Medicaid 2.0

Best Practices and Innovations from Other State Medicaid Programs

State	Topic	Best Practice	Lessons Learned and Potential Benefits	How It Could Apply to NJ Medicaid
Ohio	Purchase Authority and Administration	Elevated Medicaid to Cabinet Level and created an Office of Health Care Transformation (OHT).	Direct and immediate access to the Governor was critical to implementation of the reforms; OHT oversight of Medicaid and all other health programs provided comprehensive management of all Ohio health care spending.	Through an Executive Order Medicaid and other health care programs can be reorganized to provide greater coordination of all NJ's health care spending.
Ohio	Value-Based Purchasing	Identified a few key reform models -- CPC+ and bundled payments for episodes of care-- and required all MCOs to implement models across the state.	Using a top down approach helped standardize the use of VBP models and measures and gave providers a clear direction for Ohio's Medicaid goals for the future.	NJ could include provisions within the existing contract to require MCOs to adopt and implement the most promising VBP programs.
Ohio	Value-Based Purchasing	MCOs use community health workers as extenders to assist with case management for high utilizers.	The use of community health workers helped bridge the gap between MCOs, health care providers and social service agencies.	In communities where Medicaid ACOs have not been established, NJ could require the MCOs to identify and engage local health and social agencies' staff to provide enhanced case management services.

Massachusetts	Value-Based Purchasing	To receive DSRIP funding, all ACOs (both MCO and hospital-based) must partner with BH community partners. Community-based BH providers who become community partners will be eligible for some DSRIP payments. DSRIP will also be used to fund flexible services (e.g., air conditioners for asthmatic kids or housing stabilization and supports).	Using DSRIP funds to support community providers will help encourage MCOs and ACOs to incorporate these providers in their networks to provide BH case management. Using DSRIP to pay for social services should help reduce unnecessary emergency room visits and admissions.	The proposed waiver renewal could be modified to include having a portion of the DSRIP payments directed to services outside of the hospital in an effort to reduce the total cost of care.
Massachusetts	Value-Based Purchasing	1115 Waiver proposed 3 ACO models, one of which will allow the State to contract directly with ACOs for two-sided performance risk.	Initiating greater risk sharing options with providers is an important next step in achieving the Triple Aim.	NJ could pilot with a select group of safety net hospital-based ACOs to accept performance risk for the full continuum of services.
Massachusetts	Access and Quality	MassHealth offers multiple ACO options and will limit certain benefits to beneficiaries that do not enroll in an ACO (ie. Chiropractic services and physical therapy)	Engaging beneficiaries in selecting the highest quality providers is challenging without financial levers like copayments. The use of limitations or restrictions may motivate beneficiaries to move to higher quality providers.	Over the longer term, the waiver could be modified to include similar restrictions for beneficiaries but only when NJ has fully implemented a statewide VBP strategy that provides a choice of VBP options.
Massachusetts	Behavioral Health	MassHealth will be receiving federal reimbursement for Transitional Support Services (TSS) and Residential Rehabilitation Services (RRS) for up to 90 days of medically necessary residential treatment. The additional federal funds will be 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.	CMS willingly partnered with the State to identify methods for calculating average length of stay that fit the clinical eligibility criteria.	NJ Medicaid covers short -term residential rehabilitation. The current waiver could be modified to include a request for CMS to cover long term residential care conditioned upon the State reinvesting the State's savings into treatment services.

Connecticut	Access and Quality	Increased access to Specialists and Dental Care	State Medicaid officials made frequent and direct appeals to address provider concerns and increased reimbursement rates to boost participation.	The State could evaluate current participation and engage key provider associations to determine barriers to participation and options that would improve provider participation.
Connecticut	Value-Based Purchasing	Rapidly expanded PCMH around the state and developed a shared savings (upside) programs for FQHCs.	FQHCs were prepared to take risk and PCMHs are receiving supplemental payments of $20k-30k per practice.	NJ could adopt a requirement that all primary care providers become certified as PCMHs (or CPCs) and design a supplemental payment program to reward providers for reductions in the total cost of care.