

RUTGERS

Center for State Health Policy

A Unit of the Institute for Health, Health Care Policy and Aging Research

Update on ACO Operations and Care Management Strategies in the New Jersey Medicaid ACO Demonstration Project

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



November 2018

Table of Contents

Acknowledgments.....	i
Executive Summary.....	ii
Introduction	1
Methods.....	3
Findings.....	4
Discussion.....	11
References	15
Appendix: Year 2 Interview for ACO Leaders	16

Acknowledgments

The work in this report was conducted pursuant to the enabling legislation of the New Jersey Medicaid Accountable Care Organization (ACO), Public Laws of 2011, Chapter 114.

Support for this report was provided by a grant from The Nicholson Foundation and a grant from the Agency for Healthcare Research and Quality (AHRQ, grant number R18HS023493). The content is solely the responsibility of the authors and does not necessarily represent the official views of AHRQ.

The authors received analytic support from Jose Nova, Kristen Lloyd, Rizie Kumar, Dave Goldin, and Jolene Chou who contributed to data assembly and visualization used during interviews. The authors acknowledge assistance in obtaining and organizing Medicaid claims and encounter data from Stu Dubin, Joseph Vetrano, and Felicia Wu.



Update on ACO Operations and Care Management Strategies in the New Jersey Medicaid ACO Demonstration Project

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

Executive Summary

The New Jersey Medicaid Accountable Care Organization (ACO) Demonstration was implemented over a three-year period beginning on July 1, 2015 and recently, a one-year extension of the Demonstration was recently authorized. Previously published reports provided quantitative and qualitative information about activities leading up to and in the first year of the Demonstration. This report provides a detailed assessment of ACO activities in Demonstration year 2. It relies on the second round of interviews with leadership and care coordination staff from NJ's three certified Medicaid ACOs and the Medicaid ACO-like group, the Health Coalition of Passaic County (HCPC).

The study team performed a content analysis of the interviews and developed core themes and perspectives, which are outlined below. As in the first round, the content analysis emphasized a search for common themes across the ACOs. Although some commonality was evident, this latest round of interviews produced more information about ACO-specific activities, accomplishments, and plans for the near future. Three overarching themes that emerged from the interviews are listed below:

- Theme 1: Access to comprehensive Medicaid claims and encounter data is the most important resource made available to ACOs by the state.
- Theme 2: ACOs serve as conveners and connectors to build upon, enhance, and initiate healthcare delivery changes in their local service areas.
- Theme 3: ACOs are using startup funds (state and private) to leverage other grant revenue, which is the main source of funding for the foreseeable future. Prospects for shared savings have been deemphasized.

In the second Demonstration year, the Trenton Health Team (THT) solidified its coalition and data analytic infrastructure. This infrastructure is used to quantify details about their patient population, precisely specify and implement intervention opportunities and begin assessment of intervention effects. These data analytic capabilities have placed the THT at the center of many health and social service planning activities for their region. They have leveraged these capabilities and state funding under the Demonstration to obtain additional private funding,

which has stabilized their current financial position. At the time of the interviews, the THT was negotiating the second year of their service contract with Amerigroup and pursuing similar initiatives with other managed care organizations (MCOs).

Since they established themselves as a coalition focusing on high-need/high-cost patients before the Demonstration, the Camden Coalition of Healthcare Providers (CCHP) was not as dependent as other ACOs on state funding to sustain their operations, particularly during year 2. Accordingly, support from the Demonstration was used mainly to add depth to care management activities and to pursue cross-sector initiatives aimed at a broader range of health-related needs (e.g., coordination with jails and schools).

In the second demonstration year, the CCHP expanded their collaboration with MCOs on specific care management activities but has de-emphasized the role of shared savings. Although most MCO contracts still involve a shared savings component, emphasis is shifting toward per member per month (PMPM) management fees and contracts to support specific new initiatives (e.g., increase capacity of primary care providers to screen for and treat opioid addiction). Moreover, the coalition has not accepted any financial risk in their MCO arrangements and is not planning to do so in the near future.

In year 2, Health Greater Newark (HGN) continued to focus on the basic tasks of building their coalition and developing the required data analytic capabilities to support coordinated care management. This work has been challenging due in large part to the complex healthcare market dynamics in the Greater Newark Region. The development of competing healthcare delivery initiatives by individual health systems has made it difficult for HGN to gain attention and commitment from key providers in their service area. Efforts of HGN have focused mostly on development of their data analytics platform, which they view as central to all of their activities. With this platform, they hope to enhance and strengthen initiatives already underway in their service area and then build upon success in this strategy to advance deeper collaborations with area providers. Strengthening data analytics and coalition partnerships are viewed as key for attracting the necessary financial support to sustain their ACO. Moreover, to strengthen their ability to attract and engage providers in the region, HGN is considering extending their geographic focus beyond the three zip codes for which they were originally certified.

With grant support from The Nicholson Foundation, the Healthcare Coalition of Passaic County (HCPC) has continued their care coordination activities as a Medicaid ACO-like organization. The grant funds support a variety of activities including coalition building, data processing/analytics, hiring staff (coordinator, data analyst), and targeting the right populations to improve care and lower costs. In its development of Medicaid-focused initiatives, the HCPC draws heavily on its experience with Medicare payment and delivery reforms such as its Medicare ACO activity. Leaders from HCPC, however, emphasized that the lack of access to Medicaid claims data made available to the three certified ACOs limits their operations albeit in ways that are difficult to assess. Although they have found it challenging to engage MCOs in their work, the

HCPC executed a limited shared savings agreement with Horizon Blue Cross Blue Shield focusing on C-section rates and they have begun discussions about a service contract with Wellcare in parallel with year 2 of the Demonstration.

