

Medicaid 2.0 Blueprint for the Future



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Support for this report was provided through the generous funding of The Nicholson Foundation.



Advancing Health and Promoting Opportunity

The New Jersey Health Care Quality Institute is the only independent, nonpartisan, multi-stakeholder advocate for health care quality in New Jersey. The Quality Institute's mission is to undertake projects and promote system changes to ensure that quality, safety, accountability and cost-containment are closely linked to the delivery of health care services in New Jersey. For more information, www.njhcqi.org.

Acknowledgements

The New Jersey Health Care Quality Institute thanks The Nicholson Foundation for its generous support to undertake the process that resulted in the *Medicaid 2.0: Blueprint for the Future*. In particular, we thank Joan Randell, Chief Operating Officer and Rachel Cahill, Senior Healthcare Program Officer for their encouragement and guidance throughout this project.

We also thank the New Jersey Health Care Quality Institute Board of Directors and the Medicaid 2.0 Steering Committee for their support and leadership throughout the development of the Blueprint.

This Blueprint could not have been created without the contributions and cooperation of a wide range of experts. We met with over one hundred health care stakeholders who graciously shared their knowledge, expertise and recommendations. The report also could not have proceeded without the generous assistance of the New Jersey Office of the Governor, New Jersey Department of Health, and the New Jersey Department of Human Services, Division of Medical Assistance and Health Services. The many additional organizations that generously provided insights and information are listed in Appendix 4. We recognize that all of the experts we engaged for this report have extensive responsibilities; we are deeply grateful not simply for the help of the individuals, but for the generous support of the organizations for which they work for allowing them the time to devote to this project.

Special thanks to policymakers and health care stakeholders from Connecticut, Ohio, Massachusetts, and New York including: Connecticut Department of Social Services, Community Health Center, Inc., MassHealth, Northwest Ohio Pathways, Ohio Department of Medicaid, the Ohio Hospital Alliance, Ohio Office of Health Transformation, the Weitzman Institute, United Hospital Fund of New York, and UnitedHealthcare Community Plan of Ohio who graciously gave time to share their best practices and lessons learned from their Medicaid reform initiatives.

Last but not least, the Quality Institute is enormously grateful to the Transformation Team Leads and all of the team members who generously provided their time and expertise in the formation of the Blueprint recommendations. The Transformation Team Leads were: Dr. Kemi Alli of Henry J. Austin Health Center, Maura Collinsgru of New Jersey Citizen Action, Theresa Edelstein of the New Jersey Hospital Association, Suzanne Ianni of Hospital Alliance of New Jersey, John Kirchner of WellCare Health Plans of New Jersey, John Koehn of Amerigroup New Jersey, Evelyn Liebman of AARP New Jersey, Theodore Pantaleo of Horizon NJ Health, Jennifer Velez of RWJBarnabas Health, and Scott Waulters of UnitedHealthcare Community Plan New Jersey. A list of the Transformation Team members is available in Appendix 5.

Participation of the above listed stakeholders does not imply that they individually, or on behalf of their employer organizations, endorse any specific Blueprint recommendations.

Foreword



Advancing Health and Promoting Opportunity

This *Medicaid 2.0: Blueprint for the Future* lays out a plan to redesign and modernize New Jersey's Medicaid program. It is the result of a thoughtful process that brought together a wide variety of stakeholders from across the State, including healthcare providers, health plan officials, hospital leaders, government officials, union representatives, academics, advocacy groups, and patients.

The development of the Blueprint was conceived and funded by The Nicholson Foundation, which is dedicated to strengthening the health care delivery system that serves New Jersey's most vulnerable populations.

Like the process undertaken by Medicaid 2.0, Nicholson seeks partnerships with policymakers, stakeholders, and service providers in order to achieve transformative, sustainable systems reform.

The size of the population receiving Medicaid services and the magnitude of the State's financial investment in the program make its design of critical importance to the people who receive, provide, and pay for Medicaid services. With the expansion made possible by the Affordable Care Act, Medicaid now provides health insurance to nearly 1.8 million of New Jersey's most disadvantaged residents, including 40 percent of the State's children. The budget for New Jersey's Medicaid program, which is financed by both the federal and State government, is approximately \$15 billion annually. New Jersey's share of Medicaid represents nearly 20% of the State budget. Nearly one in five New Jersey residents rely on Medicaid to access and afford outpatient treatment, hospital care, medications, and other health-related services.

New Jersey's healthcare industry — the State's second largest employer — has a significant economic stake in Medicaid as well. Hospitals alone provide more than 142,000 jobs and \$22.7 billion in total contributions to the economy. On average, about half the revenue for safety net hospitals, and one-fourth of all New Jersey hospitals' revenue, come from reimbursements for Medicaid claims or Medicaid disproportionate share payments. These payments are critical to hospitals' financial stability.

In an era of constrained state budgets, New Jersey's policymakers, too, have an obligation to ensure that Medicaid delivers the highest-quality services in the most cost-efficient way possible.

Over the past decade, New Jersey has made efforts to improve certain elements of its Medicaid program. The Comprehensive §1115 Medicaid Waiver, which was approved by the federal government in 2012 and is in the process of being renewed, was the vehicle recently used to make these improvements. For example, under the Waiver, New Jersey Medicaid converted coverage for long-term services and supports from fee-for-service reimbursements to managed care, becoming one of the first states in the nation to implement this type of important change statewide.

Yet, much more needs to be done to modernize New Jersey’s Medicaid program for the 21st century, to restructure it and align it with the latest evidence-based research. The current program has too often failed to meet the basic needs of Medicaid recipients because of obstacles to access, fragmented care, and limited capacity to concurrently address recipients’ multiple physical, behavioral, and health-related social needs. Also, outdated technology, misaligned incentives, and lack of access to timely and accurate data hamper the efforts of providers to deliver the highest quality care. Health policy innovations that seek to achieve the “Triple Aim” — improved patient experience, improved population health, and reduced cost of care — are no longer nice-to-have add-ons. They are essential to sustaining Medicaid’s financial viability and its capacity to provide quality services to recipients.

Several other states have reengineered their Medicaid programs to address similar problems. Their efforts have reduced the costs of their programs while also improving and streamlining their health-related services. In developing this Blueprint, stakeholders drew on strategies that have been successful in these states and identified new ones that are best suited to New Jersey.

In the face of political uncertainty about the future of federal Medicaid funding, it is now more important than ever that New Jersey implement policies that will protect and improve the availability and quality of healthcare for vulnerable populations. The recommendations included in this Blueprint are a roadmap that can be followed to make the structural and clinical changes that are necessary to strengthen and sustain Medicaid over the short and long term.

The Nicholson Foundation is proud to have funded the collaborative process that led to this Blueprint’s creation. We thank all the stakeholders who freely gave their time, ideas, and expertise. We applaud their willingness to consider a wide range of ideas, and compromise when needed, to develop recommendations that have the potential to transform New Jersey’s Medicaid program.

We are deeply grateful to Linda Schwimmer, Judy Persichilli, Matthew D’Oria, Crystal McDonald, and other staff and advisors at the New Jersey Health Care Quality Institute for their outstanding work in leading this much-needed process.

Joan Randell, Chief Operating Officer
The Nicholson Foundation

Rachel Cahill, Sr. Healthcare Program Officer
The Nicholson Foundation

Medicaid 2.0 Introduction and Goals

Medicaid reform in New Jersey is an ongoing exercise. Each year the State budget process demands an evaluation of more efficient ways to operate the program. With the generous support of The Nicholson Foundation, the New Jersey Health Care Quality Institute began the Medicaid 2.0 project in March 2016 with the goal of developing a strategic Blueprint for policymakers to use to shape the program for the next decade. An overarching objective was to identify multi-year solutions to a number of the more intractable problems within the system, those that often cannot be addressed during the annual debate over State resources and the politics of the New Jersey budget. Between New Jersey's fiscal struggles and the impending federal changes, such as repeal of the Affordable Care Act and other changes to Medicaid financing, there has never been a more urgent time to take a long-term view of the direction of Medicaid and develop a flexible Blueprint to guide reform and innovation.

Essential to the development of the Blueprint was ensuring that input was obtained from all entities involved in Medicaid. Over the last year, the Medicaid 2.0 project team has met with over 100 stakeholders – beneficiaries, providers, payers, legislators and political leadership, State administrators, and others involved in providing direct service to the beneficiaries. Additionally, the Blueprint and its recommendations are informed by extensive primary and secondary research on other state Medicaid programs, services and payment systems, including site visits in Ohio, Massachusetts, New York and Connecticut. We identified five major focus areas from this extensive research: Access and Quality, Behavioral Health Integration, Eligibility and Enrollment, Purchasing Authority, and Value Based Purchasing. We then designated Transformation Teams of health care experts, which met over the course of 10 weeks to assess the problems in each of these areas and make consensus recommendations (See Appendix 5 for a list of Transformation Team members).

The Transformation Teams used their expertise to reconcile the practical application of policy ideas and reforms from other states, with their own on-the-ground experience, developing New Jersey specific goals and timetables for implementation. Setting aside self-interest and working toward consensus in this iterative process allowed stakeholders to offer solutions and innovations that are likely to be successful. Many of the recommendations in the Blueprint are taken directly from the Transformation Teams, some have been expanded upon or included based on the research and investigation of the Quality Institute.

In its final stages, the Blueprint received the benefit of the review and input of the project's Steering Committee (see Appendix 6). Throughout the Blueprint's development, we met with State Medicaid officials to ensure the data and assumptions were correct, and to solicit their input and advice. The process of developing the Blueprint is the first effort of its kind to involve all stakeholders in an inclusive, global discussion about the payment and delivery of health care to the Medicaid population. With funding support from The Nicholson Foundation, we intend to continue to work with stakeholders throughout New Jersey to support the implementation of the Blueprint recommendations. There are endless issues to cover and some exceeded our capacity and timeline for this project. We included many of those ideas in the section *Longer Term Plans to Remodel Medicaid*. Please note that the participation of the State, any of the Transformation Team members, their employer entities, or other entities listed herein does not imply their endorsement of any specific recommendations in the Blueprint.

Executive Summary

The New Jersey Medicaid Program is at a critical juncture. The State is in the midst of a years - long financial crisis, with no end in sight. The federal government is considering strategies to contain or reduce the federal share of Medicaid funding. With likely decreases in federal funding and the State's continuing financial woes, the Medicaid program will be squeezed at both ends. Therefore, no matter what happens at the federal level, State leaders must make wise decisions now, to improve the existing program thoughtfully, in a strategic way, which will better allocate more limited resources and yield long term benefits. But they must act before it is too late.

New Jersey's Medicaid system currently covers over 1.8 million residents and costs federal and State taxpayers over \$15 billion annually. In 2017, the State's share of the Medicaid program cost accounts for nearly 20% of the State budget. The Medicaid program is jointly funded by the federal government and the State; the Federal Medical Assistance Percentage (FMAP) varies by state, based on criteria such as per capita income. In New Jersey, the federal government, with the Affordable Care Act (ACA) expansion, matches \$2 in federal funds for every \$1 in State spending on the program. Any federal changes in this system, therefore, will have significant repercussions on both the health of a significant portion of the State's residents and New Jersey's overall health care infrastructure and delivery system. The new federal Administration has indicated its intent to repeal portions or all of the ACA. This could result in hundreds of thousands of New Jersey residents losing their health care coverage, unless the State were to absorb the full cost of covering those individuals.

There is no historical precedent for the elimination of coverage for the over 552,000 individuals covered through the Medicaid expansion made possible under the ACA. The elimination of the Medicaid expansion would also have a significant negative impact on the State's hospitals, which are required to care for patients regardless of ability to pay. The impact would especially harm those essential hospitals which care for a far higher share of the uninsured and those covered through Medicaid. Under the proposed federal changes, the State could receive a capped amount of federal funding adjusted annually for inflation, a move away from the 65%-35% match of federal and State dollars.

Further complicating the financial picture is New Jersey's unfunded pension and health benefits liabilities, which have triggered a series of downgrades on the State's credit rating. These downgrades and legal obligations all but compel the State to use any incremental revenues to address those outstanding obligations at the exclusion of the State's other needs. In short, there is a very real prospect that New Jersey Medicaid funding will remain flat at best, and at worst, decline significantly. For these reasons, it is essential that New Jersey accelerate and expand existing Medicaid reforms and initiate many of those included in this Blueprint. The recommendations herein aim to generate maximum efficiency and leverage savings that can be used to protect and improve New Jersey's Medicaid program for the health of its recipients and the financial viability of the health system as a whole.

The Medicaid 2.0 project, funded by The Nicholson Foundation and led by the New Jersey Health Care Quality Institute, was shaped through a year-long intensive stakeholder engagement process. The Blueprint is the result of that process. It contains 24 separate recommendations to improve Medicaid's efficiency and effectiveness.

The recommendations have been incorporated into the following broad categories:

A. Modern Foundation – these recommendations are intended to modernize the infrastructure used by the State to oversee and manage the Medicaid program.

1. Establish a New Jersey Office of Health Transformation
2. Increase Transparency of Medicaid Data
3. Improve Eligibility Processing
4. Expand Telehealth
5. Establish Unified Single License System for Integrated Care
6. Upgrade Medicaid Regulations and Managed Care Contract
7. Reduce Fraud, Waste and Abuse

B. Foundational Medicaid Reforms – these recommendations target essential functions in need of an upgrade.

8. Implement Statewide Universal Credentialing System
9. Improve the Accuracy of Network Directories
10. Standardize Quality Measures

C. Upgrades to the Medicaid Model – these recommendations propose fundamental changes to the way services are delivered.

11. Integrate Physical, Mental Health and Substance Use Disorder
12. Establish Medicaid Coverage for Long-Term Residential Services for Substance Use Disorders
13. Reconvene the Behavioral Health Integration Advisory Council

D. Financing Reform – recognizing the State's current fiscal problems, and the potential loss of significant federal funding, these recommendations are intended to improve the return on investment for beneficiaries and taxpayers.

Purchaser Power:

14. Maximize Pharmaceutical Cost Savings
15. Enhance Managed Care Organizations Performance Incentives

Value Based Purchasing and Alternative Payment Models:

16. Initiate Episode of Care Demonstration
17. Expand Patient Centered Medical Home Statewide
18. Develop Clinically Integrated Network of Care for Children
19. Develop Patient Centered Medical Home for Medically Complex Children
20. Establish a Value Based Purchasing Advisory Council

E. Path to Population Health – these recommendations are designed to address the long-term health of the Medicaid population.

21. Improve Maternal and Family Health
 - a. Initiate Maternity Episode of Care (EOC)
 - b. Improve Access to Contraception
22. Evolve the Medicaid Accountable Care Organization (ACO) Demonstration Project
23. Advance a Next Generation Delivery System Reform Incentive Payment (DSRIP)
24. Improve End of Life Care

Executive Summary of the Medicaid 2.0 Blueprint Continued

The Blueprint provides policymakers with well-vetted recommendations to achieve sustainable improvements in quality of care, cost, and outcomes for Medicaid beneficiaries. Many of the recommendations in the Blueprint can be implemented immediately. Swift implementation is essential to preserving the financial viability of the program. Nearly 2 million lives depend on it. Because of the scope of the program and competing interests, all stakeholders will need to cooperate and compromise to achieve success.

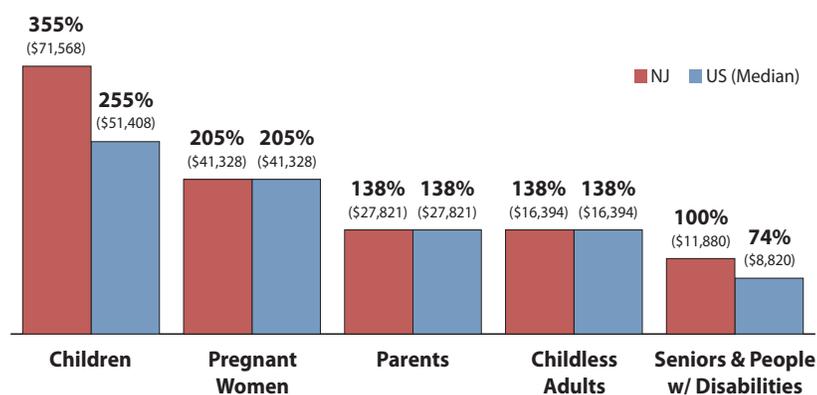
Together the recommendations in the Blueprint have the potential to save New Jersey Medicaid between one to three percent of the projected direct spending of \$11B (not including the \$4B that is earmarked for special programs and administration.) This savings estimate does not include any upfront administrative costs to establish a new program(s). The State must recognize – as they did with the implementation of Managed Long Term Services and Supports (MLTSS) – that in order for the promise of these initiatives to be fulfilled, upfront investments will be necessary. While some of these recommendations are mutually exclusive, some go hand-in-hand and should be implemented as a package (e.g. the clinical integration of physical and behavioral health cannot succeed without the integration of both licensing and financing). Many of the recommendations involve changes to the contracts with the Managed Care Organizations (MCOs) and implementation will require their active engagement.

Lastly, we fully appreciate that reform can be difficult. We do not underestimate the potential impact that many of the recommendations will have on stakeholders, but we believe the recommended reforms are necessary to put Medicaid on a sustainable footing. The Blueprint was intended to catalyze the development and implementation of system-wide improvements to the program. With support from The Nicholson Foundation, the New Jersey Quality Institute will continue to actively engage stakeholders to improve and preserve New Jersey's Medicaid program through the swift implementation of the recommendations.

New Jersey Medicaid Primer

Medicaid/CHIP eligibility levels are highest for children and pregnant women.

Eligibility Level as a Percent of FPL, as of January 1, 2017



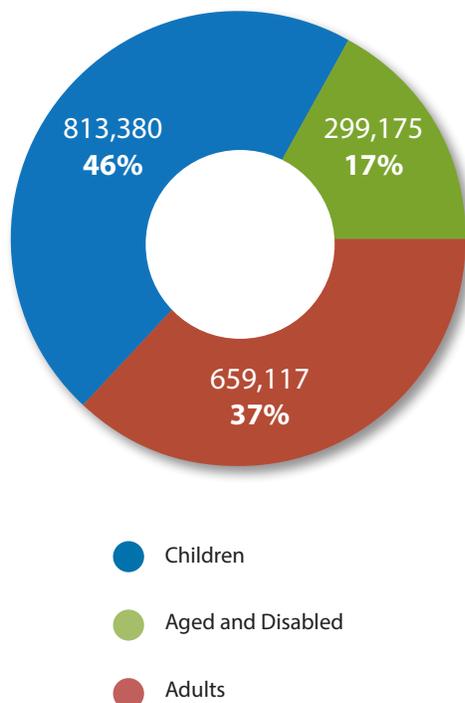
Eligibility levels are based on the Federal Poverty Level (FPL) for a family of three for children, pregnant women, and parents, and for an individual for childless adults and seniors & people with disabilities. Seniors & people with disabilities eligibility may include an asset limit.

Source: Kaiser Family Foundation. January 2017. Medicaid in New Jersey Fact Sheet. <http://files.kff.org/attachment/fact-sheet-medicare-state-NJ>

Who is covered under Medicaid in New Jersey?

Medicaid is an integral part of the State's safety net, providing health insurance to nearly 1.8 million low-income residents. Medicaid beneficiaries primarily include low-income families and childless adults, as well as low-income people with disabilities and elderly individuals. A recent study showed that 80% of adult and child Medicaid enrollees in New Jersey have at least one family member who is employed.¹ Children account for nearly 50% of those enrolled to receive Medicaid benefits as illustrated below.

