



Report of the
Healthcare
Transition Advisory Committee

Submitted to Governor-elect Phil Murphy and Lieutenant
Governor-elect Sheila Oliver

January 1, 2018

EXECUTIVE SUMMARY

The Healthcare Transition Advisory Committee proposes that the Governor-elect consider the following recommendations to accomplish these priorities:

- I. Priority: Overall transformation of health goals and enhancement of agency coordination in New Jersey to invest in population health, promote equity, and achieve better health outcomes for all**
 - i. Establish Office of Health Transformation

- II. Priority: Improve the experience, value, and accessibility of health care for all New Jersey populations**
 - i. Expand access to health insurance; reduce premiums; stabilize insurance market and preserve the gains New Jersey made under the Affordable Care Act
 - ii. End “surprise billing” through immediate out of network billing reform
 - iii. Establish a plan to insure all children in New Jersey
 - iv. Introduce a comprehensive plan to improve maternal health and birth outcomes in New Jersey
 - v. Implement Hospice and Palliative Care Best Practices and a Statewide POLST registry to provide patients’ desired End-of-Life treatment
 - vi. Establish options for meaningful use of telehealth in NJ

- III. Priority: Restore, defend, and expand state and federal family planning and access**
 - i. Direct a comprehensive, multi-agency strategy to maximize access to quality family planning care for all New Jerseyans

- IV. Priority: Address the opioid crisis and other substance abuse problems through comprehensive behavioral health integration and reform**
 - i. Initiate immediate education campaigns to target audiences including users, prescribers, caregivers and drug courts
 - ii. End regulatory logjam in Mental Health/Substance Use Disorder services

- V. Priority: Increase health care data access and utilization to promote cost transparency**
 - i. Establish a statewide database to aggregate and utilize claims information

- VI. Priority: Improve patient experiences and the quality and cost effectiveness of care in New Jersey’s Medicaid program**
 - i. Increase the use of evidence-based performance strategies in Medicaid managed care (MCO) contracts and Medicaid regulations.
 - ii. Integrate care for individuals eligible for both Medicare and Medicaid.
 - iii. Develop next-generation Medicaid Accountable Care Organizations (ACO).
 - iv. Identify and Implement Medicaid program efficiencies

REPORT

Health is a prerequisite for full participation in the labor market and public life. A fairer economy requires that we invest in improving the health of the entire state's population and address health disparities to ensure all New Jerseyans have access to quality, affordable health care and improved health outcomes.

The recommendations of the Healthcare Transition Advisory Committee reflect a broad commitment to the Health in All Policies (HiAP) approach in which the state promotes health equity by embedding health concerns into cross-sector decision making. It is essential to promote inter-agency collaborations and to take advantage of innovative opportunities in technology and with our partners in academia and the private sector to address the social determinants of health. The HiAP approach leverages creative, cross-sector solutions and a new policy paradigm to address complex health challenges and prevent rising healthcare costs from crowding out other important policy priorities. Multi-agency strategies that engage external stakeholders and employ public-private partnerships are the next generation of health-promoting cost savers.

The state's population health determinants go beyond healthcare, and include policy areas such as education, housing, environment, and social justice. Governor Murphy has the opportunity to call upon all state departments to include goals for improved health in their decision making, as well as to direct immediate and ongoing attention to systemic racism and discrimination that affects health access and outcomes in our state. We recommend an immediate pledge to the long-term goal of eliminating health disparities in the State of New Jersey.

I. PRIORITY: BEGIN OVERALL TRANSFORMATION TO INCLUDE HEALTH IN ALL POLICIES THROUGH ENHANCEMENT OF AGENCY COORDINATION AND ESTABLISHMENT OF HEALTH GOALS INCLUDING INVESTING IN POPULATION HEALTH, PROMOTING EQUITY, AND ACHIEVING BETTER HEALTH OUTCOMES FOR ALL

i. Recommendation: Establish Office of Health Transformation

New Jersey should establish an Office of Health Transformation (OHT) to guide efficient administration of State health spending and set clear goals for the State to improve overall health system performance.

Historically, crosscutting health care issues have been addressed through ad hoc workgroups convened by the Governor's Office, but the temporary nature of these workgroups leaves implementation issues to the individual departments, and have fallen short in terms of execution. In addition, they are generally structured around major federal legislation impacting the State or a public health crisis such as the opioid epidemic, but execution is hampered by difficulties with operational coordination among the many siloed departments that address health in New Jersey's executive branch.

New Jersey's health care programs have a combined cost of nearly \$20 billion. At a cost of nearly \$15 billion for FY 2016, Medicaid is one of the largest components of the State's budget and it shapes the State's safety net financing. The Medicaid program is largely administered through the Division of Medical Assistance and Health Services (DMAHS) within the Department of Human Services (DHS). The components of the Medicaid program extend to seven additional State departments and divisions. The fractured nature of Medicaid's administration, as well as other health programs, including

the State Health Benefits Program (SHBP), can lead to competing priorities and inhibit the State's ability to effectuate cohesive statewide health policies.