The accumulated experience, thus far, suggests that two major contributions of the Demonstration are the creation of a legal framework for data sharing between ACOs and the state and the subsequent data analytic platforms enabled by this framework. The lack of such a framework outside of the Demonstration is a key barrier precluding similar arrangements for the HCPC and other provider coalitions seeking to achieve similar goals for Medicaid patients. With very limited MCO engagement, shared savings have not provided a base of financial support for any of the Medicaid ACO or ACO-like organizations. Although service contract arrangements with MCOs continue to evolve, all of these organizations remain dependent on state and philanthropic sources for the majority of their funding.

The post-Demonstration period will provide an opportunity to revisit the criteria and qualifications needed to define a Medicaid ACO, or perhaps other organizational forms with similar goals. As further evidence about the Demonstration accumulates, policymakers will need to reassess the goals and expectations that can be set for ACOs and similar organizations that work to better coordinate health and related services for Medicaid beneficiaries. Although the Demonstration has recently been extended by one year, the extent to which the state can make data and other resources available to such organizations longer term will play an important role in determining how high goals and expectations can be set. Still, there is high enthusiasm among the current cohort of Medicaid ACOs and ACO-like organizations for continuing and expanding their work for Medicaid and other underserved populations. Clearly, the mission of improving care and curbing unnecessary costs, embraced by the ACOs and HCPC, is deeply ingrained, regardless of whether or not the shared-savings formulation is realized under the current demonstration. Other ways of supporting these activities merit exploration.

Update on ACO Operations and Care Management Strategies in the New Jersey Medicaid ACO Demonstration Project

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

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 legislative deliberations regarding accountable care reforms in NJ FamilyCare, which is the state's combined Medicaid and Children's Health Insurance Program (CHIP). 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 NJ FamilyCare 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 NJ FamilyCare enrollees live in the defined area.

ACOs develop their own strategies for enhanced care management, quality benchmarks, and shared savings mechanisms for addressing the needs of their target populations. Shared savings arrangements are required for Medicaid fee-for-service (FFS) populations and services, including the Medicaid portion of spending for Medicare-Medicaid Dual Eligibles. Savings arrangements between ACOs and managed care organizations (MCOs) are permitted but not required under the Demonstration.

The Demonstration was designed and implemented over several years (see Table 1 for timeline). 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 of seven applicants obtained state certification to participate in the Demonstration as ACOs. The three successful applicants were the Camden Coalition of Healthcare Providers, the Trenton Health Team, and Healthy Greater Newark.

Table 1: Demonstration Timeline

Date	Action
August 2011	Demonstration signed into law.
May 2013	Proposed Demonstration rules issued.
May 2014	Final Demonstration rules issued.
July 2015	Beginning of Demonstration Year 1 with 3 ACOs certified to participate.
February 2016	First round of claims & encounter data provided to ACOs from the state.
June 2016	End of Demonstration Year 1.
July 2016	Beginning of Demonstration Year 2. \$1 million appropriation to each ACO.
June 2017	End of Demonstration Year 2.
July 2017	Beginning of Demonstration Year 3. \$1 million appropriation to each ACO.
June 2018	End of Demonstration.
July 2018	Demonstration extended for one year with continued data access & \$1 million appropriation to each ACO.

After certification, the three ACOs received various forms of support from the state. This support, however, came in fragmented and often unpredictable ways. Each ACO received monthly Medicaid claim/encounter data feeds (including ACO patients' use of services from non-ACO providers) to assist with patient targeting, risk stratification, and care coordination strategies. But due to the time required to finalize legal agreements and data transmission procedures, the first data transmission did not occur until February of 2016, more than halfway through the Demonstration's first year. After receiving the data, the ACOs briefly received periodic technical assistance with data analytics from the state and outside organizations acting in collaboration with the state – specifically, Rutgers Center for State Health Policy (CSHP) and the Center for Health Care Strategies.

The original legislation made no provisions for ACO financial support from the state. As a result, ACOs were limited in their ability to hire staff and develop infrastructure needed to ramp up their accountable care activities. Private philanthropy, most notably from The Nicholson Foundation, filled some funding gaps. But such funding varied considerably among ACOs and was constrained by the preferences of the granting organizations. Also the initial uncertainty about whether grants would be awarded and the time-limited nature of grant awards limited plans to hire new staff. Much later in the Demonstration the state government appropriated \$1 million for each ACO as part of the budget for State Fiscal Year 2017, coinciding with Year 2 of the Demonstration. An additional appropriation of \$1 million per ACO was also made available for State Fiscal Year 2018 (Demonstration Year 3). In both cases, funds were appropriated just before fiscal year budgets were finalized, adding more uncertainty to ACO financial planning.

During the Demonstration, the three certified ACOs gained access to Medicaid fee-for-service claims and managed care encounter data, which provide information about their assigned

patients not readily available from other sources. Specifically, these data include all Medicaid-reimbursed utilization by patients living in the ACOs' service areas even if patients go outside of the area or use non-ACO providers. In July 2018, the state extended the Demonstration by one more year by making data and another \$1 million of funding available to the three certified ACOs.