MEDICAID ENROLLMENT BY CLIENT TYPE as of Dec 2016



Total Enrollment 1,771,672

Source: DMAHS Enrollment Report

Below is a description of the general categories of eligibility.

● Families

Federally, Medicaid is required to provide coverage to both parents and children in low-income families with incomes up to 138% of the federal poverty level (FPL), or \$33,534 for a family of four. New Jersey expanded coverage to pregnant women up to 205% (FPL) and children whose family income is under 355% (FPL), or \$85,050 for a family of four.²

● Individuals with Disabilities

In general, those eligible for federal disability benefits through the Social Security Administration are eligible for Medicaid. This population includes low-income, physically and/or mentally disabled adults, and adults with developmental disabilities. It also includes many middle-class families with disabled children, where only the disabled child receives Medicaid coverage. These families use commercial insurance as primary coverage and Medicaid to provide services not available through commercial coverage, such as institutional, home and community-based long-term care for the disabled child.

● Elderly

Low-income, elderly New Jersey residents are primarily eligible for Medicaid in two ways – they have either very low income (90% FPL) or are in need of long-term care services (300% Federal Benefit Rate). Because few families can afford the cost of long-term care services, which can easily exceed \$100,000 per year, many middle-class couples/individuals become eligible for Medicaid when they need long-term care services.

Geographic Distribution

The Medicaid-eligible population is spread throughout the State, and, contrary to many assumptions, is not a particularly urban phenomenon. Indeed, all but two counties (rural and urban) have over 10% of their population on Medicaid. Three counties have nearly one third of their population on Medicaid. Eighty percent of adult and child Medicaid enrollees have at least one family member who is employed.³ See the chart below.

Medicaid Enrollment by County as of December 2016

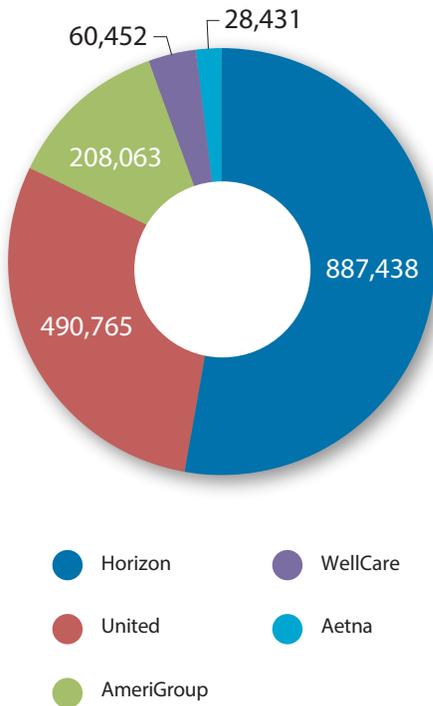
County	Children	Adults	Aged and Disabled	Medicaid County Totals	Total Population	Medicaid as a % of Total
PASSAIC	75,470	57,852	24,813	158,135	504,245	31.4%
CUMBERLAND	23,677	16,208	9,185	49,070	157,915	31.1%
ESSEX	103,696	87,339	40,548	231,583	786,943	29.4%
HUDSON	84,577	69,170	31,949	185,696	653,369	28.4%
CAMDEN	60,926	56,360	25,001	142,287	513,689	27.7%
ATLANTIC	32,683	29,581	10,892	73,156	275,362	26.6%
SALEM	6,833	5,269	2,970	15,072	65,721	22.9%
OCEAN	73,124	45,386	14,083	132,593	580,945	22.8%
UNION	56,829	41,457	18,569	116,855	544,102	21.5%
CAPE MAY	8,177	7,906	3,583	19,666	96,415	20.4%
MERCER	34,416	23,842	15,122	73,380	368,832	19.9%
GLOUCESTER	21,661	20,624	7,850	50,135	289,808	17.3%
MIDDLESEX	64,146	49,420	22,458	136,024	823,196	16.5%
WARREN	7,268	6,697	2,856	16,821	107,786	15.6%
BURLINGTON	27,664	25,069	11,203	63,936	451,626	14.2%
MONMOUTH	38,728	31,745	14,614	85,087	629,393	13.5%
BERGEN	47,916	46,472	22,150	116,538	919,010	12.7%
SUSSEX	6,316	6,672	2,865	15,853	147,192	10.8%
SOMERSET	15,738	11,659	6,747	34,144	328,246	10.4%
MORRIS	18,274	16,556	9,270	44,100	497,632	8.9%
HUNTERDON	3,983	3,830	2,029	9,842	126,319	7.8%
OTHER	1,278	3	418	1,699		
TOTAL	813,380	659,117	299,175	1,771,672	8,867,746	20.0%

Source: DMAHS Enrollment Report

How do Medicaid beneficiaries receive services?

The Medicaid program is administered through five contracted Managed Care Organizations (MCOs). Below is a chart that illustrates the number of covered lives by MCO as of November 2016.

MEDICAID ENROLLMENT BY MCO as of Dec 2016



Source: November 2016 NJ Family Care Managed Care Report – Summary by Eligibility Category

The MCOs each receive the same per member, per month capitation payments from the State. The capitation rates are adjusted for age, sex, and level of medical complexity. The MCOs then contract with medical providers across New Jersey to cover all acute and long-term care services for patients enrolled in the MCO plan. The MCOs are responsible for contracting with providers to build and ensure an adequate network for their enrolled beneficiaries, considering both geographic location as well as access to specialists. The MCOs can negotiate different models of payment to providers, such as paying a flat rate per service provided (fee-for-service), paying incentives for providing a successful series of services (episode of care), or even

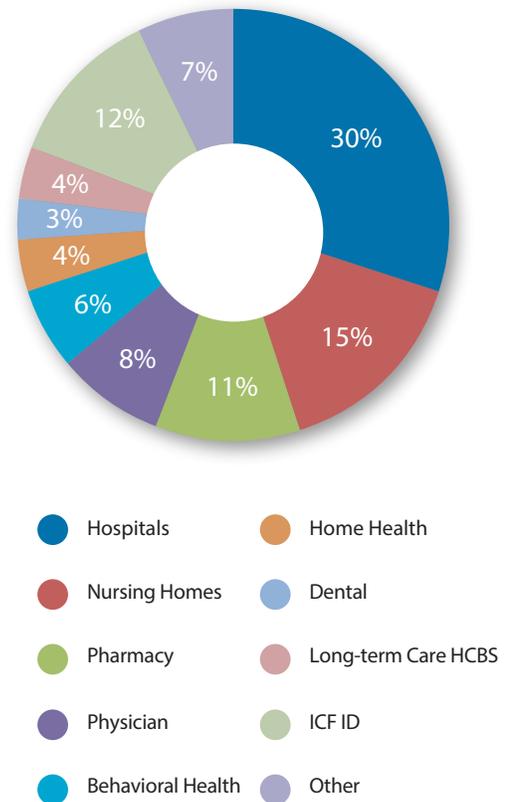
providing a regular capitated payment to care for the overall health of the beneficiary. The State requires that 85% of every dollar paid to the MCOs be used for health care services for the member. The remaining 15% provides for the cost of administration and profit.

The MCOs have an important role to play in the health care system. They are charged with establishing accessible networks of medical care providers and ensuring that the State's cost for Medicaid services remain within budget constraints. MCOs also have the unique ability to see and analyze cost and utilization data for their beneficiaries, which can and should be used by the State to inform payment and delivery models that improve quality and efficiency in the system.

MEDICAID SPENDING BY CATEGORY OF SERVICE

How are Medicaid dollars spent on health care services?

Spending on the largest categories of these services is detailed below



ICF ID – Intermediate Care Facilities Intellectual Disability
HCBS – Home and Community Based Services

Source: 2015 NJ Family Care Annual Report

The Importance of a Blueprint for the Future

As evidenced in the information outlined in the Primer, the Medicaid program in New Jersey plays a large role in the health of the State's citizens, and in the economy overall. The magnitude of the budget allocation to treat the Medicaid population underscores the importance of ensuring that the program works efficiently and effectively. The Medicaid 2.0 project work resulted in a series of recommendations that are presented in five sections.

A. Modern Foundation – these recommendations are intended to modernize the infrastructure used by the State to oversee and manage the Medicaid program.

1. Establish a New Jersey Office of Health Transformation
2. Increase Transparency of Medicaid Data
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24. Improve End of Life Care

Modern Foundation

The State's governing structure for the Medicaid program, antiquated technology systems, unwieldy contract, and outdated regulations do not fit the needs and size of a program that serves 20% of New Jersey residents and is a major part of our State economy. These foundational systems must be modernized to support a higher quality, more efficient and effective Medicaid system for New Jersey. These recommendations address the foundational steps needed to modernize the infrastructure that governs and supports the program.

RECOMMENDATION 1: Establish a New Jersey Office of Health Transformation (NJ OHT)

THE CHALLENGE: New Jersey's health care programs have a combined cost of nearly \$20 billion. At a cost of \$15 billion, Medicaid is one of the largest components of the State's budget and a critical lever in the State's safety net financing. The growing scope of the Medicaid program, and its impact on the larger New Jersey health care delivery system, require enhanced oversight mechanisms to ensure the State both maximizes its resources and achieves its larger population health goals. Although it is nearly 20% of the State budget, the Medicaid program does not report directly to the Governor.

The program is largely administered through the Division of Medical Assistance and Health Services (DMAHS) within the Department of Human Services (DHS). DHS is designated as the Single State Agency, meaning all official Medicaid business with The Centers for Medicare and Medicaid Services (CMS), a federal agency, must flow through DHS. But services and funding offered through the Medicaid program extend well beyond DMAHS to multiple State departments and divisions, including:

- Division of Disability Services (DDS)/DHS
- Division of Developmental Disabilities (DDD)/DHS
- Division of Mental Health and Addiction Services (DMHAS)/DHS
- NJ Housing Resource Center
- Department of Health (DOH)
- Department of Children and Families (DCF)
- Department of Banking and Insurance (DOBI)

The distribution of these Medicaid functions among multiple agencies can lead to competing priorities and inhibit the ability to effectuate cohesive statewide health care policies. Communications between divisions and departments is also a significant challenge for understaffed services and programs. Currently, beyond the Cabinet meetings established during the rollout of the ACA, there are no formal executive level meetings where these agencies all come together to focus on the health care needs of the State. Nor do they meet with the Department of the Treasury, Division of Pension and Benefits which oversees the State Health Benefits Program (SHBP), a \$4B health coverage plan for current and retired State employees serving approximately 800,000 people.

In New Jersey's health care delivery system, the State is both a regulator (licensing and inspections) and the payer (Medicaid and SHBP) which, at times, leads to competing priorities. For example, DOH decisions regarding the expansion of licensed services, say home health, can have unintended financial impacts on Medicaid and SHBP. However, by statutory design, DOH is only responsible for evaluating the impact on access to services in their analysis, and they are not required or permitted to consider the potential cost impact on payers.

THE SOLUTION: The State should immediately establish a New Jersey Office of Health Transformation (OHT) in order to plan for the coordinated, efficient administration of State health spending (including, but not limited to, Medicaid and FamilyCare) and to improve overall health system performance.

Looking to lessons learned from a model implemented in Ohio⁴ and Connecticut, a single planning office for strategic oversight of the State's health care needs would provide for:

- Shared services between agencies that address both health concerns and the underlying social determinants of health. These services should include legal, communications, procurement and contracting. The OHT should support all agencies to more efficiently share information, collaborate, and provide aligned direction for the program;
- Aligned quality and performance metrics that lead overall health system value and performance, improve continuity of quality between State health programs, promote transparency and measurement across programs and improve continuity of care for patients as they traverse delivery systems (physical health, mental health, school-based clinics, Medicaid, long-term services and supports); and
- Achievement of delivery system objectives including promotion of primary care; population-based interventions intended to improve health and well-being (such as housing supports, care transitions, and care management); and value based purchasing.

THE DETAILS: The Governor should appoint an Executive Director to lead the OHT with broad authority to direct the Departments on the State's health care goals. All cabinet agencies, boards and commissions should comply with any requests from the OHT Executive Director. The OHT will set a strategic vision to modernize Medicaid that includes improving care coordination for all of the Program's populations and streamlining health care administration. The OHT should engage other payers and State programs, such as the SHBP, to set expectations for overall system performance. In order to be successful, the OHT should have minimal staff to be nimble, yet have strong authority over the budgets and strategic plans of all agencies that impact the delivery and payment of health services. Ohio Governor Kasich established a similar office by Executive Order, which has shown success in pursuing a clear and strategic statewide plan for improving health care.⁵

The Executive Director of OHT should be a dynamic leader who is well trusted by the Governor, has extensive knowledge of health policy and financing, as well as have the skillset that can drive change. The OHT should identify a set of early accomplishments that will establish credibility with stakeholders and serve as a platform for a long-term innovation plan. During its first six months of operation, the OHT should fully examine and make recommendations to the Governor on how New Jersey can best leverage its purchasing power to improve overall health system performance, including the establishment of a public purchasing authority and restructuring the administrative framework of Medicaid. Consideration should be given to creating a separate Medicaid agency that reports directly to the Governor. Consolidating the purchasing power of New Jersey's health programs could yield substantial volume discounts benefiting all taxpayers. (See Recommendation 14 – Evaluate Pharmaceutical Purchasing for more details on these concepts.)

RECOMMENDATION 2: Increase Transparency for Medicaid Data

THE CHALLENGE: The lack of publicly available Medicaid cost and utilization data has been consistently identified as a major impediment to reforming the Medicaid program in New Jersey. Providers have difficulty evaluating how their services fit in the large delivery system, making it difficult for them to evaluate their participation in value based purchasing arrangements. Taxpayers and policymakers are unable to see, in a timely way, the relevant effectiveness and spending in key areas such as hospital and pharmacy, and therefore how the Medicaid program's performance – overall and by individual MCO – compares to other health care systems in New Jersey and elsewhere. This data is to inform and guide system improvements going forward.

The lack of data transparency also inhibits the work of consumer advocates who want to quantify the scope of the problems identified by consumer anecdotes. With one in five New Jersey residents enrolled in Medicaid, routine independent research is clearly in the public's interest. The Medicaid data is also important to the larger health care systems, as there are best practices in Medicaid that can be shared among all insurance carriers and medical providers.

Notably, legislation was recently signed that established the New Jersey Integrated Population Health Data (iPHD) Project. The iPHD Project was designed to facilitate research on population health and the cost efficiency of State government programs. The project will be a repository for Medicaid, DOH and other State agencies, including those managing health-related social services like housing. However, it is important to note that the legislation restricts the use of the iPHD data to researchers.

THE SOLUTION: The State should make Medicaid cost and utilization data more accessible. Consistent with the impending Medicaid Managed care rules,⁶ the State should submit its quarterly MCO encounter data to CMS and the State should make this same information available to the public. The MCO encounter data contains claims level data that indicate the date, type of service, provider, amount paid, etc. Consistent with new rules, CMS intends to aggregate this data and make it public. The State should also consider expanding the iPHD Project to include data platforms that could be accessible to the general public.

THE DETAILS: Further research should be conducted on the data collection and reporting systems used by other state Medicaid programs to determine the quality and availability of Medicaid cost and utilization data to the public, as well as how that data is used to improve spending, quality of care, and population health management. The Quality Institute and health care stakeholders should work with the State to implement the CMS Medicaid Managed Care Rule to provide Medicaid cost and utilization encounter data to CMS. This same data should be made available to the public.

RECOMMENDATION 3: Eligibility Processing *Improve Access to Medicaid Through Improved Eligibility Processing*

THE CHALLENGE: Obtaining and maintaining Medicaid eligibility is an essential component of the well-being of nearly 1.8 million New Jersey residents, ensuring their access to all medically necessary health care services through the State's contracted MCOs. The system in place to determine whether individuals are eligible for Medicaid consists of a patchwork of County Boards of Social Services (CBoSS), which provide face-to-face

enrollment assistance; Xerox (the State contractor), which processes most electronic applications; and the Federal Marketplace, which is run by the federal government. These enrollment entities use different processes and vary in their timing and accuracy rates. The current assortment of entry points is not only confusing to the Medicaid applicant, but places an administrative burden on the State, as it is labor intensive and prone to error. The comparative performance of the entities that process applications is not regularly tracked or reported by the State. Additional background details on the eligibility system are available in Appendix 7.

As a direct result of the complexity of the system, beneficiaries who are otherwise eligible lose coverage and then need to be reenrolled – a process referred to as “churn.” More specifically, eligibility is reassessed on an annual basis and individuals are required to complete and mail back reenrollment forms. Because the Medicaid population tends to have less stable residences (changing apartments, changing phone services), many individuals fail to receive the enrollment forms, or fail to return them with accurate and complete data. As a result, the State removes them from the Medicaid system, with one of two results: they resort to emergency rooms or Federally Qualified Health Centers (FQHCs) for care because they cannot access primary care without Medicaid coverage, or they find a way to reenroll but may be assigned to a new MCO and/or a new primary care provider, thus losing their continuity of care.

Based on review of January 2013 – September 2016 eligibility data, there were approximately 2,000 terminations per month due to what the State records term “Recipient Record Closed Due to Non-response to Re-determination.” There were also approximately 37,000 terminations per month over that period for “Case Record Closed Due to Ineligibility.” Notably in the

latter category, Medicaid coverage was terminated for an average of 9,000 – 10,000 newly eligible adults per month during January 2016 – Sept 2016. (A portion of the above cases cited are ineligible but at this point there is no way of verifying how many individuals actually did meet all eligibility requirements when terminated.)

THE SOLUTION: New Jersey must create a more client-centric and streamlined eligibility process and should set a three-year goal to modernize the entire intake system. As part of this modernization effort, the State should swiftly take advantage of additional federal funding from the Mechanized Claims Processing and Information Retrieval Systems (90/10) Final Rule (CMS 2392-F). This funding opportunity provides a federal 90/10 match to states for improving the Medicaid eligibility and enrollment systems.⁷

THE DETAILS: As the new intake system is developed, the State must begin to track the performance in processing and accuracy using common metrics of both County Boards of Social Services (CBoSS) and the contracted vendor, currently Xerox. With a processing baseline, the State can begin to restructure the intake system with both rewards and penalties to counties and any other vendors based on performance. These performance standards should be designed to promote consistent application of eligibility policy across counties and across federal programs. The State should take advantage of opportunities for greater automation and use of information technology solutions that provide functional connections to statewide data networks, including the Department of Human Services (DHS) data warehouse and Department of Health (DOH) health registries.

A fully functional eligibility system should reward CBoSS that offer extended hours, and should expand the use of navigators to assist applicants when necessary. It should also include an advocate/ombudsman to assist

with complaints and issues that result from the eligibility application process. There are similar ombudsmen for insurance claims and long-term care services, but they do not focus on issues with eligibility. The new system should incentivize CBoSS to use administrative renewals – that does not require the beneficiary to file a renewal form but have the State independently use alternative data sources like tax records to verify eligibility – to the maximum extent possible. These administrative renewals should include all long-term care cases and fully utilize financial and clinical determinations from federal and other State agencies.

In the short run, the State should take two relatively simple and immediate steps to prevent eligible beneficiaries from losing coverage. First, similar to the proposed eligibility policy for the State’s prison system inmates in which the waiver of renewal for eligibility is offered for up to 24 months before the renewal is required, the State should extend eligibility for an extended period. The State could adopt 12-month continuous coverage for adults to ensure eligible adults receive at least one full year of coverage. States have the option to provide adults with 12 months of continuous coverage through Medicaid, even if the person experiences a change in income during the year. This continuous coverage would provide continued access to care and reduce the level of churn. Secondly, the State should suspend redeterminations for those segments of Medicaid where the process is terminating large volumes of eligible individuals despite no change in their financial status. During the ACA expansion, the volume of new applicants became so overwhelming that the State received permission from CMS to suspend redeterminations so it could focus solely on new applications. Given the high volume of terminations and subsequent renewals in some beneficiary categories, the State should request permission to extend eligibility or suspend redeterminations until the larger scale issues that are contributing to churn can be addressed.

