



SETON HALL | LAW
Center for Health &
Pharmaceutical Law & Policy

New Jersey's Medicaid ACO Pilot Program: Moving Forward

John V. Jacobi

June 30, 2014

ACKNOWLEDGEMENTS

This Report is produced with the support of the New Jersey Health Care Quality Institute. Thanks to Tara Ragone and Kate Greenwood of Seton Hall Law School, and Linda Schwimmer, Jeffrey Brown, and Allison DeBlois of the New Jersey Health Care Quality Institute. Thanks also to the Nicholson Foundation for support of this project.

DISCLAIMER

This Report is not intended to be and may not be treated as legal advice, and does not provide a basis for any attorney-client relationship between the authors or their institution and any person. The Report is provided for information only, and is intended solely for educational use. All persons are encouraged to consult counsel to obtain specific guidance and advice on any matters discussed herein.

TABLE OF CONTENTS

I.	INTRODUCTION	4
II.	THE ACO PILOT IN NEW JERSEY	6
III.	MEDICAID MANAGED CARE	12
	A. The Growth of Managed Care in Medicaid Nationally	12
	B. New Jersey’s Comprehensive Waiver	15
IV.	DEVELOPING MISSION OF MEDICAID ACOs: COMPLEMENTARY WITH MEDICAID MCOS	18
	A. Medicaid ACOs and Community-based Population Health	18
	B. Building on Strengths: Medicaid ACOs and Managed Care	21
V.	CONCLUSION	28

I. INTRODUCTION

New Jersey's Medicaid ACO Pilot is designed to improve the care available to Medicaid beneficiaries, who too often confront barriers to primary care and coordinated care for serious illness and chronic conditions.¹ This systemic dysfunction has both human and financial costs, as preventable conditions result in emergency department or inpatient hospital care, and uncoordinated treatments deprive beneficiaries of the full benefit of our health system's power. The Legislature set the Pilot in motion with the goals of reducing inefficiencies by increasing access to primary care, behavioral health services, pharmaceutical therapies, and dental care while advancing health outcomes and overall quality.²

Can those goals be realized, given the shift in New Jersey Medicaid from a mixed fee-for-service/managed care system to one dominated by managed care? In our first Report,³ we described the history of New Jersey's ACO Pilot legislation,⁴ and many of the legal and logistical hurdles that communities must confront to participate, including federal and state antitrust and fraud and abuse statutory concerns and a range of common law issues. We also described the provision in the legislation allowing ACOs to be sustained in part through sharing with the State the financial savings generated from improvements in care delivery in fee-for-service Medicaid.⁵ In addition, we observed that approval of New Jersey Medicaid's

¹ See N.J. STAT. ANN. § 30:4D-8.1(a).

² See *id.* § 30:4D-8.1(b).

³ See John V. Jacobi, Tara Adams Ragone, and Kate Greenwood, *New Jersey's Medicaid ACO Pilot Program, Past and Future: A Baseline Report* (Dec. 31, 2013) (hereinafter "*Baseline Report*"), available at <http://law.shu.edu/Health-Law/upload/nj-medicaid-aco-pilot-program-past-future-baseline-report.pdf>.

⁴ N.J.P.L 2011, c. 114, codified as N.J. STAT. ANN. § 30:4D-8.1 *et seq.*

⁵ See N.J. STAT. ANN. § 30:4D-8.5.

Comprehensive Waiver application (“Comprehensive Waiver”)⁶ resulted in the placement of nearly all Medicaid beneficiaries into managed care.⁷ We noted that this shift away from fee-for-service Medicaid removed a principal source of sustainable funding for the ACOs.⁸

This Report takes up the relationship between the Medicaid ACO Pilot program and the managed care orientation of New Jersey’s Medicaid system, as it will move forward under the Comprehensive Waiver granted by the federal government in 2012. In the interim, the New Jersey Department of Human Services has finalized the regulations governing the Medicaid ACO Project,⁹ permitting communities to move forward with applications for certification as Medicaid ACOs. We conclude that the ACOs will have to reorient their business plans to mesh with those of New Jersey’s Medicaid-participating managed care organizations (“MCOs”), as these MCOs serve as the fiscal conduit and first-level care-delivery managers under the Comprehensive Waiver. We also conclude that the accommodation of the missions of Medicaid ACOs and Medicaid MCOs can be fruitful for both sets of organizations, and for Medicaid recipients in New Jersey. In addition, we conclude that the active participation of Medicaid ACOs, Medicaid MCOs, and New Jersey Medicaid will be necessary to realize the full benefit of the potentially transformative work of communities as they embrace Medicaid accountable care.

This Report first will briefly summarize the genesis and mission of the Medicaid ACO Pilot. It then will describe the growth and current status of Medicaid managed care, nationally and under the

⁶ See State of New Jersey, Department of Human Services, in Cooperation with the Department of Senior Services and the Department of Children and Families, *Section 1115 Demonstration Comprehensive Waiver* (Sept. 9, 2011) (hereinafter “*Comprehensive Waiver*”), approved by Letter, Marilyn Tavenner, Acting Administrator, Centers for Medicare & Medicaid Services, Dep’t of Health & Human Services, to The Honorable Jennifer Velez (Oct. 2, 2012) (hereinafter “*Waiver Approval Letter*”).

⁷ See State of New Jersey, Department of Human Services, in Cooperation with the Department of Senior Services and the Department of Children and Families, *Section 1115 Demonstration Comprehensive Waiver* (Sept. 9, 2011) (hereinafter “*Comprehensive Waiver*”), approved by Letter, Marilyn Tavenner, Acting Administrator, Centers for Medicare & Medicaid Services, Dep’t of Health & Human Services, to The Honorable Jennifer Velez (Oct. 2, 2012) (hereinafter “*Waiver Approval Letter*”).

⁸ *Baseline Report*, *supra* note 3, at 57-65.

⁹ 46 N.J.R. 5(1) (May 5, 2014), to be codified as N.J.A.C. 10:79A-1.1 *et seq.*

New Jersey Comprehensive Waiver. It then will describe preliminary results of Medicaid ACO projects elsewhere in the country, and suggest a harmonious match for managed care and Medicaid ACOs in general, and in New Jersey in particular.

