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Development of Medicaid Accountable Care Organizations (ACOs) in Three New Jersey Communities

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Introduction

To test the potential to reduce cost through better care in Medicaid, the New Jersey legislature enacted the Medicaid Accountable Care Organization (ACO) Demonstration program in 2011, creating a mechanism for provider coalitions to share in savings they generate through care improvement initiatives in designated geographic areas (NJ P.L. 2011, c.118). Coalitions working in areas with at least 5,000 Medicaid beneficiaries and meeting other criteria will be eligible for certification as ACOs which may receive shared savings (McGinnis and Small 2012). Following adoption of regulations, New Jersey will accept applications from coalitions, with the first certified ACOs likely to begin operations 2014. The Medicaid ACO Demonstration law was inspired by the work of the Camden Coalition of Healthcare Providers (CCHP) led by Dr. Jeffrey Brenner, which began care coordination and management initiatives seeking to reduce preventable use of hospital care in 2007. The Nicholson Foundation was an early supporter of the CCHP and has provided resources for the development and testing of similar strategies in Newark and Trenton, New Jersey.

This report assesses the status of ACO development in the three Nicholson Foundation-supported communities, affording comparisons among efforts launched by coalitions with varied priorities, working on strategies in markedly different stages of development, and confronting distinctive challenges associated with the status of their progress. The intent is to generate insights that may have relevance to efforts undertaken in similarly diverse contexts. A companion report estimates potential hospital costs savings from improved care for patients with high use of inpatient and emergency department (ED) care in Camden, Newark, Trenton and ten other New Jersey communities (Chakravarty et al. 2013).

Methods

Open-ended interviews, averaging 80 minutes in length, were conducted between October 2012 and February 2013 with ten coalition leaders in the three communities – Newark, Trenton, and Camden. Individuals were selected from each coalition who collectively would be knowledgeable about the key topics of the interview: targeting and identifying patients for

intervention, staffing and functioning of care coordination teams, development of care plans, facilitating ongoing access to primary care, integration of health and social services, and efforts to establish a Medicaid ACO. The interviews were audio-taped and fully transcribed for analysis using standard qualitative techniques. Transcripts were coded independently by two researchers (MY and OL), files of verbatim passages were created, dominant themes were identified within each category, and the relevance of those themes to the central focus of the study – ACO development – was substantiated and reported.

Findings on key strategies and challenges are summarized in Exhibit A relating to the status of implementation in each community, targeting of patients for intervention, the nature of the care model, and challenges to ACO development. In the narrative, all quotes (indented) are excerpted verbatim from transcripts of the interviews. This study was reviewed and approved by the Rutgers University Institutional Review Board.

Findings

Status of Implementation

The state of planning for becoming a Medicaid ACO and engaging in related activities varies across the three communities (see Exhibit A below). The Newark coalition was created in order to foster dialogue among CEOs of hospitals and other health care institutions in the wake of the closure of two area hospitals. While the immediate crisis brought on by the closures has subsided, the group has continued to meet to foster discussion among high-level officials of issues of mutual interest to their institutions as well as to the wellbeing of the community, including inadequacies in primary care capacity in the City and surrounding communities. Efforts related to establishing an ACO thus far have been confined to sponsoring a grant-funded, pilot project on care coordination. One coalition member explained:

“[We] consider it as a pilot that we might undertake in a more robust form if we thought it was useful. This kind of plan is what everybody on the board would regard as a model for the kind of collaborative services that we should be engaged in that would lead us to being able to act as a Medicaid ACO. ... It’s an aspiration.”

In Trenton, coalition activities have centered on establishing high-user care coordination teams at each of the two major hospitals in the city. The experiences of these teams will inform the development of a third, free-standing team, and all three will be joined in an ACO model.

In Camden, the coalition was established explicitly for the purpose of coordinating care for high-utilizing patients. It is a fully implemented model and served as a prototype for New Jersey’s Medicaid ACO legislation. Its unique status and deliberate purpose is crisply described in the comments of one of the respondents from Newark:

“[It was] built over several years ... able to gather participants in a carefully thought-through way, gain buy-in from hospital, ... construct an organization that has internal coherence, a well-found mission, and ... a lot of connective tissue.”