RECOMMENDATION 4: Telehealth

The State should foster the expansion of the use of telehealth and establish demonstration programs in Medicaid to evaluate the use of telehealth to improve access to specialty care, especially physician to physician eConsults and Project ECHO.

THE CHALLENGE: Access to specialty care has been a long-standing challenge for Medicaid beneficiaries. For some specialties, like rheumatology or neurology, patients may need to wait two months or longer for an appointment. Lack of access to specialty care can cause beneficiaries to seek care in higher cost venues – like emergency rooms – and, in some cases, this may result in costlier health complications and worsening of health status for the patient. Primary care practices, including FQHCs, state difficulty finding specialists willing to accept Medicaid. Reasons include low Medicaid reimbursement levels for specialists and the costly and time consuming challenges posed by obtaining credentialing by the five separate Medicaid MCOs. In some cases, access problems are simply the result of the small numbers of practitioners in some narrow sub-specialties.

The use of technology to deliver health care, health information or health education at a distance – known as “telehealth” – has great potential to address provider shortages especially for specialty care, including behavioral health, while at the same time helping to control the cost of medical care. But it also has the potential to transform how care is delivered. Around the country, there are intriguing examples of what the future may hold for health care. For example, Mount

Sinai Hospital in New York is using telehealth to offer an “ICU without walls,” a service that brings critical care units to the patient’s home.⁸ In his 2017 State of the State address, Governor Christie announced that the State would provide \$5M in new funding to expand a telehealth pilot for pediatric behavioral health. The program provides a telehealth hub with an on-call psychiatrist for pediatricians that need access to behavioral health services for their patients.

THE SOLUTION: Although the State has attempted to improve specialty care access by providing an additional \$90M to increase Medicaid physician reimbursement rates in 2016 for preventive, primary, and postpartum care services, tangible results of that initiative may not be experienced for several years. An opportunity exists in the further development and expansion of telehealth for all New Jersey residents including Medicaid beneficiaries. A recent poll of New Jersey residents from the Quality Institute, in partnership with the Eagleton Center for Public Interest Polling (ECPIP) at Rutgers, indicated that while 84% of New Jersey residents have never received medical care through electronic means, three in 10 residents would be likely to choose telehealth methods if they could have a longer visit, could receive care sooner, or spend less.⁹ There are a host of pathways to use telehealth as discussed below.

THE DETAILS: Several pathways should be considered to expand the use of telehealth in New Jersey’s Medicaid program.

eConsults: The State should establish a demonstration program to evaluate the use of physician-to-physician Electronic Consults (eConsults) as a means of addressing long standing lack of access to specialty care. In other states – California, Connecticut and Minnesota – facing similar access problems, primary care providers are beginning to use physician-to-physician eConsults to access specialists on behalf of their patients. These

eConsults allow primary care providers direct access to specialists around the country at leading academic medical centers. Early results show that eConsults substantially reduced the need for follow up specialist consultations and unnecessary medical tests because primary care providers were able to utilize the specialists’ knowledge to better assess whether further testing or referrals were needed. Reducing the number of unnecessary referrals in turn reduces the wait times for specialists for those patients in true need of a specialty consultation. A New Jersey demonstration should start with the use of New Jersey specialists and academic medical centers as the main source for eConsults, but also allow for access to specialists across the country when necessary. In-state resources could include all medical schools and other interested centers of excellence in New Jersey. To demonstrate the potential for eConsults, New Jersey’s University Hospital has offered to participate to provide physician-to-physician eConsults for patients that may require ventilator support. Given the number of disabled individuals that depend on ventilators, and the opportunity to avoid that dependence, Medicaid should include this specialty service in the demonstration.¹⁰

Expansion of Project ECHO services: The State should also develop a demonstration program with the MCOs to support the expansion and use of Extension for Community Healthcare Outcomes (ECHO) services. The ECHO model uses technology to support and educate primary care physicians by providing best-practice specialty care. The ECHO model, through multi-point videoconferencing, uses hub-and-spoke knowledge-sharing networks, where expert teams conduct virtual clinics with community providers. The State’s §1115 Waiver renewal proposes increasing the use of Project

ECHO. To achieve some level of sustainability and scale, this demonstration project should be included in the MCO contract and developed with the MCOs' support and engagement. MCO financial support for Project ECHO should be provided as a medical expense for the purpose of calculating their Medical Loss Ratio (MLR). This classification will support the spread of this needed model.

Telehealth for Psychiatric Services: In 2014, the State approved the use of telehealth for psychiatric services. Because many areas are underserved by psychiatrists, the use of telehealth brings these specialists to the patient virtually. Expansion of telehealth for mental health care will assist in addressing the challenge of recruiting psychiatrists to open practices in underserved areas and allow for flexibility in serving fluctuating service needs throughout the State. Although this was an important first step, two adjustments to the program should be considered.

First, the requirement that patients must be present in a clinic or doctor's office to obtain access to the psychiatric appointment should be reevaluated. Our research uncovered concern that physical presence limits the use of these services. Pilots that allow a telehealth appointment without requiring the patient to come to a doctor's office would increase their usefulness and convenience for the patient and therefore potentially increase usage and ultimately improve patient health outcomes and functionality. The second adjustment to the program should be improved reimbursement levels to providers. The number of psychiatrists refusing to accept any insurance, especially Medicaid, continues to grow. In a 2010 national survey, only four in 10 psychiatrists accepted Medicaid.¹¹ In light of the continued shortage of mental health providers who see Medicaid patients, telehealth should be expanded and a study of appropriate reimbursement levels to attract additional provider participation should be done.

RECOMMENDATION 5: Unified Single-License System for Integrated Care

THE CHALLENGE: The need for integrated care services is especially critical in safety-net populations. Typically, underserved populations suffer from significant health disparities, including higher rates of depression, anxiety, and substance abuse than the general population. They also suffer from higher rates of heart disease, hypertension, and diabetes, conditions that can be greatly impacted by behavioral health issues. Therefore, there is a tremendous need to offer integrated care and treat the whole person, rather than refer out to specialty services where treatment is often not received. True integration is one where behavioral health and medical health are viewed and treated together and as a whole. In their current form, New Jersey's licensing regulations do not facilitate the use of integrated care models.

The New Jersey Department of Health is the primary licensing authority for physical health care, and the New Jersey Department of Human Services administers the regulations that separately control the licensure of mental health and substance use disorder providers. The reliance on three separate licensure systems, administered by two different cabinet-level agencies for providers who offer physical, mental health, or substance use disorder services, can impede the integration of services. Based on interviews for this Project, we found a commitment by leadership of those two Departments to eliminate those regulatory barriers.

THE SOLUTION: By eliminating multiple licensing requirements, the State would lift the regulatory and financial burdens standing in the way of integrating care. Regulatory changes may be necessary to establish baseline requirements for integrated care models, in order to move toward a single-license system that demonstrates the State's commitment to integrate care.

THE DETAILS: Regulatory reorganization and simplification are necessary in licensure to improve integration of care. We recommend that the creation of a unified, single-license system for integrated physical and behavioral health, including substance use providers, be the goal. We recognize that the expertise for oversight of the various services is currently housed in both agencies. As an interim measure, before fully adopting a single license, the State could create a single point of entry and coordinated review of integrated service licensing. Oversight of integrated facilities could be accomplished through the cooperation of personnel from the two Departments. The goal should be functional: care providers should be able to understand and easily navigate appropriate regulatory requirements for the provision of integrated care. In 2016, The Nicholson Foundation funded the Seton Hall Law Center for Health and Pharmaceutical Law to conduct an extensive analysis of the licensing and reimbursement barriers to integrated care. This study and its recommendations should be the starting point for addressing this issue.¹²

RECOMMENDATION 6: Medicaid Regulations and Managed Care Contract Upgrade

The State should update the Medicaid regulations to reflect the shift of the vast majority of Medicaid beneficiaries from fee-for-service to managed care, as well as revise the Managed Care Organization contract to ensure that the MCOs are required to adhere to these updated regulations.

THE CHALLENGE: The Medicaid program in New Jersey is governed by both statute and an extensive set of regulations. The regulations cover the entirety of the program, including setting parameters for provider reimbursement methodology/rates, the type and level of documentation needed to support reimbursement, and the scope and duration of services. Other than one overarching set of regulations that applies to both the fee-for-service and managed care systems (N.J.A.C. 10:49-1, et seq.), the bulk of these regulations apply only to fee-for-service providers.

The managed care regulation (N.J.A.C. 1:74-1, et seq.) primarily focuses on the high-level requirements that each MCO must meet to qualify as an MCO in New Jersey, but generally does not address the requirements for each provider type as is done for fee-for-service providers. This leaves a disjointed regulatory scheme in which providers who bill in the fee-for-service system are subject to a relatively detailed set of regulations, while providers who bill in the managed care system are subject to far fewer regulations (e.g. rules for hospice N.J.A.C 10:53A, and rules for physicians N.J.A.C. 10:54). Because the State has moved nearly all Medicaid beneficiaries into a managed care delivery system (more than 95% of Medicaid claims are paid by MCOs), the vast majority of Medicaid regulations, which govern just the fee-for service portions of the Medicaid population, do not apply to the providers who are delivering care to the vast majority of Medicaid beneficiaries who are now in managed care. Put another way, most of the State's Medicaid regulations only apply to the situations that involve less than 5% of Medicaid beneficiaries who are still under the fee-for-service system.

With little in the way of regulatory guidance for encounters that take place in the managed care system, stakeholders (providers, beneficiaries, the MCOs, and State oversight bodies) are left to rely on the MCO contract and the individual MCO contracts with each provider to determine what requirements govern. Each of these oversight tools, the MCO contract and the individual contracts between the MCO and each provider, is a poor replacement for a uniform, transparent, accessible set of regulations. The contract itself is over 800 pages and has been amended periodically since the mid-1990s. This accretive approach has led to a confusing and difficult to understand document. Because the contract is outdated and unwieldy, the State finds it difficult to easily monitor the work under the contract, the MCOs struggle to

understand the goals established by the State, and the providers and other entities grapple to understand their obligations to the State and/or MCOs.

THE SOLUTION: The MCO contract and the State regulations must be updated to reflect the State's move from fee-for-service to managed care. The update will allow the State to effectively and efficiently govern the program as well as include incentives or requirements to help MCOs, providers, and other stakeholders align with the State's long-term vision for the Medicaid program, NJ Healthy 2020,¹³ and overall goals for improving the health of the State's residents.

THE DETAILS: We recommend that New Jersey perform extensive regulatory and contract revisions to (a) update Medicaid regulations to account for the shift from fee-for-service to managed care and to create a uniform, transparent, accessible set of regulations, and (b) streamline and simplify the Medicaid MCO Contract by cross-referencing the revised applicable regulatory provisions.

RECOMMENDATION 7: Fraud, Waste and Abuse

The State should do more to reduce Fraud, Waste and Abuse (FWA) including establishing a statewide universal credentialing platform (Recommendation 8); exploring further incentives and requirements to improve MCO efforts; and enhancing MCO and State audit requirements in the MCO contract.

THE CHALLENGE: In 2015, at the national level Medicaid spent \$29.1 billion, representing 9.8% of the total Medicaid spend, on improper payments including FWA.¹⁴ Reasons for improper payments range from honest mistakes, like incomplete paperwork, to intentional deception, like overbilling by a provider. In other government programs like Medicare, a study estimated that the rate is 3-10% for FWA.¹⁵ Another 2012 study estimated that between 7-9% of claims paid in Medicaid were attributable to FWA.¹⁶

All of the MCOs have Special Investigation Units (SIUs) and audit groups that pursue FWA. These MCO personnel perform investigations and payment audits, regularly meet with State regulators, attend professional trainings, coordinate with the State to hold provider training sessions on FWA avoidance, and share best practices. Despite their efforts, however, the size of the Medicaid program and certain inherent structural issues pose obstacles to addressing this very expensive problem. Nationally, CMS, states and the insurance industry all recognize that simply moving the system from a state-run fee for service system to a managed care system does not eliminate FWA. The states, in close concert with the MCOs, must aggressively pursue FWA to ensure that funds can be preserved to provide quality and necessary care to the beneficiaries. A 2014 federal report presented a series of recommendations to combat FWA, some of which the State stakeholders (State regulators and MCOs) are doing and others that these stakeholders should consider.¹⁷ More research is needed to address all the ways that New Jersey can improve in this area but the 2014 federal report should provide a strong starting point. Furthermore, should the Medicaid system receive cuts in federal funding, the pressure to diligently preserve resources and attack FWA will increase even more.

As indicated in the *Foundational Medicaid Reforms* section below, it is essential to have a well functioning universal provider credentialing process. Other states, such as Wisconsin, have used its state-wide universal process to reduce FWA. Wisconsin contractually requires that a MCO may include in its network only those providers who have been enrolled by the state, except in emergency situations. This practice reduces the risk of providers who have been excluded from the Medicaid system, whether by the federal government or another state, from receiving state and federal funds through an MCO.

Having a statewide universal credentialing process will also make it easier for the State to enforce network adequacy and network directory accuracy requirements which are needed to ensure that beneficiaries have sufficient access to care. Ensuring network adequacy not only addresses provider adequacy, but also helps prevent recipients from having to obtain care in more expensive and inappropriate settings such as hospital emergency departments. Reducing avoidable emergency department visits lowers costs while allowing those vital and limited resources to be utilized for the most urgent patient needs.

Next, the existing MCO contract requires that 85% of capitation payments be used for medical expenses (including other activities that improve quality such as health-related social services) on behalf of Medicaid recipients, also known as the Medical Loss Ratio (MLR). Historically, the MCOs have exceeded the 85% MLR. It should be considered, however, whether or not the MLR provision has the unintended effect of discouraging MCOs from pursuing FWA below the 85% MLR point, as any money recovered after that point must be returned to the State. An additional disincentive to uncover FWA may also be that reductions in medical expenditures through FWA efforts, even if still above 85% MLR, may lead to lower subsequent capitation rates. These issues should be considered to ensure that the State's and MCOs' interests are financially aligned to achieve program integrity through uncovering FWA, without harming quality and access to health care services.

THE SOLUTION: The State should review the MCO contract to consider further financial alignment to ensure that MCOs work aggressively with the State to pursue FWA prevention, detection, and recovery efforts. These changes should include changes to the audit and investigations processes to yield greater savings for the program.

THE DETAILS: The FWA Audit Section (7.36.2) of the current MCO Contract should be reviewed and, as needed, updated. Consideration should be given to having this language, in part, mimic the language used in the FWA Investigation portions of the Contract. Specifically, consideration should be given to including new language that would require the MCOs to employ or otherwise contract to retain a set number of auditors per number of beneficiaries enrolled in their plans.

In addition, as recommended in the CMS 2014 Best Practices Report, State oversight of MCO Audit plans should be strengthened and set forth clearly in the MCO Contract. Oversight should include: requiring the MCOs to audit certain areas within predetermined intervals; requiring timely and complete audit reports from the MCOs; establishing procedures and requirements for the State and MCOs to work together to identify certain high-risk providers and putting them on tighter audit cycles; and setting out procedures for creating corrective action plans and then removing providers from the system if they do not comply within an agreed upon timeframe.

Consideration should be given to establishing meaningful auditing and recovery benchmarks in the Contract; providing each MCO with blinded comparison information to see their performance compared to their peers on a quarterly basis; and then annual public reporting on performance of FWA recovery. Meaningful agreed upon measures would have to be established. In addition to revising the MCO Contract to include these audit related requirements, serious consideration should be given to developing overarching incentives for MCOs to improve their detection, investigation and recovery of FWA. One method for achieving this aim would be through changes to the MCO Contract relating to medical expenditures. Further research is necessary on this issue. Some ideas that are currently being discussed are available in a resource from the American Bar Association.¹⁸

Foundational Medicaid Reforms

The State has several meaningful reform initiatives pending. These initiatives would improve the credentialing process for providers, improve accuracy of MCO network directories and streamline provider quality metrics. In order to have a Medicaid program that best supports access and quality care for the beneficiaries, we need to upgrade administrative function of the system. These are important foundational changes that should receive whatever resources necessary to implement them as soon as possible.

RECOMMENDATION 8: Statewide Universal Credentialing System

THE CHALLENGE: Currently, there is a shortage of providers in the Medicaid program, which causes access issues for beneficiaries. Providers must be credentialed by each MCO with which they seek to contract.

THE SOLUTION: One of the themes that emerged from our work was the need for the State and MCOs to simplify the processes that providers must use to enroll in the networks and become eligible to care for Medicaid beneficiaries. Reducing administrative barriers to provider participation has been cited as one of the most effective ways to expand Medicaid MCO networks.

For example, one universal credentialing entity, the Council for Affordable Quality Health Care (CAQH), launched its platform in 2010 to enable providers and other health professionals in all 50 states and the District of Columbia to submit required information for

credentialing and other purposes. Such online platforms collect provider data used in credentialing, claims administration, quality assurance, emergency response, member services and more. The provider enters the data, maintains it and identifies which payer entities will have access to it. The platform thereby simplifies the initial provider application and re-credentialing processes by allowing multiple entities to access the data that is needed to credential an applicant. CAQH estimates that nationally, to date, its platform has eliminated more than 2.5 million credentialing applications, reducing provider administrative costs by more than \$99 million per year.

Although the State proposed the creation of a universal credentialing system, the project has stalled. Fortunately, many New Jersey physicians and MCOs are already familiar with such systems because they have used CAQH in the commercial market in New Jersey for almost a decade. Moreover, CMS currently requires that the State implement a single source screening and credentialing process no later than January 1, 2018.¹⁹ Thus, the State must and should proceed with universal credentialing immediately and already has a statewide model here in New Jersey that many physicians are currently using.

THE DETAILS: The State should swiftly contract with a third-party entity with a proven track record to create the universal system as quickly as possible. Consolidating credentialing will save the MCOs money in administrative costs and time and that savings should be repurposed to direct care or savings to the program. Better data from the credentialing process will also lead to more accurate network directories. Greater State control of the credentialing system will improve regulatory oversight of network adequacy and will assist in reducing FWA by reducing payments to providers who have been barred from the Medicaid system.

RECOMMENDATION 9: Network Directories

The State should improve the accuracy of network directories by implementing the recommendations of both the Workgroup and the State Auditor.

THE CHALLENGE: All stakeholders recognize that timely and appropriate access to health care is a vital goal of New Jersey's Medicaid system. In order to obtain care, Medicaid beneficiaries typically refer to the MCOs' electronic network directories to find a health care provider, obtain telephone numbers, determine the location, hours, and other relevant information about the provider. In addition, when beneficiaries choose a particular MCO they may consult each plan's online directory to determine whether the health care providers they prefer are listed in the plan's network. Therefore, it is important that consumer-facing provider network information is accessible, complete and accurate.

There are various hurdles to achieving the shared goal of accessible, complete and accurate network directories. These hurdles involve technology, improved communications, and restructuring workflow as various lists of network providers are used for contracting or credentialing but may not be optimal for a consumer-facing directory. In early 2015, DMAHS asked the New Jersey Health Care Quality Institute and the New Jersey Association of Health Plans (NJAHF) to co-lead a multi-stakeholder workgroup to:

- 1) Identify the hurdles and define the scope of the network directory problem;
- 2) Gather best practices and solutions that are under consideration or implemented nationally or in other markets; and,
- 3) Propose recommendations to improve the network directories for New Jersey Medicaid eligible consumers.