Prior reports by the Rutgers Center for State Health Policy (CSHP) have documented the Demonstration implementation process (Thompson and Cantor 2016), baseline performance measures (DeLia et al. 2018), and initial ACO operations and care management strategies in Demonstration year 1 (DeLia, Yedidia, and Lontok 2017). This report updates prior work by providing a detailed assessment of ACO activities in Demonstration year 2. It relies on the second round of interviews with leadership and care coordination staff from NJ's three certified Medicaid ACOs and the Medicaid ACO-like group, the Health Coalition of Passaic County (HCPC). Although leaders from the ACO applicant from New Brunswick were included in the first round of interviews, they have been excluded from subsequent interviews because they indicated in year 1 that they were no longer pursuing Medicaid ACO-like activities.

Methods

The study team conducted a total of 15 interviews, which included 17 individuals, across the four sites in the summer and fall of 2017. The semi-structured interviews took 60-90 minutes each and focused on each site's management & organizational strategy, quality improvement efforts, care coordination activities, efforts to address behavioral health needs, strategies for addressing high-needs pediatric populations, and future plans for improving Medicaid patient outcomes and controlling costs. Particular emphasis was devoted to eliciting changes since the first round, the role of state funding, and the changing Medicaid policy environment. As in the first year of interviews, we presented several ACO-specific charts displaying statistical patterns from Medicaid claims and encounter data. The charts included measures of healthcare spending and quality for Medicaid beneficiaries in each interviewee's ACO region compared to all Medicaid beneficiaries statewide. This information helped to focus discussions on specific activities taking place in view of performance and to elicit candid assessments of strengths & weaknesses and gaps in care that require attention. The semi-structured interview questionnaire appears in the Appendix.

The study team performed a content analysis of the interviews and developed core themes and perspectives, which are outlined below. As in the first round, the content analysis emphasized a search for common themes across the ACOs. Although some commonality was evident, this latest round of interviews produced more information about ACO-specific activities, accomplishments, and plans for the near future. Therefore, we present results on a small number of overarching themes followed by updated details about each ACO and ACO-like organization individually.

Findings

Common Themes

Theme 1: Access to comprehensive Medicaid claims and encounter data is the most important resource made available to ACOs by the state.

This point was emphasized by all three certified ACOs. Each reported on specific uses and ongoing plans for the data (which are described for each ACO below). As one interviewee from HGN noted,

“We have used the claims data to identify our readmissions problem, ... analyze the frequency of disease types, [identify]... what providers our patients were visiting, and... dig deeper on comorbid conditions with behavioral health.”

Similarly, a respondent from the THT commented:

“Where are the areas, not just of high utilization but of impact-able high utilization? [Without claims data] we didn't understand the details well enough and we hadn't built that core expertise to understand it's not the top tenth of a percent of ER utilizers. It's maybe in the top five percent and of those, how do we segment those that we can impact versus those other that are not the right areas of focus for us.”

In an informative contrast, the HCPC pointed out that the lack of access to this data source is by far the most important drawback of not being certified for participation in the Demonstration. They highlighted specific barriers to care coordination (detailed below) from not having access to the data. Although all ACOs agreed that funding is clearly important, funding was generally viewed as somewhat less important than data in terms of what state government can provide to the coalitions.

Theme 2: ACOs serve as conveners and connectors to build upon, enhance, and initiate healthcare delivery changes in their local service areas.

An interviewee from the Trenton Health Team captured the essence of this theme by describing their coalition as “... the convener of healthcare [providers], the connector of healthcare in the community, and a resource to look at regional data [and] regional quality.” The coalition also sets strategy “for a community largely focused on Medicaid beneficiaries and the underserved.” It serves as the “backbone organization” to convene and facilitate with data and coordination efforts and as an incubator of small programs.

Highlighting the potential for catalyzing cross-sector collaboration on health issues, a respondent from Camden commented:

“What is so powerful about the community based ACOs ... is that we are using data and bringing people around the table ... and making unlikely connections. An

example would be that we're bringing together the school nurses and the pediatricians. That is traditionally ... an adversarial relationship because there's just a lot of headache that happens between the schools and the practices. Kids not getting their vaccines on time or kids not getting their physicals and it causes a headache at the school or vice versa. Kids needing an asthma plan at the school that their doctor signs off on otherwise they're getting sent to the ER if they have an asthma flare up. There is a lot of operational potential if we can get these two groups talking to each other."

Theme 3: ACOs are using startup funds (state and private) to leverage other grant revenue, which is the main source of funding for the foreseeable future. Prospects for shared savings have been deemphasized.

Access to state and philanthropic funding, most notably from The Nicholson Foundation, has positioned the ACO coalitions to attract further funds to expand their work. The HCPC mentioned the role of funding from The Nicholson Foundation to follow the certified ACOs in leveraging other philanthropic funding. Specific examples of instances in which ACOs have leveraged their financial and organizational resources to launch supplemental activities are discussed below. Sustainability is likely to pose a continuing challenge, however, particularly for coalitions that do not have a long history of collaboration predating the Demonstration.

The ability to generate shared savings is less emphasized by the coalitions as it was the prior year. There are active discussions with MCOs but they are focusing more on service contracts. As an interviewee from Camden described it,

"Shared savings is a steppingstone to get to something else. There's only so much money that can be pulled out of this system."