Targeting Patients for Intervention

There was a general consensus among respondents across the three cities that reduction in hospital inpatient admissions offers the greatest opportunity for cost-savings among high-utilizing Medicaid patients. Typifying their views, a respondent from Trenton commented:

“If we’re going to bend the cost curve, it’s not about emergency department utilization. That’s chicken feed; it’s about the inpatient admissions that come after that. That’s where the money is.”

Yet, only in Camden do the targeting criteria focus exclusively on inpatient use; frequent users of emergency departments (EDs) will be flagged in the other two cities often with the assumption that high ED and hospital use are correlated. Trenton’s hospital-based high-user teams have focused thus far on the 50 patients with the highest number of annual inpatient visits, those who are readmitted within 30 days of discharge, and high ED users. Consistent with progress in implementing their model and associated experience in targeting patients, Camden has the most explicit criteria: two or more hospital admissions in 6 months with the exception of admissions for acute surgical procedures, pregnancy-related hospitalizations, oncology admissions, and exclusively mental health problems. Lessons from working with patients have refined their understanding of the bounds of their effectiveness, as reflected in the following comments:

“If it’s a psych diagnosis that is also chronic disease-related, those are patients that we try to work with. But if it’s a psych only diagnosis, people having suicide ideation or if it’s a schizophrenic patient, then that’s a patient that we ... wouldn’t be able to work with.”

“Patients with a maintenance issue or care coordination issue ... [they’re] what we call our sweet spot.”

Also, responding to ACO incentives, uninsured patients are ruled out. Among those who are left, particular attention is focused on those having two or more chronic conditions, a substance abuse problem, lack of social support, and non-medical issues that may lead to readmission. All three communities aim to address the needs of patients having mental health co-morbidities and/or housing problems.

In two of the three cities, a health information exchange (HIE) has not yet been implemented, limiting the ability to effectively implement targeting criteria. Trenton identifies

patients in the ED using the ED electronic medical record at each of the two hospitals. Newark plans to identify patients in the hospital. In Camden, the HIE provides daily reports of those patients who meet the prescribed criteria. Ultimately the goal is to rely exclusively on a data-driven triage tool to identify patients, minimizing exercise of subjective judgment.

The Nature of the Care Model

Staffing of each model varies slightly as described in Exhibit A but in all cases is built around an interdisciplinary team. A common feature is reliance on community health workers to assist patients in negotiating the health and social service systems. Other key elements of the care model described below relate to strategies for initially engaging patients, establishing and sustaining relationships with primary care providers, and integrating social and behavioral services into care plans.

Initial engagement with patients varies in intensity from making a referral in the ED to staff of the Visiting Nurse Association (VNA) (Newark) to direct contact with patients who meet criteria in the other two cities. In Trenton, social workers enroll patients while they are being seen in the ED with the hope of changing the ED culture from, as one respondent described it, “head ‘em up, move ‘em out” to “surround the patient with services.” In Camden, a nurse makes initial contact with the patient at the bedside in the hospital and collects information to guide development of a care plan.

Linkage with a primary care provider is a first-order priority in all three models. In Newark, most primary care physicians practice in the hospital outpatient clinics or the Federally Qualified Health Center (FQHC) – a configuration that is viewed as an asset to achieving a transition to essential services, medical as well as social, relying upon established networks linked with these institutions. In Trenton, the intent is to channel discharged hospital patients to the FQHC by staffing the hospital outpatient clinics with FQHC providers. A misalignment of incentives, however, poses a challenge to this effort: Reimbursement for FQHC visits is significantly higher than for hospital outpatient visits; but patients do not have a co-pay for hospital clinic visits whereas they do for FQHC services, so many prefer to seek care at the hospital. Also in Trenton, particular emphasis is placed on integrating primary care and behavioral health services:

“[I]ntegrated primary care is where you provide primary health care services and mental health services ... not just in the same building but literally at the same point in time when the patient walks through the doors.”

In Camden, the aim is for all patients to complete their first primary care visit within a week of discharge from the hospital, and a health coach is assigned to motivate patients and help them follow through with appointments. Patient goals are included in the care plan and are addressed in coaching:

“[T]hese are patients that generally people don’t ask them what they want or what they want out of this ... [Including their goals] is a method of patient engagement that’s really ... been meaningful and it’s very effective.”

Paralleling these efforts with patients, an outreach team assists providers in addressing the far-ranging needs of this patient population.

