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

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For More Information

This template is part of *The New Jersey Medicaid Accountable Care Organization Business Planning Toolkit*, which was produced by the Center for Health Care Strategies through support from The Nicholson Foundation. To download the complete toolkit, visit www.chcs.org.

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

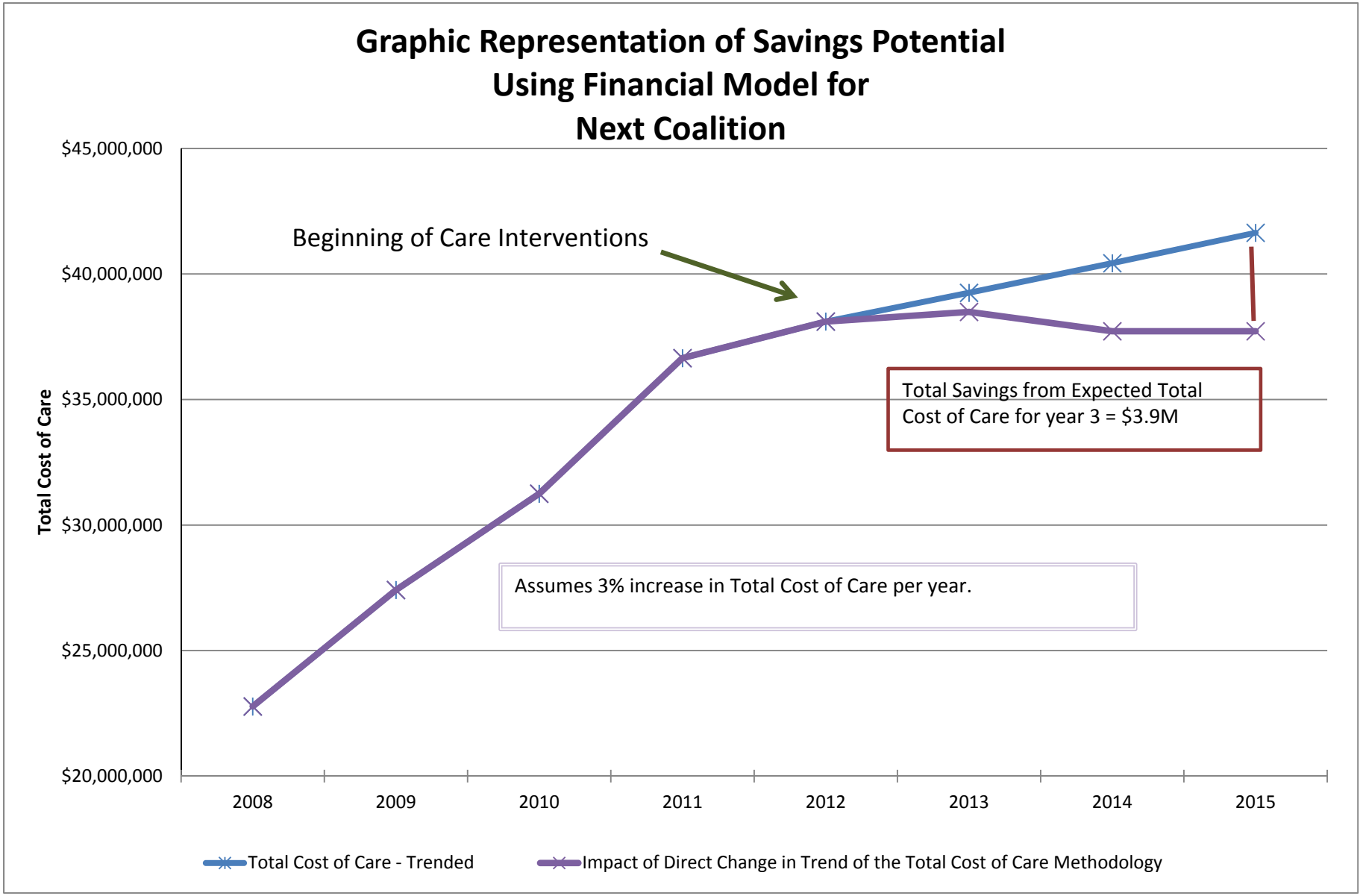
As shown in the chart titled "Graphic Representation of Savings Potential Using Financial Model for Next Coalition," the "savings" comes from the difference in overall costs of an unmanaged population vs. the overall costs of the ACO's population that has had the benefits of care coordination. In the 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.

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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

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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:	2009 3% PMPM	2009 TCC	2010 3% PMPM	2010 TCC	2011 3% PMPM	2011 TCC	2012 3% PMPM	2012 TCC	2013 3% PMPM	2013 TCC	2014 3% PMPM	2014 TCC	2015 3% 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

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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.