State departments often face competing priorities because the State serves as both a regulator (licensing and inspections) and the payer (Medicaid and SHBP). For example, Department of Health (DOH) decisions regarding the expansion of licensed services, like home health care, 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 OHT should coordinate strategic health planning and setting of goals among all Departments and Divisions. The OHT would promote aligned quality and performance metrics for all state-funded health services, improve consistency of quality among State health programs, promote transparency and measurement across programs, and most importantly, improve the continuity and experience of care for patients as they traverse delivery systems (physical health, mental health, school-based clinics, Medicaid, long-term services and supports).

In addition, the OHT would be responsible for achieving major objectives indicated in this report 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 across all State programs (especially Medicaid and SHBP). Lastly the OHT should facilitate shared services between agencies that address both health concerns and the underlying social determinants of health, including legal, communications, procurement, and contracting services. The OHT should be accountable for supporting all agencies to efficiently share information, integrate data sets and analyses, facilitate collaboration, and establish and accomplish shared goals for their programs.

The OHT can be created by Executive Order within the first 100 days of the new administration, and the office's location would be best determined by the Governor. We recommend that the OHT be led by an Executive Director with a small, nimble staff with extensive health policy and government experience. To the extent possible and to assure that OHT has access to the best program expertise in the State, existing staff with deep expertise from State health programs and New Jersey universities should be invited to work with OHT. The Governor should direct cabinet members to fully cooperate with the OHT.

Costs: Depending on the actual size and composition of the OHT team, the office would need funding for salaries, a portion of which may be offset by Medicaid federal matching funds, to the extent permitted under federal guidelines.

II. PRIORITY: IMPROVE THE EXPERIENCE, VALUE AND ACCESSIBILITY OF HEALTH CARE FOR ALL NEW JERSEY POPULATIONS

- i. Recommendation: Preserve the gains New Jersey made under the Affordable Care Act (ACA), work to expand access to good health insurance coverage at the lowest possible premium, and introduce measures to assure stability of the insurance market**

According to the latest numbers from the U.S. Census Bureau, New Jersey's uninsured rate is at 8%, the lowest the state has seen in three decades. This is in large part due to the coverage advances made under the ACA, specifically through the law's Medicaid expansion and federal marketplace premium subsidies. Nearly 70% of New Jersey enrollees in the individual market have plans issued via the marketplace, and of those roughly 80% received a subsidy in 2017 and an estimated 52% also received a cost sharing subsidies.

However, federal government actions, including defunding cost-sharing subsidies, a cut in outreach and marketing funds, and a shortened open enrollment period, all aimed to weaken the ACA. The federal tax legislation's repeal of the ACA's individual mandate will likely affect the individual marketplace and its ability to provide affordable coverage options, with premiums expected to rise in 2019 by 10% or more.

The next administration should consider pursuing the following approaches that could lower individual market premiums and stabilize the insurance market:

1. Review the feasibility of creating a reinsurance program for plan year 2019 and developing an ACA Section 1332 innovation waiver to secure federal funding to support it. Alaska pioneered this approach in 2017, and saw a large decrease in premiums.
2. Foster ACA and Medicaid enrollment through new State-led consumer outreach campaigns, and in particular work with community groups and health providers to target hard-to-reach populations, including immigrant communities and young adults.
3. Work with the legislature to review whether creating a state-based individual coverage incentive can help promote coverage affordability in the individual marketplace in New Jersey, in response to the federal tax legislation that repealed the ACA's requirement that most individuals have coverage or pay a tax penalty.
4. Work with employers in the state to explore a shared responsibility fund for those who do not provide affordable health insurance for workers that would offset the cost of covering uninsured workers in the New Jersey individual marketplace.

To create a reinsurance program for plan year 2019 and submit an ACA Section 1332 waiver, the state must pass authorizing legislation. This legislation must include a reinsurance fund and establish a funding mechanism. Legislation would also be required to establish a state-based incentive to purchase and maintain coverage.

Costs: Funding for outreach and enrollment would likely be from the general fund. Funding to seed the reinsurance fund could come from an insurance assessment or Third-Party Administrator assessment (not the general fund), and the use of the Section 1332 waiver would recoup significant federal funding for the program. Until the specific reinsurance proposal is drafted, it is difficult to provide an initial state funding estimate. Other states' 1332 waiver proposals had state funding ranging from \$16 million to \$271 million. The budget impact of a state-based incentive to purchase and maintain coverage is uncertain and will depend in part on its specific design, but revenue streams to support these and other reforms would likely be needed. If a penalty were imposed on individuals who could afford coverage but elect to remain uninsured, then those funds should be used

to assure future stability in the individual marketplace (e.g., by helping to fund reinsurance, outreach and enrollment activities, or premium subsidies).

ii. Recommendation: Protect New Jersey’s health consumers through reform of “surprise billing” and unfair out-of-network medical claim practices

Currently, New Jersey law offers protection from “out-of-network” and “surprise medical” bills to consumers in state-regulated (“i.e., fully insured”) plans and the State Health Benefit Program. Some out of network providers take advantage of this protection by charging very high out-of-network fees for emergency and surprise situations, when individuals may be physically or emotionally unable to provide consent. Health plans are required to pay these escalated charges, adding millions to costs paid by employers (including the State) through higher premiums and consumers through higher coinsurance and deductibles.

