officials in the unenviable position of informing applicants that they had failed to reach the 75% target, while denying them access to information useful in meeting it.

Nearly all stakeholders agreed that the 75% set a high bar for participation and that an ACO with a smaller percentage of participating providers might well be able to promote the goals of quality, access, and cost containment. In suggesting revisions, one stakeholder recommended that the target be set at a majority of qualified primary care providers in the ACO area. Another suggested that the law be changed to require an “adequate number of primary care providers to take care of the population.” This would allow more room for Medicaid administrators to define through regulation and other means a suitable approach – one more sensitive to the different contexts of the ACO applicants.

Lesson 3: Launching Medicaid ACOs without additional state funding impeded implementation and necessitated alternative support from private sources to sustain the initiative. During the period covered by this analysis, the absence of state funding to support the Medicaid ACO demonstration undermined implementation in several respects. It greatly limited the staff that the Medicaid agency could assign to the project, creating delay and undercutting outreach and technical assistance. The lack of a funding stream also made it more difficult for applicants to induce providers to participate in the ACOs. As noted earlier, the vast majority of stakeholders believed that any shared savings would be insufficient to cover the start-up costs of the ACOs. Nor could most applicants count on significant up-front contracts or other financial arrangements with MCOs to fund their efforts.

The absence of state funding or required participation by the MCOs made private support essential to the ACOs with the Nicholson Foundation taking the lead. The foundation provided grants to the New Jersey Health Care Quality Institute to encourage ACO applications in pertinent areas throughout the state. The Quality Institute provided technical assistance to the applicants, monitored the initial roll out of the demonstration by the state, conducted pertinent analyses, and offered suggestions to state officials for improving implementation. In no small part due to the work of the Quality Institute, applicants believed they had sufficient technical assistance in preparing their proposals. The Nicholson Foundation also provided infrastructure grants to the Camden Coalition of Healthcare Providers and the Trenton Health Team to shore up their capacity to develop and implement proposals.

Most stakeholders do not believe, however, that any future New Jersey initiative to encourage the diffusion of Medicaid ACOs should rely so heavily on private foundation support. Stakeholders in 10 of the 19 interviews recommended that a state funding stream be established for that purpose. Sensitive to this issue, the Christie administration's budget proposal for Fiscal Year 2017 contained \$3 million in funding for the three certified ACOs (NJOMB 2016).

Lesson 4: The voluntary participation of Medicaid managed care organizations envisioned by the founding ACO statute heightened the transaction costs for applicants and may weaken the ability of the ACOs to achieve their full potential. Some states, such as Minnesota, have mandated that MCOs participate in their Medicaid ACO demonstrations (CHCS 2014). In contrast, the New Jersey legislation made MCO involvement voluntary. ACO applicants did not have to create partnerships with the MCOs to obtain certification from state Medicaid officials. Yet virtually all stakeholders understood how important MCO involvement would be to achieve the quality, access, and cost saving goals of the demonstration. Most applicants reached out to MCOs and some, such as Camden and Trenton, engaged in extensive negotiations to lay the groundwork for contracts with these insurers.

For their part, MCOs had legitimate concerns about whether the emerging ACOs would bolster their ability to serve Medicaid enrollees in a cost-effective way. These organizations already deployed substantial staffs to foster care coordination for high utilizers and had to demonstrate performance on certain quality metrics. The degree to which ACOs would add value to their care coordination initiatives remained an open question. In certain cases, the presence of the ACO inhibited managed care organizations from signing contracts with providers to achieve shared savings via care coordination and other means. Factors such as these prompted one stakeholder (not an employee of an MCO) to strongly defend the initial decision of state policymakers not to mandate MCO participation. This individual noted that the ACO was "so new, unlike really any other one in the country." Under this circumstance, it would have been inappropriate "making it a contractual requirement or forcing an insurance carrier to contract with entities where there is no proven record, no data yet. These things ... should happen organically."

Should there be another New Jersey initiative to promote the diffusion of Medicaid ACOs, about half of the stakeholders support making MCO involvement mandatory. This sentiment emerged in 9 of our 19 interviews. Some stakeholders pointed to impressive shared savings results from states, like Minnesota, with mandatory MCO participation to justify their views. Another premised the recommendation on assumptions about the performance of the current demonstration: “Assuming there would be a round 2 because round 1 was showing good results ...it should be mandatory for the MCOs to participate.”