Update from the Trenton Health Team (THT)

In the second demonstration year, the THT solidified its coalition and data analytic infrastructure. Data analytics are centralized through their Care Evolution platform, which was made fully operational. This platform links their local health information exchange (HIE) with the Medicaid claims data obtained from the state. The THT uses these combined data sources to quantify details about their patient populations, precisely specify intervention opportunities, and begin assessment of intervention effects. Describing such use, one respondent commented:

"[we can] literally in ninety seconds, go in and look at how many diabetics are there in our community, how many of those have avoidable utilization patterns, how many diabetics in Trenton, in this age bracket have avoidable utilization patterns and are out of hemoglobin A1C control."

As noted in theme 2 above, the THT has positioned itself as a key convener/facilitator for the Trenton healthcare community. The Care Evolution platform has played a major role as a base of information around which the community of healthcare and social service providers organizes and plans activities. Such activities often focus on cross-sector collaboration to address problems that surface in health care delivery but are a product of broader forces. For example, intoxicated individuals routinely end up in the emergency department (ED) because they have nowhere else to go. In response, the Trenton community is developing ED diversion activities through the combined efforts of hospitals, shelters, the local housing agency, and police. Nurturing their facility for community collaboration and reflecting their success in this area, THT was invited to join the Rethink Health national consortium, which serves to enhance multi-sector partnerships that promote population health. The THT participates in and often leads other communitywide activities such as fulfillment of hospitals' Schedule H obligations, city government initiatives, Delivery System Reform Incentive Payment (DSRIP) activities, and improvement of HEDIS measures for hospitals and MCOs.

The THT has been successful at leveraging its startup funds to attract additional grant funding and achieve financial stability. Data from Care Evolution has supported grant applications with precise information about the problems and populations to be addressed. Relying on these data, the THT acquired a substantial grant from the Merck Foundation to improve diabetes care.

The THT has developed contracting arrangements with MCOs. At the time of the interview in October 2017, they were ending their year 1 service agreement with Amerigroup, supporting care management and data services, and were negotiating a similar arrangement for year 2. They were pursuing more service contracts like their arrangement with Amerigroup, discussing options with other MCOs, including Horizon and Aetna. Overall, the MCO work can be characterized more as "transactional" and less as coordinated partnerships with shared savings. The goal is to fill in gaps in what MCOs could do on their own. The THT articulated their "value proposition" for MCOs in this way:

"There's a skill set that we have of meeting Medicaid beneficiaries who are falling through the cracks, who need additional support to get self-management. Those who are capable of managing but can't navigate the system and can't get stabilized without someone from the community in their home working with them in a high touch way."

In year 2, the THT developed more focused care management approaches. These incorporated home visits from community health workers (CHWs) and health coaching and mentoring with patients through a contract with Inquisitive Health. They are maintaining a heavy focus on diabetes care. At the practice level, the THT is developing provider score cards to inform them about where they stand on selected performance measures (e.g., proportion of pregnant women receiving prenatal care during the first trimester, stable management of diabetic population). Although they have no current plans to implement pay-for-performance models,

the goal of the score cards is to generate internal competition between providers to improve performance and reveal best practices that can be broadly implemented.

Along with the newer foci, the THT maintains their earlier and broader strategy of targeting and reducing avoidable hospitalizations. Still, they emphasized that their population focus remains deliberately narrow, as they are not yet ready to scale their operations to all of Trenton.

Update from Camden Coalition of Healthcare Providers (CCHP)

As an established organization with a mission focused on care management for high-need/high-cost patients that predated the ACO demonstration project, CCHP was not as dependent upon State funding for day-to-day operations, particularly during year 2. Commenting on the use of the first-year state appropriation of \$1 million, one respondent stated:

“We are a Medicaid ACO but our care management initiative, CMI, is also work that we believe in and would be doing regardless of the state designations. So that million dollars certainly funded our clinical teams on the ground and gave us the ability to continue running our CMI program and our seven-day pledge program and funded a lot of the people who are working on that, but at the same time we're a \$10 million organization.”

Accordingly, second-year state funds were used mainly to add depth to care management activities (e.g., extending seven-day pledge to provide incentives for practices to engage in intensive care management as described below) and to pursue new cross-sector initiatives aimed at a broader range of health-related needs (e.g., coordination with jails and schools). They launched a new program to increase the capacity of primary care practices to provide addiction treatment services. In this program, primary care providers are trained to prescribe suboxone, provided incentives for obtaining the required license to prescribe, and offered enhanced reimbursement for the first three patients they treat. Among the other new initiatives pursued during the second year were the following:

- Increased reimbursement to 7-Day Pledge practices for comprehensively managing 5-patient panel of complicated patients using ACO-specified tools.
- Pilot-project to assist 15 formerly jailed patients in re-entering the health care system
- An asthma management program for complex pediatric patients.
- A new data integration effort that includes information from county jail, schools, and housing authority records.

In the second demonstration year, the CCHP expanded their collaboration with MCOs on specific care management activities but has de-emphasized the role of shared savings. Although most MCO contracts still involve a shared savings component, emphasis is shifting toward per member per month (PMPM) management fees and contracts to support specific new initiatives.

Moreover, the coalition has not accepted any financial risk in their MCO arrangements and is not planning to do so in the near future.