The Governor should work with the legislature to enact legislation to end surprise billing within his first 100 days in office. Legislation should ensure consumers are protected from surprise medical bills and employers are protected from inflated out-of-network billing.

Costs: Estimates of savings to the state and consumers have ranged from \$50 – \$133 million annually.

iii. Recommendation: Work to protect the Children’s Health Insurance Program and establish a plan to insure all children in New Jersey

Today in New Jersey, about 3.5% of individuals under 18, or about 70,000 of our children, are uninsured. An estimated 35,000 uninsured children are undocumented, 23,000 are eligible but unenrolled in Medicaid, and other children 12,000 exceed Medicaid’s income cut-off. Despite New Jersey having the second highest eligibility level nationwide at 350% of the federal poverty level, and achieving significant coverage gains post-ACA, the mission of insuring all children remains unfinished. The uninsured rate for Latino children is three times higher than for white children. Eliminating health disparities for children in our state is critical to ensuring long-term health, education and economic opportunity. There are clear benefits to insuring children, as it increases graduation rates, creates better health outcomes, including lower obesity and high-blood pressure rates, lowers teen pregnancy rates, and increases economic security for children and their families.

As of the writing of this report, the future of the Children’s Health Insurance Program (CHIP) was uncertain. In December, Congress passed a short-term spending bill that extended CHIP through March 31, but a number of states are set to run out of money before then. New Jersey can sustain its CHIP until the second quarter of 2018, but would then run out of federal funds to support the program. Advance notice must be sent to parents so they can seek other forms of coverage, and will need to be spend almost immediately. If Congress does not continue CHIP funding, the state would be required by New Jersey law to cover about 90,000 Medicaid-eligible CHIP children, but at the standard 50-50 match instead of the CHIP federal match of 88%.

Keeping these children on CHIP is an urgent priority, and covering all New Jersey children should be a high priority, with foundational steps taken in the first six months as described below. Increased outreach and enrollment efforts combined with Medicaid system improvements described in this report will also help.

- In the first 100 days, the Governor should establish a workgroup of stakeholders and organizations representing diverse consumers in NJ to propose a plan that would result in providing health care coverage for all children within four years. The plan should build upon the success of NJ Family Care, and also take into account CHIP funding and other federal budget proposals that threaten to reduce coverage for children in New Jersey.
- Require the Department of Human Services to take administrative actions to reduce the number of children who are uninsured, including improving and expediting the eligibility process.

Costs: Early planning requires minimal funding but relies upon sufficient staffing, especially for the Medicaid division, and dedication of a portion of enrollment funding to outreach for children. Commitment of state funds is required to achieve longer-term coverage for New Jersey children.

iv. Recommendation: Introduce a comprehensive plan to improve maternal health and birth outcomes

Despite concerted efforts to improve maternal and child health, women in New Jersey still experience suboptimal outcomes and disparities by region and race. Annually in New Jersey, nearly 500 babies do not live to see their first birthday. New Jersey's black infant mortality rate declined by 30% to 9.7 deaths per 1,000 live births by 2015, lower than the national rate of 11.4 deaths per 1,000 live births. However, this rate far exceeds New Jersey's white infant mortality rate of 3 per 1,000 live births. This infant mortality gap is the largest in the nation. But we can do better: up to 60% of maternal complications are estimated to be preventable.

New Jersey ranks 19th nationwide for women and children's health, according to the 2016 America's Health Rankings report from the United Health Foundation. The report also found that women's deaths related to pregnancy or childbirth are on the rise in New Jersey, citing at least 36 maternal deaths per 100,000 live births, compared to 20/100,000 nationwide. The report also noted that health disparities occurred between white mothers and women of color.

Currently, the State pays for 42% of all births through the Medicaid program, making Medicaid an ideal platform to apply evidence-based practices targeted at health disparities, with applications in commercial markets as a longer-term priority.

We can save lives, improve birth outcomes and reduce spending by prioritizing maternal health and child health improvements. Over time, better birth outcomes will improve life chances for children.