II. THE ACO PILOT IN NEW JERSEY

The New Jersey Legislature chose the ACO model to advance the goal of improving care access, quality, and efficiency in the Medicaid system, noting that this model of care delivery “has gained recognition as a mechanism that can be used to improve health care quality and health outcomes, while lowering the overall costs of medical care by providing incentives to coordinate care among providers throughout a region.”¹⁰ The acceptance of the ACO model is in part due to the substantial health systems research advancing the model.¹¹ The model achieved further currency when the Affordable Care Act of 2010 featured Medicare ACOs as one of its highlighted tools designed to assist in movement toward a more coordinated, efficient health care delivery and finance system.¹²

Medicare ACOs are intended “to facilitate coordination and cooperation among providers to improve the quality of care for Medicare [fee-for-service] beneficiaries and reduce unnecessary costs.”¹³ The coordination and cooperation among otherwise unaffiliated providers is encouraged through two mechanisms. First, providers joining a Medicare ACO to improve care through more efficient, coordinated care are eligible to share in savings achieved for

¹⁰ N.J. STAT. ANN. § 30:4D-8.1(b).

¹¹ See Elliott S. Fisher *et al.*, *Fostering Accountable Health Care: Moving Forward In Medicare*, 28 HEALTH AFFAIRS w219 (2009); Elliott S. Fisher *et al.*, *Creating Accountable Care Organizations: The Extended Hospital Medical Staff*, 26 HEALTH AFFAIRS w44 (2006).

¹² See The Patient Protection and Affordable Care Act, Pub. L. No. 111-48, § 3022, 124 Stat. 119 (2010); The Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-52, 124 Stat. 1029 (2010).

¹³ See CENTERS FOR MEDICARE & MEDICAID SERVICES, *Statutory Basis for the Shared Savings Program*, available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Statutes_Regulations_Guidance.html.

the Medicare system.¹⁴ Second, to ensure that the coordination of erstwhile competitors does not harm consumers or competition for health care services, several federal agencies released coordinated guidance documents to minimize Medicare ACO exposure to antitrust, fraud and abuse, and tax liability for the ACO's coordinated actions.¹⁵ The clear mission of Medicare ACOs, as described in the statutory and regulatory guidance, is to shift from a fragmented to a coordinated health care delivery and finance system. As Dr. Donald Berwick, then-Administrator of the Centers for Medicare and Medicaid Services described, this integrative movement is critical to improving patient care:

Whether provided through ACOs or an alternative innovation opportunity, coordinated care is meant to allow providers to break away from the tyranny of the 15-minute visit, instill a renewed sense of collegiality, and return to the type of medicine that patients and families want. For patients, coordinated care means more “quality time” with their physician and care team (a patient's advocate in an increasingly complex medical system) and more collaboration in leading a healthy life. And for Medicare, coordinated care represents the most promising path toward financial sustainability and away from alternatives that shift costs onto patients, providers, and private purchasers.¹⁶

The New Jersey Medicaid ACO Pilot clearly shares many clinical and financial goals with the ACA's Medicare ACO initiative. There are significant differences in emphasis, however, as we more fully

¹⁴ See 42 U.S.C. § 1395jjj(a)(1)(B).

¹⁵ See 42 C.F.R. Part 425. See also Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, 76 Fed. Reg. 67,026 (Oct. 28, 2011); Medicare Program, Final Waivers in Connection with the Shared Savings Program; Interim Final Rule, 76 Fed. Reg. 67,992, 68,009 (Nov. 2, 2011); Internal Revenue Service Fact Sheet, *Tax-Exempt Organizations Participating in the Medicare Shared Savings Program through Accountable Care Organizations*, FS-2011-11 (Oct. 20, 2011).

¹⁶ Donald M. Berwick, *Making Good on ACOs' Promise — The Final Rule for the Medicare Shared Savings Program*, 365 NEW ENG. J. MED. 1753 (2011).

described in our prior Report.¹⁷ Medicare ACOs are contractually constructed organizations that mimic integrated delivery systems' ability to coordinate care and manage cost. They are not closely tied to a community (other than, of course, as a result of the ACO participants' physical locations), and the Medicare Shared Savings Program attributes beneficiaries to a Medicare ACO based not on geography but rather on a retrospective analysis of the beneficiary's utilization of primary care services from an ACO provider in a given year.¹⁸ In contrast, New Jersey's Medicaid ACO Pilot is "unique in its ground-up, community-based approach."¹⁹ New Jersey's three-year Pilot focuses on combating fragmented care delivery by permitting only one Medicaid ACO in each designated area,²⁰ which the statute defines as a "municipality or defined geographic area in which no fewer than 5,000 Medicaid recipients reside."²¹

The Medicaid ACO Project roots care and finance transformation at the community level. Each Medicaid ACO must be a nonprofit corporation whose primary purpose is to improve "the quality and efficiency of care provided to Medicaid recipients residing in a given designated area."²² The governing board must include stakeholders in the community, "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"²³ At least two consumer organizations with capacity to advocate for patients from the community must have voting representation on the board, at least one of which must "have extensive leadership involvement by individuals residing within the designated area" and a physical location within the designated area.²⁴ One of the individuals representing consumer organizations must live within the ACO's designated community.²⁵

¹⁷ See *Baseline Report*, *supra* note 3, at 14-18.

¹⁸ See 42 C.F.R. §§ 425.400, 425.402.

¹⁹ TRICIA MCGINNIS & DAVID MARC SMALL, CTR. FOR HEALTHCARE STRATEGIES, INC., POLICY BRIEF: ACCOUNTABLE CARE ORGANIZATIONS IN MEDICAID: EMERGING PRACTICES TO GUIDE PROGRAM DESIGN 7 (Feb. 2012), *available at* http://www.chcs.org/usr_doc/Creating_ACOs_in_Medicaid.pdf.

²⁰ See N.J. STAT. ANN. § 30:4D-8.4(b).

²¹ See *id.* § 30:4D-8.2.

²² *Id.* § 30:4D-8.3(b).

²³ *Id.* § 30:4D-8.4(c)(2)(a).

²⁴ *Id.* § 30:4D-8.4(c)(2)(b).