The CCHP deepened their ongoing work with United Healthcare with focus on addiction screening & treatment and medication safety & adherence. For example, with support from United Healthcare, they provide enhanced reimbursement for addiction screening – specifically \$43 per patient for identifying addiction issues, making a treatment plan, and scheduling visits for treatment and counseling. Although the arrangement with United Healthcare has not resulted in documented major changes in spending or quality metrics, the Coalition leadership expressed confidence that they are learning valuable lessons from the experience about how to organize and improve care processes. In year 2, other MCOs were in discussion with the CCHP about mounting similar arrangements.

Respondents from the CCHP highlighted their efforts to develop streamlined processes for accessing multi-sector data. However, they have faced obstacles such as the turnover in state government (which affected project continuity) and the complexities of complying with health and education privacy rules under the Health Insurance Portability and Accountability Act (HIPAA) and the Family Educational Rights and Privacy Act (FERPA), respectively.

Structurally, the Coalition has developed a more flexible view of the geography in which it will focus its ACO activities. In some instances, such as its Housing First activity, it will loosen geographic boundaries to go where the need is. In other instances, geographic boundaries are influenced by practical considerations introduced by the requirements of specific MCO contracts. For example, in their work with United Healthcare, the Coalition targets physician practices in Camden, which typically include at least some patients who live outside of the officially designated ZIP codes under the Demonstration.

Update from Healthy Greater Newark (HGN)

Unlike the other two certified ACOs, HGN did not have a pre-existing coalition on which to build in developing partnerships in Newark. Establishment of a care management coalition along with an accompanying data infrastructure has been challenging due in large part to the complex healthcare market dynamics in the Greater Newark Region. One respondent noted that care management initiatives are often viewed as the distinct province of individual healthcare systems and that HGN activities may be viewed as extraneous to, or in competition with, those of large providers such as Robert Wood Johnson/St. Barnabus. These dynamics have made it difficult for the ACO to gain attention and commitment from key providers in their service area.

A major goal in HGN's care management activities is to identify and intervene with rising-risk populations – i.e., those who are approaching but have not reached high-utilizing high-risk status. An example offered by one interviewee is to intervene early to prevent congestive heart failure from progressing to end-stage: “we could get them more regularly taking their meds and get them transportation, so they can get to the cardiologist more frequently.”

HGN has been reconsidering its geographic focus. In their ACO application, they proposed and received approval to focus on three zip codes in Newark that make up a smaller subset of the Newark community to make coalition building and start-up activities more manageable. Over the first two years, however, it has become clear that the narrow geographical focus undermines the attractiveness of ACO functions to the major health systems whose patients and associated markets extend significantly beyond the service area initially identified. Currently, HGN would like to expand their focus to all zip codes in Newark and receive Medicaid claims data from the state for these zip codes. Thus far, the state has not provided them with access to data from the expanded geography.

HGN is learning from THT and CCHP in developing its Care Evolution platform, which is considered central to the success of all other activities. Interviewees from HGN indicated that demonstrating the value of the data platform is key to gaining financial commitment from hospital-partners. Initially, hospitals may use data independently to address their own high-cost/high-need patients; but HGN hopes that eventually the shared data platform and the value added by application of ACO expertise will motivate the development of collaborations addressing shared priorities.

Limited funding and lack of a clear path for future funding are major barriers for HGN. Interviewees noted that their ability to raise needed funds depends on solidifying their coalition partnerships, geographic focus, and data platform. At the same time, interruptions in funding undermined implementation of the Care Evolution platform and, without usable data, the prospects for demonstrating the value of care coordination are limited. Consequently, they have continued to be cautious in devoting resources to these activities. For example, in year 2, they were continuing their year-1 strategies of buying time from hospital care coordinators and aligning care coordination work with the demands of other ongoing activities in their community (e.g., DSRIP).

Among HGN's accomplishments cited by respondents, the ACO has made progress in building partners' interest in the program. In doing so, they have seen an increase in enthusiasm among hospitals in working with community partners. Similarly, they have strengthened the link between the ACO and the Greater Newark Health Care Coalition, which encourages ongoing involvement of the CEOs of partner institutions. Further, the deliberative process of deciding on the essential components of the data platform has promoted a clearer understanding of specific care management issues that can be effectively addressed by the ACO.

Update from Health Coalition of Passaic County (HCPC)

With grant support from The Nicholson Foundation, the HCPC has continued to develop their Medicaid ACO-like activities in parallel with the Demonstration. The grant funds support a variety of activities including coalition building, data processing/analytics, hiring staff (coordinator, data analyst), and targeting the right populations to improve care and lower costs. The data activities

include the creation of a data dashboard to be used by care coordinators and CHWs. The HCPC has also engaged a governance expert to promote high standards of performance for their board of directors. In addition, the coalition routinely monitors and receives advice from the three certified ACOs to learn about organization, data infrastructure, software, and other issues.

While they remain committed to working as a coalition, one interviewee suggested that being named an ACO specifically is not as important as they initially thought and may carry some disadvantages. For example, some providers may avoid participating because they think it will involve financial risk, which is not the case.