Steps should include the following:

1. Improve access to family planning and make contraception more available and affordable for all women, with particular emphasis on education about the health benefits of planning for pregnancies.
2. Educate and inform providers and patients about optimal prenatal care and delivery practices. The state should partner and support programs that provide peer-to-peer mentoring and other evidence-based practices that educate mothers and achieve better birth outcomes, especially for high-risk populations.
3. The state can create payment incentives for best practice patterns and reward doctors who provide better quality care, lower rates of early elective deliveries, and engage in other practices that create better birth and health outcomes.
4. The state should explore using appropriate “behavioral nudge” incentives to promote adherence to prenatal care recommendations and address risk factors (e.g., smoking during pregnancy) in the Medicaid program.

Costs: These proposals offer high returns on investment and promise reductions in disparities while strengthening families. These programs may incur short-term costs, but will change the way existing dollars are spent and ultimately save money and improve lives.

v. Recommendation: Implement hospice and palliative care best practices and create a statewide registry to assure that healthcare providers have access to patients’ advance care preferences for end-of-life treatment

Palliative care for patients with serious illnesses ensures that treatment reflects each patient’s values and preferences, which in turn improves quality of life and reduces suffering. This can lead to lower avoidable costs for both the patient and the system, for example well-managed pain reduces the frequency of emergency room visits and hospital admissions. Currently care near the end of life care often neglects patient’s needs and wants, exacerbating excessive expenditures in the last year of patients’ lives and burdening patients, providers, and society as a whole.

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 visits, and trains providers to have these important conversations with their patients. The POLST registry offers patients with advanced progressive illness or frailty a practical tool to ensure their wishes for medical treatment will be known and honored in times of crisis.

Within the first 100 days, the Governor should direct the Department of Health to create a comprehensive plan to increase provider and public awareness of the value of the POLST registry and Advance Directives, and explore policy options to implement a statewide POLST registry. The Department of Human Services should explore adding a Medicaid benefit to reimburse for advance care planning consultations, as is done in Medicare and most commercial plans.

Costs: Costs associated with advance care planning consultations in Medicaid would be relatively small – if 10,000 visits occur in the first year, the total cost (half federally funded) is estimated to be \$860,000 (if the state pays the same rate as Medicare). Ultimately, however, these consultation costs would be offset by reducing avoidable emergency department and hospitalization costs

vi. **Recommendation: Establish options for meaningful use of telehealth in New Jersey**

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 care. Around the country, there are intriguing examples of how telehealth can transform health care and access.

The Governor should direct relevant State agencies, including Medicaid, Health, Education, SHBP, and Corrections, to improve accessibility to telehealth, including examining licensing and reimbursement barriers, and establishing options for the State to use telehealth to provide health benefits to diverse populations.

Cost: Currently unknown; establish during deliberations or via estimates.

III. **PRIORITY: RESTORE, EXPAND, AND DEFEND STATE AND FEDERAL FAMILY PLANNING FUNDING AND ACCESS TO FAMILY PLANNING CARE**

i. **Recommendation: Direct a comprehensive, multi-agency strategy to maximize access to quality family planning care for all New Jerseyans**

Family planning providers are an essential part of New Jersey’s health care delivery system. Family planning services include contraception, screenings for sexually transmitted infection, cervical and breast cancer, diabetes, blood pressure, and intimate partner violence, as well as certain treatments. Through prevention, early detection, and timely treatment, family planning services yield cost savings, health benefits, improvements in productivity, and life opportunities.

In New Jersey, family planning services are delivered by multiple health care providers, including Planned Parenthood. For New Jersey’s low to moderate income residents, publicly-funded family planning services are often the only option, providing care to over 100,000 New Jersey women in 2014. There remains tremendous unmet demand.

Family planning is currently publicly funded in New Jersey through a combination of the federal-state Medicaid program, federal Title X funding, and state-only dollars. Over the last eight years, critical state funding for family planning services was eliminated, resulting in closed clinics, reduced access, and increased preventable illnesses disparately affecting lower-income populations of color statewide.

The Governor can restore, defend, and expand family planning services, starting immediately. **Restore** state family planning funding and expedite facility progress through legislation that calls for an immediate reinstatement of \$7.5M of annual funding, including a prorated amount for the current fiscal year. Reinstatement of any portion of the \$56M in state funding cut by the prior administration over eight years should be considered and advanced as budgets allow. Draw enhanced federal Medicaid matching funds for family planning services to the maximum extent permissible. **Defend** federal family planning funding including administrative filing of a State Plan Amendment to the federal Medicaid program to secure additional federal funds for women’s health services and considering entering multi-state partnerships to advocate for federal funding. **Expand** family planning services by examining public-private partnerships to better

position family planning providers to serve uninsured New Jerseyans, removing unnecessary barriers to care provision and supporting family planning provider training pipelines through partnerships with educational and workforce initiatives.

