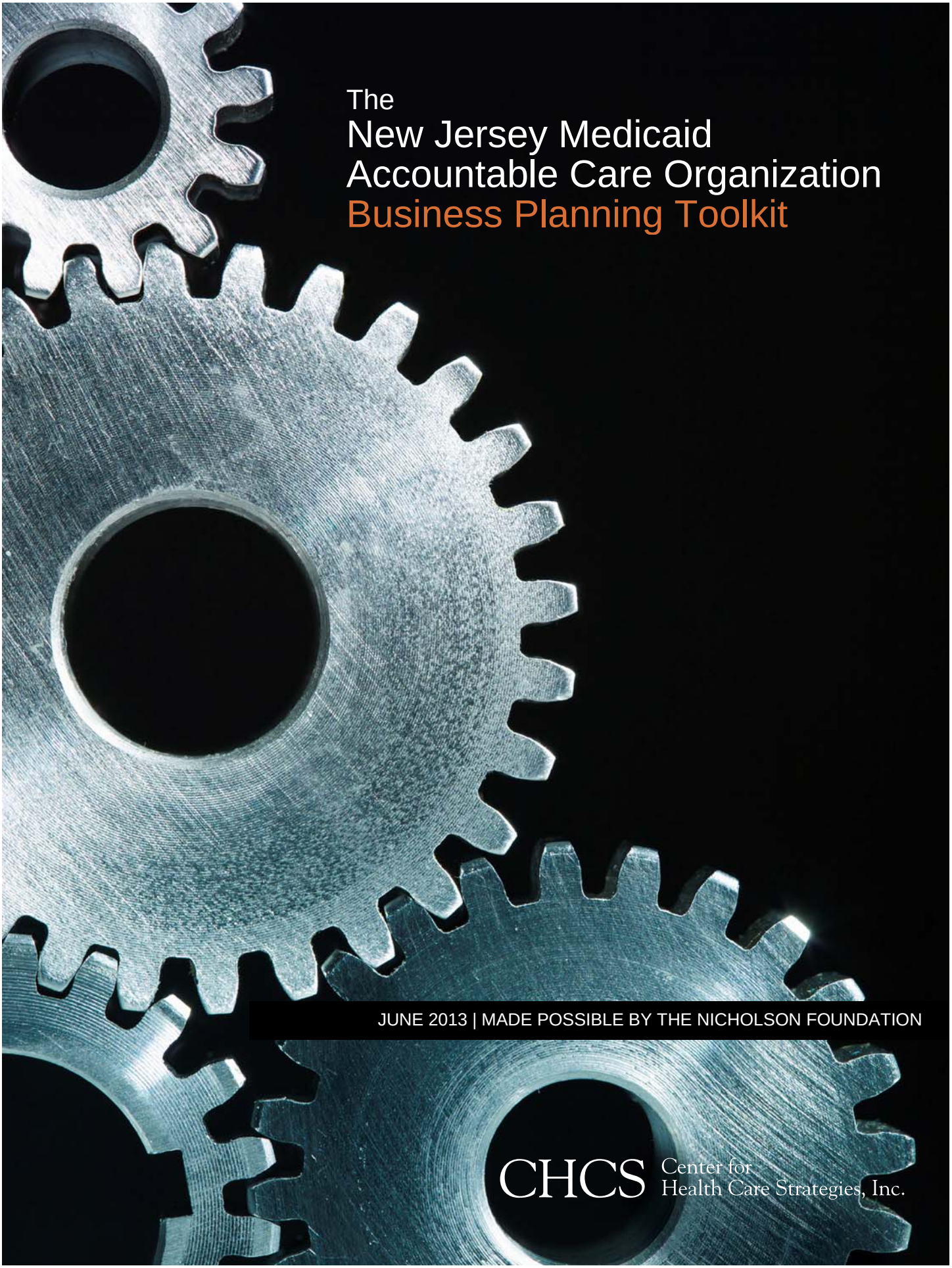

The New Jersey Medicaid Accountable Care Organization Business Planning Toolkit

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CHCS Center for Health Care Strategies, Inc.

The New Jersey Medicaid Accountable Care Organization Business Planning Toolkit

Prepared for The Nicholson Foundation by

Rob Houston, MBA, MPP, and Tricia McGinnis, MPP, MPH, Center for Health Care Strategies; Bruce Dees, Applied Health Strategies; and Derek DeLia, PhD, Rutgers Center for State Health Policy

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Electronic copies of this toolkit and related resources are available on the Center for Health Care Strategies website at www.chcs.org.

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Introduction

THE HEALTH CARE SYSTEM in the United States is transitioning from the traditional fee-for-service care delivery model toward a system that rewards quality and outcomes. The Centers for Medicare & Medicaid Services (CMS), its Center for Medicare & Medicaid Innovation (CMMI), and the commercial sector are focusing on new models that emphasize the accountability of health care providers and aim to reduce health care costs through integrated care models, such as accountable care organizations (ACOs). Early efforts in states such as Minnesota, New Jersey, and Oregon have inspired interest in using ACO models to serve the Medicaid population; with a particular focus on its most vulnerable, complex, and high-risk patients.

In New Jersey, groundbreaking legislation is enabling communities to test the viability of ACOs for the Medicaid population.[i] Through the Medicaid Accountable Care Organization Demonstration Project (Public Law 2011, Chapter 114), communities in New Jersey can establish ACOs to improve health care for Medicaid beneficiaries. The three-year demonstration supports community-based efforts to coordinate care across health settings, including hospitals, provider's offices, clinics, and home care to better serve patients, particularly those with complex needs.

Even prior to this legislation, New Jersey was at the forefront of the national ACO movement, with two promising models in Camden and Trenton. The Camden Coalition of Health Care Providers (CCHP), led by executive director Jeffrey Brenner, MD, has received national attention for its success in identifying "super-utilizers" – individuals who use excessive inpatient, emergency department (ED), and other expensive services – and deploying innovative care teams to help coordinate care for these individuals. The Trenton Health Team (THT), and its executive director, Ruth Perry, MD, are expanding access to primary care through Advanced Access Scheduling, and are on the road toward developing community-wide care coordination in the state's capital.

The Center for Health Care Strategies (CHCS) developed *The New Jersey Medicaid Accountable Care Organization Business Planning Toolkit* with funding from The Nicholson Foundation to guide communities in obtaining state approval for an ACO demonstration project. New Jersey's ACO legislation has set the framework for this demonstration, and the state Medicaid office has provided guidance to help drive the demonstration forward. Using this toolkit, New Jersey providers and stakeholders can:

1. Develop essential core ACO capabilities;
2. Understand planning pathways and key considerations; and
3. Develop an ACO approach tailored to their community's needs.

Communities in New Jersey can use this toolkit to lead their ACO-driven efforts to substantially improve health care quality and reduce unnecessary utilization and spending for Medicaid beneficiaries with complex needs. If successful, these communities can reinvest ACO savings to further improve their health care delivery systems and overall population health. Other states and communities can also adapt the guidance from this toolkit to improve access and services for Medicaid beneficiaries in their own regions.

GETTING STARTED — HOW TO USE THIS TOOLKIT

This toolkit was developed to provide ACO stakeholders in New Jersey with useful tools and resources to facilitate the initial start-up of an ACO. It is not a comprehensive "how to" manual, rather it is intended to be a primer to accelerate ACO planning efforts.

The text is divided into three sections:

- **Building the ACO Framework** – Outlines the rationale for developing an ACO, summarizes related state and federal regulations and walks through conducting a community readiness assessment;
- **ACO Nuts and Bolts** – Divides the ACO development process into five core areas: (1) Leadership and Governance; (2) Partnering with Stakeholders; (3) Data Analysis and Information Technology; (4) Improving Care Delivery; and (5) Quality Improvement. For each area, the text details *Basic Concepts*, *Essential Elements*, and *Advanced Elements* to inform ACO start-up efforts.
- **Constructing the ACO** – Guides prospective ACOs through the process for developing business and work plans.

Readers are encouraged to dip into sections as needed rather than read the toolkit cover to cover. Each subsection includes a "toolkit blueprint" outlining what is covered in that portion and a list of additional resources. Each section contains an inventory of practical tools, forms, tables, and checklists to help communities through the ACO planning process.

Quick Start Tools

At a minimum, prospective ACO leaders in New Jersey should start with the following three tools to initiate ACO development, which are located in the appendix and can be downloaded via the Center for Health Care Strategies website at www.chcs.org.

1. ***The Readiness Assessment*** – This planning activity will identify areas that need further development as outlined in the "ACO Nuts and Bolts" section.
2. ***The Business Plan*** – The business plan can guide ACO leadership to work toward financial sustainability, prioritize funding for areas in need of development, and guide informal cost-benefit analyses to determine how to allocate funds to support these areas.
3. ***The Work Plan*** – The work plan prioritizes the needs outlined in the readiness assessment and business plan, as it guides the division of labor among partners and allows revenue streams to be matched to tasks that must be accomplished within a defined timeline.

Section 1: Building the ACO Framework

1.1 Why Develop a Medicaid Accountable Care Organization?

TOOLKIT BLUEPRINT

Read this section to understand fundamental issues that providers and community stakeholders seeking to build an ACO should consider before diving into development activities.

IMPROVED CARE COORDINATION is the primary benefit of a Medicaid ACO to New Jersey communities. There are significant inefficiencies in the current health care system including delayed exchange of patient information, lack of preventive care, poor access to care, unaddressed social and behavioral factors, redundant tests, and improper financial incentives. Well-designed ACOs can improve sharing of patient information, support better care management at the point of care, and tap community resources to provide much-needed social supports such as housing, nutrition, translation, and transportation services. CCHP and THT are already having impacts on health care delivery in Camden and Trenton because their leadership truly believes in involving the community to improve health care.

Other benefits of an ACO are improved individual and population health, and the potential to reduce overall health care costs by promoting primary and preventative care and lessening the need for expensive services. Over time, the community should experience improved health outcomes and lower costs, thereby reducing the need for intensive care management interventions through the ACO. As Dr. Jeffrey Brenner from CCHP often notes, "The goal of the Camden Coalition of Healthcare Providers is to become obsolete." When CCHP's care management services are no longer needed because providers are working together and have the care coordination services that patients need, it will know that it has accomplished its ultimate goal.

A complex organization such as a Medicaid ACO begins with the commitment of a small group of people who have a stake in improving care for vulnerable populations in the community. Thus, the legislation enabling the New Jersey Medicaid Accountable Care Organization Demonstration Project specifically calls for the participation of community-based ACOs. The development process of a New Jersey Medicaid ACO can take a number of different pathways. In Camden, for example, the grassroots effort of a small provider-led group engendered the cooperative spirit by appealing to clinicians at local EDs for clinical data on their mutual patients. In Trenton, a strategic business decision to relocate a hospital from the city to the suburbs rallied the community to reinvent the city's health system, which laid the groundwork for THT's development. For many other communities in New Jersey, the Medicaid Accountable Care Organization Demonstration Project may offer the same opportunity.

The ACO development process will not be an easy one, but it will make the local health system much more effective in delivering care to the community. For more information on the benefits that CCHP and THT are already providing to their communities, please visit www.camdenhealth.org and www.trentonhealthteam.org.

1.2 Understanding New Jersey Regulatory Requirements

TOOLKIT BLUEPRINT

Read this section to learn about essential regulatory guidance for establishing a Medicaid ACO in New Jersey.

New Jersey Medicaid Accountable Care Organization Demonstration Project Legislation

The New Jersey Medicaid Accountable Care Organization Demonstration Project outlines specific requirements for ACOs in New Jersey. While additional regulations provided by the New Jersey Department of Human Services (DHS) give interested stakeholders details on how to apply for participation in the demonstration, there are several requirements outlined in the legislation that are required be a part of the application process. These requirements are listed below and detailed in other sections of this toolkit:

Register as a nonprofit corporation in New Jersey. The ACO must be incorporated as a nonprofit entity in New Jersey. A copy of the Certificate of Incorporation must be submitted with the application. Federal 501(c)(3) or other nonprofit recognition is not required, but may be beneficial to reduce federal tax burdens.

Identify a designated area that meets New Jersey regulations. The ACO must serve a specific population within a "designated area." The designated area must be either a municipality or otherwise-defined geographic area (e.g., a list of zip codes, a collection of municipal or county boundaries) that has:

- At least 5,000 Medicaid beneficiaries (fee-for-service and/or managed care);
- Participation of all general hospitals within the designated area;
- Participation of at least 75 percent of the qualified Medicaid primary care providers (PCPs) in the designated area; and
- Participation of at least four qualified behavioral health providers in the designated area.

The participation of these hospitals and providers should be shown through the submission of signed letters of support.

Establish a governing board and a mechanism for shared governance. The ACO must have a governing board with legal authority to execute the functions of the ACO, which is given through the organization's bylaws. The ACO's bylaws must reflect the board's structure as well as define its ability to support the New Jersey Medicaid Accountable Care Organization Demonstration Project's objectives. The ACO governing board must include members who represent the interests of health care providers and facilities, social service agencies, including voting representation from two or more consumer organizations with direct ties to the designated area.

Define a gain-sharing arrangement. The ACO must develop a gain-sharing arrangement, where any cost reductions achieved in the community are shared between participating providers, the state, and potentially, managed care organizations and other entities. The gain-sharing arrangement must be outlined in the ACO's bylaws or another document approved by DHS. The gain-sharing plan may either be submitted with the initial application, or within the first year of the demonstration.

Define a Quality Plan. The ACO must submit a quality plan as part of their application. This plan must outline a strategy to achieve improved performance on quality, efficiency, patient safety, and patient satisfaction metrics that will be used to evaluate the ACO.

Define a community engagement process. ACOs must define a process for engaging members of the community and provide a period for public comment for the ACO's gain-sharing plan.

State the ACO's commitment to the demonstration project. ACO applicants must pledge to become accountable for health outcomes, quality, cost, and access to care and ensure the use of electronic health records and electronic prescribing in its designated area during the three-year demonstration period.

Demonstration Regulations and Ongoing Compliance

In addition to the requirements specified in the New Jersey Medicaid Accountable Care Organization Demonstration Project legislation, DHS has posted additional requirements for initial ACO certification and ongoing compliance for public comment at http://www.state.nj.us/humanservices/dmahs/info/aco.html. DHS will also provide a checklist to those interested in forming ACOs once the regulations are finalized. Though these are only draft regulations, the ACO should familiarize itself with these minimum participation requirements to facilitate its development strategy,

ADDITIONAL RESOURCES

Medicaid Accountable Care Organization Demonstration Project Legislation
Public Law 2011, Chapter 114
www.njleg.state.nj.us/2010/Bills/PL11/114_.PDF

Starting a Nonprofit Organization Information & Links
New Jersey Department of the Treasury
www.state.nj.us/treasury/taxation/nonprofitinfo.shtml

Application for Recognition of Exemption
Internal Revenue Service
www.irs.gov/Charities-&-Non-Profits/Application-for-Recognition-of-Exemption

1.3 Conducting a Community Readiness Assessment

TOOLKIT BLUEPRINT

Read this section to learn how to utilize a community readiness assessment to strengthen the ACO program foundation and develop future goals and priorities.

A community readiness assessment should be one of the first tasks that ACO leadership should conduct when formulating an ACO development strategy. Inspired in part by the Berkeley Safety Net ACO Readiness Assessment Tool, the community readiness assessment outlined in Appendix A serves three key purposes based on the level of ACO readiness:

1. **Conceptual Level** - Evaluates the feasibility of implementing an ACO in the chosen designated area;
2. **Essential Level** - Provides information that will identify the ACO's strengths and weaknesses;
3. **Advanced Level** - Identifies needs, sets goals and benchmarks, and prioritizes ACO activities.

To be effective, an ACO must have the capacity to marshal local community resources to support better care delivery to patients in the designated area. Conducting a community readiness assessment can help the ACO pinpoint areas in which the community's capacity to collaborate with the ACO are strong, and areas that may require upfront investment. The readiness assessment can also guide the ACO leadership as they begin to engage stakeholders as well as inform business planning activities, including revenue projections and gain-sharing distributions.

While the elements outlined in the community readiness assessment are essential building blocks of a successful Medicaid ACO, they are not the only elements needed to make an ACO successful. A community readiness assessment is an important complement to other planning activities described in this toolkit, and should be performed early in the ACO development process.

The following sections organize content based on the three levels of readiness outlined above. Prospective ACO stakeholders can read these sections and complete the corresponding community readiness assessment to determine the feasibility of developing an ACO. It is recommended that ACOs achieve at least the essential level in all categories before participating in the New Jersey Medicaid Accountable Care Organization Demonstration Project.

ADDITIONAL RESOURCE

Safety Net Accountable Care Organization (ACO) Readiness Assessment Tool
School of Public Health, UC Berkeley (February 2012)
http://www.law.berkeley.edu/files/bclbe/Mar6_FINAL_combined.pdf

Section 2: ACO Nuts and Bolts

2.1 Establishing a Leadership and Governance Structure

TOOLKIT BLUEPRINT

Read this section to learn about the structure and responsibilities of an ACO's Board of Directors and Management Team.

CONCEPTUAL MILESTONES

- ✓ The ACO understands the New Jersey regulatory requirements for its board of directors.
- ✓ The ACO understands the minimal requirements it needs to get established.
- ✓ The ACO understands what its bylaws should entail and that it must be certified as a nonprofit organization in New Jersey.

ESSENTIAL MILESTONES

- ✓ The ACO has identified prospective organizations/individuals for its board and has voting representation from at least two consumer organizations.
- ✓ The ACO has appointed an executive director and identified a phased-in strategy to recruit personnel.
- ✓ The ACO has developed a set of bylaws including voting rights and procedures, and has applied to become a New Jersey nonprofit corporation.

ADVANCED MILESTONES

- ✓ The board of directors is confirmed and board-level committees, subcommittees, and a community advisory board are established.
- ✓ The ACO has its key management personnel in place including an executive director and some or all of the following: data analyst(s), care coordinator(s), legal officer(s), financial officer(s), and/or grant writer(s).
- ✓ The ACO has developed a comprehensive set of bylaws, is certified as a New Jersey nonprofit corporation, and has either applied for or received its federal 501(c)(3) status.

CONCEPTUAL ELEMENTS

To participate in the New Jersey Medicaid Accountable Care Organization Demonstration Project, applicants must follow the guidelines established by the legislation and state Medicaid regulations. While these guidelines prescribe some characteristics of the governance structure, ACOs will have flexibility regarding who to include on the board of directors, the role of the management team, clinical initiatives, and quality strategies. This section outlines the required regulations, as well as options for leadership and governance in key areas that are not prescribed in the regulations.

The leadership structure of the ACO should emphasize a shared resources model, in which participating providers and stakeholders contribute resources and expertise to the ACO mission. While roles and responsibilities should be clearly defined, the structure should support collaboration, common goals, working

across the leadership structure, and breaking down silos. Physical resources such as office space, data resources, and records management capabilities can also be shared. Every member of the ACO and its community partners should be willing to contribute resources and collaborate effectively, and this expectation should be established within the leadership and governance structure.

ESSENTIAL ELEMENTS

A Medicaid ACO must establish its nonprofit status, its bylaws, the makeup of its board of directors, and the roles and responsibilities of the management team prior to its participation in the Medicaid ACO Demonstration Project. It is critical that these elements be comprehensive, but retain some flexibility that will allow the ACO to adapt to changing circumstances and ensure fair representation of key stakeholders' interests.

Legal Structure

The key elements for an ACO's legal structure are the organization's nonprofit certification and its bylaws, which are both requirements for participation in the demonstration. ACOs may benefit from *pro bono* legal counsel to help develop their nonprofit application and bylaws.

Nonprofit Status

All ACOs must register as a New Jersey nonprofit corporation to be eligible for the Medicaid Accountable Care Organization Demonstration Project. In addition, the ACO should consider becoming a federal 501(c)(3) nonprofit public benefit corporation to lessen tax burdens. Since the 501(c)(3) certification process can be lengthy – in some cases, processing can take significantly more than a year – prospective ACOs should take this step as quickly as possible. If the ACO is an existing community-based provider of care, it should consider establishing a separate legal entity for the Medicaid ACO, rather than apply for nonprofit status using the existing organization. This allows the newly-established organization to maintain its autonomy since the new organization will likely have new partners with voting rights.

Bylaws

The ACO's bylaws must reflect the board's structure, support the Medicaid Accountable Care Organization Demonstration Project's objectives, and describe the organization's intent and the explicit methods it will use to engage the community. The bylaws must also address the:

1. Organizational structure, including board of directors and board committee membership;
2. Voting rules for the board and those committees;
3. Decision-making powers of the various committees; and
4. Roles and responsibilities of the management team.

These decisions relate to the degree of control any one stakeholder may exert over the ACO and its activities. It is important to consider the different structural approaches (e.g., number of seats, participating members, officers, committees, etc.) to create bylaws that facilitate timely decision-making without sacrificing the need for consensus.

One of the most important issues the bylaws must address is the voting method for the board of directors and its committees. Common voting options include simple majority, two-thirds majority, and unanimous decision. See Exhibit 1 for an overview of voting options.

Antitrust Concerns

The ACO must also be aware that the nature of a community-based ACO raises issues relating to antitrust provisions and monopolistic practices. While the state's enabling legislation absolves the ACO of antitrust regulations as long as it provides better health care services for the community, the ACO may still face an antitrust challenge if a person or organization suspects the ACO or its participants of collusion or price fixing. A recent advisory opinion issued by the Federal Trade Commission recommending that the Norman Physician Hospital Organization did not violate antitrust provisions by forming a clinically integrated health care network can help outline the most recent thinking and key issues around this issue.[ii]

EXHIBIT 1: **Voting Options for the Board of Directors**

Majority Requirement	Votes to Pass	Potential Impact	Discussion
Simple Majority	More than 50% of eligible votes	Most expeditious of the majority types, but allows one or two voting members or blocs to control many of the decisions that smaller stakeholders might otherwise object to. Should not be used for major organizational actions or where the rights of the minority would be restricted.	Appropriate for administrative actions, such as approving meeting minutes. Not appropriate for budget or strategic plan approval when votes of community/consumer representatives could be overwhelmed.
Two-Thirds Majority	More than 66% of the eligible votes	Seen as a high enough standard to demonstrate the will of the voting population in most cases where a large number of votes are normally cast.	Forces stronger alliance building by leadership, but smaller stakeholders could still be overwhelmed by bloc voting.
Unanimous Consent	All eligible and present votes	Requires the board chair to be a true consensus builder. Could quickly bring an organization with internal conflicts to a standstill if required for many types of board actions.	An excellent model to foster cohesion if the leadership is dedicated and the stakeholders are truly aligned. Protects the small stakeholders' rights, but can impede progress.

Unanimous Consent in Camden

CCHP strives for unanimous consent for all voting measures. After a period of internal debate, its board of directors makes a unanimous decision. Since the CCHP board of directors was established, CCHP has not had a filibuster or non-unanimous vote on a single issue. This concordance is a testament to its governing board's camaraderie and willingness to discuss and compromise on issues, as well as its clear collective goals and vision.

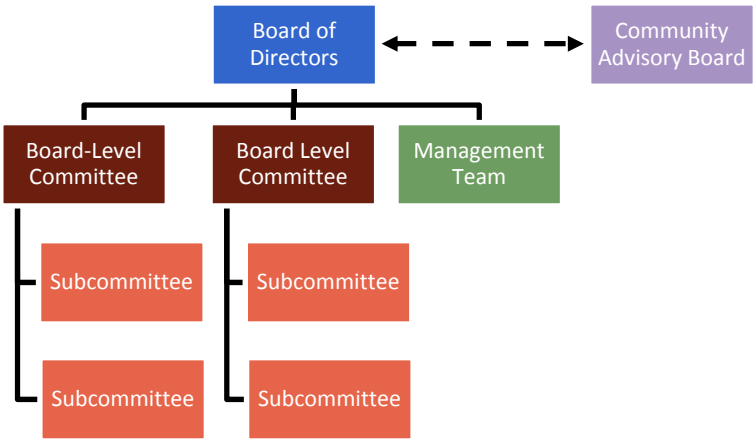
Governance Team Overview

The ACO's leadership structure is usually made up of a board of directors, board-level committees and subcommittees, its management team, and a community advisory board.[iii] The roles, makeup, and responsibilities of the leadership and governance structures of the ACO are summarized in Exhibit 2; Exhibit 3 depicts how these structures are linked to each other.

EXHIBIT 2: ACO Leadership Roles

Role	Composition	Purpose
Board of Directors	A select group of influential health care and community leaders, and other stakeholders.	Oversees and provides general direction of the ACO. Also supervises the management team.
Board-Level Committees	Permanent committees made up of board members and possibly appointees outside the board.	Provides oversight for specific ACO operational areas.
Board Subcommittees	Subcommittees can be standing (permanent) or working (ad-hoc) subsets of board-level committees. Staffed by board members and possibly appointees outside the board.	Work on specific, narrow tasks as defined by the larger committee.
Management Team	Paid staff members recruited for specific functional roles.	Manage the day-to-day operations of the ACO, including care coordination/management, financial, legal, data analysis/IT, and other activities.
Community Advisory Board	Residents, consumer advocates, and community organizations.	Provide community feedback to ACO leadership. This advisory board is independent, and not part of the board of directors or the management structure of the ACO.

EXHIBIT 3: **ACO Leadership Structure**



The Board of Directors

As the primary governing body of the ACO, the board of directors provides overall direction for the ACO, offers guidance on day-to-day management, and ensures the ACO's success in improving quality and reducing unnecessary health expenditures.

Board Structure

The individuals who participate on the ACO's board and the allocation of votes for these members will be a key factor in determining the ACO's future viability. The number of board members and board-level committees is likely to vary from community to community, but board membership should not be restricted if more influential stakeholders exist than the proposed number of seats.

Composition of the Board of Directors

The enabling legislation details specific requirements for the governing board, as follows:

Individuals representing the interest of: health care providers, including, but not limited to, general hospitals, clinics, private practice offices, physicians, behavioral health care providers, and dentists; patients; and other social service agencies or organizations located in the designated area; and

Voting representation from at least two consumer organizations capable of advocating on behalf of patients residing within the designated area of the ACO. At least one of the organizations shall have extensive leadership involvement by individuals residing within the designated area of the ACO.[iv]

Every health care provider type participating in the ACO, as well as representatives from the local agencies overseeing public health and social services, should have board representation. However, the clinical portion of the board need not be limited to these individuals. The ACO should consider adding other members, such as care coordinators or data analysts to represent the interests of all essential partners.

Consumer organizations must also have a voice on the ACO's board of directors. The input of consumer organizations will allow the ACO to gain insights from patients who can also serve as a "sounding board" to gauge the likely reception of community residents to the ACO's decisions.

An Inclusionary Leadership Philosophy

While it may be tempting to limit the number of people providing governance-level input in order to have a manageable board, a committee structure that utilizes diverse perspectives will benefit the ACO. In order to give community stakeholders a voice while not impeding the expediency of board decisions, THT developed five standing committees and a community advisory board, allowing 75 people from 29 community partner organizations the opportunity to provide input.

Since the ACO has flexibility in deciding which organizations to include on the board of directors, it should strive to include influential community organizations and other representatives that will represent the community in a constructive and beneficial manner. The more the ACO can promote the roles of the community representatives; both in the ACO leadership and at the ground level, the more likely the ACO will be successful in developing strategies for improving the overall health of the population.