²⁵ *Id.*

The statute and regulations defining the Medicaid ACO Pilot guide the activities of the ACOs to ensure their fidelity to the goals of improving access and quality while containing cost, and provide substantial protection from the application of federal and state antitrust and fraud and abuse laws.²⁶ The entire legal and regulatory superstructure is important for several reasons. First, without the protections of consumers and competition contained in the law and regulations, federal and state regulators could prohibit the collaborative activities that ACO-participating providers must pursue to improve care coordination and drive efficient use of resources. Second, the guidance contained in the law and regulations circumscribes the nature of the collaborative activities, allowing the investigational component of the Medicaid ACO Pilot to produce useful information about the success of New Jersey's Medicaid ACO experiment.²⁷ Third, the conditions provide assurance that the State and the State's Medicaid beneficiaries will benefit from the Pilot, as the structure represents the State's best judgment as to the form of Medicaid ACO most likely to be successful.

A dry recitation of the legal structures of the Pilot, important though that structure is, does not do justice to the Project, however. New Jersey's Medicaid ACOs are mission driven: those who devote their efforts to their success are committed to working with their local communities to improve residents' health and well-being, in part by

²⁶ See generally *Baseline Report*, *supra* note 3. Since the publication of the *Baseline Report*, the New Jersey Division of Medical Assistance and Health Services adopted in final form the ACO Pilot regulations. See New Jersey Department of Human Services, Division of Medical Assistance and Health Services, *Medicaid Accountable Care Organization Demonstration Project: Implementation of Demonstration Project: Adopted New Rules*, N.J.A.C. 10:79A, 46 N.J.R. 5(1) (May 5, 2014). The final regulations vary little from the draft regulations described at length in the *Baseline Report*, although there are some minor changes. For example, the final regulations require that each Medicaid ACO's quality committee "must include the ACO's medical director, primary care physicians, and at least one physician who specializes in chronic diseases." N.J.A.C. § 10:79A-1.5(c)3i(1)(B). In addition, "the governing board must include at least one primary care physician and also include representation from other physician specialties." *Id.* § 10:79A-1.5(c)3ii(1). Also, the mechanism by which the savings from the ACO's activities will be calculated was changed to permit adjustments to the basic benchmark period expenditures for "factors that affect Medicaid spending in ways that are unrelated to ACO activity." *Id.* § 10:79A-1.6(d)8ii(1). Finally, the final regulations extended the time period for consumer comment on an ACO's gainsharing plan from 30 to 45 days, to enhance the ability of community members to participate in the ACO's activities. *Id.* 10:79A-1.7(d)1.

²⁷ See N.J. STAT. ANN. §§ 30:4D-9 and 14.

improving the performance of the health care delivery system and in part by engaging in population health efforts to reduce the need for medical interventions. This community orientation is not unique or new, but the focused attention to the embrace of that mission is due in part to the creation of the Medicaid ACO Pilot. Dr. Jeffrey Brenner, whose work described the path for the creation of the Pilot, has described his vision for Medicaid ACOs:

Policy makers must begin to lay the groundwork for the new behaviors that must emerge [to replace fragmented, revenue maximizing behavior in the health delivery system] (ie, the ability to collaborate across institutions, coordinate care, improve safety/quality, share data, share resources, expand primary care, conduct regional health planning). Sadly, organizations capable of facilitating these activities do not exist for most regions.

Ultimately all health care is local. Driving down costs and improving quality will require health care providers to work together with hospitals and social service providers on the collaborative mission that focuses on the needs of their patients and community.²⁸

The Pilot's regulations reflect that commitment to encouraging genuine multidisciplinary care coordination at a local level. This commitment appears, for example, in the regulatory definition of "ACO":

an accountable care organization . . . is . . . comprised of an eligible group of ACO participants that work together to manage and coordinate care for Medicaid

²⁸ Jeffrey Brenner, *Building an Accountable Care Organization in Camden, NJ*, 9 PRESCRIPTIONS FOR EXCELLENCE IN HEALTH CARE 1 (Jefferson School of Public Health, Summer 2010), available at <http://jdc.jefferson.edu/pehc/vol1/iss9/5/>.

beneficiaries and have established a mechanism for shared governance that provides all ACO participants with an appropriate proportionate control over the ACO's decision-making process.²⁹

This collaboration must be manifested in the governance structure, such that the governing board includes a variety of health care providers drawn from hospitals, primary care, behavioral health, and social service agencies.³⁰ It must also be manifest in the description of any gainsharing plan filed by an ACO, which must demonstrate the promotion of:

- 1) Care coordination through multi-disciplinary teams, including care coordination of patients with chronic diseases and the elderly;
- 2) Expansion of the medical home and chronic care models;
- 3) Increased patient medication adherence and use of medication therapy management services;
- 4) Use of health information technology and sharing of health information; and
- 5) Use of open access scheduling in clinical and behavioral health care settings.³¹

The coordination of interdisciplinary care among community providers is vital to the Pilot's success. Community orientation however goes further. The governing board, for example, must include two consumer organizations able to advocate on behalf of community residents, and must identify "individuals in its leadership structure responsible for public engagement."³² Its gainsharing plan

²⁹ N.J.A.C. § 10:79A-1.1.

³⁰ *See id.* § 10:79A-1.5(c)(3)(ii).

³¹ *See id.* § 10:79A-1.6(a)(1)(i). *See also id.* § 10:79A-1.6(d)(1)(ix) (gainsharing plan must include a "plan to improve service coordination to ensure integrated care for primary care, behavioral health care, dental, and other health care needs, including prescription drugs").

³² *See id.* § 10:79A-1.5(c)(3)(ii)(3) and (5).

must be “developed with community input,”³³ and must be the subject of a public meeting at which the proposed gainsharing plan is discussed.³⁴ Both the governing board’s composition and the board’s decision-making process, then, must reflect roots in the community – and not only the community of health and service providers, but the community of patients and residents as well.

The complexity that has arisen since the passage of the Pilot legislation is the approval of New Jersey Medicaid’s Comprehensive Waiver, through which nearly all Medicaid beneficiaries will be MCO members. The confluence of these two initiatives – the Medicaid ACO Pilot and the Medicaid Comprehensive Waiver – requires some adjustment. Both MCOs and ACOs work toward the delivery of coordinated care to Medicaid-eligible people. In our previous Report, we briefly described the relationship between MCOs and ACOs in New Jersey’s Medicaid landscape,³⁵ a task we return to here. The following section sets out the recent developments in Medicaid managed care nationally, and in New Jersey.