IV. PRIORITY: ADDRESS THE OPIOID CRISIS AND OTHER SUBSTANCE ABUSE PROBLEMS THROUGH COMPREHENSIVE BEHAVIORAL HEALTH INTEGRATION AND REFORM

To be effective in responding to the crisis, the State must reform the fragmented and inefficient behavioral health infrastructure in which opioid addiction and other substance use disorders overlap with broader mental health issues. Initial efforts for the new administration therefore include both educational and regulatory responses.

i. Recommendation: Initiate immediate education campaigns to target audiences including users, prescribers, caregivers, and drug courts

Recent research has shown startlingly high rates of opioid prescribing in New Jersey. Getting proper information out to affected populations is an essential strategy that can be improved with little additional funding. Informational campaigns and focused leadership ending delivery system fragmentation will help in the short and medium term, without substantial expenditures.

Implementation strategy, timing and costs:

- Begin a public information campaign to alert opioid users to the enhanced risk of death from heroin purity and fentanyl substitution.
- Fully support syringe exchange programs. They are effective reducing disease transmission and could serve as a hub for outreach/education. The Department of Health should convene a summit to engage key stakeholders to develop additional prevention strategies.
- The Attorney General should work to improve prescriber awareness, building on the work of the NJ Division of Community Affairs improve prescription monitoring and opioid education efforts.
- Provide outreach to caregivers and drug courts about medication-assisted treatment (MAT), including buprenorphine and naltrexone, to improve user survival, increase retention in treatment, and decrease illicit opioid use. Many caregivers can provide MAT care with available Substance Abuse and Mental Health Services Administration (SAMHSA) accreditation. Other steps could be initiated in the first 100 days, including: Nasal Narcan access could be supported through negotiations/bulk purchase from Amphastar; creation of an EMT/police working group to initiate Narcan-to-treatment pathway; and working with Division of Consumer affairs and innovative pain management physicians to safeguard access to pain meds.

All of these strategies could begin in the first 100 days and be carried out at minimal cost.

ii. Recommendation: End regulatory logjam in Mental Health/Substance Use Disorder services

There is substantial crossover in the populations using mental health and substance use disorder services. The care system is dangerously fragmented; evidence shows that

patients/clients receive improved care in integrated settings. New Jersey's regulatory systems unnecessarily frustrate the implementation of integrated clinical care, leading to shortage of appropriate care for those in crisis, and for those whom crisis could be avoided.

Steps should include:

- Announce urgent plan to clear applications for integrated behavioral care within 6 months. Regulatory waivers and agency focus can accomplish this, and demonstrate good faith as to this long-standing problem at little or no cost.
- Conduct a "listening tour" in the first 100 days to explore behavioral health regulatory reform with advocates, caregivers, consumers, and community health organizations to highlight the commitment to create a unified licensing process for integrated behavioral health care, and to transparent and updated Medicaid reimbursement for integrated services.
- Create a working group (dedicated agency staff and select outside representatives) to update and rationalize payment and licensing policy.
- Develop an inventory of service providers from acute detox to community support to facilitate referrals and planning, including for hard-to-reach groups such as pregnant women and reentering prisoners.

V. PRIORITY: INCREASE HEALTH CARE DATA ACCESS AND UTILIZATION TO PROMOTE COST TRANSPARENCY

i. Recommendation: Establish a statewide database to aggregate and utilize claims information

The state should work across all departments within the first 100 days to create a statewide plan for reporting and use of claims data, as well as integration with health information exchanges and other data sets to support health improvement and cost savings across programs. These efforts could be accomplished through the Office of Health Transformation.

Cost, claims, and clinical outcomes data are prerequisites to evidence-based policymaking, state purchasing and consumer empowerment. State leadership is required to prompt, maintain and disseminate this type of robust data collection. Although voluntary initiatives add value, the state should comprehensively track performance across variables, measure health care utilization, determine effectiveness of public policy, support quality improvement and ultimately target cost drivers. Other states have moved ahead to leverage statewide data collection while data opacity in New Jersey continues to limit access to actionable information.

In order to ensure full participation, legislation is the optimal route to require payer participation in a statewide all-payer claims database (APCD) or similar database. If an APCD is the preferred vehicle, participation by ERISA self-insured plans may present a challenge. Other states, including Florida, have engaged the non-profit Health Care Cost Institute (HCCI) as a viable option for data collection and New Jersey should explore similar opportunities as well as collaboration with state universities and Medicaid data transparency initiatives discussed herein.

Cost: Some new resources would be required to establish an APCD, which could come from a reallocation of current insurer taxes and Medicaid funds (possibly with a federal match). User fees could offset APCD operating costs over times.

VI. PRIORITY: IMPROVE PATIENT EXPERIENCES AND THE QUALITY AND COST EFFECTIVENESS OF CARE IN NEW JERSEY'S MEDICAID PROGRAM

Improving the health and well-being of all New Jersey residents is essential to an inclusive, dynamic economy and to maintaining thriving communities. The Medicaid program covers some of the most vulnerable among us, including children, pregnant women, low-wage workers, the disabled, and the elderly. The program's reach makes it an ideal vehicle to simultaneously reward quality and value while addressing inequities and disparities. New Jersey's Medicaid program should be consumer-centric, provide equitable reimbursement to quality providers, and be accountable to regulators and taxpayers. Specifically, a high-performing Medicaid program is one that advances the triple aim:

- Improving the patient experience of care (including quality and satisfaction);
- Improving the health of populations; and
- Stemming the rise in per capita cost of health care.