The HCPC mentioned distinct advantages and disadvantages associated with the lack of certification to participate in the Demonstration. An advantage is that they are able to develop initiatives at their own pace and completely in their own way, avoiding the specific rules set forth in the Demonstration. A major disadvantage, mentioned in the general themes above, is the lack of access to Medicaid claims data from the state. Thus far, most data analytics rely on St. Joseph Hospital data. This is viewed as acceptable for now, since St. Joseph's is the only hospital in the city; but the coalition is well aware that these data have significant gaps. They do not know specifically where or how important the gaps are but feel they are missing a large amount of important information for achieving their goals.

In addition to data analytics, other activities build from earlier work organized by St. Joseph's Hospital. These include experience with Medicare payment and delivery reforms such as the Medicare Shared Savings Program (Medicare's ACO program), bundled payment, home care, and the Hospital Readmission Reduction Program. A broad goal of HCPC is to translate the Medicare experience into Medicaid ACO work. A more specific aim is to build collaboration, rather than competition, among health and social service providers. The coalition hired a third party to do a community needs assessment and combined this information with "asset mapping" of what is already in the community. They use both information sources to organize partnerships. One of the interviewees described the collaborative focus in this way:

"At the end of the day, I'd love to be able to be in a place where we can lift all these other organizations up. That we can be partnering together and not competing and not stepping on one another, but yet filling in the gaps. I see this coalition as a great way to connect the dots between potential opportunities that exist and potential need within the community."

To that end, HCPC adopted an Agency for Healthcare Research and Quality model of care coordination, the Pathways Community Hub Model. Complemented by the Hub model, HCPC is better positioned to support a variety of initiatives by targeting populations that seek to produce the greatest impact as quickly as possible by employing the services of existing community organizations. With an overall focus on high ED use and unmanaged chronic conditions, the HCPC further identified populations for focused care management including men with diabetes, COPD,

asthma, or heart disease. HCPC is piloting a community paramedic program and employing CHWs to engage these populations.

Interviewees at the HCPC described a variety of targeted initiatives under development. They are coordinating with food pantries and counseling services to address major food and nutrition needs in the local community. They are working with schools on asthma initiatives and faith-based organizations on other issues. For example, a major identified concern is substantial stigma around mental illness in the local Arab community.

Like the three certified ACOs, HCPC has faced difficulties engaging MCOs in shared savings or similar contracts and has invested substantial time and energy trying to convince MCOs about the value of engaging with the coalition. As one interviewee expressed it:

“It seems like everybody has to go from the bottom up. If there was a little bit of help from the top down, maybe we’d be more successful.”

Despite these challenges, HCPC has been successful in executing a limited shared savings arrangement with Horizon Blue Cross Blue Shield. The arrangement focuses on reducing C-section rates, and they are in discussions about expanding it to cover high-risk pregnancies. HCPC has also been in discussions with Wellcare about developing a service contract.

Interviewees at HCPC emphasized the need to continually leverage their grant funding to achieve financial sustainability. Nevertheless, HCPC remains the most optimistic about some role for shared savings in helping to support ACO activities. They believe that there is still substantial inefficiency and overuse that they can influence and share in the savings.

Discussion

This report of the experience during the second year of the Medicaid ACO Demonstration highlights a few overarching themes along with distinctive experiences reflecting the individual challenges, goals, and achievements of the ACOs. Access to Medicaid claims and encounter data from the state is foundational to all ACO activities regardless of their stage of development. There is also a growing consensus among the certified ACOs that opportunities for shared savings remain very limited and should be deemphasized as a strategic priority or source of revenue to cover operations. Although the CCHP has continued their engagement with MCOs, including shared savings contracts, they along with the THT are placing more current and future emphasis on service contracts where the ACO can specialize in elements of patient engagement and care management that remain challenging for MCOs.

The CCHP and THT have continued to progress in applying data analytics, targeting interventions, and positioning their coalitions to serve as a central hub for organization of population-based health initiatives in their local regions. Both have attracted a fairly stable base of philanthropic funding obtained to varying degrees by leveraging state data and start-up funds.

Compared to the CCHP and the THT, HGN began the Demonstration without the history of collaboration and confronted numerous challenges in building a workable coalition. Their experience offers lessons that are instructive for future development of Medicaid ACOs or similar delivery reforms. GHN operates in a complex, competitive market where many large players are pursuing related initiatives that divert attention and resources from ACO activities. This dynamic has limited the ability of HGN to serve as a local organizational hub like the other two certified ACOs. As a result, HGN has emphasized the extent to which they can help support the goals already in motion for other organizations. The complexity of the Newark healthcare market area has also led to a rethinking of the optimal geographic focus for their Medicaid ACO. Initially, GHN took a cautious approach when it first applied for ACO certification, identifying a limited section of Newark. But with increasing knowledge of marketplace dynamics, they have concluded that the restricted geographical focus within the city presents a barrier to recruiting the right mix of providers to achieve their goals.

As noted above, the HCPC was not certified as a Medicaid ACO under the Demonstration but has continued to pursue similar activities independently. Their parallel operations provide a useful perspective on how the Demonstration has progressed and how the goals of the Demonstration might be advanced longer term. Private support for HCPC from The Nicholson Foundation largely made up for lack of access to state funds. However, the key deficit from lack of ACO certification is the lack of access to Medicaid claims and encounter data from the state, which substantially limits their ability to plan, target, and evaluate care management innovations. Nevertheless, the HCPC has made continued progress in developing a coalition of health and social service providers by leveraging private philanthropy and local resources anchored by St. Joseph's hospital, which is a large academic health center.