III. MEDICAID MANAGED CARE

A. The Growth of Managed Care in Medicaid Nationally

The use of managed care in Medicaid got off to a rocky start. In the 1960s, Medicaid managed care was tainted by “illegal marketing, inadequate access, poor quality, and undercapitalized health plans.”³⁶ Increased state and federal regulatory oversight remedied many of these extreme initial difficulties, and in the 1970s and 1980s states began to experiment with greater use of managed care. The early target population for Medicaid managed care was children and their parents, and not the aged and people with disabilities, in part because the generally well parent and child

³³ See *id.* § 10:79A-1.6(a)(1)(vi).

³⁴ See *id.* § 10:79A-1.6(d)(9)(iii).

³⁵ See *Baseline Report*, *supra* note 3, at 57-65.

³⁶ Michael Sparer, *Medicaid managed care: Costs, access and quality of care*, 3 Robert Wood Johnson Foundation, Synthesis Project (Sept, 2012), available at <http://www.rwjf.org/en/research-publications/find-rwjf-research/2012/09/medicaid-managed-care.html>.

population most closely resembled the commercially insured population managed care plans were designed to cover.³⁷ The resemblance was not perfect, however, and some problems persisted due in part to additional difficulties inherent in serving a poverty population with a cluster of co-occurring socioeconomic problems.³⁸ Well into the 1990s, reviewers remained concerned that Medicaid managed care oversight failed to assure the proper balance of cost-savings for state Medicaid programs and access to high-quality networks of providers for program participants.³⁹

With increased state experience with and oversight of Medicaid managed care, states and commentators became more hopeful that the goal of cost-containment and service enhancement could be realized. Between 1990 and 1995, states increased Medicaid managed care enrollment four-fold.⁴⁰ Consumer advocates shared the hope, in light of the very low provider reimbursement rates in many states' fee-for-service systems and the difficulties many Medicaid participants had gaining timely access to health care services. As consumer advocate Geraldine Dallek opined in 1996,

Indeed, Medicaid managed care may offer the last, best opportunity to provide integrated health care for the nation's poor. However, this opportunity will be wasted if states do not learn from their own and others states' experiences how to make managed care fill the promises made by Medicaid so many years ago.⁴¹

Over time, Medicaid programs swept in the overwhelming majority of the low-risk Medicaid beneficiaries such as families with non-disabled children, and began to integrate a greater percentage of

³⁷ See Embry Howell *et al.*, *Medicaid and CHIP Risk-Based Managed Care in 20 States: Experiences over the Past Decade and Lessons for the Future*, at 2 Urban Institute (July 2012), available at <http://www.urban.org/publications/412617.html>.

³⁸ See Marsha Gold *et al.*, *Medicaid Managed Care: Lessons From Five States*, 15:3 HEALTH AFFAIRS 153, 153 (1996).

³⁹ See U.S. GENERAL ACCOUNTING OFFICE, *MEDICAID: STATES TURN TO MANAGED CARE TO IMPROVE ACCESS AND CONTROL COSTS*, 4 GAO/HRD 93-46 (Mar. 1993).

⁴⁰ See Gold *et al.*, *supra* note 38, at 153.

⁴¹ Geraldine Dallek, *A Consumer Advocate On Medicaid Managed Care*, 15:3 HEALTH AFFAIRS 174 (1996).

those with chronic illnesses and disabilities, including the elderly.⁴² States hoped that plans' and regulators' increased experience with Medicaid managed care would permit MCOs to maintain appropriate provider networks, improve care coordination, and enhance care access within fiscally manageable limits.⁴³

But concerns remain on two fronts. The first concern is that the delivery of care to poverty populations is sufficiently different in some cases to call into question large managed care plans' ability to succeed with very poor, very vulnerable populations. As Michael Sparer has observed, "The health care delivery system for the poor is entrenched and decentralized, and health plans generally lack the leverage to ensure systemwide changes."⁴⁴ And Geraldine Dallek has questioned the extent to which a shift to managed care can significantly shift a health care system that has historically underserved the poor: "Unfortunately, the move to Medicaid managed care also could result in the institutionalization of a separate and unequal system of care for Medicaid beneficiaries."⁴⁵

The second concern is that the increasing influx of the most vulnerable Medicaid beneficiaries – those with chronic illness and disability – into Medicaid managed care will challenge the plans' care delivery systems. At the heart of Medicaid managed care are trade-offs among cost, quality, and access.⁴⁶ Shortages of specialty providers necessary for the care of these vulnerable populations long have been a concern in Medicaid managed care plans.⁴⁷ In addition, new methods of caring for high-risk patients are still developing, and "we really need to learn more about how these plans handle long-term care and chronic illness, and the sicker and more frail populations."⁴⁸ Notwithstanding these concerns, most states feel "an economic and political imperative"⁴⁹ to expand Medicaid managed care, even while they work with plans to ensure that high-quality care is provided, and

⁴² See Sparer, *supra* note 36, at 4.

⁴³ See *id.*; John K. Iglehart, *Desperately Seeking Savings: States Shift More Medicaid Enrollees To Managed Care*, 30 HEALTH AFFAIRS 1627, 1628 (2001).

⁴⁴ Sparer, *supra* note 36, at 16.

⁴⁵ Dallek, *supra* note 41, at 176.

⁴⁶ See Sparer, *supra* note 36, at 23.

⁴⁷ See Howell *et al.*, *supra* note 37, at 37-42.

⁴⁸ Iglehart, *supra* note 43, at 1628 (quoting Diane Rowland, Chair of the Medicaid and CHIP Payment and Access Commission (MACPAC) and Executive Vice President of the Kaiser Family Foundation).