In addition to confounding incentives and organizational constraints, reported challenges to realizing the aims of the care models centered on both patient and provider behaviors. Respondents across the cities suggested that patient and provider agendas are likely to differ and may be at odds with respect to ACO goals:

“[O]ne thing that can really be hard for the people we’re engaging [is] that they don’t really necessarily care about health care costs. So why do they really, fundamentally care about staying out of the hospital? ... Because if someone feels sick, they have been taught that a hospital is a place you can go for help, and it is.”

“Some patients don’t want to be engaged in their own health ... [Others believe that] more health care is better care even if it’s from 15 different providers.”

Challenges confronting primary care physicians in addressing the needs of patients with complex conditions were frequently acknowledged. While efforts to provide assistance are planned or underway, respondents expressed wariness that shortcomings could be overcome in many cases, further limiting primary care capacity.

“We’ve had patients fired from [primary care] offices ...right after we go and visit with them (physicians). ... [T]here’s offices around that just aren’t capable of dealing with these complex patients that are very high-risk medically, high-cost, readmitted on an average once a month.”

“[Physicians] are running ‘em through a mill, they’re seeing them (high-needs patients) as economic billing entities ... they’re not giving them the best ... care outside of the hospital. They’re doing so during the hospitalization, but they’re not making sure they get the outpatient care they need. ... They have to have a passion for it. It’s a different type of doctor.”

Challenges to ACO Development

Chief among the challenges encountered in ACO development, as documented in the interviews, were organizational issues, adequacy of financial incentives, intractability of social problems, and limitations in provider capacity. As evidenced below, the nature of the barriers differed, to some extent, by the stage of development in each community, from planning to full implementation.

Organizational Facilitators and Barriers: Currently in its planning stages, the Newark coalition views the power and strategic positioning of its partners, as a prime asset:

“The fact that in Newark, NJ you’ve got the CEOs of the four hospitals, the physicians, the FQHC, the city government, the VNA ... you’ve got all of these people meeting, trying to push forward ... is a remarkable achievement.”

Such appreciation, voiced by several respondents, was grounded in an acknowledgment that forging partnerships among institutions having overlapping but often competing interests is inherently difficult. At the same time, respondents viewed the volatility in the hospital market as a major constraint on progress. The future of two of the four remaining hospitals in the region is uncertain, which undermines the prospects of long-term commitments.

In Trenton, concern was voiced that the uncertainties associated with gain-sharing may have deleterious effects on inter-organizational relationships among partners, resulting from unrealistic expectations:

“[The] biggest challenge [is] to manage expectations of many partner organizations [who] believe that there will be revenue streams because of the ACO and gain-sharing.”

In Camden, coalition members had significant input into writing of the Medicaid ACO legislation, and several criteria for ACO designation are patterned after the Camden model. Congruence between the mission of the Camden coalition and the aims of the legislation was cited by respondents in explaining their intent to be certified as an ACO. At the same time, they expressed concern about addressing inter-organizational challenges arising from superimposing a care management model on the existing system. In particular, the need to avoid duplication of services was viewed as requiring persistent attention. There was also a concern that partners in the community may view participation in coalition initiatives as an implicit acknowledgment of inadequacies in the services they provide on their own. One respondent emphasized the importance of reassuring partners:

“We’re really just trying to enhance what exists and improve what’s there for the purposes of reducing health care costs and involv[ing] ... access for people in the community.”

Gain-Sharing and Financial Incentives: Respondents from all three communities expressed varying degrees of skepticism about the prospects for gain-sharing to promote widespread development of ACOs. One respondent (Newark) rejected the assumption that the magnitude of funds from gain-sharing will be sufficient to promote development of ACOs and to sustain their functioning:

“It will be more expensive [to mount an ACO] than gain-sharing will permit. It is absolutely the right thing to do for other reasons.”

Another respondent, more sanguine, voiced concerns about the transition from soft money:

“Right now, we’re running off of grant funding ... How can we work with payers, ... the State, so that we can provide these services and be able to get enough of a gain share so that we can become financially stable and sustainable?”

A third concern emanates from the fact that the economic incentives promised by gain-sharing apply once an ACO is established. Support for developing an ACO is generally not available:

“[I]s there an incentive for an organization to work toward an accountable care model?”