The two lead organizations engaged a variety of stakeholders, as well as DMAHS, to assist in developing recommendations to the State.²⁰ The workgroup's proposed recommendations to address the issue were presented to the State in the first quarter of 2016. On January 25, 2017, the Office of State Auditor issued an audit report finding significant problems persist in both the accuracy of the network directories and State oversight of the network adequacy and directories.²¹

THE SOLUTION: The State should immediately implement the NJHCQI/NJAHP workgroup recommendations.²² In addition, the State should routinely verify the accuracy of the MCO network directories and use the claims inactivity reports, which MCOs are already required to monitor, to identify providers who may no longer be actively participating in the MCO networks and should be removed from the directories. These recommendations are discussed in greater detail in the January 25, 2017 report of the Office of the State Auditor.

THE DETAILS: The directories need to be redesigned through the lens of a consumer, to ensure that they include all the information necessary for a consumer to choose a MCO and easily find the type of provider they

need. The key recommendations identified by the Workgroup were:

- Reduce administrative burden and streamline data reporting processes by designating a third-party clearinghouse for universal credentialing of providers and maintenance of provider data. This will reduce the burden on providers, allowing single source verification for all Medicaid MCOs. This also creates an incentive for providers to ensure they are providing accurate and updated information.
- Create robust provider attestation processes to ensure data attestation every 120 days, including incentives, penalties, and building the process into daily workflows.
- Ensure that primary care providers attributed to patients are actually primary care providers as defined in the MCO contract and regulations (general pediatrics, family medicine, general Internal Medicine, OB/GYN where appropriate) and not specialists.
- Add a required data field for providers to designate their primary practicing location(s) (define “primary practicing location(s)” by where a provider regularly sees new and existing patients and specifically include the days and hours by location(s)). Providers, for credentialing purposes, may list other locations with the MCO but those locations would not be included in the directory if not marked as “primary practicing locations.” For each “primary practicing location,” the provider should indicate whether new patients are being accepted at that location.

Additional recommendations are available in the Medicaid Managed Care Online Network Directories Recommendations.²³

RECOMMENDATION 10: Standardized Quality Measures

The State should establish a standardized set of core quality measures for adults and pediatrics to use in State programs including Medicaid.

THE CHALLENGE: As the science of quality measurement has advanced, the number of available measures for each program has grown. Federal and state governments, as well as payers and delivery systems, each use similar but differing measures for various programs and purposes. Although some measures are aligned, others are different enough that it creates an administrative burden and costs on all parties. Misalignment hampers the ability for the State, payers and providers to follow a clear path for improving and measuring quality. For instance, in reviewing the measures for federal and State Medicaid and Medicare population health programs and alternative payment models, the Quality Institute found that in 2016, payers and providers were reporting on over 800 measures.²⁴

THE SOLUTION: The 800 measures currently being used were put under review as part of the New Jersey State Innovation Model (SIM) design award. The SIM Quality Metrics Alignment Advisory Group was formed to examine how best to align quality metrics across payers and delivery systems to improve quality and reduce redundancy. The Quality Institute inventoried all the measures that must be reported through current

Upgrades to the Medicaid Model

State and federal health care initiatives, including various Medicaid demonstration projects, Center for Medicare and Medicaid Innovation programs, MCO performance measures, and the Disproportionate Share Program. Next, it identified where and how measures and incentives can be made uniform and aligned to increase collaboration and decrease measure fatigue and reporting burdens.

In May 2016, as a result of the feedback from the advisory group, the Quality Institute released the Quality Measure Alignment Report, which, among other recommendations, harmonized the 800 measures into a set of 31 core quality metrics for adults and pediatrics that would support alignment across several New Jersey and federal quality and efficiency improvement initiatives. Streamlining measures across initiatives will enable to the State to align MCO and provider incentives and increase collaboration between them.

THE DETAILS: The State should adopt the recommendations outlined in the Quality Measure Alignment Report, conducted at the direction of the SIM Quality Metric Alignment Advisory Board. More specifically, the core set of 31 metrics identified in the report should be adopted by the State as the core set of harmonized metrics to be used when designing future Medicaid projects, incentive programs, and the MCO contract performance measures.²⁵ An independent entity, either within or outside of government, should be commissioned to house the harmonized metric set. The entity would be responsible for periodically reviewing and updating the core measure set, as quality measurement science evolves, and gathering continuous stakeholder feedback as priorities evolve.²⁶

While many aspects of the Medicaid program have been upgraded over time, there are still segments of services that remain unmanaged without care coordination, most notably behavioral health services. As mentioned, the need for integrated care services is especially critical for underserved populations who suffer from significant health disparities, including higher rates of depression, anxiety, and substance misuse than the general population. It is essential to offer integrated care and treat the whole person, rather than refer out to specialty services, where treatment is often not received. The benefits in both quality of life and costs can be substantial.

True integration is one where behavioral health and medical health are viewed and treated together and as a whole. Reforming health care must revolve around a model of care in which the base standard of medical care is integrated care – the coordinated delivery of physical health, mental health, and substance use disorder (SUD) services.

The opioid crisis that continues to confront New Jersey's health care system presents a host of challenges that impact all payers but particularly Medicaid. Our research did not specifically address these issues but some evidence based ideas that our Transformation Team members provided are included in the section on *Longer Term Plans to Remodel Medicaid* and should be considered as part of the solution to helping people with substance abuse disorders. In addition, we identified a potential opportunity for New Jersey to increase federal Medicaid reimbursement which, if secured, could be used to invest in addressing the crisis.

RECOMMENDATION 11: Integrated Physical, Mental Health and Substance Use Disorder

The State should create pathways which support and encourage a move toward integrated care for physical, mental health and substance use disorders.

THE CHALLENGE: Much of today's care delivery for New Jersey's Medicaid population is siloed and lacks an integrated care approach. The lack of integrated care contributes to four large problems:

- **System Fragmentation:** The State's focus on programs, rather than individualized service needs, has resulted in behavioral health services that have evolved into a fragmented, patchwork quilt of programs that are unable to adequately address individuals' complex needs. Fragmentation does not allow beneficiaries to move seamlessly between higher and lower levels of care, and makes it difficult for them to receive support for their co-occurring behavioral health and physical health problems. Providers do not have a financially sustainable incentive to provide care that is both individualized and integrated, leading to the perpetuation of a model of care that is inherently unresponsive, and results in poor physical and behavioral health outcomes, all at increased costs.
- **Misaligned Service Priorities:** Existing regulations and governance, while well intentioned, tilt the State's focus towards reimbursable services, rather than an examination of a population's behavioral and physical health needs. This ultimately limits providers' ability to intervene effectively to address these health disparities and effectively offer needed whole-person services.

- **Health Disparities:** Significant health disparities confront those with serious mental illness, including increased morbidity (increased incidence of chronic medical diseases), increased mortality rates, numerous obstacles blocking access to primary care, increased reliance on high-cost emergency and inpatient care, and other problems.
- **Lack of Prevention and Evidence –Based Early Intervention:** With the emergence of defined screening techniques to detect behavioral health problems particularly for children, the potential to identify problems early in life has increased significantly. Integrating screening services into primary health care systems, school settings, and community-based programs can lead to early interventions that can prevent problems from arising or escalating.

Additional background information is available in Appendix 8.

THE SOLUTION: The State must undertake comprehensive system reforms that redesign financing mechanisms and realign service priorities to support integrated care. These reforms should: focus on population health needs, "retool" physical and behavioral health providers to provide integrated care that addresses co-occurring behavioral health and physical health problems, reform State regulations to support integrated care, and incentivize providers to improve health outcomes for people served. Additionally, these reforms should be applied across all Medicaid populations regardless of their level of need. Integrated care must be available to those with significant behavioral health needs but also to individuals with mild and moderate behavioral health disorders. Those with mild and moderate disorders should be able to access behavioral health treatment in their primary care setting.

While there is early evidence that integrated care can yield substantial savings – particularly from reduced emergency department visits and fewer inpatient admissions – there are no projected savings to the State from integration. We do however expect some measure of savings at the MCO level and recommend that the State require these savings to be reinvested in network enhancement in the form of case rates. The case rate would be a comprehensive rate for all behavioral health services, typically paid on a per-member per-month (PMPM) basis. These case rates would include payments for the social determinants of health (housing, food insecurity, unemployment, education) which have been shown to positively impact quality of life and health outcomes.

THE DETAILS:

A solution should:

- **Create an MCO Contract that emphasizes integration** – The contract between the State and the MCOs should: (1) stipulate that integrated care become the standard of care and (2) carve in behavioral health services for all adults regardless of their level of need. With a carve-in, the MCOs will be responsible for ensuring that all providers use a standardized patient’s assessment to appropriately evaluate a person’s presenting medical, psychiatric and social determinant needs. The individual’s plan of care should address the behavioral health and primary care needs, as well as include integrated service planning and treatment, appropriate to the level of care required.
- **Implement Financial Integration** – New Jersey should incorporate Medicaid adult behavioral health services under the MCO scope of work with progressive degrees of risk sharing. Under this approach, the MCOs and providers can experiment with the use of case rates or episodes of care, both of which shift the risk for costs in excess of their

payments to the providers. To facilitate this transition toward risk sharing, we recommend the State establish a multiyear glide path to ensure the existing network capacity remains intact. A staged transition recognizes that the community mental health and substance abuse systems currently lack the financial capacity and clinical resources to engage in the value-based initiatives that would provide the necessary flexibility to fully integrate care.

The current conversion from contract-based payments to fee-for-service has challenged the community providers to reassess their approach and capability for delivering services. As such, converting these services to full risk during this time would endanger the existing provider networks. A thoughtful glide path, however, could ensure that the necessary protections are in place to maintain robust mental health and substance use networks and provide a continuum for the State to share risk for behavioral health services with the MCOs.

Determining the precise timeframe, and its component parts for this transition, represents a balancing act. Recognizing adoption of these changes will pose a challenge to providers, it is true that a longer phase-in will delay the benefits of integration.

A recommended phased glide path is detailed below:

- **Financial Integration Stage 1 – Claims and Data**
The State should initially convert the responsibility for claims payments to the MCOs. The MCOs would not have responsibility for authorization, provider rates, or use of services, all of which would remain with the State. But MCOs would have access to their members’ mental health and substance use services utilization

data and be responsible for arranging referrals and coordinating care with physical health providers. Even with this limited integration (claims and data), the MCOs would have better means to coordinate care to avoid acute care costs. This first stage would also provide the data necessary to set at-risk rates for the MCOs in the future, a step critical to Stage Two.

● **Financial Integration Stage 2 – Performance Incentives**

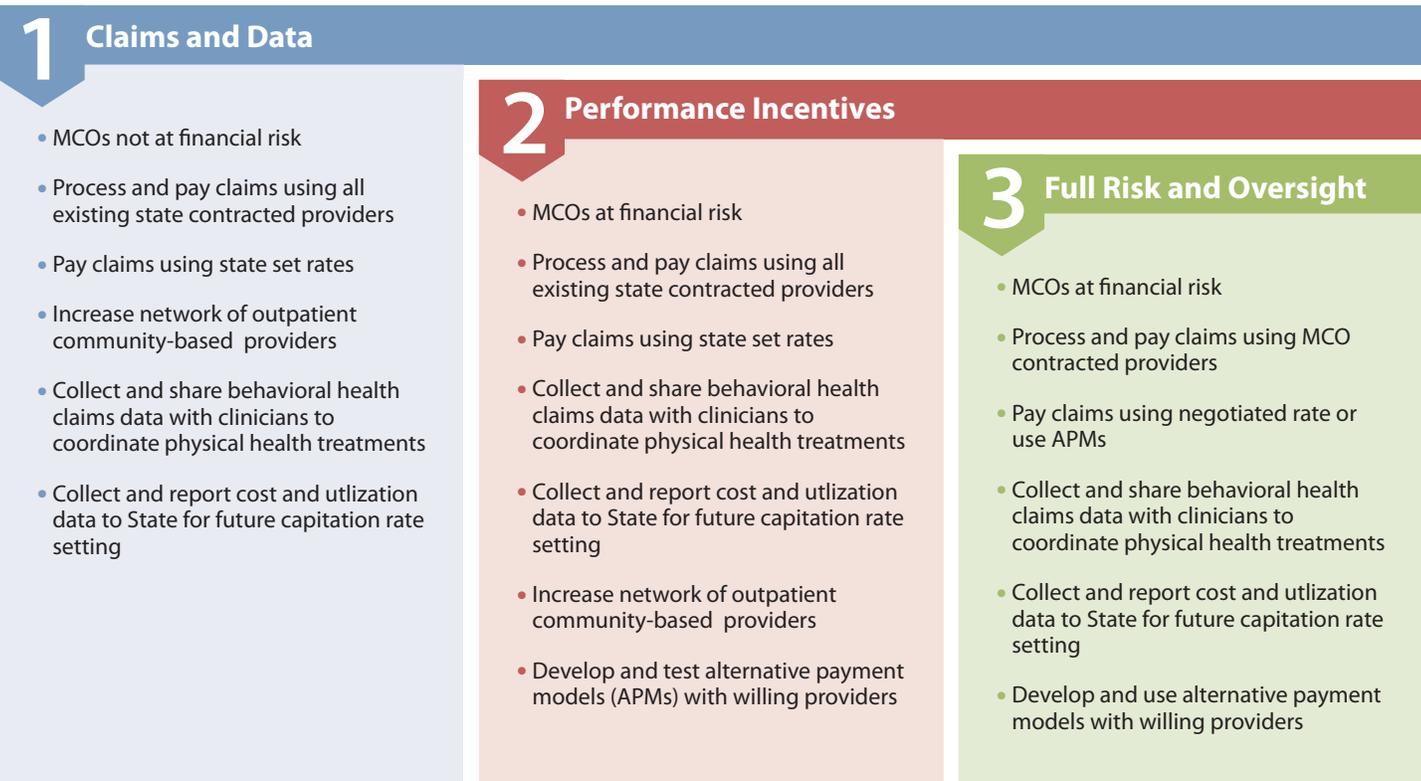
In this stage, MCOs would be at-risk for the entire cost of care and would receive a per-member per-month capitation payment for all behavioral health services. The MCOs would contract with any willing providers and pay, at a minimum, the State’s fee-for-service rates. Assuming the financial risk, the MCOs can begin to experiment with more innovative models such as case rates and episodes of care payments. They could test rewarding providers that have the capability to assume some risk and invest their resources in

support services that avoid emergency room visits because of chronic homelessness. The MCOs would be required to make investments to foster that capability in providers who are not yet prepared to engage in these models.

● **Financial Integration Stage 3 – Full Risk and Oversight**

In the final stage, the MCOs would take on full responsibility for the utilization of services, the networks, and setting reimbursement rates to providers. This last stage must be coupled with a dedicated and sufficiently staffed team of State quality and oversight staff that will ensure that the level and quality of services are measured by meaningful individual level outcomes.

Glide Path for Financial Integration of Behavioral Health Services into MCOs



Implement Clinical Integration

New Jersey should facilitate the development of integrated care models across the State for all Medicaid recipients, regardless of the level of need. Integrated care at the clinical level – between physical, mental health and Substance Use Disorder (SUD) practitioners – requires that there be an understanding among providers that integrated care is the new standard of care. True integration requires an integrated electronic medical record that captures data from behavioral and physical health examinations and tests. Because the capital costs of an integrated EMR will challenge most community providers, the State's assistance in accessing the required capital is essential.

To facilitate the integration of behavioral health services at the primary care level, the Patient Centered Medical Home (PCMH) which provides the basis for a team-based care approach, should include immediate access to a mental health or SUD professional for screening either onsite or by using telehealth resources.

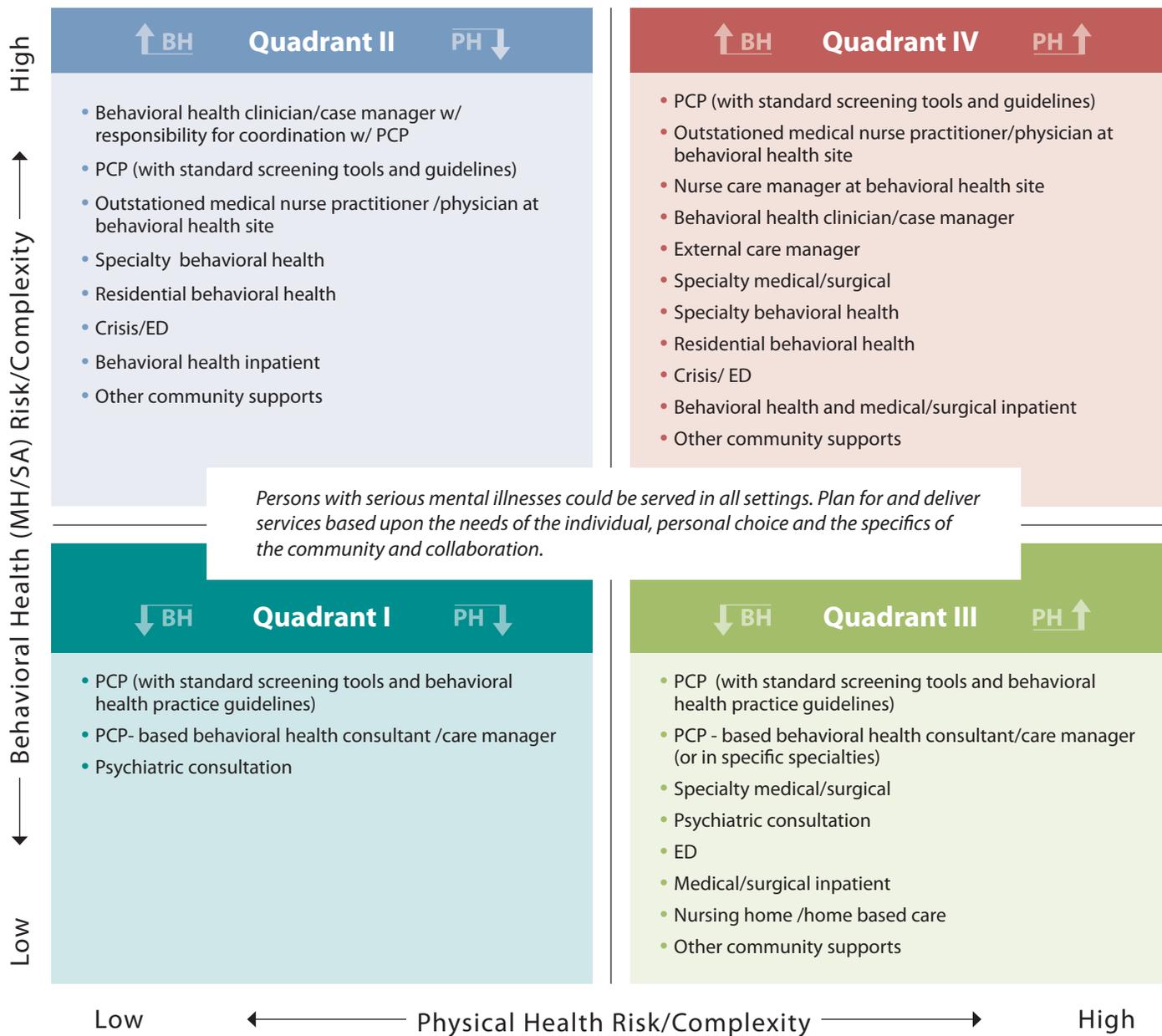
These integrated clinical practice models should incorporate the following elements to varying degrees depending on the level of need:

- Telehealth
- Peer Support
- Practice Extenders, such as Advanced Practice Nurses
- Colocation of services
- Team-Based Care
- Updated Needs Assessment, to ensure individuals receive the right level of service
- Updated Beneficiary Assessments, to assure services are teaching beneficiaries the necessary skills which empower them to assume personal control and responsibility for the creation and sustainment of healthy habits and routines that avoid costly services and support

- Care Navigators, who are available to answer questions, clarify concerns and move care forward when gaps are discovered or follow through is erratic. These navigators are available to individuals in care, family members, and care team members and function as a coordination hub during care transitions or times of crisis.

