Program Brief: Community-Based Medicaid Accountable Care Organizations
August 2017

The incoming administration should support a statewide movement to advance the development of community-based, data-driven entities, focused on improving the coordination and delivery of care, that improve population health initiatives for some of our state's most vulnerable individuals. The community-based Medicaid Accountable Care Organizations in Camden, Trenton, and Newark, have built a strong foundation for this work.

Executive Summary

- In August 2011, New Jersey (NJ) certified three community-based Medicaid Accountable Care Organizations (ACOs) in the state under The Medicaid Demonstration Project [the Demonstration Project] (established by NJ P.L. 2011, Chapter 114). These community-based Medicaid ACOs are groups of doctors, hospitals, and other health care providers who are collectively responsible for the care of an enrolled population. By collaborating, sharing information, and focusing on key quality standards, the ACOs seek to deliver more coordinated, efficient, and effective care.[1]
- Despite significant challenges with the law that established the Medicaid ACOs, including a lack of upfront funding, voluntary managed care participation, and onerous regulations, the Medicaid ACOs have helped to create and support an important foundation for population health work in their communities, especially for patients with complex health and social needs.[2]
- Preliminary findings from the Medicaid ACO work demonstrate promising results, including reductions in emergency room and inpatient hospital costs and significant improvements in coordination between health care and social service providers.[3]
- The Demonstration Project will end in 2018. The next administration has an exciting opportunity to set the vision for the Medicaid ACOs beyond the Demonstration Project. For the next administration, it will be imperative to create flexible requirements for the Medicaid ACOs, streamline the data reporting process, and encourage increased managed care participation.

I. Introduction

In 2011, NJ created a three-year pilot project to test a community-based Medicaid ACO model. Community-based Medicaid ACOs are neutral nonprofit entities grounded in regional collaboration and shared accountability across the health care continuum. A community-based Medicaid ACO works by convening multiple, and often competing, health care and social service stakeholders in a given geographic area to improve the coordination and delivery of patient care. In August 2011, NJ certified three community-based Medicaid ACOs in the state through The Medicaid Demonstration Project [the Demonstration Project] (established by NJ P.L. 2011, Chapter 114). The legislation designed the NJ Medicaid ACO model based on various ACO models across the country and the work of the Camden Coalition of Healthcare Providers

(Camden Coalition). Under the legislation, the ACOs are eligible to receive a portion of the shared savings should they improve quality and reduce costs. The legislation was enacted without funding and did not mandate Managed Care Organization (MCO) participation in the project.[1]

In 2015, the Camden Coalition, the Trenton Health Team, and Healthy Greater Newark became legally certified community-based Medicaid ACOs as they met the eligibility criteria specified under the law.

II. Medicaid ACOs Across The Country

Ten states across the country have active Medicaid ACOs that are financially supported through State Innovation Model grants, 1115 Waiver funding, the Delivery System Reform Incentive Program (DSRIP), or Managed Care Organizations. Many Medicaid ACOs were created by state Medicaid offices or the executive branch of the state government; for example, the governor of Minnesota used his executive power to establish Medicaid ACOs, and the Oregon Medicaid ACO was spearheaded by the state's Health Authority (and later championed by the Governor).

Nationally, Medicaid ACOs show significant promise and have been supported by upfront investments from the state. Colorado's ACO-like organizations have reported $77 million in net savings to Medicaid and have demonstrated lower rates of emergency room visits, high cost imaging, and reduced hospital readmissions for the enrolled population. Minnesota has attributed $76.3 million in savings within the first two years of its Medicaid ACO program, and Vermont reported $14.6 million in savings in its program's first year.[4]

III. Community-Based Medicaid ACOs in New Jersey: The Demonstration Project

Since certification, the NJ Medicaid ACOs have made substantial progress by building and sustaining important data and information infrastructure to support population health analyses and initiatives; supporting stakeholder engagement to improve community wide coordination and collaboration; and building capacity to do citywide and targeted quality improvement work.

A. Data and information systems

Each ACO community has developed or operates a sophisticated Health Information Exchange (HIE), which is a collaborative data-sharing effort to improve care delivery in a community by offering participating local and regional providers secure real-time access to shared medical information. Timely access to this information provides high-quality decision support, prevents the duplication of services, reduces costs, and improves the quality of patient visits. In addition, HIEs enable population health analyses and allow interventions focused on subgroups experiencing poor outcomes and avoidable high costs. HIE participants include hospitals, primary care practices, laboratory and radiology groups, social service organizations, correctional facilities, and other licensed health care facilities and providers.