Addressing Social Problems: The failure of existing systems over the years to address the types of challenges posed by high-utilizing patients can be viewed as a product of our segmented service delivery arrangements. The needs of these patients do not respect boundaries between health and social service systems. Acknowledgment of challenges in bridging social and health care services was prominent in the interviews. Discussing the process of implementing care plans, one respondent (Trenton) commented:

“It’s the social determinants that are major ... all the things that are ... out of our control. ... It’s easy to say, ‘here’s your medication, take it with food, keep it refrigerated.’ But what happens if they don’t have a refrigerator? ... The medication you prescribe is an antipsychotic and it needs to be refrigerated.”

Others cited the financial consequences of ignoring social needs:

“You have to look at how much does it cost to place a homeless person in permanent housing versus how much they cost when they’re ill and they can’t get the services they need and they’re homeless.”

“I’ve recently had a patient who was discharged to the street and wound up going right back into the hospital a few days later, was there for almost a month in the ICU, and, you know, discharged back to the street. — If you’re making — let’s just call it a \$200,000 investment in somebody through this admission, and you’re going to discharge him back to the street and we have to fight to get him into maybe a motel for a few days, and he’s going to a shelter; it seems completely insane that we would do that and lose all that cost. So housing is a huge issue.”

Typically, awareness of the health impacts of homelessness, hunger, and other consequences of poverty was accompanied by resolve to address barriers to integrating health and social services.

Availability of Services: Respondents in all three cities expressed a concern about limits on primary care capacity, and reliance upon interdisciplinary care management teams was designed to optimize productivity and effectiveness of existing primary care providers. In addition, among Newark respondents, particular attention was devoted to perceived shortages of behavioral health providers:

“... [W]hether the patient is uninsured or Medicaid-eligible, lack of capacity limits access.”

In Trenton, similar concerns were voiced about shortages of specialists and associated access to services of cardiologists, gastroenterologists, hematologists, and endocrinologists.

Conclusions

This study was designed to yield a snapshot at one point in time in the trajectory of Medicaid ACO development in each of three New Jersey communities. When the interviews were conducted, each coalition was at a different stage: Newark had completed a pilot study on care coordination that may inform development of an ACO; Trenton had staffed two hospital-based, high-user teams that will be incorporated into an ACO; and Camden had established a fully implemented model, which served as a prototype for the ACO legislation. Each stage in development yields distinctive challenges which may have relevance to other communities planning or attempting to mount similar initiatives. Among the commonalities observed, hospital inpatient admissions were viewed in all cities as the most promising focus for cost-savings. Similarly prominent across the communities was an intent to address the needs of patients having mental health co-morbidities and/or housing problems. Though respondents acknowledged the persistent challenges of addressing the health consequences of poverty, they all expressed commitment to the goal of bridging social and health care services. Initial engagement with patients varied in intensity from referral by ED staff to the VNA to assessment while the patient is getting ER services or at the bedside in the hospital.

Among challenges to implementing care plans, respondents expressed concerns that patients often have personal goals that are at odds with achieving ACO aims, and primary care providers are frequently unprepared to address the complicated mix of social and health care needs. Organizational barriers to ACO development included instability in the hospital market in one city, unwieldy expectations of new revenue streams generated by gain-sharing in another, and inter-organizational challenges posed by superimposition of a care management model on the existing system in the third. Respondents across all three cities expressed skepticism about the prospects that gain-sharing will be of sufficient magnitude to promote development of ACOs and sustain their functioning. Shortages of services were also cited as barriers to effective functioning of ACOs, including limits of primary care capacity as well as scarcity of needed

specialists. Despite the challenges, coalition participants demonstrated an enduring commitment to improving care for high-needs patients and regarded inter-institutional collaborations central to ACO formulations, as essential to making progress.