The approach to each model should be driven by the providers based on the patient's level of need for mental health services using the four quadrants model illustrated on the next page.²⁷

The Four Quadrant Clinical Integration Model



Source: National Council for Community Behavioral Healthcare. Behavioral Health/Primary Care Integration and the Person-Centered Healthcare Home. April 2009. P. 23
<http://www.allhealth.org/BriefingMaterials/BehavioralHealthandPrimaryCareIntegrationandthePerson-CenteredHealthcareHome-1547.pdf>

Most seriously ill individuals receive care from at least some of the following Division of Mental Health and Addiction Services' programs: Supportive Housing/ Residential Intensive Support Team (RIST), Integrated Case Management (ICMS), Program of Assertive Community Treatment (PACT), Outpatient Programs, Residential Programs, Partial Care, and Intensive Outpatient Programs (IOP). Because care is coming from so many different programs, we recommend that the State require and provide funding to add a registered nurse (RN) Case Manager to focus on integrating physical and behavioral health care. The RN Case Managers should work closely with both beneficiaries and team members, ensuring all aspects of need are met in an expeditious and outcomes-focused manner. The RN Case Manager should also work closely with Care Navigators who should be trained in accessing other service needs in a timely manner. Standardization of processes between MCOs and network providers is essential to ensure the Case Manager's time is spent with beneficiaries rather than processing next steps.

To integrate physical and behavioral health care for those high need individuals with significant but not institutional levels of need (Quadrants II and IV), the State should build on existing and developing models, such as the Behavioral Health Home (BHH). Given the fluidity of the new integrated care models, (BHHs or Certified Community Behavioral Health Clinics) we recommend the following components be included:

- Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention and crisis stabilization
- Screening, assessment and diagnosis, including risk management
- Person-centered treatment planning
- Outpatient mental health
- Substance use services
- Primary care screening and monitoring
- Targeted case-management
- Psychiatric rehabilitation services
- Peer support, counseling services, and family

support services

- Connections with other providers and systems (criminal justice, foster care, child welfare, education, primary care, hospitals, etc.)

For all other Medicaid adults (Quadrants I and III), we recommend the State build on the existing Patient Centered Medical Home (PCMH) framework and offer enhanced reimbursement to PCMHs that provide team-based care and immediate access to a mental health or SUD professional for screening, either onsite or by using telehealth resources. While PCMHs are not widely available in the Medicaid market in New Jersey, it is strongly recommended that these models of care delivery be expanded immediately to include Medicaid patients and this change should be included in the MCO contract and regulations.

RECOMMENDATION 12: Long-Term Residential Services for Substance Use Disorder

The State should improve treatment for individuals with Substance Use Disorders (SUD) by modifying the current waiver to include a request for CMS to cover long-term residential care, conditioned upon the State reinvesting the savings into treatment services.

THE CHALLENGE: Currently federal regulations prohibit federal reimbursement for more than 30 days of residential rehabilitation. As a result of no federal matching funds, New Jersey Medicaid currently covers short-term residential rehabilitation for Substance Use Disorders (SUD) of 30 days or less. The State covers long-term residential rehabilitation with only State funding for longer than thirty days, but that funding is limited. Because of those limitations, some patients who require more long-term rehabilitation are not receiving services.

THE SOLUTION: One solution was identified in the project’s site visit to Massachusetts. MassHealth, the Massachusetts Medicaid program, now receives federal reimbursement for Transitional Support Services (TSS) and Residential Rehabilitation Services (RRS) for up to 90 days of medically necessary residential treatment.²⁸ The additional federal funds are being used to fund 480 new RRS placements. The new federal funds will also be used to purchase care coordination and recovery coach services for members with significant SUD needs. New Jersey should consult with MassHealth and develop a proposal to cover long-term rehabilitation services for Medicaid that reinvests federal funding to expand SUD services.

THE DETAILS: MassHealth indicated that CMS was willing to consider a unique interpretation of the 30-day limit for residential rehabilitation. It proposed to CMS that if the collective number of residential days, including both long-term and short-term stays, averaged under 30 days in total, their state would be eligible for federal Medicaid funding. New Jersey should calculate its number of residential days, including both long-term and short-term stays, and calculate the combined average number of days. If the average amount is 30 days or less, the State should pursue the necessary waiver to obtain federal approval and subsequent matching federal Medicaid funds.

RECOMMENDATION 13: Behavioral Health Integration Advisory Council

The State should reconvene and revisit the composition of the State’s public-private Behavioral Health Integration Advisory Council to monitor and improve fiscal and clinical practice integration.

THE CHALLENGE: The behavioral health recommendations outlined above represent a seismic shift in the provision of behavioral health services for Medicaid adults. The conversion to full-risk managed care, and the development of value based arrangements between MCOs and providers, are some of the largest changes to the system in decades.

THE SOLUTION: Major system transformation will take place over a period of years, allowing time to assess and adjust the efforts to coordinate the delivery of physical health, mental health and substance use disorder (SUD) services into an integrated care model. A dedicated group of experts is necessary to provide independent oversight and counsel and to ensure the larger goals of integration and population health management are being met.

THE DETAILS: To ensure that these recommendations are properly executed and evaluated, we recommend that the State reconvene and revisit the composition of the existing oversight board to be comprised of beneficiaries, State representatives, advocates, providers and MCOs. The group should meet quarterly and report directly to the Commissioner of the Department of Human Services. The group should be organized in the same manner as the Managed Long Term Services and Supports (MLTSS) steering committee. The Division will also be responsible for supplying any data the advisory committee may need to achieve its mission.

Financing Reform

Purchaser Power

Spending \$15 billion last year on Medicaid, the State is the largest purchaser of health care services in New Jersey. Medicaid contracts with five managed care organizations (MCOs), for all Medicaid covered services except for behavioral health, which is paid through a State regulated fee-for-service system. The rates paid to the MCOs are set by the State based on historical cost experience. Any MCO qualified by DOBI, which has passed all readiness testing, can participate in the Medicaid managed care program.

Under the State's contract, MCOs are responsible for reimbursing providers for services. The State budget projects hospitals will be reimbursed \$4.1B for services in FY 2017, nursing homes will receive \$1.8B in payments, and pharmacies will take in \$1.9B (1.3B net after pharmaceutical manufacturers' rebates.) MCO leverage varies depending on their market share, but the majority have sufficient leverage with most hospitals to negotiate competitive pricing. Beginning in July 2017, the State plans to allow the MCOs to use the same pricing leverage with nursing homes as part of Managed Long Term Services and Supports (MLTSS).

RECOMMENDATION 14: Pharmaceuticals

Analyze the State's current system of purchasing pharmaceuticals for Medicaid beneficiaries and consider whether greater savings could be achieved through alternative strategies.

THE CHALLENGE: Pharmacy benefits are procured by the MCOs using Pharmacy Benefits Managers (PBMs). They are responsible for negotiating prices and paying the pharmacies. Substantial federally required rebates from pharmaceutical manufacturers are provided to ensure Medicaid obtains the best price on pharmaceuticals, with the exception of the Veterans Administration. But the current system lacks any

capacity to verify whether the rebate law is being met, and that price growth is not exceeding the increase in rebates.

The use of separate PBMs by each MCO may not yield the most efficient price for these services. This is difficult to determine, however, without greater public information on the pricing for the most common prescriptions and how they vary by each MCO's PBM. Using five separate PBMs may also equate to greater overall administrative costs for the system. Moreover, the State uses one PBM for purchasing pharmaceuticals for its employee and retiree program (SHBP), which raises further questions as to whether the purchasing power should be consolidated for both the Medicaid program and the SHBP.

THE SOLUTION: Other states have successfully leveraged their state's total spend on pharmaceuticals by combining programs and implementing other strategies like value based purchasing and personalized medicine using genomics.

The potential savings from alternative procurement methods can be significant. State Medicaid programs and employee health funds have been able to reap significant savings through innovative procurement strategies. For example, a recent National Conference of State Legislatures report referenced that "in Washington State, Washington State's Health Care Authority, which coordinates the Prescription Drug Program for the state's Medicaid, public employee, and worker compensation programs, is using an integrated approach to value-based pharmaceutical purchasing. The evidence-based drug review process involves a thorough analysis of quality and effectiveness before applying cost considerations. The process, which includes an evidence based preferred drug list and supplemental rebates from pharmaceutical manufacturers, is producing savings of

\$22 million each year to Washington — almost 5 percent of its Medicaid fee-for-service drug spending — and \$38 million in combined state and federal spending.”²⁹ New York’s FY 2018 budget proposes price ceilings for high-cost prescription drugs. Under this proposal, the state “would impose a 100 percent supplemental rebate for any amount that exceeds a benchmark price recommended by the Drug Utilization Review Board.”³⁰

THE DETAILS: The State should conduct a review of Medicaid data to determine if the following strategies would result in cost savings to the State:

- **Maximize Rebates** – review the quarterly audits of the MCOs to determine if the State is receiving all available supplemental rebates. This review should also determine whether pharmacy costs are being audited for accuracy by an outside company as required by MCO contract terms, and, if so, is there a reconciliation at the end of the year to make sure the State receives all owed rebates.
- **Pricing Legislation** – consider legislation that stipulates if a pharmaceutical manufacturer raises prices in the contract year and that price impacts the State, then the manufacturer should be required to provide reasons for the increase. This concept is reflected in a law in Vermont and in a bill (A-762) proposed by Assemblyman Moriarty.
- **Value Based Purchasing (VBP)** – explore the use of outcomes-based contracting that focuses on quality outcomes with pharmaceutical products that have a proven record of efficacy. Commercial payers are beginning to include these provisions in their contracts with PBMs.³¹
- **Statewide Pharmacy Benefits Manager (PBM)**– explore the use of one PBM for Medicaid rather than separate purchasing by each MCO. The State should also explore the use of one PBM for all State-funded pharmaceutical purchases, including both Medicaid and the SHBP, and examine whether this would significantly increase savings to the State. The PBM could develop a single Preferred Drug List (PDL), with appropriate stakeholder input, for all Medicaid prescription claims. The State may be able to use the PDL to further leverage its purchasing power and receive greater supplemental rebates, both of which would produce savings.
- **Multistate Purchasing** – explore whether New Jersey should join a regional purchasing cooperative with other states. By combining purchasing power with multiple state Medicaid and state benefits programs, there is potential to significantly leverage purchasing power with State funds. This idea should be researched.
- **Patient Specific Medication Risk Management** – Explore the use of new technologies in pharmacology data and genomics to reduce the number of medications patients need, increase the quality of patients’ outcomes, and support more targeted medication pathways based on the growing field of precision medicine, especially in oncology. More research on these ideas is needed but leaders in these fields are based in New Jersey and should be engaged in this work.³²

RECOMMENDATION 15: Managed Care Organizations Performance Incentives

The State should update the current MCO contract to restructure performance incentives to align with the use of the Value Based Purchasing (VBP) and Alternative Payment Models (APMs) identified in the next section.

THE CHALLENGE: The State's current process for setting MCO capitation rates involves the State's contracted actuaries collecting the previous year's cost and utilization data from the MCOs. They then apply cost trending factors to these costs to account for growth in pricing and changes in utilization patterns for setting next year's rates. This process inadvertently discourages MCO innovation, as rates are based on the cost experience. Simply put, if MCOs save money and show low costs one year, they will be faced with reduced rates for the next year. There are no incentives in the contract to reward the MCOs for using or expanding the use of Alternative Payment Models (APMs) and thereby bringing down the Total Cost of Care (TCOC).

THE SOLUTION: With the expansion of Medicaid, the federal move away from fee-for-service payments to APMs, and the inclusion of nearly all services in the MCO contract, the MCO contract must be revamped to support the development of APMs that will benefit patients, providers, the MCOs, and the State. As previously mentioned, aligning the quality and efficiency measures between the State and MCOs with the measures the MCOs use in their provider contracts will align the parties and move the system toward better improved quality and needed cost controls.

THE DETAILS:

The State must provide a financial model in the MCO contract that supports the use of APMs to reduce State costs, improve quality, and increase beneficiary satisfaction. They must align the MCO Contract performance payment incentives with the quality and efficiency measures to be used in the APM contracts between MCOs and providers.

As an example, The State of Tennessee included the following language in its MCO contract to facilitate the use of Episodes of Care. The performance provisions cited below are tied to the ultimate level of MCO compensation:

"Implementation of payment reform strategies at a pace dictated by the State:

- *For episodes this is approximately three to six (3-6) new episodes per quarter with appropriate lead time to allow payer and provider contracting. For PCMH this includes annual waves beginning January 1, 2017 of twenty to seventy-five (20-75) new primary care practices with appropriate lead time to allow payer and provider contracting;*
- *Participate in a State-led process to design and launch the initiative's payment reform strategies, including the seeking of clinical input from payer medical teams and clinical leaders throughout Tennessee for the development of new episodes."*

Value Based Purchasing and Alternative Payment Models

Medicare and many other state Medicaid programs are moving aggressively towards alternative payment models (APM). CMS has set a target of having 50% of all Medicare payments linked to APMs by 2018.³³ Innovation in APMs has led to a menu of payment models that states and commercial payers alike are adopting. State Medicaid programs are requiring MCOs and providers to expand statewide adoption of models like Comprehensive Primary Care Plus and episodes of care payment programs. Commercial insurers have taken their cue from CMS and now offer many of the same types of models.

States that have Medicaid Delivery System Reform Improvement Payment (DSRIP) programs are using them to finance and support the conversion to APMs and share risk with their hospitals. CMS has indicated that states must restructure their DSRIP programs to facilitate improvements in the quality and cost of care

by requiring hospitals to share downside risk (incur costs in excess of the overall amount paid through DSRIP). In some states, a portion of DSRIP funds are being directed towards services that address the social needs of beneficiaries including housing and employment services.

At their core, these APM initiatives have one thing in common – properly aligning the financial incentives between payers and providers. By rewarding providers for achieving quality measures, payers intend to improve outcomes and reduce costs. In some cases, there has been clear evidence of success. Both PCMH and episodes of care payment programs have shown improvements in certain measures. ACOs have shown great progress in achieving success in quality measures, but have had inconsistent results on demonstrated savings.³⁴

New Jersey Medicaid currently has several limited APM demonstrations.³⁵ At the payer and provider level, several quality initiatives are aimed at specific segments of the Medicaid population, such as those with chronic conditions or high utilizers. Of these early efforts, PCMH and Behavioral Health Homes have shown positive results in both quality and cost. APM initiatives by the State, such as the Medicaid ACO Demonstration Project and DSRIP, are still in progress and have not been formally evaluated to date. The MCOs also have multiple proprietary value based initiatives underway but results are not publicly available.

Despite these targeted APM initiatives, New Jersey's quality outcomes are far worse than the national average on key measures, such as for hospital readmission rates, pre-term birth and low birth weight.³⁶ In addition, the unnecessary use of hospital emergency rooms and the cost and management of end of life care remain disproportionately expensive compared to their respective national benchmarks.

The need for alternative payment models that reward quality outcomes has never been greater than it is now. The Medicaid program must catch up with the rest of the health care market in New Jersey where these programs have already proliferated. The State should model its alternative payment model initiatives, both in its timeline and content, with recent federal law in this area.³⁷ These targets should be established in consultation with the Value Based Payment Advisory Board outlined at the end of this section.

RECOMMENDATION 16: Episode of Care Demonstration

The State should establish demonstration projects around three to five Episodes of Care (EOC) models.

THE CHALLENGE: Currently there are no EOC programs operating in the New Jersey Medicaid program and there are no financial incentives for MCOs or providers to develop Medicaid EOCs. Indeed, as mentioned above, there is a built-in disincentive to save money because MCO rates are based on the past year's costs.

THE SOLUTION: EOC payment models have the potential to reduce costs and greatly improve outcomes. By setting an overall payment for the entire set of services, MCOs are incentivized to keep costs down and improve quality in order to avoid costly complications. Medicare's experience to date with EOC and bundled payments show the potential benefits of the model.³⁸ In states like Ohio, Arkansas and Tennessee, Medicaid EOC initiatives have been underway for several years.³⁹

Under the EOC concept, a "conductor" is designated to manage the care of members with a specific medical condition such as congestive heart failure (CHF) or those undergoing a procedure such as a knee replacement.

The conductor can be a physician, hospital or other clinician. Using various data sources, the conductor is responsible for managing outcomes-focused care by selecting the best and most efficient sources of care. Unlike current practice where one provider is responsible for a surgery, another for the hospitalization and others for services such as skilled nursing facilities or home health, the conductor is responsible for managing the entire “episode.” This is an effective means to deliver high quality care and control costs. These EOC pilots have also included learning collaboratives wherein best practices are shared and overall practice performance has improved. Current NJ EOC pilots are based on retrospective payment and have “upside only risk”, meaning the provider does not share in risk but may receive a share of the savings dependent upon delivering both quality outcomes and a reduction in TCOC.

THE DETAILS: The State should establish a formal EOC demonstration requiring the MCOs to administer a model for between three and five episodes of care. We recommend, at a minimum, including Total Joint Replacement, Maternity and Cardiac Care. Over time, prospective payments or risk-based EOC should be considered and successful demonstrations should be expanded statewide. These models should be included in the MCO contract.

RECOMMENDATION 17: Statewide Patient Centered Medical Home (PCMH)

THE CHALLENGE: A 2010 statute directed Medicaid to establish a three-year pilot demonstration for medical homes focusing on the frail elderly and those with chronic diseases. A medical home is a team-based health care delivery model led by a health care provider. Also known as a Patient Centered Medical Home (PCMH), the care model is intended to provide comprehensive and continuous medical care to patients with the goal of obtaining maximized health outcomes. DMAHS has a

Memorandum of Agreement (MOA) with four of the five MCOs to have them participate in a pilot to enhance or create infrastructure, within their networks, for medical home services. To date, there are a very small number of primary care practices participating in the model. This should improve over time. CMS is rewarding providers that are participating in APMs and will be penalizing those that cannot demonstrate the ability to do so.

THE SOLUTION: In the commercial and Medicare markets in New Jersey and nationally, patient centered medical homes have produced early results showing savings generated through better care coordination and communication with beneficiaries and throughout the delivery system. Consistent with our recommendation to move towards better integrated care, medical homes embrace this way of coordinating care delivery. As part of its overall APM target, New Jersey Medicaid should include a PCMH program.

THE DETAILS: Building upon the demonstration, the State should expand the PCMH model over the next five years to include as many primary care practices that qualify. The model should include reimbursement options that link quality and efficiency benchmarks to incentive payments and shared savings. The PCMH model should be open to all primary care practices including Federally Qualified Health Centers (FQHCs) and hospital-based primary care clinics. As part of the PCMH model, the practice should provide comprehensive care as defined in the CMS CPC Initiative, which relies upon a team-based approach and includes practice extenders such as Advanced Practice Nurses (APNs), social workers, community health workers and other professionals. The PCMH program should have standardized quality metrics which will be set forth in the MCO contract and will thereby reduce the administrative burden on providers.