Qualities of Successful Board Members

The experiences of CCHP and THT demonstrate that successful board members tend to be thoughtful, enthusiastic, and detail-oriented change agents. Since the ACO approach requires a fundamental change to the health care delivery system, board members who are receptive to change will benefit the ACO tremendously by breaking down barriers and seizing new opportunities.

Potential disparities in in-kind and direct funding contributions between stakeholders may result in significant differences in the number of votes one stakeholder receives relative to another. As an example, the enabling legislation requires every general hospital in the ACO's designated area to participate in the ACO. However, one hospital might fully support the initiative with clinical and administrative staff; another may provide start-up capital; while a third may agree to participate, but not contribute resources. In this scenario, the first hospital may be rewarded with more seats than the other two, and the third hospital may receive only a single seat. Community or provider organizations that were not prominent in the initial ACO development may still offer valuable perspective and should be invited to participate in the ACO's community advisory board. Again, a flexible board structure, that includes a bi-annual review of the board's voting requirements, will allow for the board to evolve and invite additional stakeholder group participation over time. Both CCHP and THT have achieved strong stakeholder and community representation on their boards, contributing to the success. Board structures for both organizations are detailed in Exhibits 4 and 5.

EXHIBIT 4: **Camden Coalition of Health Care Providers Board of Directors**

Name	Title/Organization	Role on Board	Stakeholder Group Represented
Vince Pappacio	Executive Vice President/COO, Reliance Medical Group	Chair	Providers
Lesly D'Ambola, DO	Medical Director, St. Luke's Catholic Medical Services	Vice-Chair	Hospitals
Anthony Phoenix	Leader, Camden Churches Organized for People	Secretary	Community Organizations
Sharon Buttress, MD	Medical Director, CAMcare Health Corporation	Treasurer	Federally Qualified Health Centers
Ramon Acosta, MD, PC	Provider/Owner, Ramon Acosta, MD, PC	Board Member	Providers
Kim Barnes	Vice President for Planning and Development, Lourdes Health System	Board Member	Hospitals
Louis Bezich	Chief of Staff, Cooper University Hospital	Board Member	Hospitals
Amit Bhalodia, DO	Physician, Virtua Health Camden	Board Member	Providers, Hospitals
Martha Chavis	Workforce Director, Camden Area Health Education Center	Board Member	Community Organizations
Patrick Ervilus, NP	Family Nurse Practitioner, River Primary Care	Board Member	Providers
Joan Gray	Director of Ambulatory Services, Virtua Health Camden	Board Member	Hospitals
Joe Hummel, MD	Chief of Emergency Medicine, Virtua Health Camden	Board Member	Hospitals
Jeff Kleeman, MD	Physician, Fairview Village Family Practice	Board Member	Providers
Tom Knoche	Consultant, Fair Share Housing, Northgate II	Board Member	Community Organizations
Evelyn Liebman	Associate State Director for Advocacy, AARP	Board Member	Consumer Advocates
Anthony Mazzarelli, MD, JD, MBE	Senior VP of Operations and Deputy CMO, Cooper University Hospital	Board Member	Hospitals
Stephen Shultz	Chief of Staff, Volunteers of America – Delaware Valley	Board Member	Community Organizations

EXHIBIT 5: **Trenton Health Team Board of Directors**

Name	Title/Organization	Role on Board	Stakeholder Group Represented
Robert Remstein, DO, MBA	Vice President for Medical Affairs, Capital Health	President	Hospitals
James Brownlee, MPH	Director and Health Officer, City of Trenton Division of Health	Vice President	Local Public Health Resources
Christy Stephenson, RN, MBA	Executive Vice President for Strategic and Clinical Transformation, St. Francis Medical Center	Treasurer	Hospitals
Kemi Alli, MD	Chief Medical Officer, Henry J. Austin Health Center	Secretary	Federally Qualified Health Centers
Dennis Dooley	Vice President, Planning & Development, Capital Health	Board Member	Hospitals
Cathleen Bennett	Director, Policy and Strategic Planning, New Jersey Department of Health	Board Member	Government Officials
Ruth Carter	Director, Social Work Services, City of Trenton	Board Member	Social Services
Jerry Jablonowski	President and CEO, St. Francis Medical Center	Board Member	Hospitals
Maria Juega	Executive Director, Latin American Legal Defense and Education Fund	Board Member	Community Organizations
John Monahan	President and CEO, Greater Trenton Behavioral HealthCare	Board Member	Behavioral Health Providers
Harry Postel	Director of Behavioral Health Services, Catholic Charities, Diocese of Trenton	Board Member	Community Organizations, Behavioral Health Providers
Pamela Pruitt	Vice President for Business Development, WIMG/Morris Broadcasting	Board Member	Media Organizations
George C. Stokes	CEO, Henry J. Austin Health Center	Board Member	Federally Qualified Health Centers

Board-Level Committees

The board of directors should empower standing board-level committees to oversee specific duties of the board. These committees are largely responsible for the success of the ACO in their respective areas and may be charged, either formally or informally, with researching key issues in their subject area and producing reports for the larger board. Board-level committees also offer an opportunity to engage stakeholders in the topics that they are especially interested in. Potential ACO board-level committees are listed in Exhibit 6.

EXHIBIT 6: **Examples of Board-Level Committees**

Committee Name	Purpose
Care Delivery	Chronicle and evaluate successful and unsuccessful practices in care coordination and care management.
Community Engagement	Develop and implement methods to recruit and utilize community resources to transform the community's health care delivery system.
Data	Develop a data strategy and infrastructure plan.
Executive	Oversee board-related activity between meetings and address logistical concerns.
Finance	Provide overall guidance and strategies for generating and allocating funds for ACO activities and development.
Incentive Distribution	Provide methodology for rewarding providers meeting defined ACO quality and performance measures.
Personnel	Supervise hiring and evaluation of management team.
Population Health	Provide statistical reporting and develop condition-based initiatives.
Population Total Cost of Care	Calculate per member per month costs of the care being rendered.
Provider Performance	Develop measurement tools and track quality reporting.
Quality	Monitor improvement of patient and population health outcomes and ensure the use of evidence-based processes by showing quality metrics
Value	Focus on methods and strategies to provide better value by increasing quality and reducing costs.

While there may be many different committees that serve a variety of purposes, the board of directors must make sure that each committee does not operate in a silo. Issues raised during committee meetings must be vetted by the larger board and the board should consider using cross-functional committees to encourage collaboration.

The Value Committee

THT has re-envisioned the traditionally separate quality and finance committees into a value committee that focuses on linking quality and overall cost. The value committee is comprised of quality professionals, financial professionals, and external experts who evaluate performance goals and reporting, as well as provide guidance on innovative care coordination and measurement models.

Board Subcommittees

In addition to board-level committees, a Medicaid ACO should incorporate subcommittees into its governance structure. These subcommittees can be either standing or ad-hoc (as needed) in nature, and can be used to address a variety of key areas such as performance data, provider recruitment, fundraising, or task forces for specific clinical conditions. Through subcommittees, small groups of experts and key stakeholders can oversee areas or the development of projects that may be too cumbersome to discuss with a larger group of board members. Once an idea or process is fully developed, it can be brought to the larger committee, and the entire board, for approval.

Management Team

The management team is responsible for the day-to-day oversight of the ACO's clinical activities, data analysis, and administrative and financial operations. This team is overseen by an executive director, who should have a seat on the board of directors and be the principal conduit between the board and ACO managers and staff. In addition to the executive director, staff should include care coordinators (and possibly internal care management teams), data analysts, financial/accounting officers, and clerical/administrative staff. Staff may also include legal personnel, grant writers, and other administrative support functions. For an ACO just starting out with a limited budget, a smaller staff where personnel perform multiple functions may be warranted.

Executive Director Profiles

The Executive Director is perhaps the most important part of the ACO. This individual should be a devout "ACO Champion" who is dedicated to the cause and can advocate on its behalf. Ideally, the Executive Director should also be a provider to ensure the overall leadership of the ACO is clinically-focused. A brief profile of the Executive Directors of CCHP and THT are below:

Jeffrey Brenner (CCHP) – Jeffrey Brenner, MD had worked as a primary care physician in Camden for many years, when, in 2002, he and a small group of Camden-based PCPs began to have breakfast meetings to discuss health care issues in the city and share triumphs and common challenges. From these meetings, the Camden Coalition of Health Care Providers was born. Through Dr. Brenner's guidance, the organization has developed to include a robust internal database, a city-wide health information exchange fed by data from all three Camden hospitals, and care teams that identify and interact with "super-utilizer" patients. Dr. Brenner's long-term goal for the organization is to improve health care delivery to an extent where the coalition's services are no longer needed – or as he often says, to "become obsolete."

Ruth Perry (THT) – A longtime ED physician and executive based in Philadelphia, Ruth Perry, MD was hired to lead the Trenton Health Team in 2011. From her background in Philadelphia, as well as her corporate leadership experience, Dr. Perry realized that many ED and inpatient visits were the medical manifestation of social problems, which the medical system was not structured to address in an integrated manner. The desire to work collaboratively with others to develop innovative and integrated solutions to these issues was the impetus for her to join the Trenton Health Team. Dr. Perry has built THT's collaborative organization and partnered with local hospitals and clinics to provide care teams to form a community-based health improvement organization for the City of Trenton. THT has grown rapidly and, through the generosity of The Nicholson Foundation, is building the infrastructure to advance its strategic objectives.

No matter what the overall staff composition of the ACO looks like, the management team should encourage collaboration, communication, and alignment toward overall goals. Most health systems have internal management structures that are highly specialized, but these structures often work in vertical silos instead of collaboratively across departments. One way to achieve greater collaboration is to develop cross-functional teams that meet regularly to discuss how to achieve larger goals at the ACO level.

Community Advisory Board

The community advisory board is a separate entity from the board of directors and management team, but its input should inform the strategies developed by the governance team. The board of directors should develop the structure of the community advisory board, but allow it to function largely autonomously to generate honest feedback to drive ACO policy, partnerships, and resource decisions. This community entity gives residents, patient advocates, and community stakeholders a greater voice in the ACO's development and will likely increase the support from these stakeholders. Further, the community advisory board offers an effective way to formalize a community engagement process, which is required by statute.

ADVANCED ELEMENTS

While the prior section outlined the core elements necessary for developing formal ACO governance structures, this section details specific areas for board and management team oversight. The board of directors and

management team will have separate oversight responsibilities, but should regularly coordinate efforts to achieve collective short-term and long-term goals.

Areas of Board Oversight

Aside from the traditional organizational leadership roles (such as approving strategic goals and objectives, oversight of the executive director or chief executive officer, coordinating with external auditors, etc.), the board of directors must fully understand the health and social service needs of local residents and set goals for the ACO to meet those needs. The following are critical areas for board oversight, which may also be delegated to board-level committees or subcommittees, but must be accountable to the entire board of directors.

Oversee ACO Performance Measurement and Evaluation

Performance measures should provide a clear picture of the ACO's accomplishments and enable the ACO leadership to manage the organization. It is incumbent upon the board of directors to set up data access agreements, put an infrastructure in place, and firmly establish data and quality strategies. Since ACOs are exempt from anti-trust provisions as long as they improve quality and do not increase costs, the board of directors must ensure that it communicates effectively with participating providers, so providers report their quality and payment data both accurately and on a timely basis. The board must also consider how to measure individual provider/practice-level performance. Transparency of results within the ACO may be uncomfortable for health care providers at first, but they are necessary for quality measurement and reporting purposes. Providers generally realize the importance of transparency and acknowledge the need for agreed-upon clinical and financial performance measures and are thus more willing to be transparent with their practices.

Prioritize Resource Allocation

Each New Jersey provider community will likely begin its pathway to becoming an ACO with limited resources to accomplish ambitious objectives. As a result, the board of directors should work with the management team to prioritize health interventions and develop tools to facilitate decision-making, including critical organizational structures, baseline data and reporting capabilities, grant writing and funding skills, and well-designed clinical intervention teams. One lesson from previous delivery system integration attempts from Medicare, commercial ACOs, and patient-centered medical homes (PCMHs), is the long-term benefits of growing incrementally rather than initially investing in a substantial infrastructure with a high fixed cost base.[v] Therefore, an ACO should consider conducting initial cost-benefit analyses to determine what tasks are most crucial to its early success.

The board of directors should also leverage existing clinical resources in the community as a first step in optimizing the community's utilization of health care resources. An ACO can utilize existing care coordinators in primary care practices, and exchange data and best practices with managed care organizations (MCOs) and hospitals. These partnerships can reduce the need to hire additional personnel and demonstrate the effectiveness of the ACO to potential donors and health plan partners involved with these partner entities.

As directed by the Medicaid Accountable Care Organization Demonstration Project's regulations, the board of directors must also address how providers and the ACO as a whole spend their gain-sharing distributions. While the ACO does not need to develop rigid rules to govern the providers' use of these distributions, it does need providers to report how funds are spent to the ACO management team.

Establish Community Relationships/ Philosophy

The board of directors has a key role to play in engaging community stakeholders and establishing productive relationships within the ACO's designated area. The board should continue to seek community feedback on a variety of matters, some of which include:

- Medical and behavioral services that are seen as needed or desired;
- Information on community issues that may impact the social determinants of health;
- Accountability for health outcomes, quality, cost and access to care; and
- The method of distribution for the proceeds of the gain-sharing arrangement.

More community engagement strategies are detailed in Section 2.2.

Areas of Management Team Oversight

While coordination between the board and the management team is critical, day-to-day oversight in all areas – clinical, financial, and administrative – is the responsibility of the ACO's management team. Because an ACO is intended to be light on administrative needs but heavy on clinical change, the management team should foster a lean organization that rewards growth and multidisciplinary thinking. Similarly, the ACO should focus on integrating patient-level information to empower the area's providers and not build additional layers of providers or administrators.

Clinical Oversight

Developing a consistent, yet flexible, care management approach is one of the key roles of the ACO management team. The overarching goals of care management functions developed by the management team will assure that the team is appropriately matched to the community's needs and that interventions are appropriate and consistent with the ACO's mission.

Another clinical oversight role the management team must provide is assuring timely responses to patient safety issues and complaints, which the ACO must report to the New Jersey DHS on an annual basis. The management team should consider collecting these reports quarterly to allow the ACO to take appropriate steps toward addressing problems more frequently, and to ensure that the ACO is not blindsided by a deluge of poor reports at the end of the year.

More information on care delivery roles and responsibilities is available in Section 2.4.

Financial Management

Financial management is critical for the management team and the ACO as a whole. A major portion of the successful ACO's revenue will come from gain-sharing contracts (see Section 3.1 for more information on developing a business plan). However, the revenue recognition accounting rules designed to prevent fraud make estimating and recording this type of revenue rather complex. Few accounting firms are experienced with this type of estimation accounting, so the ACO leadership must be diligent in understanding the accounting rules. In the early stages, advice from actuarial and managed care consultants can assist the board of directors in understanding these concepts.

ADDITIONAL RESOURCES

Norman PHO Advisory Opinion
United States of America Federal Trade Commission (2013)
http://www.ftc.gov/os/2013/02/130213normanphoadvltr.pdf

Getting to There from Here: Evolving to ACOs Through Clinical Integration Programs
Kaufman, Hall & Associates (2011)
www.advocatehealth.com/documents/app/ci_to_aco.pdf

Pro Bono Partnership
www.probonopartner.org

2.2 Partnering With Stakeholders

TOOLKIT BLUEPRINT

Read this section to learn how to develop strategies to engage and partner with critical stakeholders in the ACO community.

CONCEPTUAL MILESTONES

- ✓ The ACO understands the essential role that health care stakeholders play in the organization and has identified several health care stakeholders for initial outreach.
- ✓ The ACO understands the essential role that community stakeholders play in the organization and has identified several community stakeholders for outreach.
- ✓ The ACO understands that in addition to provider and community stakeholders, residents, government officials, and public health and social services offices must also be engaged.

ESSENTIAL MILESTONES

- ✓ The ACO has achieved the New Jersey Medicaid Accountable Care Organization Demonstration Project requirements by receiving the support of all general hospitals, 75 percent of Medicaid primary care providers, and four qualified behavioral health providers in its designated area.
- ✓ The ACO has a written community engagement plan, but the plan has not been fully implemented. The ACO has engaged many community stakeholders, and some informal stakeholder relationships have been established. The ACO has also satisfied the community stakeholder presence requirement with its board membership structure.
- ✓ The ACO engaged a number of local politicians and won some support, has set up public feedback mechanisms, and has begun to collaborate with local public health and social services offices.

ADVANCED MILESTONES

- ✓ The ACO has achieved the New Jersey Medicaid Accountable Care Organization Demonstration Project requirements by receiving the support of all hospitals, 75 percent of Medicaid primary care providers, and four qualified behavioral health providers in its designated area. The ACO also has broad support from FQHCs, clinics, and specialists, and has formed contractual relationships with managed care organizations. One or more health care stakeholders have also been designated as an "ACO Champion."
- ✓ The ACO has a written community engagement plan. Community representatives are fully integrated into the ACO and have roles on the community advisory board. The board of directors has an active community stakeholder presence, with some in a leadership role. Informal and formal mechanisms are in place, and the ACO has established specific programs with community organizations and services that will help residents gain access to care and encourage active participation in their own health care plans.
- ✓ Political entities in the area support the ACO, as do the vast majority of community residents. Local and state social services and public health offices are active partners, provide input and possibly services on a regular basis, and at least one representative serves on the board of directors. Residents are also aware of the feedback mechanisms in place for them and have an active voice through the community advisory board.

CONCEPTUAL ELEMENTS

Establishing partnerships with stakeholders is an essential part of building a Medicaid ACO, and thus, participation in the New Jersey Medicaid Accountable Care Organization Demonstration Project requires significant stakeholder support. However, ACOs must engage stakeholders much more meaningfully than these basic requirements dictate in order to have a successful community-based program.

Providers, payers, patients, community organizations, government services, and political leadership must all be consulted as the ACO is formed, and continue to remain engaged once the ACO begins providing services in the community. Since so much of an ACO's success is predicated on communication and a desire to make a positive health impact on the community, stakeholders must not only buy into the ACO concept, but become active participants in the organization with a vested interest in its success.

ESSENTIAL ELEMENTS

Types of Stakeholders

ACO stakeholders can be categorized into three groups: (1) health care stakeholders; (2) community organizations; and (3) other stakeholders (including consumer representation). A list of the stakeholder groups in these categories is shown in Exhibit 7:

EXHIBIT 7: Types of Medicaid ACO Stakeholders

Health Care Stakeholders	Community Organizations	Other Stakeholders
• Hospitals • PCPs • Behavioral Health Providers • FQHCs and Clinics • Specialists • MCOs	• Community Service Organizations • Faith-Based Organizations • Housing and Homeless Services • Food Pantries and Soup Kitchens • Transport Services • Patient Advocates	• State and Local Public Health Resources • Social Services • Government Officials • Community Residents

In order to build a successful Medicaid ACO, stakeholders from each of these categories must be engaged to support the aims of the ACO.[vi] It is important that ACOs identify and collaborate with these key stakeholder groups, as each has an important role to play to enhance the ACO's ability to improve health care delivery in the community. While this list of stakeholders may seem daunting, developing a broad-based stakeholder coalition is possible, as evidenced by the collaborations of CCHP and THT, which are listed in Exhibit 8.

EXHIBIT 8: Partnerships Forged by CCHP and THT

Category	Stakeholder Type	Camden (CCHP)	Trenton (THT)
Health Care Stakeholders	Hospitals	Cooper University Hospital; Our Lady of Lourdes; VirtuaHealth	Capital Health; St. Francis Medical Center
	PCPs	CAMCare; Fairview Village; St. Luke's; Individual practitioners	Lotus Medical Center, Individual practitioners
	Specialists	Individual practitioners	Individual practitioners
	Behavioral health providers	Individual practitioners	Greater Trenton Behavioral Health, Individual practitioners
	FQHCs and clinics	CAMcare, Project H.O.P.E.	Henry J. Austin FQHC, Trenton Department of Health
	MCOs	United Healthcare	
Community Organizations	Community service organizations	Camden Area Health Education Center; Fair Share Northgate; Twin Oaks; Volunteers of America	Planned Parenthood, Homefront, Isles, Children's Home Society; Latin America Legal Defense and Educational Fund; Mercer Street Friends
	Faith-based organizations	Camden Churches; People Improving Communities through Organizing (PICO)	PICO, Catholic Charities, Concerned Pastors, Trinity Episcopal Cathedral, Shiloh Baptist Church, Turning Point United Methodist Church
	Housing and homeless services		Rescue Mission of Trenton, Mercer Alliance to End Homelessness
	Food pantries and soup kitchens		Trenton Area Soup Kitchen
	Transport services		
	Patient advocates	AARP	New Jersey Health Care Quality Institute
Other Stakeholders	State and local public health		Trenton Department of Health and Human Services
	Social services		Mercer Board of Social Services, NJ Office of Minority Health
	Government officials	State Senator Joe Vitale, Municipal, County, and State Officials	State Senator Joe Vitale, Municipal, County, and State Officials
	Community residents	Individual Residents	Individual Residents

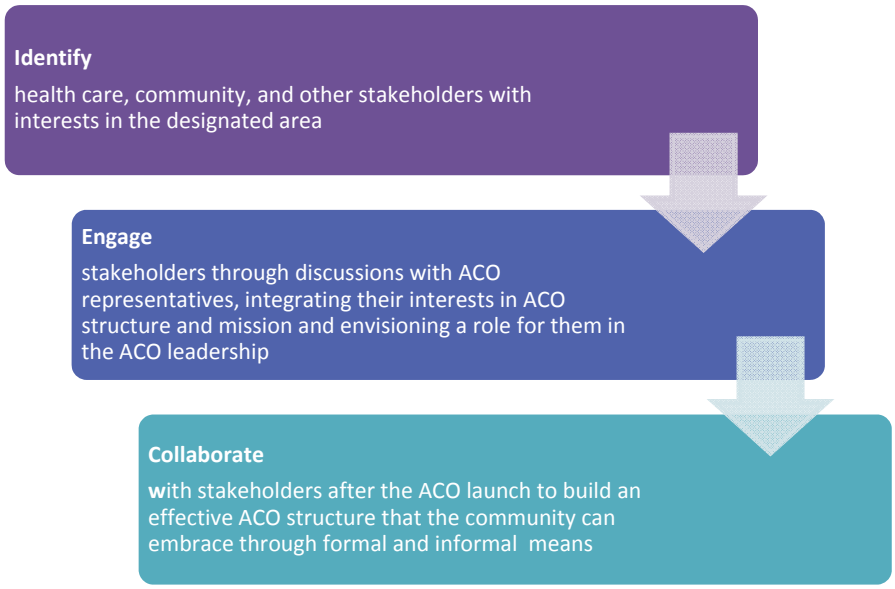
PICO: Working with Faith-Based Community Organizations

In generating stakeholder support, both CCHP and THT benefitted from the assistance of the People Improving Communities through Organizing (PICO) National Network, a faith-based organizing group that helps local communities identify social problems and unite people based on their common faith to spur change in those areas. In Camden, PICO helped to get the project off the ground by organizing meetings at local churches where CCHP members explained the city's health problems and the benefits of patient-centered and coordinated care. THT engaged PICO as part of its unified Community Health Needs Assessment, and PICO assisted THT in learning more about the barriers that residents confront in accessing health care through one-on-one interviews and community forums. For more information about PICO, visit: www.piconetwork.org.

Developing Partnerships with Stakeholders

Forming partnerships with stakeholders involves: (1) identifying stakeholders and the different partnership opportunities for health care, community, and other local resources; (2) engaging potential partners to join the ACO community; and (3) collaborating with stakeholders and partners over the course of the demonstration and beyond (see Exhibit 9).

EXHIBIT 9: The Stakeholder Partnership Process



ADVANCED ELEMENTS

Stakeholder partnerships can be cultivated through a concerted effort to recognize each stakeholder's point of view and build a long-term, mutually beneficial relationship. While stakeholder identification is fairly straightforward, certain strategies can be employed to facilitate the engagement process and develop meaningful formal and informal mechanisms of ongoing collaboration.

ACO Champions

It is important to identify specific individuals and/or organizations who may develop into champions of the ACO cause. Without such individuals, the ACO is likely to remain "a great idea everyone supports" rather than a transformative force in the community. These "ACO Champions" can act as ambassadors to the rest of the community, recruit peers, and garner support. In some instances, they may even serve as the public face of the organization.

Stakeholder Engagement Strategies

Stakeholder engagement can be a difficult process that involves identifying stakeholder interests, patience, persistence, and the use of proper incentives. The engagement process includes educating stakeholders about the ACO and its benefits as well as making formal or tacit agreements of participation or collaboration with the ACO. Recommendations for engaging potential stakeholders are listed below.

1. **Stakeholders may require different approaches.** An ACO should be thoughtful in tailoring its engagement strategy and talking points to each potential partner. Elements such as personality, ideological beliefs, financial interests, age, and countless other characteristics should be considered tailoring outreach and framing ACO development to appeal to their needs.

2. **Recognize that hospitals are important.** Hospitals have an immense amount of leverage when negotiating the particulars of an ACO arrangement, given that legislation requires that all general hospitals in the designated area participate in the ACO. As a result, ACO leaders should prepare to offer multiple seats on the board of directors and/or larger gain-sharing portions to hospitals.

3. **Acknowledge that PCPs are essential.** Many PCPs will be willing to participate in the ACO, but some PCPs will inevitably resist for reasons ranging from low Medicaid reimbursement rates to a general resistance to change. While ACOs can afford not to engage with every PCP in the designated area, larger provider groups and providers who are employed by area hospitals or clinics should be approached, as their participation can help greatly toward achieving the required 75 percent participation rate.

4. **Do not neglect MCOs.** An ACO must establish partnerships with MCOs to be sustainable. Other stakeholders such as influential providers or hospital systems can help bring MCOs to the table and relay the benefits of ACO participation.

5. **Approach likely collaborators first.** The best way to approach reluctant participants is to build a broad coalition of established support. Thus, hesitant stakeholders can directly see the benefit of the ACO from their perspective of peers. They are also more likely to view the establishment of a Medicaid ACO as inevitable if local peers have already signed on.

6. **Educate first, negotiate later**. Stakeholders should fully understand the purpose of the ACO prior to serious discussions about supporting or participating in the ACO. Ask stakeholders what they have heard about ACOs to determine what level of education to provide.

7. **Correct erroneous knowledge**. ACO leaders may need to address misconceptions about the goals and impact of an ACO on various stakeholder interests.

8. **Develop targeted talking points.** An ACO representative should have talking points tailored to each stakeholder. These points should be naturally woven in the conversation based on the stakeholder's interests and knowledge.

9. **Use board membership as an incentive**. A seat on the board (or multiple seats in the case of hospitals) offers the opportunity for prestige, influence, and partial control of the organization, which could convince some organizations to support the cause. This incentive can also be offered to influential community organizations, which would likely find it appealing to be represented.

10. **Be amicable—from start to finish.** When meeting with a stakeholder, it is always the best strategy to part on the best terms possible. Not all of these conversations will go smoothly, but the ACO representative should sum up the conversation, express his or her intent to follow up in the near future regardless of the party's level of interest, and follow through on this promise.