⁴⁹ Sparer, *supra* note 36, at 23.

that emerging methods of caring for vulnerable beneficiaries are adopted.⁵⁰

B. New Jersey's Comprehensive Waiver

On September 9, 2011, New Jersey sought a broad set of waivers from standard Medicaid principles. While the Comprehensive Waiver request included a number of components, a major aspect was its request for permission to move nearly all New Jersey Medicaid beneficiaries into managed care.⁵¹ New Jersey has been a leader in the expansion of Medicaid managed care; in 2011, approximately seventy-seven percent of New Jersey beneficiaries were enrolled in a managed care plan.⁵² With the Comprehensive Waiver, New Jersey requested an expansion to additional populations, including the elderly, persons in long-term care, and people with disabilities who previously had participated in fee-for-service Medicaid.

The proposal opened with an explicit reference to the dual historic goals of Medicaid managed care: the improvement of care for beneficiaries, and gains in efficiency for the State:

Over the past decade, the State of New Jersey's (State) NJ FamilyCare/Medicaid program has made tremendous progress in establishing a well-managed, efficient delivery system of care for acute/medical services. The State's managed care program has been recognized nationally for its early use of innovative approaches, such as health-based risk adjustments, health plan efficiency adjustments and overall use of

⁵⁰ See Howell *et al.*, *supra* note 37, at 63.

⁵¹ *Comprehensive Waiver*, *supra* note 7, at 1.

⁵² See U.S. Dep't of Health & Human Servs., Centers for Medicare & Medicaid Services, *Medicaid Managed Care Enrollment Report: Summary of Statistics as of July 1, 2011*, at 4 (2011), available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Medicaid-Managed-Care/Medicaid-Managed-Care-Enrollment-Report.html>.

health plan encounter data within the capitation rate-setting process.

Today, however, much of the State Medicaid program remains outside of this efficient delivery system of care and is instead an unmanaged fee-for-service (FFS) delivery system. There are some features of managed care under FFS programs that include utilization and care management without the financial incentives of at risk managed care. Given the reality of the State's budget, the current program is not sustainable and does not best meet the needs of the individuals it serves. Successful expansion of delivery system care innovations to the services and populations that are presently covered under FFS will pave the way for better care, additional savings and management opportunities.⁵³

The waiver application argued that a benefit of the approval of the Comprehensive Waiver would be that it would enhance the State's "flexibility to define who is eligible for services, the benefits they receive and the most cost-effective service delivery and purchasing strategies."⁵⁴

The application further argued that it would permit greater care coordination than that provided under fee-for-service Medicaid.⁵⁵ With respect to those dually eligible for Medicare and Medicaid, for example, the application assured that the State would require that participating managed care organizations adopt innovative care coordination methods:

Many of the dual eligibles are chronically ill, seriously disabled, or both. Complex health care needs require access to an integrated system where the delivery of care is approached from a health home that promotes care management. Effective July 1, 2011, MCOs in

⁵³ *Comprehensive Waiver*, *supra* note **Error! Bookmark not defined.**7, at 1.

⁵⁴ *Id.* at 2.

⁵⁵ *Id.* at 64.

the State are required to participate in health homes. . . . Integrating care has the potential to greatly contribute to quality improvements and potential savings which could be reallocated to better meet the needs of the dual eligibles.⁵⁶

The application also argued that further employment of innovative integrated care models supports the grant of the Comprehensive Waiver. In addition to the requirement that MCOs develop medical home pilots,⁵⁷ it argues for the benefits of the Medicaid ACO Pilot as a means of improving care within the system created by the Comprehensive Waiver:

ACOs [share the goals of home health pilots of] improving the quality of care delivered to patients through implementation of patient focused care planning activities that are coordinated by providers who are held accountable for the cost and outcomes of care. Ultimately, ACOs provide for greater alignment of provider incentives throughout the health delivery system by implementing a transparent process to measure performance of the participating providers and to incent efficient service delivery through a model of shared savings.⁵⁸

New Jersey's application was approved in most respects, and in all respects relevant to this Report, in a letter dated October 2, 2012 for the time period October 1, 2012 to June 30, 2017.⁵⁹ The approval was subject to "special terms and conditions" on a number of issues,⁶⁰ some of them relevant to this Report, as is described in Section IV

⁵⁶ *Id.* at 65.

⁵⁷ *Id.* at 73.

⁵⁸ *Id.* at 76.

⁵⁹ See Waiver Approval Letter, *supra* note 7.

⁶⁰ See *id.* at 4 (citing to Special Terms and Conditions ("STC") accompanying the Waiver Approval Letter, *see supra* note 7).

below. The next Section describes a melding of the missions of Medicaid managed care and Medicaid ACOs.

IV. DEVELOPING MISSION OF MEDICAID ACOs: COMPLEMENTARY WITH MEDICAID MCOs

A. Medicaid ACOs and Community-based Population Health

New Jersey is one of many states that has initiated experiments with Medicaid ACOs. A recent study reports that “at least 9 states have approved and adopted an accountable care model for providing care to their Medicaid beneficiaries.”⁶¹ At a quite general level, states have similar goals in adopting ACO programs:

ACO arrangements could . . . help Medicaid achieve better-coordinated care that effectively supports complex health needs for some of the most vulnerable patient populations. . . . ACOs can potentially improve beneficiaries’ health through better support for quality care and coordination, while states may see reduction in overall costs as the health care system moves toward greater value.⁶²

Minnesota’s Medicaid ACO project, for example, was created by its legislature in 2010 as a demonstration project.⁶³ The demonstration, like New Jersey’s, has the goals to “enhance primary care as well as care coordination while integrating acute and long term care with

⁶¹ S. Lawrence Kocut *et al.*, *Early Experiences with Accountable Care in Medicaid: Special Challenges, Big Opportunities*, 16 POPULATION HEALTH MANAGEMENT S-4, S-6 (2013).