NJ is unique as the Camden and Trenton ACOs share HIE access with each other (as well as with NJSHINE, a health care services company that runs an HIE

throughout Southern NJ). This shared technological platform has positioned New Jersey to become a national leader in Medicaid population health analytics. The connectivity between the HIEs enhances population and individual level analyses of health, wellness, or disease states. The shared HIE also allows the ACOs to track high-need and high-cost patients as they travel across the state.[5]

B. Stakeholder engagement

The ACOs engage, convene, and encourage collaboration across diverse stakeholder groups, often competitors outside of the ACO. This collaboration has helped create innovative social service interventions for some of the most vulnerable and complex patients.[*] For example, Camden City's Housing First Pilot Program, modeled after Trenton's successful Housing First program, engages local housing, behavioral health, and physical health care providers to identify, target, house and support chronically homeless[†] and complex patients. This pilot program hinges on the successful collaboration across the ACO communities. To date, the preliminary findings from Camden City's Housing First Pilot Program are showing a 60 percent decrease in hospital utilization per days at risk after patients obtain housing.

C. Citywide Quality Improvement Initiatives

The ACOs have (or will develop) targeted and city wide quality improvement initiatives. Informed by data, technology, and various health care experts and stakeholders, each ACO has developed unique population health initiatives for their communities. For example, the Camden Coalition has a care coordination intervention for complex patients, including the top ten emergency room users in the city. The Camden Coalition also operates programs for local health care providers to improve transitions of care for hospitalized patients through highly coordinated citywide workflows that engage hospitals, primary care providers and community partners. In Trenton, the ACO generates reports from their HIE to track quality measures on a monthly basis, as well as expanded their care management program for complex patients through partnerships with agencies across the city. The Newark ACO has commenced data analysis identifying high-risk health care utilizers, specifically behavioral health patients with medical comorbidities to better understand the health and social needs for this patient population.[8]

---

[*] A relatively small patient population for whom the current health system is ill-equipped to meet the myriad of interrelated medical, behavioral, and social challenges they may face including those often considered 'non-medical' such as addiction, housing, hunger, and mental health. They often experience poorer outcomes despite extreme patterns of hospitalization or emergency care.[6]

[†] Chronic homelessness defined: someone who has experienced homelessness for a year or longer, or who has experienced at least four episodes of homelessness in the last three years (must be a cumulative of 12 months), and has a disability. A family with an adult member who meets this description would also be considered chronically homeless.[7]

IV. Preliminary Impact and Findings

The Camden and Trenton ACO's work suggest promising results, including reductions in emergency room and inpatient hospital costs. The Camden Coalition recently worked with UnitedHealthcare and the Rutgers Center for State Health Policy (CSHP) on its first year performance evaluation and found a positive savings rate despite factors outside of the ACO's scope of influence (including rising pharmacy and private duty nursing costs). The Camden and Trenton ACOs have also generated new learning about complex patients; strategies for effective partnerships with NJ's MCO's; and how to continue to improve the evaluation of the shared savings contracts.[3]

In addition to these preliminary results, NJ contracted CSHP to evaluate the Demonstration Project through a series of qualitative and quantitative analyses. The qualitative evaluation, which was released in May 2016, concluded that: the detailed nature of the legislations may have impaired the ACOs from reaching their full potential; numerical targets for ACO participation by primary care providers limited the ACOs potential; the lack of state funding impeded the ACOs' ability to sustain their initiatives; voluntary MCO participation impairs the ACOs' potential; and the quality metrics imposed do not capture the impact of the ACO work. CSHP is expected to release the quantitative evaluation Summer 2017.[9]

V. Challenges

Although the Demonstration Project legislation presented an important opportunity for the Medicaid program, the Medicaid ACOs have encountered several challenges:

- The prescriptive nature of the legislation, and the significant change in the Medicaid program from fee-for-service to mostly managed care have made operating the NJ Medicaid ACOs difficult. MCOs were not required to participate in the ACO Demonstration Project and majority have been slow to engage with the ACOs.
- There is no reliable funding source for the ACOs. In Fiscal Year 2017, the New Jersey Department of Human Services (DHS) allocated $1.5 million in state funding and leveraged $1.5 million in federal match funding to invest $3 million to support the ACOs in the second year of certification; there was no startup funding which impacted the Trenton and Newark ACOs. By contrast, other states have supported their ACOs by using the 1115 Waiver process to leverage federal funding; directly invested in the ACO model; or have fully integrated the ACO model into the Medicaid system.
- Strict requirements, such as rigid numerical targets for ACO participations from providers in the ACO communities impeded on the Demonstration Project from achieving its full potential.
- Lack of alignment between the metrics that were evaluated as determined by the state law and the work actually being conducted by the ACOs.[9]

VI. Preliminary Recommendations

As the federal and state governments look to reform the Medicaid system to improve quality and decrease costs, support for the ACOs is necessary to advance the Medicaid ACO model given the promising evidence from the Demonstration Project and similar models across the country, as well as the tremendous investment already made in the project. It is vital to ingrain the Medicaid ACOs in New Jersey's Medicaid system, and ensure that the opportunities, services and initiatives of the ACOs become accessible for more Medicaid patients and providers across the state.