RECOMMENDATION 18: Clinically Integrated Network of Care for Children

THE CHALLENGE: Nearly half of those enrolled in Medicaid are children. While most are relatively healthy, there are approximately 30,000 children with serious disabilities that require a host of physical and social support services. It is estimated that there another 150,000 children with chronic health conditions.⁴⁰ Access and quality vary for these young beneficiaries depending on where they live in the State.

THE SOLUTION: To better address the medical needs of New Jersey children, Medicaid should encourage hospitals and pediatricians to develop a clinically integrated network of care for children. Ohio has put the idea into practice. To enhance pediatric provider-driven care, Cincinnati Children’s developed a partnership with Ohio’s MCOs. Using their Health Network by Cincinnati Children’s (HNCC), the provider network assumed the financial risk of caring for children in two Medicaid MCOs. HNCC sought Medicaid “medical management” dollars to design the optimal care model for a population of children, while leveraging resources through a global capitation payment model. The Health Network developed a community-based network of providers and aligned incentives for the delivery of high-quality care to children served by Medicaid.⁴¹

THE DETAILS: In order to facilitate the development of the network, the State should include financial incentives for the MCOs to contract with a certified network. A clinically integrated network would provide a platform for evidence-based medicine and data-driven clinical initiatives that would improve outcomes, increase efficiencies and reduce costs. This network should include a full array of children’s behavioral health and developmental services providers.

RECOMMENDATION 19: Patient Centered Medical Home Pilot for Medically Complex Children

THE CHALLENGE: As noted, Medicaid provides coverage for nearly half of New Jersey’s children and the program has become vital to families of children with complex medical conditions. In the past, many children born extremely premature, or with serious congenital conditions, did not have a high survival rate. However, advances in medical technology have dramatically improved survival rates for these children. It is estimated that nationally these children represent six percent of the total number of children enrolled in Medicaid but account for 40% of the spending on behalf of Medicaid children.⁴² Historically, commercial insurance coverage included limits on scope and/or duration of certain services, such as private duty nursing or institutional long-term care. The costs of these services exceed the financial capacity of most New Jersey residents, leaving Medicaid as the insurer of last resort for these services for many severely ill or disabled children.

THE SOLUTION: New Jersey Medicaid should establish a PCMH pilot for children with medical complexity.



THE DETAILS: Under this pilot, an estimated 50-100 children would be assigned to a medical home operated by New Jersey provider groups with proven experience in serving children with medical complexities. For a monthly care coordination fee, the designated providers would coordinate all care for these patients, including the use of out-of-state providers when necessary. The medical home provider would be evaluated on quality metrics and the total cost of care. The children would be selected to participate in the pilot using the Pediatric Medical Complexity Algorithm (PMCA) developed by Washington State Medicaid.⁴³

RECOMMENDATION 20: Value Based Purchasing Advisory Council

The State should establish a Value Based Purchasing Advisory Council to oversee the use of Value Based Payments (VBP) and Alternative Payment Models (APMs).

THE CHALLENGE: VBP and APMs represent fundamental changes in the reimbursement and care delivery methods used by both the MCOs and providers. Around the country, there are many initiatives that are in the early phases of implementation and, thus, there is limited research regarding their long-term outcomes as well as their effect on the provider's capacity to manage financial risk. The inclusion of non-traditional, health-related social services, such as housing, in these models further complicates their implementation.

THE SOLUTION: To ensure that these major system transformations are monitored and evaluated over the years as federal and State programs and health delivery evolves, a dedicated group of experts is necessary to provide independent oversight and counsel to ensure the larger goals of the reforms are being met.

THE DETAILS: Medicaid should establish a Value Based Purchasing Advisory Committee made up of industry experts including, but not limited to, each of the operating MCOs in the State, and at least one of

each of the following experts representing: consumer advocacy, beneficiaries with chronic conditions, quality improvement, acute-care hospital, children's hospital, post-acute facility, certified Medicaid ACO, PCMH certified physician, housing, Health Information Exchange, pharmacist, pharmacy manufacturer, behavioral health, substance abuse, etc.

Medicaid staff would be responsible for reporting to the VBP Advisory Committee about each of the current value-based programs operating within Medicaid and run by each of the MCOs. The report should include the parameters of the program, how many beneficiaries are affected, and what, if any, quality improvements and cost savings have been achieved through the efforts of the programs. The Division will also be responsible for supplying any data the advisory committee may need to achieve its mission.

The role of the advisory committee will be to make recommendations to the State about the percentage of Medicaid payments that should be tied to value based programs, new value based programs to consider, and to encourage the appropriate use of data in furthering the goals of any current value based program in operation in the State. The advisory committee will meet quarterly and create a public-facing report about the state of value based programs in Medicaid on an annual basis. The report will include an outline of the current approval process for value based programs within Medicaid.

Path to Population Health

Medicaid population segments lend themselves to the benefits of population health (e.g. improved health outcomes of particular groups like children with asthma or people with disabilities who have chronic conditions). New Jersey Medicaid's effort to expand to population health has been bolstered by DSRIP funding and has centered on the current ACO Demonstration project. Based on our research, there are opportunities to significantly improve the care for women of child bearing age and those with chronic conditions.

However, for many safety net providers, the transition to population health can be challenging. The hospitals and community providers in our urban areas have not had the resources to become ACOs and purchase the health information technology systems that allow them to track patients and treat them in a way that focuses on preventive health and outcomes. Funding should be re-deployed to support them in this work. As outlined in the State's waiver renewal, DSRIP funding should continue to be used to assist providers in population health strategies in their communities that aim to reduce and eliminate preventable illnesses and diseases by creating an environment that is committed to wellness and prevention.

Maternal and Family Health

In 2014, Medicaid covered 42% of all births in New Jersey⁴⁴ at an estimated annual cost of nearly \$700M. By most measures, New Jersey Medicaid maternal and infant health outcomes are subpar; rates of elective C-sections and pre-term and/or low birthweight babies remain well above national quality averages.⁴⁵ Infants born with complications from pre-term and/or low birthweight require treatment in hospital neonatal intensive care units (NICU), costing New Jersey Medicaid an additional, and often avoidable, \$150-\$200M per year.

New models for delivering care are being explored both here in New Jersey and around the country. Strong Start for Mothers and Newborns is a CMS effort to test new approaches to prenatal care for women enrolled in Medicaid who are at risk for having a preterm birth. The Strong Start model in New Jersey uses a centering (or a grouping) model for prenatal care that has shown seven percent reduction in the preterm birth rate. More recently, the data has shown a lower rate of C-sections for all women enrolled in Strong Start. The preterm birth rate for African American and Hispanic women was substantially lower for Strong Start participants.⁴⁶ Similar positive results are documented by Healthy Start programs in other states. A South Carolina Strong Start pilot reported that participation in the program reduced premature birth risk by 36%, and low birth weight by 44%, and led to 28% lower risk of being admitted to a NICU.⁴⁷

Access to contraceptives also contributes to improvement in the health of mothers and babies. By ensuring individuals have timely access to the contraceptive method of their choice, states support safer spacing between births and reduce the number of unintended pregnancies. Indeed, for every dollar of public funding spent on contraception services, Medicaid, in turn, saves \$5.68 in costs associated with unintended pregnancies and infant care.⁴⁸ Improving birth outcomes and maternal health is both a public health and a budgetary priority for Medicaid.

For every \$1 of public funding spent on Contraception Services, Medicaid saves \$5.68 in cost associated with unintended pregnancy and infant care

Source: Guttmacher Institute Analysis, Contraceptive Needs and Services, 2010⁴⁸

RECOMMENDATION 21 A: Maternity Episode of Care (EOC)

New Jersey Medicaid should implement an episode of care for maternity that includes services for the mother and baby from the prenatal period through 30 days postpartum (or 60 days for frail babies).

THE CHALLENGE: Maternity care in Medicaid is challenging for many reasons. First, many new mothers become eligible for Medicaid upon becoming pregnant, because the maximum income allowed to qualify for Medicaid is higher for pregnant women. However, many newly pregnant women do not know they are now Medicaid eligible and delay seeking obstetrical care believing they are not covered. This confusion creates an unnecessary barrier to receiving critical prenatal care in first trimester. More importantly, multiple complex medical conditions and socio-economic circumstances, such as inadequate housing and substance abuse, affect Medicaid beneficiaries at much higher rates and have significant impacts on birth outcomes.

The cost of maternity care varies depending on the type of delivery and hospital. Care coordination is complicated because prenatal care, labor, and birth are often paid for and delivered as three distinct periods.

THE SOLUTION: A well designed EOC for maternity that incorporates new models for engaging patients will address many of these challenges. Care coordination is essential to improving quality and reducing costs in maternity care. In addition, CMS and state Medicaid

programs have been experimenting with a variety of models of care. One such model encourages the use of patient engagement models like the Healthy Start centering program which uses group-based prenatal care. CMS also uses value based payment models, such as the Episode of Care payment model discussed earlier, which is designed to aggregate prenatal care, labor and birth services and properly align the financial incentives to improve quality, access and care coordination. These models have shown early positive results in New Jersey and other states.

THE DETAILS: The Health Care Payment and Learning Action Network lays out the basic components of an Episode of Care for Maternity Care.⁴⁹ We recommend that the EOC operate within the following parameters:

- Begin as upside risk only, where the MCO shares in any savings with the provider partners. But, if the providers do not achieve the quality and cost benchmarks, their only risk is that they do not receive any additional payments.
- Ensure that incentive compensation requires provision of the postpartum visit and a consultation of contraceptive options post-delivery.
- Provide for consistency in quality measurement.
- Include the mother and baby.



- Provide wraparound services that address opioid use as well as comprehensive drug, alcohol, and postpartum depression screening.
- Ensure access to contraception inclusive of long acting reversible contraceptives and IUD placement at time of delivery.
- In the preterm period, provide access to hydroxyprogesterone caproate for women who have had a previous pre-term delivery, which is currently not consistently available.
- Stop payment for Early Elective Delivery (EED).
- Provide access to and funding for evidence-based models such as Centering for maternal care, Nurse Family Partnership, Strong Start and Healthy Families, to optimize maternal child health outcomes.

RECOMMENDATION 21 B: Use of Contraception

New Jersey should modify current reimbursement policies to expand the availability of Long Acting Reversible Contraceptives (LARCs).

THE CHALLENGE: Women's individual decisions in contraception play a large role in whether the chosen method is used in its most effective method. Lack of timely access to birth control leads to insufficient birth spacing, causing health complications to both the mother and the baby.

Long Acting Reversible Contraceptives (LARCs) include both the intrauterine device (IUD) and the birth control implant. The medical procedures used for both require a physician to insert/remove the designated device. This procedure can occur immediately after birth at the

hospital or at any time in a physician's office. Because of the multiple settings for the procedure, and the fact that Medicaid covers LARCs as a pharmacy benefit, reimbursement for these services has been confusing for providers and has, in turn, limited the availability. Additionally, providers have shared that they are unable to stock the LARC devices due to the upfront costs. This, combined with the requirement that some MCOs have for preapproval before LARC insertion, causes confusion, delay, and ultimately reduces patients' access to LARC.

THE SOLUTION: One of many birth control options that hold appeal for women is LARC; inserted once, women are relieved of the daily responsibility to be sure they are using birth control. CMS has encouraged states to improve access to LARCs and has offered a variety of strategies to restructure reimbursement and facilitate their use.⁵⁰

LARCs have been shown to reduce unintended pregnancies and help prevent insufficient birth spacing, thereby reducing the risk of low-weight and/or premature birth. The expanded use of LARCs in Colorado resulted in significant drops in the birth rate among teens and young adult women. Also in Colorado, from 2009-2013, the abortion rate among women between 15 and 19 years old dropped 42% and between 20 and 24 years old dropped 18%.⁵¹

THE DETAILS: The State should develop and implement postpartum LARC insertion policy that includes the following parameters:

- Eliminating pre-approval for LARC insertion (Fee-for-Service Medicaid does not require pre-approval, but some of the MCOs may).
- Providing reimbursement for evaluation/management (E/M) visits, where a practitioner and beneficiary discuss contraceptive options, in addition to same-day LARC insertion or removal procedures (Illinois strategy).

- Allowing for reimbursement separate from any encounter payment the provider may receive for implanting the device.
- Encouraging public/private partnerships to fund the purchase of LARCs to stock in provider offices (similar to Delaware, Colorado).
- Allowing reimbursement for providers to have conversations on contraception prior to delivery.

RECOMMENDATION 22: The Future of the Medicaid Accountable Care Organization (ACO)

In July 2015, three community-based coalitions, the Healthy Greater Newark ACO, the Trenton Health Team, and the Camden Coalition of Healthcare Providers, were designated by the State as Medicaid ACOs under a 2011 State law that established a three-year demonstration project. The project officially began in January 2016 when the three organizations received the Medicaid encounter data for the beneficiaries who live in specific areas of Camden, Trenton and Newark. Three other community coalitions in Paterson, New Brunswick, and Gloucester/Cumberland Counties also applied to be part of the program, but ultimately were not certified by the State.

Evolve the Medicaid ACO Demonstration Project

The State should revise its current Medicaid ACO Demonstration Project to create a program that better reflects the innovative work that the three State-certified

and non-certified ACOs are doing, and retains the elements of that work within the currently structured Medicaid program. The existing ACOs should be grandfathered into this program and work with the State to redesign the model. The model should be open to additional communities which also need community-based care coordination and other services focused on the social determinants of health.

THE CHALLENGE: While the underlying purpose of the legislation has proven prescient, the detailed and prescriptive nature of the legislation and subsequent regulations were at odds with the migration of the Medicaid program from fee-for-service to fully managed care. This issue, compounded by the fact that MCOs were not required to participate in the ACO and the pilot was not aligned with or incorporated into the goals of the State's Medicaid Waiver, have made implementation of the demonstration project flawed from the outset. Details can be found in the 2016 Rutgers Center for State Health Policy report, *"The New Jersey Medicaid Accountable Care Organization Demonstration: Lessons from the Implementation Process."*⁵²

THE SOLUTION: The need to focus on care coordination, the social determinants of health, and the ability of community-based organizations to address these issues, has been proven around the country in models with greater state support.

Colorado's ACO-type organizations have reported \$77 million in net savings to Medicaid and have demonstrated lower rates of emergency room visits, high-cost imaging and hospital readmissions. Minnesota has attributed \$76.3 million in savings within the first two years of its ACO program, and Vermont reported \$14.6 million in savings in its program's first year.⁵³

The Medicaid ACOs and the other community-based coalitions that organized to do this work are uniquely poised to address the social determinants of health. They can successfully manage the holistic needs of the highest utilizers of health care in their community who are facing issues such as homelessness, mental illness, chronic disease mismanagement, and lack of wraparound services to manage their care.

CMS recognized the need to expand this work by creating the Accountable Health Communities model, which will fund organizations across the country starting in the summer of 2017 and help them focus on the health-related social needs of Medicare and Medicaid beneficiaries.⁵⁴ UnitedHealth Group, the largest insurer in the country, is opening a national program office in Camden to further develop and expand this model across the country. Over the next three years, the Camden Coalition and UnitedHealthcare will be working together to develop, test, and scale new national models of care for patients with complex health and social needs.

THE DETAILS: A proposed model with greater flexibility should be developed by the ACO advisory council workgroup and incorporated into the MCO contracts in the sections on APMs, integrated models of care and data sharing. The new model should be evaluated over time, as appropriate, to ensure that the State is meeting its goals to address direct health care delivery and the social determinants that impact whether the system is working for the beneficiaries.

One idea that the Council should consider is designating qualified non-profits as Medicaid Community Coalitions (MCCs), a concept that builds on the current Medicaid ACO model. The MCCs would have less prescriptive requirements than ACOs allowing greater

innovation that was intended in the first iteration of the demonstration project. The State would certify MCCs, share data with them, and evaluate their outcomes. Their goals and performance measures would align with the MCO and provider goals and their role would be spelled out in the MCO contracts.

Under this approach, qualified non-profit organizations would apply to Medicaid to be certified by the State as Medicaid Community Coalitions to:

- Provide population health management through care coordination services;
- Offer health-related social service interventions such as housing and critical behavioral health services;
- Create innovative evidence-based models for a “high utilizer” and/or “rising risk” Medicaid population within a specific geographic area; and
- Utilize health data to coordinate care and improve the health of their community members who receive Medicaid.

Current State-certified Medicaid ACOs will be grandfathered into the new program, as they are already undertaking much of this work. The MCC application would specify the applicant’s designated area, and may propose a designated area that includes zip codes or geographic regions that are not contiguous.

Once certified by the State, the newly formed MCCs would be eligible to contract with MCOs to provide services based upon their agreed needs and skill sets. The contract should include elements of an alternative payment model. Agreed upon quality measures would be set forth in the MCO contract, along with overall program design, and would include results reported at least annually.

RECOMMENDATION 23: Next Generation Delivery System Reform Incentive Payment (DSRIP) Program

New Jersey's 2012 Medicaid waiver included the DSRIP program. DSRIP provides funding to a select number of hospitals to develop and implement targeted population health programs such as diabetes and asthma management. The State's waiver renewal seeks to extend the program for an additional five years, but with significant changes that will begin in year three. The State will encourage collaboration by hospitals and use a portion of these funds to engage community providers to provide necessary social services. The State also included, as part of their waiver renewal, the use of up to two percent of the funding to reward beneficiaries for preventive care.

Amend the DSRIP Program

The State should amend the DSRIP program to improve the program's performance and use the program's financial leverage to increase provider focus on population health.

THE CHALLENGE: States with DSRIP programs have been advised by CMS that over the long-term, CMS will no longer support DSRIP as another form of financial assistance to hospitals. CMS has stressed that the funding devoted to DSRIP should be tied to quality incentives; should be included in the MCO capitated rates and then paid to providers through alternative payment model contracts which are based on performance measures and may include dual-sided risk. Additionally, hospitals participating in DSRIP programs have had difficulty engaging community-based partners and beneficiaries, because the program does not provide sufficient resources to support these partners.

THE SOLUTION: New Jersey should amend its DSRIP program to improve provider participation and the State's return on investment, better link performance and payment, improve data transparency, and establish a roadmap to improve coordination between the hospitals and payers to ultimately deliver better care coordination to beneficiaries.

THE DETAILS: To facilitate these broader population health goals which also expand the types of services and entities receiving these funds, the State should increase DSRIP funding by at least \$33M (\$16.5M State share) to allow greater participation by hospital and community partners, while also targeting funds to hospitals in areas with large Medicaid/charity care populations. The State should also emphasize the care management of high-utilizers of hospital and physician services with chronic conditions.

The funding mechanism should ensure:

- Performance and payment are aligned
- Ongoing and meaningful access to Medicaid data to DSRIP partners for population health management
- Identification of target beneficiaries, particularly those in the "rising-risk" population and high-utilizers of hospital and physician services
- The use of community partners to address the population's social determinants of health, including the need for housing

The State should also create a roadmap with approaches for contracting between MCOs and DSRIP participants, creating a path to sustainability once DSRIP funds are no longer available. It should include suggested pathways for commercial/Medicare participation where

such participation makes sense. This roadmap should be developed by a workgroup of DSRIP stakeholders, including New Jersey Department of Health (DOH), Medicaid, DSRIP participants, and MCOs.