Understanding Provider Arrangements and Industry Trends

In order to recruit a strong provider base, ACOs must understand trends in the provider community. With many health systems moving to acquire physician practices, many more physicians will be employed by hospitals or health systems. In addition, many physicians are already participating in quality incentive programs and innovative payment structures. In addition to changing the way these providers are paid, this trend will also have an impact on:

- **Provider Representation.** The type of representation the providers will wish to have in the governance and clinical roles within the ACO may be affected by this trend. If a community has a high proportion of providers employed by health systems, provider groups and independent providers may have fewer representatives on the board of directors, but may also be rewarded by different internal incentive programs for delivery of care.
- **Alignment with other ACO initiatives.** Many independent providers are aligning with ACOs for Medicare and commercial populations. The degree to which they may be allowed to integrate with the Medicaid ACO may be impacted by the governance rules of those alternative ACOs.
- **Anticipated Return on Investment.** Every provider will have specific and varied expectations on how that collaboration will be rewarded based on their perceived value. The ACO must be mindful of this when developing a gain-sharing plan.
- **Deceptive Impact of Individual Providers.** A review of the community's providers may reveal a certain provider or provider group to have a larger than expected Medicaid practice, which could be more influential to the success of a Medicaid ACO than the community's more vocal, assumed, leaders.

Identifying Potential Roles for Key Stakeholders

Each stakeholder has a particular role in influencing ACO success, and each stakeholder also has much to gain from participating in or supporting the ACO. While the roles of clinical providers and health care facilities are easily apparent, the participation of MCOs is crucial to provide the ACO with patient and population-level data and create gain-sharing arrangements. In addition, stakeholders such as community service, faith-based, and social services organizations can provide essential services that are typically not offered via the medical community. An outline of potential roles for these stakeholders is described in Exhibit 10.

EXHIBIT 10: Potential Stakeholder Roles

Stakeholder Group	Potential Roles
Health Care Stakeholders	
Hospitals	▪ Provide inpatient and ambulatory data to identify super-utilizers ▪ Provide, or partner with, care teams
PCPs	▪ Provide necessary primary care services ▪ Assist patients with managing their conditions
Specialists	▪ Involvement in care plan for special conditions
Behavioral Health Providers	▪ Can serve as primary provider for Medicaid beneficiaries with co-occurring mental health or substance abuse issues ▪ Often have close ties to community organizations and social services
FQHCs and Clinics	▪ Major providers of primary care for Medicaid patients ▪ Usually have close ties to community organizations
MCOs	▪ Crucial partner for ACO revenue due to gain-sharing arrangement ▪ Source of patient- and population-level data
Community Stakeholders	
Community Service Organizations	▪ May offer health services such as in-house nurse visits, cultural competency training, and translation services ▪ Advocacy and patient information efforts
Faith-based Organizations	▪ Spiritual and other supports ▪ Community influence and unity ▪ Organize meetings
Housing and Homeless Services	▪ Provide permanent or temporary shelter, critical for stabilizing patient health
Food Pantries and Soup Kitchens	▪ Provide adequate food and nutrition
Transport Services	▪ Provide access to care through transportation, which is particularly important for disabled patients
Patient Advocates	▪ Patient support services (e.g., Medicaid enrollment) ▪ Advocacy and patient information efforts
Other Stakeholders	
State and Local Public Health Agencies	▪ Access to population-level data through public health registries ▪ Prevention and wellness programs coordinated with quality improvement efforts
Social Services Organizations	▪ Referrals to state, local, and community services and access to public benefits, e.g., food stamps, Medicaid, public assistance ▪ Working as part of, or with, care teams
Government Officials	▪ Public support and exposure
Community Residents	▪ Information about community needs ▪ Suggestions about how to improve the ACO

Ensuring Stakeholder Collaboration

Once stakeholders have expressed an interest in participating in or supporting the ACO, appropriate mechanisms must be in place to involve stakeholders throughout the ACO's ongoing development. This can be done through a variety of formal and informal structures.

- **Formal Structures.** Leadership and governance structures of the ACO can facilitate stakeholder collaboration. While a role on the board of directors is the most obvious mechanism, the organization can structure board-level committees or subcommittees to gather information from health care and community stakeholders to find ways to gain buy-in from these groups and enable effective partnerships. Community organizations, residents, and patient advocates can be engaged through the community advisory board. More information on these strategies and the board of directors is available in Section 2.1.
- **Less Formal Mechanisms.** Simple ways to encourage collaboration include holding quarterly or yearly public status meetings, informal breakfast meetings, conducting community surveys, or "open houses" to provide updates to and garner feedback from community stakeholders. Such activities can offer the opportunity for community members and health care professionals to provide feedback on how the ACO is working and how it can be improved.

ADDITIONAL RESOURCES

PICO National Network
www.piconetwork.org

MD Link: Partnering Physicians with Community Organizations: A Toolkit for Physician Champions
The National Council on the Aging, Center for Health Aging (2005)
http://www.innovations.ahrq.gov/content.aspx?id=1432

Developing Effective Partnerships with Health Care Providers
Department of Health & Human Services, Administration on Aging
http://www.aoa.gov/AoA_programs/HCLTC/ADRC_CareTransitions/Toolkit/chapters/CareTransitionsToolkitChap3.pdf

Community Based Organization and Health Care Professional Partnership Guide
National Initiative for Children's Healthcare Quality
http://www.nichq.org/advocacy/obesity_resources/Guide%20for%20CBOs%20to%20Work%20with%20HCPs_Final.pdf

Effective Clinical Partnerships Between Primary Care Medical Practices and Public Health Agencies
American Medical Association (2010)
http://www.ama-assn.org/ama1/pub/upload/mm/433/clinical-partnerships.pdf

2.3 Performing Data Analysis and Building an Information Technology Infrastructure

TOOLKIT BLUEPRINT

Read this section to learn how to develop data analysis and information technology infrastructure that can evolve with the needs of the ACO.

CONCEPTUAL MILESTONES

- ✓ The ACO understands the importance of data to care management and has identified sources of data. It is also aware of the basic requirements needed to perform data analysis.
- ✓ The ACO knows the elements it needs to establish a minimum data infrastructure, and plans to obtain these elements.
- ✓ Less than 30 percent of ACO providers currently use electronic health records (EHRs), but providers are aware of their benefits and resources available to help them convert to EHRs.

ESSENTIAL MILESTONES

- ✓ The ACO has set data-related goals and has at least one reliable source of data. A rudimentary data structure is in place, and the ACO intends to share information between providers and facilities, and analyze data. The ACO also has a method in place to promote provider use of electronic health records (EHRs).
- ✓ The ACO has an internal database and access to data for analysis purposes.
- ✓ Between 30 and 75 percent of ACO providers currently use EHRs. These EHRs are also compatible with each other and the health information exchange (HIE) that the ACO receives data from (if applicable). The ACO has also recommended an EHR type to its providers.

ADVANCED MILESTONES

- ✓ The ACO has a robust data strategy. It has at least two reliable sources of data and the capability to exchange this data among providers, facilities, and the ACO data analysts. It has a plan, which is consistent with time and resources, to develop a functioning HIE or access data from an already established HIE, an internal database and analysis software, and has a plan for providers without EHRs to obtain them, though more than half of them already have EHRs. There is at least one full-time staff member dedicated to data analysis.
- ✓ The ACO has a sophisticated internal database and either hosts, or has access to, an HIE.
- ✓ Over 75 percent of ACO providers currently use EHRs that are interoperable with each other and the ACO's HIE. At least 50 percent of these providers use the ACO-recommended EHRs or another interoperable EHR with discrete data fields.

CONCEPTUAL ELEMENTS

Since data is both a means of identifying patients in need of additional care and measuring the impact of improved care management on these patients, it is an integral part of the ACO's success. Smart use of data will

enable an ACO to improve care coordination across the community and evaluate the success of both individual ACO interventions and the overall impact of the ACO. ACOs must be able to collect, share, and analyze data, both internally and externally, to facilitate effective communications between providers to coordinate care. Strategic use of data is essential for ACOs to: (1) identify the populations and individuals in a community that can benefit most from care management; (2) monitor the cost of care provided to the ACO patient population, and; (3) measure the ACO's performance. Information technology (IT) that allows data sharing and analysis includes both the physical hardware needed to transmit the information and the software needed to analyze the data effectively.

ESSENTIAL ELEMENTS

Effective data analysis is one of the cornerstones of ACO success. While an ACO may not have all the sophisticated data "bells and whistles," at a minimum, a start-up ACO should understand the following six areas:

1. State and federal regulations governing data collection and analysis;
2. Types and sources of data available;
3. Collecting, storing, and linking data;
4. Data analysis;
5. Methods to benchmark data and gauge the success of the intervention; and
6. Familiarity with IT infrastructure, software, and tools needed to obtain the data.

This section outlines the "need-to-know" information for ACOs regarding each of these areas.

Camden's Data Advice: "Just Get Started"

While the IT components mentioned in this section may seem daunting, CCHP recommends just getting started, rather than waiting for an ideal system to be constructed. An ACO does not need advanced software, a PhD researcher, or a software vendor to begin analyzing data. All it needs is access to basic patient or claims data and a dedicated data analyst with programming skills who can take a look at the data and identify patterns and relationships.

State and Federal Regulations Governing Data Collection and Analysis

While at times data-sharing regulations may seem directly incongruent with effective coordination of care, better understanding of regulations will help ACOs ensure patients and providers that their health information will remain confidential and will not be used inappropriately.

The most widely recognized federal data regulation is the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which requires health care providers to: (1) obtain patient consent when patient information is shared between practices, providers, and other entities; and (2) keep patient information private. Hospitals, providers, and medical staff should be well acquainted with the statute; thus, the impact on ACOs should not be onerous. In addition to following existing HIPAA protocol to secure patient privacy, the ACO must ensure that patients consent to the sharing of their medical records by developing an "opt-out" contract. Medicaid ACOs may want to provide hospitals, FQHCs, and other facilities that house patient records with sample language for opt-out forms. CCHP uses a simple "opt-out" contract for patients served by the Camden Health Insurance Exchange (HIE) (available at www.camdenhealth.org).

Since behavioral health is an integral part of ACO success, another important federal regulation is 42 CFR Part 2, which places added restrictions concerning the sharing and confidentiality of substance abuse information. While behavioral health providers are very familiar with these requirements, many PCPs or specialists may not be as familiar, and may need to be informed of these added safeguards.

New Jersey's data-sharing regulations require that all patient data be secured for use in regional health information organizations (HIOs), which are HIEs that store patient records from local and commercial exchanges in their designated region, and the New Jersey Health Information Network (NJHIN), the state-wide HIE that facilitates information exchange between the HIOs. New Jersey also requires that all ACOs have the capacity to report quality data on select measures to the state at an aggregate level. While this aggregate data is not held to the same privacy standards as individual patient information, ACOs must ensure that this data is converted without any identifying information and transmitted securely to the state.

Types and Sources of Data Available

For ACO purposes, there are two primary levels of data, patient-level and population-level data, each of which can be broken down by data type or source. See Exhibit 11 for an overview of the types and sources of data.

EXHIBIT 11: Types and Sources of Data

Data Type	Description	Advantages/Disadvantages	Potential Source(s)
Claims	Data transmitted between providers and payers such as MCOs for reimbursement/payment. Includes services and payment information.	Good for individual-level data across all care settings and payment information, but has a substantial lag in transmission.	MCOs, providers, hospitals, Medicaid
Inpatient Admissions/ Discharge	Information on hospital stays including diagnoses, procedures, length of stay, and discharge disposition.	Great source to target identify patterns of inpatient service use. Might be discrepancies between admissions and discharge information.	MCOs, hospitals, Medicaid
Ambulatory	Information gleaned from ambulatory care services and ED outpatient data.	Important source of information for ED utilization, but only serves a limited scope.	MCOs, hospitals, Medicaid
Immunization	Individual and population level data for state-issued or required vaccinations and other medical procedures.	A useful resource, especially from a population health perspective, but a limited scope.	Public Health Department
Pharmacy	Pharmacy utilization statistics including prescriptions issued and filled.	Offers data that may not be captured in inpatient or claims data.	MCOs, providers, pharmacies, Medicaid

Data Type	Description	Advantages/Disadvantages	Potential Source(s)
Patient Experience	Data provided from patients to rate providers, hospitals, and overall impressions of their health care experience.	Offers insights on intangible feelings that cannot be captured by other data types and can deliver more targeted data based on the questions asked. However, in a small sample size, these data are particularly variable.	Individuals, MCOs, providers, hospitals
Electronic Health Records (EHRs)	Individual patient medical records/ history.	Provides detailed data on the patient's condition, may not be "countable" through use of notes fields and may not contain all procedures if all providers contributing to the patient's care do not use EHRs.	Individuals, providers

Data Types

Patient-level data is collected through several mechanisms, including claims submitted by providers and facilities to health plans for payment, hospital inpatient and ambulatory data, immunization records, and EHRs. This data can be used to identify patients with high rates of avoidable or unnecessary utilization of health care services. Sharing patient-level data across PCPs, hospitals, specialists, nurses, and care teams can enable providers to work together more effectively and identify opportunities to reduce repeated tests and procedures. It can also enable the ACO to track a patient's condition, treatment, and cost over time.

Population-level data is aggregated, de-identified data that can be used to assess the effectiveness of ACO activities on the community as a whole or some subset of the community (e.g., people with diabetes, residents of the East Ward, those under 30 years of age, etc.). Almost any form of patient-level data can be aggregated into population-level data, provided there are enough samples to be statistically valid. This information can be used to determine the large-scale impact of the ACO over time and among different populations.

Data Sources

ACOs can collect data from many sources including claims data from Medicaid health plans, hospitals, providers, and patient surveys, census data, birth and death certificates, and agencies such as state and local public health departments. Data from these sources can be shared through a real-time HIE, through periodic downloads from an MCO, provider, or hospital source, or through contracts arranged with data warehouses. In mining data to improve population health, there are a number of publicly available resources that can offer insights into the community and/or provide benchmarks for initial quality measurement. These include the Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute's County Health Rankings and Roadmaps (www.countyhealthrankings.org), the Agency for Health Care Research and Quality (AHRQ) (www.ahrq.gov/data), and the Centers for Disease Control and Prevention (CDC) (www.cdc.gov).

Rutgers Center for State Health Policy Data Book

A data book prepared by the Rutgers Center for State Health Policy (CSHP) and funded by The Nicholson Foundation, examines specific patterns of hospital utilization for residents of Camden, Newark, Trenton and 10 other low-income communities to identify opportunities to improve care and reduce costs. The utilization measures, based on hospital discharge data over 2008-2010, include rates of: (1) avoidable, ambulatory care sensitive, inpatient hospitalizations; (2) avoidable/preventable treat-and-release ED visits; (3) inpatient high users; (4) ED high users; and (5) 30-day all-cause readmissions. The data book provides information on the demographics and health insurance sources of these patient populations, as well as estimates of savings from reduced costs if each study region were able to emulate the best performing region among them. More information is available at www.cshp.rutgers.edu/MedicaidACO.

Collecting, Storing, and Linking Data

Initially, the most important use of data will be to identify patients with unmet clinical needs. Information about essential data elements that the ACO will need for this task is provided in Exhibit 12.

EXHIBIT 12: Essential Data Elements

Element	Purpose(s)	Source(s)
Age	Risk adjustment	Enrollment, uniform billing, claim files
Sex	Risk adjustment, care targeting, data linkage	Enrollment, uniform billing, claim files
Name	Data linkage/identification of repeat utilization	Enrollment, uniform billing, claim files
Date of birth	Data linkage/identification of repeat utilization	Enrollment, uniform billing, claim files
Social Security number	Data linkage/identification of repeat utilization	Enrollment, uniform billing, claim files
Diagnosis codes	Identification of preventable use, risk adjustment	Uniform billing, claim files
Procedure codes	Identification of over or under use of services	Uniform billing, claim files
Inpatient days	Resource use, identification of preventable utilization	Uniform billing, claim files
Intensive care unit days	Resource use, identification of preventable utilization	Uniform billing, claim files

ACO coalitions may begin collecting hospital inpatient admissions data at first to identify chronic preventable utilization. It will be important to establish a frequent data feed of patient-level hospital administrative records

and to make use of available ambulatory care and pharmacy data to uncover important gaps in care. Although it is possible to conduct a rough needs assessment without this information, it is essential for evaluating care management opportunities. Publicly available hospital billing data can be useful for an initial community-level assessment, although these data do not support analysis of utilization patterns of individual patients. Claims data that can be obtained from MCOs is another useful source of data. A data-sharing protocol with MCOs can be arranged in conjunction with the ACO's gain-sharing agreement with the MCO.

ACOs will also need to know whether they will store/access data in: (1) an offline database; (2) an external HIE; (3) an internal HIE; or (4) some combination of these. If the ACO participates in an HIE outside of its control, it will need to make sure that the HIE remains connected to the ACO's data feed and complies with HIPAA and state privacy regulations. However, if the ACO hosts its own HIE or has an offline database (which is not real-time), it will need to store the patient data itself. This endeavor requires a much greater effort than simply sharing data with an HIE, because storing and securing the data becomes the ACO's responsibility.

Once the data is stored, patient records should be linked to track individual patients over time. Linking multiple records associated with a single patient is fairly straightforward when a consistent identifier exists for all patients such as correctly coded name, date of birth, and/or Social Security Number (SSN). Unfortunately, most administrative databases are subject to errors of completeness or accuracy in these identifiers. Therefore, more sophisticated linkage methods are often needed to link records for the same person with inconsistent identifying information (e.g., John versus Jon or SSN with two adjacent digits transposed).

Data Analysis

Once data has been received and linked, the ACO can analyze it on both an individual level, to improve care and develop care management best practices, and on a population level, so it can generate statistics and determine the ACO's impact on the community as a whole.

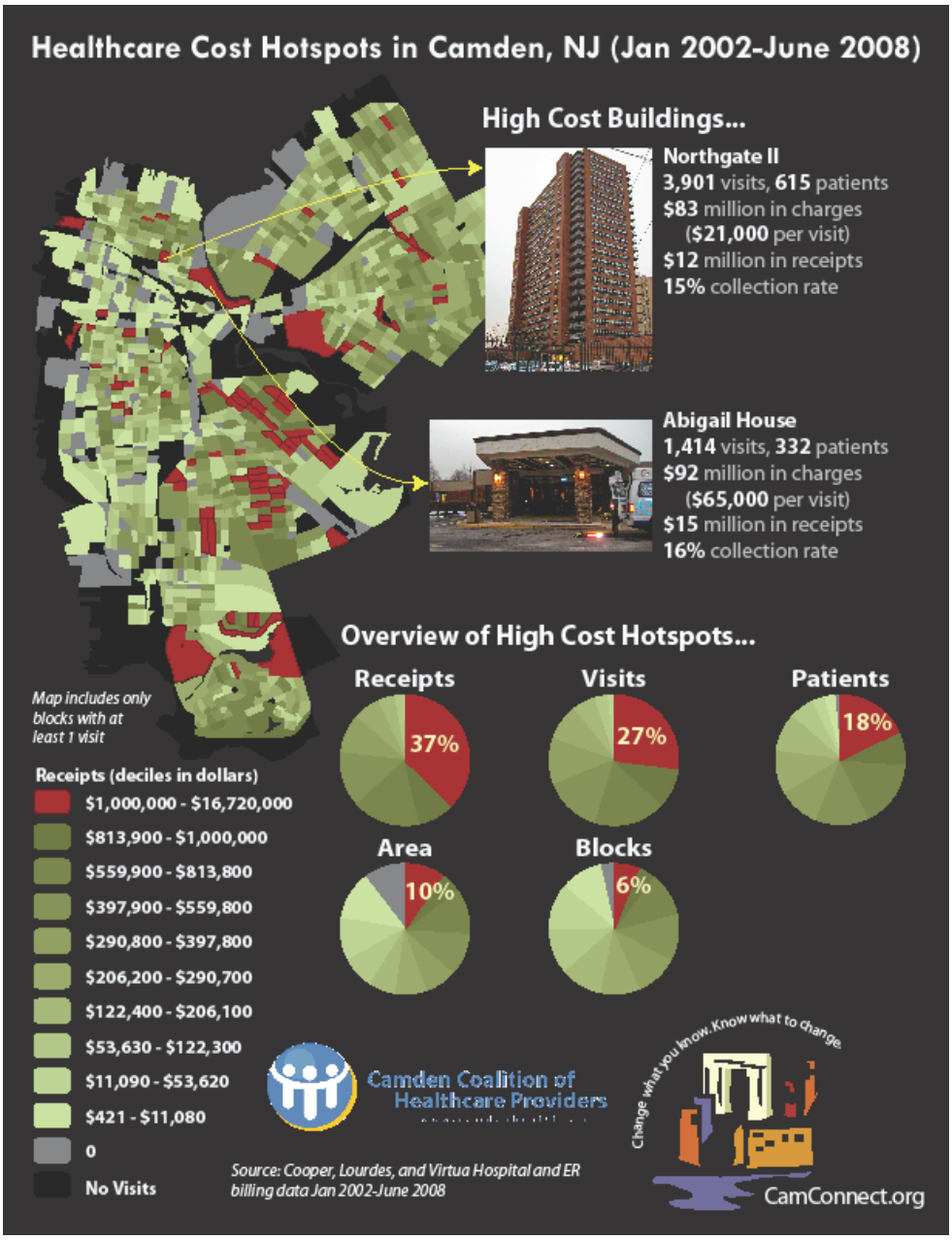
Patient-Level Analysis

There are many types of analyses that can give ACOs greater understanding of individual patients. One promising approach for identifying patients likely to benefit from care management is to identify hospital "super-utilizers." Because of the high cost of inpatient care, it may be most effective to target care management to patients with repeated inpatient admissions (e.g., three or more inpatient stays over six months), as opposed to patients who do not use much inpatient care but rely on emergency departments for routine care. Finding and reaching inpatient super-utilizers may require access to hospital databases, such as billing records. With appropriate provisions to safeguard protected health information under HIPAA (e.g., business associate agreements with hospitals), ACOs can work with identified hospital data. Screening for inpatient super-utilizers using diagnostic or other information may also be needed to apply ACO care management resources. This data can be used for tracking and reporting, both internally, to gauge the overall impact of the interventions on the community through cost and utilization, and externally, to produce comparisons of the ACO's patients with the population as a whole.

Population-Level Analysis

A useful technique for assessing population-level data is a "hot-spotting" analysis. This analysis involves geo-coding and mapping of care utilization data to uncover geographic areas where care coordination may be effective in improving health and reducing costs This may be done by mapping rates of preventable hospitalizations or other indicators across subsets (e.g., zip codes, census tracts) of the ACO's geographic area. In this type of analysis, it is important to look for consistent patterns over several years to avoid random fluctuations. To begin, ACOs may use simple mapping tools and add greater sophistication at later stages. An example of a hot-spotting analysis done by CCHP is shown in Exhibit 13.

EXHIBIT 13: "Hotspotting" Example



Methods to Benchmark Data and Gauge the Success of the Intervention

ACOs will need to benchmark their performance against an external standard to understand whether care coordination is having the desired impact. While benchmarking is a necessary part of evaluating ACO activities, determining how to compare the ACO's performance to the benchmark can be challenging. Evaluation of ACO performance requires a counterfactual comparison – i.e., a measure of what would have happened in the absence of redesigned care under the ACO. Ideally, the ACO would compare its performance to a similar population of patients who do not receive the same care management interventions. This may be feasible with some hospital use indicators, but in other cases, a rigorous comparison group will not be available or practical.

A middle ground might be achieved by comparing performance within the ACO to a statewide trend. This approach was recently proposed by the Rutgers Center for State Health Policy to DHS to evaluate whether Medicaid ACOs have reduced per capita spending under the New Jersey Medicaid Accountable Care Organization Demonstration Project.[vii] The ACO can also use the public data sources mentioned earlier in this section for this purpose. Over time, the ACO can use its past performance as a benchmark for measuring future success.

Familiarity with IT Infrastructure, Software, and Tools Needed to Obtain the Data

An ACO must have the proper infrastructure in place to collect, share, and analyze data. Not every ACO will have the same data needs, or the same ability to analyze and store data at its launch. Therefore, it is important for potential ACOs to identify their data capabilities and needs prior to setting up an IT infrastructure and as part of the work plan efforts. At a minimum, an ACO needs access to an internal, offline database that can store and analyze data and a data-savvy person to analyze and report the data.

ADVANCED ELEMENTS

An effective data analysis and IT infrastructure is the foundation of any successful ACO, though a successful ACO does not require a fully-functional, advanced IT infrastructure from day one. Costs for a full-fledged HIE and data analysis operation are prohibitive, and almost certainly must be phased-in. This section describes techniques and strategies that an ACO can employ to refine its data and IT infrastructure and build on it over time.

Advanced Data Collection and Links

While an ACO can begin care coordination efforts with offline hospital data, ultimately, ACO care management teams will need much more granular and comprehensive data specific to their communities and patients. While charity care and claims data are good short term data sources, HIEs and HIOs can be valuable portals for accessing richer datasets.

Data Management in Camden

CCHP analyzes patient-level data to identify super-utilizer patients through the Camden Health Database and the Camden HIE. Using the database, CCHP collects inpatient and ED claims data from all three city hospitals (Cooper University, Our Lady of Lourdes Medical Center, and Virtua Health Camden), cleans the data, and performs a probabilistic match to link patient records. The database also allows CCHP to obtain population data to perform hot-spotting and geo-mapping, calculate useful data measures such as average cost and visits per patient, and produce data fact sheets. CCHP is able to combine real time data from the Camden HIE with historical data and use algorithms to identify super-utilizer patients, comparing those who were recently hospitalized to their previous hospitalization history. Once these patients are identified, a care team is assigned and more detailed information is collected through home or hospital visits to determine the intervention strategy.

Collecting data on care management activities will enable ACOs to: (1) track care management services provided to individuals and populations over time; (2) measure the impact of those activities; (3) manage the care team more effectively; and (4) refine the care management model over time. For example, CCHP uses its care management software, which it developed using the online application building tool TrackVia (www.trackvia.com), to input triage information, care management intake data, risk stratification data, and care

management activities. CCHP also uses an EHR to document clinical notes. Further information on the role data plays in care management activities can be found in Section 2.4.

Advanced Aspects of IT Infrastructure and Software

As an ACO begins to move toward more sophisticated data analysis to drive its interventions, its leadership will need to ensure that the ACO has uninterrupted real-time HIE access, a functional EHR, and the personnel to ensure that data exchange and analysis runs effectively.

HIE Access

New Jersey is currently planning a statewide exchange of patient health records, through its New Jersey Health Information Network (NJHIN), which will be supplied by a federated system of regional HIOs. Each ACO must decide whether to "build" a new HIE or "borrow" access by partnering with an existing HIE. Camden has a city-wide exchange that functions as its own HIO and Trenton hopes to have its HIO functional by the end of 2013. Both of these exchanges will feed directly into the NJHIN. While an ACO should certainly consider building its own exchange, it may be more practical for most ACOs to feed directly into an established HIE initially, such as a hospital system's established HIE or a partnership with a regional HIO, given the significant start-up costs. Once the ACO is more familiar with the data collection process and the best ways to store, manage, and analyze its data, it can then consider whether to operate its own exchange. The benefits and drawbacks of these two options are listed in Exhibit 14.