Current Situation: Medicaid in New Jersey today

Medicaid is the federal-state public health insurance program for low-income Americans and certain categories of disabled populations. It is also the single largest source of federal funding for the State. Medicaid currently provides health insurance coverage for almost 1.8 million New Jersey residents including 552,000 New Jerseyans who gained Medicaid coverage through the ACA Medicaid expansion. Over 40% of New Jersey's children are insured by the Medicaid program. The program covers 42% of births and 65% of nursing home care.

The annual federal-state Medicaid budget for New Jersey in FY 2016 was almost \$15 billion under a 50-50% federal-state funding formula. 20% of New Jersey's annual state budget is dedicated to the Medicaid program. The importance of Medicaid to its beneficiaries and to the entire health care system cannot be overstated. Any federal changes to this system will have significant cradle-to-grave care repercussions and will dramatically alter New Jersey's overall health care system.

Today, looming threats target the New Jersey Medicaid Program. The federal government is considering strategies to contain or reduce its share of Medicaid funding. Although Congressional proposals which would have cut \$800 billion nationally from Medicaid over the next ten years failed, they are expected to resurface. Recently-enacted federal tax legislation would significantly add to the federal debt and likely result in calls for entitlement reform, including cuts to Medicaid and other safety net programs that would starve the state of resources needed to continue vital programs.

Below are four recommended actions that can begin within the first six months of the Governor's term to advance these goals:

i. Recommendation: Conduct assertive outreach and enrollment efforts and continue to streamline eligibility determination procedures

New Jersey Medicaid enrollment dropped from an August 2016 high of 1,768,494 to 1,753,770 individuals by November 2017. Nevertheless, significant numbers of New Jerseyans remain eligible but unenrolled in the program: as of 2016, 36% (or 335,000) of New Jersey's uninsured population is eligible for Medicaid. This number includes approximately 23,000 of New Jersey's 70,000 uninsured children who are Medicaid-

eligible but unenrolled Many individuals have not been reached due to limited funding for outreach and enrollment efforts, others find the eligibility process cumbersome, and families with mixed immigration status have confusion about eligibility.

NJ should immediately: (1) issue a Call to Action among advocates and stakeholders to provide targeted Medicaid enrollment and renewal assistance to individuals and (2) complete essential upgrades to Medicaid eligibility systems while holding eligibility determination workers accountable for timely and accurate processing. The State should lead and engage Medicaid Managed Care Organizations (MCOs) in an effort to retain eligible enrollees in the program.

Costs: Federal contributions for enrollment assistance include 50% federal contribution for Medicaid outreach; 65% federal funding for CHIP outreach if administrative funds are available under the existing allocation; eligibility processing costs are matched with 75% federal funding and upgrades to the IT system are matched at 90%.

ii. Recommendation: Integrate physical and behavioral health services to improve care overall and address the opioid crisis

Evidence-based care for people with substance use disorders and mental health needs is best provided in a clinically integrated setting. People with opioid addictions, for example, are best treated in settings in which primary care and co-occurring mental health needs are addressed. Regulations should provide for a unified, single license for integrated physical and behavioral health care. As an interim measure, the State could create a single point of entry and coordinated review of licensing for outpatient facilities, in order to get appropriate care on line as soon as possible.

Medicaid has an important part to play if the state is to encourage integrated clinical services. To date, Medicaid has “carved out” most behavioral health care from its MCO contract, resulting in gaps in coverage, and its fee-for-service payments too frequently create barriers to coordinated care.

In the first 100 days, the State should clear the backlog of applications for licenses to provide integrated outpatient services, using waivers when necessary. This short-term reform will enable sensible care for opioid addiction and other illness—from acute, to transitional, to community care. Advocates and the care-giving community have been requesting these actions for several years.

In the first six months, reform the Medicaid MCO contract to carve-in behavioral health to support integrated care. Also in the first six months, the Department of Banking and Insurance (DOBI) should begin to engage in active outreach to health insurers to establish, the State’s commitment to parity in mental health and addiction services in response to anticipated federal inaction, and to encourage insurers’ movement to value-based payment methods to improve coordination of care for the privately insured. Insurers are already inclined to move in this direction.

The cost of these actions would be administrative/professional time only.

iii. Recommendation: Advance evidence-based strategies to improve patient-experiences, quality and cost-effectiveness of Medicaid

The next administration should increase the use of evidence-based performance strategies in Medicaid managed care (MCO) contracts and Medicaid regulations, and integrate care for individuals eligible for both Medicare and Medicaid.