Exhibit A. ACO Development in Three New Jersey Communities

● Plans and ○ Challenges

	Newark	Trenton	Camden
Current Status of Implementation	<ul style="list-style-type: none"> ● Grant-funded pilot project on care coordination sponsored by CEO organization (the coalition); lessons learned may contribute to development of ACO ● Coalition formed to foster dialogue among CEOs of hospitals in midst of crisis precipitated by closure of two hospitals and continues to meet to address issues of mutual concern (e.g., lack of primary care capacity) ● The coalition will not implement an ACO – will be a planning body and will “spin it off.” 	<ul style="list-style-type: none"> ● Hospital-based high user teams (demonstration project) ● Goal: develop free-standing team for patients who are not attached to particular hospital and link with hospital-based teams in ACO model 	<ul style="list-style-type: none"> ● The model is fully implemented and served as a prototype for NJ ACO legislation ● Coalition has collaborated with partners, recruited staff, established health information exchange (HIE), implemented care model, enrolled and graduated patients
Targeting of Patients	<ul style="list-style-type: none"> ● People with housing issues, behavioral health and/or substance abuse problems; people seeking pain medicines from multiple hospitals ● Don’t yet have an operational health information exchange; in absence would identify patients in the hospital 	<ul style="list-style-type: none"> ● 50 highest hospital users ● 30-day hospital readmits ● ED high users ● Typically patients with behavior health and/or substance abuse problems ○ Insufficient experience to refine criteria to distinguish those patients who can and cannot benefit ○ Rely on ED electronic medical record to identify patients; don’t yet have comprehensive data base 	<ul style="list-style-type: none"> ● Two or more hospital admissions in 6 months; rule out admissions for acute surgical procedure, pregnancy-related, oncology-related, exclusively mental health ● Rule out uninsured ● Among those left, focus on those w/ two or more chronic conditions, substance abuse problem, lack of social support, other non-medical factors that may lead to readmission ● HIE provides daily report of anybody with two or more hospital admissions and criteria are then applied to select eligible patients ● Prevalent characteristics: 45-65 years old, housing barriers, cocaine abuse (affecting heart conditions) – not much alcohol abuse ○ Ruling out uninsured eliminates patients who could benefit from intervention

	Newark	Trenton	Camden
Care Model	<ul style="list-style-type: none"> • ED staff would identify high utilizers and refer them to VNA; VNA staff would assess patient at home or elsewhere for services • Community health worker would assist in accessing appropriate housing services or public benefits, and would encourage patient to keep appointments and maintain relationship with primary care physician • Most primary care physicians in Newark practice at hospital outpatient clinics or FQHC so have potential linkages with social and behavioral health providers 	<ul style="list-style-type: none"> • Identify patients in ER • Staffing: currently APRN, nurse case-manager, social worker; will add 2 community health workers • Emphasis on integrating primary care and behavior health services in same setting • Staff hospital clinics with FQHC providers to facilitate linkage to other services <ul style="list-style-type: none"> ○ Access to primary care is confounded by lack of transportation, low health literacy, and crime ○ Misalignment of incentives: reimbursement is higher for FQHC services but patients do not have a co-pay for hospital clinic visits 	<ul style="list-style-type: none"> • Care team consists of RN, LPN, social worker, outreach specialist, health coach, and community health worker • Care plan is a checklist of social and medical tasks to be completed • Patient goals are included in care plan in order to foster empowerment • RN makes initial contact while patient is still in the hospital • Coaching is designed to activate patients and help them follow through with appointments • Aim to complete the first primary care physician visit within 7 days of hospital discharge • Outreach assists providers in addressing needs of these patients (particularly those who lose contact with primary care physician) • Monthly meetings with collaborating providers <ul style="list-style-type: none"> ○ Many primary care providers are not equipped to provide services to patients of this complexity ○ Despite targeting, it is difficult to let go of loyal patients who have not reduced utilization
ACO Development	<ul style="list-style-type: none"> • Existence of coalition of CEOs engaging in routine dialogue is an asset to planning <ul style="list-style-type: none"> ○ Volatility in hospital market poses significant constraints (future of 2 of 4 hospitals serving the region is uncertain) ○ Shortage of community services (particularly behavioral health) is a major obstacle ○ Gain-sharing will not provide sufficient funds to initiate and sustain an ACO 	<ul style="list-style-type: none"> • Impetus is from the hospitals which currently support 2 high-user teams • Coalition fostered by the fact that 90% of providers are employed by 4 corporate partners (2 hospitals, FQHC, and health department) <ul style="list-style-type: none"> ○ Transition from soft money will be difficult ○ Partner organizations have unrealistic expectations for revenue streams from ACO gain-sharing 	<ul style="list-style-type: none"> • Coalition members had significant input into writing of the ACO legislation and several criteria for ACO-designation are patterned after the Camden model <ul style="list-style-type: none"> ○ Need to avoid duplication of efforts of other providers ○ With changing funding streams, partners feel threatened ○ Model is superimposed on existing system – partners in that system do not want to view their services as inadequate ○ Economic incentives apply once an ACO is established; support for developing an ACO is not available

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