EXHIBIT 14: Benefits and Drawbacks of "Building" or "Borrowing" HIE Access

Issue	Discussion of Benefits and Drawbacks
Access to data	Access to data should be the same whether the ACO decides to build an HIE or borrow its HIE access. Both options will allow the ACO to feed into the NJHIN and exchange patient EHRs with other HIEs and HIOs.
Content control	If an ACO borrows its HIE access, it loses control over the type and quality of information exchanged. If the ACO builds its own HIE, it will be able to dictate how, and what type of data is tracked. For example, an ACO-designed HIE may have more discrete fields and fields that target specific populations. These potential fields can allow the ACO's data analysts to sort, filter, and aggregate population data.
Flexibility	Building its own HIE will allow the ACO to modify its data fields and content "on the fly." For example, if the ACO discovers that there is a correlation with access to a pharmacy within a five-block radius and adherence to a prescription drug regimen, it could create a check box to house this data and chart future impact. If the ACO borrows access to an HIE, however, the HIE administrator would have to make this change, which could be cumbersome and less timely.
Cost	There are prohibitive costs associated with building an exchange. While gaining access to an HIE is virtually free for providers with a compatible EHR in place, building an HIE requires the purchase of servers, records management and security software, and personnel to administer the HIE, as well as assure access to participants.

Electronic Health Records (EHR) Software

HIEs share information obtained from EHRs. Yet, fewer than 42 percent of New Jersey office-based physicians used an EHR system in 2011,[viii] though nearly 3,000 additional providers went live with their EHR systems between January 1, 2012 and March 31, 2013.[ix] Many other New Jersey providers are interested in converting to EHRs, but many practices may find the administrative and training costs prohibitive. There is still, however, grant money available from the American Recovery and Reinvestment Act of 2009 (ARRA) to help providers make the conversion. More information about this funding opportunity can be found at www.healthit.gov. In addition, the State's Regional Extension Center, NJ-HITEC, located on the campus of the New Jersey Institute of Technology, is available to assist practices in converting to EHRs and achieving meaningful use. The guidance is free of charge for PCPs who qualify for the ARRA federal incentive program and up to 500 specialists or subspecialists that request services. More information can be found on NJ-HITEC's website: www.njhitec.org.

The ACO may consider recommending EHR software for its providers. The choice of an EHR software will depend on how an ACO plans to implement its HIE access. A guide to considering these options is shown in Exhibit 15.

EXHIBIT 15: EHR and Records Management Software Considerations Chart

Consideration	Reasoning
Functionality	Functionality is the most important aspect that ACOs will need to consider when purchasing an EHR and/or records management software. Features to consider include: - Electronic registry system - Collaboration capabilities - Workflow engine - Data analytic capabilities - Clinical decision-making tools - E-prescribing functionality - Patient personal health record access
Ease of use / interface	Ease of use and an intuitive interface is another critical component of EHR or records management software. If the ACO personnel are not comfortable using the software, it could lead to erroneous record-keeping practices and flawed data.
Discrete fields	Discrete fields are an important factor to guide the efficiency and reliability of EHRs. While many EHRs offer text-based fields allowing open-ended responses for clinical personnel, this encourages responses that are not searchable or countable. Therefore, an EHR that has the majority of fields as drop-down menus, check boxes, or other discrete fields, is preferable.
Interoperability with regional, state, and federal information exchanges	An EHR and a records management software package must be interoperable with both the regional HIOs, the New Jersey Health Information Network, and the federal information exchange that is under construction. While most EHR and records management software applications are interoperable these days, this could be a very costly mistake if overlooked.
Security	Security is always a concern when patient medical records are being transmitted and accessed electronically. The records management software will have password-protected access and may have some sort of security-enhancing application. Even more important, however, is that the database is stored on an isolated, secure server, so software security is not an issue. If the ACO plans to construct its own HIE, security for the HIE servers becomes a much more important concern, as it must be connected to the internet to operate.
Cost	Cost is a key factor in deciding whether to purchase an EHR and/or records management software and what system to purchase. To keep costs down, ACO leaders should look for a package that offers the core functionality needed by the ACO without unnecessary "bells and whistles." Records management software can usually be purchased "off the shelf" or as a customized version. While customized applications are usually more expensive, they may offer the optimal array of features.

Personnel

To effectively develop and maintain an ACO's data infrastructure and analysis capabilities, the organization must hire personnel to carry out these duties. CCHP currently has three people on its data and analytics staff:

1. **Director of Research and Evaluation** – Oversees data collection, management, and analysis. Responsible for the ACO's overall data strategy and for devising methods to facilitate data exchange between providers

and the ACO, as well as collect data that can be analyzed to identify patients, show trends, and reveal other individual and population-level insights.

2. **Data Analyst** – Cleans the incoming data, summarizes the data, and writes code to process the data. This is an ongoing process as new data elements are added to the ACO's data feed. The data analyst also helps with public reporting, fact sheets, and visualizations.

3. **Evaluation Manager** – Builds the data collection infrastructure to help monitor and report on program processes and outcomes.

While these personnel are critical for serving essential data functions, the ACO does not need to have a large IT staff to begin analyzing data. An ACO may begin its data analysis efforts with a single, dedicated employee, though it will likely require more data-related personnel in the future.

ADDITIONAL RESOURCES

County Health Rankings and Roadmaps
www.countyhealthrankings.org

Data Sources
Agency for Healthcare Research and Quality
www.ahrq.gov/data

Centers for Disease Control and Prevention
www.cdc.gov

Linking Client Records from Substance Abuse, Mental Health and Medicaid State Agencies
U.S. Department of Health and Human Services (July 2001)
www.nri-inc.org/projects/OSA/Protocol/AppendixB.pdf

Instruments
Medical Outcomes Trust
www.outcomes-trust.org/instruments.htm

TrackVia
www.trackvia.com

Office of the National Coordinator for Health Information Technology
www.healthit.gov

NJ-HITEC
www.njhitec.org

Post-Hospitalization Mortality: Linking Methods
Thomson Reuters (2008)[x]

2.4 Improving Care Delivery

TOOLKIT BLUEPRINT

Read this section to learn how to design care management approaches to address individual patient and population-wide needs in your designated ACO area.

CONCEPTUAL MILESTONES

- ✓ The ACO understands the importance of care coordination and has a plan to develop a care management strategy.
- ✓ The ACO has the desire to develop a care management strategy.

ESSENTIAL MILESTONES

- ✓ The ACO has identified some patients who will potentially benefit from care management. It has at least one internal care team or an external care team that works with the ACO.
- ✓ The ACO has developed a care management framework that identifies patients and provides them with the opportunity to enroll in care management services and build a relationship with a PCP.

ADVANCED MILESTONES

- ✓ The ACO has its own multidisciplinary care team(s) and a robust method of identifying patients that would benefit from care team interventions. It actively coordinates with hospitals, FQHCs, and its own data analysts to identify patients and track patient progress. Care teams also have access to community resources such as food pantries and homeless shelters to help patients with non-medical, health-related problems.
- ✓ The ACO has a comprehensive care management strategy and tools to help identify and stratify patients such as intake forms, health risk assessments, and other needs assessment tools. There is also a care management timeline that assesses patients from intake, to stabilization, and eventually, graduation. The care teams meet patients where they are, and communicate actively with patients' PCPs; if the patients' do not have a PCP, the care teams help to facilitate a relationship with one.

CONCEPTUAL ELEMENTS

Traditionally, health care services are provided at physician's offices and in hospitals in a fee-for-service payment arrangement, but this model has been challenged as inefficient and a primary cause of rising health care costs. Often, a patient's PCP will not be informed when a patient is seen in the ED or has an inpatient hospital stay, either because of poor records management, lack of communication during transitions of care, or, in many cases, because the patient does not have a PCP.

Employing effective care coordination techniques can help Medicaid ACOs meet patients where they are and help manage their overall health, rather than treating symptoms as they arise. This improved coordination should reduce the burden on ED and inpatient care settings and lead to operational efficiencies that can result in significant cost savings.

ESSENTIAL ELEMENTS

An important goal of improving care delivery is to ensure that patients get the right care, at the right time, in the right setting. ACO care teams can help stabilize individuals who may have complex care needs, face complicated social challenges, and/or do not have an established primary care or behavioral health relationship. The teams strive to coordinate care across providers, increase access to timely care, promote self-management skills, engage the patient and his/her family in care, and establish (or re-establish) individuals' relationships with his/her primary physician. Within an ACO, these care coordination efforts may happen virtually, or through care team visits at a provider's office or in a patient's home.

An ACO can improve care delivery by: (1) identifying populations and patients who can benefit from enhanced care coordination and intensive care team interventions; (2) encouraging effective care coordination; and (3) building a care model and workflow that will help accomplish the ACO's objectives. These elements can support care coordinators and care teams in providing targeted care to the patients who need it most, while offering the appropriate level of care for those who may not need as intense an intervention.

Identifying Populations and Patients

One core element of care management is to identify the target population of patients who can benefit the most from care management interventions. Research suggests that care management efforts are most likely to generate cost-savings if they can accurately target individuals at high risk of future hospitalizations.[xi] Targeting these groups may be accomplished through data analysis, provider referrals, or utilization of health risk assessment tools.

Since resources will be limited, especially at the outset, the ACO should focus care team efforts on high-intensity interventions for a limited number of its highest-cost patients who are likely to benefit from care team interventions, rather than spreading the care team's efforts too thinly. Most individuals who require low-intensity interventions can benefit simply from establishing or enhancing a relationship with a PCP and do not need face-to-face interventions with a care team.

Promoting Effective Care Coordination

For an ACO to achieve effective care coordination in the community, it must have care teams composed of the right individuals, timely access to data, and support from the community. Depending on the ACO's population needs, teams can be tailored to serve particular patient populations and health conditions, and/or intervene at different intensity levels. Care teams are typically small, multi-disciplinary groups of two to five individuals with different areas of expertise. This structure ensures that there is always someone on the team to address varying patient needs. Care teams may include some combination of:

- Registered nurse or nurse practitioner;
- Social worker;
- Behavioral health counselor;
- Medical assistant;
- Health coach; and/or
- Lay health worker (e.g., community health worker, patient advocate, promotora, or peer support specialist)

External Care Teams are an Option

CCHP has performed successful interventions with care teams that work directly for the coalition. However, using hospital-provided care teams at the outset is a viable option for ACOs that may not have adequate initial funding. THT started its program by coordinating visits from care teams from two affiliated hospitals in Trenton – Capital Health Regional Medical Center and St. Francis Medical Center – before recently establishing its own care management team.

Community-based organizations can also be strong partners with care teams in delivering better care. Support from such organizations can help address the social, cultural, economic, and environmental barriers preventing patients from pursuing timely preventive care and successful self-management or healthy behaviors, which is essential to achieving improved clinical and cost outcomes.

Building a Care Model and Workflow

ACO leadership must develop a care model and workflow. Having an established written plan, with well-defined roles and responsibilities, is key to having the care management team function as a cohesive unit and understand the common expectations and intended outcomes of their interventions. One effective approach to building a care model is to start with one super-user patient and dig deeply with that patient. Understanding this "hardest case" by identifying his or her goals, history, barriers, and motivations can give great insight into not only how to build an intervention for the patient, but also provide guidance to an eventual care team model for the community, and the individual patient care plans that will result from the care model.

Another way to foster the development of an appropriately tailored care model is by addressing basic questions regarding outreach, patient engagement, patient assessment, provided services, and evaluation. Sample questions can be found in Exhibit 16.

EXHIBIT 16: Questions to Determine Care Model and Workflow

Outreach
▪ What strategies will the care team use to outreach to and engage the target patient population? ▪ Which member of the care team will do the initial outreach to individuals? Will the team include dedicated outreach staff?
Patient Engagement
▪ What will be the mode and frequency of contact with patients once they are engaged? For example, will the care team make home visits?
Patient Assessment
▪ What tools will be used to conduct needs assessments? How will these be administered? ▪ What tools will the team use to help the patient identify and move toward appropriate goals for care management? How will the team track movement towards these goals? ▪ Which member of the care team will be responsible for which interventions? ▪ How will the team document and share information gathered during its efforts? For example, will the team meet regularly to review and discuss cases and strategies? ▪ How will the team determine if care management is no longer necessary for a particular patient?
Necessary Services
▪ What range of patient needs will the care team address? For example, will the team help patients gain access to housing, jobs, income, other non-medical services and supports? ▪ What relationships (and potentially data-sharing agreements) will be developed with other local providers and community-based resources/supports? ▪ How will the care team involve the patient and family members in decision-making? ▪ How will the care team link the patient to behavioral health services and supports?
Evaluation
▪ How will the ACO know if interventions are making an impact? ▪ How will an ACO know if/when it is necessary to make changes to the care model/workflow and try a new strategy? ▪ What specific types of metrics (e.g., process measures, satisfaction surveys) should be captured from the start to assess whether changes are necessary?

ADVANCED ELEMENTS

Techniques to Identify Populations and Patients

As mentioned earlier, the three primary methods to identify populations and patients are data analysis, referrals, and health risk assessments. Of these three methods, all can be used to identify patients who can be targeted for interventions, but population-level identification can only be reliably achieved through data analysis. Referrals and health risk assessments are addressed below, while data analysis is discussed in Section 2.3.

Referrals

Once the ACO is a recognizable entity in the community, PCPs or hospitals may refer individual patients whom they believe could benefit from more effective care management and care coordination to the ACO. Patients referred might include those who are frequently admitted to the hospital for recurring medical issues, seen in the ED for avoidable or unnecessary care, or those with chronic conditions whose needs are not being met. However, the ACO will need to develop policies and procedures around how to handle referrals, especially for patients who do not meet the defined criteria for inclusion in care management activities, to ensure that patients in the ACO can truly be helped by care interventions.

Health Risk Assessments

A health risk assessment can provide critical insights into an individual's need for care management by identifying a patient's immediate medical, behavioral, or social needs and their relative urgency. The assessment can be used to stratify patients into subgroups or risk tiers. Assessments can be conducted in a variety of ways (such as verbally by a care coordinator or through a written self-assessment) and at different times (such as upon enrollment, or once every six months). While an ACO may consider developing its own assessment, there are many effective tools available that can serve as appropriate templates. There may, however, be an advantage to using more than one assessment tool – for example, a brief tool for an initial consult, a more lengthy assessment tool for a more in-depth discussion with the individual, and a re-assessment tool used over the course of the intervention.

Self-assessment tools can be an easy way to gain key information about a patient's health, but they also have drawbacks. For example, self-reported "poor" health status, low perceived control over one's own health, and lack of social supports are key indicators of future risk, and can help differentiate individuals with seemingly similar diagnostic profiles. However, self-administered tools lack the personal connection that is made when a health risk assessment is made by a care coordinator, who may be able to clarify questions, ensure completion of the survey, help with language barriers or health literacy issues, and start building a relationship with the patient.

Risk Assessment Tools from Camden

CCHP uses three health risk assessment tools to assess potential patients for care management activities: (1) a triage data collection form, which combines data from its HIE and data analysis to identify patterns in ED and inpatient visits as well as chronic conditions and risk factors; (2) a pre-enrollment/risk-stratification tool, administered by a care coordinator at the patient's bedside during an inpatient encounter; and (3) an intake form, which is a self-assessment form used during the patient's first home visit. These three tools can be found on the program resources page of CCHP's website, www.camdenhealth.org.

Effective Care Coordination Strategies

While certain aspects of any care coordination process will depend on trial and error, the strategies used by CCHP and THT have already shown positive results, and may merit replication in other New Jersey ACOs.

Care Coordinators

Care coordination can be performed by a variety of staff members, including medical personnel (PCPs, nurse practitioners (NPs), registered nurses (RNs)); non-traditional health care workers including community health workers (CHWs); community organizations; or non-licensed clinical office staff. Although PCPs must be involved in care coordination activities, the PCP can merely serve as the point of accountability for the patient, while day-to-day coordination can be performed by others. Further, it is important to note that the ACO care coordination teams will likely not be the only care coordination services available in the designated area. As a result, the ACO care teams should be able to effectively work alongside existing or planned teams in the community's provider or social services locations.

THT's Community-Wide Clinical Care Coordination Teams

Often, patients who frequent hospital emergency rooms are in need of a primary care provider and/or some assistance in resolving social concerns such as homelessness, substance abuse, or behavioral health issues. THT's Community-wide Clinical Care Coordination Team (C4T) is composed of physicians, care managers, nurses, and social workers from the THT partners, as well as representatives of community behavioral health and social service agencies. THT takes a holistic approach in looking at recurring users of emergency rooms. It brings together care managers and clinical staff from area hospitals, the Henry J. Austin Health Center, and community partners, such as Mercer Alliance to End Homelessness, Greater Trenton Behavioral Health, Catholic Charities, and the Rescue Mission of Trenton to connect individuals to care in the community. These efforts have been successful in reducing non-emergent visits to the EDs of St. Francis and Capital Health System.

In addition to coordination with care providers and existing care teams, each community must not only manage services with hospitals, PCPs, FQHCs, and patients, but also with the local health department, housing services, and social services in the designated area. A monthly, city-wide meeting of the ACO with the health and social services organizations can be effective in building these partnerships and addressing patient needs.

Advanced Access Scheduling

THT has worked with the outpatient clinics to implement Advanced Access Scheduling, a care delivery model developed by Mark Murray, MD, MPA. Dr. Murray's model used data to determine the optimal number of patients each physician in the city's seven clinics could reasonably handle while ensuring that the physician also had time available for patients who needed same-day visits. In this approach, all patients are assigned their own doctors. Since the Trenton clinics implemented the new model a year ago, appointment wait times are shorter and consistency of care has improved since patients are seeing the same physician. This approach leads to increased efficiency because when a provider or team is familiar with patients and their health issues, the visits are shorter.

Working with Community-Based Organizations

Community-based organizations bring their local expertise and experience to engage the patients and communities that ACOs will serve. Additionally, these organizations can potentially act as "staff extenders," helping the care team link patients to a wider range of health and social services, educate patients and families, provide culturally-appropriate communication, and facilitate activities in convenient locations such as schools, workplaces, religious sites, and recreational centers.

Care coordinators seeking partnerships with community organizations will need to set mutual goals and identify areas for collaboration. Such activities will include jointly identifying community needs; finding local champions; developing trust through shared responsibilities; gathering continuous community feedback; and finding vehicles to evaluate, sustain, and celebrate partnership progress.

How to Build a Beneficial Care Model and Organize Workflow

Stratification of Patients

The ACO may opt to use the information gleaned from its health risk assessment and other data to stratify patients into subgroups either by type of services or the level of intensity of services they need. For example, stratification might group people with similar medical, social, or behavioral health needs, which will allow the team to more appropriately target and/or prioritize outreach and interventions. The team can stratify patients by identifying patient characteristics that warrant a specific care team approach. For example, patients who are at high risk may be assigned to a more comprehensive care team, with more intensive interventions, and/or for a longer period of active engagement than patients at moderate risk. However, stratification may not work for all communities. CCHP, which had previously used a stratified structure to identify "high risk" and "moderate risk" patients, has recently shifted away from a stratified model in favor of a single patient intake stream.

Patient Engagement

Whether the ACO chooses to stratify its identified super-utilizer patient population or not, care coordination should engage patients in a meaningful way and foster partnerships with the community. Outreaching to individual patients is an ongoing effort that will include meeting the patient where he/she lives and/or receives care and services. Patients targeted for care management may have insufficient or outdated contact information; unstable housing; negative experiences with the health care system; unstable relationships; complex medical needs; a mental health and/or substance abuse condition – all factors that could make contacting and engaging them very difficult. They may also have challenges related to language, culture, and health literacy that can make engagement even more difficult.

To effectively engage patients, the care team should ensure that: (1) patients are able to access their provider and/or care teams whenever necessary; (2) patients have regular channels to provide feedback to the care team; (3) patients' values – and those of their families and caregivers – are respected in care and treatment decisions; and perhaps, most importantly, (4) patients are treated – and see themselves – as part of the care team. Other strategies to consider include using community health workers or peer support specialists who live in the same communities as the patients, as well as employing a motivational interviewing approach to patient engagement. Motivational interviewing is a patient-centered method of engagement and ongoing communication that is based on meeting patients in a comfortable, familiar environment, addressing goals defined by the patient, and gradually helping patients identify and work toward more ambitious goals. The use of a care plan can also facilitate patient engagement through the formal tracking of progress around mutually agreed upon goals and tasks.

Developing a Care Plan

One critical component of the care model is a care plan, which is a documented game plan that will be used by all members of the multi-disciplinary team. The personalized care plan is developed with ongoing input from the patient and potentially from his/her family or chosen caretaker. The care plan maps out the patient's needs, goals for care management, key actions taken, and other important milestones. The care plan is kept up-to-date by the care team as the patient's needs and goals change. Each patient's care plan will be based on the ACO's care model template. A care plan template used by CCHP can be found at www.camdenhealth.org.

Stabilizing and Graduating Patients

Eventually, individuals who are well-served by the ACO care team will no longer need high-touch care management, and the care team will need to consider if, when, and how to transition individuals off interventions. The team should consider its transition strategy so, over time, patients can be stabilized and moved from intensive one-on-one care management supports to an ongoing relationship with a primary physical or behavioral health provider and possibly a lower-touch service. Identifying measures to indicate when the patient is stable from a medical and/or social point of view (e.g., regularly attends PCP visits, achieved care plan goals, reduced inpatient or ED use, obtained stable housing, etc.) is one way to determine stabilization and graduation.

CCHP's Care Management Intervention Timeline

CCHP has developed a comprehensive Care Management Intervention Timeline, which includes patient identification, classification, and graduation protocol, which its care teams follow through the cycle of patient care. This document is available at www.camdenhealth.org.

Additional Resources

The Promise of Care Coordination: Models that Decrease Hospitalizations and Improve Outcomes for Medicare Beneficiaries with Chronic Illness
Mathematica Policy Research, Inc. (March 2009)
http://www.nyam.org/social-work-leadership-institute/docs/N3C-Promise-of-Care-Coordination.pdf

Motivational Interviewing
www.motivationalinterview.org

Revamped Scheduling Systems Promote Access, Reduce No-Shows, and Enhance Quality, Patient Satisfaction, and Revenues in Primary Care Practice
Agency for Healthcare Research and Quality Health Care Innovations Exchange
http://www.innovations.ahrq.gov/content.aspx?id=1856

Complex Care Management Toolkit
California Quality Collaborative (April 2012)
http://www.calquality.org/documents/CQC_ComplexCareManagement_Toolkit_Final.pdf

Improving Chronic Illness Care
www.improvingchroniccare.org

Reducing Care Fragmentation: A Toolkit for Coordinating Care
The Commonwealth Fund (2011)
http://www.improvingchroniccare.org/downloads/reducing_care_fragmentation.pdf

Resources for Linking Clinical Practices and Community Organizations to Improve Care
Agency for Healthcare Research and Quality Health Care Innovations Exchange
http://www.innovations.ahrq.gov/linkingClinicalPractices.aspx

Building Teams in Primary Care: Lessons Learned
California HealthCare Foundation
http://dttac.org/services/health_systems/pdfs/BuildingTeamsInPrimaryCareLessonsLearned.pdf

2.5 Ensuring Quality Improvement

TOOLKIT BLUEPRINT

Read this section to understand New Jersey's requirements for ACO quality reporting and measurement and learn how to develop a continuous quality improvement strategy.

CONCEPTUAL MILESTONE

- ✓ The ACO recognizes the New Jersey-required core and voluntary measures and has the means and infrastructure to track and report them.

ESSENTIAL MILESTONE

- ✓ The ACO has the capability to report the New Jersey-required core and voluntary measures and plans to add additional measures that will benefit the ACO's care management activities.

ADVANCED MILESTONE

- ✓ The ACO currently tracks not only the New Jersey-required core and voluntary measures, but additional measures that benefit the ACO's care management activities. These measures are tied to gain-sharing payments, and the ACO also fosters communication between care teams, data analysts, PCPs, and its board of directors to encourage quality improvement initiatives.

CONCEPTUAL ELEMENTS

New Jersey Medicaid ACOs are charged with improving health care quality in their communities, and must document these improvements to the state. Improving quality not only involves enhancing health outcomes for individuals served by the ACO, but also includes making a positive impact on population health, assuring effective and efficient health care processes, and reducing unnecessary utilization of health care services.

To evaluate the ACO's impact on quality, relevant metrics should be universally applied to track improvements or shortcomings in care delivery, total cost of care, resource utilization, patient outcomes, patient satisfaction, and the use of evidence-based processes. However, since care teams must also be able to track results that are not easily measured by metrics, such as a patient's health care knowledge or nutritional habits; ACOs should also consider developing mechanisms outside of explicit reporting of quality metrics to assess quality improvement progress.

ESSENTIAL ELEMENTS

Required Core Quality Measures

New Jersey requires ACOs to measure and report a core set of 21 quality measures on an annual basis. There are six domains: (1) Prevention and Effectiveness of Care; (2) Acute Care; (3) Behavioral Health; (4) Chronic Conditions; (5) Resource and Utilization; and (6) Patient Experience. A list of these measures can be found in Exhibit 17.

EXHIBIT 17: Core Quality Measures for ACOs

Prevention and Effectiveness of Care
▪ Screening for Clinical Depression and Follow-Up Plan ▪ Annual Dental Visit
Acute Care
▪ Respiratory Syncytial Virus in Neonates <35 Weeks
Behavioral Health
▪ Initiation and Engagement of Alcohol and Other Drug Dependence Treatment ▪ Anti-depressant Medication Management
Chronic Conditions
▪ Annual Monitoring for Patients on Persistent Medications (year 2) ▪ Annual HIV/AIDS Medical Visit
Resource and Utilization
▪ Emergency Department Visits ▪ Inpatient Readmission Within 30 Days ▪ Preventable Hospitalizations ▪ Provider Visit Within 7 Days of Hospital Discharge ▪ Return to ED Within 7 Days of Hospital Discharge ▪ All Hospitalizations ▪ Percent of PCPs Who Successfully Qualify for EHR Incentive Payment
Patient Experience
▪ Getting Timely Care, Appointments, and Information ▪ How Well Your Doctor Communicates ▪ Patient's Rating of Doctor ▪ Access to Specialists ▪ Health Promotion and Education ▪ Shared Decision Making ▪ Health Status / Functional Status

Voluntary Quality Measures

New Jersey also requires ACOs to report six "voluntary" quality measures. While reporting six measures is mandatory, the ACO can select one measure from a list of 14 Prevention and Effectiveness of Care measures and five measures from the 25 Chronic Conditions options provided by the state. A list of these voluntary measures is provided in Exhibit 18.