⁶² *Id.*

⁶³ MINN. STAT. § 256B.0755.

social support services, all of which are expected to reduce costs.”⁶⁴ Similarly, Colorado’s Accountable Care Collaborative has four main goals that are quite similar to New Jersey’s:

- 1) Ensure access to a focal point of care or medical home;
- 2) Coordinate medical and non-medical care and services;
- 3) Improve member and provider experiences; and
- 4) Provide the necessary data to support these goals and move them forward.⁶⁵

A feature of many Medicaid ACO projects that makes them stand out, however, and that establishes their value in advancing quality and efficiency in Medicaid care, is their strong community orientation. As we describe above, New Jersey’s Medicaid ACOs are distinguished from Medicare and commercial ACOs in their community-based population health focus, and are therefore rooted in their patients.⁶⁶ Like New Jersey’s ACOs, many states, including Colorado, Oregon, Iowa, and Vermont, require that their Medicaid ACOs have a community, population health focus.⁶⁷ This community orientation was recently described by advocates of localized attention

⁶⁴ Jennifer N. Edwards, *Health Care Payment and Delivery Reform in Minnesota Medicaid 3* (The Commonwealth Fund Mar. 2013), available at <http://www.commonwealthfund.org/publications/case-studies/2013/mar/minnesota-medicaid-payment>. Cf. N.J. STAT. ANN. § 30:4D-8.1(1)(d) (Medicaid ACO advanced to facilitate improved access to primary care, coordinated care for people with chronic conditions, while improving systems efficiency).

⁶⁵ Colorado Department of Health Care Policy and Financing, Accountable Care Collaborative: Legislative Request for Information #2 (Nov. 1, 2013), available at <http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1251647685492>. These goals are quite similar to those set out in New Jersey’s regulations for New Jersey’s Medicaid ACOS, as is described in Section II above:

- 1) Care coordination through multi-disciplinary teams, including care coordination of patients with chronic diseases and the elderly;
- 2) Expansion of the medical home and chronic care models;
- 3) Increased patient medication adherence and use of medication therapy management services;
- 4) Use of health information technology and sharing of health information; and
- 5) Use of open access scheduling in clinical and behavioral health care settings.

N.J.A.C. § 10:79A-1.6(a)(1)(i); see text accompanying *supra* note 31.

⁶⁶ See text accompanying *supra* notes 17-25.

⁶⁷ Kocut *et al.*, *supra* note 61, at S-7 – S-9.

to the health needs of residents, with attention to making improvements in socioeconomic conditions harmful to health as well as improving facilities for addressing sickness when it occurs:

[New community-based organizations] could build on existing community or regional multi-stakeholder organizations and/or initiatives. They would need to have not only the charge of the Triple Aim but also a carefully defined geographic focus, a portfolio of projects that address population health and health care reform, and sustainable funding. Their purpose would be to build understanding of the problems and create interventions to move the focus from health care to health based on a community's vision and goals.⁶⁸

Why is this geographic orientation so important in poverty communities? The health status of populations is in part a factor of access to health care, but it also is a function of the socioeconomic and ecological conditions where residents live; the social determinants of health statistically swamp medical issues from a causal perspective.⁶⁹ The physical, economic, and social structure of a community can play a role in determining health status. Health care providers are aware of these effects, but to address them they need community organizations to assist them:

In low-income populations, poor health outcomes are often driven by poverty and related social issues, including unstable housing and employment, problems getting transportation, and insufficient access to a nutritious diet. A recent survey found that physicians believe that unmet social needs directly lead to

⁶⁸ Sanne Magan *et al.*, *Achieving Accountability for Health and Health Care*, MINNESOTA MEDICINE, Nov. 2012, at 37, 38, available at <http://www.ncbi.nlm.nih.gov/pubmed/23243752>.

⁶⁹ See RICHARD WILKERSON, *THE IMPACT OF INEQUALITIES* (2005); David R. Williams & Pamela Breboy Jackson, *Social Sources of Racial Disparity in Health*, 24 HEALTH AFFAIRS 325 (2005); David Mechanic, *Rediscovering the Social Determinants of Health*, 19 HEALTH AFFAIRS 269 (2000).

compromised health status, but do not feel confident in their capacity to help their patients meet those needs.⁷⁰

Medicaid ACOs rooted in the community will not solve the broad range of issues resulting from poverty. But, with “place-based”⁷¹ community involvement in their organization and management,⁷² Medicaid ACOs have the opportunity to both understand the region’s often-fragmented care delivery system and also to build into health promotion and care systems a deep understanding of the context in which illness arises and health can flourish. This community orientation is significant for purposes of this Report, as it picks up a thread from the discussion of Medicaid managed care in the previous Section.

B. Building on Strengths: Medicaid ACOs and Managed Care

As New Jersey’s Medicaid ACOs prepare to begin operations,⁷³ a key issue in the success of the Pilot will be the relationship between the ACOs and the Medicaid MCOs.⁷⁴ The need for mechanisms to structure the partnership between MCOs and ACOs arises due to the different and complementary competencies of the two sets of organizations. Medicaid MCOs have the potential to provide very valuable services by, among other things, improving the

⁷⁰ MCGINNIS & SMALL, *supra* note 19, at 3 (citation omitted).

⁷¹ See Charles Bruner & Amy Fine, *Going Beyond Coverage to Improve Community Health*, Center for the Study of Social Policy, Mar. 2012, available at <http://www.acalibrary.org/home/community-health-aca-place-based-initiatives-and-prevention>.

⁷² See *supra* Section II (describing the community orientation of New Jersey’s Medicaid ACO Pilot). See also Alexis Skoufalos & Kate Cecil, *The Journey to Creating Safety Net Accountable Care in New Jersey*, 16 POPULATION HEALTH MANAGEMENT S-12, S-15 (2013) (“The optimal vision for the [New Jersey Medicaid ACO Pilot] is highly community oriented and based on a shared governance model, wherein those who receive the services have an important voice. In contrast, other models are more technocratic (governance through decision making by experts), which has the potential to create tension.”).

⁷³ This Report is being drafted as the regulatory deadline for the initiation of the three-year pilot period for New Jersey’s Medicaid ACOs approaches. See N.J.A.C. § 10:79A-1.5(a)(4) (certification for application for participation due 60 days after the regulations’ effective date, *i.e.*, July 7, 2014).

⁷⁴ See *Baseline Report*, *supra* note 3, at 57-65.

network of health care providers available to Medicaid recipients. Decades of inattention to provider reimbursement rates and provider services left some states bereft of a Medicaid provider network worthy of the name. Medicaid MCOs have the capacity to assemble a suitable network through the use of quality metrics and patient satisfaction data.⁷⁵ They also can create the opportunity for the provision of acceptable provider reimbursement by skillfully guiding utilization to encourage the use of preventive and efficient services in favor of more expensive care.⁷⁶ They have the “back office” capacity for such administrative management and for the oversight of billing and claims payment.