New Jersey has \$10 billion in contracts with Medicaid MCOs. MCO contracts and associated regulations have developed incrementally over time and have become multi-layered and complicated. Under leadership of the Commissioner of Human Services and involving other agencies of state government, patient advocates, program stakeholders, and outside experts, New Jersey should undertake a compressive review of MCO contracts and associated regulations. Changes should be identified that achieve administrative efficiencies and increase incentives (e.g., value-based payment strategies, pay-for-performance, and delivery system reforms such as patient-centered medical homes) for MCOs to improve patient experiences and the quality and efficiency of care. To the maximum extent permissible, MCO contracts and regulations should also enable and reward MCOs and healthcare providers for helping to address social deterrents of health such as employment opportunities and housing.

People concurrently enrolled in both Medicare and Medicaid (“dual-eligible”) beneficiaries experience high rates of chronic illness and are high cost. Integration of primary, acute, and behavioral health care, and long-term services and supports for dual-eligibles saves money and offer better outcomes. Integration requires investment to prompt clinical and programmatic coordination, but yields substantial long-term benefits.

In New Jersey, we have approximately 175,000 (12%) dual-eligibles among 1.485 million Medicare enrollees statewide. Nationally, in 2011, dual-eligible enrollees accounted for 20% of Medicare enrollees, yet 35% of Medicare spending. The same individuals comprised only 14% of Medicaid enrollees but represented 33% of Medicaid spending.

NJ Medicaid should work with all stakeholders to design a full-integration model for the 175,000 dual-eligibles not already in a Dual-Eligible Special Needs Plan (DSNP) in New Jersey that builds upon the current success of MLTSS. In this context, “full integration” means that funding for both programs flow to one responsible entity like an MCO or a PACE provider where beneficiaries receive their full array of Medicare and Medicaid benefits, with added care coordination, beneficiary protections, and access to additional or enhanced services. The federal government is willing to partner with states to test models.

It is recommended that the Administration convene the Medicaid agency and the Department of Human Services along with participating Medicaid health plans and key stakeholders including consumer advocates and caregivers to design an integrated model complete with consumer protections, improved quality and optimal savings to submit to the Centers for Medicare-Medicaid Coordination Office for approval to offer dual-eligible members in CY 2019.

Costs: Savings to both Medicaid and Medicare can be accrued through better alignment, coordination, and integrated funding streams for all dually eligible members, which in turn result in quality care provided in less acute settings. Currently, approved demonstrations include 1 to 5.5% Medicare and Medicaid capitation rate reductions with the ability of health plans to earn back a portion based on meeting quality measures.

iv. Recommendation: Develop next-generation Medicaid Accountable Care Organizations (ACO)

The current Medicaid ACO demonstration project (established under P.L. 2011, Chapter 114) ends in 2018. Drawing findings from the project evaluation conducted by Rutgers Center for State Health Policy, engaging ACO stakeholders, and working with legislators, the Commissioners of Human Services and Health should develop a plan for a renewed ACO initiative. The new model should continue to address the needs of individuals with complex health and social needs, especially those with avoidable use of high cost health care. Next generation ACOs should be designed to enhance care coordination for complex patients and address social determinants of health including, for example, housing, food insecurity, transportation, job training, education, and legal assistance. The program design should include a sufficient and financing mechanism for the ACOs.

- **Accelerate the implementation of the Integrated Population Health Data (iPHD) Project** (established under NJ PL 2015, Ch. 193), with an emphasis on assessing policy options to address social determinants of health, improve quality of care, and identify efficiencies in state program administration.
- **Develop a Medicaid data transparency initiative.** The Department of Human Services should develop a public-facing Medicaid data website to enable the public to query aggregated information about patterns of and trends in Medicaid utilization and spending by enrollee demographic characteristics and health conditions. The web interface should be modeled on a similar initiative in South Carolina and enable access only to summary data that fully maintains Medicaid enrollee anonymity and confidentiality. The web interface should be compliant with all federal and state privacy laws and contractual obligations to MCOs and Medicaid providers.

v. Recommendation: Identify and implement Medicaid program efficiencies

In the first six months of the next administration, the state can take two important steps to making Medicaid more efficient: 1) implement a universal, statewide credentialing system and improve oversight of providers and 2) establish a Single Pharmaceutical purchasing mechanism.

A shortage of Medicaid providers prevents access to care for beneficiaries in New Jersey. Reducing administrative barriers to provider participation is cited as one of the most effective ways to expand Medicaid MCO networks. Credentialing is the primary administrative prerequisite for providers seeking to join a Medicaid MCO network—providers must be credentialed by each MCO with which they seek to contract. Ideally, the provider enters and maintains his/her data, potentially granting access to multiple payer entities and simplifying the re-credentialing. These standardized platforms also reduce administrative costs and fraud.