EXHIBIT 18: Voluntary Quality Measures for ACOs

Prevention and Effectiveness of Care (select one)
▪ Childhood Immunization Status ▪ Adolescent Immunization ▪ Well Child Visits First 15 months ▪ Well Child Visits 3, 4, 5, & 6 years of age ▪ Adolescent Well Care ▪ Weight Assessment and Counseling for Children and Adolescents ▪ Frequency of Ongoing Prenatal Care ▪ Medical Assistance with Smoking and Tobacco Use Cessation ▪ Cervical Cancer Screening ▪ Colorectal Cancer Screening ▪ Tobacco Screening and Cessation ▪ Breast Cancer Screening ▪ Chlamydia Screening in Women aged 21-24 ▪ Prenatal and Postpartum Care
Chronic Conditions (select five)
Cardiovascular Disease ▪ Cholesterol Management for Patients with Cardiovascular Conditions ▪ Controlling High Blood Pressure ▪ Complete Lipid Panel and Low-Density Lipoprotein (LDL) Control ▪ Use of Aspirin or Another Antithrombic Medication ▪ Beta Blocker Therapy for Left Ventricular Systolic Dysfunction ▪ Drug Therapy for Lowering LDL Cholesterol ▪ Angiotensin Converting Enzyme (ACE) or Angiotensin Receptor Blockers (ARB) Therapy for Patients with Coronary Artery Disease (CAD) or Left Ventricular Systolic Dysfunction (LVSD)
Diabetes ▪ HbA1c Testing ▪ HbA1c Poor Control >9 ▪ HbA1c Good Control <8 ▪ LDL Screening ▪ LDL Control <100 mg/Dl ▪ Neuropathy Monitoring ▪ Blood Pressure Control <140/80 mmHg ▪ Eye Exam
Respiratory ▪ Use of Appropriate Medications for People with Asthma ▪ Medication Management for People with Asthma ▪ Use of Spirometry Testing in Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease (COPD) ▪ Pharmacotherapy of COPD Exacerbation
Resource/Utilization ▪ 30 Day Readmission Rate Following Acute Myocardial Infarction (AMI) ▪ 30 Day Readmission Rate Following Heart Failure (HF) ▪ 30 Day Readmission Rate Following Pneumonia (PNE) ▪ COPD Admission Rate ▪ Congestive Heart Failure (CHF) Admission Rate ▪ Adult Asthma Admission Rate

Demonstration Quality Measures

In addition to the core and voluntary measures, the state requires ACOs to report six demonstration quality measures. However, unlike the other groups of measures, these measures will not be included in gain-sharing calculations. These demonstration measures are listed in Exhibit 19.

EXHIBIT 19: Demonstration Quality Measures for ACOs

- Follow up After Hospitalization for Mental Illness
- Medication Reconciliation (year 2)
- Mental Health Utilization
- Transportation
- Referrals/Connections to Social Supports (housing, food)
- Identification of Alcohol & Other Drug Services

Tying Quality to Payment

The New Jersey Medicaid Accountable Care Organization Demonstration Project requires quality to be improved in order for gain-sharing payments to be made. Exhibit 20 shows how ACO quality improvement efforts will be evaluated during the demonstration.

EXHIBIT 20: ACO Quality Measurement Requirements by Year

Year	ACO Measurement Requirement
1	Reporting only, performance is not measured.
2	Relative performance improvement must be shown for at least two quality measures.
3	Relative performance improvement must be shown for at least five quality measures, and absolute improvement must be shown for at least two quality measures.

Tying quality to payment on the provider level can be accomplished through a variety of methods, including a quality threshold that providers must meet in order to receive gain-sharing distributions, or a payment scale that rewards exceeding quality objectives with a higher percentage of payments (e.g., if a provider achieves 25 percent above his or her quality target, he or she receives an additional percentage of gain-sharing payments above the standard payment).

The New Jersey Medicaid Accountable Care Organization Demonstration Project Draft Regulations also include the option of a phased approach where gain-sharing efforts could be focused on an identified subgroup of patients (e.g., diabetics). While the regulations do state that the shared savings must be identified for all Medicaid costs within the designated area by the final year of the demonstration, an ACO may choose to focus on a specific condition or population during the first year of the project. This phased approach may be an option for ACOs that have identified a specific high-need population in their designated area that is large enough to affect and measure savings. Additional aspects of linking quality and payment are discussed in Section 3.1.

Possible Additional Quality Measurement Requirements

In addition to the 21 required, six voluntary, and six demonstration quality measures that ACOs must report in the first year of the demonstration, New Jersey DHS may decide to include additional required, voluntary, or demonstration measures to be reported in years two or three that may or may not be tied directly to quality payment.

ADVANCED ELEMENTS

Additional Quality Measures

ACOs may want to track additional measures to get a clearer picture of what is working in their communities (proposed measures will be subject to review and approval by DHS). Adding more quality measures may not be as difficult as it may seem, since the infrastructure and data sources will already be in place for the required measures. In order to determine which additional measures to track, the ACO will need to identify the data needed and the feasibility of its collection. Additional measures should be evaluated based on: (1) the degree of validity and accuracy of the measures' baseline; (2) the degree to which the measures reflect the overall goals of the ACO; and (3) the degree to which the providers are able to impact those measures in the short term. In order to target feedback on interventions unlikely to produce results on a clinical level, but that would otherwise benefit the patient, ACOs might consider non-traditional quality metrics that speak to public health, patient satisfaction, and non-medical conditions outside the realm of the doctor's office such as chronic homelessness and inadequate nutrition.

There are many organizations that offer recommendations and assess the validity of recognized process, outcome, and patient experience measures. A list of some of these resources is listed in Exhibit 21.

EXHIBIT 21: Quality Measure Sources

Source	Description	Link
AHRQ (CAHPS)	The Agency for Healthcare Research and Quality has developed a number of health care quality indicators to help track clinical processes and outcomes. The agency also operates the National Guideline Clearinghouse, which evaluates the validity of its own quality measures and those produced by other groups. The Consumer Assessment of Health Care Providers and Systems is an AHRQ-produced list of patient experience measures, which is updated yearly. The data is easily comparable with other geographic and clinical areas, as AHRQ regularly produces surveys reporting national CAHPS performance.	www.ahrq.gov and www.cahps.ahrq.gov
CMS	The Centers for Medicare & Medicaid Services produces some of its own quality measures, it is best known for aggregating existing measures into its own recommended measurement sets. Among its most useful sets are the Medicare Shared Savings Program (MSSP) measures developed for Medicare ACOs and its core Medicaid quality measures, which directly affect the population targeted by ACOs in the New Jersey demonstration.	www.cms.gov
NCQA (HEDIS)	The Healthcare Effectiveness Data and Information Set (HEDIS) is produced by the National Committee for Quality Assurance, a nonprofit organization. HEDIS measures are tracked and reported nationally on an annual basis.	www.ncqa.org
NQF	The National Quality Forum is a nonprofit entity that acts as a clearinghouse for national standardized health care measurement sets. It is a trusted authority for evaluating the validity of quality measures and could be a good resource to evaluate the measures that an ACO is considering.	www.qualityforum.org

Quality Improvement Techniques

Many health care innovators have adopted a culture of continuous quality improvement and use routine measurements of quality indicators as part of an ongoing improvement cycle. Implementing a continuous quality improvement process includes identifying the following:

1. Who will be involved in target setting and at what frequency (i.e., monthly, quarterly)?
2. What measures have been identified as meaningful to track the ACO's progress?
3. How will performance be routinely monitored? What type of data collection is feasible on a routine basis (i.e., monthly/quarterly)?
4. How will this data review impact changes in care team activities and interventions with patients?

Routine and meaningful target setting is an important component of continuous quality improvement as it guides the care teams' daily activities. At least quarterly, ACOs should collect/measure current performance and compare to targets as well as nationally-recognized quality, utilization, and cost benchmarks to assess the

success of a given intervention. A core group of stakeholders, including front-line care team staff, should be involved in such discussions to ensure continuous improvements in existing care delivery processes.

Additional Resources
Institute for Healthcare Improvement **www.ihi.org**
Agency for Healthcare Research and Quality **www.ahrq.gov**
Center for Medicare & Medicaid Services **www.cms.gov**
National Committee for Quality Assurance **www.ncqa.org**
National Quality Forum **www.qualityforum.org**
Quality Improvement Methodology U.S. Department of Health and Human Services Health Resources and Services Administration **http://www.hrsa.gov/quality/toolbox/methodology/index.html**

Section 3: Constructing the ACO

3.1 Developing a Business Plan

TOOLKIT BLUEPRINT

Read this section to learn how to construct a functional business plan and create a sustainable ACO model.

CONCEPTUAL MILESTONES

- ✓ The ACO has decided to develop a gain-sharing arrangement, but will do so within a year of the start of the ACO demonstration.
- ✓ The ACO recognizes that it needs to develop a business plan that compares costs and revenues and measures the total cost of care (TCOC).
- ✓ The ACO has identified outside sources of funding and plans to approach them.

ESSENTIAL MILESTONES

- ✓ The ACO has either accepted the CSHP gain-sharing arrangement, modified it slightly to suit the needs of its community better, or established its own gain-sharing methodology.
- ✓ The ACO has developed a business plan with a total cost of care measurement, but does not have a gain-sharing arrangement in place.
- ✓ The ACO has access to limited start-up funding from its members, a foundation, or a federal or state program.

ADVANCED MILESTONES

- ✓ The ACO has either: accepted the CSHP gain-sharing arrangement; modified it slightly to suit the needs of its community better; or established its own gain-sharing methodology. It also has a gain-sharing arrangement with at least one MCO.
- ✓ The ACO has developed a business plan with a total cost of care measurement based on its gain-sharing arrangement.
- ✓ The ACO has access to significant start-up funding from its members, a foundation, or a federal or state program, as well as funding from a MCO.

CONCEPTUAL ELEMENTS

A business plan is an essential part of developing a Medicaid ACO. The ACO must be able to project future income and expenses in order to develop a budget for staff and infrastructure and guide the future development of the ACO both during the three-year demonstration period and in the future. Additionally, the business plan will allow the ACO to present a clear and consistent picture of what it hopes to achieve from a financial perspective to providers, other stakeholders, and the community as a whole. The plan will also serve to establish benchmarks for provider recruitment, revenue sources beyond a gain-sharing arrangement (such as in-kind investment, grant funding, and fundraising), infrastructure development, and a sustainability plan that can allow the ACO to thrive beyond the demonstration period.

It is important to note that the ACO's return on investment is not simply measured in dollars and cents, but also the value of the ACO to the community. Improved outcomes, increased collaboration, operational efficiencies, and better population health are net gains that will not show up on the ACO's balance sheet, but provide tangible benefit to the community. Transitioning to a new paradigm of health care delivery and payment will undoubtedly involve some financial growing pains, but the result will be a more effective system that serves low-income residents of the community.

ESSENTIAL ELEMENTS

Start-up Medicaid ACOs should expect to face many business-process issues similar to those of other health care provider entities. Because these issues have been well-documented in other sources -- such as the *ACO Toolkit* from Brookings-Dartmouth, the McManis Group's *The Work Ahead: Activities and Costs to Develop an Accountable Care Organization* commissioned by American Hospital Association, and *Will Your Accountable Care Organization Pilot Succeed?* published by Thomson Reuters -- this section does not focus on general health care business process planning. There are, however, some unique aspects that a Medicaid ACO will face when it develops a business plan that merit discussion.

The business planning process is an essential step toward sustainability in which the ACO must address simple, but key questions, such as:

- What level of resources will be needed to achieve savings?
- How will the savings be measured?
- Where will the gain-sharing payments come from?
- How much of these gain-sharing payments should be distributed?
- How will the gain-sharing payments be reinvested?
- How often should gain-sharing payments be distributed?

A useful business plan template for New Jersey ACOs developed by Applied Health Strategies (AHS) and funded by The Nicholson Foundation is found in Appendix B. The template includes the necessary components and structure of a business plan that will be helpful establishing an ACO.

Since ACOs are a relatively new concept in the health care world, estimating start-up costs, recurring expenses, and gain-sharing targets can be a very imprecise process, especially given the variability of each ACO community. There have been a wide range of ACO start-up expense projections from various sources, most focused on Medicare ACOs. For example, the Medicare Shared Savings Program Final Rule estimated ACO start-up costs to be $1.7 million,[xii] while the Institute for Health Technology Transformation estimates $7.5 to $11.3 million for a 200-bed hospital,[xiii] and the American Hospital Association (AHA) projects costs of $5.3 to $12 million, depending on the structure and size of the ACO.[xiv] While Medicaid ACOs can expect different projections than Medicare or commercial ACOs, these projections (and the process in which they were made) can still prove valuable for New Jersey Medicaid ACOs. For calculations performed later in this section, any cost projections will use the values posited by the AHA study, since these projections are the highest of the studies mentioned, and therefore, allow ACOs to account for the greatest overhead expense. The authors do not make any judgment on which one of these documents, if any, are the most accurate or useful.

ADVANCED ELEMENTS

Financial projections are likely the most important part of a Medicaid ACO's business plan, since they must prove that the ACO will be financially viable and provide gain-sharing returns to participating providers. In order to produce accurate financial projections, the ACO must be able to estimate revenues, expenses, and gain-sharing distributions over time, and in doing so, make the case for sustainability.

Understanding the ACO's Structure and Partnerships

The ACO leadership must understand the composition and structure of the ACO in order to create an accurate business plan. Issues such as the population of the designated area and the roles and participation of providers, FQHCs, MCOs and community organizations may impact revenues, expenses, and distribution projections, as well as risk-adjustment mechanisms. Therefore, it is recommended that different scenarios are projected based on these variables.

Revenue Projections

An ACO's revenue will stem primarily from a combination of gain-sharing payments and outside capital investment. The ACO must ensure that the estimated revenue from of these two sources exceeds projected start-up costs in the short-term, and is sustainable over projected future costs.

Developing a Gain-Sharing Plan

Budget estimates and the ACO business plan must account for the way savings are calculated and whether these gain-sharing amounts are sufficient to sustain the ACO over time. Since most Medicaid health care services in New Jersey are provided through a managed care delivery system, the primary source of revenue income will come from the gain-sharing percentage the ACO negotiates with its partner MCOs.

The statute authorizing the New Jersey Medicaid Accountable Care Organization Demonstration Project requires Medicaid ACOs to propose methods for defining how savings will be measured and shared. As noted in the statute, the Rutgers CSHP will provide technical assistance to facilitate implementation of the demonstration. As part of this technical assistance, the CSHP developed a recommended methodology for measuring savings, available at www.cshp.rutgers.edu/Downloads/9290.pdf, which builds upon the approach used in the Medicare Shared Savings Program (MSSP) and makes modifications to address issues of concern for New Jersey's Medicaid population. Highlights include:

- The method uses Medicaid claims data to calculate per capita health care spending for all Medicaid beneficiaries in the ACO's designated area;
- All spending amounts are risk adjusted using the Chronic Illness and Disability Payment System (CDPS), which is currently used to set New Jersey Medicaid managed care plan premiums;
- A health care inflation trend rate is applied to the risk-adjusted spending to determine an expected per member per month (PMPM) cost of care for ACO patients;
- Savings are established if actual spending in the performance year is less than the expected amount for the ACO's patients in that year. This expected amount is based on three years of baseline data just before ACO formation. A process of projecting and updating is used to create the counterfactual comparison (i.e., what per capita spending in the performance year is expected to be in the absence of ACO care management).

Although Medicaid ACOs are not required to use this methodology, they may find it advantageous to use the recommended method, or a modified version of it, since it has been designed to achieve the objectives of the Medicaid ACO Demonstration Project.

Estimating Total Cost of Care

For budgetary purposes, many of the ACO's start-up revenues will be based on calculations of the total cost of care (TCOC) for the designated area. This metric will allow total gain-sharing revenues to be estimated, provide a tentative budget for care management activities and administrative expenses and identify revenue shortfalls that must be addressed via capital investments from sources outside the ACO.

Beginning with the end result in mind, the ACO should develop an estimate of the patient population's TCOC. The TCOC is the sum of all health care expenditures for eligible Medicaid beneficiaries served by the ACO, and is typically broken down into a PMPM figure. This estimate will form the basis from which the ACO's potential impact on utilization will be estimated. Ideally, estimates should be derived for each of the MCOs in the ACO's designated area, as the ACO will need to negotiate a gain-sharing arrangement with each plan.

Modeling the cash flow for a start-up is a critical function of the business plan. As discussed in detail below, the amount of gain-sharing is the negotiated portion of the savings the ACO will receive when the actual TCOC is subtracted from the budgeted TCOC. In building the business plan, the ACO leadership and advisors will develop reasonable estimates of the budget using all available data. For discussion purposes, if an area has 20,000 Medicaid patients and the average TCOC is expected to be $500 PMPM, then the budget equations look like this: $500 x 20,000 = $10 million per month or $120 million per year.

Savings from care management efforts must be estimated as well. For the purposes of this example, a two percent reduction of total costs will be assumed, based on the minimum savings rate (MSR) threshold established by the Medicare Shared Savings Program (MSSP), which is a widely accepted standard. Unlike the MSSP, the gain-sharing model recommended by the Rutgers Center for State Health Policy does not use an MSR when calculating savings. This threshold, however, is still a useful method to use for projecting savings. There are a variety of resources in addition to the MSSP MSR to project potential savings as discussed in the *ACO Toolkit* published by the Brookings-Dartmouth ACO Learning Network and *Predictive Modeling: A Guide for State Medicaid Purchasers* published by the Center for Health Care Strategies, which outlines how cost savings can be forecasted (see Additional Resources at the end of this section for web links).

Returning to the example above, and assuming a reduction of two percent of total costs after a year of care management efforts, the actual TCOC would be $117.6 million and the savings from the expected budget would be $120 million – $117.6 million = $2.4 million for the year. How these savings will be shared, however, is dependent upon the terms of the gain-sharing arrangements the ACO has with the state and MCOs.

In the New Jersey Medicaid Accountable Care Organization Demonstration Project, CSHP will be providing benchmark analyses and evaluations of the ACO's proposed gain-sharing arrangements, but it will be up to each ACO to negotiate the best possible deal with each Medicaid managed care plan. When working with MCOs, a well-developed, detailed, and thoughtful analysis that yields revenue and cost-sharing estimates and an accompanying budget can give ACOs a considerable advantage in bargaining, as it will allow the ACO to present a concrete reference point for negotiations.

For planning purposes, it will also be important to determine when the MCO will distribute the agreed-upon savings to the ACO. Since all medical claims must be settled before savings are actually realized, reconciliations (which will determine the TCOC) are typically done at least six months after the year is over. As a result, the ACO must decide how it plans to provide services for 18 months without generating a payment from the MCO. Two potential solutions to this dilemma are having the MCO provide periodic interim payments or payment for care management services provided by the ACO.

The typical care management services payment model has the ACO receiving a monthly payment of $2 to $5 for each member in the ACO's population. All of the ACO's care management activities would be funded from this PMPM, and total payments for the year would be included in the ACO's TCOC. There have also been some commercial pilot programs where a case rate is paid for each person receiving services, and others where the

ACO is paid on a fee-for-service basis, depending upon the actual time expended in coordinating care. All of these costs could be deducted from the ACO's gain-sharing payment or be included in the TCOC for the purposes of the gain-share reconciliation.

An alternative approach to improving the frequency of cash flows is to break a portion of the anticipated gains into a series of quarterly payments that the ACO receives throughout the year. These periodic interim payments are a prepayment of the forecasted gain-share, and must be conservatively estimated so as to avoid an overpayment situation. This methodology has been used by CMS in a number of Medicare programs with providers.

Walking through this scenario provides insight into a few additional aspects that must be addressed in the business plan:

- The savings in the example above results from a two percent reduction in the TCOC. Would this be a reasonable achievement in the first year? In the second year?
- If the estimated TCOC is correct and a two percent reduction results in $2.4 million; will that be the revenue limit for the ACO or will there be other sources of income?
- If $2.4 million is the revenue limit, could the ACO develop the clinical team and infrastructure to achieve such a reduction in costs and operate for less than $2.4 million per year in expenses?
- What portion of the savings would the providers and institutions need as incentive payments in order to maintain their participation with the ACO?

Estimating Gain-Sharing Revenues without a Gain-Sharing Plan

While New Jersey Medicaid ACOs have the option to establish a gain-sharing plan up to one year after the ACO is established, this strategy could make formulating the ACO's financial projections difficult. If the ACO decides to defer development of its gain-sharing plan, it can simply estimate savings using the two percent MSSP minimum savings rate and a 50 percent share of projected overall savings for the ACO (one percent of the TCOC). While this method would not yield more reliable numbers than a defined gain-sharing agreement that has been approved by MCOs and providers, it will set the bar at a reasonable level so the ACO can see how a likely scenario would impact its financial viability.

Capital Sources for Start-up Funding (Prior to Incentive Distributions)

There are a number of organizations that are potential sources of start-up funding, and to a lesser extent, operational funding, that can sustain the ACO prior to the receipt of gain-sharing revenue.

With the recent efforts to reform health care delivery in the U.S., a number of private foundations have developed an interest in providing grants that support groups that are developing unique approaches. The Robert Wood Johnson Foundation, The Nicholson Foundation, and Bristol-Myers Squibb Foundation, among others, are interested in well-conceived programs that are likely to bring about substantive change and are sustainable once the start-up funding has been exhausted.

The same concept is driving the funding for programs enabled by the recent Affordable Care Act of 2010. The Center for Medicare & Medicaid Innovation (CMMI) (http://www.innovations.cms.gov/) has developed a number of programs that have funded innovative delivery models in organizations across the country. There are also a number of federally funded opportunities that support health IT initiatives such as the Office of the

National Coordinator for Health Information Technology (http://healthit.hhs.gov/), and local opportunities through the New Jersey Regional Extension Center NJ-HITEC (http://www.njhitec.org/) to acquire EHRs.

As mentioned previously, health plans could also be a potential source of capital, as some have begun to provide start-up funding to ACOs and other care management efforts. Since the goals of MCOs are very similar to those of the ACO (better overall health of enrollees, fewer inpatient and preventable ED visits, reduced costs), a Medicaid health plan may be willing to invest some capital in an initiative it believes will present an overall return on investment.

Estimating Expenses

The ACO must ensure its sure expenses for personnel, infrastructure, and care coordination efforts do not exceed projected revenues from the gain-sharing arrangement and other capital sources to remain viable and on budget. Uncovering all of the responsibilities and costs of operating a successful ACO is a key function of the business planning process. Blending projected revenues with the expenses will help the ACO leadership develop a pragmatic growth plan that can lead to a sustainable organization.

The estimated personnel expenses of the ACO can be developed using the current costs per FTE for clinicians, IT, administrative, and financial staff. Estimating the number of clinicians that the ACO will need in order to make the needed impact will be more difficult, but the experiences of similar local or grassroots efforts can be integrated into the model. IT personnel expenses and the care management team should be built at a measured pace. As the ACO's experience and revenue grow, it will be better positioned to manage additional patient populations and implement a greater array of clinical initiatives and IT infrastructure.

Different Approaches toward Start-up Expenses

CCHP began its grassroots, bottom-up work with a simple data structure run on a basic Microsoft Access database and devoted much of its early funding toward getting care management teams in the field, while more sophisticated data tools and a legal staff came later. Conversely, THT started from the top down, hiring an executive director and reaching agreements with local hospitals to provide existing personnel to work on care teams. Now that THT has additional funding in place, the organization is currently looking to hire a grant writer, assume administrative functions, and form its own care teams, in addition to working on developing its data infrastructure and analysis capabilities.

In addition to care management functions, other operating costs an ACO must prepare for include:

- Legal, actuarial, and consulting expenses;
- Grant writing and reporting costs;
- Insurance (general liability, directors and officers, errors and omissions, malpractice, etc.);
- Acquisition and ongoing costs of IT systems to manage the data and clinical intervention;
- Patient education resources and materials; and
- Administrative costs to cover provider care management efforts and health plan contracting.

Affiliated Accountable Care Organizations

One resource New Jersey ACOs may utilize is the Affiliated Accountable Care Organizations (AACO) collaborative, which is sponsored by the New Jersey Health Care Quality Institute (NJHCQI), and funded by The Nicholson Foundation. The collaborative brings together Medicaid, Medicare, and commercial ACOs and communities interested in forming ACOs to share information, experiences, and resources. The AACO provides shared resources for its member organizations, including technical, financial, legal, and advocacy resources, which ACOs can use to get their programs off the ground without prohibitive costs. For more information on the AACO, please visit www.njhcqi.org.

While it may be tempting to account for these costs as fixed and budget for them accordingly, much of the financial flexibility the ACO will have during its first few years will determine when to phase in these services and how much expense to allocate for them. Therefore, it is recommended that variable costs like the ones listed above are budgeted for in general terms (e.g., $500,000 for IT development, not $3,000 for a server). These amounts should not be viewed as spending authorizations, but rather built-in budgeted amounts for necessary expenses that are capped at the designated amount.

Estimating the Upfront Financial Resource Requirements

The Medicaid ACO is a unique organization, so it is difficult to accurately predict what the start-up costs will be for such an endeavor. A national literature review of cost estimates, largely based upon surveys of recent commercial and Medicare start-up ACOs, provides a wide spectrum of estimates. For example, one survey done by the McManis Group commissioned by the American Hospital Association has a prototype ACO (80 PCPs / 1 hospital) expecting $5.3 million in start-up costs and $6.3 million in annual operating costs. The cost breakouts appear within reason, though the single largest expenditure is for a $2 million fully-integrated EHR for all system participants, which many ACOs may not opt to purchase initially.[xv] However, there are ways for a Medicaid ACOs to avoid this large an upfront financial burden.

Over the past 20 years, a number of well-funded integrated delivery systems failed because they invested heavily in infrastructure and then assumed risk over large populations without first developing the care teams necessary to affect change in the patient care processes and improve patient outcomes. As a result, an ACO's IT infrastructure should be brought along slowly. A robust patient registry and claims-based data warehouse should provide sufficient information resources to begin the process of bringing effective care management to the community. Based on whether the community's health care providers already provide HIE connectivity, and the existing capabilities of the ACO's provider network, discussions with several system vendors suggest that the start-up data infrastructure costs could range from $150,000 to $400,000. Ongoing annual costs for management and analysis should range from $150,000 to $250,000, and financial and management information systems support should be budgeted as $200,000 during the ACO's formative years.

Recent recruiting activities in New Jersey reveal that the cost of care managers (RNs or LPNs) is between $75,000 and $130,000. Using an average of $100,000 per individual, a team of six clinicians would run $600,000 annually. However, the ACO might be able to use non-traditional health care workers such as community health care workers (CHWs) or health coaches, to ease the financial burden. Additionally, the ACO can use care teams provided by the stakeholder hospitals and providers in the early stages, and then progress to an ACO-based team that collaborates with those provider-based teams.

Altogether, start-up costs for a Medicaid ACO should range between $2 million and $3.5 million with the expectation that the ACOs members and partners will provide some in-kind resources to help minimize costs.

Preparing for the Future

ACO leadership will need to develop some knowledge of actuarial practices in order to properly manage the ACO's finances and develop a business plan for future years. As seen above, the majority of the organization's ongoing revenue will be dependent upon driving the TCOC below the expected level. Therefore, understanding the cost trends in the community's population and where to set the expected level becomes a critical management function.

Getting to the best estimate for the TCOC over time requires getting the ACO's claims data as clean and accurate as possible, and then developing expected trend factors using qualified actuaries. The financial results calculated from data collected by the ACO must be validated through comparison with additional data points such as the state's published spending levels and the annual reports from participating health plans. Once these results are compared, the ACO can estimate the upcoming budget and expenses, including how much overall costs will increase and among which procedures and service lines.

The trend factors suggested by the actuaries are merely percentages that are applied to the costs in the previous year's data. They should be challenged so that the underlying assumptions are all known and fully understood. Here, the ACO's collective knowledge of the community is critical, since it will help identify which clinical conditions are being successfully addressed and which are not being adequately controlled. Furthermore, if there are new interventions, facilities, and/or providers that can help reduce one or more of the costs addressed in the trending, this information should be factored into projections. The entire actuarial process should be an iterative one, as actuarial projections are only best estimates.

Additionally, it is important for ACOs to understand the process and the rationale behind the trend factors. If the ACO understands this, the ACO data and analytics team can analyze data and monitor trends throughout the year, and adjust the trend factors if conditions change or the factors prove to be poor estimates, rather than waiting for yearly actuarial analysis to make these changes.