With leadership and commitment from the incoming administration, the ACOs can continue upon the significant progress they have made and embed learnings and successes into the larger Medicaid system so that the opportunities, services, and initiatives of the ACOs become accessible for more Medicaid patients and providers across the state. In addition, DHS included language in the NJ FamilyCare 1115 Comprehensive Demonstration Application for Renewal this year regarding "regional collaborative organizations." The DHS cited the certified Medicaid ACOs as three of the seven proposed regional collaborative organizations, since the ACOs already have the infrastructure to support the goals of the 1115 Waiver.[10] It is encouraging to see that both DHS and the Department of Health recognize the significance of this community-based population health work.

The incoming administration is strongly encouraged to continue to support and expand upon the work of the Demonstration Project to advance important population health work as follows:

1. Include greater flexibility in requirements to allow for a more tailored community approach (e.g., provider participation).
2. Streamline the data reporting process and assure the timeliness and validity of quality metrics; include suggestions from the Medicaid ACOs about meaningful metrics to measure rather than solely state imposed metrics.
3. Encourage increased Managed Care Organization participation in these programs by implementing the appropriate financial, contractual or programmatic mechanisms.
4. Provide funding to the Medicaid ACOs to allow these organizations to build the infrastructure and capability to begin and sustain their work.
5. Work with the community-based Medicaid ACOs and other stakeholders such as New Jersey Health Care Quality Institute to set the vision for the ACOs beyond the Demonstration Project.

Endnotes

---

[1] State of New Jersey Department of Human Services. (2011). *Accountable Care Organization.* Retrieved from http://www.nj.gov/humanservices/dmahs/info/aco.html

[2] Camden Coalition of Healthcare Providers. (2012). Retrieved from https://www.camdenhealth.org/housing-first-pilot-program/

[3] Truchil, A., Singer, S., Martinez, Z. *Medicaid Shared Savings Evaluation: Lessons Learned From The Camden Coalition's First Performance Evaluation* [White Paper]. Retrieved 2015, from the Nicholson Foundation: file:///C:/Users/Mennis/Downloads/Nicholson_Shared%20Savings%20WhitePaper_07052016%20Revised%20(2).pdf

[4] Center for Health Care Strategies, Inc. (2017). *Medicaid Accountable Care Organizations: State Update* [Fact Sheet]. Retrieved from https://www.chcs.org/media/ACO-Fact-Sheet-06-13-17.pdf

[5] New Jersey Health Care Quality Institute. (2016). *Medicaid ACOs in New Jersey* [PowerPoint slides]. Retrieved May, 2017, from http://www.nj.gov/humanservices/dmahs/boards/maac/MAAC_Meeting_Presentations_4_20_16.pdf

[6] Camden Coalition of Healthcare Providers. (2012). *Housing First in Camden Pilot Program* [Fact Sheet]. Retrieved from https://www.camdenhealth.org/housing-first-pilot-program/

[7] National Alliance to End Homelessness. (2016). *Chronic Homelessness* [Fact Sheet]. Retrieved from http://www.endhomelessness.org/pages/chronic_homelessness_overview

[8] DeLia, D., Yedidia, M., Lontok, O. (2017). *Year 1 of the New Jersey Medicaid Accountable Care Organization Demonstration Project: Assessment of Operations and Care Management Strategies* [Reports]. Retrieved from Rutgers Center for State Health Policy: http://www.cshp.rutgers.edu/Downloads/11150.pdf

[9] Thompson, F.J., Cantor, J.C. (2016). *The New Jersey Medicaid Accountable Care Organization: Lessons from the Implementation Process* [Reports]. Retrieved from Rutgers Center for State Health Policy: http://www.cshp.rutgers.edu/Downloads/10950.pdf

[10] State of New Jersey Department of Human Services. (2017). *NJ FamilyCare 1115 Comprehensive Demonstration Application for Renewal*. Retrieved from http://www.state.nj.us/humanservices/dmahs/home/NJ_Comprehensive_Waiver_Renewal_for_public_comment.pdf