Lesson 5: Assuring the timeliness and validity of quality metrics, promoting greater congruence among the measures used by Medicaid ACOs and other payers, and paring the reporting costs associated with the metrics may well increase prospects for the diffusion of successful ACOs. As noted earlier, applicants did not have to submit detailed plans concerning quality metrics as part of their proposals. Nonetheless the draft metrics state Medicaid officials proposed did generate concern among stakeholders during the initial implementation phase. This concern found expression in a report prepared by the New Jersey Health Care Quality Institute in consultation with ACO applicants and other stakeholders (NJHCQI 2015). Three clusters of recommendations emerged from the report. First, the Quality Institute recommended replacement of certain outdated metrics in the state’s draft proposal with more recent indicators endorsed by such nationally respected entities as the National Quality Forum and the US Agency for Healthcare Research and Quality.

Second, the Quality Institute recommended aligning the quality metrics of various payers and initiatives to streamline the number of measures. The institute staff placed particular emphasis on aligning ACO metrics with those of Medicaid MCOs. It proposed this step “not only because it provides consistency but because it aligns the incentives of the MCOs and the ACOs, improving the likelihood that the two entities will collaborate.” The Quality Institute also endorsed greater congruence between the ACO metrics and those embedded in New Jersey’s Delivery System Reform Incentive Payment (DSRIP) program. Authorized under the state’s comprehensive Medicaid waiver, this initiative provides bonus payments to hospitals and other collaborating providers if they score well on an array of quality metrics. Nearly 70% of New Jersey’s acute care hospitals are participating in DSRIP, including those specified in the seven ACO applications (Gusmano and Thompson 2015). In fact, under the New Jersey State Innovation Model Design Award (SIM) analysis is underway to examine opportunities for aligning quality reporting requirements of Medicaid ACOs, MCOs, and other payer initiatives (including the DSRIP).

Third, the Quality Institute endorsed steps to reduce the technical complexities and costs of reporting requirements. Aligning and streamlining metrics, as discussed above, serves that end. In addition, the report affirmed that “metrics derived exclusively from [Medicaid] ... claims data would be the easiest and most feasible to report.” Most of the draft mandatory measures proposed by the state emanate from these data. In cases where the metrics did not, however,

the Quality Institute recommended either removing them or using proxy measures based on claims data. In keeping with this recommendation and in the interest of assuring consistency between measures used to administer the ACO gainsharing provisions and the pilot's formal evaluation, Medicaid administrators and stakeholders are discussing having the Rutgers Center for State Health Policy calculate claims-based quality measures on behalf of the ACOs. While acknowledging the importance of reporting on patient satisfaction, the institute differed with the state on the utility of the CAHPS survey. State officials had endorsed CAHPS as one important option for the ACOs. But the Quality Institute stressed that the Medicaid ACOs "did not have the capital or infrastructure" needed to use CAHPS. It further underscored that "generating a sufficient sample size for Medicaid ACO providers is improbable if not impossible due to the size of some of the areas." The Quality Institute therefore recommended a more feasible and less costly approach to tapping patient satisfaction.

The extent to which the state should adopt the suggestions of the New Jersey Health Care Quality Institute remains an open question. But at a minimum, the institute's report captures many of the concerns expressed by the stakeholders we interviewed. It provides a sound platform for further deliberation about and the improvement of the quality metrics.

Additional Policy Considerations

A range of policy options were proffered by stakeholders interviewed for this report, some with a high degree of consensus and others where disagreements remain. For example, most stakeholders agreed that if the state were to enact ACO renewal legislation, it should be less prescriptive than the law authorizing the demonstration. In contrast, clear disagreements remain about whether MCOs should be required to participate in gainsharing in a future iteration of the ACO program.

Some areas with little disagreement, such as the desire to align and streamline quality metrics required of the ACOs and MCOs, highlight potential pathways to reinforce incentives that may help pave the way to greater voluntary cooperation between the ACOs and MCOs or less resistance to requiring MCO participation. While most stakeholders considered the issue of MCO participation in the context of possible ACO program renewal legislation, the state's MCO contract is another important vehicle the state could use to encourage or require ACO-MCO cooperation. In fact, modifying the MCO contract to promote engagement with ACOs would be consistent with the strategies the state has pursued in recent years to enhance quality of care and address cost concerns for Medicaid enrollees. Such a strategy could be used alone or in concert with legislation reauthorizing the ACOs.

Stakeholders also broadly agreed that the mechanism in the ACO law to assure adequate participation of primary care providers in the ACOs did not work well. The difficulties fueled by the 75% participation requirement and related statutory language were probably an unintended

consequence for those who designed the demonstration. Looking to the future, some stakeholders suggested delegating more authority to Medicaid administrators to determine what level of provider participation should be considered adequate, although this approach may not satisfy others who are concerned about the adequacy of involvement of qualified providers. There may be some lessons for how to assure adequate participation without getting into the sorts of measurement difficulties that arose during demonstration's implementation. Specifically, network adequacy regulations generally rely on ratios of providers to enrollees, which are easier to measure than the "denominator" of participating providers at any point in time. A rule could be fashioned, for example, requiring participation of a minimum number of primary care providers per 1,000 attributed Medicaid enrollees in the designated ACO region. Additional rules could be applied to assure diversity of primary care participants, such by specialty or whether they are in private practice or work for hospitals or FQHCs.