Physicians and health plans in New Jersey currently use the universal Council for Affordable Quality Health Care (CAQH) credentialing platform in the commercial health insurance market, which enables providers in all 50 states and the District of Columbia to regularly update their information and make it accessible to multiple health plans and regulatory entities. Credentialing is streamlined via an online platform that collects multiple categories of provider data for various functions. In addition to credentialing, these include claims administration and quality assurance. Earlier State procurement

efforts on Universal Credentialing stalled, but federal law requires the State to implement a solution immediately.

New Jersey should proceed with universal credentialing for the Medicaid program immediately. The federal Centers for Medicare and Medicaid Services requires that the State implement a single source screening and credentialing process no later than January 1, 2018. The Department of Human Services should leverage the existing statewide model here in New Jersey that many physicians currently use in commercial markets-CAQH.

New Jersey spends over \$3.5B annually for pharmaceuticals through Medicaid (\$2B before rebates/\$1.2B net of rebates) and through the State Employee Benefits Program (\$2.3B). Given the scope of spending, the State should leverage its considerable demand to procure pharmaceuticals as cost effectively as possible. Currently, the State Medicaid program includes the pharmacy benefit in every contract with each of five MCOs. In turn, each MCO works with its own Pharmacy Benefit Manager (PBM) or internal vendor, which is then responsible for negotiating prices and paying the pharmacies. Surprisingly, the current system lacks any capacity to verify compliance with federal rebate law, including, for example, ensuring that price growth does not outpace rebates.

The current arrangement raises two critical concerns. One, whether the use of separate PBMs by each of five MCOs yields the most efficient price for these services. This is difficult to determine, however, without data on pricing for the most common prescriptions and how they vary by each MCO's PBM. Secondly, whether using five separate PBMs adds unjustified administrative costs, complexity and chance for error to the system.

In contrast, for the SHBP, New Jersey contracts with one PBM (Optum Rx). Many other states either bid the Medicaid pharmaceutical benefit contract and use one vendor, as New Jersey does for SHBP, or participate in multi-state collective purchasing to leverage greater negotiating power.

The State, through Treasury and relevant departments, should immediately determine the most effective way to purchase all pharmaceuticals procured through State funded programs. If applicable, the lengthy RFP design process should begin immediately.

Costs: Currently these costs are part of administering the program. Universal credentialing will streamline the process and save the program money. Note that the State has no choice but to do this, and is subject to penalties and loss of federal funding if it does not comply. Savings from reforming pharmaceutical procurement could be significant (\$100M+). However, it is important to note the State share of Medicaid savings would be between 30-50% of the total saved.

Co-Chairs:

Dr. Omar Baker
Dr. Shereef Elnahal
Dr. Balpreet Grewal-Virk
Valerie Harr
Heather Howard
Linda Schwimmer
Maria Vizcarrondo

Deputy Policy Director:

Magda Schaler-Haynes

Committee Members:

Hansel Asmar; Renee Baskerville; Cathleen Bennett; Omar Bey; Lisa Bhimani; James Blazer; Triste Brooks; Chrissy Buteas; Gail Callandrillo; Jocelyn Chisholm Carter; Joel Cantor; John Clancy, Jr.; Laurie Clark; Bill Colgan; Jackie Cornell; Alana Cuerto; Mark Daniele; Michellene Davis; Sonia Delgado; Tracie DeSarno; Jon Dolan; Margaret Donlon; Larry Downs; John Fanburg; Madeline Ferraro; Robert Garrett; Pat Gillespie; Dr. Sanjay Gupta; Kyung Hee Choi; Michael Hoffman; Jillian Hudspeth; Stephanie Hunsinger; Suzanne Ianni; John Jacobi; Joni Jones; Arthur Kapoor; The Honorable Patrick J. Kennedy; Deana Lykins; Kelly Maer; Mark Manigan; Iveth Mosquera; Christine Ordway; Obiler Ozio; Les Paschall; Doug Placa; Satish Poondi; Joan Quigley; Natassia Rosario; David Rousseau; Judy Schmidt; Valerie Sellers; Ritesh Shah; Milly Silva; Anthony Slimowicz; Jerry Starr; Christine Stearns; Garrick Stoldt; Ann Twomey; Carlos Underland; Jeff Warren; Anthony Welch; Debra L. Wentz; Dr. Muhammad Zubair.

The Governor, Lieutenant Governor, and the entire senior transition team staff greatly appreciate the immense amount of work, participation and expertise that all our co-chairs, committee members and deputy directors who staffed each committee provided since the transition began in November. This hard work and positive energy about how New Jersey can once again become a national leader has resulted in a robust set of recommended priorities and actions for the incoming administration to consider. As with any collaborative endeavor, many recommendations and opinions were expressed and debated during the committee meetings and the drafting of the reports by co-chairs, committee members, and Deputy Directors. The final reports may contain recommendations that do not reflect the concurrence of all co-chairs or committee members, nor of the organizations they represent. These reports are purely advisory and do not reflect the positions of the Governor-elect or any other elected official.