Additional Resources

ACO Toolkit
Engelberg Center for Health Care Reform, The Dartmouth Institute (January 2011)
https://xteam.brookings.edu/bdacoln/Documents/ACO%20Toolkit%20January%202011.pdf

The Work Ahead: Activities and Costs to Develop an Accountable Care Organization
American Hospital Association and the McManis Group (April 2011)
www.aha.org/content/11/11apr-aco-workahead.pdf

Will Your Accountable Care Organization Pilot Succeed?
Truven Health Analytics (February 2012)
http://now.eloqua.com/e/f2.aspx?elqFormName=wpaper&elqSiteID=861&c=701G0000000PV4Z&redir=%20%20http://img.en25.com/Web/ThomsonReuters/MDS_11211_0612_ACO_White_Paper_D4.pdf

Predictive Modeling: A Guide for State Medicaid Purchasers
Center for Health Care Strategies (August 2009)
www.chcs.org/publications3960/publications_show.htm?doc_id=992610

Medicare Shared Savings Program: Accountable Care Organizations; Final Rule
Centers for Medicare & Medicaid Services (November 2, 2011)
www.gpo.gov/fdsys/pkg/FR-2011-11-02/pdf/2011-27461.pdf

Recommended Approach for Calculating Savings in the NJ Medicaid ACO Demonstration Project
Rutgers Center for State Health Policy (July 2012)
www.cshp.rutgers.edu/Downloads/9290.pdf

Center for Medicare & Medicaid Innovation
www.innovations.cms.gov

Office of the National Coordinator for Health Information Technology
http://healthit.hhs.gov

NJ-HITEC
www.njhitec.org

Robert Wood Johnson Foundation
www.rwjf.org

Bristol-Myers Squibb Foundation
www.bms.com/foundation/Pages/home.aspx

New Jersey Health Care Quality Institute
www.njhcqi.org

3.2 Developing a Work Plan

TOOLKIT BLUEPRINT

Read this section to learn how to develop a work plan to allocate resources and prioritize goals for the ACO over time.

CONCEPTUAL MILESTONE

- ✓ The ACO understands that it needs a work plan timeline and will develop one.

ESSENTIAL MILESTONE

- ✓ The ACO has a timeline in place and has broad activities and goals outlined on it.

ADVANCED MILESTONE

- ✓ The ACO has completed a detailed one/two-year work plan that aligns closely with the business plan and involves detailed activities and goals.

CONCEPTUAL ELEMENTS

Since New Jersey communities participating in the New Jersey Medicaid ACO Demonstration Project are essentially reforming their care delivery systems from the ground up with limited funding, having a functional work plan is vital. A work plan is effectively an extension of the business plan in which a timeline is developed to guide the development of the ACO and its components. A well-designed work plan will allow the ACO to organize, prioritize, and plot a strategy for developing the ACO, thus providing a sense of order to a complex and potentially chaotic development process.

ESSENTIAL ELEMENTS

While an effort has been made to order the sections of this toolkit as chronologically as possible, the activities explored in many of the sections (especially Sections 2.2 through 2.4 pertaining to stakeholders, data analysis, and care delivery) must be conducted simultaneously. These activities may have varying start and end points for different ACOs due to differences in community composition, EHR implementation, pre-existing stakeholder alignment, and other factors.

Though there are many different variables that factor into an ACO's work plan, there are a few general guidelines that can be followed. In general, the New Jersey Medicaid Accountable Care Organization Demonstration Project can be broken into three distinct periods over the first year: (1) application; (2) preparation; and (3) post-launch. Many activities will span two or all of these three periods and remain ongoing past the first year.

A useful tool to help organize a work plan is a Gantt chart, which offers a visual and chronological representation of all tasks that the ACO will be pursuing during a particular time period, as well as the duration of these tasks. A sample Gantt chart for a hypothetical ACO, *HealthyJersey,* is in Appendix C.[xvi] Although hypothetical, this example nevertheless provides a useful outline of the decision-making process of a start-up ACO and can help articulate the goals of a typical ACO.

ADVANCED ELEMENTS

The remainder of this section walks through *HealthyJersey* work plan example using the Application, Preparation, and Post-Launch periods illustrated in the *HealthyJersey* Gantt chart example.

The Application Period

HealthyJersey, like any ACO, will have to submit an application for DHS approval. As a result, most of its application period tasks and goals involve getting its application ready for approval. The first task that an ACO should perform is conducting a baseline readiness assessment to assess the ACO community's current state of affairs and identify current strengths, weaknesses, and needs (further information on conducting a readiness assessment is described in Section 1.3). Once this assessment is complete, the ACO should begin to prepare itself for the application process. Following is a month-by-month approximation of how the fictitious *HealthyJersey* might approach the ACO application period:

- **Month 1** -- Identifies community resources and develops short-term data, IT, and legal strategies (using consultants rather than a staff to minimize overhead expenses) with a focus on minimizing costs while it also searches for sources of funding. Many of these processes will continue throughout the application period and beyond.

- **Month 2** -- Focuses on galvanizing support in the community and building its management infrastructure. It starts by developing bylaws for the ACO, as well as engaging clinical stakeholders and beginning to construct its board membership. The ACO will also begin to develop its internal analytics database, as this can be a large task for a start-up nonprofit organization that does not have an established IT infrastructure.

- **Month 3** -- Begins most of its preparations for the application, including engaging and collaborating with community stakeholders and existing medical stakeholders, developing a care team model and quality strategy, and beginning to develop a business and gain-sharing plan. While a gain-sharing plan is not necessarily part of the initial application process (it can be submitted up to a year after the application is approved), *HealthyJersey* decided to do it as part of its initial application since it plans to use the model developed by the CSHP outlined in Section 2.3 and available from www.cshp.rutgers.edu/Downloads/9290.pdf. *HealthyJersey* also believes that developing a gain-sharing plan at the outset of its development will allow it to more accurately gauge financial projections of its business plan. In addition to these activities, *HealthyJersey* will begin to contract with local hospitals and practices to provide data for its database, which is already under development.

- **Months 4 & 5** -- Uses its newfound legal resources to apply for New Jersey nonprofit status and federal 501(c)(3) nonprofit status, hire the essential members of its management team, and compile and submit its application. *HealthyJersey* realizes that the New Jersey and federal nonprofit designations cannot be expected to be approved immediately, so it will apply as soon as it can find the right legal assistance and develop its bylaws, which could occur prior to month four. Once everything is in place on its application, *HealthyJersey* will submit its application to DHS.

The Preparation Period

While *HealthyJersey* awaits approval from DHS, it will continue to seek out sources of funding, engage all types of stakeholders, further develop its database, analytic capacity, and negotiate contracts with data providers. In addition to these continued tasks, the ACO will seek to develop a long-term data analysis plan and infrastructure, so it is actionable upon approval of the ACO. At the end of the projected three-month preparation period, *HealthyJersey* will begin to hire the first members of its care team so it can begin training prior to the launch of the ACO.

The Post-Launch Period

Once *HealthyJersey*'s application is approved, it will continue its seven existing tasks, including hiring care team members and developing a long-term data plan, which it will now act upon by developing its IT infrastructure and analyzing real-time data and putting its care teams in the field. In addition, it will resume adding the final members of its management team. While *HealthyJersey* could have also decided to hire a full-time legal staff or create its own HIE, its leadership decided to defer these opportunities to years two and three of the demonstration so it can better assess its needs and financial situation for what it considers "luxury" items.

Discussion

HealthyJersey, and all ACOs, should not be rigidly bound by a work plan. While a Gantt chart can appear to be a stepwise path to success, it should not be viewed as a static plan. Instead, it should be perceived as a flexible guide that can be modified as circumstances change. For example, *HealthyJersey* should not settle on a legal resource by month three simply because it is slated to do so in the work plan if it has not found the right firm or attorneys. Similarly, if the ACO application is not approved by month nine as the Gantt chart forecasts, *HealthyJersey* should not begin putting care teams in the field and procure expensive IT equipment before the ACO has been approved. A Gantt chart and work plan can be a valuable component of an ACO's planning, but it should not be considered a constraint.

Additional Resource

Recommended Approach for Calculating Savings in the NJ Medicaid ACO Demonstration Project
Rutgers Center for State Health Policy (July 2012)
www.cshp.rutgers.edu/Downloads/9290.pdf

Conclusion

NEW JERSEY COMMUNITIES have a unique opportunity to positively influence population health and health care quality for their most vulnerable residents through the Medicaid Accountable Care Organization Demonstration Project. The demonstration offers communities the potential to reduce the overutilization of inpatient and ED services at overtaxed safety net hospitals. Gain-sharing savings can then be reinvested in improvements in health care and access at the community level, and help control the growth in statewide Medicaid expenses. While many communities are likely to embrace this new ACO opportunity, the upfront investments, in terms of both financial and time commitments, are significant.

Finally, because there is a large amount of overlap between tasks and responsibilities in developing and running an ACO, the amount of coordination needed between the functional areas of the ACO is substantial. The development of an ACO is truly an iterative process, requiring a great deal of flexibility from the board of directors, the management team, and the community. While some commonalities will exist across ACOs, the areas of stakeholder engagement, governance, care delivery, quality strategy, and data and IT development will vary greatly depending on available provider networks and community resources. The ACO leadership must make sure that these substantive areas are aligned across community partners so the overarching goals of the ACO can be achieved. Business and work plans will inevitably evolve as the ACO learns more about the population in its designated area and develops a more nuanced approach to serving them. The business and work plan templates provided in this toolkit offer an essential starting point to help ACO leaders focus on the high-level goals that will allow true transformative success to be achieved in the community.

Endnotes

[i] From this point forward, the term ACO will refer to a Medicaid ACO unless otherwise noted.

[ii] Meier MH. *Norman PHO Advisory Opinion*. United States of America Federal Trade Commission. February 13, 2013.

[iii] Throughout this section, the terms "ACO leadership" and "governance team" refers to the collective whole of the Board of Directors, its Committees and Subcommittees, and the Management Team.

[iv] Senate and General Assembly of the State of New Jersey. An Act establishing a Medicaid Accountable Care Organization Demonstration Project and supplementing Title 30 of the Revised Statutes. P.L. 2011-114. August 18, 2011. Page 3.

[v] Pizzo JJ, Grube ME. *Getting to There from Here: Evolving to ACOs Through Clinical Integration Programs Including the Advocate Health Care Example as Presented by Lee B. Sacks, MD*. Kaufman, Hall & Associates: Skokie, IL. 2011. www.advocatehealth.com/documents/app/ci_to_aco.pdf.

[vi] Note that this is not an exhaustive list of key stakeholder groups. The importance and influence of stakeholder groups will vary from community to community and the ACO should seek to engage the key stakeholder groups in its service area.

[vii] DeLia D & Cantor J. *Recommended Approach for Calculating Savings in the NJ Medicaid ACO Demonstration Project*. Rutgers Center for State Health Policy: New Brunswick, NJ, July 2012. www.cshp.rutgers.edu/Downloads/9290.pdf.

[viii] Hsiao CJ, Hing E, Socey TC, Cai B. *Electronic Health Record Systems and Intent to Apply for Meaningful Use Incentive Among Office-Based Physician Practices 2001-2011*. NCHS Data Brief, no. 79. Hyattsville, MD: National Center for Health Statistics. 2011.

[ix] Statistic obtained from NJ-HITEC membership data, New Jersey's Regional Extension Center.

[x] Thomson Reuters. *Post-Hospitalization Mortality: Linking Methods. Report submitted to the Agency for Healthcare Research and Quality for the Healthcare Cost and Utilization project*. Santa Barbara, CA. December 2008.

[xi] Brown R. *The Promise of Care Coordination: Models that Decrease Hospitalizations and Improve Outcomes for Medicare Beneficiaries with Chronic Illnesses.* The National Coalition on Care Coordination (N3C). March 2009. http://www.nyam.org/social-work-leadership-institute/docs/N3C-Promise-of-Care-Coordination.pdf.

[xii] Centers for Medicare and Medicaid Services. *Medicare Shared Savings Program: Accountable Care Organizations; Final Rule*. United States Government Printing Office: Washington D.C. November 2, 2011. www.gpo.gov/fdsys/pkg/FR-2011-11-02/pdf/2011-27461.pdf.

[xiii] Institute for Health Technology Transformation. *Accountable Care Organizations: 10 Things You Need to Know About Accountable Care.* Institute for Health Technology Transformation: New York. 2011. http://premierit.intel.com/servlet/JiveServlet/previewBody/6441-102-2-9618/ACO%20Report.pdf.

[xiv] Moore K, Coddington D. *The Work Ahead: Activities and Costs to Develop an Accountable Care Organization*. Prepared for the American Hospital Association by McManus Consulting : Chicago, IL. April 2011. www.aha.org/content/11/11apr-aco-workahead.pdf.

[xv] Ibid.

[xvi] This Gantt chart provides an example for a hypothetical ACO and the timeline for development process is for illustrative purposes only. The work plan and timeframe that an actual New Jersey ACO may develop for its first year may vary greatly from this illustration.

Appendix A: Community Readiness Assessment

Overview

This community readiness assessment is designed to evaluate the feasibility of a community-based Medicaid ACO in a New Jersey community. This self-assessment tool can be used by ACO leaders to evaluate the ACO's current stage in the development process and identify the areas it needs to improve in order to participate in the New Jersey Medicaid ACO Demonstration Project.

The assessment corresponds with Sections 2 and 3 of this toolkit to assess ACO readiness in the following seven key areas:

1. Establishing a Leadership and Governance Structure
2. Partnering with Stakeholders
3. Performing Data Analysis and Building an Information Technology Infrastructure
4. Improving Care Delivery
5. Ensuring Quality Improvement
6. Developing a Business Plan
7. Developing a Work Plan

ACOs can score their readiness in each of these areas with the following values, which correspond with the organization of content in the toolkit:

- The Conceptual Level (1 point)
- The Essential Level (2 points)
- The Advanced Level (3 points)

Individual scoring criteria for each section and question are provided. Scoring should be strict. If the ACO does not meet every aspect of the question's criteria, fewer points should be assigned. If the person scoring the ACO's level of development does not know how to score the ACO for a particular question, he or she may refer to the corresponding section in the toolkit narrative to assess the level of ACO development. If there is still doubt to the ACO's level, he or she should round down (for example if the reviewer is not sure if the question deserves a response of conceptual level or essential level, he or she should round down to the conceptual level).

SECTION 1: **Establishing a Leadership and Governance Structure**

Q1: Does the ACO have an established board of directors that meets New Jersey regulatory requirements and encourages ACO success?
✓ **Conceptual Level (1 pt)** – The ACO understands the New Jersey regulatory requirements for its board of directors. ✓ **Basic Level (2 pts)** – The ACO has identified prospective organizations/individuals for its board and has voting representation from at least two consumer organizations. ✓ **Advanced Level (3 pts)** – The board of directors is confirmed and board-level committees, subcommittees, and a community advisory board are established.
Score: _____

Q2: Has the ACO established a management team to oversee day-to-day ACO operations?
✓ **Conceptual Level (1 pt)** – The ACO understands the minimal requirements it needs to get established. ✓ **Basic Level (2 pts)** – The ACO has appointed an executive director and identified a phased-in strategy to recruit personnel. ✓ **Advanced Level (3 pts)** – The ACO has its key management personnel in place including an executive director and some or all of the following: data analyst(s), care coordinator(s), legal officer(s), financial officer(s), and/or grant writer(s).
Score: _____

Q3: Has the ACO developed by-laws and become a nonprofit corporation?
✓ **Conceptual Level (1 pt)** – The ACO understands what its bylaws should entail and that it must be certified as a nonprofit organization in New Jersey. ✓ **Basic Level (2 pts)** – The ACO has developed a set of bylaws including voting rights and procedures, and has applied to become a New Jersey nonprofit corporation. ✓ **Advanced Level (3 pts)** – The ACO has developed a comprehensive set of bylaws, is certified as a New Jersey nonprofit corporation, and has either applied for or received its federal 501(c)(3) status.
Score: _____

ESTABLISHING A LEADERSHIP AND GOVERNANCE STRUCTURE SCORE **(Add all scores in section and divide by 3)** _____

SECTION 2: **Partnering with Stakeholders**

Q1: Has the ACO begun to collaborate with health care stakeholders?
✓ **Conceptual Level (1 pt)** – The ACO understands the essential role that health care stakeholders play in the organization and has identified several health care stakeholders for initial outreach. ✓ **Essential Level (2 pts)** – The ACO has achieved the New Jersey Medicaid Accountable Care Organization Demonstration Project requirements by receiving the support of all general hospitals, 75 percent of Medicaid primary care providers, and four qualified behavioral health providers in its designated area. ✓ **Advanced Level (3 pts)** – The ACO has achieved the New Jersey Medicaid Accountable Care Organization Demonstration Project requirements by receiving the support of all hospitals, 75 percent of Medicaid primary care providers, and four qualified behavioral health providers in its designated area. The ACO also has broad support from FQHCs, clinics, and specialists, and has formed contractual relationships with managed care organizations. One or more health care stakeholders have also been designated as an "ACO Champion."
Score: _____

Q2: Has the ACO begun to collaborate with community stakeholders?
✓ **Conceptual Level (1 pt)** – The ACO understands the essential role that community stakeholders play in the organization and has identified several community stakeholders for outreach. ✓ **Essential Level (2 pts)** – The ACO has a written community engagement plan, but the plan has not been fully implemented. The ACO has engaged many community stakeholders, and some informal stakeholder relationships have been established. The ACO has also satisfied the community stakeholder presence requirement with its board membership structure. ✓ **Advanced Level (3 pts)** – The ACO has a written community engagement plan. Community representatives are fully integrated into the ACO and have roles on the community advisory board. The board of directors has an active community stakeholder presence, with some in a leadership role. Informal and formal mechanisms are in place, and the ACO has established specific programs with community organizations and services that will help residents gain access to care and encourage active participation in their own health care plans.
Score: _____

Q3: Has the ACO begun to collaborate with government entities and residents?
✓ **Conceptual Level (1 pt)** – The ACO understands that in addition to provider and community stakeholders, residents, government officials, and public health and social services offices must also be engaged. ✓ **Essential Level (2 pts)** – The ACO engaged a number of local politicians and won some support, has set up public feedback mechanisms, and has begun to collaborate with local public health and social services offices. ✓ **Advanced Level (3 pts)** – Political entities in the area support the ACO, as do the vast majority of community residents. Local and state social services and public health offices are active partners, provide input and possibly services on a regular basis, and at least one representative serves on the board of directors. Residents are also aware of the feedback mechanisms in place for them and have an active voice through the community advisory board.
Score: _____

PARTNERING WITH STAKEHOLDERS SCORE **(Add scores in section and divide by 3)** _____

SECTION 3: **Performing Data Analysis and Building an Information Technology Infrastructure**

Q1: Does the ACO have a functional data strategy?
✓ **Conceptual Level (1 pt)** – The ACO understands the importance of data to care management and has identified sources of data. It is also aware of the basic requirements needed to perform data analysis. ✓ **Essential Level (2 pts)** – The ACO has set data-related goals and has at least one reliable source of data. A rudimentary data structure is in place, and the ACO intends to share information between providers and facilities, and analyze data. The ACO also has a method in place to promote provider use of electronic health records (EHRs). ✓ **Advanced Level (3 pts)** – The ACO has a robust data strategy. It has at least two reliable sources of data and the capability to exchange this data among providers, facilities, and the ACO data analysts. It has a plan, which is consistent with time and resources, to develop a functioning HIE or access data from an already established HIE, an internal database and analysis software, and has a plan for providers without EHRs to obtain them, though more than half of them already have EHRs. There is at least one full-time staff member dedicated to data analysis.
Score: _____

Q2: Does the ACO have a robust IT infrastructure?
✓ **Conceptual Level (1 pt)** – The ACO knows the elements it needs to establish a minimum data infrastructure, and plans to obtain these elements. ✓ **Essential Level (2 pts)** – The ACO has an internal database and access to data for analysis purposes. ✓ **Advanced Level (3 pts)** – The ACO has a sophisticated internal database and either hosts, or has access to, an HIE.
Score: _____

Q3: How many ACO providers use EHRs?
✓ **Conceptual Level (1 pt)** – Less than 30 percent of ACO providers currently use electronic health records (EHRs), but providers are aware of their benefits and resources available to help them convert to EHRs. ✓ **Essential Level (2 pts)** – Between 30 and 75 percent of ACO providers currently use EHRs. These EHRs are also compatible with each other and the health information exchange (HIE) that the ACO receives data from (if applicable). The ACO has also recommended an EHR type to its providers. ✓ **Advanced Level (3 pts)** – Over 75 percent of ACO providers currently use EHRs that are interoperable with each other and the ACO's HIE. At least 50 percent of these providers use the ACO-recommended EHRs or another interoperable EHR with discrete data fields.
Score: _____

PERFORMING DATA ANALYSIS & BUILDING AN INFORMATION TECHNOLOGY INFRASTRUCTURE SCORE (Add all scores in section and divide by 3) _____

SECTION 4: **Improving Care Delivery**

Q1: Does the ACO have existing care management teams?
✓ **Conceptual Level (1 pt)** – The ACO understands the importance of care coordination and has a plan to develop a care management strategy. ✓ **Essential Level (2 pts)** – The ACO has identified some patients who will potentially benefit from care management. It has at least one internal care team or an external care team that works with the ACO. ✓ **Advanced Level (3 pts)** – The ACO has its own multidisciplinary care team(s) and a robust method of identifying patients that would benefit from care team interventions. It actively coordinates with hospitals, FQHCs, and its own data analysts to identify patients and track patient progress. Care teams also have access to community resources such as food pantries and homeless shelters to help patients with non-medical, health-related problems.
Score: _____

Q2: How does the ACO perform care management activities?
✓ **Conceptual Level (1 pt)** – The ACO has the desire to develop a care management strategy. ✓ **Essential Level (2 pts)** – The ACO has developed a care management framework that identifies patients and provides them with the opportunity to enroll in care management services and build a relationship with a PCP. ✓ **Advanced Level (3 pts)** – The ACO has a comprehensive care management strategy and tools to help identify and stratify patients such as intake forms, health risk assessments, and other needs assessment tools. There is also a care management timeline that assesses patients from intake, to stabilization, and eventually, graduation. The care teams meet patients where they are, and communicate actively with patients' PCPs; if the patients' do not have a PCP, the care teams help to facilitate a relationship with one.
Score: _____

IMPROVING CARE DELIVERY SCORE **(Add scores in section and divide by 2)** _____

SECTION 5: **Ensuring Quality Improvement**

Q1: Does the ACO have an established quality strategy?
✓ **Conceptual Level (1 pt)** – The ACO recognizes the New Jersey-required core and voluntary measures and has the means and infrastructure to track and report them. ✓ **Essential Level (2 pts)** – The ACO has the capability to report the New Jersey-required core and voluntary measures and plans to add additional measures that will benefit the ACO's care management activities. ✓ **Advanced Level (3 pts)** – The ACO currently tracks not only the New Jersey-required core and voluntary measures, but additional measures that benefit the ACO's care management activities. These measures are tied to gain-sharing payments, and the ACO also fosters communication between care teams, data analysts, PCPs, and its board of directors to encourage quality improvement initiatives.
Score: _____

ENSURING QUALITY IMPROVEMENT SCORE _____

SECTION 6: **Developing a Business Plan**

Q1: Has the ACO established a functional gain-sharing arrangement?
✓ **Conceptual Level (1 pt)** – The ACO has decided to develop a gain-sharing arrangement, but will do so within a year of the start of the ACO demonstration. ✓ **Essential Level (2 pts)** – The ACO has either accepted the CSHP gain-sharing arrangement, modified it slightly to suit the needs of its community better, or established its own gain-sharing methodology. ✓ **Advanced Level (3 pts)** – The ACO has either: accepted the CSHP gain-sharing arrangement; modified it slightly to suit the needs of its community better; or established its own gain-sharing methodology. It also has a gain-sharing arrangement with at least one MCO.
Score: _____

Q2: Does the ACO have a functional business plan in place?
✓ **Conceptual Level (1 pt)** – The ACO recognizes that it needs to develop a business plan that compares costs and revenues and measures the total cost of care (TCOC). ✓ **Essential Level (2 pts)** – The ACO has developed a business plan with a total cost of care measurement, but does not have a gain-sharing arrangement in place. ✓ **Advanced Level (3 pts)** – The ACO has developed a business plan with a total cost of care measurement based on its gain-sharing arrangement.
Score: _____

Q3: Does the ACO have access to start up funding from capital sources?
✓ **Conceptual Level (1 pt)** – The ACO has identified outside sources of funding and plans to approach them. ✓ **Essential Level (2 pts)** – The ACO has access to limited start-up funding from its members, a foundation, or a federal or state program. ✓ **Advanced Level (3 pts)** – The ACO has access to significant start-up funding from its members, a foundation, or a federal or state program, as well as funding from a MCO.
Score: _____

DEVELOPING A BUSINESS PLAN SCORE (Add all scores in section and divide by 3) _____

SECTION 7: **Developing a Work Plan**

Q1: Does the ACO have an established work plan?
✓ **Conceptual Level (1 pt) –** The ACO understands that it needs a work plan timeline and will develop one. ✓ **Essential Level (2 pts)** – The ACO has a timeline in place and has broad activities and goals outlined on it. ✓ **Advanced Level (3 pts)** – The ACO has completed a detailed one/two-year work plan that aligns closely with the business plan and involves detailed activities and goals.
Score: _____

DEVELOPING A WORK PLAN SCORE _____

Community Readiness Assessment Scoring

What the scoring criteria means:

1. **The Conceptual Level** – The area is a weakness. The ACO has a general idea of this area, but should continue to develop this area in a more practical way.
2. **The Essential Level** – The area is solid. The ACO is doing well in this area, and should continue developing this area.
3. **The Advanced Level** – The area is a strength. The ACO is well ahead of schedule in this area.

All decimals should be rounded down a level (e.g., 1.5 rounds down to the conceptual level, 2.66 rounds down to the essential level).

There is no overall score for this assessment. While the ACO will need to get to at least the Essential level of each section to achieve a successful ACO launch, it is likely that the community is not working at that level yet. Few ACOs will score at the advanced level for individual sections of the assessment, but may score advanced in individual questions.

In addition to assessing the current state of the ACO's community, the results of this assessment can be used to drive the development of a work plan and allocate resources to the correct areas. As a result, the ACO may want to use the assessment as a tool to identify areas of weakness and track ongoing growth.

Appendix B: Business Plan Template

Working Draft of the Safety Net ACO Business Plan
for the "Next Coalition"

Prepared by

Applied Health Strategies

through support from the Nicholson Foundation

Table of Contents

Introduction to the Template

The following business plan template is designed to present an overview of what should be included in a New Jersey Safety Net Accountable Care Organization's business plan. The template has two parts: A commentary and an example.

The commentary portion is located at the beginning of each section and acts as a reader's guide for the business plan to follow. This commentary is italicized.

The example portion is a hypothetical working draft of a business plan for the fictitious Next Coalition, which can be used as a brief illustration of how a business plan can be organized. The Next Coalition, like the ACOs in New Jersey, is not a full-fledged ACO, and as a result, it does not have a complete business plan yet. Because the template is a working draft, it should not be considered a final version that is presented to those outside the organization, but rather a discussion of content and presentation of the business plan in development. A working draft can help the ACO leadership towards its goal of creating a final business plan to share with stakeholders. (For example, in the working draft, statements are often made like, "the ACO will…". The difference between a working draft and final business plan is that many of these "wills" will likely be filled in by things the ACO has done or concrete action steps to accomplish these goals.) It is important to emphasize that ACO coalitions should not feel compelled to follow this business plan format exactly or include all aspects of the example portions of the plan. There are many variables and purposes to a business plan, and ACO coalitions are encouraged to deviate from this model to suit their own purposes. Additionally, since this is only an example used for illustrative purposes, it is not as detailed as a typical business plan would or should be.