The HCPC is distinguished from the three certified ACOs by its prior experience with multiple Medicare payment and delivery reforms. They have drawn upon this experience to set up their initial operations as a Medicaid ACO-like organization and pursue shared savings and service contracts with two Medicaid MCOs. Thus far, the coalition's shared savings arrangements have focused on narrowly defined services (e.g., childbirth) rather than broad population-based savings from reducing overall emergency department and inpatient use. Interestingly, the HCPC was the only provider coalition that maintains strong optimism about the potential for shared savings within the New Jersey Medicaid program.

A major issue raised by all four organizations interviewed is that regular access to Medicaid claims and encounter data for all their patients across all healthcare providers is crucial for organizing care coordination activities for Medicaid patients. These data are widely identified as the most important resource provided by the state. Thus, two major contributions of the Demonstration, thus far, are the creation of a legal framework for data sharing between ACOs and the state, and the subsequent data analytic platforms enabled by this framework. The lack of such a framework outside of the Demonstration is a key barrier precluding similar

arrangements for the HCPC and other provider coalitions seeking to achieve similar goals for Medicaid patients.

Although the certified ACOs relied upon the state for start-up funding for various activities, private philanthropy (most notably from The Nicholson Foundation) also played a large role in ACO financing. In some cases, state funds combined with access to data were used to generate additional private financial support to pursue care management and population health objectives. In contrast, shared savings have not played any role in generating resources for ACO operations for two reasons. First, MCOs have had only limited engagement with ACOs, which is a key limitation, since the vast majority of New Jersey Medicaid beneficiaries are enrolled in managed care plans. Second, ACOs have focused predominantly on specialized interventions for specific subpopulations (e.g., diabetics, homeless) making it difficult to generate population-wide savings. Although shared savings might emerge within some narrowly focused areas (e.g., newborn delivery at HCPC), broad-based shared savings are now de-emphasized in favor of MCO contracts with ACOs based on the delivery of specialized services for a care management fee, either upfront or PMPM. Even under these arrangements, however, ACOs must clearly establish their particular niche in patient engagement and care coordination where they can be more effective than MCOs acting on their own. Moreover, the extent to which MCOs can be required or encouraged through incentives to engage with ACOs is a salient policy issue for the post-Demonstration period.

The post-Demonstration period will provide an opportunity to revisit the criteria and qualifications needed to define a Medicaid ACO, or perhaps other organizational forms with similar goals. Prior reporting has documented the difficulties and confusion around the original criteria for becoming a Medicaid ACO under the Demonstration (Thompson and Cantor 2016). As shown in earlier work (DeLia, Yedidia, and Lontok 2017), and reinforced in this report, Medicaid ACOs in New Jersey have operated in a somewhat fluid space, engaging in broader community health improvement strategies with components and organizations outside of the ACO itself. This fluidity might be explored further in consideration of a future Medicaid ACO designation or related Medicaid reform. The analysis above also suggests that prior experience implementing healthcare delivery initiatives as a coalition is important for making progress as a Medicaid ACO, even if that experience has taken place outside of care delivery to Medicaid patients (e.g., HCPC).

As further evidence about the Demonstration accumulates in the coming year, policymakers will need to reassess the goals and expectations that can be set for ACOs and similar organizations that work to better coordinate health and related services for Medicaid beneficiaries. Although the Demonstration has recently been extended by one year, the extent to which the state can make data and other resources available to such organizations longer term will play an important role in determining how high goals and expectations can be set. Still, there is high enthusiasm among the current cohort of Medicaid ACOs and ACO-like organizations for continuing and expanding their work for Medicaid and other underserved populations. Clearly,

the mission of improving care and curbing unnecessary costs, embraced by the ACOs and HCPC, is deeply ingrained, regardless of whether or not the shared-savings formulation is realized under the current demonstration. Other ways of supporting these activities merit exploration.

References

- DeLia D, R Kumar, J Nova, K Lloyd, and D Goldin. 2018. *Spending and Utilization Indicators in the New Jersey Medicaid ACO Demonstration Project*. New Brunswick, NJ: Rutgers Center for State Health Policy. <http://www.cshp.rutgers.edu/Downloads/11390.pdf>.
- DeLia D, MJ Yedidia, and O Lontok. 2017. *Year 1 of the New Jersey Medicaid Accountable Care Organization Demonstration Project: Assessment of Operations and Care Management Strategies*. New Brunswick, NJ: Rutgers Center for State Health Policy. <http://www.cshp.rutgers.edu/Downloads/11150.pdf>.
- NJDHS, DMAHS (New Jersey Department of Human Services, Division of Medical Assistance and Health Services). 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.
- 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.
- Thompson FJ, and JC Cantor. 2016. *The New Jersey Medicaid Accountable Care Organization Demonstration: Lessons from the Implementation Process*. New Brunswick, NJ: Rutgers Center for State Health Policy. <http://www.cshp.rutgers.edu/Downloads/10950.pdf>.