Conclusion

ACOs have proliferated over the last five years in the United States and number over 700. The vast majority of these operate under the auspices of Medicare or commercial insurance companies (Shortell et al. 2015, 648). More recently, a growing number of states¹⁶ have begun to initiate Medicaid ACOs in an effort to foster greater access to higher quality care while paring program costs. New Jersey was one of the first states to authorize such an initiative. For reasons we address in this report it took New Jersey nearly four years to complete the initial implementation phase culminating in the certification of three of seven ACO applicants. Going forward, state Medicaid officials have also indicated a willingness to work with ACO applicants that did not receive formal certification (colloquially referred to as "ACO look-alikes"). While not the focus of this report, the ACOs in conjunction with state Medicaid officials, MCOs, and others must now develop implementation strategies to realize the goals embedded in the founding legislation. The law calls for the Department of Human Services, working in concert with the state Department of Health, drawing on data provide by the Rutgers Center for State Health Policy, to assess annually ACO progress toward quality and cost sharing objectives. If the experience going forward leads policymakers and other stakeholders to favor further expansion of Medicaid ACOs in New Jersey, the lessons presented in this report merit consideration.

¹⁶ In addition to New Jersey, states with Medicaid MCOs include Colorado, Illinois, Maine, Minnesota, Oregon, Rhode Island, Utah, and Vermont. Ten other states are actively considering the authorization of Medicaid ACOs (CHCS 2016); see also Koscot et al. (2013).

References

- Austin JM, AK Jha, PS Romano, SJ Singer, TJ Vogus, RM Wachter, and PJ Pronovost. 2015. "National Hospital Ratings Systems Share Few Common Scores and May Generate Confusion Instead of Clarity." *Health Affairs (Millwood)* 34 (3): 423–30.
- Cantor JC, S Chakravarty, J Tong, MJ Yedidia, O Lontok, and D DeLia. 2014. "The New Jersey Medicaid ACO Demonstration Project: Seeking Opportunities for Better Care and Lower Costs among Complex Low-Income Patients." *Journal of Health Politics, Policy and Law* 39 (6): 1185–211.
- CHCS (Center for Health Care Strategies). 2014. *Medicaid Accountable Care Organizations: Program Characteristics in Leading-Edge States*. Hamilton, NJ: CHCS.
http://www.chcs.org/media/ACO_Design-Matrix-053014.pdf.
- . 2016. *Medicaid Accountable Care Organizations: State Update*. Hamilton, NJ: CHCS.
<http://www.chcs.org/media/ACO-Fact-Sheet-032116.pdf>.
- Gawande A. 2011. "The Hot Spotters." *The New Yorker*. Accessed January 25, 2016.
<http://www.newyorker.com/magazine/2011/01/24/the-hot-spotters>.
- Grogan CM. 2015. "Encouraging Competition and Cooperation: The Affordable Care Act's Contradiction?" *Journal of Health Politics, Policy and Law* 40 (4): 633–38.
- Gusmano MK, and FJ Thompson. 2015. "An Examination of Medicaid Delivery System Reform Incentive Payment Initiatives Under Way in Six States." *Health Affairs (Millwood)* 34 (7): 1162–69.
- Kocot SL, C Dang-Vu, R White, and M McClellan. 2013. "Early Experiences with Accountable Care in Medicaid: Special Challenges, Big Opportunities." *Population Health Management* 16 (Suppl. 1): S4–11.
- Leibenluft RF. 2015. "Antitrust and Provider Collaborations: Where We've Been and What Should Be Done Now." *Journal of Health Politics, Policy and Law* 40 (4): 847–74.