The financial modeling and budgetary discussion in this template are the work products of Applied Health Strategies, LLC, and use real data that has been compiled from multiple sources to represent a fictitious coalition seeking to develop a Safety Net Accountable Care Organization in the State of New Jersey. The market assessment and other narrative have also been compiled from multiple sources and are presented as examples for use by other interested coalitions.

Executive Summary

The Executive Summary is the abstract of the business plan, a summary of everything it will present in greater detail in the ensuing pages. It spells out the content and goals of the plan, hitting all the highlights. This section is key if the ACO is seeking outside funding as it introduces possible investors to the business. The ACO should be sure to include background about its organization, the market opportunity, capital requirements, a mission statement, an overview of management, competitors, your business's competitive advantages, and a summary of your financial projections over the next three years. If the business plan's primary audience is management and major stakeholders, a simple summary may suffice. The Executive Summary should be completed in the Final Draft only. If a summary is available prior to the final draft, many time-constrained managers will utilize this expeditious, but unproductive pathway to gather information.

This Business Plan is to be used as a working guide for the leadership of Next Coalition ("NC") in its quest to become a certified Safety Net Accountable Care Organization ("ACO") for its community of Jerseytown, NJ. The unique nature of the Safety Net ACO requires competing health care providers, health systems and physicians alike, to cooperate in the development and operation of a single entity, dedicated to the care of the medically underserved residents of the city.

NC believes that the services provided by the coalition will be of sufficient value, in both quality and efficiency, that the payors, both NJ State Medicaid and the Managed Medicaid health plans, are able to recognize significant savings in the Total Costs of Care ("TCC") for those residents. Eventually, the ACO will be able to function on a sustained basis utilizing a portion of those savings.

The NC is well positioned and has developed a cohesive leadership team that is acutely aware of the community's needs and the challenges that the NC faces. As the coalition prepares for certification under the New Jersey Medicaid Accountable Care Organization Demonstration Project regulations, it continues to pursue the following initiatives:

1. The development of the clinical teams within the ACO will continue while engaging and integrating the community providers formally into the care coordination processes.
2. The Information Technology infrastructure will be a high priority, including enhanced analytical capabilities.

3. The leadership team will prepare to engage the managed care plans by becoming familiar with the forecasting models contained herein, and formally developing the negotiating and gainsharing guidelines.
4. The NC has already made the shift to value based thinking, and the next step will be to adopt and measure Quality Metrics.

The estimated revenue from the shared savings contracts appears to be sufficient for sustainability. Current estimates place the 2015 membership at 27,000 individuals, and with a reduction of the population's medical cost trend from 6% per year to 2% per year, the 2015 savings would be $3,900,000. The specific gainsharing arrangements must be negotiated, but the overall level of potential savings appears reasonable to move forward with establishing an ACO to improve care and reduce costs for the safety net population in Jerseytown.

Introduction

In the Introduction, the ACO should provide the reader with a broad perspective of the business case for the initiative. Touch on any and all pertinent issues especially historical information of the community that may impact the ACO's business strategy. The ACO may also opt to include challenges it faces.

Organizational Review:

The organizational review should provide background information about the ACO, its structure, mission, partnerships, and goals. For an ACO, this should include the participating organizations, board structure and membership, a general overview of funding streams and financial information and work done to date, which may include care management activities.

The Next Coalition is 501(c)(3) nonprofit organization which serves as a community health improvement collaborative for the six zip codes of Jerseytown, New Jersey. The collaborative is an innovative partnership between Jerseytown Memorial Medical Center, the All Caring Health System, The George Washington Federally Qualified Health Center, and the Department of Health of the City of Jerseytown. The vision of the Next Coalition is to make the city of Jerseytown the healthiest city in the State of New Jersey. Its mission is to transform healthcare for the city of Jerseytown, New Jersey, by forming a committed partnership with the community to expand access to high quality, coordinated healthcare. The Next Coalition has five strategic initiatives, with active and innovative programs in each one. The initiatives are:

- Expanding Primary Care Access
- Community-wide Clinical Care Coordination
- Data Sharing For Population Health
- Community Engagement
- Expanding The Infrastructure For A Safety-net Accountable Care Organization

In terms of governance and structure, the NC has a well-established board with numerous community representatives participating in various advisory capacities. The organization's 13-member board includes two members of both hospital systems, the FQHC, and the city's department of health, as well as one representative from the Jerseytown Behavioral Health Group, Jackson Street Neighborhood Organization, St. Thomas Catholic Church, The Jerseytown Homeless Coalition, and Patient Advocates, Inc to ensure that important health care and community stakeholders have a voice in the ACO's development. The board also has five standing committees, an executive committee, quality committee, finance committee, data committee, and a community engagement committee. The NC is a relatively young organization and has yet to build out the complete management infrastructure needed in order to assume the responsibility for the eligible population. The organization currently employs an Executive Director, and a grant was recently received that will provide for the needed

expansion of the staff. Though this growth is well timed, additional staff will be required to handle the expected 27,000 lives. The enclosed gainshare model is intended to provide decision support through modeling of the potential impact of the ACO on the residents' Total Cost of Care.

Marketing Plan

The marketing plan should show how the ACO plans to impact its community and the benefits that it can provide to its audience (stakeholders, especially MCOs). The marketing plan should include a market assessment section, which presents an overview of its community (market); a product development section, which should outline the services offered by the ACO; and a communications plan to reach out to members of the community to promote ACO services.

The enabling legislation for the Safety Net ACOs was developed around the state's need to reduce the overall costs of care for the residents covered under the New Jersey Medicaid program. The overall approach is to utilize care coordination techniques to reduce wasteful spending that arises from the patients' unguided movements through random providers of care. The NC has developed a strategy that can reduce the Total Cost of Care ("TCC") by identifying the priority patients and guiding them through an individualized care plan. However, in order for the start-up ACO to generate the revenue needed for sustainability, it must partner with the Medicaid Managed Care Plans that cover over 95% of residents. A key to the ACO's success will be its ability to engage Medicaid plans and develop a substantive shared savings incentive program with realistic goals and rewards.

Market Assessment

The NC's planning area is focused on Jerseytown's six zip codes, where 36.3% of the total population of 114,168 is below 200% of the federal poverty level (FPL), based on 2010 data. Both of Jerseytown's hospitals, as well as the George Washington Health Center and City of Jerseytown Health Clinics, serve the residents of NC's proposed planning area (12345, 12346, 12347, 12348, 12349 and 12340) and each of these entities is an organizational partner with NC:

Jerseytown Zip Code	*Total Population*	*Population Below 200% FPL*	*Percent Population Below 200% FPL*
12345	1,233	930	75.4
12346	15,521	7,282	46.9
12347	23,666	10,459	44.2
12348	36,916	13,208	35.8
12349	26,193	7,016	26.8
12340	10,639	2,607	24.5
NC's Population	114,168	41,502	36.3%

The City of Jerseytown is in Central County and is the county seat. It is officially part of both the New York metropolitan area and the Jerseytown Metropolitan Statistical Area. As of the 2010 United States Census, the population of the county was 366,513, an increase of 15,752 (4.5%) from the 350,761 enumerated in the 2000 Census, making it the 12th-most populous county in the state. Central County is ranked 80th among the highest-income counties in the United States. Central County is also home to several major universities and colleges. Central County is also home to several large pharmaceutical, biotech and financial services companies. The Bureau of Economic Analysis ranked the county as having the 78th-highest per capita income of all 3,113 counties in the United States (and the sixth-highest in New Jersey) as of 2009.

This ranking would probably be higher except for Jerseytown. In short, Jerseytown, NJ is an impoverished city that is surrounded by significant affluence. This contrast is reflected in the following table that demonstrates significant health disparities between Jerseytown and the entirety of Central County.

Profile Characteristics	***Jerseytown (six zip codes)***	***Central County***
African American	52.0%	20.3%
Hispanic/Latino	33.7%	15.1%
Unemployment Rate	12.5%	7.8%
Child Poverty Rate	32.6%	11.9%
No Health Coverage	23%	14%
High School Graduation Rate	69.5%	86.5%
County Health Ranking Data:	***Jerseytown (six zip codes)***	***Central County***
No Prenatal Care	3.0%	1.3%
Hypertension	31%	22%
Diabetes	16%	6%
Obesity	39%	23%
Persons Living With HIV/AIDS (per 10,000)	116.8	32.2

The demographic and sociological statistics, illustrated in the above tables, demonstrate that the NC catchment area is serving a poor and vulnerable population that has significant unmet medical and psychosocial problems. The Next Coalition began to address their vulnerable population's health needs with foundation funding in 2011-2012, and will continue to do in the future. These health risks can continue to be addressed with the support of New Jersey's Medicaid managed care plans.

Since 2009, the State of New Jersey has sought to control costs by mandating election of a participating Medicaid Managed Care organization ("MCO") as a condition for receipt of Medicaid benefits. The enrollment in Central County was reported on 3/31/12 to be as follows:

Medicaid MCO in Central County	**Enrollment**
MCO 1	6,443
MCO 2	36,479
MCO 3	4,210
MCO 4	3,389
Total MCO Enrollment =	**50,521**
Total DHS Eligibles	53,180
Percent Covered	95%

There is no discernible reason to assume that the enrollment breakout by health plan would be different in the 6 zip codes of NC's designated area: 12345, 12346, 12347,

12348, 12349 and 12340. Therefore, the leadership of the Next Coalition must build an initial marketing plan around the need to partner with the two MCOs with populations of sufficient size to render reliable medical cost trend calculations: MCO 1 and MCO 2.

Relationships should be cultivated with the remaining plans as the possible growth in the Medicaid eligible population would allow those plans to grow to a suitable size. During the interim, the NC should prepare an alternative approach for those patients, as well as the unassigned patients in its zip codes.

Product Development

An Accountable Care Organization is aptly named because it assumes a role of responsibility and accountability that applies to multiple customers and stakeholders. Each patient that an ACO engages should be considered a direct customer of its services. Each provider whose patients receive some type of attention from the ACO is also considered a direct customer, and worthy of a specific plan for attention. In the context of sustainable revenue development, NC considers the Medicaid Managed Care plans as the key customers, and the ACO's programmatic management and provision of care coordination services as the product.

As with any purchase decision, the customer will make their own value determination, and the decision to purchase will be based upon a number of factors that provide value to the organization. The NC will build a plan to address the following concerns that an MCO's evaluation of a provider's program of care coordination services will likely include:

1. Are the services truly medically necessary and of sufficient value to the MCO members?
2. Will the services lead to a direct reduction in the Total Costs of Care?
3. Will the quality of the health care be measurably improved?
4. Is the program redundant to the MCO's existing/planned programs?
5. Will the program confuse the MCO's members? The MCO's provider network?
6. Will the MCO be able to administer the program:
    a. Will the savings be clearly attributable to the program and calculable?
    b. Will the program be open to fraud and abuse?
    c. Will the MCO be able to plan and properly pay the payments?

   d. Will the MCO be able to supply the necessary claims and quality metric data?
   e. Will the program expose any shortcomings of the MCO's management?
   f. Will the overall cost of administering the program eat up any cost savings?
7. Will the program have any marketing/public perception benefits to the MCO versus the competition?
8. What are the outside / regulatory pressures regarding this program?
9. How much of the savings must the MCO share in order for the program to commence?
10. Will the program put the MCO (or the career of MCO supporters) at risk if the program fails?

It is the sum total of the answers to the previous questions that will drive the MCO managers' ultimate decision to partner with the ACO or not.

Therefore, the marketing plan will be designed to present the program in a comprehensive, yet simplified manner that requires little effort and risk on the part of the MCO mangers. Initial program description materials will be developed that describe the process of care coordination from patient identification and prioritization through to the delivery of the final quality and financial metric reports that the MCO can verify with their own internal information. The administrative burden that the MCO will have to assume under the program will be minimized via a well thought out process diagram that is based upon that particular MCO's known operational process. The burdens and benefits will be described in a manner that is easily understood by skeptical MCO managers. Facts based upon past performance will make the sell easier, but the hesitancy on the part of the MCOs will be based upon their knowledge of their own limitations, and their yearly goals and objectives. This sales cycle (process) will be lengthy, so preparing the plan and materials will be done as soon as possible following the ACO's approval in the demonstration .

The "product packages" described above will take into consideration the significant reconciliation and payment cycle times for incentive programs based upon gainsharing. The discussion of the cycle times' impact on revenue recognition and cash receipts in the following financial section presupposes a set of interim payments based upon a capitation payment for care coordination services or a direct fee-for-service payment process.

Communications Plan

Currently, the NC plans to communicate these benefits to MCOs through a series of white papers on relevant topics and face-to-face meetings. Health care consumers will be made aware of the opportunities the ACO provides for care coordination through printed brochures and fact sheets, as well as open community forums, which will be held quarterly.

Financial Projections

The Financial Plan should include the financial outlook for the entire duration of the New Jersey Accountable Care Organization Demonstration Project. (3 years). The ACO must estimate revenues, expenses, and profits (or losses), and should identify potential funding streams. One of these funding streams will be the ACO's income from its gainsharing arrangements. If the ACO does not have a gainsharing plan in place, it can use a 50 percent share of estimated TCOC as the projection. The ACO should use this interactive workbook to model separate scenarios, to allow for variability in patient population, funding, and participation by providers and managed care organizations.

The Shared Savings Concept

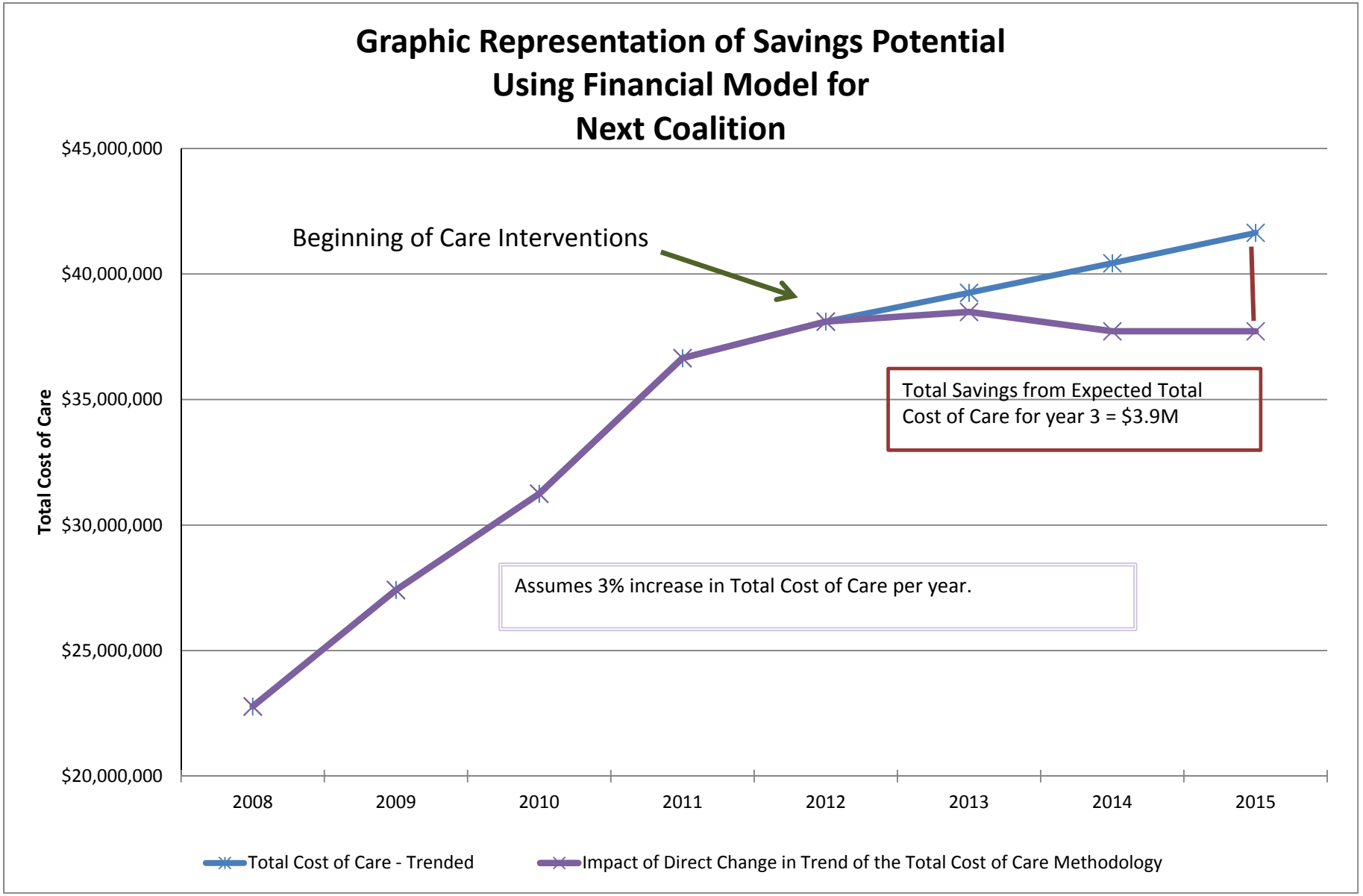
As shown in the chart titled "Graphic Representation of Savings Potential Using Financial Model for Next Coalition," the "savings" comes from the difference in overall costs of an unmanaged population vs. the overall costs of the ACO's population that has had the benefits of care coordination. In the chart the blue line represents the unmanaged (or counterfactual) population's Total Cost of Care ("TCC"). The TCC is the sum of all payments made for eligible Medicaid benefits for all the members in a population. The TCC is typically broken down into a monthly average by recipient (per member per month or "PMPM"). The purple line is the TCC for the population to be managed by the ACO.

In this example, driven by the underlying financial model described below, the care interventions begin at the end of 2012 and start to reveal a break in the medical cost trend of the ACO's population by the end of 2013. This trend continues through the end of 2015. As discussed in detail below, the gain share is the negotiated portion of the savings the ACO will receive when the actual TCC is subtracted from the counterfactual TCC. In this example, the total amount saved is $3.9 million or $13.64 PMPM.

In an optimal partnership for this type of endeavor, each party should have some potential for reward, as there is no savings without the concerted efforts of each party.

This seems simple enough, but the key is the delivery of the payment: since all claims must be settled before the savings is actually realized, the reconciliations are typically done at least 6 months after the year is over. Therefore, a key for the NC's business planning is: how to provide services for 18 months before seeing an incentive payment.

Currently, the ACO is considering Partial Interim Payments and payment for care coordination services provided by the ACO to help bridge this gap.


Graphic Representation of Savings Potential
Using Financial Model for
Next Coalition
$45,000,000
$40,000,000
$35,000,000
$30,000,000
$25,000,000
$20,000,000
Total Cost of Care
Beginning of Care Interventions
Total Savings from Expected Total
Cost of Care for year 3 = $3.9M
Assumes 3% increase in Total Cost of Care per year.
2008
2009
2010
2011
2012
2013
2014
2015
Total Cost of Care - Trended
Impact of Direct Change in Trend of the Total Cost of Care Methodology

The Model

In order to properly project the possible savings, and thus the revenue available to support the operations, NC needs to understand the size of the populations to be managed and the average Total Costs of Care ("TCC") as expressed in dollars paid in claims per member per month ("PMPM"). The following is a description of the Excel shared savings model developed by AHS specifically for the Safety Net ACO project. It is an interactive "What if" model with numerous parameters that can be adjusted to fit different potential scenarios of population size, baseline costs, overall trend, and potential impact of the ACO's care interventions. The Excel workbook has been provided to the ACO leadership for their use and analyses. The printed representations provided herein are for descriptive purposes only.

AHS and its partner firm, Presscott Associates, has accessed multiple data sources in an attempt to provide a fact based estimate of the population that the Next Coalition will likely have in their designated area.

1. The OptumInsight data warehouse's calendar year 2008 claims and eligibility as reported by the MCO 1 Medicaid Managed Care Plan by zip code for Central County.
2. The New Jersey Universal Bill database compiled for the State Department of Health Services. It comprises all hospital discharges and outpatient services including Emergency Department visits.
3. The NJ Department of Banking and Insurance's HMO enrollment reports for the period 2008 through 2012.
4. The full NJ Medicaid claims and enrollment dataset for the 2009 through 2011 period has been requested and, once available, can be incorporated into the projections in the final business plans.

As is typical when starting such as endeavor, there was little data specifically for this population. Therefore, multiple data points should be used to provide estimates of the current costs of NC's population. Some strategies to remedy this deficiency include:

1. Get actual costs and member months of the population (residents of the NC zip codes) from historical data.
2. Get historical and current MCO membership numbers– statewide and by county.
3. Assume the proportions of MCO membership remain constant by zip code and county – that will give member months in the NC zip codes.

4. Use known Medical Cost Trends to bring the PMPM up to date. With member months and PMPM you can estimate current Total Costs.
5. Apply reasonably conservative future Medical Trend estimates to that population's costs – and provide a cost reduction "What If" factor to estimate potential savings.

Methodology

Step 1: Baseline Costs.
The first step in the buildup was to generate a proper weighted average PMPM for the ACO's designated area from the MCO 1 data by consolidating the five zip codes that contain sufficient data for their MCO 1 residents (data for zip 12340 was insufficient). In 2008, MCO 1's Total Cost of Care, not including Behavioral Health costs and Pharmacy costs (which were estimated to be $25-$30 PMPM), was $117.71.

Step 2: Trend Development.
A cost trend was developed by using the base PMPMs for the zip codes and bringing them to 2012 and beyond to 2015 by year over year percentage increases of 3%. *This conservative trend number was selected as a starting point for two reasons; one, the base costs do not include pharmacy, which is one of the segments of medical spend that has experienced a tremendous increase in recent years; and two, the purpose of the model is to estimate revenue potential, therefore conservatism dictates minimizing estimated revenue.* The model has individually adjustable yearly inflation parameters so that the model can accommodate new information as it is developed. In this step, we held the member months constant in order to focus on the pure TCC trend.

Step 3: Membership estimates.
The MCO 1 baseline member months were converted to an estimate of actual membership by zip code through a comparison with the DOBI enrollment reports. This same approach was used to generate member month statistics by zip code for each year for the MCO 2 membership as reported to DOBI. Those enrollment reports were not available by county in past years, so the proportion of membership by county in the current year was applied to the earlier years. This actually overstated the average member months per enrollee in 2008, but since this statistic was not germane to the calculations, it was left overstated. This process developed reasonable enrollment figures for NC's designated area.

Step 4: Consolidated Membership and Trend.
ACO-specific PMPM and member month totals were estimated by consolidating the member month estimates for the MCO 2 population within the designated area and those known for the MCO 1 population. One significant assumption was the application of the MCO 1 PMPM for the MCO 2 population. The model has an index parameter so that, should definitive information come to light showing the MCO 2 PMPM to be significantly different that the MCO 1 PMPM, the model can easily accommodate the new cost base. The costs were trended out to 2015 as a baseline or counterfactual population.

Step 5: Modeling Intervention Impact:
In this final step of the model, three "what if" scenarios are enabled. The blue shaded boxes contain parameters for seeing what the impact would be if:

1. The Total Cost of Care were to be improved by X%;
2. The TCC's trend were to be X%; and
3. The estimated cost savings from interventions on specific cases were to be realized.

This estimated cost savings approach can handle the anecdotal or "one off" cases where a patient with 200 admissions last year was now experiencing only 2 this year. At a rate of $5,000 per admit, that is a real savings of approximately a $990,000 dollars. The chart on page 22 has been included showing the calculated costs of the admissions and visits of the Medicaid recipients in the NC's designated area during 2011. The estimates of savings generated from improving the utilization rates of specific cases can be much more compelling when using these known costs per unit.

Each of these scenarios provide a total cost savings and a PMPM that is fed directly into a proforma and allows different scenarios to be modeled. The specifics of what costs should, or should not be included, or precisely how the calculations should be made will need to be compared to the benchmarks proposed by DeLia and Cantor in the publication *Recommended Approach for Calculating Savings in the NJ Medicaid ACO Demonstration Project*, a copy of which is available at www.cshp.rutgers.edu/Downloads/9290.pdf.

The Proforma:
A proforma was created using the most recent ACO expense budget and linking the revenues to the model. In the blue shaded boxes the managers can postulate various budgeting scenarios by adjusting the parameters to arrive at final scenarios and projections for the final business plan. Gainsharing percentages, partial interim

payments, declining grant funding, and individual expense categories can be modeled with the resulting bottom line instantly available.

Applied Health Strategies, LLC

Step 1

2008 Baseline Population Total Costs of Care by Medicaid Program Type

Jerseytown Next Coalition

Designated Area	TANF				SSI Non-Dual				CHIP				Combined Population			
	Mbr Mths	Avg Mbrs	PMPM	TCC	Mbr Mths	Avg Mbrs	PMPM	TCC	Mbr Mths	Avg Mbrs	PMPM	TCC	Mbr Mths	Avg Mbrs	PMPM	TCC
12345	3,664	305.3	96.69	354,286	321	26.8	320.97	103,030	480	40.0	57.08	27,396	4,465	372.1	108.56	484,713
12346	5,880	490.0	77.53	455,862	574	47.8	449.90	258,240	664	55.3	36.70	24,366	7,118	593.2	103.75	738,468
12347	6,094	507.8	105.73	644,295	754	62.8	249.81	188,359	621	51.8	581.04	360,825	7,469	622.4	159.79	1,193,479
12348	2,202	183.5	98.01	215,817	200	16.7	232.06	46,413	268	22.3	45.91	12,303	2,670	222.5	102.82	274,533
12349	3,640	303.3	68.47	249,226	340	28.3	308.02	104,725	270	22.5	44.26	11,951	4,250	354.2	86.09	365,903
NC Totals	21,480	1,790.0	89.36	1,919,487	2,189	182.4	320.13	700,767	2,303	191.9	189.68	436,842	25,972	2,164.3	117.71	3,057,096
Other Central	10,805	900.4	84.17	909,494	1,134	94.5	374.26	424,410	3,647	303.9	49.84	181,766	15,586	1,298.8	97.25	1,515,670

One Zip Code yielded insufficient activity to model: 12340

Applied Health Strategies, LLC

Step 2

2008 Baseline Population Total Costs of Care Trended to 2015

Medical Trend alone - Holding Membership constant

Jerseytown Next Coalition

Designated Area	Combined Population Mbr Mths	Avg Mbrs	PMPM	TCC	Trend Factors: 3% 2009 PMPM	2009 TCC	3% 2010 PMPM	2010 TCC	3% 2011 PMPM	2011 TCC	3% 2012 PMPM	2012 TCC	3% 2013 PMPM	2013 TCC	3% 2014 PMPM	2014 TCC	3% 2015 PMPM	2015 TCC
12345	4,465	372.1	108.56	484,713	111.82	499,254	115.17	514,232	118.62	529,659	122.18	545,549	125.85	561,915	129.62	578,773	133.51	596,136
12346	7,118	593.2	103.75	738,468	106.86	760,622	110.06	783,441	113.37	806,944	116.77	831,153	120.27	856,087	123.88	881,770	127.60	908,223
12347	7,469	622.4	159.79	1,193,479	164.58	1,229,283	169.52	1,266,162	174.61	1,304,146	179.85	1,343,271	185.24	1,383,569	190.80	1,425,076	196.52	1,467,828
12348	2,670	222.5	102.82	274,533	105.91	282,769	109.08	291,252	112.36	299,990	115.73	308,990	119.20	318,259	122.77	327,807	126.46	337,641
12349	4,250	354.2	86.09	365,903	88.68	376,880	91.34	388,187	94.08	399,832	96.90	411,827	99.81	424,182	102.80	436,907	105.89	450,015
NC Totals	25,972	2,164.3	117.71	3,057,096	121.24	3,148,809	124.88	3,243,273	128.62	3,340,572	132.48	3,440,789	136.46	3,544,013	140.55	3,650,333	144.77	3,759,843
Other Central	15,586	1,298.8	97.25	1,515,670	100.16	1,561,140	103.17	1,607,974	106.26	1,656,213	109.45	1,705,900	112.73	1,757,077	116.12	1,809,789	119.60	1,864,083

The average number of members for the NC Coalition is calculated by dividing the membermonths by 12.
It is used for reasonableness testing only and further calculations will be based upon MCO reports to the state.