ACOs in their current form in New Jersey and elsewhere are not capable of providing such large scale, sophisticated health finance and care management roles.⁷⁷ They are, however, perfectly suited to the provision of coordinated care to vulnerable populations in discrete communities.⁷⁸ The two roles nest; MCOs are expert at system-wide management of provider networks and claims management, and ACOs are ideally situated to provide intensive services sensitive to the nature of the local delivery system’s pathways, and, more significantly, the community’s social, ecological, and economic circumstances.⁷⁹

As we noted in our first Report, commentators have suggested that the two respective competencies of ACOs and MCOs could be fruitfully merged:

Under a hybrid model MCOs and providers partner to jointly meet ACO core capabilities, dividing responsibilities based on their respective strengths. Health plans continue to perform compliance, state rate setting, and contracting functions and develop payment

⁷⁵ See Sparer, *supra* note 36, at 15-16.

⁷⁶ *Id.* at 11-12.

⁷⁷ See MCGINNIS & SMALL, *supra* note 19, at 7.

⁷⁸ See *supra* Section IV(A).

⁷⁹ This is, of course, something of an overstatement. Some MCOs have invested significant time and energy into sophisticated care management services, and over time ACOs may develop the capacity independently to bear risk. But the relative allocation of competencies holds, in large part because the primary tasks of the MCOs require substantial scale, and the primary tasks of the ACOs require deep community involvement on a more modest geographic scale.

models. Plans deliver additional support to providers through encounter and claims reporting, analytics/informatics, project management, and investment capital. . . . This model can tap the strengths of both MCOs and providers. Intensive care coordination and management are essential ACO functions and, many would argue, can only be done at the local provider and community level.⁸⁰

This merger of the two functions has attractions, as it would allow close interaction between the two pieces of the coordinated care puzzle. Such a merger is mildly problematic under the current New Jersey Medicaid ACO Pilot law, as the governance requirements are quite clear that the leadership of Medicaid ACOs must comprise community representatives, providers, and social service agency representatives.⁸¹ It is certainly conceivable that partnerships between ACOs and MCOs could nevertheless be created to merge their competencies.

Well short of such a merger of function is a fruitful, if minimalist, way to think of the relationship between Medicaid ACOs and MCOs. ACOs could serve as subcontractors for MCOs, taking on services that their close community ties and intensive care coordination missions suggest. This means of collaboration could be thought of as a “‘business to business’ model.”⁸² This subcontractor model has already been adopted by MCOs and some of the organizations that will become Medicaid ACOs, and further mutually advantageous arrangements are likely to be struck in the future.

What of the Legislature’s original vision of Medicaid ACO activity? The Medicaid ACO Pilot legislation anticipated that participants in Medicaid ACOs would obtain financial support in two ways. First, to the extent the participants provide Medicaid-reimbursable services, they would continue to receive their provider reimbursements as before, either from New Jersey Medicaid (for fee-for-service patients) or from an MCO (for patients covered by a

⁸⁰ See MCGINNIS & SMALL, *supra* note 19, at 6-7.

⁸¹ See N.J. STAT. ANN. § 30:4D-8.4(c)(2) (setting out required governing board composition).

⁸² See MCGINNIS & SMALL, *supra* note 19, at 11.

Medicaid ACO).⁸³ Second, each ACO would file a gainsharing plan with New Jersey Medicaid⁸⁴ or with a Medicaid MCO that voluntarily enters into a gainsharing arrangement with an ACO.⁸⁵ The law contemplates that ACOs would, under these gainsharing plans, receive compensation for some *pro rata* share of the imputed effect of the ACO's population health activities. That effect would be calculated by computing a benchmark reflecting the per-beneficiary Medicaid expenditures in the community selected by the ACO for coverage, adjusted by some delineated factors.⁸⁶ That benchmark amount then would be compared to the actual Medicaid expenditures (also adjusted by some delineated factors), and the ACO's share of the savings (if any) then would be remitted to the ACO for distribution according to the ACO's approved gainsharing plan.⁸⁷

As is described above, however, there are virtually no fee-for-service Medicaid recipients in New Jersey following the approval of the Comprehensive Waiver. Also, participation of MCOs in gainsharing is voluntary.⁸⁸ Fruitful collaborations on discrete projects are certain to arise between Medicaid MCOs and ACOs. It has been less certain that full, population-based collaborations between the MCOs and ACOs will arise. The structure of the relationship between New Jersey Medicaid and the MCOs, however, suggests that such full partnerships can and should come to pass.

First, the Comprehensive Waiver addresses at length the sophisticated risk adjustment methodologies applied to premium rates for Medicaid ACOs.⁸⁹ The attention paid to this issue is important. As we described in our previous Report, inadequate risk adjustment could leave Medicaid ACOs with the risk of adverse selection, in two waves. Initially, random selection could leave a plan with a membership with higher than average risk. In addition, and more significantly, in the absence of effective risk adjustment, a Medicaid MCO could face conflicting incentives when it comes to enrolling high-risk members. On one hand, it has an obligation, and in many cases a corporate mission, to provide for access to excellent care for

⁸³ N.J. STAT. ANN. § 30:4D-8.12(a).

⁸⁴ *Id.* § 30:4D-8.5.

⁸⁵ *Id.* § 30:4D-8.7.

⁸⁶ *Id.* § 30:4D-8.5(b)(6).

⁸⁷ *Id.* §§ 30:4D-8.5(c) and (d).

⁸⁸ *Id.* § 30:4D-8.7.

⁸⁹ *Comprehensive Waiver, supra* note 7, at 30-31.

all eligible for membership in its plans. On the other, superlative care for high-risk members could come to be known in the community, leading to a progressive increase of high-risk members. Both problems can be addressed by risk adjustments, the goal of which is to render all classes of potential MCO members – regardless of their risk level – similarly attractive from a fiscal perspective.