- NJDHS, DMAHS (New Jersey Department of Human Services, Division of Medical Assistance and Health Services). 2013. "Medicaid Accountable Care Organization Demonstration Project, Implementation of Demonstration Project, Proposed New Rules: N.J.A.C. 10:79A." *New Jersey Register* 45 N.J.R. 1080(a), vol. 45, no. 9, May 6.
- . 2014. "Medicaid Accountable Care Organization Demonstration Project, Implementation of Demonstration Project, Adopted New Rules: N.J.A.C. 10:79A." *New Jersey Register* 46 N.J.R. 791(a), vol. 46, no. 9, May 5.
- NJHCQI (New Jersey Health Care Quality Institute). 2015. *NJ Medicaid ACO Demonstration Quality Metrics Recommendations Overview*. Princeton, NJ: NJHCQI.
<http://www.njhcqi.org/wp-content/uploads/2015/03/C2.-Quality-Measures-Recs-Overview.pdf>.
- NJOMB (New Jersey Office of Management and Budget). 2016. *The Governor's FY 2017 Budget: Budget Summary*. Trenton, NJ: NJOMB.
<http://www.nj.gov/treasury/omb/publications/17bib/BIB.pdf>.
- NJ P.L. 2011, c.114. *An Act Establishing a Medicaid Accountable Care Organization Demonstration Project and Supplementing Title 30 of the Revised Statutes*. Enacted by the Senate and General Assembly of the State of New Jersey.
http://www.njleg.state.nj.us/2010/Bills/PL11/114_.pdf.
- Shortell SM, CH Colla, VA Lewis, E Fisher, E Kessell, and P Ramsey. 2015. "Accountable Care Organizations: The National Landscape." *Journal of Health Politics, Policy and Law* 40 (4): 647–68.
- Yedidia MJ, O Lontok, and JC Cantor. 2013. *Development of Medicaid Accountable Care Organizations (ACOs) in Three New Jersey Communities*. New Brunswick, NJ: Rutgers Center for State Health Policy. <http://cshp.rutgers.edu/Downloads/10040.pdf>.

Appendix: Medicaid ACO Interview Protocol

The interviews with stakeholders were semi-structured and varied depending on the position held by the interviewee. The core topics the interviews explored appear below.

1. What has been your role in the Medicaid ACO development process since passage of the authorizing legislation in 2011? What prompted your interest in the initiative?
2. As you may know, it took nearly four years from the date the ACO legislation was signed until the certification of the ACOs. What is your understanding of why the implementation process took that long? In retrospect, do you have any recommended changes to the legislation or regulations that could have shortened the implementation timeline?
3. The requirements embedded in the authorizing legislation and state regulations set the stage for the development of ACO proposals. I will probe specific implementation issues later in the interview, but want to start broadly. In your view, what were the most difficult challenges faced by those seeking to obtain certification as a Medicaid ACO? How successful were they in dealing with these challenges?
4. The law sets general requirements for provider participation. For example, it requires that within the ACO's designated area all general hospitals and 75% of the qualified primary care providers "support" the application. To what extent did provider participation issues present difficult challenges for those seeking to establish Medicaid ACOs? To what degree did Medicaid's relatively low provider payment rates contribute to any problem? What strategies were used to surmount participation challenges?
5. In a related vein, did securing the support and participation of managed care organizations raise any problems in the proposal development process?
6. To what degree did the requirement that the applicant have a commitment to electronic prescribing and medical records in the designated area present challenges in putting together a compelling proposal for ACO certification? Did general concerns about access to timely and valid performance and cost data complicate and in any way hinder proposal development?
7. The authorizing legislation requires that an ACO's designated area have no fewer than 5,000 Medicaid recipients. Did calculating this figure and achieving this enrollment target create problems for those seeking to submit applications?

8. Did requirements concerning ACO governance (e.g., board composition and public participation) create any implementation issues for applicants? Or were these tasks easily managed?
9. The state of New Jersey intends to promulgate about 20 “mandatory measures” to gauge the performance of the Medicaid ACOs and an additional menu of measures from which the ACOs will voluntarily select certain options. Did concerns about the quality measures create any complications or difficulties for those seeking to develop ACO proposals?
10. In a similar vein, did concerns about gainsharing pose any implementation challenges? Were estimates of the level of potential shared savings high enough to motivate providers to participate in the ACO? Did concerns about how any savings would be allocated among providers create issues in drafting the proposals?
11. To what extent do you believe that shared savings will cover ACO start-up and operational costs?
12. Do you believe that more applicants would have been certified as Medicaid ACOs if they had more access to technical assistance? If so, who should provide such assistance?
13. Was the 60-day application period sufficient for provider coalitions to submit competitive ACO proposals of high quality?
14. To what degree is private foundation support important in developing a compelling Medicaid ACO proposal? Is obtaining such support a prerequisite for having the capacity to establish a Medicaid ACO?
15. What recommendations do you have for encouraging the development of effective Medicaid ACOs in New Jersey? Would you favor changes in the authorizing legislation or in the Department of Human Services’ regulations and approaches? Which changes should receive the highest priority?
16. Have we neglected to discuss any issues that you think are important for understanding the early implementation experience with the Medicaid ACO demonstration?



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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