The workgroup should consider:

- New fee-for-service payments to cover the costs of new interventions
- Quality targets/bonuses to be earned
- Shared savings for certain populations within the DSRIP attribution list
- Shared savings for the whole population of DSRIP attributed beneficiaries
- Any other payment models that are deemed to support access and quality for DSRIP attributed beneficiaries

The roadmap would also include recommendations for memorializing DSRIP investments in Medicaid by transitioning money into payment rates to hospitals and other providers at the end of the program.

RECOMMENDATION 24: A New Model for End-of-Life Care

New Jersey should adopt a model of end-of-life care that creates greater understanding of and respect for end of life care options.

THE CHALLENGE: According to the Dartmouth Atlas of Health Care, Medicare expenditures at the end of life in New Jersey are among the highest in the nation. New Jersey residents, in the last six months of life, spend 30% more days in the hospital, see physicians 43% more often, and spend 44% more days in the intensive care

unit compared to the average American.⁵⁵ In a 2014 report, New Jersey ranks 42nd in the nation for patients' median days on hospice care at 18 days versus 23 nationally.⁵⁶ The National Quality Forum reports that many dying persons enroll in hospice too late to fully realize the benefits available.

Although for many years, patients with cancer made up the majority of hospice patients, this is no longer the case, as persons with other conditions such as dementia, heart disease, and lung disease now account for more than 63 percent of hospice admissions.⁵⁷ According to a 2016 "Health Matters Poll" conducted by the New Jersey Health Care Quality Institute and the Rutgers Eagleton Center for Public Interest Polling:

- 61% of New Jersey adult residents are comfortable with the idea of aging and have thought about their wishes for medical treatment near the end of their life.
- Six out of 10 New Jersey adult residents have no written documents expressing their wishes for end-of-life care.
- 38% of New Jersey adult residents have not had conversations about advance care planning.
- Only three out of 10 New Jersey adult residents, 65 years of age and older, are aware of the Five Wishes advance directive or POLST.

The public is comfortable with aging and discussing end of life, however very few are making plans and many are not aware of important care options or advance care planning documents. More must be done to avoid unwanted expensive care.

THE SOLUTION: The State should adopt a model for end-of-life care that encourages greater use of hospice care, allows palliative care to co-exist with curative care, creates a statewide registry for Practitioner Orders

for Life Sustaining Treatment (POLST) forms, pays for advance care planning provider visits, and trains the new generation of providers to have these important conversations with their patients.

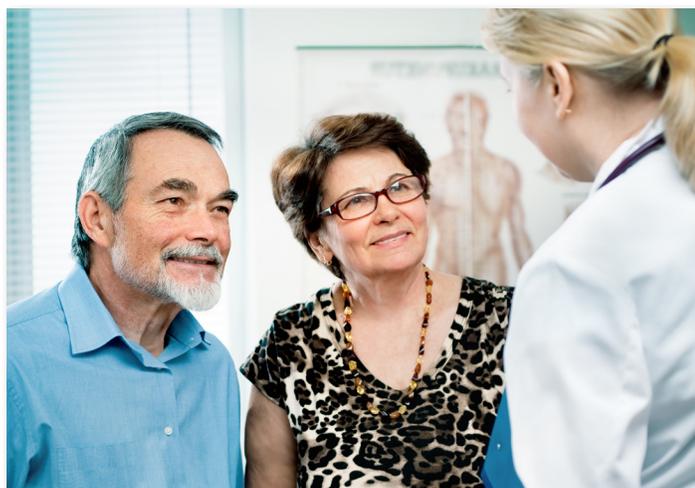
THE DETAILS: Several pathways should be pursued to increase provider and community conversations about end-of-life care options that result in better quality care for patients and improved knowledge about care options. These pathways include:

Allow Palliative and Curative Care to Co-exist –

Introducing palliative care earlier in the course of treatment for some chronic conditions like heart failure, will provide access to important services, including an opportunity for individuals/families to have conversation around goals of care. New Jersey should adopt a model of end-of-life care like the Aetna Compassionate Care Model that allows palliative care to co-exist with curative care.⁵⁸ The model uses a claims-based algorithm to identify members with advanced illness who may benefit from integrated case management, allowing the member to pursue aggressive curative treatment for advanced illness as well as palliative care with the goal of treating the patient holistically. Studies show reduced cost and higher patient satisfaction with greater use of palliative care when it coexists with curative care.⁵⁹

Increase Use of POLST, other Advance Directives, and Promote “End of Life” Conversations –

Increasing the use of POLST and other Advance Directives will enhance individual choice and reduce



costs of care, while preventing unwanted treatments and hospitalizations. The POLST is a State-recognized medical order for treatment which is signed by a patient's provider and follows the patient in any setting.

The State should partner with the New Jersey Health Care Quality Institute and other outside, trusted organizations that are working in the State to educate the public and health care providers about the importance of end-of-life decisions and documenting them in the POLST or an Advance Directives.⁶⁰ This is especially important for individuals who are nearing the end of life (e.g. individuals entering long-term care facilities for long term care; individuals with early stage dementia; individuals with life-limiting illnesses such as chronic heart failure, or oncology patients not responding to therapy).

Implement a POLST Registry – To easily track and allow reliable provider access to patients' POLST status, the State should develop a POLST registry, like Oregon and California, which is part of a statewide health information network that providers can access.

Pay for Advance Care Planning Consultations –

To further encourage provider and patient consultation about end-of-life choices, the State should allow doctors, nurses and social workers to bill Medicaid for advance care planning visits, as is done in Medicare.⁶¹ The Medicare codes allow providers to bill for initial and follow-up consultations.⁶²

Train the Next Generation of Providers – The State health professional schools should require end-of-life care consultation training in their respective curricula. In order to change New Jersey's poor rankings on end-of-life care, the State will need providers who are ready to raise this difficult topic and assist their patients in choosing the care that reflects their life goals and values.

Longer Term Plans to Remodel Medicaid

The extensive primary and secondary research, as well as the hundreds of conversations conducted for this Project, resulted in raising many issues which we either did not have the time or resources to explore in more detail. So as not to lose the benefit of identifying these issues for future research and collaboration, we include them here. We recommend that policymakers consider them over the next year to determine if they could improve New Jersey's Medicaid program.

- **Overall Cost Cap** – Some states are using global spending caps to control Medicaid costs. New York limits Medicaid growth to no more than the growth in the Medical Care Consumer Price Index (CPI). Biannually, the Ohio legislature limits the growth in MCO per member per month capitation rates and typically uses the Medical Care CPI.
- **Screening Services for Autism** – Access to autism diagnostic and treatment services for children is limited for several reasons including the lack of dissemination and use of proper diagnosis methods at the primary care level; lack of reimbursement to physicians to support the additional resources they need to care for this population and the lack of coordination of these services between schools and providers; and the lack of support services for the families. Staff from DMAHS, Children's System of Care, DOBI and DOH are collaborating to build a comprehensive package of services to provide to youth with autism as part of the Medicaid State Plan.

- **Ambulatory (Bedless) Hospitals** – States are beginning to license facilities that provide the entire scope of hospital services without the need of inpatient beds. These facilities maintain 24/7 emergency departments and operating rooms, and offer a mix of imaging, telemedicine and short-term observation care. Technology plays a key role and allows patients to avoid being kept overnight for monitoring as many routine checks can be done through remote digital technology.
- **Children Aging Out** – New Jersey maintains a robust system of behavioral health care for children through the Children's System of Care (CSOC). Medicaid eligibility is established automatically upon age 18 for all youth who are in the custody of the Division of Child Protection and Permanency (DCPP) (formerly known as DYFS) until the age of 26. However, children beyond the age of 21 aging out of CSOC are often unable to obtain the mobile crisis response, or home and community care and treatment options because these services are limited or unavailable.

Transition into adult services too often equates to discontinued treatment at a time when increased stressors and underlying behavioral health conditions increase. The foster care experience points to a larger



longstanding issue for children with complex needs, be it physical or behavioral. Because children in Medicaid receive more robust benefits than adults when they become of age, they often face the loss of support and care coordination services that are not available to adults.

- **PACE Lite** – There are nearly 300,000 aged, blind and disabled Medicaid beneficiaries. Nearly 15,000 make use of adult day health centers. These centers are increasingly becoming a focus for use as a medical home. Seeing the patient at their facility for up to five days per week provides a perspective like no other.

The Program for All Inclusive Care for the Elderly (PACE) is a successful, but fairly limited program for Medicare beneficiaries with long-term care needs built around a similar outpatient facility. In PACE, the provider, usually a hospital system, receives both the Medicaid and Medicare funding directly and assumes the full risk of the patient's total cost of care. As an alternative, the concept of coordinating benefits between insurance carriers (DSNPs) may allow beneficiaries to be able to use the existing adult day health center's as a base for providing comprehensive patient care. The Quality Institute conducted a focus group at an adult day center in Vineland that captured beneficiary feedback on this very issue.⁶³

- **Medicare Bonus** – Unless Congress permits Medicare to mandatorily enroll their beneficiaries in a managed care plan, the State will continue to struggle to coordinate care for dually eligible individuals. Some duals are enrolling in the Dual Eligible Special Needs

Plans (DSNPs) but many are not. This disconnect leaves the MCOs that cover the Medicaid services with little incentive to manage those services/ costs covered by Medicare for which they are not responsible (eg. hospital, pharmacy and physician care). The State should consider proposing to CMS that Medicare pay MCOs a bonus when they demonstrate the Medicare beneficiaries total cost of care has been kept within or below the total cost of care targets.

- **Expanded Function Dental Assistants** – Access to dental care for Medicaid members has been a perennial target for reform for the same reasons that specialist participation is limited – reimbursement levels are low and the credentialing process is long and costly. As physician assistants and advanced practice nurses have helped address the demand for more primary care medical professionals, dental assistants can provide a valuable resource that allow dentists to expand their panel of patients. Pennsylvania permits Expanded Function Dental Assistants (EFDAs) to place, condense, carve and contour amalgam restorations as well as etch, place, and finish composite restorations.
- **Community Supports and Resources for Individuals with Substance Use Disorder (SUD)**
As part of the State's comprehensive solution for addressing the opioid crisis, it should consider including a network of community supports and

resources to assist individuals in recovery. Individuals with SUD can achieve a full and satisfying life in the community, especially when they can access effective services and support systems. These support systems should incorporate wellness programs and peer support.

As defined in the Substance Abuse and Mental Health Services (SAMHSA) Wellness Initiative, wellness is being in good physical and mental health. Wellness can improve quality and length of life, especially for people with behavioral health conditions.⁶⁴ Reducing health disparities prevents early deaths and may also lower the nation's healthcare costs. An analysis of medical expenditures, published in 2015 by the Agency for Healthcare Research and Quality, shows that trauma-related disorders, cancer, mental disorders,⁶⁵ heart conditions, and arthritis and other non-traumatic joint disorders are the most costly conditions among American adults ages 18 to 64.⁶⁶

The Wellness Initiative also promotes the use of wellness strategies as practical ways to start developing healthy habits that have a positive impact on physical and mental health. The Wellness Initiative is based on a model developed in New Jersey for

use in mental health and substance use treatment/recovery programs.

Per SAMHSA, the Eight Dimensions of Wellness are:

- **Emotional** – Coping effectively with life and creating satisfying relationships
- **Environmental** – Good health by occupying pleasant, stimulating environments that support well-being
- **Financial** – Satisfaction with current and future financial situations
- **Intellectual** – Recognizing creative abilities and finding ways to expand knowledge and skills
- **Occupational** – Personal satisfaction and enrichment from one's work
- **Physical** – Recognizing the need for physical activity, healthy foods, and sleep
- **Social** – Developing a sense of connection, belonging, and a well-developed support system
- **Spiritual** – Expanding a sense of purpose and meaning in life

Endnotes

- ¹Kaiser Family Foundation. *New Jersey Medicaid Fact Sheet*. <http://files.kff.org/attachment/fact-sheet-medicaid-state-N>
- ²NJ FamilyCare Annual Report 2015. http://www.state.nj.us/humanservices/dmahs/news/NJ_FamilyCare_2015_Annual_Report.pdf
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Appendix 1: Blueprint Recommendations Scorecard

Medicaid 2.0 Blueprint Recommendations Scorecard 		Quality	Access	Cost Savings	CMS Approval or Waiver	Legislation	Regulation	I.T. Upgrade	MCO Contract Change
		Modern Foundation							
1	Office of Health Transformation	■	■	\$		E.O.*			
2	Increase Transparency for Medicaid Data	■	■	\$		■	■		
3	Eligibility Processing	■	■	\$\$	■	■		■	
4	Telehealth	■	■	\$\$			■		■
5	Unified Single License System for Integrated Care	■	■	\$			■		
6	Medicaid Regulations and Managed Care Contract Upgrade	■	■	\$\$			■		■
7	Fraud, Waste and Abuse	■		\$\$					■
Foundational Medicaid Reforms									
8	Statewide Universal Credentialing System	■	■	\$				■	■
9	Network Directories	■	■	\$\$					■
10	Standardized Quality Measures	■		\$			■		■
Upgrades to the Medicaid Model									
11	Integrated Physical, Mental Health and Substance Use Disorder	■	■	\$\$\$	■		■		■
12	Long Term Residential Services for Substance Use Disorder	■	■	\$\$\$	■				
13	Behavioral Health Integration Advisory Council	■	■	\$\$\$	■				
Financing Reform									
14	Pharmaceuticals	■		\$\$\$		■	■		■
15	Managed Care Organizations Performance Incentives	■	■	\$\$\$					■
16	Episode of Care Demonstration	■		\$\$					■
17	Statewide Patient Centered Medical Home	■	■	\$\$					■
18	Clinically Integrated Network of Care for Children	■	■	\$					■
19	Patient Centered Medical Home for Medically Complex Children	■	■	\$\$					■
20	Value Based Purchasing Advisory Council	■	■	\$\$					
Path to Population Health									
21	Maternal and Family Health	■	■	\$\$\$			■		■
22	The Future of the Medicaid Accountable Care Organization (ACO)	■	■	\$\$	■				■
23	Next Generation Delivery System Reform Incentive Payments (DSRIP)	■	■	\$	■				
24	End of Life Care	■	■	\$\$	■		■		■

\$ = Some Savings \$\$ = Significant Savings \$\$\$ = Substantial Savings *E.O. = Executive Order

Appendix 2: Acronyms

ACA	Affordable Care Act	FQHC	Federally Qualified Health Center
ACO	Accountable Care Organization	HCBS	Home and Community Based Services
APM	Alternative Payment Model	HNCC	Health Network by Cincinnati Children's
APN	Advanced Practice Nurse	ICF-ID	Intermediate Care Facilities – Intellectual Disability
BHH	Behavioral Health Home	ICU	Intensive Care Unit
CAQH	Council for Affordable Quality Healthcare	IME	Interim Managing Entity
CBoSS	County Board of Social Services	iPHD	Integrated Population Health Data
CCBHC	Certified Community Behavioral Health Clinics	IUD	Intrauterine Device
CHF	Congestive Heart Failure	LARC	Long Acting Reversible Contraception
CMS	Centers for Medicare and Medicaid	MCC	Medicaid Community Coalition
CPC	Comprehensive Primary Care	MCO	Managed Care Organization
CPI	Consumer Price Index	MLR	Medical Loss Ratio
CSOC	Children's System of Care	MLTSS	Managed Long-Term Services and Supports
DCF	Department of Children and Families	NICU	Neonatal Intensive Care Unit
DCPP	Division of Child Protection and Permanency	NJAC	NJ Administrative Code
DDD	Division of Developmental Disabilities	NJAHP	NJ Association of Health Plans
DDS	Division of Disability Services	NJHCQI	NJ Health Care Quality Institute
DHS	Department of Human Services	OHT	Office of Healthcare Transformation
DMAHS	Division of Medical Assistance and Health Services	PACE	Program for All Inclusive Care for the Elderly
DMHAS	Division of Mental Health and Addiction Services	PBM	Pharmacy Benefits Manager
DOBI	Department of Banking and Insurance	PCMH	Patient Centered Medical Home
DOH	Department of Health	PDL	Preferred Drug List
DSNP	Dual Eligible Special Needs Plan	PMPM	Per Member Per Month
DSRIP	Delivery System Reform Incentive Payments	POLST	Practitioner Orders for Life Sustaining Treatment
ECHO	Extension for Community Healthcare Outcomes	RN	Registered Nurse
ECPIP	Eagleton Center for Public Interest Polling	RSS	Residential Rehabilitation Services
EED	Early Elective Delivery	SHBP	State Health Benefits Program
EFDA	Expanded Function Dental Assistant	SIM	State Innovation Model
EMR	Electronic Medical Record	SSA	Social Security Administration
EOC	Episode of Care	SSI	Supplemental Security Income
FFS	Fee for Service	SUD	Substance Use Disorder
FMAP	Federal Matching Assistance Percentage	TCOC	Total Cost of Care
FPL	Federal Poverty Level	TSS	Transitional Support Services
		VBP	Value Based Purchasing

Appendix 3: Glossary of Terms

Accountable Care Organization (ACO) – A group of doctors, hospitals, and other health care providers, who provide coordinated high quality care to patients. ACOs are intended to tie provider reimbursements to quality metrics and reduce the total cost of care for attributed patients. When an ACO succeeds both in delivering high-quality care and reducing costs, it will receive a financial benefit, typically through a shared savings or shared savings/risk arrangement.

Alternative Payment Model (APM) – A payment model that incentivizes providers to improve quality and outcomes, and to contain costs. APMs help to promote patient value and efficiency by shifting some financial risk to providers. APMs are a broad term for the variety of risk-based or budget-based payment models in use today such as ACOs.

Behavioral Health Home (BHH) – A continuing standard of care that allows individuals to have all of their health care needs identified, addressed, and treated in a coordinated way. The same team of clinicians and practitioners either deliver, or coordinate the delivery of, all the necessary medical, behavioral, and social supports required for the individual, acknowledging the impact each area has on the others. It is not a residential program. It is a whole-person care delivery model.

Bundled Payment – An initiative that links multiple services beneficiaries receive during an episode of care into a single payment. This system holds providers responsible for both cost and performance, usually with the goal of encouraging care coordination. Bundled payments may lead to improved care transitions, fewer hospital readmissions, and better delivery of appropriate care following discharge – potentially at a lower cost.

Capitation – Payment methodology wherein an organization is paid a standard fee per covered patient (often per-member per-month) to reimburse all services rendered (the total cost of care).

Certified Community Behavioral Health Clinics (CCBHC) – The Excellence Act established a federal definition and criteria for Certified Community Behavioral Health Clinics (CCBHCs) and stipulated that CCBHCs may receive an enhanced Medicaid reimbursement rate based on their anticipated costs of care. CCBHCs are responsible for directly providing (or contracting with partner organizations to provide) nine required types of services, with an emphasis on the provision of 24-hour crisis care, utilization of evidence-based practices, care coordination, and integration with physical health care.

Children’s System of Care (CSOC) – The Children’s System of Care, formerly the Division of Child Behavioral Health Services, serves children and adolescents with emotional and behavioral health care challenges and their families; children with developmental and intellectual disabilities and their families; and, children with substance use challenges and their families. CSOC is committed to providing services based on the needs of the child and family in a family-centered, community-based environment.

Comprehensive Primary Care (CPC) – The Comprehensive Primary Care initiative is a four-year multi-payer initiative designed to strengthen primary care. Since CPC’s launch in October 2012, CMS has collaborated with commercial and state health insurance plans in seven U.S. regions to offer population-based care management fees and shared savings opportunities to participating primary care practices to support the provision of a core set of five “Comprehensive” primary care functions. These five functions are: (1) Risk-stratified Care Management; (2) Access and Continuity; (3) Planned Care for Chronic Conditions and Preventive Care; (4) Patient and Caregiver Engagement; (5) Coordination of Care across the Medical Neighborhood.