The Comprehensive Waiver describes New Jersey Medicaid’s multi-prong effort to provide effective risk adjustment. It uses “demographic characteristics (i.e. age, gender and geographic area), and pharmacy drug utilization of the covered members.”⁹⁰ The risk adjustment methodology uses a system that applies different scales of risk adjustment for seniors, the blind and disabled, non-disabled adults, and families with non-disabled children.⁹¹ The separation of the scales permits differential analysis of classes of Medicaid beneficiaries with very different risk profiles. When data necessary for use in the risk adjustment system are not available for a particular beneficiary, the Comprehensive Waiver describes a manual process that permits the scoring of the risk level of that beneficiary.⁹²

New Jersey’s methodology holds the promise of effectively addressing adverse selection issues. The section of the Comprehensive Waiver addressing service delivery to high-risk populations explains that “The State has extensive experience using both [fee-for-service] and MCO encounter data to support rate development and risk adjustment.”⁹³ The commitment by the State in the Comprehensive Waiver to responsibly integrate people with chronic illness and disabilities into managed care,⁹⁴ and the terms of the Special Terms and Conditions accompanying the Waiver Approval Letter⁹⁵ assure that adjustments would be readily made should the methodology prove over time to be insufficiently sensitive to address adverse selection issues.

Second, the Comprehensive Waiver and the New Jersey Medicaid’s MCO contract⁹⁶ demonstrate New Jersey Medicaid’s

⁹⁰ *Id.* at 30.

⁹¹ *Id.* at 31.

⁹² *Id.*

⁹³ *Id.* at 68.

⁹⁴ *Id.*

⁹⁵ STC, *supra* note 60 (accompanying Waiver Approval Letter, *supra* note 7).

⁹⁶ The contract between New Jersey Medicaid and participating MCOs describes this risk methodology as well. *See* CONTRACT BETWEEN STATE OF NEW JERSEY

character of comprehensive case management of vulnerable beneficiaries that the Medicaid ACOs will be empowered to provide. The Comprehensive Waiver describes the requirement that contracting MCOs provide “comprehensive care coordination.”⁹⁷ In addition, the Comprehensive Waiver discusses the integration of health homes, a fundamental building block for Medicaid ACOs, into the MCO delivery system as a means of enhancing access to care and population health management.⁹⁸ It also describes the role of Medicaid ACOs in the waived delivery system, and describes the ACOs as important mechanisms for broadly providing care for vulnerable populations within designated geographic areas:

Within the context of the State’s managed care delivery model, ACOs will provide access to all the services currently available [I]t is the State’s expectation that ACOs be integrated into their respective communities and . . . assist in the coordination of community based services that can close the gap between individual recipients need and available services. . . .⁹⁹

New Jersey’s MCO Contract requires that MCOs coordinate care with community partners, including community social service agencies and behavioral health providers.¹⁰⁰ MCOs are required to monitor their success with health promotion and care access, and to report performance measure results on a wide variety of population health measures.¹⁰¹ They have particular contractual obligations with respect to care for elderly enrollees and people with disabilities, including overseeing “life indicators” including:

DEP’T OF HUMAN SERVS. DIV. OF MEDICAL ASSISTANCE & HEALTH SERVICES AND [Medicaid MCO], CONTRACTOR (Jan. 2014) (hereinafter “MCO CONTRACT”), Article 8, at 9, *available at* <http://www.state.nj.us/humanservices/dmahs/info/resources/care/>.

⁹⁷ *Comprehensive Waiver*, *supra* note **Error! Bookmark not defined.**7, at 68.

⁹⁸ *Id.* at 72-76.

⁹⁹ *Id.* at 77.

¹⁰⁰ MCO CONTRACT, *supra* note 96, Article 4, at 34.

¹⁰¹ *Id.*, Article 4, at 43-56.

- i. Degree of personal autonomy;
- ii. Provision of services and supports that assist people in exercising medical and social choices;
- iii. Self-direction of care to the greatest extent possible; and
- iv. Maximum use of natural support networks.¹⁰²

The support of these important aspects of care for vulnerable populations, often intimate in nature and usually rooted in family and community, as is described in Sections II and IV(A) above, is squarely within the mission and anticipated competence of Medicaid ACOs. Partnership in achieving these important goals for Medicaid's highest risk beneficiaries is a natural.

New Jersey Medicaid will, under the MCO Contract, review each MCO for compliance with its obligations to beneficiaries, which will require evaluation as well by external quality review organizations.¹⁰³ In addition, New Jersey Medicaid will pay performance-based incentives to MCOs for their success in several areas, including rating by an outside quality-rating service, and for connecting their members to appropriate prenatal and preventive care.¹⁰⁴ These premium enhancement payments give MCOs an immediate, positive incentive to partner with community-based ACOs that have the capacity to improve these important, but elusive, health indicators.

The State's program of coordinated care, as evidenced in both the proposal of the Comprehensive Waiver and the adoption of the Medicaid ACO Pilot law, suggests the importance of coordination and partnership between Medicaid MCOs and ACOs. The missions of Medicaid ACOs and MCOs, their economic incentives, and their obligations under regulation and contract support close and fruitful coordination for the benefit of Medicaid beneficiaries.

¹⁰² *Id.*, Article 4, at 51.

¹⁰³ *Id.*, Article 4, at 64-68.

¹⁰⁴ *Id.*, Article 8, at 7-8.

V. CONCLUSION

The State proclaimed its commitment to improving the health status of vulnerable Medicaid beneficiaries in its Comprehensive Waiver and in the adoption of the Medicaid ACO Pilot law. The mandate for meshing the two sets of organizations, and the coordination of the legal and contractual requirements of both, has not always been clear. However, an examination of the vision encapsulated in the Comprehensive Waiver establishes that the State intends to move elder Medicaid beneficiaries, and those with disabilities and chronic illness, into managed care to provide them with the benefit of coordinated care management to improve their access to excellent care. An examination of the mission and structure of Medicaid ACOs in New Jersey and elsewhere establishes that these organizations are capable of providing an integration of social and medical services for vulnerable persons on a population basis, through community focus and partnership. The combination of these two sets of missions and competencies can further the State's goal of improving coordinated and efficient care for all Medicaid beneficiaries by coupling the local, community-based orientation of Medicaid ACOs with MCOs' larger-scale sophistication in the financial management, utilization evaluation, and network formation and maintenance functions. All three partners – the State, Medicaid ACOs, and Medicaid MCOs – have incentives and missions consistent with broad partnership for the good of all Medicaid beneficiaries.