One Zip Code yielded insufficient activity to model: 12340

Applied Health Strategies, LLC

Step 3

ACO Membership in Medicaid HMOs

Using: NJDOBI reports as of 3/31/12
MCO 1 2008 Data
Known data points are Bold and Italicized

	2008				2009				2010				2011				2012			
	Members	%	Member Months	%	Members	%	Member Months	%	Members	%	Member Months	%	Members	%	Member Months	%	Members	%	Member Months	%
MCO 2																				
Total Statewide Members	***373,439***				***437,167***				***474,351***				***539,385***				***545,015***			
Central	24,995	6.7%			29,261	6.7%			31,749	6.7%			36,102	6.7%			***36,479***	***6.7%***		
MCO 2 – NC Zips	15,621		167,505	62%	18,287		196,090	62%	19,842		212,769	62%	22,562		241,939	62%	22,798		244,465	62%
MCO 2 - Other Central	9,374		100,521	38%	10,974		117,675	38%	11,907		127,684	38%	13,540		145,190	38%	13,681		146,705	38%
			268,026	100%			313,765	100%			340,453	100%			387,129	100%			391,170	100%
MCO 1																				
Total Statewide Members	***247,771***				***286,245***				***357,272***				***410,196***				***411,914***			
Central	3,876	1.6%			4,477	1.6%			5,588	1.6%			6,416	1.6%			***6,443***	***1.6%***		
MCO 1 – NC Zips	2,422		***25,972***	***62%***	2,798		30,005	62%	3,492		37,450	62%	4,010		42,998	62%	4,027		43,178	62%
MCO 1 - Other Central	1,453		***15,586***	***38%***	1,679		18,006	38%	2,096		22,474	38%	2,406		25,803	38%	2,416		25,911	38%
			41,558	***100%***			48,011	100%			59,924	100%			68,801	100%			69,089	100%
Average MbrMths per enrollee	10.7																			

Key Assumptions:

1. Percentage of plan membership in the ACO zip codes vs. balance of county zip codes remains constant over time
2. Percentage of plan membership by county remained constant over time
3. The Member Months from the MCO 1 data vs. estimated Membership yields a constant member month per enrollee rate
4. Total Membership tops out in 2012 with approximately 97% eligibles enrolled. ACA growth not in these figures
5. Membership is estimated from member month per enrollee statistics from the MCO 1 data
6. MCO 1 member months per enrollee in 2008 indicates they had greater penetration in Camden in 2008 as a percentage of total

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Step 4

Total Costs of Care for Two MCO Populations

The Next Coalition	Combined Population				Trend Factor: 3% 2009			Trend Factor: 3% 2010			Trend Factor: 3% 2011			Trend Factor: 3% 2012		
	Mbr Mths	Avg Mbrs	PMPM	TCC	Mbr Mths	PMPM	TCC	Mbr Mths	PMPM	TCC	Mbr Mths	PMPM	TCC	Mbr Mths	PMPM	TCC
MCO 1 - NC Zips	***25,972***	2,422	***117.71***	***3,057,096***	30,005	121.24	3,637,758	37,450	124.88	4,676,620	42,998	128.62	5,530,466	43,178	132.48	5,720,238
					Approx Membership:		2,798	Approx Membership:		3,492	Approx Membership:		4,010	Approx Membership:		4,027
MCO 1 - Other Central	15,586	1,453	97.25	1,515,670	18,006	100.16	1,803,555	22,474	103.17	2,318,610	25,803	106.26	2,741,936	25,911	109.45	2,836,022
Costs of Care Estimated by using MCO 1's PMPM:																
MCO 2 - NC Zips	167,505	15,621	117.71	19,716,563	196,090	121.24	23,773,665	212,769	124.88	26,569,649	241,939	128.62	31,118,745	244,465	132.48	32,386,864
					Approx Membership:		18,287	Approx Membership:		19,842	Approx Membership:		22,562	Approx Membership:		22,798
MCO 2 - Other Central	100,521	9,374	97.25	9,775,225	117,675	100.16	11,786,685	127,684	103.17	13,172,898	145,190	106.26	15,428,284	146,705	109.45	16,057,001
Relative Cost Performance of MCO 2 can be adjusted if sufficient information warrants																
MCO 2 PMPM Index	*1.00*															
Aggregated Total Costs of Care																
NC Totals	**193,477**	**18,043**	**117.71**	**22,773,659**	**226,095**	**121.24**	**27,411,423**	**250,219**	**124.88**	**31,246,269**	**284,937**	**128.62**	**36,649,212**	**287,643**	**132.48**	**38,107,102**
NC Membership					Approx Membership:		21,085	Approx Membership:		23,334	Approx Membership:		26,572	Approx Membership:		26,824
Other Central	116,107	7,683	97.25	11,290,895	135,681	100.16	13,590,239	150,158	103.17	15,491,508	170,993	106.26	18,170,219	172,617	109.45	18,893,023

Key Assumptions:

1. Percentage of plan membership in the ACO zip codes vs. balance of county zip codes remains constant over time
2. Percentage of plan membership by county remained constant over time
3. The Member Months from the MCO 1 data vs. estimated Membership yields a constant member month per enrollee rate
4. Total Membership tops out in 2012 with approximately 97% eligibles enrolled. ACA growth not in these figures
5. Membership is estimated from member month per enrollee statistics from the MCO 1 data
5. Average Members Figures are estimated from membership reports from NJ Medicaid.
6. MCO 1 member months per enrollee in 2008 indicates they had greater penetration in Camden in 2008 as a percentage of total

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NJ Medicaid Discharge Data

Calendar Year 2011 Utilization For Residents of The Next Coalition's Designated Area	Days	TOTAL CHARGES	CALC'D MEDICAID PAYMENT	MEDICAID OUTLIER	TOTAL CALC'D MEDICAID PAYMENT	% of Chgs	Cost per Day	Number of Cases	Cost per Case
All Cases in Facility Database	22,019	286,581,767	26,047,143	1,096,302	27,143,445	9%	1,233	5,663	4,793
Medicaid Fee For Service	7,985	90,651,001	8,248,461	568,644	8,817,106	10%	1,104	1,407	6,267
Managed Medicaid	14,034	195,930,766	17,798,681	527,658	18,326,339	9%	1,306	4,256	4,306
MCO 2	12,665	177,145,751	16,201,949	447,623	16,649,573	9%	1,315	3,906	4,263
MCO 3	776	11,842,600	1,056,239	57,958	1,114,197	9%	1,436	188	5,927
MCO 1	593	6,942,415	540,493	22,077	562,570	8%	949	162	3,473
Inpatient Cases	21,072	265,349,061	24,919,433	1,083,426	26,002,859	10%	1,234	4,716	5,514
Medicaid Fee For Service	7,828	87,948,043	8,047,146	568,644	8,615,790	10%	1,101	1,250	6,893
Managed Medicaid	13,244	177,401,018	16,872,287	514,782	17,387,069	10%	1,313	3,466	5,016
MCO 2	11,921	159,811,011	15,325,850	434,747	15,760,597	10%	1,322	3,162	4,984
MCO 3	759	11,505,573	1,037,725	57,958	1,095,683	10%	1,444	171	6,408
MCO 1	564	6,084,434	508,712	22,077	530,789	9%	941	133	3,991
Same Day Surg/Med Cases	947	21,232,706	1,127,710	12,876	1,140,586	5%	1,204	947	1,204
Medicaid Fee For Service	157	2,702,958	201,315	-	201,315	7%	1,282	157	1,282
Managed Medicaid	790	18,529,748	926,395	12,876	939,271	5%	1,189	790	1,189
MCO 2	744	17,334,740	876,099	12,876	888,976	5%	1,195	744	1,195
MCO 3	17	337,027	18,514	-	18,514	5%	1,089	17	1,089
MCO 1	29	857,981	31,781	-	31,781	4%	1,096	29	1,096

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Potential Savings Impact Worksheet

Step 5

The Next Coalition	Combined Population Mbr Mths	Avg Mbrs	PMPM	TCC	Trend Factor: 2013 3% Mbr Mths	PMPM	TCC	Trend Factor: 2014 3% Mbr Mths	PMPM	TCC	Trend Factor: 2015 3% Mbr Mths	PMPM	TCC
MCO 1 - NC Zips	***25,972***	2,422	***117.71***	***3,057,096***	43,178	136.46	5,891,845	43,178	140.55	6,068,601	43,178	144.77	6,250,659
					Approx Membership:		4,027	Approx Membership:		4,027	Approx Membership:		4,027
MCO 1 - Other Mercer	15,586	1,453	97.25	1,515,670	25,911	112.73	2,921,103	25,911	116.12	3,008,736	25,911	119.60	3,098,998
MCO 2 - NC Zips	167,505	15,621	117.71	19,716,563	244,465	136.46	33,358,470	244,465	140.55	34,359,224	244,465	144.77	35,390,001
					Approx Membership:		22,798	Approx Membership:		22,798	Approx Membership:		22,798
MCO 2 - Other Central	100,521	9,374	97.25	9,775,225	146,705	112.73	16,538,711	146,705	116.12	17,034,872	146,705	119.60	17,545,918
MCO 2 PMPM Index 1.00													
NC Totals	**193,477**	**18,043**	**117.71**	**22,773,659**	**287,643**	**136.46**	**39,250,315**	**287,643**	**140.55**	**40,427,824**	**287,643**	**144.77**	**41,640,659**
NC Membership					Approx Membership:		26,824	Approx Membership:		26,824	Approx Membership:		26,824
Other Central	116,107	7,683	97.25	11,290,895	172,617	112.73	19,459,814	172,617	116.12	20,043,608	172,617	119.60	20,644,916

Percent Improvement in the Total Cost of Care:

	1%			3%			5%	
	Net Trend Factor: 2013	**1.97%**		**Net Trend Factor: 2014**	**-0.09%**		**Net Trend Factor: 2015**	**-2.15%**
	Mbr Mths	**PMPM**	**TCC**	**Mbr Mths**	**PMPM**	**TCC**	**Mbr Mths**	**PMPM**	**TCC**
	287,643	135.09	38,857,812	287,643	134.97	38,822,840	287,643	132.07	37,988,149
	Savings:	**$ 1.36**	**$ 392,503**	**Savings:**	**$ 5.58**	**$ 1,604,985**	**Savings:**	**$ 12.70**	**$ 3,652,510**

Direct Change in the Trend of the Total Cost of Care:

	Net Trend Factor: 2013	**1.00%**		**Net Trend Factor: 2014**	**-2.00%**		**Net Trend Factor: 2015**	**0.00%**	
	Mbr Mths	**PMPM**	**TCC**	**Mbr Mths**	**PMPM**	**TCC**	**Mbr Mths**	**PMPM**	**TCC**
	287,643	133.81	38,488,173	287,643	131.13	37,718,409	287,643	131.13	37,718,409
	Savings:	**$ 2.65**	**$ 762,142**	**Savings:**	**$ 9.42**	**$ 2,709,415**	**Savings:**	**$ 13.64**	**$ 3,922,250**

Estimated Dollar Savings from the Total Cost of Care:

	$ 600,000			$ 1,000,000			$ 10,000	
	Net Trend Factor: 2013	**1.43%**		**Net Trend Factor: 2014**	**0.41%**		**Net Trend Factor: 2015**	**2.97%**
	Mbr Mths	**PMPM**	**TCC**	**Mbr Mths**	**PMPM**	**TCC**	**Mbr Mths**	**PMPM**	**TCC**
	287,643	134.37	38,650,315	287,643	134.92	38,809,824	287,643	138.94	39,964,119
	Savings:	**$ 2.09**	**$ 600,000**	**Savings:**	**$ 5.63**	**$ 1,618,000**	**Savings:**	**$ 5.83**	**$ 1,676,540**

Key Assumptions:

1. Percentage of plan membership in the ACO zip codes vs. balance of county zip codes remains constant over time
2. Percentage of plan membership by county remained constant over time
3. The Member Months from the MCO 1 data vs. estimated Membership yields a constant member month per enrollee rate
4. Total Membership tops out in 2012 with approximately 97% eligibles enrolled. ACA growth not in these figures
5. The PMPM for MCO 1 is used for the MCO 2 estimates.
6. Membership is estimated from member month per enrollee statistics from the MCO 1 data

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JERSEYTOWN'S NEXT COALITION PROFORMA WORKSHEET

			2012	% Change	2013	% Change	2014	% Change	2015
	Membership (See Membership Assumpt Tab)								
1.	Under Incentive Contracts	% of County = 50%	0		26,824		26,824		26,824
2.	Total Eligible in Zips	% of County = 62%	32,972		32,972		32,972		32,972
3.	Total Eligible in Central County		53,180	0%	53,180	0%	53,180	0%	53,180
4.									
5.	**REVENUE**								
6.	Grants								
7.	Direct		1,400,000	30%	1,820,000	-20%	1,456,000	-50%	728,000
8.	Care Coordination Fees	PMPM = $ 3.00			53,112		80,473		80,473
9.	**Gainshare Calculations**								
10.	Est Savings BUT Not Reconciled Therefore, NOT Counted As Revenue YET	ACO's Share = 60%			*457,285*		*1,625,649*		*2,353,350*
11.	Partial Interim Payments	% of Expected = 20%			60,362		325,130		470,670
12.	Gainshare Paid Paid After Reconciliation						396,924		1,300,519
13.	Miscellaneous		0		0		0		0
14.	**Total Revenue**		**$ 1,400,000**		**$ 1,933,474**		**$ 2,258,527**		**$ 2,579,662**
15.									
16.	**EXPENDITURES**								
17.	**Salary**								
18.	100 · Salaries		350,000	69%	590,000	2%	601,800	2%	613,836
19.	105 · Fringe Benefits		140,000	69%	236,000	6%	250,160	6%	265,170
20.	Total Salary		$ 490,000		$ 826,000		$ 851,960		$ 879,006
21.									
22.	**Other Expenses**								
23.	Equipment		20,000		17,427	2%	17,775	2%	18,131
24.	Office Supplies		7,290		7,500	2%	7,650	2%	7,803
25.	Meeting Expenses		2,000		1,000	2%	1,020	2%	1,040
26.	Travel		3,652		1,862	2%	1,899	2%	1,937

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JERSEYTOWN'S NEXT COALITION PROFORMA WORKSHEET

Continued

27.	Training	1,102		3,373	2%	3,441	2%	3,510
28.	Professional Fees License, DEA	1,000		1,000	2%	1,020	2%	1,040
29.	Contracted Services							
30.	Data Analyst (Local University)	50,000		60,000	2%	61,200	2%	62,424
31.	Communications/Public Affairs	60,000		100,000	2%	102,000	2%	104,040
32.	Human Resources and Payroll Services	15,000		10,200	2%	10,404	2%	10,612
33.	Audit and tax	30,000		15,000	2%	15,300	2%	15,606
34.	Health Iinformation Exchange Vendor	100,000		100,000	2%	102,000	2%	104,040
35.	Legal	40,000		20,000	2%	20,400	2%	20,808
36.	Accounting	20,000		15,000	2%	15,300	2%	15,606
38.	Dues, Books & Subscriptions	100	2%	102	2%	104	2%	106
39.	Auto Purchase	19,387	2%	19,775	2%	20,170	2%	20,574
40.	General & Admin Costs	25,922	2%	26,440	2%	26,969	2%	27,509
41.	Printing & Copying	476	2%	486	2%	495	2%	505
42.	Rent & Utilities - Elec/Tel	338	2%	345	2%	352	2%	359
43.	Miscellaneous	4,012	2%	4,092	2%	4,174	2%	4,258
44.	Insurance	20,234	2%	16,000	2%	16,000	2%	16,000
45.	Program Expenses	3,508	2%	3,578	2%	3,650	2%	3,723
46.	Patient Incentive Payments		2%	2,000	2%	2,040	2%	2,081
47.	Total Other Expenses	424,021		425,180		433,363		441,711
48.								
49.	**Total Expenditures**	**$ 914,021**		**$ 1,251,180**		**$ 1,285,323**		**$ 1,320,716**
50.								
51.	**Interest Income**	238	2%	243	2%	248	2%	253
52.								
53.	**Net Profit/(Loss) - Available for Incentives**	**$ 486,217**		**$ 682,537**		**$ 973,451**		**$ 1,259,199**
54.								
55.								

The Gainshare Distribution

The ACO leadership will create a Gainshare Distribution working group of participating providers sufficient to provide adequate representation for the primary care providers, specialists, and hospitals. The group will have a facilitated learning experience on motivational incentives and the various techniques that have been successfully used by other organizations.

The proforma model describes a range of possible savings pools, and the legislation has been crafted wisely such that the utilization of the funds must be to the benefit of the community. The working group facilitator can then elicit what types of suggestions the provider community has that would fit within those parameters. Provider expectations need to be well understood early on in the process.

With the recent approval of the NJ Medicaid waiver, a major shift will be occurring in the methodology for paying for Disproportionate Share and Graduate Medical Education costs at Safety Net Hospitals. In Section XIII FUNDING POOLS of the SPECIAL TERMS AND CONDITIONS ("STCs"), the Waiver establishes the Delivery System Reform Incentive Payment ("DSRIP") Pool. No longer will the use of the proportion of the hospital's Medicaid Patient Days to overall Patient Days be the primary metric for determining a hospital's share of available payments. This Patient Day metric will be impacted by the utilization improvements in the ACO, and would likely have reduced the share of payments to the hospital. The STC goes on to describe a set of plans and programs that the hospitals must put into place for the benefit of the community in order to be eligible for future payments. This presents an excellent opportunity for the NC hospitals to align their DSRIP plan with the ACO's efforts. As a result, the hospitals participating in a Safety Net ACO will have a great advantage in terms of potential positive performance on outcomes measures versus their peers in areas without a viable Safety Net ACO. Since the plans envisioned within the waiver have yet to be developed, the NC will need to integrate the DSRIP plans into their intervention planning for maximum benefit when these plans become available.

Some of the rational parameters that may be used to guide the distribution include:

1. The number of ACO members in the panel of any participating primary care provider.
2. The Total Cost of Care of the members of each panel compared with the other primary care panels.

3. The degree of change in the TCC within a panel.
4. The presence of care coordinators in the primary care offices / medical homes.
5. The provider's satisfaction scores of the members in their panel.
6. The degree of change in the satisfaction scores within a panel.
7. The provider's scoring in composite outcome metrics.
8. The degree of change in the composite outcome metrics within a panel.
9. For hospitals, the degree to which they have contributed capital, real or in-kind, to the ACO.
10. The degree to which a hospital has promoted the cause of the ACO and made operational changes to reduce the costs of treatment and readmissions.

This will likely be a long and somewhat contentious process with many iterations of the prospective distribution methodology.

Quantifying Improvement

Given the ACO's focus on quality improvement and measurement, and the cost of doing so, the ACO should establish a quality improvement section as part of its business plan. In this section, the ACO should lay out the quality metrics it will measure, its quality benchmarks, its measurement procedure, and how quality is tied to payment. This section will be especially useful when developing a gain sharing arrangement with MCOs.

The governance team will provide sufficient direction to the clinical and administrative managers such that the ACO ties in the mandatory quality metrics and the voluntary metrics they select from those measures provided by the State of New Jersey to payment. The ACO will also consider additional measures to add at a later time to ensure a proper mix of outcome, process, and patient experience measures. The baseline data for the designated area will be carefully analyzed to establish a proper baseline from which to set the improvement targets.

The leadership team at the NC is well-versed in such analysis and goal directed activities. Board leaders have accepted the concept of "Metric Management," and are pursuing supporting data for each of their initiatives. The NC has also developed an approach based on the Camden Coalition's work on "Hotspotting" and the NC's community collaboration on care coordination has demonstrated an excellent understanding of the targeted and multidisciplinary approach. Since the ACO will be required to demonstrate its effectiveness and corresponding value to the community by reporting these nationally accepted measures of performance, it will also establish performance expectations at the individual provider/practice level.

The NC will consider how to tie payment to quality on both an ACO and provider level as part of its gainsharing arrangement, which will be submitted to the state at a later time.

Extensibility

A section on extensibility should also be included to show how the ACO plans to serve a growing need over time. This growth may be a result of an increase in members served, an expanded designated area, greater demand for services, or other variables. This section should show how the ACO will deal with this matter, which may involve additional funding, personnel, infrastructure, and/or information technology resources.

Preliminary estimates place the total membership that would be immediately available for the Next Coalition ACO at 26,000. However, the ACO aims to expand the beneficial components of their various programs to the appropriate members in the broader population to achieve its goal of making Jerseytown the healthiest city in New Jersey. The coalition's care teams have had early success managing patients with high rates of emergency department use and in-patient recidivism.

As a reference on the matter of staffing resource forecasting, care coordinator case load levels from the successful entities in the Medicare Care Coordination Demonstration project were used in the table below. It is readily apparent that a centralized care coordination program would require substantial teams of coordinators.

Number of Care Coordinators Needed				
		Caseload of Coordinator		
ACO's Population	% in Need of C C	100	75	50
25,000	10%	25	33	50
25,000	15%	38	50	75
25,000	20%	50	67	100
37,500	10%	38	50	75
37,500	15%	56	75	113
37,500	20%	75	100	150

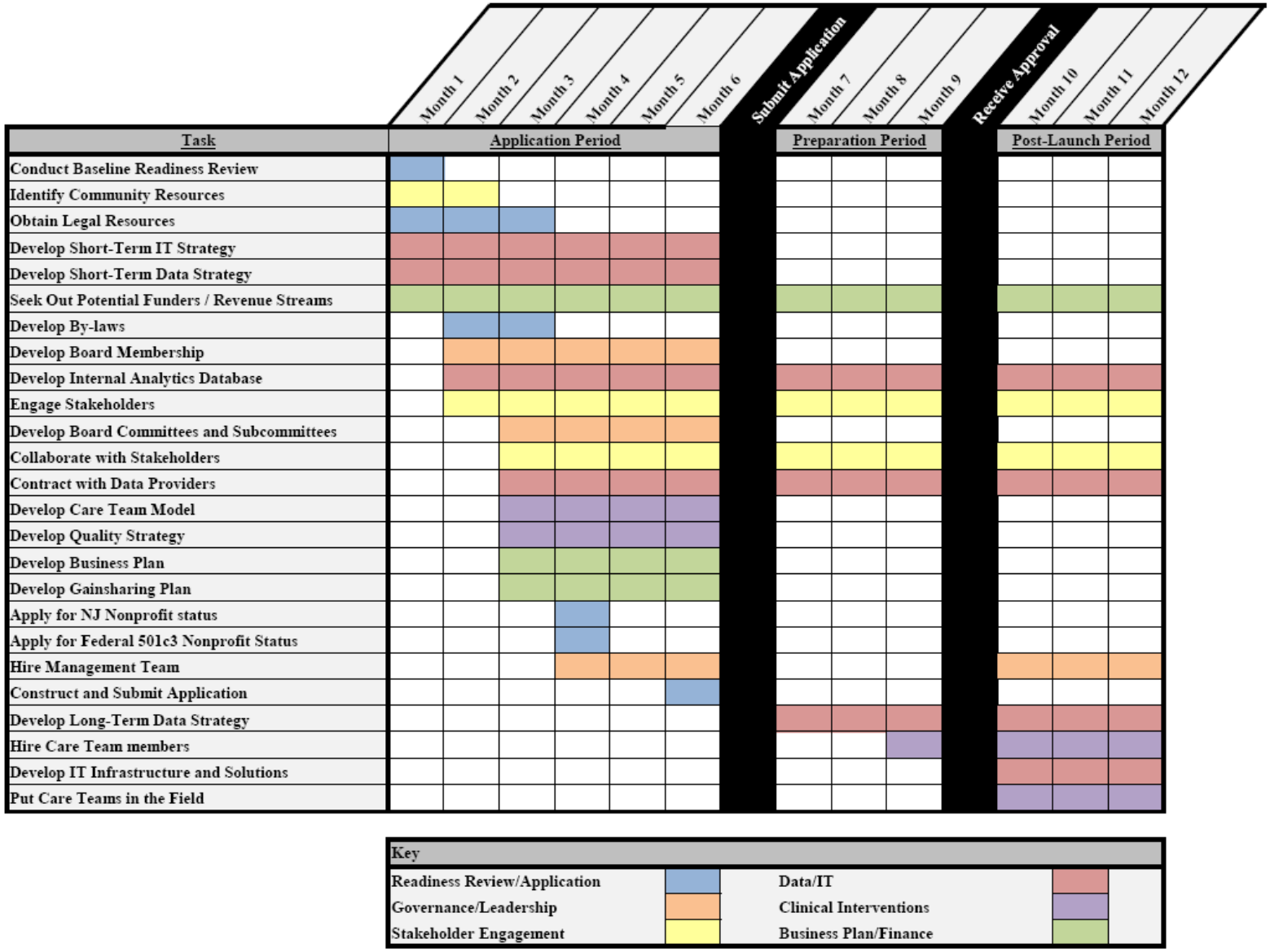
The key will be in the ability of the NC clinical team to efficiently interact with the existing providers and the care coordination resources present within those practices. In this manner, the ACO's team could be seen as the hub for the data and information, with the ability to handle the toughest cases using their multi-disciplinary care teams. The transfer of best practices and techniques, as well as the development and dissemination of resource guides, can make the local providers much more efficient.

This type of approach is another reason that the development of a comprehensive understanding of the participating ACO providers' performance and capabilities is critical to the success of the NC's Safety Net ACO.

ACO Readiness Assessment Tool

A useful attachment to the Business Plan may be the Community Readiness Assessment provided in Appendix A. In addition to identifying whether the ACO itself is ready to apply for the New Jersey Medicaid Accountable Care Organization Demonstration Project, it can also signal to potential funders, partners, or other interested parties that the ACO is ready to become a force of change in the community.

Appendix C: Sample Work Plan



About The Nicholson Foundation

The Nicholson Foundation works to address the complex needs of vulnerable populations in New Jersey's urban areas by encouraging the reform of health and human services delivery systems. The Foundation acts through partnerships with government, civic intermediaries, and local service providers. The Nicholson Foundation carries out its mission by convening like-minded partners, making funds available to seed new processes and programs, and providing grantees with technical assistance during project research, planning, and implementation. For more information, visit www.thenicholsonfoundation-newjersey.org.

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The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care access and quality for low-income Americans. CHCS works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.

CHCS Center for Health Care Strategies, Inc.

200 American Metro Blvd., Ste. 119
Hamilton, NJ 08619
609.528.8400
www.chcs.org

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