Delivery System Reform Incentive Payment (DSRIP) –

Resulting from the Section 1115 waiver program, a federally funded initiative that provides states with funding to support hospitals and other provider organizations that commit to changing how care is provided to Medicaid beneficiaries.

Dual Eligible Special Needs Plan (DSNP) –

Dual Eligible Special Needs Plans (DSNPs) enroll beneficiaries who are entitled to both Medicare (Title XVIII) and Medical Assistance from a State Plan under Title XIX (Medicaid), and offer the opportunity of enhanced benefits by combining those available through Medicare and Medicaid.

Early Elective Delivery (EED) – scheduled cesarean sections or medical inductions performed prior to 39 weeks of gestation without medical necessity.

Episode of Care (EOC) – Methodology that includes all services provided to a patient with a medical problem, usually within a specific period of time, across a continuum of care in an integrated delivery system. Each episode of care includes a defined set of services delivered by designated providers in specified health care settings related to treating a patient's medical condition or performing a major surgical procedure.

Fee-for-Service (FFS) – Payment to medical providers for the number of hours, visits, or services rendered. Payment is based on the volume of services provided rather than process, quality, or outcomes involved.

Hospice – Hospice offers medical care geared toward maintaining or improving quality of life for someone whose illness, disease, or condition is unlikely to be cured. Each patient's individualized care plan is updated as needed to address the physical, emotional, and spiritual pain that often accompanies terminal illness.

Hospice care also offers practical support for the caregiver(s) during the illness and grief support after the death. Hospice is available to the patient and the entire family when curative measures have been exhausted and life prognosis is six months or less.

Interim Managing Entity (IME) – The IME serves as a single point-of-entry for those seeking treatment for substance use disorders. The IME ensures that individuals are receiving the right level of care for the right duration at the right intensity. The IME is meant to allow the state to manage its resources across payors and across the continuum of care.

Managed Care Organization (MCO) – Health care organizations that administer medical benefits and absorb financial risk in exchange for a predetermined monthly fee. MCOs combine the functions of health insurance administration, utilization management, and care coordination, and contract with a network of hospitals, physicians, and other providers to provide health care services.

Medical Loss Ratio (MLR) – The percentage of premium an insurer spends on administration, marketing, and profits, rather than on claims and expenses that improve health care quality.

Palliative Care – A comprehensive approach to treating serious illness that focuses on the physical, psychological, spiritual, and existential needs of the patient. Its goal is to achieve the best quality of life available to the patient by relieving suffering and controlling pain and symptoms. Palliative care may be given at any time during a patient's illness, from diagnosis on.

Patient Centered Medical Home (PCMH) – Method of organizing primary care that emphasizes care coordination and communication to provide patients with timely, well-organized, and integrated care. The PCMH model also seeks to enhance access to teams of providers within a health care organization.

Appendix 4: List of Medicaid 2.0 Stakeholder Meetings

Per-Member Per-Month (PMPM) – A total cost of care payment that refers to the dollar amount paid to a provider each month for each person for whom the provider is responsible for providing services.

Practitioner Order for Life-Sustaining Treatment (POLST) – A POLST form is a medical order indicating a person’s preferences for end-of-life care. In most states, this form is intended for use only during the final stages of life. In New Jersey, the POLST form can be filled out at any time. Individuals complete the form with their physician based on the contents of any relevant directives, discussions with the provider, and treatment preferences.

Shared Savings or Shared Savings/Risk – These payment models can be either one-sided (upside—just shared savings without risk) or two-sided (upside-downside—shared savings/risk). In both, the providers receive a percentage of savings relative and benchmarked to costs. Two-sided (shared savings/risks) models require providers to share in the financial risk by accepting some accountability for costs that exceed the benchmarks.

Total Cost of Care (TCOC) – Calculation that includes the complete range of health care services for patients typically used in population-based or shared savings payment methodologies.

Value Based Payment (VBP) – A strategy used to promote quality and value of health care services. The goal of VBP is to shift from volume-based payment, such as fee-for-service, to payments that are linked in some way to evidence-based processes and/or patient outcomes.

AARP New Jersey
AbleTo, Inc.
Advocates for Children of New Jersey
Aetna Better Health of New Jersey
Alliance for the Betterment of Citizens with Disabilities
American Cancer Society
Amerigroup New Jersey, Inc.
Amerihealth Caritas
Autism New Jersey, Inc.
BAYADA Home Health Care
Beacon Health Options
Camden Coalition of Healthcare Providers
CarePlus New Jersey
CarePoint Health System
Carrier Clinic
Center for Health Care Strategies
Centers for Medicare and Medicaid Services
Central Jersey Family Health Consortium
Chamberlain College of Nursing
Children’s Specialized Hospital
Christian Health Care Center
CMH Consulting Group, Inc.
Collaborative Support Programs of New Jersey
Communications Workers of America Local 1081
Community Care Behavioral Health Organization
Community Health Center Visiting Nurse Association of
Central Jersey
Consulting Knights, Inc.
Continuum Health Alliance
Cooper University Health Care
Coriendo, LLC
Daughters of Miriam Center/The Gallen Institute
David G. Kostinas & Associates
Deborah Heart and Lung Center
Disability Rights New Jersey

Division of Medical Assistance and Health Services
 EMET Realty
 First Children Services
 Fox Chase Cancer Center Temple Health
 Fox Rothschild LLP
 Gateway Health Plan
 Geisinger Health System - Atlanticare
 Get Going, LLC
 Gibbons P.C.
 Greater Newark Healthcare Coalition
 Greater Trenton Behavioral HealthCare
 Health Care Association of New Jersey
 Health Professionals and Allied Employees
 Healthy Greater Newark Accountable Care Organization
 Henry J. Austin Health Center
 Hoagland, Longo, Moran, Dunst & Doukas, LLP
 Home Care and Hospice Association of New Jersey
 Horizon Blue Cross Blue Shield of New Jersey
 Horizon NJ Health
 Hospital Alliance of New Jersey
 Inspira Health Network
 Integrated Care for Recovery
 Integrity, Inc.
 Janssen Pharmaceuticals, Inc.
 Jersey City Medical Center
 JFK Health
 Komjathy and Kean
 Labor Health Alliance
 Leading Age New Jersey
 Legal Services of New Jersey
 Lewin Group
 LifeSpan Care Management, LLC
 Lilly USA LLC
 Manatt, Phelps, and Phillips, LLP
 March of Dimes
 Marwood Group
 Maxim Healthcare Services
 MDA Advantage Insurance Company of New Jersey
 Medical Society of New Jersey
 Mental Health Association in New Jersey, Inc.
 Metropolitan Family Health Network
 National Council on Alcoholism and Drug
 Dependence - New Jersey
 National Partnership for Women & Families
 New Haven Legal Assistance Association
 New Jersey Association of Community Providers
 New Jersey Association of Health Care Social Workers
 New Jersey Association of Health Plans
 New Jersey Association of Mental Health and Addiction
 Agencies, Inc.
 New Jersey Association of Nurse Anesthetists
 New Jersey Citizen Action
 New Jersey Family Planning League
 New Jersey Hospital Association
 New Jersey Innovation Institute
 New Jersey Oral Health Coalition
 New Jersey Policy Perspective
 New Jersey Primary Care Association
 New Jersey Reentry Corporation
 New York City Health and Hospitals
 Newark Beth Israel Medical Center Children's
 Hospital of New Jersey
 Northeast Carpenters Fund
 Novartis Pharmaceuticals Corporation
 Oaks Integrated Care
 Optum Data Management
 Pfizer
 Planned Parenthood of Northern, Central and
 Southern New Jersey
 Quality Outcomes Healthcare Consulting
 Regional Cancer Care Associates LLC
 RubiconMD, Inc.
 Rutgers Center for State Health Policy
 Rutgers New Jersey Medical School
 Rutgers University Behavioral Health Care
 Rutgers University School of Public Health
 RWJ Partners
 RWJBarnabas Health
 RWJBarnabas Health Behavioral Health Center

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Planned Parenthood

Saint Peter's Healthcare System
Salem County Board of Social Services
Senior Whole Health
Seton Hall University School of Law
St. Joseph's Healthcare System
St. Joseph's Regional Medical Center
Statewide Parent Advocacy Network
Supportive Housing Association of New Jersey
Tabula Rasa HealthCare, Inc.
Teladoc
The Arc of New Jersey
The Boggs Center
The Innovations Collaborative, Inc.
Trenton Health Team
Trinitas Regional Medical Center
UnitedHealthcare Community Plan New Jersey
UnitedHealthcare Community Plan Ohio
United Hospital Fund - Medicaid Institute
University Hospital
ViiV Healthcare
Virtua Health System
Virtua Marlton Hospital
VITAS Healthcare
VNA Health Group
VNA Health Group Center for Primary Care
and Public Health
WellCare Health Plans of New Jersey, Inc.
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Zufall Health Center

We apologize for any omissions.

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Dentist
Chair, New Jersey Oral Health Coalition

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Appendix 6: Steering Committee List

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President and CEO
NJ Health Care Quality Institute

Judith Persichilli
President Emeritus
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Steering Committee Members:

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Former NJ Congressman;
CEO, Health Transformation Alliance

Heather Howard JD
Former NJ Department of Health Commissioner;
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Appendix 7: Background – Medicaid Eligibility and Enrollment

New Jersey Medicaid has made significant advancements in eligibility processing. For example, there is now an online application for most Medicaid categories and the County Boards of Social Services (CBoSS) have been encouraged to use an administrative process for renewals that avoids the need for an exchange of documentation between the State and eligible families.

However, despite these advances, the system remains fragmented, leading to delays in application processing as well as unnecessary levels of formal (paper) renewals. Having both Xerox and the CBoSS responsible for many of the same things inevitably leads to confusion for the applicants. The 21 individual County Boards of Social Services receive eligibility instructions from the State, but oftentimes are free to interpret the State's guidance as they see fit (since the County is ultimately footing the bill). This leads to disparate policy interpretations from county to county that directly impact families trying to negotiate what is already a very complex process.

There has been no performance analysis of the eligibility system as a whole. Xerox is measured for contract performance, but the County Boards of Social Services operate without any performance benchmarks in large part because of the lack of standard automation. The

State had been working on a technology solution for the last decade, but that effort was abandoned in 2015. Without a system in place to collect the processing data, such as time lag from receipt to approval/denial, it is impossible to measure the system's performance. The lack of data and standardization limits meaningful improvements in the future and hinders the State's ability to provide any incentives for a more efficient system.

Improvements in processing will improve timeliness, lead to higher consumer satisfaction and reduce costs; and for counties, it will become a potential source of property tax relief.

Customer Service

In addition, the use of traditional work hours by the CBoSS limits a working family's ability to garner technical assistance in completing applications. For those with more complicated needs, such as long-term care or disability, eligibility involves not just a financial test but also a clinical assessment (sometimes done through a separate federal agency) to determine level of need. Other than the CBoSS representatives, there are no formal supports available for individuals that need assistance with their Medicaid application.

Appendix 8: Background – Behavioral Health Integration

Current New Jersey Behavioral Health Landscape

The ACA Medicaid expansion has infused the adult behavioral system with new funds and resources allowing the State to increase rates and expand the scope of services, particularly for Substance Use Disorder (SUD). However, for the most part, these services remain outside the Medicaid managed care delivery system which provides all other health care services for beneficiaries. Behavioral health services are provided largely through a network of hospitals and community providers. SUD services are managed by an Interim Managing Entity (IME) that provides oversight and coordination of SUD services.

Reimbursement for most of these services is being converted from contract based reimbursement to fee-for-service system and is scheduled to go into effect July 2017. In July 2016, the State increased reimbursement by \$127M (State and federal dollars) to improve access and better align reimbursement for behavioral health services. We note that, for the purposes of the following recommendations, however, adequate reimbursement for an integrated care delivery system must promote a sustainable delivery infrastructure, including staffing models, physical plant requirements, and continued unmet needs of underinsured individuals.



Integration of Physical and Behavioral Health Services

The integration of physical and behavioral health is a cornerstone of Medicaid reform. Isolated by funding and State agency boundaries, the historical dysfunction among these services is pervasive at every level of the delivery system. Beneficiaries using mental health services, must overcome the persistent stigma associated with behavioral health services and then be subjected to care delivery and payment systems that remain mostly bifurcated. Under these conditions, there is little incentive – financial or otherwise – for medical providers and behavioral health providers to coordinate care, leading to suboptimal health outcomes for individuals.

There is no designated point of accountability for the whole person needs (physical and behavioral health) and because services are often delivered in siloes, gaps and interruptions in treatment result particularly during transition between care settings and during major life changes (such as being released from incarceration; aging out of DCF; I/DD transition to adult system). These problems are exacerbated by limited community capacity, which prohibits behavioral health services from being provided in the most appropriate, lowest-acuity settings possible, including less intensive outpatient and primary care settings. The opportunity to screen individuals to identify and effectively treat their behavioral health needs in the lowest acuity setting and coordinate necessary services is timely and represents best practice. Medicare, for example, is reimbursing as of January 1, 2017 for integrated mental health professionals in primary care practices. For these reasons, the integration of physical and behavioral health is now a major goal in the State's waiver renewal. Per the renewal, the State's objective is "to achieve better care coordination and the promotion of integrated behavioral and physical health for a more patient centered care experience, and; to offer aligned financial incentives and value-based payments."

To illustrate how this lack of integration impacts the lives of Medicaid beneficiaries consider the following example:

Sam is a 59 year old single white male, who lives independently in an apartment. He has struggled with delusions and auditory hallucinations, which have been treatment resistant. He has a sister who lives locally and works full time with small children. Sam has done rather well within the community, enjoying watching sports and intermittently attends a day treatment program.

Over the past 5 years, Sam developed chronic cellulitis on his lower left leg. He had difficulty identifying physical symptoms of illness, so his physical illness would progress unnecessarily. He often needed wound care, however transportation was an ongoing struggle in ensuring his needs were met. As he was mobile, he was unable to obtain home care and often would miss his appointments. He would be hospitalized for lower leg infections without the knowledge of his psychiatric provider. Upon presentation to his psychiatrist, it would be noted that he had bandages on his left foot. The nursing staff member who was present one day offered to change the dressing, at which time it was observed that 2 toes had been amputated. The client was unaware he had lost 2 toes, and the family was neither aware that he had been hospitalized nor that he had a surgical procedure.

The following could have prevented this outcome:

- *Information sharing between hospitals and providers of care.*
- *Alerts from MCO when a known consumer enters an ER or is admitted to ANY hospital*
- *Ability to outreach and discharge plan with hospital staff and team staff.*
- *MCOs and team working with beneficiaries prior to discharge to ensure services acceptable to the consumer are in place prior to return to the community.*

- *Follow-up with all discharges in a timely manner.*
- *Access to “home checks” to assess physical and mental health issues addressing them immediately preventing ER and inpatient stays.*

Current State of Integration

At the clinical level, behavioral health and physical care are integrated for individuals living with serious mental illness⁶⁷ through the State’s Behavioral Health Home model, which the State intends to expand statewide. For groups that do not fall into the serious mental illness designation – both children and adults – the integration of behavioral health and primary care is emerging, but progress is challenged by inconsistencies in State licensing requirements, lack of available clinicians, and lack of sustainable financing.

At the payment level, the MCOs are only responsible for physical health care needs for the majority of Medicaid beneficiaries. MCOs are only at risk for behavioral health for the MLTSS population (long term care) and individuals with developmental disabilities. In addition, the State’s licensing framework limit the co-location of behavioral health and physical health services. Several aspects of current Medicaid reimbursement impede



behavioral health integration, including limits on billing behavioral health and physical health care on the same day, confusion over what codes can be billed and by what providers, discontinuities caused by the carve out, and the disconnect between clinical best practices for coordinated care and payment codes. As a result of this limited reimbursement, providers can bill only for licensed services, the provision of necessary services is limited and care is neither person-centered nor coordinated. More recently the State has granted case-by-case waivers of its licensing regulations to facilitate co-location, but the State has not put forth a comprehensive co-location strategy.

Administrative Barriers to Integration

The clinical case for integration of behavioral and physical care is now well-established. Over a decade of clinical research establishes that integration of care holds the key to health improvement and cost containment. Innovative care providers have worked to adjust their practice models to incorporate holistic care models, in which mental health, substance use disorder, chronic physical health conditions, and primary care are managed in concert. Care innovation requires thoughtful adjustment of professional roles, and collaboration among professionals and paraprofessionals.

In New Jersey, as in other states, the laws regulating the licensure of care providers have not kept pace with clinical innovation. Licensing regulations are intended to protect beneficiaries and advance health planning goals. Licensing regulations serve these purposes by creating “guard rails” that create structural requirements

within which clinical variation can flourish. Over time, clinical advances and emerging public policy goals require responsive changes in the shape and nature of those guard rails. Separate regulation of substance use disorder, mental health, and primary care may have been responsive to a prior era’s needs.

The current clinical consensus, in favor of integrated care, suggests that such separation is no longer necessary. In fact, the experience of many care providers reveals that this separation is harmful to integration goals. Behavioral health providers have increasingly sought to add some primary care services in order to improve the health status of their beneficiaries. At the same time, primary care providers have sought to add some behavioral health (both mental health and substance use disorder) services to serve their patients not engaged in behavioral health care.

Many of these care providers have experienced regulatory roadblocks. Current regulations do not encourage integrated care, and in some cases frustrate attempts toward integration. Care providers have received confusing and conflicting interpretations of those regulations from licensing personnel. Complying with legacy regulations, administered by separate agencies and divisions, can be time consuming and at times prohibitively expensive. The time and money



devoted to regulatory compliance is, of course, a cost of doing business in health care. It goes without saying that the time and money spent on such compliance should be serving valid patient-protection and health planning goals, and not outdated and superseded regulatory legacies.

Transformation Teams Recommendations – Overarching Principles

The recommendations that follow are based on the overarching principle that the integration of primary care and behavioral health care should be achieved through networks of acute care and behavioral health providers reimbursed through a single funding stream. Two important caveats:

1) These recommendations do not address care for individuals in State institutions or children. Children's mental health services are managed by the Department of Children and Families' Children's System of Care (CSOC), and the State considers the CSOC a national model; and

2) These recommendations do not address the needs of individuals who do not qualify for Medicaid. This would include the remaining uninsured but, equally important, individuals who are underinsured.

Integration Principles:

- Provider payment methods that recognize the

greater complexity of dealing with individuals who experience co-occurring behavioral health disorders and medical disorders;

- Elimination of redundant licensure and regulation;
- Creation of effective standard of care for integrated care delivery and monitoring;
- Development of capable and sufficient behavioral health networks with appropriate medical or behavioral health acute care resources and capable and sufficient acute care primary care provider networks with appropriate behavioral health resources;
- Improved support and incentives for linkages/ collaboration between behavioral health care and acute care medical providers who serve the same individuals;
- Improved outcomes must be measurable;
- Workforce development to cross train behavioral health care and primary care as well as include paraprofessional including peer health navigation and wellness coach roles for skills teaching and ongoing support for health maintenance;
- Expedient and efficient mechanisms for referrals to specialty care, which would permit communication between staff and network providers in order to connect beneficiaries with additional services.



Notes





The New Jersey Health Care Quality Institute is the only independent, nonpartisan, multi-stakeholder advocate for health care quality in New Jersey. The Quality Institute's mission is to undertake projects and promote system changes to ensure that quality, safety, accountability and cost-containment are closely linked to the delivery of health care services in New Jersey.

For more information, www.njhcqi.org.