Appendix: Year 2 Interview for ACO Leaders

ACO Management and Organization

1. For new interviewees: What is your role at the ACO? What are your major responsibilities?
For prior interviewees: Has your role or major responsibilities changed significantly over the past year?
2. Last year, the state appropriated \$1 million for your ACO. Broadly, what kinds of staffing or activities did these funds support? What did the funds allow you to accomplish that would have otherwise not gotten done? Did the state support fill gaps in other funding or funding that was discontinued? Have you tried to leverage the state dollars to attract other resources? If so, what are outcomes, thus far?
3. We now know that the state will/will not appropriate additional funds to the ACOs. ADD QUESTIONS RELEVANT TO THE FUNDING OUTCOME.
4. Have you experienced significant staff or leadership turnover since the ACO began? If so, does this turnover have a marked impact on your ability to sustain key ACO functions? Are you able to recruit replacements who have the requisite competence to continue the initiatives? Are there cases in which the required expertise is so unique that adequately prepared people are difficult to find? Are there initiatives that have been abandoned due to the loss of a key staff member?
5. What is the status of the ACO's relationship with Medicaid managed care organizations? Do you have shared savings contracts or other formal arrangements in place? Are they working as planned? Will they be sustained? Do they need substantial renegotiation? Are other contracts currently under negotiation?

Quality Surveillance and Improvement

6. Since March of 2016, your ACO has been receiving claims and encounter data for patients in your geographic from the state. Can you give me an example that typifies your use of specific data in care management? (PROBE FOR DETAILS.) How far along are you in processing and using the data? What barriers have you overcome? Have you already made use of these data in your ACO activities? (PROBE FOR EXAMPLES.) What barriers remain to achieving your goals for integrating the data in your ACO activities?

7. Do you/will you use these data in tandem with other data sources (e.g., local HIE, internal records)? What kinds of analytics are you doing (epi-type surveillance, identifying areas of high need, internal tracking of performance metrics)?

8. Which quality metrics are the major foci of your current improvement efforts? Have you made changes during the past twelve months in those you have been monitoring? IF SO, WHY?

9. Now that we are well into the Demonstration, how have your strategies for improving performance on these indicators evolved? Are you expanding any early initiatives? Are there any major lessons learned or course corrections? 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. Following up on the patterns we shared last year from the Medicaid claims data, I'm going to show you some patterns from the data on particular ambulatory care sensitive conditions that may be relevant to your quality improvement efforts.

- Incidence and cost of admissions for specific conditions for Medicaid patients in your region
- Comparison with State's Medicaid population 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? Please elaborate.

11. Similarly, we'd like to share with you some recent patterns from the claims data regarding rates of follow-up within 7 days of hospital discharge.

- Rate of follow-up for the most current year in comparison with the rate for the previous year for your region as well as for the State as a whole.
- Selected characteristics of patients who are followed up compared to those who are not in your region.
 - Percentage of those having a behavioral health condition
 - Percentage using multiple primary care providers.

Do you see these patterns as responsive to any of your current or planned care management strategies? Why or why not?

Are you concerned about any of them? Do they suggest areas that merit future attention?

Care Coordination

12. What are the structures that you currently have in place for improving care coordination for your patients? How have they evolved since last year at this time?

Camden: Have your meetings with providers, as part of your 7-day pledge initiative, expanded to focus on other quality metrics as well? Has your intensive work with high-utilizing patients changed in significant ways? What has been your experience thus far with informing ministers when a member of their congregation has been hospitalized?

Trenton: What has been your experience with your C4T clinical coordination and your care management teams? How have they evolved since last year?

Newark and Paterson: Do you have centralized mechanisms for care coordination – 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?

13. We would like to observe and interview providers in your ACO who are responsible for care coordination efforts.

Trenton: We've talked about observing your care management meeting. Can we arrange to do that in the next month or two?

Camden: Last fall, we observed a couple of your meetings with providers concerning the 7-day pledge and found them very informative. Would it be appropriate to observe more of these meetings to see how their focus has evolved?

Newark and Paterson: 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.

14. Last year, we shared with you patterns on prevalence of behavioral health problems among Medicaid patients in your ACO region along with spending and rates of avoidable hospitalization among this subset of patients. This year, we have some patterns to show you regarding follow-up of patients subsequent to hospitalization for mental illness.

- As context, this chart shows the prevalence of mental illness among Medicaid patients in your ACO region and associated spending.
- For these patients, here are the rates of follow-up within 7 days of discharge for a mental illness last year (corrected) and this year.

- This chart shows some characteristics of those patients who receive follow-up care following hospitalization as compared with those who do not (e.g., use of multiple primary care providers).

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?

15. Have you implemented any new strategies for bridging health, behavioral health, and social service systems in caring for patients who have complex needs? Please elaborate.

16. As you know, a large proportion of Medicaid spending is on care of pediatric patients. Have you implemented any strategies that address the quality, coordination, and/or costs of care for this population? How would you currently assess the prospects for improving the care provided to these patients or the associated costs?

Overall ACO Performance and Future Plans

17. What would you say are the most important accomplishments of your ACO thus far? Based on what signs or markers? Where do you hope to see the most significant improvements in patient care and/or costs in the coming year?

18. What areas for improvement are unaddressed currently but merit attention over the longer run?

19. What is your vision for the ACO and its activities as the Demonstration comes to an end? Are there specific elements of your organization that you would seek to expand or reduce? What kinds of resources or partnerships would be needed to sustain your activities longer term?

20. How do you see broader external factors, such as the changing federal policy environment and potential state-level changes, affecting your ACO and its related goals? Are there particular challenges or opportunities that you see on the horizon?


The logo for Rutgers University, featuring the word "RUTGERS" in a red, serif font. The letter "R" is stylized with a long, sweeping tail that extends downwards and to the left.

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

